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It's a birth not a procedure: an ethnographic study of intrauterine fetal death in a labor and delivery unit of an american hospital setting

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**IT'S A BIRTH NOT A PROCEDURE: AN ETHNOGRAPHIC STUDY OF
INTRAUTERINE FETAL DEATH IN A LABOR AND DELIVERY UNIT OF AN
AMERICAN HOSPITAL SETTING**

by

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DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

In partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

2012

MAJOR: ANTHROPOLOGY

Approved by:

Advisor

Date

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DEDICATION

To my family: past, present, and future

ACKNOWLEDGMENTS

A line from one of my favorite movies of all time illustrates my view of the dissertation process: “If it was easy everyone would do it.” The journey has been one of epic proportions and included many key people in the process. I want to thank Dr. Sherylyn Briller, who wore many “hats” as the chair of my committee, mentor, supporter, and alas, editor. What began as an academic relationship over the last nine years has developed into a treasured friendship. I would like to extend my appreciation to the members of my dissertation committee, Drs. Andrea Sankar, Allen Batteau, Stephanie Schim, and Teresa Thompson for sharing their knowledge and expertise along the way. A heartfelt thank you to the nurses, doctors, chaplains, social workers, and ancillary health care staff who warmly welcomed me into the labor and delivery unit and the hospital setting. You made me feel more like your colleague than a researcher.

I cannot thank my family enough for helping me up when I fell down, encouraging and supporting me to stand up and fight when the roadblocks seemed insurmountable. Thank you to my husband John, and my children John Mac and my newest daughter Dominique, Mary, Patrick, and Erin Griffin. Thanks for believing in me especially when I could not believe in myself. Even though my parents Geraldine Frances Flood and Ellsworth Wallace McLeod have passed away long ago, they instilled in me a thirst for knowledge and a desire to pursue my dreams. I learned from my Dad that a “McLeod never gives up” in the face of adversity. They would be so proud of my accomplishments! Thank you

to yet another John Griffin, who many years ago took over the role of my “Dad,” for treating me to many great meals at Thomas’ restaurant and being there for our family in innumerable ways. Thanks to the entire Griffin clan for your support. I remember with love and longing “Mom,” Grace Griffin, who passed away September 9, 2009. I love you all.

During some of my darkest hours when plagued with my own thoughts and insecurities, the women and their families that comprised this research would come to mind. I knew I could not let them down. Their experiences are too important to keep silent. Thank you for welcoming me into your labor rooms and your homes. This research would have not been possible without you!

In addition, thanks to all of my maternity patients throughout the course of my labor and delivery career, particularly those whom I cared for when they experienced a pregnancy loss. You initially sparked my interest in the topic of pregnancy loss that was further fueled by my own pregnancy loss. When I learned I was pregnant for the fourth time, it was also the weekend of my father’s funeral. To this day, I can feel the intense joy and grief that came together on that weekend only to later lose the baby and experience profound desolation.

Finally, we welcomed our first grandchild, a baby boy into our family on September 17, 2011. I firmly believe that a baby is life renewing itself! Thank you Erin Elizabeth for the gift of Ethan Javion Griffin! You are a wonderful mother! Ethan is my bundle of joy, a golden nugget of love!

To all of you mentioned herein and others too numerous to mention who helped me reach my goal, one last word: “I give thanks to God for you in my life.”

PROLOGUE

“It’s a birth not a procedure”

As a professional nurse, it has been a privilege to bear witness and care for women in a labor and delivery unit either during the birthing process that brings forth a “live” newborn or the birthing process juxtaposed with the pregnancy loss process that brings forth a “deceased” fetus. As a young graduate registered nurse I desired to work in a “happy” place such as I perceived labor and delivery to be. I was able to achieve my goal immediately upon graduating with my Bachelor of Science Degree in Nursing. What I was not prepared for, nor did I understand, was that a unit I viewed as “happy” could also bring forth great sorrow for a small group of women and their families who experienced a pregnancy loss, namely an intrauterine fetal death (IUFD). Over the course of my career and alongside my experiences with this specific group of women and their families, I was inspired to investigate the difficult topic of pregnancy loss.

In order to develop an understanding of pregnancy loss it was necessary to examine the subject from multiple perspectives including the women and their families, the health care staff, and my own as a nurse-anthropologist. In addition to investigating these multiple perspectives, it was also important to consider the cultural context of the labor and delivery unit where IUFD occurs.

The original title was, “A study of customary care practices related to women and their families who experience pregnancy loss in a labor and delivery unit of an American hospital setting.” The title has evolved into what it is now as

a result of several factors. Key factors include the long process of my anthropology graduate education, research approval through the University's Institutional Review Board (IRB), yearlong ethnographic study, and subsequent data analysis process. Consequently, I sharpened my social scientist lens and thus, my research title. I became more keenly aware of how nursing and anthropology could work synchronously for the study of IUFD in the labor and delivery unit. As a result, I have come to appreciate the "big picture" as it relates to such a sensitive topic like pregnancy loss. One of the women in my study who participated in a post-hospitalization interview clearly defined her IUFD loss experience as a birth, not a procedure. Her statement was the impetus for changing my dissertation title to, "It's a birth not a procedure," because it better characterizes the IUFD process.

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CHAPTER 1

INTRODUCTION

Statement of Problem

The purpose of this qualitative study was to more meaningfully understand the process when women and their families experience pregnancy loss in a labor and delivery unit of an American hospital setting. Pregnancy loss is a lay term that describes a fetus that dies while still in the womb (Layne, 2003). In a hospital setting, fetal death or mortality is considered a reproductive loss that occurs at any gestational age. Falling under the fetal death umbrella are medical diagnoses such as miscarriage, spontaneous abortion, and stillbirth (MacDorman, Munson & Kirmeyer, 2007). In the labor and delivery unit, fetal death is given the medical diagnostic label of intrauterine fetal death (IUFD).

As a form of fetal death, an IUFD is both a physical and social process that is medically managed in the labor and delivery setting. In a highly death adverse American culture, knowledge about how IUFD with medical intervention is experienced by women and their families in the labor and delivery unit is limited. More knowledge can inform a better understanding of how life, death, and personhood issues are socially and culturally handled during this difficult event for women, families, and health care staff.

The IUFD process, construction of personhood, and meaning making can be anthropologically viewed as a ritualistic process. Ritual, a classic topic in anthropology, has been studied over time and cross-culturally. Ritual is an essential component of all human social action (Durkheim, 1912/1995;

Rappaport, 1979) and in the “constitution of human societies” (Turner, 1967, p. 241). One major area within ritual studies relates to life’s transitions, including birth and death.

IUFD is a birth and death related event that poses a cultural conundrum in American society. On the one hand, childbearing is esteemed in American culture and as a result, it may foster a sense of success (Davis-Floyd, 2003). On the other hand, American culture is highly death adverse often resulting in taboos and silences that serve to reinforce a sense of failure (Layne, 2003). An IUFD is a specific kind of “sad” event juxtaposed on what “normatively” is considered a “happy” event. As such, it is a unique circumstance that invites scrutiny to discover how this birth-death event is handled in a social and cultural context.

The process of birthing, IUFD and their resultant rituals converge, across time and space, to take place within the context of the labor and delivery unit of an American hospital. The hospital is an important location in which to examine the organization of life, death, and personhood. In this setting, health care staff apply their professional principles to provide patient care; however, these principles are never devoid of culture. In this study therefore, I set out to investigate ways in which the construction of personhood is either supported or undermined in this cultural context.

Study Aims and Scope

The aims of this study were to:

1. identify and describe the making of customary care practices related to pregnancy loss in this medical setting.
2. identify and describe how pregnancy loss events are experienced and associated meaning making by women and families.
3. identify and describe the organizational context of handling pregnancy loss events, customary care practices, and associated meaning making by health care staff.

The ethnographic approach is highly relevant for studying fundamental human issues such as the making of categories of birth, death, and personhood. This research study examines how ritual processes that are enacted by women, their families, and health care staff during IUFD contribute to the cultural construction of personhood. These ritual processes take place in the social and cultural context of a labor and delivery unit in an American hospital setting. In this setting, it is important to investigate the ways that the organization supports or undermines the making of personhood.

Ethnography can emphasize the experiential and subjective nature of how humans are determined to be born, alive, dead, and a person over time and in different contexts and settings (Kaufman & Morgan, 2005). Ethnographic methods provide opportunities for in-depth exploration and understanding of IUFD, ritual process, and the making of personhood within the social and cultural context of the hospital setting. As such ethnography allows for the rich description of multiple perspectives of women, their families, and health care staff. In addition, examining what people say, their actions, and use of artifacts

facilitates learning about and understanding how ritual processes related to IUFD support or undermine the making of personhood.

Literature Review

In order to attempt to understand the process when women and their families experience IUFD in labor and delivery, it is important to discuss relevant literature from multiple disciplines that form the foundation for the study of this sensitive topic. The multiple disciplines I focus on here include anthropology and health care related literature, especially from the disciplines of medicine and nursing. Although some of the literature refers to pregnancy loss in general, this study is about one specific type of pregnancy loss that in the labor and delivery unit is known as IUFD.

Ritual Theory

Ritual theory is highly relevant to use as the guiding framework for this study related to IUFD. Such a framework can provide insight into how ritual processes enacted by women, their families, and health care staff during IUFD contribute to the cultural construction of personhood. IUFD is comprised of two life cycle transitions, birth and death. Life transitions such as birth and death constitute a significant area within ritual studies. Therefore ritual theory can be advantageous when investigating how women, families, health care staff, and even communities organize around these transitions.

The work of van Gennep and Turner comprise a large volume of classic, cross-cultural anthropological literature on ritual. More contemporary anthropologists who made significant contributions to ritual theory include

Rappaport and Moore and Myerhoff. These anthropologists were instrumental in situating religious and secular rituals within a theoretical framework, as described next.

van Gennep (1909/1960) was the first anthropologist to coin the term, *rites de passage*, that have key attributes of structure, process, and liminality. The rites of passage are further subdivided as follows: rites of separation, transition rites, and rites of incorporation (p. 11). Individuals, groups, and cultures experience rites of passage as a series of structured, purposeful rites that transform individuals and modify social interactions among communities.

Victor Turner (1967) further characterized transition rites and the liminal state “as a process, a becoming” (p. 94). An individual, group, or society is “betwixt and between the positions assigned and arrayed” by law or custom (p. 95). Turner (1967) considered symbols to be the smallest unit of ritual analysis that includes “objects, activities, relationships, gestures, and spatial units in a ritual situation” (p. 19). These symbols convey messages through verbal and non-verbal communication.

Both van Gennep and Turner assert that rituals occur over time and in the space of a social setting. Rituals, as processual events, are molded by culture and convey meaning to the participants. These ideas must be kept in mind during this research when considering ritual processes that relate to both birth and death during IUFD and how personhood is either undermined or supported in the social and cultural context of a faith-based hospital setting. Women, their families, and health care staff construct meaning around their experiences in the

labor and delivery unit of an American hospital setting. When considering birth and death in a faith-based hospital, both religious and secular forms of ritual are relevant for studying the hospital context.

In addition to rites of passage, some other key characteristics of ritual described by anthropologists Roy Rappaport and Moore and Myerhoff is discussed next. Rappaport demonstrates the formal characteristics of ritual and how regional relationships are regulated. To illustrate, Rappaport (1968) examined pig slaughter among the Tsembaga Maring of New Guinea and its relationship to the ecosystem. The Maring ritual regulated the timing and tempo of war, the quantity of pigs, and people. Rappaport (1971) drew an analogy between the function of ritual and the function of a thermostat. However, a thermostat only regulates temperature and the Maring cycle had many more variables to be considered within ritual.

Following his earlier studies, Rappaport became less interested in the function of ritual and increasingly interested in ritual as a mode of communication among social groups and the deeper meanings conveyed by ritual. Rappaport (1999) describes how messages with complex meaning can be transmitted through non-verbal communication and the use of senses. Ritual that encompasses seeing, hearing, touching, or smelling adds a complexity to meaning beyond what can be communicated through language alone (Rappaport, p. 252).

Rappaport (1999) suggests that communication is the essence of ritual. Rappaport is interested in how socially important secular messages can be

communicated by participants during religious ritual. Rappaport (1971) makes a claim that statements to the spirits are “always” included in religious rituals and relate to the purpose of the ritual (Rappaport, 1971, p. 67). Ritual conveys information about the “physiological, psychological, or sociological states either to themselves or one or more participants” (Rappaport, 1971, p. 63).

Ritual is formal, traditional, and performed at regular intervals in a patterned or repetitive way. These intervals are times determined by the clock, calendar, or special circumstances (Rappaport, 1999). Ritual also has an affective component as well. As such, ritual is comprised of symbolic activities that mark important and transitional times like birth and death.

These transitions may also be considered time of crisis and disruption of the natural order. Therefore, these rituals performed in a variety of contexts also help to promote social connections to the living and the deceased that provide a sense of stability and continuity (Moore & Myerhoff, 1977).

Anthropologists Moore and Myerhoff (1977) also identified similar characteristics of ritual such as, formality and inevitability: “In its repetition and order, ritual imitates the rhythmic imperatives of the biological and physical universe” (p. 8) and “commands attention of the participants” (p. 7). Ritual participants receive social and cultural messages that serve to order life and make it predictable. Messages, implicit or explicit, work to align the belief system of an individual with that of the social group conducting the ritual.

Having introduced ritual theory, rites of passage, and characteristics of ritual, I will next discuss in greater detail how these anthropologists mentioned

above and others applied these classic ideas specifically to death and birth processes. This discussion begins with death, followed by birth, personhood, hospital birth rituals, and how these processes meet in a unique birth-death related event, namely IUFD.

Death Rituals

Some key early anthropological scholarship involved living with tribal societies and writing ethnographies focusing on death rituals. van Gennep, Robert Hertz, and Clifford Geertz were at the forefront in studying death rituals. Through their work one can see how death can be socially made and understood through ritual.

van Gennep's (1909/1960) *rites of passage*, describes the social process that takes place when a member of a community dies. Post-mortem rituals change the deceased into a new entity, and affect the social solidarity of the larger society. During rites of separation, the deceased and their family are isolated from their community causing interruption in their usual way of life. How close the family is to the deceased can determine the length of isolation and mourning.

The deceased enters a liminal period where they are neither alive nor an ancestor. Post-mortem rituals such as preparing the body, burial, or cremation are intended to transform the deceased into an ancestor. Rites of incorporation mark the complete transformation of the deceased into another entity as the family and mourners return to their normal way of life. When the living gathers

together for a meal or any future commemorations at predetermined times, it reaffirms the solidarity of the group (van Gennep, 1909/1960).

Hertz (1907/1960) showed that death is not a destruction of a person's life, rather it is a "social event and the beginning of a ceremonial process by which the dead person becomes an ancestor, and death is like a social afterlife, making it a kind of rebirth" (Kaufman & Morgan, 2005, p. 323). He concluded that death is not only a physical event rather there are social aspects that culturally determine how funeral practices are conducted. Ritual may not be successful in transforming individuals or reaffirming the social cohesion of a group or community.

In this vein Geertz (1957) documents a failed Javanese funeral ritual. Religious ritual normally counteracts fear and anxiety related to death and reaffirms social solidarity among the Javanese. During a changing religious and political landscape in Java the absence of the appropriate ritual authority to organize and conduct the proper post-mortem rituals for a young boy results in a contentious situation. As a consequence, the family fears that the boy's spirit will continue to hover over the house.

A ritual feast, known as a Slametan, was to be conducted within a few hours of death and extend over a three-year period of time. The Javanese view the Slametan as an especially meaningful framework for facing death. In this case the ritual feasts were also improperly carried out based on Javanese cultural mandates. The feast threatened rather than promoted the social solidarity of the Javanese people causing significant agitation among the boy's

family and community. Thus, social and cultural disruption for the boy's parents and the larger Javanese community persisted long after the funeral.

Customary rituals that are performed in an expected manner such that participants believe their expectations were met can be considered as one characteristic of a successful ritual. Other key characteristics of a successful ritual may include the presence of ritual authorities and the conduct of culturally expected rituals.

To recap, I have highlighted above some key ideas from the anthropology literature that relate ritual to mortuary practices. Death as a rite of passage, a physical and social process, and notions of failed or successful ritual are applicable to the contemporary study of IUFD within the hospital setting. Consequently I will draw upon these ideas in analyzing the data from my study. As previously noted, IUFD is the juxtaposition of a death with a birth. Having first summarized some key points about ritual processes related to death, I next consider ritual processes related to birth and how persons are biologically and socially made.

Birth Rituals

van Gennep (1909/1960) also recognized childbirth as a rite of passage. As a result of pregnancy being identified as a time of transition, rituals during and after childbirth were intended to establish a woman's new role as a mother. As a result, a woman's moral and social status was elevated particularly in a first pregnancy. van Gennep (1909/1960) also detailed how after childbirth, rites of

incorporation facilitated women's return to their previous social groups in their new roles as mothers.

Like the mother, the newborn must also go through a sequential rite of passage during birth. The physical act of an infant's separation from the mother is perhaps the most significant although there are important social aspects to such a ritual (Turner, 1969). The ritual cutting of the umbilical cord can also be considered an important symbolic gesture that separates the newborn from the mother and can be viewed as the beginning of personhood.

Personhood

Although the physiological separation process of birth is considered to be universal, the process of social birth is culturally specific (Davis-Floyd, 2003). One type of incorporation rite that has been frequently discussed in the cross-cultural literature relating to social birth and personhood is the ritual of naming a newborn (Conklin, 1996; Kaufman & Morgan 2005; Schwarz, 1997). An unnamed infant, in many cultural contexts, is not considered a person (Morgan, 1996, p. 29). Naming, in part, allows the infant to be accepted into the social group and promotes social dialogue about who this individual is in the group.

From reading the cross-cultural literature, one learns that social birth and the process of naming can be more significant than physiological or biological birth. In some cultures, a baby is not considered an infant until certain rituals have taken place. For example, among the Wari, infant personhood is developed in a sequential process that occurs between mother and infant.

Personhood is initiated through physically caring for a newborn by means of feeding and nurturing. Personhood is initiated socially through the intermingling of body fluids (Conklin & Morgan, 1996). A Wari infant is named at six weeks of age whereas in highland Ecuador women may delay naming an infant until age one. Delayed naming can be related to extremely high infant mortality rates; in such situations women do not usually assign individuality to an infant. Upon death in a Brazilian context, infants may be transformed into angel babies (Scheper-Hughes, 1992).

In addition to naming a newborn infant, there are other cultural ways of determining what constitutes a person including roles and statuses at different moments in the life course. Mauss describes “person” as a combination of “*personne*” and “*moi*” with the latter known as the “self” (Carrithers, Collins, & Lukes, 1985). Other writings detail how an individual came to be considered as a self-contained entity, “a category of being that could be accompanied by a title and name as a legal ‘person’ and citizen of the state” (Carrithers, Collins, & Lukes, 1985, p. vii).

The concept of the person and ideas of the “self” exists in all cultures yet the definition varies within cultures (Geertz, 1984). In the United States, biological birth is considered synonymous with social birth and the beginning of social and legal personhood (Conklin & Morgan, 1996). Naming, issuing a birth certificate, and the provision of social security numbers to infants at birth denote the onset of conditional personhood. Full personhood is achieved in adulthood when adult roles are assumed such as a family member, a mother, a father, or a

spouse Luborsky 1994). These roles include relationships that are negotiated between individuals, groups, and communities that highlight how personhood is socially made and determined by culture (Fortes, 1987). For the discussion here, it is important to note that roles and statuses become especially important during life-crisis rituals particularly those associated with funerals (Fortes, 1973). Birth can also be considered a life crisis as the notion of person and family is re-configured.

Fetal personhood can be further linked to other political and cultural ideas that are highly contested in the United States. Although it is beyond the scope of this literature review to discuss the American societal debate over abortion in detail, the ideas that have emerged from this political discourse about fetal personhood matters to this discussion. Fetal personhood came to the fore in discussion as a result of a landmark case on abortion brought before the United States Supreme Court (*Roe v. Wade*, 1973).

The Court ruled abortion was a fundamental right under the Constitution. One of the more salient discussion points relates to the definition of fetal viability and personhood. The fetus is not considered an independent, legal person within the fourteenth amendment of the United States Constitution unless the fetus is able to survive outside a woman's body (*Roe v. Wade*, 1973).

Since the original ruling the topic continues to be revisited in American politics today as a kind of "lightning rod" that relates to the definition of human life. These ideas about viability and fetal personhood have spun-out into medical practice where there has been an unsuccessful attempt to neatly categorize a

fetus as one who is a viable person or one who is not. As a result, these political and cultural discussions have blurred the boundaries related to the timing and definition of fetal personhood.

In summary, anthropologists consider personhood as a social and cultural construct rather than a physiological or biological designation. For this study, it is important to recognize that personhood is closely linked to reproduction and birth and the creation of roles of mother, father, and baby (Ginsburg & Rapp, 1995). All of the above indicates that personhood may be assigned and also rescinded by a community in different circumstances. Additionally, how personhood relates to the biomedical context where this study takes place is further discussed.

Ideas about fetal personhood converge in the biomedical context of labor and delivery where a fetus may be characterized as a patient and viability defines personhood. Morgan (1999) describes the American contemporary view “of the fetal body as a real, bounded, and continuous entity that develops from fertilization through birth and beyond” (p.45). Technological advancements in obstetrics such as pregnancy ultrasounds and the use of fetal monitors have led to the evolution of a fetus as a legitimate patient (Layne 2003). As a result of the fetus becoming a patient, a woman may treat each pregnancy as a significant life event (Reagan, 2003) to be medically managed at earlier stages of pregnancy (Layne, 2003).

Hospital Birth Rituals

In addition to changing ideas of personhood, other aspects of the United States birth context have evolved over time and bear further consideration.

There are a number of key anthropological works that look at how birth processes occur in varied cultural contexts. Brigitte Jordan's (1993) ethnography describes childbirth in the 1970's in four different cultures: the Yucatan, Holland, Sweden, and the United States. In her comparative cross-cultural study of birth practices in these four different contexts, Jordan (1993) illustrates that variations of the birthing process and its attendant rituals arise from a "local, culture-specific definition of the event" (p. 48). She explains that in the United States, birth is seen as a medical procedure that is culturally defined and socially interpreted as belonging to the medical domain. In the American medical context, birth requires "technical competence" that Jordan (1993) interprets as "medical professional expertise" (p. 52). By this she means that doctors actively manage the disease process while patients take on a more passive role. As such, patients are expected to trust a physician's medical expertise.

Using Jordan's ethnography as a foundation, Davis-Floyd (2003) contends that moving birth from the home to the hospital in the United States resulted in changing notions of American birth and its accompanying ritual processes. For Davis-Floyd (2003) hospital birth rituals have key characteristics, can be understood within the rites of passage (van Gennep 1909/1960), and themes of liminality (Turner, 1967), as previously introduced.

In her ethnography, Davis-Floyd (2003), elaborates on what she labels in the U.S. as a "technocratic model of birth" that considers the woman's body as a machine (p. 52). The "technocratic model of birth" often values the information

produced by machines rather than by people. Such information is frequently used to justify the medical management of the hospital birthing process.

Rituals of hospital birth, according to Davis-Floyd (2003), are the hospital routines utilized in the medical management of the birth process that support the reality of the technocratic model which “forms the basis of both Western biomedicine and American society” (p.10). Examples of hospital routines include women’s experiences wearing the traditional hospital gown, having a fetal monitor wrapped around their pregnant abdomens, and infusing intravenous fluids in their arms. Davis-Floyd (2003) describes these obstetrical routines as cultural constructs that can structure the birth process, make birth calming, orderly, and decrease the stress of the birth process on women and their families and the health care staff who care for them (p. 13).

Given the prevalence of these practices in the United States, many women do not object to hospital birth routines. In interviewing women for her research, Davis-Floyd (2003) learned that women not only feel safer in the hospital, “they prefer some technological intervention in birth” (p.xviii). A striking example to support her view is the dramatic increase of women opting for anesthesia, such as a labor epidural, to manage the pain of the birthing process. As a result women may have certain cultural expectations for labor and birth that can be associated with perceptions of success or failure. Personhood may also be supported or undermined in the hospital setting.

Like the mother, a baby also encounters post-birth routine procedures that illustrate the technocratic model of birth such as the Apgar scoring that is

designed to describe a baby's condition at birth. It is the first rating that society gives to the newborn. When the score is high indicating a healthy baby, the hospital can take "credit for a job well done" (Davis-Floyd, 2003, p. 135).

In technocratic birth, the hospital can also take credit for "facilitating the bonding process" between mother and newborn after birth even though the bonding process has been shown to begin prenatally (Davis-Floyd, 2003). In the clinical literature, pediatricians Klaus and Kennell (1976) believed there is a "sensitive" period after birth where mothers, fathers, and the newborn undergo an exploratory process as they get to know one another. Identification of family resemblances in the newborn is one aspect of this exploratory process as is feeding, holding, and responding to a newborn's needs.

Since their initial research was published, there has been great controversy about whether a "sensitive" period even exists. It is also ironic that women must have a bonding or attachment process "facilitated" by health care professionals, when throughout history it has been noted that mothers and their newborns have stayed together after birth (Davis-Floyd, 2003). The hospital staff is invested in not only promoting the bonding process but they have been charged with observing and recording these natural activities to determine if a woman is indeed "attached" to her newborn, and therefore whether she can be culturally described as a "good mother."

The rituals that define the bonding process continue to perpetuate social and cultural messages about the mother in particular. For a woman, participating in the bonding process reinforces society's message that a woman is now a

mother and that she has been duly transformed (Davis-Floyd, 2003). The experience of bonding and creation of family is culturally meaningful for both women and men. As mothers and fathers bond with their infants, they become part of an ongoing family tradition, and fulfill life course goals.

In short, personhood for a fetus and parenthood for a woman and man are constructed during hospital birth rituals. Women also have certain expectations about their labor and birth in labor and delivery that relate to technology, pain relief, and the “bonding” process. A woman’s expectations may be either met or unmet resulting in perceptions of success or failure.

IUFD Rituals

Thus far in the discussion of ritual theories, birth and death rituals have been treated as distinct categories. Yet for this study, they are meshed with one another and come together in a birth-death related event that in the labor and delivery unit is known as IUFD. It is unclear how many women and their families are affected by pregnancy loss overall, including IUFD specifically because it is a difficult topic for women, their families to discuss, and health care professionals to discuss. People may just avoid the issue altogether because they just do not know what to say (Layne, 2003).

Despite the lack of adequate discussion on the topic of pregnancy loss and not knowing how many women and their families are affected, the feminist anthropologist Linda Layne (e.g. 1996, 1997, 2000, 2003) is still perhaps the most prolific writer in the Anthropology field dealing with the social and cultural issues surrounding pregnancy loss. Her research closely examines the dynamic

relationship between birth, death, personhood, and parenthood. Having personal experience with multiple fetal losses, she then studied pregnancy loss support groups (Layne, 2003). She draws on her personal and professional perspectives when critiquing her feminist colleagues for rarely adequately addressing the topic of pregnancy loss (Layne, 1997). Layne (2003) believes that ongoing taboos surrounding death that relate to faulty reproduction work together to limit acknowledging and supporting women who experience a pregnancy loss. Layne (2003) regards women who experience pregnancy loss and their fetuses as liminal beings who are “stuck in the middle of an uncompleted rite of passage” (p. 59). When a pregnancy ends with a fetal death, there are no rites to reincorporate the woman into society and fetal personhood may be rescinded. The rite of passage for Layne (2003) is both a social and physical event that involves men and women, “albeit in different ways” (p. 61).

Pregnancy loss that is not socially acknowledged in a death adverse American culture, results in what Linda Layne (2003) noted as a frequent theme of isolation in her study of women and pregnancy loss support groups. This topic is surrounded in silence. Women who experience a pregnancy loss often may be reluctant to talk about it. Cecil (1996) suggests that a woman’s silence may be based on the concept of reproductive failure. This line of argument would be that a woman’s primary role has been childbearing, therefore, a birth of a nonviable baby would constitute a failure (Cecil, 1996) and similarly Layne (2003) argues culturally non-existent.

After a loss women may feel social pressure from families and friends to forget. However, Layne (2003) contends that the support in the hospital during a loss process was significantly improving and that more support was now available. Hospitals offer more support by gathering mementos to memorialize a baby in the form of “traces of the body,” and “artifacts of civil society” (Layne, 2003). Mementos offer “proof” of a baby’s existence and a woman’s motherhood (Layne, 2000).

Layne recognized that photographs are an especially important memento that reminds parents that they did have a baby. Dressing the baby and taking pictures permit bereaved parents to indulge in the postnatal American ritual of attributing family resemblances” (Layne, 2003, p. 100) as does spending time with the baby after birth.

“Artifacts of civil society” include certificates of birth, death and baptism, hospital identification bands, and tape measures. These artifacts are considered authentic because they come from the religious or civil authorities that provide them. Layne also considers (2003) items of clothing as artifacts that represent being human and a person. Together, these artifacts along with the process of naming allow women to socially construct personhood for their deceased fetus. “He was a real baby with real baby things” (Layne, 2003, p. 103). Women argued, “size and amount, whether it be of the body, length of a lifetime, or number of memories, are irrelevant as markers of value” (Layne, 2003, p. 131).

Women and their families may use artifacts in two ways: as part of a home memorial or they might put them away and look at them periodically. On a larger

scale memorialization can also take the form of periodic public commemorations. In the latter situation, planting a tree as a living memorial, images of flowers and butterflies have come to be symbolic of a deceased infant or child. Nature is prominently featured in parents' stories about their loss (Layne, 2003).

In literature from the clinical disciplines in the United States and Great Britain, other authors support Layne's assertion that the practices surrounding pregnancy loss have indeed changed considerably within the last 15 years (McCreight, 2008). When admitted to the hospital, a picture of a flower may be affixed to the door of the patient room to designate that she is a woman experiencing a pregnancy loss, for example. Nurses who see the symbol may use certain policies and procedures to describe nursing actions related to caring for these specific patients. In the nursing literature terms such as "practices" (McCreight, 2008; Chichester, 2005), "procedures" (Trulsson & Radestad, 2004), and/or "bereavement protocols" (Dimarco, Renker, Medas, Bertosa & Goranitis, 2002) are often used to refer to these pregnancy loss rituals. While many of individual practices have improved, there is still a need to better holistically understand what is socially going on in IUFD ritualized processes.

The clinical literature documenting such ritualized actions indicates that healthcare staff believe a pregnancy loss is more than a medical procedure. Like Layne (2003), the clinical literature describes the importance of obtaining mementos to give to a woman and her family as part of post-mortem care of the fetus. Parents are also encouraged to see and hold their baby to facilitate the bonding process. Parents are assisted with decision making related to the fetal

remains that may include cremation and/or planning a funeral. Mementos may be given in some type of memory box. Mementos or “tokens” (Trulsson & Radestad, 2004, p.194) memorialize an infant and create memories for a woman and her family (McCreight, 2008). Religious and secular rituals performed on the body of the deceased fetus, may help the woman to believe in fact that she did give birth and that she is a mother. The staff caring practices just described usually fall under the purview of a hospital bereavement program or hospital policies and procedures. However, “few have either been randomly or even systematically tested for efficacy. Many programs use techniques which are widely accepted as helpful but lack rigorous evaluation” (Gold 2007, p. 234).

In summary IUFD is the conflation of a birth and a death ritual. In the situation of a fetal death a woman and her family must alternatively construct personhood for their fetus during the birth process in the labor and delivery unit. The literature suggests that rituals such as naming, collecting artifacts or mementos, spending time with the fetus after birth, and ongoing, periodic commemorations are some meaningful ways that fetal personhood and parenthood may be constructed during IUFD.

Organizational Culture

A key aim of this dissertation involved identifying and describing the organizational context of handling pregnancy loss events, customary care practices, and associated meaning making by healthcare staff. I am particularly interested in the overarching organizational issues that structure life, death, and personhood in the hospital setting. Within the labor and delivery unit specifically, it is important to study IUFD, the ritual processes involved, how personhood is supported or undermined, and the meaning health care staff assign to the event.

The American hospital environment and medical care continue to be changed by consumer demands for a more holistic view of the patient as a person and to incorporate the family in patients' care. "In the 1970's birth and death were replaced by birthing and dying" (Kaufman, 2005, p.68) to reflect the active participation of patients and families in these events and in decisions about their health care. As a result, birth and death events may be viewed as physical, social, and organizational processes that involve patients, their families, and the health care staff.

In her hospital based ethnography focusing on ICU settings, anthropologist Sharon Kaufman (2005) deals extensively with how death is culturally and socially made and organized within life and death situations in that type of unit. She sought to understand the cultural forces of institutions that create paradoxes for both hospitalized patients and the professionals who work in the hospital setting. Despite focusing on a different type of unit, patient, and family population, her research informed my understanding about how labor and

delivery health professionals handle fetal death in an American hospital setting nowadays.

IUFD in labor and delivery although infrequent relates to life and death issues that, in my nursing experience, are very difficult when it involves a fetus that was once alive and parents who have lost their dream of their perfect baby. Also applicable to my study is Kaufman's (2005) exploration of the historical and contemporary influences on hospital culture, such as the pressures of time, the patient's condition, the technological possibilities, what must be done, and what cannot be done. Additionally, she examined decision-making processes by health care staff, including those that caused them to feel pressure to get things done completely and efficiently (Kaufman, 2005).

As such, Kaufman's (2005) key findings are also relevant for the current study. Findings suggest that hospitals like all cultures produce contradictions. Clinicians may experience conflicts with death because they have been socialized to cure disease. The hospital system often shapes care in the hospital in ways that take a toll on doctors, nurses, patients and families due to tensions and inadequate communication between and among them. Furthermore, the hospital contributes to redefining personhood through a series of medical assessments or treatments performed on patients. These ideas relate to the study of IUFD rituals in the labor and delivery setting.

In considering what staff do in a hospital, filling out paper and computerized forms is a key element of their staffing role that requires significant time and attention. Hospital documents are necessary for the construction of a

medical case and documenting ongoing patient progress. Indeed these documents may be seen as having a “life” of their own as they trace what is happening with a patient. As such, there is much to be learned from examining these documents in greater detail, as I will do later with the IUFD paperwork trail (chapter 5), especially how documents construct personhood in the case of IUFD.

Heimer (2006) suggests that within organizations, people’s activities and attention are structured through the use of “forms, checklists, routines,” and meetings. (p. 97). Liedner (as cited in Riles, 2006) suggests that documents, particularly scripts, might be used as a “crutch” that ensures key tasks are completed. Documents can be considered standard operating procedures in hospitals. In addition, hospitals can have their own “rhythm and rules,” “performance standards,” and “troublesome duties” that members are expected to carry out (Schwartzman, 1993, p. vii) that may cause health care staff to become “overwhelmed by routines” (Heimer, 2006, p. 98).

For this particular research in the cultural context of an American hospital setting, it is important to understand how documents structure the physical, social, and organizational processes related to an IUFD and how documents relate to the construction of personhood, and meaning making for women, their families, and the health care staff.

Study Chapters

Chapter 2 discusses the participants and methodology; Chapter 3 describes the research setting; Chapter 4 details official processes and Chapter 5 discusses the official documents utilized with an IUFD in the context of the labor and delivery unit and the hospital at large. Case studies are presented in Chapters 6 and 7. Chapter 6 is an exemplar case that describes how ritual successfully created personhood. Chapter 7 is a second exemplar case that discusses how ritual failed to construct personhood. Chapter 8 describes the hospital's annual infant memorial service. Chapter 9 summarizes findings and presents the conclusion to this ethnography.

This research adds to the existing anthropology literature on ritual processes relating to birth, death, and assigning personhood. Specifically this study further considers how fetal personhood and parenthood is created through IUFD rituals at the boundary of life and death in an American hospital labor and delivery unit context. During IUFD a woman and her family have cultural expectations about how rituals meet or do not meet their expectations. The success or failure of IUFD rituals related to language, action or non-action, and the collection of mementos or artifacts in the labor and delivery unit advances ideas found in the available anthropology literature. A fetus can become a person and a woman a mother during IUFD; these ideas challenge the notion that a person becomes a nonperson through death (Kaufman & Morgan, 2005). Finally, this study of IUFD rituals and the meaning that women and their families

attribute to the creation of personhood also adds to the available anthropology literature.

CHAPTER 2

THE PARTICIPANTS AND METHODOLOGY

This ethnographic study's methods consisted of engaging in participant-observation, and conducting in-depth, and follow-up interviews. This study lasted 12 months and was designed to closely examine customary care practices when women and their families experience an intrauterine fetal death (IUFD) with medical intervention in a labor and delivery unit of an American hospital setting.

This chapter includes a description of: (1) phase one and related activities of recruitment, participant observation, in-depth interviews, and classification of types of health care staff, (2) phase two and related activities of participant observation, follow-up interviews of health care staff, women and their families and (3) data management and analysis procedures.

Phase One

Recruitment: Health Care Staff

In beginning this study, I believed developing a professional relationship with the health care staff including physicians, nurses, and other staff on the labor and delivery unit was highly important to build trust and facilitate recruitment for research on this sensitive topic. One way I accomplished this relationship building was through conducting a series of short formal presentations to introduce the study to the staff. I presented the purpose, specific aims, and methodology of the study to the health care staff during shift change using a standardized recruitment script. After I gave a description of the

study using the script and explained the consent form, I answered the staffs' questions. Staff then had an opportunity to read and sign a consent form after each presentation or decline to be in the study. Although there were no staff related exclusions, any member of the staff could self-select out of the study at any time. I conducted a total of four staff presentations.

Participant Observation: General Direct Care Provision Activities

A second way that I accomplished relationship building was to spend significant time on the labor and delivery unit shadowing members of the health care staff during general direct care provision activities. I observed the labor, delivery, and post-partum process and related nursing care and medical procedures. The broader organizational context for the care provision activities could also be observed such as, implementation of policies and procedures governing the birth process, roles and responsibilities enacted by the health care staff, interactions between and among staff, and women and their families. In this unit, the staff I shadowed welcomed me as a participant observer. This experience was designed to allow the staff to get to know me and I them over time. It also offered them an opportunity to ask additional questions about the study. Before engaging in the observation, I obtained written consent from the health care staff if it had not been acquired during one of the short, formal presentations. Health care staff could refuse or withdraw their consent at any time during the observation component; however, no one declined or withdrew their consent to be observed.

In-Depth Interviews: Health Care Staff

While spending time on the unit during phase one, a convenience sample of consenting health care staff members were invited to participate in a one time, face-to-face, 30-60 minute long audio-recorded, in depth interview with open-ended questions (N=10). These questions related to the customary care practices of women and their families who experience IUFD with medical intervention in the labor and delivery setting. Additional questions referred to the organizational context for handling IUFD and associated meaning making for health care staff when caring for women and their families. Health care staff either volunteered or I asked them individually to participate in an interview. We mutually negotiated a time and location for the interview. Written consent was obtained prior to the interview, if not acquired before during one of the short formal presentations. All staff agreed to participate and completed the phase one in-depth interview process.

Classification: Types of Health Care Staff

The interview participants were divided into four general categories based on established roles that existed within the labor and delivery unit and the hospital at large: registered nurses, physicians, pastoral care chaplains, and a social worker. Many of these staff members (described below) had significant roles and varying perspectives on IUFD with medical intervention in the labor and delivery unit.

The Registered Nurses

The four nurses can be described as follows: One labor and delivery staff nurse primarily responsible for patient care, one charge nurse who supervises the labor and delivery unit on the day shift, one nurse manager of the obstetrical units. The last nurse is a director of nursing primarily responsible for the overall administration of women's services.

The Physicians

The three physicians included one attending obstetrician-gynecologist who has a private practice and hospital privileges, one physician who was in her third, or final, year of residency in an obstetric and gynecology program, and one physician who was a hospital pathologist.

The Pastoral Care Chaplains

Both chaplains were members of the pastoral care department. One chaplain has taken on a leadership role in the pregnancy loss process as a bereavement services chaplain. One chaplain also had an additional part-time role as a spiritual leader of an outside congregation.

The Social Worker

The social worker was a member of the social work department. She was primarily responsible for providing new mothers and their newborns with additional resources and support services as needed.

The health care staff in-depth interviews occurred at a variety of locations at the hospital. Interviewee convenience was the primary factor in selecting an interview location. Except for one staff member who chose to be interviewed in

the labor and delivery conference room, the remainder of the interviews took place in each participant's office. Five in-depth interviews were audio-recorded and five were not audio-recorded. Interviews were transcribed and checked for accuracy to ensure accurate reflection of the participants' responses. Next, an interview table summarizes the categories of interview participants.

Table 1: In-depth Interviews Conducted with Health Care Staff (n=10)

Participant Designation	Number Interviewed	Women/ Men	Roles
RN's	4	4 Women	2 Staff RN 1 Manager 1 Director
Physicians	3	3 Women	1 Resident 1 Attending 1 Pathologist
Chaplains	2	1 Woman 1 Man	1 Spiritual Care 1 Spiritual Care
Social Worker	1	1 Woman	1 Maternity Support

Phase Two

Participant Observation: IUD Direct Care Provision Activities

The two months of observing general direct care provision activities gave me a sense of practices related to live births that I could relate to IUD. Once the in-depth interviews and direct care provision activities were completed, the next phase of the research began. I observed the customary care practices of health care staff when women and their families experience an IUD with medical intervention in the labor and delivery unit. Care practices that could be

observed were the admission of a woman and her family to the labor and delivery unit, the labor, delivery, and postpartum process with related medical procedures, and post-mortem care of the fetal body. In addition, the organizational context such as, the implementation of policies and procedures that inform IUFD rituals, and interactions between and among staff, and women and their families could also be observed.

I was notified by a cell phone call when a woman was admitted to labor and delivery with a medical diagnosis of IUFD for a planned medical induction of labor in the following manner: Between the hours of 7 a.m. to 5 p.m., Monday through Friday, the nurse manager or her designee called me. Between the hours of 5 p.m. to 7 a.m., Monday through Friday and during weekends, the labor and delivery charge nurse called me.

During the phone call I asked the nurse manager, her designee, or charge nurse to examine the nursing admission assessment form for any written evidence that would exclude the woman and her family from the study such as, a history of domestic violence in the current or prior pregnancy. A woman and her family were eligible if they were over 18 years of age, spoke English, and had no known cognitive, mental, or other impairments that could negatively affect their ability to give verbal consent to the participant observation component. I sought and was granted HIPAA authorization by the hospital that allowed me to review a woman's chart prior to a woman and her family's interview.

In the absence of any initial exclusion, I arrived at the hospital approximately one to two hours after a woman was admitted with the medical

diagnosis of IUFD. At that time, I requested permission to begin observing the assigned registered nurse and other health care staff after the process was discussed, questions answered, and consent obtained if not completed during one of the short formal presentations. Health care staff could refuse or withdraw their consent at any time during the observation component. However, no one declined to be observed or withdrew from the observation.

Once I had the staff's consent, then I could move on to asking a woman and her family's permission to be present during the labor and delivery process. Once a woman and her family were settled in their labor room, the registered nurse assigned to care for a woman and her family, approached the woman and her family using a standardized script. The registered nurse script briefly introduced me to the woman and her family. The registered nurse asked permission of the woman and her family to invite me into the labor room to meet them and to discuss my research. Once in the labor room, I introduced myself and met with the woman and her family to explain my research using a standardized script. At that time, the woman introduced herself, identified and introduced her family member(s) to me as her primary support person(s). I inquired whether the woman and her family would consent for me to come along with staff as they cared for her in the labor and delivery unit. All women and their families consented to the participation observation component.

After the consenting process was successfully completed, I began shadowing the assigned registered nurse and other staff. Since my research study focused on the customary care practices of staff in labor and delivery,

when women and their families gave verbal permission, it allowed me to be present during the IUFD process and observe staff caring practices. A woman and her family could refuse or withdraw their consent at any time during the observation component. However, no one declined or withdrew their consent.

The labor and delivery process could occur over a time frame of a few hours to more than one day. I was the one constant person in the process, whereas the primary nurse assigned to care for a woman and her family changed shifts every twelve hours. With every change of shift for physicians, nurses, or other staff, I obtained consent of the oncoming staff as needed. While I was present as a researcher I was told multiple times over the course of the study, by the staff and women and their families, that my consistent presence over time offered support for the staff and women and their families. Shadowing staff ended either when the IUFD process was completed or when a woman was transferred to another patient unit for additional care. A total of ten women and their families were recruited. Next, key information about the women and their families who experienced IUFD in labor and delivery and consented to be study participants are summarized in Table 2.

Table 2: Women and their Families Experiencing IUFD with Medical Intervention in the Labor and Delivery Unit (n=10)

Case Number (#)	*Gestational Age (In Weeks)	Primary Support Person(s)	Follow-Up Interview
1	25	Aunt & Fiancé	No
2	15	Mother	No
3	30	Husband	Yes
4	15	Husband	Yes
5	22	Boyfriend	No
6	15	Husband	No
7	21	Mother	No
8	34	Boyfriend	No
9	34	Husband	No
10	25	Boyfriend	No

***Gestational age was rounded to the nearest week**

Based on time and resources, I decided that ten families was a feasible number for data collection activities. Women ranged in age from 20 to 41. Fetal age at the time of the IUFD medical diagnosis ranged from 15 weeks to 34 weeks. It was the first pregnancy for five women and a second or subsequent pregnancy for the remaining women. In addition, four women were Caucasian, five were African-American, and one woman's ethnicity was unknown.

Follow-Up Interviews: Health Care Staff

The second set of interviews involved asking a member of the health care staff who provided care to selected women during labor and delivery to participate in a one time, face-to-face, 10-20 minute long, follow-up interview

using open-ended questions (n=10). Nine of ten interviews were conducted with the primary nurse who spent the most time with a woman and her family. They had the most knowledge of the IUFD process experienced by a woman and her family; specifically labor and delivery, postpartum, post-mortem care of the fetal body, and organizational context of the IUFD process. Usually the woman's primary nurse participated in a short, follow-up interview. One nurse was the primary nurse for two different women that allowed her the unique ability to compare and contrast each woman and her family's experience with me. One chaplain participated in an in-depth interview and a short, follow-up interview.

For all the health care staff follow-up interviews, the interviewee and I mutually agreed on a time and location for the interview. There was some variability noted in the timing of the follow-up interview. Given that the labor and delivery nurses worked 12-hour shifts and may have worked a "stretch" of several shifts in a row, it was important to allow them time to (1) recover from shift work and (2) reflect on the IUFD case. The short, follow-up interviews with the registered nurses were informal, occurring in a private area on the labor and delivery unit such as an empty labor room, staff lounge, or the nurse manager's office while I met the chaplain in her office within the pastoral care department. All interviewees allowed me to take notes during the interviews. Open-ended questions focused on the staff general impressions of the IUFD case and more specifically, they were asked to reflect on the care practices they either participated in or witnessed being performed by other health care staff. In addition, staff were asked to consider the woman and her family's experiences in

their descriptions. Prior written consent was obtained from the participant either during the series of short presentations, prior to in-depth interviews, or prior to observing them during the IUFD process.

Follow-Up Interviews: Women and Their Families

Another set of interviews involved women and their families. The nurse manager identified eligible women for a face-to-face, 30-60 minute long, interview with open-ended questions, either individually or with their family member or members. Eligible women were those who experienced IUFD in labor and delivery. The nurse manager reviewed their medical record to obtain the woman's phone number. With this information, she called them six weeks after discharge to inquire about their interest in participating in a future interview, two-to-three months post-hospitalization at a time and location of their choosing. At the time of the call, the nurse manager followed the procedures outlined in the interview script. In addition, the nurse manager extended an invitation to family members to participate if the woman chose to have them present at the interview.

A woman and her family could refuse to answer any or all questions or remove themselves from the study at any time. In addition, the interview could be either audio-recorded or conducted with note taking at a woman and her family's discretion. Women and their families were asked about their experiences as in-patients and after discharge from the hospital. The timing of the follow-up interview served three purposes: (1) it allowed time for a woman and family to grieve; (2) it offered a woman and her family an opportunity to talk

about their pregnancy loss with someone who was present with them in the hospital setting; and (3) to thank them for their participation. A woman and her family who agreed to participate in the interview two to three months post-hospitalization gave written consent at the time of the interview.

Despite the nurse manager's best efforts at recruitment, only two women and their families participated in an in-depth follow-up interview. Both women chose their husbands to participate in the interview. They were also the primary support persons for the women in the labor and delivery unit. The problems the nurse manager encountered included: incorrect or changed phone numbers, unanswered phone calls, and unreturned voice mail messages. These problems with recruitment in the bereavement phase are consistent with what other researchers have found regarding difficulties in this type of recruitment (Meert, Briller, Schim, & Thurston, 2009). In hindsight, the nurse manager believed that the timing of the post-hospitalization interview could also be problematic because by 8-12 weeks after delivery women have had their six-week postpartum check-up with their obstetrician. Following their check-up, the nurse manager suggested that women and their family members might have returned to work. Both interviews that occurred were conducted at the women's respective homes with their husbands present. Written consent was obtained prior to the interview and all family members agreed to be audio-recorded. The purpose of the interview was to give a woman and her family an opportunity to discuss their hospital experience, the conduct of IUFD rituals, and associated meaning making.

Data Management and Analysis

I obtained detailed field notes from my participant observation of ten women and their families who experience IUFD with medical intervention within the context of the labor and delivery unit. I observed and recorded the IUFD process with its attendant religious and secular rituals, social interactions, and formal and informal conversations on the labor and delivery unit. I recorded the multiple perspectives of the woman, her family, and the health care staff.

The ethnographic data collected from participant observation and interviews was transcribed in a line-by-line format and coded. Recurrent themes, phenomena, domains, issues, and topics were utilized to organize the data. Data was analyzed using ritual theory to answer the research question and related specific aims.

CHAPTER 3

RESEARCH SETTING

This chapter describes (1) the selection of a research site, (2) the metropolitan area, suburban city and community where the hospital is located and (3) a walk through of the site. Pseudonyms are used to conceal the identities of the hospital, surrounding communities, state, and people.

Site Selection

In considering what hospital to select as the field site for this research on IUFD, I thought about several factors. First, I knew the hospital prior to its consideration as a potential research site by way of an academic relationship. Since 1999, I have been responsible for supervising senior nursing students in the maternity specialty at a university near the metropolitan area where the hospital is located. The faith-based hospital is one of many clinical facilities where undergraduate nursing students may be placed for their maternity rotation. I have collaborated with the labor and delivery nurse manager and registered nurses as they identify clinical learning opportunities for current nursing students. Collaborating with the staff allowed me to establish a professional relationship and led me to believe that I would be able to build the rapport necessary for conducting the study. As a faculty member educating students at the hospital, I was considered an invited guest by the hospital's affiliating schools coordinator. I was not an employee of the hospital or supervisor of their personnel.

Second, I conducted a pilot study in 2005-2006 to fulfill requirements for two doctoral level courses in Medical Anthropology. At this time, I began to study the topic of IUFD. The methodology for the pilot studies included several in-depth interviews with labor and delivery registered nurses along with a nurse manager as they narrated their professional experiences either caring for women and families who experienced an IUFD or supervising staff. Two registered nurses and one nurse manager volunteered from what became my approved dissertation site for the pilot conducted in 2006. As a result of my academic relationship coupled with this pilot study, a mutual trust and respect developed between the staff and me. A mutual regard for each other facilitated my access to the hospital's labor and delivery unit. The staff recognized that I would be able to respectfully work with these vulnerable families and handle their research information with the proper confidentiality and empathy owed to this sensitive subject matter. These factors along with my extensive experience as a labor and delivery nurse were important in gaining permission to utilize this research site for my dissertation research.

The hospital's location was also important in the site selection process. The hospital was accessible from either my home or work. An IUFD with medical intervention is a relatively infrequent event in the labor and delivery unit. When the nurse manager, her designee, or the charge nurse identified a potential candidate for the research, it was necessary that I was readily available to come to the labor and delivery unit one to two hours following a woman's hospital admission to observe IUFD practices.

From my pre-existing relationship with the hospital, I further realized that labor and delivery would have adequate numbers of patients for the conduct of the research study. The patient census will be detailed further in a later section of this chapter. Next, I describe the community where the hospital is located followed by a discussion of the research site itself under the heading of “St. Grace Hospital.”

Community Description

The research site, “St. Grace Hospital,” is located in a suburban city, “Capewich,” which is located approximately ten miles outside “Middletown” a large Midwestern, urban city. The United States Census 2010 reports that in recent years, the region, the state, and its cities have been greatly affected by an unemployment crisis, an ongoing weak economy, national housing collapse and resulting foreclosure crisis. As a consequence of these trends there has been significant population loss. The census report further indicates that for the last decade the state has suffered a -1.0% population decline. The downward spiral is led by Middletown with a significant double-digit loss in population while Capewich experienced a less dramatic loss (<http://www.census.gov>).

The region’s weak economy has also been blamed for a record low birthrate that reflects an exodus of young, childbearing age people leaving the region in search of jobs. A “domino” effect is expected as low birth rates lead to a smaller work force and less growth in the economy.

A decreasing population, weak economy, and a smaller workforce can be tied to the unemployment crisis in the region. Statisticians from the U.S.

Department of Labor Statistics for December 2010 reported that 15 states, including the state where the hospital is located, had an unemployment rate of 10% or more compared to a national unemployment rate of 9.6% (<http://www.bls.gov>).

The city of Capewich is approximately 26.3 square miles and in the 2010 Census was reported to have a population over 70,000. Within the population, there has been a -6.5% change in the total number of households although there has been a 10.5% increase in households with seniors 65 years of age and older. This mirrors regional demographic trends of migration, population losses, and an aging baby boomer generation (<http://www.census.gov>).

Although St. Grace Hospital employs a large number of the city's residents, Capewich is also recognized as a business and manufacturing center with a large number of institutions of higher learning. Approximately half of its residents are employed in education, health, social services and manufacturing sectors. The median income for a household is greater than \$50,000 with 68% reporting a minimum of some college up to and including graduate or professional degree (<http://www.census.gov>).

In the last decade, Capewich has witnessed an additional changing demographic trend with respect to ethnic diversity. The number of non-Hispanic whites has decreased while the number of blacks has increased. The nursing director stated that St Grace Hospital has an ethnic composition similar to the community as a whole.

St. Grace Hospital

St. Grace Hospital has a large network of acute care facilities, outpatient medical and specialty centers located throughout the region and nation. It is a faith-based hospital with a long history in the Capewich community. Over the years St. Grace Hospital has been the recipient of a variety of external awards.

An important factor considered in this hospital's selection as the research site, was the numbers and types of obstetrical patients cared for in the labor and delivery unit. The unit has sufficient numbers of births necessary for adequate recruitment. For example, the labor and delivery unit recorded 1,553 total births during the fiscal year from July 2009 through June 2010. Out of the 1,553 births 37 were considered stillbirths. In the yearly report, there was no distinction made between a fetal loss occurring between 12 and 19 weeks and a stillborn occurring at 20 weeks gestation or later although the required paperwork to be completed, and customary care practices may differ somewhat. In other words, the terms IUFD and stillbirth may be used interchangeably. According to the nurse manager, stillbirth accounted for .42% of the total births.

The hospital also has a Neonatal Intensive Care Unit (NICU) that may be a leading factor in a woman's and her family's choice to birth at St. Grace. Hospitals in the United States that have NICUs are designated according to the level of complex care available to newborns. The goal, using uniform definitions, is to improve outcomes for high-risk infants including those born preterm, of very low birth weight, or with other serious illnesses (Stark, et al. 2004). With acute care of high-risk newborns an important consideration in the choice of a hospital,

St. Grace's NICU has neonatologists and highly trained nurses who provide specialized care to the smallest and most frail infants born at St. Grace Hospital. According to the nurse manager, this information allows women to make an informed decision about where to birth their babies, particularly if they are at increased risk to develop pregnancy complications.

In summary, a past and present collegial relationship with the nursing staff, a faith-based teaching hospital located within a multicultural community, sufficient numbers and types of births, a NICU unit, variety of professionals and available resources, made this hospital an appropriate one for me to closely examine customary care practices related to women and their families experiencing an IUFD with medical intervention in a labor and delivery unit of an American hospital setting.

A Walk Through St. Grace Hospital and the Labor and Delivery Unit

As I considered how to describe the hospital from multiple perspectives, I came to realize the extent to which I view this setting as a woman and mother, anthropologist, a registered nurse, and as a nurse educator. Because I am comfortable in a hospital setting generally and on the labor and delivery unit specifically, I can take for granted the things I see because they have been an integral part of my everyday work world for over 30 years. With these caveats in mind, I proceed with a "walk through" of the hospital to provide a visual image of the space and bring this hospital setting to life for the reader, beginning outside and moving inside through the main visitor entrance. The "walk through" was developed over the course of many visits to the hospital. As such, it represents

how I saw this place in the later stages of my fieldwork and what stood out to me as noteworthy. As I continue to think about what it would be like to come to this facility for a medical induction of labor due to IUFD, now I have come to see this hospital more than ever as a site of a birth-death ritual.

Approaching the hospital by car I look up to see an imposing building adorned with the hospital's name and health system logo. The visitor parking lot is conveniently located near the main entrance. After parking here in the visitor lot, I begin walking on a sidewalk towards the main entrance. I notice two concrete religious statues on my left, one located behind a wrought iron gate while the other is just off the sidewalk. The latter statue is of interest as it of a small cherub with wings, a sign at the base of the statue that states, "little ones to him belong." As I stop and gaze at the cherub I wonder if somehow it relates to pregnancy loss. I looked around for a dedication plaque, however, seeing none I am left to my own thoughts about its meaning.

The main thoroughfare for cars is on my right. As I approach the main entrance of the hospital, I walk under a canopy, pass the valet desk and enter through a revolving glass door. I find myself in a spacious, modern, well-lit lobby. Natural light beams in through floor-to-ceiling windows facing the main entrance. It feels like a lobby typical of most hospitals with its neutral colors, furniture and wall art. Despite painted walls of a bland beige color, it appears that an effort has been made to make the lobby feel inviting with its couches and chairs. I count approximately seven couches that have a brown leather seat while the remainder of the couch is covered in an abstract patterned fabric, the colors of

fall leaves. Several chairs match the décor of the couches. Around ten soft, velvety, solid maroon colored chairs are interspersed throughout the lobby. The maroon covering appears to be an accent color from the couch fabric. Up on the wall is a liquid-crystal (LCD) screen with a message welcoming visitors to the hospital. Although the message is inviting the format of delivery is institutional. The hospital gift shop is on my right and information desk is located on my left. I continue walking straight ahead passing a small coffee shop and registration office on my right, restrooms on my left. Outside the restroom are benches for seating and a large framed print depicting a nature scene.

Just passing the restroom, I stop in front of an unusual image. It is a poster-sized photograph, about five feet high of a little girl with short blond curly hair dressed as a nurse wearing a white uniform and nurse's cap. A toy stethoscope hangs from her neck. As a professional I am confused by the image of a child dressed as a nurse. I wonder about its purpose in the hospital's main lobby. As I continue to look at the sign I see that the girl has her finger up to her mouth as if to say, "shhh." Above the poster is a sign with the visiting hours for the patient rooms where women and their babies go following birth for continued mother-baby care. The first two lines of the sign state that only two visitors are allowed per patient and that all visitors must have a visitor pass. The last line directs visitors to obtain passes at the information desk in the main lobby.

I stop at an intersecting corridor. If I turn right a hallway leads me to the pastoral care department offices, followed by the physician lounge, conference center, and the Chapel. If I turn left, a long beige corridor leads to an "after

hours” exit. Having no need at this time to go right or left I continue walking straight ahead and stop in front of the main hospital elevators. I enter an elevator and push the button for the designated floor where the obstetrical units are located.

As the elevator door opens at my floor I exit and look around. The locked entryway to the labor and delivery unit is directly in front of me. The entrance is locked for security reasons. A sign suspended from the ceiling confirms I am outside the labor and delivery unit. To my right is a hallway to the women’s health unit. To my left are a family waiting room and hallway to access the mother-baby unit. Although these units are ancillary to the primary research site of labor and delivery they are important to mention. Following IUFD, women may be transferred to the women’s health or mother-baby unit to receive postpartum care under specific circumstances that are delineated in chapter four.

I observe that the walls are the same nondescript beige color found in the lobby. There is a large black onyx colored, three-dimensional sculpture of a smiling mother, father, and small baby entwined in each other’s arms hung on the wall opposite the elevators. I can only imagine what it must feel like to be a woman to look at that sculpture, knowing your purpose for coming to labor and delivery is not the usual purpose to leave with a living baby. The sculpture also idealizes the family unit. A woman’s experience can be vastly different from this “ideal” if, when she leaves the unit, she does not have a living baby in her arms or the father of the baby by her side.

I wonder what it must feel like for a woman here for an IUFD to stand outside the labor and delivery unit not really knowing what is ahead for herself and her family in terms of the medical procedures she faces, her room assignment, or the health care staff that she will meet. Perhaps she will feel as overwhelmed as I do as I approach and stop at the heavy, beige, fortress like, automatic double doors to the labor and delivery unit door.

This is the main entrance to the labor and delivery unit. I look through small windows in the doors that allow me to see a long hallway straight ahead. I face a small plastic, square box containing a doorbell and speaker. It states to “use the button to call the nursing station.” The glass windows have multiple stickers on them cautioning those that enter that these are automatic doors. The left door opens outward. A red circular sticker reaffirms this with a warning, “do not enter automatic door,” while the right door opens into the main hallway to labor and delivery with a green circular sticker that states, “caution, automatic door.” There are multiple cautions and warnings seemingly everywhere that all the patient care areas are under 24-hour camera surveillance. When a patient rings the buzzer the unit clerk will either ask for her name or sometimes let her in without confirming her identity. The clerk can see who is outside the unit requesting entry by looking at four surveillance screens that are positioned to the left of the nurses’ station and her desk.

I notice a second box outside the labor and delivery unit. Authorized persons use this box or badge scanner to access the unit. I was given a badge as an official researcher that allowed me access to the unit, the locker room, and

the staff parking lot. After I scan my badge to enter the unit the double doors open automatically. I proceed down the long hallway that is about 25 yards in length. Mid-way through my walk is another red sign reiterating the area is under 24-hour surveillance. I wonder if families would feel safer with the surveillance or feel anxious about being watched. Windows with a view of the campus are on the outer wall while windows on my right have drapes so I cannot look into this hospital area.

During the day the hallway is bright with natural light. To my amazement, at the end of the hallway I see another poster-sized photograph of a little girl dressed as a nurse, in a white uniform, nurse's cap and a toy stethoscope hanging down from her neck. She has her finger up to her mouth as if to say, "shhh." This photograph is eerily similar to the one in the lobby although the child's pose and sign above it with instructions for visitors are different. Above this photograph is a sign that instructs visitors that they "must stop at desk." Since I have seen this sign in the lobby and now in labor and delivery I wonder considering the maternity context if this is supposed to be humorous? If I were a patient or family member I question if this child-like portrayal of a nurse would inspire my confidence in the nursing staff. Or if I am here for an IUFD maybe seeing this poster of a child, "playing nurse" might make me feel quite sad.

I was curious about the history of the posters so I questioned the nurse manager. She shared with me that similar posters were placed in various areas of the hospital but did not know their exact locations. She has learned that some of them have disappeared from the hospital premises. In the past when she has

come to work, she noticed the poster outside the labor and delivery unit turned to face the wall. As a result, the image of the little girl was no longer visible. The nurse manager conjectured that while the hospital's intent was possibly humorous, she believed the posters do little to elevate nursing as a profession.

I turn left. To my right is a three-bed obstetrical (OB) evaluation room, more commonly known as the "triage" area. According to hospital policy only one visitor is allowed per patient in triage. On my left is the OB registration office. The L-shaped nurses' station or desk is located on my right just past the triage area. Surveying the nurses' station I see patient charts, computers for electronic charting, several chairs on the outer perimeter of the desk, telephones, a copy and fax machine, and four security screens. A variety of binders with resource materials the staff may need for reference purposes are also available at the desk, one of which is the *Perinatal Loss Resource* binder. Fortunately when there is an IUFD case, patients and families cannot see these reference binders as they are down low obscured from view under a shelf.

Within the inside of the desk area is the nurse manager's office, and a small medication room accessible only by badge. Outside of the manager's door are several clear plastic labeled pockets mounted on the wall next to the pneumatic tube system. Of particular interest to my study is one of the clear, plastic pockets labeled "perinatal loss paperwork." Nurses, following an intrauterine fetal death (IUFD) case, place select paperwork in this pocket. The nurse manager reviews the perinatal loss paperwork for each case to determine if, and what kind of follow-up may be needed. The words on this clear plastic

wall pocket are handwritten in small letters. They cannot be read from a patient or visitor's vantage point at the nurses' station. The perinatal loss binder, paperwork and their integral role in the IUFD process will be further discussed in chapter five.

The nurses' station is noisy on the day of the walk through as it is most days when I have been on the unit in different capacities. Sounds of talking are interspersed with an occasional laugh. There are phones ringing, call lights buzzing, and staff paging or being paged on the overhead speakers. I get a "whiff" of fresh coffee brewing that permeates the area with an inviting odor rather the nondescript, air-controlled hospital smell.

Everyone seated at the nurses' station is dressed alike with the same base layer of clothing that is a two-piece scrub top, pant, and a running type shoe. In addition, some physicians were wearing white lab coats, and nurses wore brightly colored short jackets covering their scrubs. A few staff members were wearing surgical hats having just finished a case in the operating room.

The unit is in the shape of a square with four equal sides. There are 12 labor, delivery, and recovery rooms (LDR). The LDR's are located on the perimeter of three of the four sides of the square. All have windows on the outer wall. Most windows have an unencumbered view of the outside except for LDRs six through eight that look out into hospital rooms and offices of the Annex unit. The inside of those rooms are not visible due to drapes hanging on the windows. Two of the 12 rooms are designated as post-partum beds for high-risk maternity

clients needing additional care in the early postpartum period. However, all of the 12 rooms are equipped to accommodate a postpartum woman.

Continuing past the desk, I observe LDR rooms one through five are located on my left. On the right, in order of appearance, is the Pyxis medication machine (computerized medication dispensing machine), the linen closet, dirty utility room, entrance to the OR suite, unisex staff restroom, and clean utility room. A stairwell is at the end of the corridor marked as a fire exit.

Walking through the unit's various halls I notice general sights and sounds in the area. On this particular day most of the LDR rooms are occupied. It feels like a bustling thoroughfare with staff and families walking to and from the LDR rooms. I also hear the beating of a fetal heart on a monitor, a woman in active labor, and I pause briefly to await the cry of the baby after birth. I hear her family squealing with delight as the new baby enters the world. I wonder what it would be like if, as a woman, I was admitted for a medical induction of labor for an IUFD, and I was a witness to other babies crying and smiling families.

To the right of the nurses' station, is another corridor where LDR's six, seven, and eight and a staff lounge are located. Opposite from these LDR's rooms are a physician workstation, a pantry where the coffee pot is located, a five-bed post-operative recovery unit, and a linen closet. When I turn left at the point where the staff lounge anchors the two halls, I am in a hall that runs parallel to the one where labor rooms one through five are located. These LDR rooms, numbered 9 through 12, are the furthest away from the nurses' station. While there is no designated in-patient LDR room for a woman admitted for an IUFD,

LDR 12 is preferred as it is the last room before the stairwell. The purpose of this room assignment at the end of the hall, according to the nurses I have interviewed, is that a woman and her family experiencing an IUFD may have quieter and more private surroundings in rooms at the end of the hall. If LDR 12 were unavailable, then LDR 9, LDR 10, or LDR 11 would be suitable next choices.

Opposite LDR rooms 9 through 12 are a unisex restroom, an environmental cleaning room, the perinatal support room, and entrance to the OR suite, that complete the last side of the square. There are four operating rooms. However, one is used for storage only. Entry is restricted to individuals who are wearing appropriate scrub attire including a scrub outfit, a surgical hat, shoe covers, and a mask. Another stairwell is at the end of the corridor near the entrance to the OR suite.

Another consideration in a patient's room assignment is the close proximity of the perinatal support room to LDR's 9 through 12. This room has all the forms, resource information for parents, and supplies for the health care staff necessary for the IUFD process. Specifically, this is the one room where post-mortem care of the fetus is completed. Due to its importance for this study it will be described in-depth here.

When I opened the door to the perinatal support room for the first time I was amazed at the size of the room. I felt like I was in a small clothes closet. There was no obvious ventilation so I felt hot and claustrophobic. It is a tiny space that can barely accommodate two people. If a third person is needed in

the room I have been told by nurses that either the door has to be propped open or one person has to step out of the room and wait their turn in the hall.

I stop and survey the room from the threshold of the perinatal support room. On my left is a bedside table like those found in a patient room. In a patient room it is typically used as a surface for placement of meal trays. Here in the context of the perinatal support room it is utilized as a work surface. Straight ahead at the far end of the room I notice a wooden bookshelf with various memoranda taped on the front or above the bookcase. On the wall above the bookcase is wall art depicting two Disney babies in pastel pink and blue colors: a baby “Mickey and Minnie Mouse.” I learned later that the Disney wall décor was hung by a former registered nurse who herself had experienced IUFD. Although the nurse manager indicated she thought that the art was “weird,” she guessed that the nurse hung the art to demonstrate that women who have an IUFD do give birth and to normalize a non-routine event. The manager also believed the art was an effort to cheer up an otherwise small, somber, hospital colored beige room used for post-mortem care practices related to an IUFD. Moreover, this room is utilized as a workroom for staff only. The perinatal support room is not a place where a bereaved family would see their fetus. Parents who wish to see and hold their fetus do so in the privacy of their assigned LDR room.

On the top of the bookcase I glimpse various supplies that may be utilized during the IUFD process such as, small bottles of water, stickers, pens, and clipboards. There are several shelves within the bookcase. There is a small supply of items (i.e. angel pins) that may be available to be given as keepsakes

to the parents. These items may be purchased by the nursing staff or donated by individuals from outside the unit or from the community. The two remaining shelves contain written resource materials for families in the form of booklets, pamphlets, or bereavement folders.

To the right of the wooden bookcase are a series of open shelves with more items that may be used in the IUFD process. I notice clear bags of knit baby outfits with labels attached that denote varying sizes from small to large. There are also knit clothes and blankets just scattered on the shelves with no apparent organization. Volunteers from the community knit the outfits and donate them to the hospital. The clothes are then dispersed to the NICU and labor and delivery units. The volunteers are not aware that some of the clothes may be used to dress a fetus born as a result of an IUFD. In her interview, the nurse manager relayed that sometimes the outfits and blankets are made with “left over” yarn in odd colors. It is sad that a matching “head to toe” outfit and blanket are rarely found. For example, a sweater may be knit in one color of yarn and stitch while the hat, booties, or blankets may be another color and stitch altogether. Women here for an IUFD occasionally request to have their baby dressed in an outfit they brought from home. This scenario is unlikely to regularly happen for two reasons: the first is the unpredictable nature of the loss event and second, if the loss occurs early in the pregnancy either a woman may not have had a baby shower or prepared for the baby by buying infant clothes. If they have clothing, they may only have purchased clothes that would fit a baby that

was expected to be born at full term. Even preemie-sized clothes may be too big in this situation.

I pause when I see a few preemie size diapers on the shelves. How small they are, I remark to myself. Finally, hand-painted memory boxes made of very sturdy cardboard and hand-sewn, fabric stuffed animals are also found on a shelf. These items are also donated however; the memory boxes are painted by an organization of women who are knowledgeable about their use for an IUFD. The medium size boxes are either heart-shaped or round with appropriate pictures painted on the outside cover such as, flowers, teddy bears or angels. Opening a box, there was a small white paper signed “with love” by the artist. The paper stays in the box.

Underneath the shelves is a two-drawer file cabinet that has the necessary blank forms to be completed either for a fetal loss, stillbirth, or a live birth and death. Unlike the messy bags of clothing tossed on the shelves the forms and paperwork are well-organized and neatly labeled in file folders in the cabinet. It seems that the paperwork is deemed more important than suitable clothing to dress a fetus. Due to the room’s small size and lack of storage, I was informed that extra bereavement folders and memory boxes are available in the pastoral care department.

Located on the right wall of the perinatal support room is a small baby-changing table with a flat plastic surface. Underneath the changing table is an assortment of white plastic shrouds that are cut to size to adequately wrap a fetus before being taken to the morgue.

On top of the changing table and to the right of the table is a box of “Plaster of Paris” compound with which to make impressions of the fetal feet in a plastic heart-shaped mold. Above it are the directions to make the molds with the correct proportions of powder and water. Bottled water, as was previously mentioned, is kept on the top shelf of the bookcase. On that particular day there was a thin film of powder on the surface of the table that had not been cleaned up. I notice that there is no running water or sink in the room available for cleaning, or even hand washing. When I asked the nurse manager about the lack of a sink for hand washing, she shared with me that some time ago there was a reorganization of some spaces on the unit, including this one. The current perinatal support room was once used as a closet to store IV poles. The room once used as the perinatal support room was much larger and is now used for storage. Death was literally and effectively demoted to a closet. In addition, the room felt messy with supplies scattered about in a state of disarray. I surmise that the staff member who last used the perinatal support room for post-mortem care hurriedly exited the room. Death pervades this small, windowless room. I feel sad as I close the door yet relieved that death is hidden from a woman and her family. Thinking momentarily like a nurse, I am aware that only the staff knows about the activities that take place behind the closed door of the perinatal support room.

After closing the door to the perinatal support room I went into several empty LDR rooms. I noticed they are relatively small. The rooms are furnished and decorated identically. On the threshold of the door I survey the interior of

one of the LDR rooms. The walls of the LDR rooms and ancillary rooms on the unit are painted hospital beige like hallways in the unit and in the hospital. Although I noticed some framed nature scene prints interspersed throughout the unit's corridors, there is no artwork in the LDR rooms due to lack of available wall space. However, there is a flowered wallpaper border behind the bed near the ceiling. This border matches the curtains on the windows. The flower motif is an attempt to create a home-like feel despite sparse decorations. A small cross, in keeping with the hospital's faith-based ministry, is opposite the bed on a small wall by the private bathroom.

There are few furnishings in the LDR room. I notice a large hospital bed, designed for the birthing process, in the center of the room. A cabinet at the head of the bed resembles a headboard one might find in someone's home bedroom. Behind the cabinet hidden from view are oxygen and suction outlets and related equipment. The cabinet is kept closed unless there is an emergent need for the equipment. Next to the bed is an equipment stand on top of which is a computer for electronic charting while underneath is a fetal monitor. Drawers below the fetal monitor and within a series of cabinets to my right contain a variety of supplies needed for care provision. There is also extra counter space for the staff's use.

Two chairs are provided in the room for visitors, one of which folds out into a bed. A small kitchenette type table where the visitors may eat is located under the outside window. Family members may place their belongings on the table or on the windowsill. In the rear of the room opposite the bed and in full view of the

patient is an equipment alcove where the infant warmer is located along with other supplies such as an infant scale and delivery table. A rolling cart referred to as a delivery table is brought into a LDR room. This infant care area can be partitioned off from the room by an accordion pleated room divider. Sometime in advance of a birth the delivery table is set-up with sterile instruments and other medical supplies used by the delivery attendant. The table is then tucked away behind the room divider to maintain its sterility and to keep it out of the way until it is needed.

When a woman is admitted for an IUFD in labor and delivery, the accordion pleated room divider remains closed such that the infant warmer is not visible to either the woman or her family. When the birth is imminent the room divider is opened briefly to bring out the sterile delivery table and placed near the foot of the bed. Then the door is closed again. When the fetus is born, if the parents initially decline seeing or holding the fetus, the physician or nurse will pull the room divider back just far enough to allow them to fit through the opening and place the fetus in the infant warmer. The accordion pleated door is closed and remains closed until some time after the birth. Later a woman and her family often change their minds about seeing and holding the fetus. If not the fetus will be taken to the perinatal support room where a nurse initiates post-mortem care.

This “walk through” lays the foundation for chapter four that delineates the official process when women and their families experience IUFD with medical intervention in the labor and delivery unit.

CHAPTER 4

OFFICIAL PROCESSES

This chapter focuses on key physical, social, and organizational processes for health care staff, women patients and their families in the context of labor and delivery. I relate these processes to “normal” birth rituals, birth-death (IUD) rituals, and roles and responsibilities of health care staff as they manage the IUD process. Staff decide on an ad hoc basis when a fetus is called by a “given” name, called “baby,” or referred to by the medical diagnosis of IUD. For consistency in language, a fetus born as a result of IUD will be referred as a “fetus” in health care staff discussions. On the other hand, a woman and her family may call their fetus by “name” or refer to their fetus as “baby.” The information in this chapter is primarily based on participant observation activities and in-depth interviews with health care staff. Pseudonyms have been assigned to the health care staff, women, and their families.

Health Care Staff

A variety of health care professionals work in the labor and delivery setting including resident and attending physicians, Certified Nurse Midwives (CNM), and registered nurses. There are no unlicensed nursing assistants or technicians. Rather staff nurses are all registered nurses. Professionals consulted on an as needed basis in this setting include anesthesiologists, Certified Registered Nurse Anesthetists (CRNA), neonatologists, pastoral care chaplains, and social workers. Some of the staff may participate in two important rituals, one religious and one secular, that are conducted twice daily. One

religious ritual is a prayer offered by one of the pastoral care chaplains over the hospital's loudspeaker and second, are "huddles and team meetings" conducted by various members of the health care staff and localized within the labor and delivery unit. Both rituals happen once in the morning and once in the evening. Next, I will describe these everyday rituals in further detail.

Prayer Ritual

I learned from interviewing two chaplains that they rotate the responsibility of saying the prayers among those chaplains scheduled to work either on the day or the evening shift. A chaplain chooses the content and conduct of the prayer. Chaplains may use prayers that are unscripted, traditional, from the Bible, or a combination of these three. Prayers are non-denominational, last between one and three minutes long, and contain a message of healing for patients facing illness or surgery, their families, and the health care staff who provide direct or indirect care. A similar prayer routine is repeated in the evening. I heard from various health care staff that they believe prayer is a positive aspect of working in a faith-based hospital. No staff member voiced any objections to the prayer ritual.

The first time I was on the unit and heard the prayer, I stopped and bowed my head. I was quickly reminded as I stood there in the middle of the nurses' station that I was on a busy unit and not standing in a chapel or church. Most of the staff continued with the task they were working on at that particular moment. I also observed that the prayer is in competition with the typical noises and sounds of a hospital unit made from the doorbell, telephones, call lights, talking,

copy machine, and even the ice machine. More than one nurse described the unit as too “stimulating” to pay attention to the daily prayers. Some of the nurses ignored the noisy distractions and listened to the prayer depending on the chaplain offering the prayer. One nurse said:

I'll stop if it's Joseph because he gives a well-rounded prayer, he blesses patients and caregivers who are ill or who are going to surgery, blesses the families and caregivers.

(Nurse #1, In-Depth Interview)

The nurses believe chaplain Joseph's prayers are more memorable because of their all-inclusive nature and his soft-spoken voice. A few nurses reported that they cannot understand a second chaplain's prayers because of his accent and are annoyed by a third chaplain who “reads from a prayer book in a sing-song voice.” When the latter two pray, few nurses stop what they are doing to listen and when asked, the nurses were unable to remember the content or context of the prayers.

The nurses also shared with me that the women do not usually comment on the prayers even though when the LDR room is open the prayer can be heard from inside the labor room. They thought that perhaps many of them were medicated or their physical condition precluded their ability to concentrate on the prayer. Another possibility is that the staff does not view it as important with all that is going on clinically to attend to a woman's reaction to the prayer. Only one of the women in this study who experienced an IUFD in labor and delivery was a notable exception. At the family's three-month post-hospitalization interview, Ella Wright stated that she appreciated the two morning prayers she heard over the loudspeaker during her two-day stay as a patient in the labor and delivery unit.

She indicated that she did not hear the evening prayer likely due to her active labor condition.

When chaplain Joseph came up to see her on the first day of her labor induction Ella made a point of complimenting chaplain Joseph on his morning prayer as he sat down at her bedside. To me it seemed that they formed a common bond through prayer as chaplain Joseph spent a very long time at the bedside talking and praying with her. Everything I had heard from the staff about chaplain Joseph's soothing voice and his ability to empathetically pray came to light as I observed him at Ella's bedside holding her hand. I too felt comforted as I listened to him talk and pray with her. Ella and Andrew Wright's case is discussed in greater detail in a later chapter.

Huddles/The Team Meeting Rituals

Huddles are a unit level specific ritual that involves various health care staff working on particular patient care units. These are structured routines in their timing and conduct, even to the format for the communication process within them. Early on in my participant observation I noticed that sheets of white paper describing this routine were posted on the two staff bathroom doors. I was curious about the paper's placement as it was strategically placed in clear view opposite the toilet. I was told that the placement was deliberate and it was there to remind staff about the established unit routine. I learned that the huddles were instituted to meet requirements for hospital accreditation. In addition to morning and evening report, huddles take place at a designated time twice per day in the room labeled "physician workstation" opposite the nurses' station. On one

occasion I asked the charge nurse what the “unofficial” name of the room was because I never heard it called the “physician workstation” as designated by the sign outside the door. She thought for a moment and mused, “the report room?” Over time, I learned that it was much more than just a room for report.

During my time on the unit I saw that this room is really the activity “hub” of the unit, more so than the nurses’ station. This room is a central location where the nurses, resident and attending physicians, medical and nursing students, may be seen convening in front of a white “grease board” where each woman’s confidential information is posted via their labor room number. The health care staff congregates in this “inner” room for several reasons. The most significant reason is that the workstation has a door that can be closed when discussing a woman’s confidential information. Secondly, the room is quite large in size with telephones and computers available for the staff’s use. As such, it is the only relatively private room on the unit where the health care staff can meet. The unit staff may also place their backpacks or tote bags in the room for easy access during the course of their shift since the locker room is one floor below the labor and delivery unit. There is also a bookcase with a variety of obstetrical medical textbooks used for reference books on the shelf. Therefore, for a variety of reasons health care staff and others with access to the unit are constantly coming and going from this room.

According to written and anecdotal information I obtained, the labor and delivery huddles are periodic meetings designed to identify safety concerns, prioritize workload, and update the plan of care of women based on their

admitting diagnosis. Huddles include the patient's primary care nurse, in-house attending, resident, charge nurse, neonatologist, and anesthesiologist. Health care staff, not specifically mentioned, are also referred to as "team members." Patient data, risk factors, plan of care, and evaluation of fetal monitor strips are specifically reviewed for each patient. The communication process is structured through the acronym SBAR: Situation, Background, Assessment, and Recommendation.

A huddle lasts as long as is necessary to discuss each patient. If there is only one patient on the unit a huddle may take only a few minutes. If all twelve-labor rooms are occupied with patients and the unit is busy, then the huddle can be as long as 30 minutes. External factors can affect a huddle causing one or more staff members to make a quick exit from a huddle and return to a huddle. If anyone misses a portion or the entire huddle, it is the charge nurse's responsibility to maintain open communication between staff members. A nurse's patient may put her call light on, have a rapid birth, or the fetal heartbeat may develop an ominous pattern on the fetal monitor. Any of these changes demand immediate attention from the staff, huddle or no huddle. The charge nurse told me that the timing of the huddles require "flexibility" on the part of each health care staff member. She summed up the purpose of the huddle in this way, "we do them so everyone's on the same page."

On the guidelines, there are seven general high risk factors or obstetrical complications and their specific details that are always discussed in a huddle. In no specific order of importance they are: "rule out" labor (is a woman in real or

false labor?), Preeclampsia, decreased fetal movement, preterm labor, bleeding, Diabetes, and IUFD. The specific physical details of each condition such as vital signs, laboratory work, procedures, and the social context are discussed. Relevant psychological, spiritual, ethical, cultural, and emotional considerations are also addressed in the huddle. These considerations are discussed in a variable order depending on the situation. In addition, the huddle offers the health care staff an opportunity to use a holistic approach in planning care practices for these patients. By a holistic approach they mean planning care that addresses the aforementioned considerations related to the “whole” person.

When a woman and her family are admitted for either a planned or unplanned induction of labor for a medical diagnosis of IUFD, information regarding when and how the fetal death was diagnosed, the medical induction process, and the context for the loss are all discussed during the huddle. It is customary that the charge nurse, in advance of a woman’s arrival, will pre-assign or designate a LDR room on the back hall close to the perinatal support room. I noticed that the tone of the huddle becomes more somber when the staff discusses a woman and her family who are due to arrive on the unit, and remains somber throughout a woman and her family’s stay in labor and delivery.

Huddles are an important ritual to help structure and manage patient information, and staff time in what can otherwise be a hectic, chaotic situation. As a labor and delivery nurse I know how quickly a woman’s condition or that of her fetus can change thus causing uncertainty and chaos on the unit. In addition, as a nurse I know that the census on the unit is always in a state of flux as new

women are admitted while others give birth and are transferred to the mother-baby unit for postpartum care.

Although unit policy dictates the timing and conduct of the huddles, any member of the health care staff may call impromptu meetings when there are concerns. It is the primary nurse who likely requests an impromptu huddle. An impromptu huddle may occur once or twice a shift. The charge nurse and nurse manager truly could not tell me how often an impromptu huddle is called because they are not documented in any official manner. Despite the lack of documentation, I observed impromptu huddling by various staff on an as needed basis. What I was told was that patient care decisions are negotiated among the health care staff even when there is not a consensus of opinion. With regard to huddles, the nurse manager said, “the staff here is pretty good about working together to care for a patient and her family.” By that the nurse manager meant that the staff utilize teamwork to meet the needs of a patient and family.

During the first phase of my participant observation, I spent significant time on the unit observing the care of women in labor and delivery. Most frequently, I observed direct care provision activities of the nurses because of their significant role at the bedside. In thinking about the registered nurse’s patient assignment, one must understand that she is the primary nurse for one to two assigned women patients and is responsible for the well being of both mother and fetus. In addition, the nurse includes the family as they have an important role providing support to the laboring mother during the labor and delivery process.

Hospital Birth Rituals

Initially I discuss the standardized labor and delivery routines or birthing rituals that are implemented when a woman and her family come to labor and delivery to be evaluated for admission and birth of a viable fetus. Next, I discuss how the process may be similar or different for a woman and her family who experience an IUFD with medical intervention.

I begin my description with several scenarios that may occur when a woman arrives in labor and delivery to birth a viable fetus. The most common occurrence when a woman comes to the unit is that she either walks in with her family or arrives via a wheelchair escorted by a hospital transporter. Initially a woman is taken to the OB evaluation room that is more commonly known as the triage area. It is a small three-bed unit with a curtain separating the stretchers from each other in the patient care area. If there are no patients in the OB evaluation room when a woman arrives, it is likely that the triage nurse is helping other nurses on the unit. If there are women present in triage, a nurse is present in the triage unit. In this situation, the triage nurse oftentimes hears an approaching wheelchair and will meet a woman at the door of the triage area. If not met by the triage nurse at the door a woman will continue on to and stop at the nurses' station. Typically the first person a woman meets at the nurses' station is the unit secretary who will ask the woman her name, doctor's name, and purpose for her visit. The unit secretary will page the triage nurse over the loud speaker, unless the nurse happens to be standing at the nurses' station, to take a woman either to triage, directly to a labor room, or to the post-operative

recovery room that is also used for special obstetrical procedures and for preparing a woman for a scheduled Cesarean Section.

One nurse assigned each day by the charge nurse during morning report, staffs the OB evaluation room. The nurse is responsible for greeting the woman and determining the reason for her coming to labor and delivery. The dialogue may be something like: "Hi, I'm Cathy! I'll be your nurse while you're in triage. We'll be together for about an hour or so." Following the introduction, the questions are rather standard: Which baby is this for you? What's your due date? Do you know what you're having? Tell me what brought you to labor and delivery? Who's with you today?" The nurse listens carefully to a woman's responses to get a sense of how emergent her symptoms may be, how a woman feels about being pregnant, and to gather information about her family.

The woman is asked to change into a patient gown, and lay on a stretcher. Either before or after taking the woman's vital signs, the nurse places a fetal monitor on a woman if she is far enough along in her pregnancy that the fetal heartbeat may be heard and recorded. The monitor consists of two belts that encircle the outside of a woman's abdomen. The external contraction monitor denotes the presence of any uterine activity while the ultrasonic transducer transmits fetal heart sounds. Uterine activity and the fetal heartbeat are transmitted to a graph allowing for an immediate visual representation on the fetal monitor. The volume may be adjusted to project the fetal heart tones into the triage area whereby sometimes the nurse can listen and make a judgment about the rate and regularity of the fetal heartbeat through listening. The nurse

will also evaluate the paper graph produced by the fetal monitor. The most exciting part of the triage experience for a woman and her family member can be listening to their baby's heartbeat on the fetal monitor. After being evaluated by a resident physician and in collaboration with a woman's primary health provider, the woman may be discharged home, may be admitted to a labor room (LDR), or may stay in triage for short-term observation.

In the event that a woman is admitted to labor and delivery, the triage nurse will move her to an unoccupied LDR room. A primary nurse, as assigned by the charge nurse, will assume the woman's care. She orients a woman and her family to their labor room. This process involves showing the woman and her family how the bed, television, and call light work. Intravenous fluids started in triage continue to infuse throughout the birthing process. Once again the fetal monitor is placed on a woman's abdomen and the sound of the fetal heart may provide a pleasant distraction in the room. Depending on the specific circumstances of a woman and her family, the mood in the room may be light and cheerful. I have often observed that a woman and her family can be anxious and excited at the same time. Frequently they will ask, "How long will this take?" A woman and her family are ready for labor and delivery to be over in order to meet their baby. However, labor may be considered a physical process that takes an unpredictable length of time.

In my direct care provision activities, I observed labor contractions that gradually became closer together, lasted longer, and intensified over time. There is quite a bit of pain involved in the birth process. Many women received a labor

epidural to manage their pain. The anesthesiologist generally asked family members to leave the LDR room during epidural administration. Consistently, I observed that during the painful birthing process families more than the women seemed to enjoy listening to the fetal heartbeat on the monitor.

The labor process eventually culminates in birth. When a woman gives birth, the baby is placed on the woman's abdomen as the nurse stimulates the baby to cry and dries the baby off. There may be a wide range of emotions expressed by the woman and her family at the time of birth from crying to quietly gazing at the newly born baby. The attending physician or midwife also calls out: "It's a boy (or girl)" while the nurse reads and calls out the time of the birth from the computer screen. While the baby is on the mother's abdomen, the doctor hands a pair of scissors to the primary support person to cut the umbilical cord. The Apgar score is completed at one and five minutes after birth and recorded on the electronic chart. It is interesting that for the staff this may mean the end of the labor and birth process, yet for families it may be viewed as adding a new family member and the beginning of the process of child-rearing.

Approximately the first two hours after birth the woman and her newborn "recover" from the birth process. The nurses initiate and complete physical assessments for both mother and infant and facilitate the bonding process. At the end of the two-hour period of time the woman, her newborn, and family, are transferred to the mother-baby unit for postpartum care. The primary nurse wheels the mother, who is holding her infant, via a wheelchair or stretcher to her new room with the family following behind. At that point the nurse usually

congratulates the woman and her family one last time and wishes them all the best in their new life as parents.

IUFD Rituals

What I have concisely described is a fairly typical low risk labor, delivery, and recovery process for a woman and her family who are admitted to the hospital to deliver a viable fetus. During IUFD In a labor and delivery unit death can be understood in the context of birth when a fetus dies in the womb. IUFD is a juxtaposition of a birth event with a death event that forms the term IUFD ritual. Whereas the prior discussion focused on the key events when a fetus is born alive, this discussion describes key events when a fetus is born following IUFD. When IUFD occurs in the labor and delivery setting it adds a layer of complexity not found in a typical birth. I begin the discussion of what can be expected with a woman's arrival on the labor and delivery unit having received the medical diagnosis of IUFD.

There may be a slight modification in the admitting scenario for a woman who comes to labor and delivery for a planned medical induction of labor related to IUFD versus a woman coming to labor and delivery to deliver a viable fetus. The woman is not in labor, therefore, the woman usually walks to the desk. The staff may be expecting the woman as her name and reason for induction has been recorded ahead of time in a "special procedures" schedule book. What may also happen is that the obstetrician or office staff sends a woman from the office either immediately after medically diagnosing IUFD or some hours later. Another possibility is that the office sends a woman to triage to have the fetal

heart tones assessed because the woman has not felt any fetal movement. Because I was notified of only the scheduled procedures, I did not observe either of the latter two possibilities.

I was informed by the nurses that sometimes women, medically diagnosed with IUFD, will come to labor and delivery with small children in tow or unaccompanied by a family member. The nurses become angry with physicians or office personnel who send women to the unit without first notifying the unit by telephone. One nurse described it this way:

The doctors think we are lazy and don't want to work, that's why we don't want them to come to the unit right away. That's not it at all, a woman needs time to process the information she just heard and besides, what's the rush?

(Nurse #2, In-Depth Interview)

The nurses then must manage a very stressful situation for the woman, perhaps her children, family members and the health care staff. Additionally, the nurse manager is always informed of the situation and she follows up with the physician.

Under most circumstances, the nursing staff and unit clerk anticipate the arrival of a woman experiencing IUFD. The nurse, who has already been assigned during morning "report" to be the woman's nurse, tries to meet her at the desk and take her directly to a pre-determined labor room. Several nurses told me they do not want the woman to have to state why she came to labor and delivery to spare her the pain of having to say something like, "I'm here because my baby died." It is an especially thought-out practice that demonstrates sensitivity for the woman and her difficult circumstances. However, it is not a

specific official unit policy nor is it routine. Novice nurses learn from more experienced nurses who either role model or convey this practice through the oral tradition.

Bridget Keen, in her post hospitalization interview with me, recalled this part of her experience. I have assigned the pseudonym of “Bridget” to the woman (more of Bridget’s case in Chapter 7). Bridget was diagnosed with an IUFD in the doctor’s office and subsequently had the IUFD documented through an ultrasound. Bridget came to the labor and delivery unit twice and compared her experiences when she stopped at the nurses’ station. The night before Bridget’s scheduled medical induction of labor, Bridget came in to receive a medication to “ripen” or soften her cervix. Bridget walked in and stopped at the nurses’ station. One of the nurses said, “Are you Bridget? I know why you’re here.” She immediately took Bridget and her husband to a labor room. Once the ripening agent was placed, Bridget was discharged and sent home to return in the morning. The next morning when she came in for the actual medical procedure, she again walked to the nurses’ station. The conversation went something like this: someone (she wasn’t sure who it was), asked, “What are you here for?” Bridget responded, “I’m here to deliver.” The staff person asked, “Oh are you in labor?” Bridget said, “No (she draws out the word no deliberately as she’s telling me the story), and then it was kinda like I had to take it further, I’m like no, they told us to come back at 8 a.m., they are going to induce labor, we lost the baby yesterday.” The person sheepishly responded, “Oh, ok.” Bridget sighed as she said, “It was so hard.”

Like Bridget, women accompanied by their family, are escorted to a LDR room or what is called a labor room in the back hall when available. Bridget appreciated having their room “on the other side,” Bridget’s husband Joseph reminded her that she had to walk down a long hall and turn left to get there. She recounted how difficult it was for her to walk past the happy families in the hallway and hearing newborns crying from inside the labor rooms. When Bridget shared this story with me I remember thinking that I just cannot imagine how heartbreaking it would be for a woman to encounter happy people and hear newborn babies crying while walking to her labor room.

Other women may have had similar experiences walking to their labor room although this discussion was the most extended one I had about that particular kind of moment. One woman indicated that once in the labor room she felt shielded from the painful experience of seeing other happy families in the hallway. Standard birth routines or birth rituals normally initiated in the OB evaluation room are conducted in the labor room such as having the woman change into a gown, obtaining vital signs, starting intravenous fluids, drawing blood work, completing a history and physical examination, and discussing the medical induction procedure. The various health care staff talk quietly and usually do not ask the woman to relive the events surrounding the diagnosis of IUFD. This information is usually communicated from a woman’s attending physician to the resident physician or primary nurse. Sometimes the woman’s attending physician or Certified Nurse Midwife will meet her on the unit when she arrives or will come in several hours later to see how she is doing. Because a

medical induction of labor may take a considerable length of time, a woman's primary health care provider may come and go from the unit. The health care provider may see patients in their office, do surgeries, or if it is late in the evening go home to await a call to return closer to the time of birth.

The mood in the room is likely somber and sad. I have seen women and their family members appear stoic, teary-eyed, or openly crying. Sometimes their response depends on how long they have known about the fetal death. One registered nurse told me a story about a woman who found out in triage her baby had died. The nurse said, "I'm usually good at getting fetal heart tones right away so when I couldn't get them immediately, I called the resident in to do an ultrasound. Well, there was no heart motion on the screen, and the woman began crying outright in triage with such raw emotions, it was so sad." She also recalled the woman was in a state of shock and disbelief. Multiple times she requested a "second opinion." She thought that there was some mistake. This nurse believes that women who have an IUFD diagnosed in triage have a more difficult time with the labor and delivery process versus women who have the medical induction scheduled one or two days after receiving the IUFD diagnosis. She believes it gives them some time to prepare and process what happened to them. There is no official unit policy on the timing of the medical induction of labor.

Once a woman and her family are in their labor room and the induction of labor begins, the silence is noteworthy. Although an external fetal monitor may be used depending on how far along a woman is in her pregnancy to document

labor contractions during the medical induction of labor. However, the fetal portion is not medically necessary. Instead of two belts encircling her abdomen, now there is only one. The sound of the fetal heart beating in the room is conspicuously absent.

Soon after a woman, who has experienced a loss, is admitted into her LDR room, several things happen although in no specific order: the door to the LDR room is flagged with a sticker, a “support packet” is given to a woman and her family, and health care staff who may actively participate in the loss process are notified. Each one of these steps and the rationale of why these steps are carried out are discussed individually beginning with the “sticker.”

The sticker is a picture of a flower that is meant to symbolize a fetal death. It is very small in size, about two by two inches. It alerts all personnel who enter the room that the woman inside the room and her family have experienced a loss. For example, a representative of the dietary department may deliver a meal tray to a woman and may have no prior knowledge of the loss until she sees the flower on the door. Knowing that the family has experienced a loss assists the dietary person or other health care staff involved in the direct or indirect care of the patient to be sensitive to a woman and her family’s situation. Upon entering a patient’s room being quiet and respectful rather than overly cheerful would be characterized as an appropriate demeanor.

Sometime after the flower is attached to the labor room door, a “support packet” is also given to a patient and her family. During my participant observation activities, I learned that the packet was developed by the hospital.

Leafing through the packet, I noticed that the author or authors are not identified. It explains the history of the flower, ways families experience grief, suggestions for handling grief, counseling information, and books about grief suitable for a woman, her family, and children.

The primary nurse is responsible for giving the “support packet” to a woman and her family early on in the IUFD process. The nurse makes a special trip into the patient’s room to bring the packet. Although there is no set time for the packet to given to a woman and her family, I have observed that the nurses give written or verbal information in small doses over the course of the labor induction process to avoid overwhelming a woman and her family. Typically, the nurse would knock on a woman’s door, wait for a woman or her family to say, “Come in,” open the door and approach the woman’s bed with the packet in hand. The nurse would ask the patient how she is feeling and listen to a woman’s response. At some point in the conversation the nurse may, in one short sentence, say, “Here’s a packet of information for you about the grief process. You can read it anytime when you feel ready. Let me know if you have any questions.” The woman typically places the packet on the bedside stand unopened. At other times, the nurse may use the information as teaching tool.

The obstetrical policy also requires a woman’s primary nurse to notify various health care staff that may actively participate in the IUFD process. The nurse notifies the pastoral care department, RTS Bereavement Services (Resolve Through Sharing) chaplain (this program will be discussed shortly), and the attending obstetrician. A woman is offered a visit from a social worker. If she

accepts the nurse notifies the social work department too. During the interview with the social worker, I was told that the department has modest funds to assist families with burial expenses. The social worker also provides a woman and her family with community resources on grief and loss support groups.

The nurse notifies pastoral care and the RTS bereavement services chaplain by making two separate phone calls. I asked one of the chaplains to explain to me why messages have to be left on two different phone numbers within the pastoral care department when a loss occurs. I was told that there is a primary chaplain who responds to messages about miscarriages, fetal or newborn deaths that happen in the hospital. In case she is not working on a particular day, a message will be left on the alternate line as well so any chaplain may respond to a woman and family experiencing a loss. In addition, any chaplain can respond to a message left on the department voice mail in the pastoral care office. This line is also used for reporting any adult death within the hospital setting.

A woman's primary nurse documents the date and time that the flower was attached to the labor room door, the support packet was given, and health care staff notifications were made on a standardized checklist that is designed specifically for a woman experiencing a miscarriage, fetal loss, stillbirth or a live birth and death. Noting the date and time matters as the nurse manager told me it is one way to hold the nurse accountable for completing the aforementioned steps early on in the IUFD process. Additionally, the form requires boxes to be

checked or blanks to be filled in by hand (the documentation process is covered in greater detail in Chapter 5).

In her interview the bereavement services chaplain, who responds to the RTS message line, shared with me that she has been specially trained in bereavement services by participating in a RTS workshop. A few years ago several labor and delivery nurses also went to the workshop. However, most of those nurses either have transferred to other units or resigned their positions at St. Grace Hospital.

According to RTS literature available on the World Wide Web, it is “known world-wide as the gold standard for perinatal bereavement education.” It is not stated in the information available on the web what is meant by the “gold standard,” how it is achieved, or what organization bestowed such a status upon them. Established in 1981, this not-for-profit organization focuses on providing bereavement care information for organizations (<http://www.bereavementservices.org>) nationally and worldwide. The organization is faith-based, provides health care professionals with education, training, and resources in bereavement services related to families who experience miscarriage, stillbirth, and newborn death. Additionally, they offer coordinator training to implement a perinatal bereavement program in organizations to advance quality health care.

The logo on the website has “Bereavement Services” in large letters. Underneath in small-italicized letters is “Resolve Through Sharing.” The emphasis is on the larger letters rather than the smaller ones. It seems that their

mission and vision are admirable despite their “catch line” as one chaplain called it. During his interview, he indicated that he was not sure he liked the name. He had not attended a training session given by RTS. As an anthropologist the first word “resolve” is an interesting one. I wonder if grief can be resolved merely through sharing, especially so early in the bereavement process. RTS seems to align with a death adverse culture in “resolving” the matter of death as quickly as possible. The literature has demonstrated that women and their families find this hard to do (Layne, 2003). One of the labor and delivery nurses who experienced an IUFD ten years prior to my interview with her said, “It doesn’t ever go away, sometimes it just hits me out of the blue.”

Overall, RTS is a strange concept. However, some good things come out of it such as the example I describe next. During my participant observation activities I observed one of the staff nurses who had attended the RTS training. In particular I was impressed with her creative ability to obtain memento pictures using special poses of the baby’s feet that she had learned as part of her RTS training.

Sometime after being notified by telephone, one of the chaplains comes to the unit and visits with a woman and her family. Obstetrical policy and procedure mandates that all women who experience an IUFD will receive a minimum of one visit from a hospital chaplain. Both hospital chaplains told me in their interviews that they are trained as bereavement counselors. However, they do not introduce themselves as such rather they identify themselves as chaplains. The chaplains believe that when introducing themselves for the first time as

“chaplains,” the term can be considered more generic rather than immediately introducing themselves as bereavement counselors. These latter words are associated with death, they said. During the first visit, the chaplain asks about a woman’s religious affiliation, if any. They may pray with the woman and her family when deemed appropriate. A woman and her family may request a prayer service or sometimes women and their families will go along with these services if suggested by a chaplain.

A woman may call on her own spiritual advisor or decline any further hospital pastoral care services at the initial visit or anytime thereafter. On occasion a woman has asked a chaplain to leave her room. One time I observed a nurse who was caring for a woman who experienced an IUFD. The nurse offered to call and have a chaplain come visit the woman and her family. The woman and her family were hesitant to see a hospital chaplain. I overheard the nurse say to the woman and her family, “Your spiritual care is just as important as your physical care.” However not all women and their family members may see it that way. Despite this comment, the woman and her family declined to see a chaplain from the pastoral care department.

To accommodate a visit from a woman’s priest, minister, rabbi, or Imam the visitor policy is relaxed when a woman and her family experience an IUFD. I observed as many as ten family members accompany a woman and her family to labor and delivery. They provide support by their presence, making a food “run,” driving family members to and from home when needed, and offering to babysit children. I have witnessed nurses ministering to a woman’s family by asking

them how they are feeling, if she can get them a cup of coffee or a box lunch, searching for additional chairs for the labor room, freely giving family members pillows and blankets, even putting fresh linen on a pull-out chair for a family member spending the night.

Several nurses discussed in their interviews that talking with a woman and her family allows them to take cues from the questions a woman and her family may ask to determine a woman and her family's readiness to learn about the IUD labor and birth process, and how it is the same or different from a "live" birth. These nurses discussed how they give information gradually over the course of the medical induction and subsequent labor, delivery, and after birth following the tempo set forth by a woman and her family. Several of the nurses reported that early on in the induction process they rarely gave any information about the labor and delivery process until they had a sense of a woman's feelings regarding the fetal death. However, they willingly answered questions asked by the woman and her family. In the interviews the nurses shared with me how they established rapport and determined a woman's readiness for information. Once a woman and her family were ready, nurses prepare a woman and her family for the labor and birth process including what the baby will look like.

Using the term "options," a physician, nurse, or pastoral care chaplain describe choices a woman and family have for their deceased baby's body. Options that nurses discussed with a woman and her family include touching and holding their infant, knowing the sex of the infant, autopsy and genetic studies

(offered by the physician/resident physician), choosing a name, and having a naming ceremony, bathing or dressing the infant, and making funeral arrangements. A woman and her family are also informed of the yearly memorial service and grief support services available through the pastoral care office.

The hospital policy uses the term “available fetal remembrances,” to describe “mementos” that the nurse might obtain following the baby’s birth. These mementos include obtaining footprints, writing the birth information on a “certificate of remembrance” card, cutting a lock of hair, and taking photographs of the baby’s body. All items used in the infant’s care (hat, clothing, blanket, tape measure), are offered to the family to take home with them. In the case studies that follow there is more to learn about what these discussions are like and how they occur.

Besides documenting on a standardized IUFD checklist, the primary nurse and other health care staff document the ongoing induction process on the computer. In my direct care provision activities, I observed how similar the physical labor process was for women either birthing a living baby or birthing a deceased fetus. I observed labor contractions that gradually became closer together, lasted longer, and intensified over time. In either situation, a woman experienced quite a bit of pain in the birthing process. Pain management options that were discussed with women included administration of opioid medications or a labor epidural.

Once a woman’s cervix begins to open or dilate the birthing process may occur quickly especially when the fetus is very small. As a result the attending

physician may miss the delivery. Some nurses believed that some physicians intentionally do not attend the delivery. One nurse succinctly stated:

I'm quite disappointed in that doctor who didn't come to the delivery. And I'm like, really, you know, I know the baby isn't alive but it's not all about that, it's about your patient.

(Nurse #2, In-Depth Interview)

This nurse also thought that some of the resident doctors tried to make an “emotional connection” with a patient while some of them avoid it. If an attending physician misses the birth for whatever reason, the resident physician is available on the unit to deliver the fetus. When birth is imminent or happens very quickly, there is a flurry of activity preparing a woman and the room for the delivery. I observed that several more health care staff enter the room and stand-by to assist the attending, resident physician, or primary nurse during the actual birth.

Next, I describe characteristics of the IUFU birth process that I witnessed during my participant observation activities. The LDR is relatively dark and quiet at the time of birth. The fetus does not cry, there is no movement, and the color may be ruddy or blue depending on the gestational age. When a woman gives birth, the fetus is usually placed gently on the foot of the bed while the doctor or certified nurse midwife, rather than the significant other, typically cut the umbilical cord. The delivering health care provider checks for any signs of life. These signs include a heartbeat, breathing, or movement. In one situation where a Certified Nurse Midwife was the delivery attendant, the husband did cut the cord after his wife declined. At the same time the fetus is delivered, the primary nurse reads the birth time from the computer screen and documents it in the chart. The

fetus is wrapped in a hospital towel or baby blanket. One nurse described her experience with a fetus born later in pregnancy: "I think it's more real. You know the smaller ones are bad, but when you do the term ones then you know just how much more difficult it is."

During IUFD, I observed that there is no jubilation in the LDR room when a woman delivers. On the contrary, crying or sobbing may be heard coming from the mother and her family or they may not openly express any emotion. The fetus may be handed to the woman's primary nurse who may walk the fetus over to the infant warmer behind the closed, accordion pleated door. Another scenario I observed was that a physician might either walk the fetus to the warmer or place the fetus in the arms of a waiting family member. It rarely happens that a woman and her family member (s) are ready to hold the fetus immediately upon birth but the option is presented to the family. Usually they want time to think about their decision to see, let alone hold the fetus that they usually refer to as "baby." A second nurse comes in to help the primary nurse usually begins fetal post-mortem care. The assistance of a second nurse is all but required for the following reasons: to assist with post-mortem care either in the LDR room or to take the fetus to the perinatal support room where the supplies are available to make mementos to give to the parents. The woman's primary nurse then can stay in the room and focus on the woman and her family.

As a labor and delivery nurse, I know that the birth is not yet complete because the afterbirth or placenta must still be delivered. However, during her interview, an obstetrician explained issues that can occur with the placenta. A

woman may have to wait for the delivery of the placenta which may be extended from the few minutes typical of a live birth to several hours for IUFD. A retained placenta is considered a common complication of this type of birth. During the time the placenta remains inside a woman's uterus, a woman may still be in a considerable amount of pain and may bleed excessively. What I observed is that women are often very concerned about their condition and can become extremely anxious both from the pain and waiting for the placenta to birth. In the same interview, the obstetrician informed me that if the placenta does not deliver spontaneously a surgical procedure, a Dilation and Evacuation (D&E), is done in the operating room.

The physician may remove the placenta in the operating room while the patient is under general anesthesia. I remember one woman who had to undergo a D&E procedure after waiting three hours for the placenta or afterbirth. She was so terrified, she repeatedly asked me while squeezing my hand, "Am I going to die, am I going to die?" while her husband paced in the labor room. She asked the same question of her attending doctor, her nurse, and any health care staff entering or leaving the room. I stayed by her side holding her hand and wiping the perspiration off her face with a cool cloth. As I stood at her bedside I kept thinking that it just was not fair that she had to have a birth-death (IUFD) event and an operation within hours of each other. Once the procedure in the operating room is completed a woman returns to her labor room for post-operative care and to wake up from general anesthesia.

What I have just described is the medical management of one type of circumstance that can take place with respect to the delivery of the placenta. After the birth of the placenta and when a woman's physical condition becomes in the words of the health care staff, "stabilized," the social aspects of the death are acknowledged and the nurse begins to facilitate the grief process through a variety of care practices.

Parents most often choose to see the fetus at or shortly after delivery whereas holding their fetus may take some time, if it happens at all. A fetus born less than twenty weeks gestation has a very "fetal" appearance that may frighten the parents. They are extremely small in size, the skin is ruddy in color, and shiny in texture. Eyes may be fused shut and nostrils filled with a visible white substance. Nurses encourage but do not push a woman and her family to hold the fetus. I have observed them prepare the family for what the fetus will look like. Some adjectives the nurses use are, "the baby is cold, shiny, dark in color." A woman and her family always seem to appreciate privacy with the fetus although in small increments of time. The primary nurse usually checks in on the family every fifteen minutes or so to see how they are doing. Some families do not like to be left alone in their labor room for longer periods of time. Most of the families I was with during the participant observation component of the study, carefully thought about and named the fetus using, a first, middle, and last name. Many of the women and their families would then use the name in conversations with the nurse following the birth or they would use the term "baby." The nurse

also tended to use the baby's first name in talking with a woman and her family although it was a variable practice.

A woman and her family are given time alone to make decisions. Some decisions the parents may be asked to make include arrangements for the fetal body such as, an autopsy, genetic studies, and a private burial or hospital cremation. The latter option is only available for a fetal loss or stillbirth. The fetus may be donated to an area hospital for research purposes. Donation is neither encouraged or discouraged, it is merely presented as an option to the family. Rarely does a family choose this option, and it never occurred during my time on the labor and delivery unit. Sometimes a woman and her family are unsure of the arrangements or the woman is unable to make any immediate decisions due to her physical or emotional condition.

During the first two hours following birth the post-mortem care of the fetus continues either in the perinatal support room or in the woman's labor room. Two of the nurses I observed doing post-mortem care called the perinatal support room the "DBR." The first time I heard a nurse say it, she asked me, "Do you know what the DBR is?" I thought she was giving me a test and I had no clue. I said, "No, I don't know." She smiled and said, "It's the dead baby room!" I did not know what else to say but, "Oh." Later as I thought about the name, I could not help but think it was somehow irreverent to the baby. My next thought was that perhaps the nurses used the title as a coping mechanism to relieve their own sadness about the loss. It is only a term used among themselves because it would be perceived as callous to say that anywhere near women and their

families. One of the nurses, in an attempt to justify the name, told me that sometimes-even families laugh in-between their profound sadness to cope with their loss situation.

The nurse makes a determination about the post-mortem care that can be done based on the fetal age at the time of birth and the condition of the fetal body. The body may be gently bathed but only if necessary. The skin easily peels and the fetus is very fragile so handling is kept to a minimum. The fetus is dressed in an outfit chosen from the bags of knit items in the room unless the family has brought in an outfit from home. Only one family I saw had their own outfit. One of the family members was charged with making a trip to the woman and her boyfriend's home to get the outfit. Once dressed and wrapped in a blanket, individual pictures are taken of the fetus and pictures of the woman and her family holding their "baby." The unit has its own camera but the printer is in the NICU necessitating a trip by a nurse to the NICU, time permitting, to print the pictures.

On the other hand, a family may request the non-profit organization, Now I Lay Me Down to Sleep (NILMDTS), to come to the labor and delivery unit and take professional pictures. The bereavement photography is free of charge to families experiencing a loss. The primary nurse makes the call to the organization when she learns that the parents want professional photographs done. This step allows the local NILMDTS office to locate a photographer and have that person "on-call" to come to the hospital and photograph the fetus after birth.

A woman founded the organization in 2005 after her own loss (<http://www.nowilaymedowntosleep.org>). The photography service excludes some deceased fetuses' from being photographed. The fetus must be at least 20 weeks gestation and have suffered no excessive deterioration or complications during the birth. The organization asks that the nurse use judgment about the appropriateness of pictures. Only one family, Ella and Andrew Wright, requested pictures by the organization. In her post-hospitalization interview, Ella's comment was that the photographer helped her see the "beauty that was left in her baby's body."

Oftentimes I observed that a woman and her family might express some fear about what the fetus might look like in the pictures. In thinking about this one opportunity to take pictures of their fetus, most of the women and their families want the nurses to take the pictures. However, a few families leave the pictures at the hospital. If they are left at the hospital they are stored in the pastoral care department indefinitely according to the bereavement services chaplain that I interviewed. It was unclear to me why families may leave the pictures at the hospital. I am told that families typically do not offer an explanation for their decision. I can speculate that perhaps the image of death in a picture may be just too real for a family to deal with and they might prefer not to have a picture as a lasting reminder of their fetus.

During my participant observation activities, I was able to observe a professional photographer in an IUFD situation. From the NILMDTS photographer, I learned that the fetal feet do not suffer the deterioration most

commonly seen on the face and body. She made a point of expertly posing and photographing the feet as she explained that the skin on the soles of the feet rarely peels like the tops of the feet or other parts of the body. Women and their families seem relieved that the feet have a typical shape with five toes on each foot. In addition to the pictures, two types of fetal footprints are obtained: an imprint with black ink and a “Plaster of Paris” mold. Nurses explained to me that when the fetal loss happens very early in pregnancy footprints or the molds might be unobtainable. Any mementos or artifacts are placed in a “memory box.”

I observed how nurses select a memory box from the supply located in the perinatal support room. Their choices are based on size of the box, the sex of the fetus, and the motifs on the cover. The selection process can be quite subjective often based on what box the nurse likes best. Other mementos that go into the box include a “certificate of remembrance,” and a “baby” identification band or bracelet for the family. The name, weight, length, date and time of delivery are hand printed on these two items. When families decline to take the memory box with mementos home, they are also stored in the pastoral care department for future retrieval.

When a nurse determines a woman and her family’s readiness to see the memory box with the mementos inside, I observed that the primary nurse brings the completed memory box to a woman and her family. Sometimes the woman may be alone in her room. The family may have gone home, to get something to eat, or they may be out of the room making phone calls. The nurse, taking her cue from the woman, may take one of two courses of action with the memory

box: either she places the box on the bedside stand for the woman to open when she is ready or she will open the box and show the woman what is inside. Women that open the box, I have observed, often take out each item and tenderly hold them. Sometimes, tears course down their cheeks. For me, it was a heart wrenching experience to watch this process.

Once all the rituals are completed, the fetus may stay in the woman's labor room for an undetermined length of time. However, if a woman requires other than routine post-partum care such as administration of antibiotics, she will be transferred to the women's health unit for continued post-delivery care. Rarely does a woman get transferred to the mother-baby unit. Nurses are sensitive to the IUFD situation because the idea of being on the same unit with new mothers and their living babies may just be too much for a woman and her family to bear.

When the census of the labor and delivery permits, a woman and her family are able to stay in labor and delivery after birth until the time of discharge rather than be transferred to another unit for postpartum care. When given this option, many women and their families choose to have the fetus stay in the room until they are discharged. During the interview process, nurses stated that they would prefer to keep women in the labor and delivery unit rather than as one nurse succinctly stated, "bouncing them around." The fetus will stay in the "infant warmer" opposite the woman's bed although the infant warmer is not being used to warm the fetus. The nursing staff refer to this piece of equipment as the "infant warmer." One woman powerfully stated, "It's the only night I have."

Not all women and their families want their “baby” to stay indefinitely in the LDR room. A woman may say things like, “I’m ready for the baby to go” without ever saying the word “morgue.” When a woman and her family are ready for the fetus to go to the morgue, a “baby” bracelet is completed with the woman’s identifying information and placed around the fetus’ waist. The fetus is wrapped in a white, plastic shroud that is cut to size. Labels inside and outside of the shroud contain a woman’s identifying information. The fetus is wrapped in several baby blankets. Along with the appropriate paperwork, the fetus is hand carried by the woman’s primary nurse to the morgue.

The hospital policy and procedure issues another cautionary statement when it states, “The fetus is NOT placed in formalin under any circumstance.” One nurse told me that “years ago” babies were called, “bucket babies” because they were put in formalin. Since the time when a fetus was called a “bucket baby,” practice changes have occurred. Whereas at one time in the hospital a fetus was treated more like a specimen, a fetus is now treated more like a separate human being, a person. This change in part can be traced to several factors. One factor has to do with the health care staff witnessing the lived experiences of women and their families in the hospital setting and advances in bereavement research overall. As a result of their hospital experience whether they determine it to be good or bad, some women and their families have exerted pressure on hospitals for an IUFD event to be treated more like a birth and less like a medical procedure. From all of the above, one can also conjecture that

cultural ideas about viability and fetal personhood have also led to changes in hospital policy and procedures.

CHAPTER 5

DOCUMENTS

The previous chapter described the official process by which an IUFD “works,” now the discussion turns to the official documentation process when a woman and her family experience an IUFD in labor and delivery. In this chapter I also describe how the health care staff fill out and handle a series of key documents. Putting these things together will help with anthropologically analyzing how death is physically, socially, and organizationally managed in the labor and delivery setting through documents. The information in this chapter is derived from participant observation activities and health care staff interviews.

Accordingly, the discussion begins with an introduction to documents as they relate to ethnographic research. Next, the IUFD documentation process is described along with the component parts of the perinatal loss binder, the standardized IUFD checklist, and a variety of official hospital and state forms that generate a “paper trail.” Last is an analysis of what can be learned through the process as it directly relates to “documenting a life.”

Introduction

In general, documents may be considered ethnographic artifacts of a particular type that are encountered during fieldwork in a variety of settings (Riles, 2006). While these documents, as artifacts, are important to ethnographic research, the response to the documents is the key to informing knowledge and understanding about a particular topic (Riles, 2006). Ethnography can be

considered a response to one's informants as social persons, but also a response to the artifacts—"the knowledge, the commitments, the practices-others introduce to us in the ethnographic encounter" (Riles, 2006. p. 24). These documents have a temporal rather than a static nature whereby they are "becoming" rather than just "being" (Riles, p. 18).

The hospital is one specific context or setting where myriad documents are utilized to structure a medical case, involve social interactions, and are used to document a patient's progress. Heimer (2006) studied documents in the NICU from the perspective of both the health care staff and parents of ill infants. Heimer (2006) found that staff read documents as cultural texts to produce medical knowledge. In the NICU, parents used documents as artifacts to construct the life of their infant. These documents and artifacts "are particularly important in creating the sense of time and historicity that undergirds our understanding of how a human life unfolds" (Heimer, 2006, p.102).

Despite focusing on a different type of unit, patient, and family population, Heimer's (2006) ethnographic research informed my understanding about how the health care staff in labor and delivery fills in and ritually handles key documents during an IUFD with medical intervention. In addition, documentation can be thought of as a ritualistic process that occurs over time and space.

Perinatal Loss Binder

One of the resources available to the attending physicians, resident physicians, and labor and delivery nurses that can sort out the process of form completion is the *Perinatal Loss Binder*. The nurse manager refers to the binder

as the *Perinatal Loss Binder* and uses the word “perinatal” as an umbrella term that includes three categories: (1) a fetal loss that occurs between 14 and 19 weeks gestation; (2) a stillbirth that occurs at or after 20 weeks gestation or a fetus that weighs greater than 400 grams; or (3) a live birth and immediate death.

Dividers separate the binder into an introductory section followed by the three aforementioned categories of perinatal loss. Opening the binder, the first section contains four documents: an unnamed “decision tree,” the hospital policy and procedure, the standardized IUFD checklist, and perinatal loss discharge instructions.

The categories of: fetal loss, stillbirth, and live birth and death organize the remaining three sections. Within each section there are completed sample forms that can be used as a reference or as a script. A pseudonym, “Jane Doe” and Jane’s plausible information fills in the blanks on the applicable forms. Handwritten and highlighted areas on each form indicate where the appropriate health care staff or a woman and her family sign their names. These steps were designed to make the form completion process as clear as possible to reduce documentation errors.

At the end of the binder is a list of funeral homes if a woman and her family request that information followed by the hospital’s mission statement. It is interesting to me that I saw no one refer to the contents of the binder during the course of my participant observation activities. Rather they would prefer to consult with the RTS bereavement services chaplain, the nurse manager, or their peers for help. The health care staff told me on numerous occasions that they

feel overwhelmed with the paperwork process. It may be easier to ask someone to answer a question rather than take the time to handle another binder and set of forms.

There are other possible explanations as to why the perinatal loss binder is rarely utilized in an IUFD case. One explanation could be that the staff would rather consult a human being about sensitive issues surrounding an IUFD. An alternate explanation may be that some health care staff do not know what questions to ask, information to look for, or where to obtain it because they have yet to be involved in a specific situation. The stress of caring for a woman and her family experiencing an IUFD and the organizational expectation to fill out the forms correctly may also lead staff to consult with another person for emotional support. Having another staff member validate that the forms are being filled out correctly may reduce the stress of the person asking the question.

As I discussed in the prior chapter the binder is kept at the nurses' station out of public view. Every July when a new group of interns and residents come to the unit, the nurse manager takes the binder to a meeting of the new physicians and reviews each and every form based on the type of loss: fetal loss, stillbirth, or a live birth and death. During my participant observation activities I attended one of these meetings with the nurse manager. I observed how quickly she leafed through the binder. At the end of her ten-minute presentation, she asked, "Any questions?" There were none. I surmised there were no questions because it would be difficult as a new doctor in a new hospital to absorb all the instructions let alone all the caveats that make the forms perplexing. I am

wondering about the degree to which the residents' medical education in a death adverse culture had prepared them to ask questions about this topic.

At the end of the meeting the nurse manager asked the interns and residents to notify her when a woman was admitted to labor and delivery with the medical diagnosis of IUFD so she could, in turn, notify the risk management department. According to the nurse manager, notification of risk management is required when a woman and her family are admitted to labor and delivery with a perinatal loss. Other types of loss reported to risk management would include a maternal or neonatal death. Overall, the nurse manager indicated that she is aware of times where a family's grief turned to anger and then was directed toward the health care staff. She further suggested that a woman might need someone to blame for her loss. I am reminded of the American cultural value that someone needs to be blamed when a death occurs, particularly when it involves a fetus or newborn. As a result, notification of risk management related to any type of maternal or perinatal death is mandatory in order to preempt future problems.

Standardized IUFD Checklist

When a woman is admitted to the labor and delivery unit either with the expectation of a "live" birth or with a medical diagnosis of IUFD, an electronic medical record is initiated to document the physical processes related to labor and birth. In the labor and delivery unit, the documentation process may also be referred to as "charting." However, there is a second set of paper documents that figure prominently for a woman admitted for IUFD. Although a nurse

administrator told me that the hospital has established a “paper-light” record keeping system since gradually phasing in an electronic medical record or chart, I have observed that there is nothing “paper-light” about documenting an IUFD event. These paper documents include a standardized IUFD checklist along with a variety of official hospital and state forms. Adding these additional items makes the documentation process unwieldy for the nurses and exacerbates the stress of the situation. As a result, nurses have verbalized to me how they sometimes avoid taking care of women diagnosed with IUFD because of the amount of paperwork to be completed is overwhelming. The IUFD paperwork adds to the electronic charting process thus, it is time-consuming.

Considered indispensable by the nurses, the IUFD checklist is a nursing form that structures the IUFD charting process. Only the nurses fill in the blanks or check the boxes on the paper checklist. Nurses usually keep the checklist at the desk either inside or attached to the outside of their assigned patient’s binder. One of the nurses referred to the paper checklist as a “Bible” because it gives the nurses instructions on what to do. One nurse stated, “As few times as nurses deal with this you go, let’s see less than 18 weeks and more than 500 grams (laughs), now what I do is blah, blah, blah.”

From an anthropological perspective, the nurses use the checklist to determine the structure and order of IUFD events. I was interested to see how the nurse is responsible to date, time, and sign their initials for over 30 items on the paper checklist. The checklist summarizes information on major areas related to an IUFD event: (1) the birth such as, the date and time of delivery, the

number of weeks gestation, the sex and weight of the fetus; (2) telephone notification of various health care staff including a woman's attending obstetrician, the pastoral care department, RTS (Resolve Through Sharing) bereavement services chaplain, and the social work department if a social work consultation is requested by a woman and her family; (3) flagging a woman's LDR room with the flower sticker that denotes a fetal death; (4) gathering "available fetal remembrances" or mementos for a woman and her family such as footprints, photographs, a lock of hair, a baby bracelet, clothing worn by the fetus, and (5) options chosen by a woman and her family regarding autopsy, genetic studies, cremation and/or burial arrangements for the fetal remains.

There are interactions between a woman, her family, and her fetus that relate to the social process of IUFD that are also listed on the paper checklist. A woman and her family have an option whether to see, touch, hold, name, and have privacy with their baby. If a woman and her family request a naming ceremony and/or a prayer blessing these religious rituals are performed by a pastoral care chaplain or a different spiritual advisor chosen by a woman and her family. The nurse documents if and when these social interactions occurred, the time, and enters her initials on the checklist where appropriate.

I have witnessed nurses completing the checklist in one sitting. For example, one nurse wrote the time "1745" alongside at least twenty of the approximately 30 items on the checklist. Instead of documenting how the IUFD process unfolded over time and the space of the labor and delivery setting, filling in the checklist became a rote activity for the nurse. Perhaps, it is easier to just

fill in the blanks as one nurse stated in her interview when reflecting about her nurse colleagues' approach to the IUFD checklist:

Sometimes nurses, it bothers me, they kind of just go down the paper checklist, paging yadda yadda check, paging yadda yadda check, if the patient isn't ready to talk to them then what's the point of just checking a box?

(Nurse #2, In-Depth Interview)

This example highlights the repetitive and patterned nature of the IUFD checklist and how it intensifies the IUFD process for some of the nursing staff.

Official Forms

On the reverse side of the checklist is a grid that identifies a legal, state form a woman and her husband must complete when they experience a perinatal loss. The grid assists the health care staff in the selection of the appropriate forms to be completed based on the three specific categories of perinatal loss previously described during the perinatal loss binder discussion. In addition, instructions are included on distributing the forms within the labor and delivery setting and the broader hospital context. These legal forms are often where the paper trail becomes problematic.

One of the residents indicated in her interview just how frustrated she was with the legal paperwork, "The paperwork is too much. It's repetitive. One-half of the boxes don't apply, and there are too many to begin with." One of the obstetricians echoed the same sentiments:

The paperwork is too much. It would be easier if I could fill the forms out on the computer a little at a time while the patient is in labor instead of waiting until after birth. There are so many problems like forms go missing. One of my patient's husbands had to return to the hospital to sign for the fetus' release. There has to be a better way.

(Physician #3, In-Depth Interview)

This example is one of several where the forms were misplaced or lost. A nurse offered this further explanation about problems with the paperwork:

It seems like we are reinventing the wheel with every IUFD case. We don't seem to grasp it. It just seems like it's digging deep to try to get it right. That for me is the biggest worry having the family come back in to sign papers. Its happened before.

(Nurse# 2, In-Depth Interview)

Even though in large bold print the hospital policy states, "All forms must be signed prior to the mother being discharged," in reality this step does not always happen according to the policy. The policy also states that any incomplete forms are placed on a woman's chart to be completed prior to her discharge from the hospital. This policy has also been ineffective in preventing forms from being lost or misplaced.

The health care staff wants to be respectful of families' grief and not give them too many forms to fill out or pressure them to make quick decisions about disposition arrangements for the fetus. On one hand they feel pressured to get the forms completed accurately and within a "reasonable" length of time and on the other hand, they understand families' need to think through important decisions about their fetus.

Specifically, the physicians and nurses verbalized that they felt like they were "bombarding" families to make quick decisions about autopsy, genetic studies, or arrangements for the fetal body in order to complete the paperwork. They recognized that a woman and her family might need more time to make such decisions, whatever that decision may be. As a result, the health care staff feel stressed because they are "caught in the middle" between meeting their

organizational responsibilities and families need for sensitivity during such a difficult time. The next example from my participant observation activities highlights the organizational tensions about what is “good” care in an IUFD situation.

During one particular IUFD case the patient’s primary nurse took the fetal body to the morgue without the “mortuary release form” that designates arrangements for the body. In the morgue log book the nurse wrote, “paperwork coming.” She stopped in the nurse manager’s office on our return from the morgue to inform her that she brought a baby’s body to the morgue without the paperwork. The nurse manager responded to the nurse, “You know Dr. X (the pathologist) will be calling us.” The nurse further stated, “The family doesn’t know what they want to do with the baby’s remains. I don’t understand the rush. When other people in the hospital die don’t they have time to decide on a funeral home?”

From the physicians’ perspective their focus is more on the medical procedures that inform the IUFD protocol such as, confirming an IUFD loss through ultrasound, monitoring the medical induction of labor, pain management, and supervising medical aspects of the birth process rather than it is on the fetus. Sometime after the birth process is completed, it is the attending or resident physician’s responsibility to explain and obtain the parent’s signatures if they desire an autopsy or genetic studies.

Both the attending and resident physicians told me that they often look to the nurse as the expert on the selection of and completion of the correct forms.

In addition, the primary nurse examines the forms to be certain that the delivering health care provider has completed their portion of the paperwork along with their signature before they leave the unit. By physicians placing the responsibility for coordination of the forms on the primary nurse, this responsibility creates added stress for the nurses' and elicits tension between the physicians and nurses.

Approximately two hours after a woman gives birth and she has been up to the shower, the primary nurse brings all the appropriate paperwork into the LDR room. It is the nurse's responsibility to get the parent's signatures on the appropriate lines of the correct forms. A consent form is completed if a woman and her family desires an autopsy. One form, the "final disposition of a stillbirth" is done in duplicate such that, a woman and her family receives the original while the copy accompanies the fetus to the morgue. A "mortuary release form" is also completed designating the final disposition of the fetal remains. The latter form also accompanies the fetus to the morgue. Once the forms are completed the nurse then finishes the IUFD checklist. As previously discussed some of the forms relating to an IUFD case either goes to the morgue with the fetus or in the clear plastic pocket outside the nurse manager's office for her review. A copy of the IUFD checklist and the legal form entitled, "report of fetal death" form is also placed in the clear, plastic pocket for the bereavement services chaplain to pick up and file in her office. This IUFD process reaches a conclusion in the labor and delivery unit when the documentation of the hospital birth routines and the physical, social, and organizational processes that relate to IUFD are completed.

Although the health care staff viewed the completion of the IUFD forms or paperwork as a neatly bounded process that goes on while a woman is on the labor and delivery unit for an IUFD event, the pastoral care chaplains and pathologist when interviewed did not see things the same way. The two pastoral care chaplains I interviewed interface with women and their families who experience an IUFD in labor and delivery or an early miscarriage in the Emergency Department. Likely due to their theological training, the chaplains stated that they believe that life begins at conception. One of the chaplains discussed her perspective when a woman and her family experience a fetal death:

A woman and a man were once individuals however; through the birth process become parents. The baby becomes a part of a family's heritage: the baby could be a sibling or a grandchild and the baby has a place in the family.

(Chaplain #1, In-Depth Interview)

The bereavement services chaplain has the most significant role in the IUFD process with women and their families in the hospital. She keeps a copy of the aforementioned "report of fetal death" in her office in the pastoral care department to identify families eligible to participate in the annual infant memorial service. She described the IUFD paperwork as "voluminous," and the process "taxing" and "overwhelming" for the parents and the health care staff. Tensions have also arisen between the bereavement services chaplain and the labor and delivery nurses. If the chaplain is working on a shift where an IUFD event is happening, she will come to the unit at some point and check on the official documentation process. I observed one such conflict during my participant

observation activities. I was with this particular nurse as she cared for a woman and her family during an IUFD event. The woman had given birth approximately one hour before this verbal exchange.

The bereavement services chaplain was at the desk observing the primary nurse complete the “report of fetal death form” line by line and box by box. The nurse intentionally left one box blank that asked for the date of a woman’s “last loss.” According to the nurse this information was not on any document in the patient’s binder other than she had two other losses as a result of voluntary terminations of pregnancy. The nurse and chaplain got a little “short” with each other. The chaplain asked the nurse to go ask the woman for the date of her last loss. The nurse emphatically stated, “I’m not asking the patient the date of her last loss in front of a room full of people.” The nurse realized this issue around the woman’s previous obstetrical history required sensitivity. The nurse was not going to be bullied by the chaplain to get that information. At that moment the nurse was advocating for her patient who was more of a priority than a form with one incomplete box. When I asked the nurse manager to comment on what I had witnessed she informed me that friction does occur quite frequently between the bereavement services chaplain and the nursing staff at these kinds of moments.

The bereavement services chaplain did not discuss any instances of discord between herself and the nursing staff during her interview. Rather, the chaplain focused on problems that have emerged related to record keeping at the state and federal government levels. She has been asked by parents, “What

proof do I have that I had a baby?” Though women are cued to ask this question for pragmatic reasons, they are also asking a much larger meaningful question about what “proof” do they have that they had an actual baby, a person. The documents do not seem to fit into a woman’s reality. When there is no death certificate issued by the state in the case of an IUFD, a woman has been instructed by a chaplain to ask her primary care provider for a letter to send to the medical insurance company that explains hospital charges or to an employer to provide a reason why she needs time off from work.

In an interview with a second pastoral care chaplain he also described occasions when he has talked with a woman or a family member on the telephone about an IUFD they experienced in the hospital. A woman or a family member will call the pastoral care department after leaving the hospital to request information on the infant memorial service or to inquire about what forms they actually signed in the hospital because they do not remember. I did not specifically ask about this particular situation. However, later I thought calling a chaplain was rather odd. I surmised that a woman and her family might call a pastoral care chaplain rather than their attending physician because they feel a closer connection to the pastoral care chaplain. Since fetuses leave the hospital only on a quarterly basis, a woman and her family may also call wondering if their “baby’s” ashes are at the hospital or cemetery.

During her interview, the pathologist identified and clearly articulated several more concerns with the paperwork, morgue procedures, and autopsies that can negatively affect a woman and her family who experience and IUFD in

labor and delivery. This pathologist described three important points related to morgue procedures often mis-communicated to women and their families: 1) autopsy results may take as long as 12-16 weeks to complete, 2) families who choose cremation and hospital disposition of the ashes think the fetal body leaves the hospital the day after birth when in fact the bodies leave the hospital quarterly and are cremated together, and 3) there is no fee for an autopsy. The pathologist underscored the importance of communicating accurate information to families. She summed it up by saying, “these cases tie up hours of time” interfacing with all the health care staff, funeral homes, families, and reporting agencies like the medical examiner’s office.”

As a consequence of these problems, the pathologist took on the responsibilities for handling fetal or newborn losses when she realized the process was, “too loopy goopy.” From her perspective, the pathologist believes that a fetal loss is a low priority in the labor and delivery unit. Second, the pathologist presumes that the labor and delivery unit attempts “to get the patients off the floor as soon as possible.” For these reasons, the pathologist concludes that transferring or discharging a woman from labor and delivery too soon causes the IUFD paperwork to be incomplete or lost. In her interview she stated, “A fetal loss is a real downer. I don’t know how the nurses do it. Everyone passes the buck, there’s enough trouble taking care of the live births, let alone the deaths.” The pathologist identified just how “messy” the organizational process is in the case of an IUFD.

It is interesting to note that both the director and nurse manager were glad that the pathologist took this role on as someone who is supposed to be charged with death in this cultural context. The pathologist is also invisible in the process because her office is off the unit in the pathology department.

Documenting a Life

Having described the steps of documenting an IUFD and related paperwork trail, I will now turn my attention to further analyzing the physical, social, and organizational processes of recognizing a birth-death related event (IUFD) in the hospital setting as it relates to assigning and rescinding personhood, and meaning making. These processes are intertwined with one another and should not be considered separate entities. I will illustrate organizationally and technocratically how the fetus becomes “more dead” over time and space and a woman’s status as a “mother” is rescinded through the documentation process. As introduced in chapter one, it is important to consider key attributes of structure, process and liminality in discussing a rite of passage related to a birth-death related ritual, the official documents, and resulting paper trail.

Women and their families experience rites of passage as described by van Gennep (1909/1960) during life and death transitions. When a woman and her family experience an IUFD rites of passage are structured within the context of a labor and delivery unit. Most of the documentation processes related to an IUFD are structured in labor and delivery. However, when documentation is minimal or absent the paperwork process creates a conditional state of liminality for a

woman, her family, and fetus that extends from the hospital to home. Over time and space liminality is reinforced during each rite of passage.

Death Rituals

When a woman and her family learn about the death of their fetus, rites of separation begin with the diagnosis and continue with a woman's admission to the labor and delivery unit. In the hospital setting a woman physically separates from her fetus during the labor and birth process. At the same time rites of separation delineate social separation and death that accompanies a woman's isolation from her extended family and community. While isolated a woman, her family, and fetus are considered to be in a transitional or liminal state.

According to Turner (1967) the liminal state can be described as a "process, a becoming" (p.97). Symbols are key units in rituals analysis that include objects, activities or relationships over time (Turner, 1967, p. 19). Beginning with admission to the labor and delivery unit, both a woman and her fetus become invisible through the documentation process. Whereas a woman's physical processes are documented in the electronic medical record there is an absence of documentation related to the fetus. There are no fetal heart tones to hear or document on a fetal monitor. Thus, a woman and her fetus become mired in the liminal state. In this liminal state, the IUFD checklist and official documents organize the IUFD process. The IUFD checklist has been initiated although most of the boxes and blanks are yet to be filled in. No official hospital or state documents have been completed. The incomplete paperwork can be considered symbolic of their liminal state.

Birth Rituals

During pregnancy, taboos separate a woman from her non-pregnant counterparts and broader society (van Genep, 1909/1960). However, transition rituals documented along with the birthing process are intended to socially recognize a woman's position as a mother and a newborn's position as a person. In other words, documenting a woman's position and the life of her fetus in a "normal" birthing process should be fairly clear-cut. Physical separation culminates with birth while social birth is culturally specific (Davis-Floyd, 2003). In some social contexts, a name given to a newborn at birth can be considered the start of personhood (Morgan, 1996). In the biomedical context a fetus may be recognized as a patient and if viable the designation leads a fetus one step closer to personhood.

In the biomedical context for a woman hospital birth routines or rituals embody the technocratic model of birth. These rituals are repetitive, structure the birth process, and decrease the stress on a woman, her family, and staff. Under "normal" circumstances the staff is very proficient at managing the birth rituals when a fetus is viable due to the redundancy inherent in their caring practices and charting for these types of births. The staff acknowledged that they are accustomed to efficiently documenting the routine labor and delivery processes.

Under "normal" circumstances when a baby is born alive in an American hospital in the labor and delivery unit context, a new medical record that is separate from the mother, is created and used to document ongoing progress. In my experience as a labor and delivery nurse, the newborn receives its first

number at birth: that of a baby case number or medical record number. Then the baby receives an Apgar score, the first rating provided to an infant by society. The woman completes a birth certificate worksheet and signs her name as the infant's mother when applying for the baby's legal birth certificate and social security number. These are examples of how a name, birth certificate, and social security number are added further to assign legal and social personhood to a living infant through official forms.

Less frequently, in a situation of a live birth and death, whereby a fetus shows even brief signs of life and then dies, the health care staff also makes a separate chart for the infant. The infant also receives a baby case number. In addition, two legal documents, a birth certificate and a death certificate, are generated in the case of a live birth and death. According to the state, a fetus that is physically separate, shows signs of life and subsequently dies is categorized as a legal person. Under these circumstances personhood is authenticated through documents.

IUFD Rituals

Birth and death converge in the labor and delivery unit in a paradoxical birth-death ritual when a woman and her family experience IUFD. In this biomedical setting, neither the fetal monitor strip is documented on the mother's electronic medical record, nor is the Apgar score, or facilitation of the bonding process on the maternal or infant's record. Without the typical documentation of these birth rituals a woman and her fetus are made invisible in yet another way.

These birth rituals also exemplify the technocratic model of birth. Additionally, the hospital's needs become the priority whereby the organization is a more important social unit than a woman and her family. Documentation is focused more on medical procedures that inform the IUFD process such as, confirming an IUFD loss through ultrasound, monitoring the medical induction of labor, pain management, and supervising medical aspects of the birth process for the woman rather than it is on the fetus. Through the documentation process a woman is not acknowledged as a mother and fetal personhood is rescinded.

In the instance of IUFD, a baby case number is not assigned to the fetus nor does a woman complete a birth certificate worksheet. Thus, there is no creation of a separate medical record or a birth and death certificate to assign a fetus personhood status. The fetus is present in a physical form yet is not a living, breathing baby. A potential exists for the fetus and the woman to remain mired in a liminal state, because the fetus is neither officially recognized by the state nor the hospital as having been born nor died. The woman is also not socially recognized as a mother because she does not complete a birth certificate worksheet nor does she fill in the information that pertains to or write her name on the line where it indicates, "mother." Due to the lack of legal documentation in the form of birth and death certificates, the fetus becomes "more dead" over time and space especially during the IUFD process. This documenting the "life" when a fetus is born as a consequence of an intrauterine fetal death is "messy."

When there is an absence of a birth and death certificate, a woman and her family assigns personhood in the form of naming their infant and collecting mementos. Through the course of my research I found that a woman, having given birth to a fetus in labor and delivery as a result of IUFD, believes her fetus is a person. A woman begins to assign personhood status during pregnancy with recognition of the fetus as a patient (Morgan, 1999). Naming, interacting with the deceased fetus after birth, and receiving mementos gathered by the health care staff can be utilized by a woman to culturally construct personhood for a deceased fetus. When talking about the fetus, parents either use the name they bestowed or refer to the fetus as “baby.”

Artifacts such as mementos are important for a woman because these objects “serve as ‘proof’ of the fetus’ existence and the woman’s motherhood” (Layne, 2000, p.103). These mementos create a story of fetal life and as such are meaningful for a woman and her family who utilize them, in place of legal forms, to construct personhood for their fetus.

Nurses are most often responsible to carry out activities associated with assigning personhood in this IUFD context, especially the gathering of “available fetal remembrances” or mementos. I observed that the nurses who take care of women and their families go out of their way to facilitate the religious and social rituals that occur during IUFD. Nurses would often say in their interviews that they make mementos or facilitate the bonding process not because it is a hospital requirement listed on the IUFD checklist but because they value the process. The nurses demonstrated by way of their actions that each fetus is

significant no matter how the fetus is identified on the IUFD checklist. Often during my observation activities I heard nurses say, “the patient and her family are my priority right now, I’ll chart later.”

Normally when birth occurs that produces a healthy baby, a woman’s transition to motherhood is complete. She is incorporated back into her community as a mother, a couple as parents, and a baby as a person and member of a family. With the lack of the physical presence of a living baby to take home from the hospital or legal documentation, a muddy situation arises with the question: is a woman a mother? The only documentation a mother has that offers “proof” she had a baby is the original of the “final disposition of a stillbirth” form. Layne (2003) has demonstrated that a community may rescind incorporation of a woman as a mother without living proof of a baby. As a result, a woman may experience an “uncompleted” rite of passage (Layne, 2003, p. 59). Although documents have a temporal rather than static nature whereby they are “becoming” rather than “being” (Riles, 2006, p. 18), the hospital and state forms are the last steps in the IUFD process that determine the fetus is finally socially dead.

Organization Culture

In Kaufman’s (2005) ethnography, she dealt extensively with how death is culturally made and organized in specific types of units in hospitals. Kaufman (2005) discovered there are cultural forces within hospitals and patient care units that create paradoxes for the patient and professionals that work there. St. Grace Hospital is no exception especially related to the ritualistic process of

documentation. As a group the health care staff reiterated over and over their frustration with the prohibitive amount of legal and hospital paperwork necessary to be completed in IUFD. To the staff the documentation process is hardly a mundane process of filling in blanks or checking boxes on either the IUFD checklist or the official forms. Rather the paperwork is one of the most complicated parts of the loss process. The staff described the hospital and state forms as confusing and wish the entire documentation process could be simplified. They verbalized that maybe the confusion comes from the fact that IUFD cases happen relatively infrequently; therefore they never achieve a sense of proficiency about which forms to choose, and thus complete. The frequent expression by the staff that they are not proficient in managing death, through the documentation process, in the labor and delivery context can be considered as an indicator of the staff having a “problem” with death (Kaufman, 2003). I surmise that the staff cannot get the paperwork “right” because they would rather avoid death that is visibly present in a birth-death related ritual or they do not want to get it “right.” Such a “problem” with death could reflect the death adverse culture of the health care staff, the labor and delivery unit and the broader hospital context.

The health care staff feels the pressures of time related to their decision-making processes as they manage the IUFD process in labor and delivery. The staff can be viewed as “stuck” in between the organization’s priorities and the welfare of a woman and her family. The health care staff, particularly the nurses, are on the “front” line in managing the documentation process. The nurses who

are most involved in the care of a woman and her family feel pressured to get the IUFD documents completed quickly and efficiently. A tension is created among the health care staff that causes inadequate communication between and among the physicians, nurses, chaplains, and the pathologist in a variety of circumstances.

When IUFD occurs in labor and delivery, the health care staff documents in several places. Physicians and nurses both document in the electronic medical record for the purpose of constructing a medical case and record ongoing patient progress. The nurses have the sole responsibility for filling out the IUFD checklist, and both physicians and nurses document on the official hospital and state forms. Documents, either electronic or paper, are intended to ensure that key tasks are completed. For the health care staff who document in several distinct places and record different observations, the health care staff verbalized how they became quite overwhelmed with charting routines. While documentation should be an orderly process, the health care staff cannot wait to finish. These examples highlight the nature of fetal death related to the documentation process.

For a woman, her family, and health care staff who experience IUFD, documentation encompasses physical, social, and organizational processes. Whereas the hospital may view the documentation process as a bounded organizational event once the paper trail is complete, a woman and her family's experience with IUFD is not so neat. A woman, her family and their needs are too often made to feel invisible during IUFD with the documentation process. A

woman and her family do not get to indicate their readiness either to make decisions about tests or arrangements for their fetus or when to sign the official forms. A woman is discharged with one form and a box of mementos on her lap that she can use to culturally construct personhood for her baby. The woman and her family are also permanently left with a complicated and problematic life course issue when asked, "How many children do you have?"

CHAPTER 6

RITUAL SUCCESSFULLY CREATES PERSONHOOD: A CASE EXEMPLAR

Introduction

Past chapters have described how the official process of IUFD, as a birth and death ritual, creates personhood for a woman and her fetus in the labor and delivery unit. This chapter presents findings from the lived experience of IUFD for a woman and her husband, Ella and Andrew Wright (pseudonyms), when their ritual expectations were met in labor and delivery. In the next chapter I will illustrate what happens when ritual expectations are unmet. After a brief introduction, the theoretical framework of Geertz (1957) will inform this chapter and the analysis of Ella and Andrew's lived experience. Findings describe the significance to participants when customary rituals are performed in an expected manner. Finally, how the findings add or contradict existing research in this area is discussed.

Ella and Andrew Wright

Ella, 30 weeks pregnant, learned her fetus had died at a routine office visit. Ella was admitted to the labor and delivery unit to have her labor induced. At the time of the fetal death, Ella and Andrew Wright were parents of a 13 month-old daughter named Mary. Ella identified herself primarily as a "stay at home Mom" while Andrew was a minister of two large Christian congregations. Living their faith through organized religion and their personal relationship with God, family, and community were central to their personhood. Ella and Andrew's expectations for culturally appropriate behavior, practices, and interactions

surrounding Ella's delivery did signal to Ella and Andrew that they had given birth to a baby, albeit a dead baby. Details that follow describe how Ella's labor and delivery was similar to Mary's birth. Specific details include those related to key health care staff that were present throughout the birthing process who appropriately interacted with Ella and Andrew and carried out post-mortem rituals.

“A Javanese Example” (Geertz, 1957)

I chose to examine this particular ethnography because of its relevance to my own research. Since adopting an interpretivist framework for this study, I turned to Clifford Geertz to explore his use of the concept of ritual as a “pattern of meaning” and a “form of social interaction” (1957, p. 52). While living among the Javanese Geertz was able to interpret the meaning of Javanese funeral rituals by observing the interactions of the ritual participants. Geertz (1957) framework is applied to my own analysis of ritual where expectations were either met or unmet by my participants. Next, I summarize the salient points of Geertz's ethnography used to analyze the current case and the case in the following chapter.

Geertz (1957) witnessed funeral rites for a young Javanese boy, Paidjan, who died unexpectedly. Typically, ceremonies and burial rituals succeeded in bringing the Javanese people safely through the post-mortem mourning period with the assurance that the Javanese community would continue on despite the death of one of its members. Although results of Paidjan's case cannot be generalized to all funeral rituals in Java, the end result of his case was a disruption in the natural social order and the healing process for his parents that

happened when cultural traditions were unsupported. Geertz identified an element of incongruity between how Javanese rituals were customarily enacted during funeral rites for Paidjan and what rituals actually took place. Incongruity related to absence of ritual specialists, improper post-mortem rituals, and hurried or disorganized communal feasts.

The “Modin” was the single most important religious specialist responsible for officiating at funerals in the Javanese community. The “Modin” organized funeral rituals using culturally patterned language and actions. Post-mortem rituals were initiated in the home of the deceased.

Following Paidjan’s death Javanese cultural practices dictated the timing and conduct of post-mortem rituals. These rituals included washing the body with sacred water, placing cotton pads in certain orifices, and wrapping the body in muslin. When these rituals were delayed Paidjan’s body became rigid making bathing difficult. In addition, unsacralized water was used during the bath. Unable to follow customary post-mortem rituals, Paidjan’s relatives became agitated. As a result of delays and improper conduct of rituals, the ritual participants believed that Paidjan’s spirit threatened to linger around house rather than be guided appropriately to the hereafter.

After directing the preparation of the body, the “Modin” was responsible for leading the mourners to the cemetery, and conducting graveside services. However, due to a changing political and religious climate the “Modin” refused to officiate at Paidjan’s funeral. His refusal resulted in a cascade of adverse events

that extended long after Paidjan's funeral, particularly related to the communal feast also known as the Slametan.

The Javanese incorporated a communal feast, the Slametan, as a key ritual form during specified circumstances to make an offering to the spirits and to reaffirm social cohesion of the living. The communal feast was used to mark life's transitions such as, birth and death as well as religious occasions or holidays determined by the calendar. In the case of a funeral, the Slametan was held in the home of the survivors. Typically, eight or ten families congregated in one home where the ritual feast took place. Participants performed the ritual according to a customary pattern. Special meals symbolizing religious beliefs would be prepared by one family, set out on mats, and eaten by the invited neighbors. The Javanese people believed in the Slametan as a significant framework for meaning throughout the life course that not only pleased the spirits, but brought neighbors together in a social ritual of solidarity.

Because the Slametan occupied such a central role in Javanese life, any alteration in its form or content was especially disruptive. A Slametan was supposed to occur according to a cultural mandate within a few hours of Paidjan's death. The ritual would also take place at other culturally ordered times until the separation of the living and dead was thought to be complete approximately three years after the first feast. The first Slametan to honor Paidjan was served late. Like the absence of a "Modin," the second Slametan three days later was not performed as a formal ritual in the manner assigned by custom.

Geertz (1957) concluded that the rituals became a matter of political conflict that ultimately changed the pattern of meaning of the funeral rites for the participants. Their social cohesion was negatively affected. Aberrant rituals weakened the bonds that held the social group together. Absence of ritual specialists to conduct proper post-mortem rituals and a disorganized Slametan led Geertz to conclude that Paidjan's funeral was a failed ritual. Funeral rituals failed to transform Paidjan into an ancestor and his parents into mourners, thus undermining personhood and the solidarity of their community. Rather than healing, disorganization occurred causing persistent social and cultural disruption that lasted long after Paidjan's death. In the final analysis of the failed funeral ritual, Paidjan's mother had not "recovered from her experience" while his father isolated himself in another town, unable to face the people of his own community (Geertz, 1957, p. 47).

Findings

This study provided opportunities for in-depth exploration and understanding of IUFD through the lived experience of Ella and Andrew Wright. In addition, their lived experience also demonstrated how ritual and personhood are co-constructed within the social and cultural context of the hospital setting. In the case of Ella and Andrew Wright, data suggest that expectations for the appropriate ritual process were met. In addition, rituals associated with IUFD were successful in creating personhood for mother and fetus and the development of family. In support of findings, data are provided in the three areas of language, actions, and artifacts. The last section presents data

following Ella and Andrew's homecoming in support of how parenthood continued to be constructed. Substantive details from interviews and field notes are included in the discussion.

Language and Personhood

Overall language, in the form of verbal and non-verbal modes of communication, supported the making of personhood for Ella and her fetus. However, the construction of personhood for Ella and her fetus was initially framed around obstetrical language. I received a phone call from Ella's primary day shift nurse. She stated:

We have a 30 week IUFD here if you're interested.

(11:00 a.m. Field Note #1)

The woman's name was not used in the phone conversation. The woman's diagnosis, history of the "IUFD," and "plan of care" was described using the special language of obstetrics. This woman's identity was that of a patient diagnosed with a fetal death. When I arrived on the unit I received the rest of the information from the same primary day shift nurse that I spoke with on the telephone:

The patient is a 30-week IUFD diagnosed in the office yesterday. This is her second pregnancy and she has a 13 month-old girl at home. The family wants an autopsy and genetic testing done because the ultrasound results show cysts and fluid in the fetal abdomen. The doctors will take a tissue sample from the Achilles heel for genetic testing. Her next dose of Cytotec is due in about an hour. The family is planning on having a professional photographer come from the NILMDTS organization (Now I Lay Me Down To Sleep) to take post-mortem pictures.

(12:30 p.m. Field Note #2)

Medical terminology described Ella's personhood in terms of her patient status. This label is customary in the hospital setting and the label alone does

not designate a failed ritual. However, I knew about Ella as a patient and knew nothing about her emotional state, feelings about a fetal death so far along in her pregnancy, or her social support system. I could not help but wonder if such a loss late in pregnancy would be more difficult for a woman to grieve. Left to my own thoughts I simply asked for her name and information about who had accompanied her to the labor and delivery unit.

Ella's fetus was known as a "30-week IUFD" rather than a fetus or baby. At a gestational age of 30 weeks, Ella's fetus was medically categorized as a stillbirth per the official hospital policy detailed in Chapter 4.

Ella's baby was viable, could have lived outside the womb, and been a patient in the NICU if born alive. Due to her advanced gestational age, Ella conceptualized a baby rather than a fetus. Up until this point in her pregnancy, Ella was able to regularly hear the fetal heart beat at her routine office visits. An ultrasound at 20 weeks determined the baby was a boy.

Ella chose a Certified Nurse Midwife as her obstetrical care provider. The CNM is a Master's prepared RN who specializes in the care of women across the age continuum. Ella's midwife explained to me that she is part of an obstetrical practice with an obstetrician available for "back-up" if she needs it. She also shared with me that she delivered Ella's first baby who was born premature and was admitted to the NICU right after birth due to breathing difficulties. Having experienced Mary's birth in labor and delivery, Ella referred to the unit in this way:

For me, I did, I felt, you know that this is the place of life and it would continue to be the place of life. Although I read that some ladies find it

very difficult because they realize that their experience is different than what most of the women are experiencing at that time, I appreciated my time there.

(Ella, Interview, 3 Months Post-Hospitalization)

Actions and Personhood

Many health care staff were present during Ella's labor, birth, and post-birth period. One specific staff member, the chaplain, had a significant role in constructing personhood for Ella and Joel. In the early afternoon, the chaplain knocked on Ella's door and asked if he could come in. Ella invited him in to her LDR room. While Andrew had gone home to check on Mary, Ella asked me to stay with her. I sat in the chair while Ella and the chaplain talked for about 30 minutes. Initially, the chaplain (#2) introduced himself to Ella and they made "small talk" about the 7a.m. prayer over the loudspeaker:

Ella: Did you recite the prayer over the loudspeaker this morning?"

Chaplain (#2): "I did."

Ella: "I really enjoyed it." (The chaplain pulls up another chair by Ella's bed and gently touches her hand as he discusses his own experience with his daughter-in-law's loss. They talk for some time.)

Chaplain (#2) (Later): "May I give you a blessing?"

Ella: "I would like that."

Chaplain: "Dear Lord, please bless Ella, give her strength during this tragic loss. Bless her with an uncomplicated delivery."

(Through tears) Ella: "God be merciful to my baby if something is wrong. I don't want my baby to suffer. We named him before we even became pregnant. His name is Joel. It means God is my incalculable strength."

Chaplain (#2): Going forward allow people to come along side you and minister to you, walk with you. God will come alive when 2 or 3 gather in

his name. Share the loss together because it's a different experience for fathers.

(2:00 p.m. Field Note #4)

The Certified Nurse Midwife was responsible for the conduct of Ella's birth rituals. While on the unit for six hours, the Midwife directed the health care team in making sure Ella's physical and emotional needs were met. In addition to monitoring Ella's labor pattern, the Midwife spent a considerable amount of time at Ella's bedside as a supportive presence. Birth rituals, guided by the Midwife, created a calm environment in Ella's LDR room. Therefore, Ella rarely used her call light to request assistance.

Based on her success with an epidural during Mary's birth, Ella requested similar pain relief measures during Joel's birth. Ella did not want to experience any pain and her expectation for a medicated birth was met. Ella received an intravenous dose of a narcotic and epidural anesthesia for pain management. Both were given in a timely manner. Ella recalled:

Even the physical aspect was good because the Midwife told me, "You don't have to feel any pain if you don't want to." So that's the way I approached it I thought, the pain isn't going to get me anywhere so I'm just going for no pain.

(Ella, Interview, 3 Months Post-Hospitalization)

Thirty minutes before delivery Ella's pastor from childhood came to visit with Ella and Andrew. Later, I learned that he came to pray with the couple. The nurse and I stepped out to give them some privacy. Suddenly, the Midwife called the nurse through the intercom to come to Ella's labor room. The nurse and I had been sitting at the desk and as a result almost missed the birth. Birth rituals during Joel's birth also mirrored that of a live birth:

It's late evening. We walk in to a dark LDR room. Once my eyes adjust I see Ella sitting with her legs crossed, stroking the baby between her legs saying, "poor baby, poor baby." She says, "I felt some pressure and I felt him coming." No one speaks. The CNM asks Ella if she would like to cut the cord. "I don't think I can with how I'm sitting," Ella replies. "Maybe Andrew wants to." He wasn't able to do it when Mary was born." Andrew slowly cuts the cord. It reminds me of a live birth. The midwife wraps the baby and hands him to Andrew. She waits for the delivery of the placenta. Andrew says, "He's getting worse as I hold him." I don't know what he means but he seems scared. I can't see the baby's coloring because the room is very dark. The curtains are closed. It is a somber atmosphere in the room. It is dark and silent. There is no baby's cry.

(9:00 p.m. Field Note #9)

Artifacts and Personhood

Following Ella and Andrew's time alone with the baby, the nurse weighed Joel. He was one pound, six ounces and was 14 inches long. The nurse noticed that his face had flecks of vernix on it, a cold cream like substance that protects the fetal skin in utero from the amniotic fluid. The nurse gently washed and patted dry Joel's face. Bathing Joel's face was another way that the nurse normalized his birth as all babies receive a bath sometime after birth. Ella noticed Joel's clean face almost immediately:

Oh you washed his face. Ella smiled and looked pleased.

(10:00 p.m. Field Note #10)

In the meantime, the professional photographer was notified of the birth so she could come to the unit and conduct the post-mortem ritual of photographing the baby. In preparation for the photo shoot, the nurse looked for an outfit in the perinatal support room for Joel. Not finding a matching outfit in the support room, we went to the NICU and found a beautiful small, yellow outfit with a matching hat, sweater, and blanket. Back in the perinatal support room, the nurse dressed Joel. Joel's personhood was further constructed through another marker of

humanness: that of clothing (Layne, 2003). Ella reflected on the meaning of Joel's outfit:

So I really appreciate the little robe and hat that they gave too because I could, I can imagine his size, I've held it many time just to have the feeling again of him in my arms. The fact that it was yellow was really a blessing too, because as I was washing it, it started to get the glow of acrylic yellow and to me it was like a resurrection, a reminder that he will be beautifully smelling the next time I see him again, he'll have the glow of death.

(Ella, Interview, 3 Months Post-Hospitalization)

The nurse also selected a memory box to hold the mementos:

In the perinatal support room, the nurse is gazing at a shelf that has three hand-painted memory boxes on it. She takes each one off the shelf and shows them to me. Thinking aloud she describes each one. Here is a teddy bear in a winter scene, here's one that is green with flowers on it, and this one is a beige one with two angels. She sets the latter one on the table stating: "I think this one is best. They now have two angels: one at home and one in heaven." I watch as she writes Joel's name, date, and time of birth on the inside lid of the memory box.

(11:00 p.m. Field Note #11)

Through taking photographs, the photographer was key in constructing personhood for Ella, Andrew, and Joel. The photographer took pictures of Joel's hands and feet in the perinatal support room. Then the nurse, accompanied by the photographer and me, brought Joel in to Ella's room. With permission, the photographer took a red rose from a flower arrangement Ella received earlier in the day. Ella held the rose, commonly used to symbolize love, while holding her baby. More pictures were taken of Ella and Andrew holding Joel. They were a family. Ella appreciated the presence of the photographer for more than just her expertise with photography:

She was able to help me see the beauty that was still left in his body because when he was first born I just saw him as a traumatized little baby that had suffered so much by the looks of him. But she just was so, expressive about how cute his little features here and there were, and she

opened my eyes to his beauty. And then I could see the family resemblance and I could start imagining what he would look like.

(Ella, Interview, 3 Months Post-Hospitalization)

Ella and Andrew engaged in the post-partum American ritual of attributing family resemblances to a new baby during their time together as a mother, father, and baby (Layne, 2003). Joel's personhood was further supported through this ritual process while Ella, as a new mother looked at Joel's face and asked Andrew, "Who does he look like?"

I watch quietly as Ella and Andrew closely examine Joel's face. In surprise, Ella remarks, "Look at his upturned nose! I love his fingers and toes. He has Andrew's ear. My earlobe is attached!"

(12:00 MN Field Note #12)

After the photographer left the unit, the nurse notified the evening chaplain to come to the unit and bless Joel. A different chaplain than the morning one came up to the labor and delivery unit. He made certain that the timing was right for Joel's blessing in relation to Ella's physical condition. The chaplain, Andrew, the Midwife, and the nurse all held hands in a tight semi-circle around Ella's bed as she held Joel while the chaplain blessed Joel and prayed for the family's healing. Ella remarked that his prayer was "genuine and heartfelt." Once again participating a religious ritual brought Ella and Andrew some peace and comfort. Ritual aligned with their self-concept as Christians.

Because of Joel's size many more mementos or artifacts could be obtained to construct his personhood. The nurse made traditional black footprints, "Plaster of Paris" molds of Joel's feet, a baby bracelet, and a "Certificate of Remembrance." All the items were placed in the memory box along with the yellow outfit Joel wore during pictures. The tape measure used to

determine his length was also included. Joel had baby things to acknowledge his personhood. Several hours after birth Ella and Andrew were ready for Joel to have the genetic test completed. Additionally, Ella wanted to take a shower and both Ella and Andrew wanted to eat a light meal. The nurse took the baby to the perinatal support room where the resident took a tissue sample of Joel's Achilles heel for genetic testing and the sample was sent to the laboratory. Following the procedure and similar to a live birth, Joel spent the night in Ella and Andrew's room. They appreciated their time together as a family until discharge the next morning.

Homecoming and Parenthood

Ella and Andrew identified meaningful ways to grieve, albeit differently. While testimonies were not helpful to Andrew, Ella avidly read women's testimonies on the Internet and in books. Ella and Andrew continued to actively manage their grief in the early months after their hospitalization. Their family, friends, and church community welcomed Ella and Andrew home:

Yeah going through it you may think you're alone, but then I had close friends call on the phone, pray with us, they heard it somewhere on the prayer chain. And that was very, very good. Then I had a conference call, our denomination is set up with a headquarters. We have a president and all that. So he had called us, him and his team. You know called us: "We're thinking about you and praying for you right now." Right from the executive room on speakerphone. I mean I have that memory."

(Andrew, Interview, 3 Months Post-Hospitalization)

Ella recalled:

The first time we went to church, ladies kept coming up to me and saying, "I understand because I lost this many children. I lost them in between these particular living children." In fact one lady that leads the Bible group said, "We got on to the topic some while back uh during Bible study and it

turns out that about half of us had pregnancy losses of one kind or another.

(Ella, Interview, 3 Months Post-Hospitalization)

Once home, Ella purchased two more memory boxes and hand-painted them. To the boxes, she added condolence cards she received from family and friends and meaningful poems. Andrew also found it meaningful to have the memory box and mementos:

I believe that um, for me it was kind of essential for closure to be there with the photographer and to have those pictures; they'll be scrapbooked; there will be a little photo on the shelf and um you know whenever you need a picture or a thought it's there. What had helped me too was the nursing staff gave us a keepsake, a memory box that we shared with family and everything. We have even added things in there, and so yeah it is definitely, you know, something we'll have for a long time.

(Andrew, Interview, 3 Months Post-Hospitalization)

Andrew wrote a letter to a grown-up Joel. He remarked that putting his feelings down on paper helped with his grief:

What was probably more difficult to me was that I saw Joel more than beyond the holidays. I saw Joel, um, you know, giving Joel at a certain age his first pocket knife, giving Joel at a certain age a you know a bee pellet gun, that was kind of tradition for my father. Seeing Joel you know, baptized, seeing Joel through all these, you know I saw Joel way up in the future. I saw fishing trips, hiking trips, canoeing, biking, I saw all of that. So my grieving process was um, that's why I needed the letter to say you know hey, "I was never able to do these things with you, but this is what I had hoped to do with you, but we're separated for the time being.

(Andrew, Interview, 3 Months Post-Hospitalization)

The final religious ritual took place at the cemetery where Joel's ashes were buried in the hospital's infant memorial garden. Surrounded by 20 family members and a few of the health care staff, Ella and Andrew were in communion with nature as they mourned Joel's life and death. The memorial service and its attendant religious rituals of church hymns, Bible verses, and unison prayers

supported the construction of personhood for Joel, creation of family for Ella and Andrew, and the start of an ongoing tradition:

“We’re looking forward to going back there when the snow melts and you know just being there and remembering.”

(Andrew, Interview, 3 Months Post-Hospitalization)

Discussion: Relevance of findings to the ritual framework articulated by Geertz (1957).

The first finding suggests that through ritual, personhood was successfully constructed for Joel during IUFD. Although Ella and Andrew experienced rituals differently, they believed that Ella did give birth to a baby, albeit a dead baby. When confronted with IUFD, Ella negotiated the meaning of what constituted a successful birth. Language, action, and artifacts were three key areas that required Ella’s negotiation.

Through language, Ella negotiated the meaning of the labor and delivery unit and birth itself. A successful birth is usually equated with the birth of a living baby (Lovell, 1983). For Ella, describing the labor and delivery unit as a “place of life” laid the foundation for creating Joel’s personhood. Ella believed that the unit symbolized the place whereby mother and babies are successfully made through the birthing process, irrespective of whether babies were born living or dead.

Second, Ella and Andrew chose a Biblical name for Joel well in advance of pregnancy. Ella and Andrew utilized his name in social dialogue on the unit, and during the three-month post-hospitalization interview. In American culture, naming a newborn is an important step in initiating personhood and incorporating the baby in the social group (Morgan, 1996). Early naming was the start of Joel’s personhood.

Obstetrical terminology on the labor and delivery unit could have undermined personhood for Ella and her fetus. Among the health care staff, particularly the day shift nurse, Ella was discussed as a patient with the medical diagnostic label of IUFD or stillbirth. Although such labels aligned with official hospital policy, the Certified Nurse Midwife (CNM) consistently referred to the fetus as a baby or “Joel” in initial and ongoing conversations with both Ella and the health care staff. The night shift primary nurse also called Joel by his given name and referred to him as Ella and Andrew’s “angel.” Thus, the CNM and the night shift nurse had an active role in supporting Joel’s personhood through language.

Language and the actions of the health care staff assisted in meeting Ella and Andrew’s cultural expectations for Joel’s birth. The health care staff can be likened to Geertz’s ritual specialist, or “Modin.” Through experience and education, the chaplains, CNM, RN, and photographer could be considered ritual specialists. The ritual specialists attending to Ella, Andrew, and Joel during birth were actively engaged in directing the various religious and secular rituals necessary for creation of personhood. Although they each had a specific role in the ritual process, their roles worked synergistically to successfully support the creation of personhood for Joel.

The CNM was the key ritual specialist engaged in directing the hospital birth rituals. The CNM conducted Ella’s delivery much like that of a live birth by guiding Andrew in the ritual cutting of the umbilical cord and wrapping the baby and handing him immediately to Andrew to cuddle. As the primary ritual

specialist, the CNM was present for an extended period of time during Ella's labor and delivery. As a result, the CNM structured the birth rituals making Joel's birth orderly, and calming for Ella and Andrew. Successful birth rituals conducted by the CNM supported the making of Joel's personhood.

Joel's blessing after birth was a particularly important moment as religious rituals were an integral part of Ella's self-concept as they were for Andrew. The ritual was solemn, and the chaplain conducted the blessing at a slow, deliberate pace as the participants all held hands in solidarity around Ella's bed. Religious rituals reaffirmed Ella and Andrew's Christianity and were integral for healing. The religious rituals appeared to comfort Ella and Andrew. Although the Slametan undermined the social solidarity among neighbors, Joel's ritual blessing reaffirmed the social cohesion of the family unit.

Unlike Paidjan's disrupted post-mortem rituals, Ella successfully negotiated the construction of Joel's personhood through hospital mementos or artifacts. Photographs, clothing, a baby bracelet, and footprints were given to Ella and Andrew in a memory box. These mementos or artifacts created Joel's story and provided evidence that he was a baby with real things (Layne, 2003). Ella and Andrew were also able to recognize family resemblances through the photographer's guidance. Thus Joel's personhood was constructed in alternate ways from a birth certificate or social security number that typically assigns conditional personhood to an infant born in America (Luborsky, 1994).

The second finding suggests that ritual transformed Ella and Andrew into bereaved, childless parents. Ella received recognition that she was yet again a

mother who had a baby although the baby died. Once home, Ella and Andrew continued the ritual process of gathering more mementos and placing them in additional memory boxes to be shared with family and friends. Creating personhood for Joel was an ongoing process that reaffirmed Ella and Andrew's identities as a childless mother and father.

A supportive family and church community also recognized Ella and Andrew as bereaved, childless parents. Ella's full personhood was related to her success in various roles as wife, mother, family member, and minister's wife (Luborsky, 1994). However, Ella identified her primary role as that of mother. Ella's motherhood was created through the birth process and defined by Ella's framework of success. Her framework for success included both living and deceased babies.

In summary, referring to Joel as "baby" or by his given name rather than IUFD or stillborn, the presence and expertise of a variety of ritual specialists that worked synergistically to facilitate religious and secular rituals, and creating Joel's birth story through mementos or artifacts successfully supported the construction of Joel's personhood during IUFD. Ella and Andrew were reintegrated into their social group as a bereaved, childless mother and father thus supporting their parenthood. Last, the infant memorial service supported the creation of family and the beginning of an ongoing tradition.

Personhood and Anthropology

The boundary between life and death has been a topic of ongoing interest to anthropologists. At this boundary, the lived experience of people, how personhood is negotiated, and meaning making is of specific interest to anthropologists (Kaufman & Morgan, 2005). Ways that culturally determined rituals supported personhood were explored through Ella and Andrew's case exemplar. Ella and Andrew were open to and willingly participated in rituals surrounding Joel's birth. As a result of their willingness, ritual successfully constructed personhood for Joel and Ella. Furthermore, cultural expectations for labor and delivery were met.

Ella and Andrew's lived experience is congruent with the literature describing how personhood is negotiated at the boundary of life and death and how personhood of women is linked to reproduction and birth (Kaufman & Morgan, 2005; Ginsburg & Rapp, 1995). Similarly Ella and Andrew's case demonstrates that fetal personhood is only somewhat related to biology and the concept of viability. Of greater interest to anthropologists is how their case is reflects the making of social personhood through ritual.

The available literature discusses how fetal personhood is made during pregnancy loss or IUFD through viability, naming, and the ritual collection of mementos or artifacts. Joel was considered viable at the time of his birth. He would have been able to live outside Ella's womb had he been born alive. Viability, as a marker of Joel's personhood, is consistent with current literature.

Second, Joel's personhood began with the selection of his name prior to conception. Although early naming is not corroborated with the literature, what is confirmed by the literature is that naming an infant is associated with initiating personhood and his entry into the social group. With a name, Joel's personhood and his unique story were further developed during his birth with the collection of clothing, footprints, pictures, and other items that showed Joel's human characteristics. Mementos reflected not only Joel's personhood rather included Ella's motherhood.

Their case challenges the literature that suggests women receive social pressure to forget when a pregnancy ends with a fetal demise. Ella and Andrew's case contradicts this notion. Individuals, groups, and communities participated in ritual that successfully constructed dual personhood for Joel and Ella. Ritual focused on remembering not forgetting about Ella's pregnancy, labor, delivery, and Joel's birth.

Their case also challenges the idea that during death nonpersons are created (Kaufman & Morgan, 2005). Ella and Andrew constructed personhood for Joel despite IUFD within the social context of the hospital. In fact, Ella and Andrew associated success with IUFD. Their case illustrates that death during birth can be considered a successful ritual process, create personhood for a fetus, and create roles for a woman and man as bereaved, childless parents.

CHAPTER 7

RITUAL FAILS TO CREATE PERSONHOOD: A CASE EXEMPLAR

Introduction

The last chapter presented the case of Ella and Andrew Wright where ritual expectations were met during IUFD. This chapter presents findings from the lived experience of IUFD for a woman and her husband, Bridget and Joseph Keen (pseudonyms), when ritual expectations were unmet. As in the Wright case the theoretical framework of Geertz (1957) informs this chapter and is used in the analysis of Bridget and Joseph's lived experience with IUFD. Findings describe the significance to participants when expected rituals are performed in an unexpected manner. Finally, how the findings add or contradict existing research in this area is discussed.

Bridget and Joseph Keen

Bridget was 15 weeks pregnant when, at a routine office visit, a fetal heart beat could not be heard. Bridget had brought along her two young sons to the appointment telling them how excited they would be to hear the baby's heartbeat. A series of ultrasounds confirmed IUFD. The next day Bridget, accompanied by Joseph and her mother, was admitted to labor and delivery. Bridget and Joseph expected to achieve roles of mother and father with this pregnancy (Luborsky, 1984). Bridget had specific plans for motherhood and raising children that were important to her self-concept. As Bridget explained to me:

We planned to have three children exactly two years apart with birthdays in the same month.

(Bridget, Interview, 3 Months Post-Hospitalization)

Bridget's plan went unfulfilled, as only her two older boys met her criteria for success. This step was the first of many whereby Bridget's cultural expectations for birth and motherhood were unmet. In addition, Bridget and Joseph's expectations for culturally appropriate behavior, practices, and interactions with health care staff did not signal to her and her husband that she had given birth to a baby, albeit a dead baby. Details that follow demonstrate inappropriate health care staff practices, behaviors, and interactions with Bridget and Joseph during IUFD that lead to an adverse outcome or failed ritual. Rather than the birth she expected in labor and delivery, Bridget believed she had a medical procedure. Her cultural expectations for a birth despite IUFD were unmet.

Findings

Like the last chapter, this case provided an opportunity for in-depth exploration and understanding of IUFD through the lived experience of Bridget and Joseph Keen. Their particular case is analyzed as the antithesis of Ella and Andrew Wright's experience that was presented in the last chapter. Bridget and Joseph's lived experience demonstrated how ritual and personhood were not co-constructed within the social and cultural context of the labor and delivery unit of an American hospital setting. Although they believed birth rituals were important to the labor and delivery process, rituals associated with IUFD failed to create personhood for mother and fetus and the further development of family. Ultimately, Bridget and Joseph's expectations for the appropriate ritual process were unmet. In support of these findings, data are presented in the three areas

of language, action, and artifacts. The organization of the data into these three broad areas mirrors that of the last case. Data presented in the last section following Bridget and Joseph's homecoming further demonstrates how parenthood failed to be constructed. Substantive details from interviews and field notes are included in the discussion.

Language and Personhood

Elements of verbal and non-verbal communication undermined the construction of personhood for Bridget and her fetus. In the biomedical context of labor and delivery, the health care staff used common medical terminology that had objective meaning to the staff. Medical terminology along with the specialized language of obstetrics was a way to create order when conducting hospital birth rituals on the labor and delivery unit. Using a person's name in social dialogue may be considered an important key to personhood. The following example illustrates this point. When I arrived on the labor and delivery unit, the nurse relayed only minimal objective facts to me:

Charge Nurse: "The patient's in 12 (LDR room), she's a 15 week IUFD."

Cathy: "What's her name?"

Nurse: "Bridget."

Cathy: "Who's with her?"

Nurse: "A woman and man, maybe her mother and father?"

(12:00 p.m. Field Note #1)

I knew the patient by her room number and medical diagnosis. I had to ask for her name. Even then I did not receive a name for either support person.

I asked myself, who was Bridget? Initially I knew nothing about Bridget's thoughts and feelings about what such a sad event meant to her as a woman and mother. Language served to reinforce Bridget's status as a patient rather than a person.

As discussed in Chapter 4, at 15 weeks gestation, Bridget's fetus was medically categorized as a "fetal loss." Staff decided on an ad hoc basis what terminology they would use when referring to an IUFD in dialogue. However, what I observed is that the majority of the staff use the medical diagnostic label of IUFD.

Issues of size and viability also affected the terminology used to describe Bridget's fetus. Bridget's fetus was estimated to be very small in size and non-viable. In other words, Bridget's fetus could not live outside the womb. Viability as such can be used to distinguish a baby from a fetus. Because Bridget's fetus was considered non-viable, staff typically spoke of Bridget's fetus in discussions as a fetus rather than a baby. Alternatively some health care staff avoided referring to the fetus by any name at all prior to birth. In addition, Bridget did not have a name chosen for her fetus because she was not expecting to give birth at 15 weeks of pregnancy. Although a name is an important marker for personhood (Morgan, 1996) it was not unusual that this fetus was initially unnamed.

Actions and Personhood

From experiencing the birth of her boys, Bridget had certain expectations for a culturally appropriate birth experience that did not come to fruition. Timely medication administration was one issue:

I pull up a chair next to Bridget's bed. Joseph is sitting opposite me. I notice that Bridget had been crying. I see tissues on the bed; her eyes are red, and a little bit swollen. I'm taken aback when Bridget blurts out, "I don't feel special - I've been waiting here since 8:00 a.m. waiting for a pill that I could have gotten from my pharmacy and taken at home. They stuck me in a bed and left me alone. I feel like I'm waiting behind the live births."

(12:00 p.m. Field Note #2)

A comfort medication to relieve symptoms of her stuffy nose was also late:

I'm sitting in my usually chair in Bridget's room. It is now mid-afternoon. Bridget mentions: "I asked for Sudafed this morning when I arrived at 8 this morning. I have a stuffy nose and a headache from crying and I still don't have it." I think to myself: I mean is this for real? A patient has to wait 6 hours for this medicine? Unbelievable!

(2:00 p.m. Field Note #3)

Bridget and Joseph expressed their frustration when Bridget's call light went unanswered mostly during the day shift:

Bridget: "Or just even somebody that when I said I was in pain would get me the meds or, remember we waited forever for the Cytotec? I mean we waited to start the whole process and she (the nurse) said she would be right back. And I pushed my button but nobody was there, I never experienced that. When we were in the hospital the other two times, when you push your button they come, they weren't coming."

Joseph: (echoes): "I'll be right back."

Bridget: "No your not, you're not coming back."

Joseph: "In my world right back doesn't cut it, I need to know you'll be back in five minutes or you' ll be back in two and a half hours. Tell me what's going to happen."

Joseph: "If it's two and half-hours that's fine I can deal with that. But don't set my expectation to be right back, meaning my right back is five ten minutes. So, it's a lot about communication."

(Bridget & Joseph, Interview, 3 Months Post-Hospitalization)

Bridget's primary nurse was one key member of the labor and delivery health care staff. Bridget also requested to see a social worker and chaplain. She expected them to come to her LDR room and assist with answering her questions. Bridget was searching for information on how to tell her older boys about the fetal death and requested to see a social worker:

I had to wait four hours to see a social worker and when we did the social worker was pretty useless. I had really high hopes for that social worker, and um you know we got a packet of information about an inch thick of just things she printed off from Google. I could have done that.

(Bridget, Interview, 3 Months Post-Hospitalization)

The second staff member Bridget was adamant about meeting with was the chaplain. There was a knock at the LDR door:

Bridget: "Come in."

Chaplain: "I'm one of the chaplains from the pastoral care department. Mind if I sit down?"

Bridget: "Course not."

(While pulling up a chair next to the bed, the chaplain asks Bridget to tell the story of her loss which she does. Then he intermittently talks and prays. Joseph is a non-participant in the prayer ritual)

Chaplain: "Bad things happen to good people. Loss is part of the ups and downs of life." (The chaplain says more prayers).

Bridget: "I'm Catholic. My faith is very important to me. I want my baby blessed. Will someone come and bless my baby?"

Chaplain: "Yes, of course."

(2:30 p.m. Field Note #4)

As previously mentioned, the nurse was another essential staff member primarily responsible for Bridget's care. When her shift was over, the day shift primary nurse came in to say her goodbyes to Bridget and Joseph. Behind the curtain out of Bridget's view, the nurse motioned for me to come out of Bridget's room:

I come out of Bridget's room just a few steps behind the nurse. She leans up against a wall in the hallway so I do the same. She wants to talk to me. Our eyes meet. However, I say nothing. The nurse tells me that Bridget asked her when she was admitted when she would see an obstetrician. "I told her that the doctors were in deliveries and they'd be in to see her when they were done." Why is she telling me this? The nurse quickly moves on to tell me the name of Bridget's night shift nurse yet I can't stop thinking about what she said before.

(6:30 p.m. Field Note #6)

Bridget confirms what this same nurse said to her:

"So for the first three hours in the hospital it became very evident that we were a lower priority because my baby was not alive. But for a nurse to say, "We've had a lot of live deliveries going on now." That was tough to take."

(Bridget, Interview, 3 Months Post-Hospitalization)

After the nurse left, Joseph went to the cafeteria to buy food for dinner. I promised Joseph that I would not leave Bridget alone. I sat in the chair by Bridget's bed. During our time together Bridget expressed concern for Joseph:

I have my faith but I worry about Joseph because he has nothing to get him through this.

(6:45 p.m. Field Note #7)

At another time during the interview, Bridget recalled the questions she had when she arrived on the labor and delivery unit:

My first question: what's going to happen to the baby afterwards? What do we do, we never considered burying a child, we don't even know if that's what we should do. And then second of all is can I get the baby blessed? (With a note of desperation she raises her voice and says): Can

please somebody come here and bless the baby? I remember I asked that question like a hundred times. Can somebody bless the baby? Who's going to come here and bless the baby?

(Bridget, Interview, 3 Months Post-Hospitalization)

The third essential member of the health care staff, in addition to the social worker and chaplain, was Bridget's obstetrician. The obstetrician was "on-call" covering for Bridget's private physician who had two days off. He was responsible for directing the hospital birth rituals, yet he was absent from the labor process and Bridget's delivery. In his place, the resident physician acted in the role of the primary labor and delivery attendant. I remember Bridget's birth vividly:

The room is dark and quiet as it is late in the evening. It's just the four of us: the nurse, Bridget, Joseph, and me surrounding Bridget's bed. Joseph is holding Bridget's hand. Bridget thinks she's going to vomit. The nurse hands me a bucket just in case. I'm holding a large pink plastic bucket in one hand and a cool washcloth for Bridget's forehead in the other. Bridget exclaims, "My water broke." The nurse looks under the sheet. The nurse reassures Bridget that it's OK that she's leaking clear fluid and blood. While that may be so, it looks pretty scary to me. I see Bridget's body began to shudder. The nurse calls out to the desk for the resident doctor to come and check Bridget's progress. He examines Bridget and declares he's not going to rush anything along, let her body do the work. "I thought I'd be scared, but I'm just sad," Bridget says. Fifteen minutes later Bridget says she feels rectal pressure. I'm expecting Bridget's obstetrician to walk in her room at any time. Hurry, you're going to miss it! No, it's the resident who just knocked and came in the LDR room. This time when the resident checks Bridget there are fetal parts in Bridget's vagina. Let me know when you feel a bulge between your legs and he leaves the room. I dumbfounded that he left the room when Bridget was so close to delivery. Five minutes later Bridget tells the nurse in a scared, shaky voice, "I feel a bulge." I watch as the nurse pulls the sheet back and the baby slips out of Bridget onto the bottom of the bed. The nurse calmly covers the baby with a surgical towel and calls out to the nurses' station for the resident to come to the room again. Time stands still. Other than muffled sobs coming from Bridget, no one speaks, no one acknowledges the birth. What is appropriate to say? What time was the baby born? Is it a boy or a girl? The resident comes in the room and says nothing as he clamps and cuts the umbilical cord in two places. He picks

up the baby, still covered with a surgical towel, hands the baby to the nurse who places the baby in the cold infant warmer at the opposite end of the room. I'm mesmerized by what's happening. I turn my attention back to Bridget. She's bleeding. The nurse pages the chaplain to come up and do the blessing. As he enters the room, Bridget tries to sit up and breathlessly says: "Will you bless my baby?" She's lightheaded and feels faint. I watch the doctor and nurse work to control Bridget's bleeding. The chaplain arrives. He's in and out of the room in less than a minute after he waves his hand over the baby and mutters words under his breath that could not be heard or understood from where Bridget's bed was across the room. Not a word was spoken to Bridget and Joseph before, during, or after the blessing. The timing of the chaplain's arrival was unfortunate to say the least.

(9:50 p.m. Field Note #8)

In my follow-up interview with Bridget's delivery nurse she remarked:

I asked why D. X didn't come for the delivery and no one knew why. Dr. X is very compassionate. He didn't have an established doctor-patient relationship with Bridget. Maybe that's why he didn't return.

(Nurse #3, Interview, 2 Days Post-Delivery)

Bridget also reflected on her birth experience and the health care staff:

Where this was just so much of a procedure on doctor's time, on your time, you're making this happen for us. That's just it, obviously different experiences and different situations but thinking in hindsight about it, I don't know why I was expecting the level of urgency with this birth that I expected with the others because it just wasn't there. So much could have been overlooked with a healthy baby. It was just so artificial to begin with.

(Bridget, Interview, 3 Months Post-Hospitalization)

Artifacts and Personhood

Naming, artifacts, and mementos could have been alternate ways for Bridget and Joseph to create personhood for their fetus yet did not. Bridget and Joseph delayed the naming process:

Bridget and Joseph ask for some time alone with Avery. The nurse wraps the baby in a baby blanket and hands them the baby to cuddle. The nurse asks Bridget, "Do you have a name picked out for the baby?" They do not. The nurse tells them we'll be back in 15 minutes or sooner if they put

their call light on. When we return to Bridget's room I notice the baby is resting in the infant warmer with a wallet-sized picture of Bridget, Joseph, and their boys resting on top of the baby blanket. Bridget says, "The baby's name is Avery, a name that can be used for either a boy or a girl." Bridget asks the nurse to use the picture somehow in the pictures she's going to take of the baby and send the picture with the baby and her voice trails off . . . it seems like Bridget can't bring herself to say the word morgue.

(11:00 p.m. Field Note #9)

Avery was taken to the perinatal support room where the artifacts and mementos could be collected and placed in a memory box. The nurse took pictures using the unit's digital camera. The printer paper ran out after the nurse developed only two of the pictures. The nurse left instructions for the day shift to finish printing the remaining pictures. Bridget postponed looking at the pictures until the next day. She felt overwhelmed by the birth process and needed time to reflect on what had happened:

I don't want to see any of the pictures. Perhaps tomorrow. It's a lot to absorb. I need some time.

(Midnight, Field Note #10).

The contents of the box were quite limited because of Avery's size. Avery weighed two ounces and was five inches in length. In the memory box were two photos, a tape measure, a baby bracelet, a "Certificate of Remembrance" with faint black footprints on the bottom of the certificate, an angel pin and Avery's hat and blanket that were worn in the pictures. No outfit or "Plaster of Paris" molds of Avery's feet were collected. However, the nurse wrote Avery's name, birth date, time, weight and length on the inside cover of a memory box that was green with flowers hand-painted on it.

The night shift primary nurse reflected on the picture taking and naming processes:

They chose a universal name, Avery. Some of the pictures were left undeveloped. Several of the pictures I took were of the hand resting on Mom's arm in the wallet-sized picture. Hopefully the day shift followed through. The printer was out of ink and the pictures would not print. I was adamant about getting pictures to acknowledge the loss. I wanted to show the family that this wasn't just a medical procedure.

(Nurse #3, Follow-up Interview, 2 Days Post-Delivery)

The day shift nurse primary nurse promised that the pictures of Avery would be mailed to Joseph's email as he requested. When that did not happen, Bridget and Joseph could only focus on the pictures they did not receive rather than the ones they received. As Joseph succinctly stated:

That's the only meaningful thing that we have, so it was hard to lose those pictures.

(Joseph, Interview, 3 Months Post-Hospitalization)

Incredulous, Bridget said:

So don't give me 'lip service,' if the printer paper's out tell us and Joseph will run to Walgreen's and get you more paper. Those are the only pictures we have of Avery. Just understand that I don't have anything to take home other than a box, with what you put in that box right now.

(Bridget, Interview, 3 Months Post-Hospitalization)

Homecoming and Parenthood

Bridget and Joseph did not know what to believe or make of their birth experience. Once home they became isolated, angry, anxious, and felt powerless as the following examples demonstrate:

Yeah well that's the thing, every little thing that happened during, after, and then weeks after were just things that snapped everything back to the day it happened. And then so it didn't allow I think Joseph and I to grieve like we would normally want to grieve. It made us grieve on the path of whatever the hospital was dishing to us at that moment.

(Bridget, Interview, 3 Months Post-Hospitalization)

Bridget's obstetrician informed her that genetic studies of Avery failed to be completed in labor and delivery. The ultimate insult to Bridget's self-concept occurred when her obstetrician blamed Bridget for the genetic studies not being completed. Bridget recalls her 8-week post-partum appointment:

And um, I'm just trying to get past this and I want the results from the genetic testing. And I mean she was going through like everything and going through the autopsy report and things like that. And, um, and then I said well genetic testing, what happened? She says, "Well I wanted to talk to you about that she's like there wasn't genetic testing orders and it said because of what the patient had requested." And I'm like whoa time out, I just burst out into tears, I was just like you're kidding me right? And you know the first, I remember doctor, my initial thought was to immediately go find who did this. I remember I was just kind of like, this is it, this is the last straw, who's responsible? I want to know a name and I want them to know the kind of pain that they have caused me right now.

(Bridget, Interview, 3 Months Post-Hospitalization)

Bridget described the different grieving processes she and Joseph were experiencing. Bridget and Joseph had different expectations for the appropriate time frame to express grief. These differences caused Bridget to feel social pressure from Joseph to move on with her life:

Well I told Joseph, you know Joseph even weeks after, even weeks after the miscarriage, you know Joseph and I have been going through different grieving processes of course. But um you know I remember a couple of, so it was probably like four, gosh even more than that it was like at our 8-week appointment with the doctor. I was just going to go back to work and Joseph was saying in our private conversations, Bridget you just have to deal with it you just have to get on with life. And I was like, every day Joseph something happens. And it was just we were checking out of the doctor's office on my eight-week kind of post-partum appointment and the woman was like, "Oh this is your eight-week after appointment, congratulations!" And I wanted to be like, read your chart bitch.

(Bridget, Interview, 3 Months Post-Hospitalization)

Discussion: Relevance of findings to the ritual framework articulated by Geertz (1957).

The first finding suggests that ritual failed to construct personhood for Bridget and Avery during IUFD in the social context of the labor and delivery unit. Although Bridget and Joseph experienced rituals differently, they did not believe they had a birth, albeit the birth of a dead baby. They believed they had a medical procedure. Their cultural expectations for a labor and delivery similar to their prior experience delivering their two boys were unmet. In this discussion section, the lived experience of Bridget and Joseph Keen is compared and contrasted to that of Ella and Andrew Wright highlighted in the last chapter. In addition, Bridget and Joseph's lived experience reflects the failed Javanese funeral ritual as described by Geertz (1957). Findings were supported by data from the three key areas of language, action or non-action, and artifacts.

Language undermined personhood for Bridget and Avery. Whereas in Ella and Andrew's case they had a name chosen for Joel before pregnancy, Avery received a name after birth. The naming process was also complicated by the fact that Avery's sex could not be determined. Therefore, a name was

chosen that could identify either a boy or a girl. Late naming by Bridget and Joseph undermined Avery's personhood. In addition, Avery did not have a clear identity as either a boy or a girl that could have affected the naming process

From experiencing the birth of her boys, Bridget had certain expectations for a culturally appropriate birth experience that did not come to fruition. Similar to the parents reaction to Paidjan's failed post-mortem rituals in the Javanese example, disorder and disruption prevailed as Bridget and Joseph became isolated in their LDR room beginning with Bridget's admission to the labor and delivery unit (Geertz, 1957). Words combined with action or inaction clearly communicated to Bridget and Joseph that they were having a medical procedure rather than a birth. Through her words and inaction Bridget's day shift primary nurse prioritized the living births over Bridget's birth.

Bridget's birth ritual stands in stark contrast to Ella's birth ritual. Ella had all the staff and resources available to her during her birth. Ella's birth mirrored her prior birth making it feel familiar as if she was giving birth to a living baby. The end result was that Joel's personhood was successfully constructed.

On the other hand, verbal and non-verbal communication during IUFD rituals failed to create personhood for Bridget and Avery. Bridget's birth experience was nothing like the birth of her two boys due to absent or perceived ineffective ritual specialists, lack of a meaningful religious ritual, and unfinished or improper post-mortem rituals.

The obstetrician, in parallel fashion to the Javanese "Modin," was the primary ritual specialist responsible for directing and conducting Bridget's IUFD

ritual. For Bridget, the chaplain and social worker were other ritual specialists expected to have a key role in the process. During the boy's Javanese funeral, the Modin claimed that he did not know correct rituals for someone of a different religion and refused to participate (Geertz, 1957). Perhaps because the obstetrician was the "on-call" physician like the nurse suggested or due to other unknown reasons, the obstetrician was not present during Bridget's delivery as is expected in births for living babies. Miscommunication between Bridget, Joseph and the health care staff combined with the absence of key health care staff caused social and cultural disruption in the lives of Bridget and Joseph. A ritual conducted without ritual specialists, is a failed ritual (Geertz, 1957).

Absence of ritual specialists negatively affected the cultural framework of meaning for the Javanese. Likewise, the same was true for Bridget and Joseph. The Slametan, or ritual meals in the Javanese culture, was considered a sacred symbol that provided a meaningful framework for facing death for the Javanese people (Geertz, 1957). For Bridget her faith and Avery's blessing was a meaningful framework for her to face Avery's death. Avery's blessing came at an inopportune time when Bridget was in a fragile physical state. It was not a typical religious ritual.

I concluded from the number of times Bridget asked for a chaplain to bless her baby, and sharing with me how important her faith was to her that Bridget believed it was essential to have Avery blessed. Bridget's cultural expectations for a meaningful Catholic blessing were unmet. The absence of ritual specialists to conduct and guide religious and secular rituals along with action or most

notably, inaction on the part of the health care staff collectively undermined personhood for Bridget and Avery.

Unlike Ella and Andrew's many mementos they acquired for Joel, due to Avery's two-ounce weight, there were fewer artifacts available. There was no outfit Avery's size or "Plaster of Paris" molds made of Avery's feet. The post-mortem ritual of collecting mementos was left unfinished when the remaining pictures of Avery were supposed to be emailed to Joseph and were not. Therefore, incomplete post-mortem rituals failed to construct Avery's personhood.

The second finding suggests that ritual failed to transform Bridget and Joseph into bereaved, childless parents. Although Bridget perceived herself as a well-educated, confident, working woman, and mother of two boys, Bridget did not receive any recognition that she was yet again a mother who had a baby, a deceased baby. In addition, Bridget felt angry and powerless about how her birth experience was handled that in turn, interfered with her grieving.

Bridget was not successful in assuming full personhood in her role as the mother of three living children (Luborsky, 1994). Her self-concept was further jeopardized when Joseph indicated that it was time to get over Avery's death. Bridget could not negotiate her identity as a mother with the one person who meant the most to her: Joseph. Bridget also had few opportunities to explore and negotiate her new role as a childless mother with individuals, extended family members, and communities such as her female work colleagues. Joseph

was Bridget's primary support person. On the other hand, Ella and Andrew had a large family and larger church family that supported them in their grief.

Bridget's self concept was negatively affected when her obstetrician blamed her for the incomplete genetic testing. Bridget felt acute anger and emotional pain in response to the physician's remark. Bridget was rendered powerless during this social interaction. Bridget believed that some negative experiences could have been overlooked with the birth of a healthy baby. Culturally appropriate behavior, practices, and interactions surrounding a birth failed to signal to Bridget that she had given birth to a baby, albeit a dead baby. Rather, Bridget had a medical procedure done on the doctor and nurse's time.

Personhood and Anthropology

As described in the previous chapter, anthropologists are interested in the lived experience of people, the making of personhood, and meaning making at the boundary of life and death (Kaufman & Morgan, 2005). Bridget associated reproduction and birth with the making of Avery's personhood and her motherhood (Ginsburg & Rapp, 1995). Both ideas are supported by the anthropological literature. Bridget's cultural expectations for a birth failed to be realized.

Similar to Paidjan's funerary example, ritual failed to create personhood for Avery causing serious disruption in Bridget's life's course (Geertz, 1957). Findings related to Bridget's case are also in line with Lovell's (1983) research. By not acknowledging Avery as a person Bridget's labor and delivery experience

were negated and therefore Bridget was “stripped” of her motherhood role (p.760).

Similar to Layne’s finding (2003), Bridget could remain mired in a liminal state, in “uncompleted” *rites of passage* (van Gennep, 1909/1960); Layne, 2003, p. 59). Bridget and Joseph failed to become a childless mother and father. This case study challenges assumptions that size of a fetus matters in constructing personhood. Bridget considered Avery, who only weighed two ounces, a person.

The available literature also describes how fetal personhood during IUFD can be alternately negotiated and made through viability, naming, the ritual collection of mementos or artifacts, and the presence and support of key health care staff. Like the literature proposes had Avery been viable, named earlier, and more mementos were available to be collected in proper post-mortem rituals by appropriate staff, personhood might have been successfully constructed. As suggested by Kaufman & Morgan (2005), in death Avery was made into a nonperson.

Bridget and Joseph’s case adds to the literature that women feel social pressure to forget. Their case also supports the literature that describes the existence of more failed IUFD rituals than successful rituals. Available research further indicates that IUFD rituals have improved over the last decade. Bridget and Joseph’s case challenges this latter scholarly assertion. This case study, like the previous one, are replete with ideas for future Anthropological research related to IUFD, its relationship to birth, death, personhood, and meaning making for women, their families, and health care staff.

CHAPTER 8

THE ANNUAL INFANT MEMORIAL SERVICE

In the last two chapters the lived experience of IUFD of two women and their husbands and how their ritual expectations were either met or unmet in the labor and delivery unit was described. This chapter discusses the annual infant memorial service that demonstrates how ritual constructs personhood outside of the hospital setting and the way in which women, their families, and the health care staff attribute meaning to their experience. This analysis, informed by ritual theory, takes place at the end of the chapter. Findings describe the significance of ritual to memorial service participants. Finally, how the findings add or contradict existing research in this area is discussed.

Introduction

The pregnancy loss support movement has worked diligently to increase awareness about the topic of pregnancy loss by helping to create a nationally recognized pregnancy and infant loss remembrance month. By 2001, 47 United States governors officially signed a proclamation “honoring October 15 as Pregnancy and Infant Loss Remembrance Day” (Layne, 2003, p. 239). One of the goals of the pregnancy loss support movement has been to break the silence on the topic of pregnancy loss. There has been some measure of success as Layne (2003) noted that the topic was covered “more frequently in the popular media” (Layne, p. 239).

To coincide with the annual Pregnancy and Infant Awareness Loss Month observed annually in the United States, St. Grace Hospital conducts an infant memorial service once a year in the month of October. All women and their families who experienced an IUFD or a live birth and death in labor and delivery were invited to attend. Also invited were women and their families whose babies were born alive in labor and delivery, admitted to the NICU, and subsequently died while patients in the intensive care unit. These latter groups of women and their families were not part of my research study.

Families were invited to attend if they had experienced a death during an 11-month span of time that started from the last infant memorial service to September 15th of the following year. The deadline of September 15th allowed the infants' ashes to be interred at the west side cemetery or sprinkled over a pond at the east side cemetery prior to the service. Any woman delivering after the September 15th deadline would be invited to attend the next Infant Memorial Service held the following year. As a result means women who delivered after September 15th could wait almost one full calendar year before being invited to a hospital ceremony memorializing their infant.

Findings

During my study, I observed ten families during my yearlong IUFD participant observation activities. However, only one family participated in the memorial service. Ella and Andrew Wright experienced an IUFD three weeks before the memorial service and participated in the October 2010 memorial service. For me, attending the infant memorial service represented the end of

my research study at St. Grace Hospital: from inception of the study, to obtaining IRB approval, and on through the year long process of collecting data.

Prior chapters discussed how ritual and personhood were co-constructed within the social and cultural context of the hospital setting whereas this chapter describes the construction of personhood during the hospital's infant memorial service in the community setting. In this setting, rituals were successful in creating personhood for mother and fetus and the development of family. In support of these findings, data are provided in the areas of language, action, and artifacts. However in contrast to the two previous chapters describing the lived experience of IUFD for two women and their husbands, these areas are more intertwined within the memorial service. Therefore, they are not described in discrete data sections. Substantive details from interviews and field notes are included in the discussion.

History of the Annual Infant Memorial Service

According to one of the nursing directors, who was one of the founding members and the primary leader of the memorial service, the purpose of the memorial service was described as follows:

Some years back, we decided to have a memorial service and um so that we could invite families back to give them kind of a formal opportunity to grieve over their baby, to reach some closure. So often in a pregnancy loss there are no material goods besides the baby and people in any death don't like to talk about it, especially when a baby dies. So we really wanted a formal opportunity to let families know that we care and to tell them about our mission - -caring is part of our mission, umm so we put together the Memorial Service. It really soothes my soul as well to moderate this service

(Nursing Director, In-Depth Interview)

The service was conducted twice: once in the morning and once in the afternoon at each of the two cemeteries affiliated with St. Grace Hospital. Every woman who experienced IUFD or a newborn loss was invited to attend. The two cemeteries were located on the east and west side of town, respectively. The goal of the site selection was that one of the cemeteries would be in close proximity to a family's home thus providing easy access to attend the infant memorial service and visit the cemetery as often as they wished. The nurse manager liked having the memorial service at the cemetery:

I think it's nice because it gives the patients knowledge of where their babies ashes are at and an opportunity for them to get to know the setting.
(Nurse Manager, In-Depth Interview)

The services were two and one-half hours apart to allow the staff to get from one cemetery to the next. The staff stopped to eat at a restaurant somewhere in between the two cemeteries. It was a time to debrief about the first memorial service and to discuss if any adjustments needed to be made prior to the next service. Unfortunately, in 2010 and for several years prior, the ceremony was held during severely inclement weather. There was a cold, driving rain. The nursing director, nurse manager, labor and delivery staff nurses, and others to be described later in the chapter persevered and conducted the ceremony, there was some discussion among the nursing staff about moving up the ceremony to the month of September. The leader decided against moving the day because the service would no longer coincide with the national Pregnancy and Infant Loss Awareness Month.

The nurse manager discussed how one year they organized and held the infant memorial service in St. Grace Hospital's chapel:

Very few families attended. That was the one and only time we had it in the chapel. We also tried having it outside in the front of the hospital around the cherub statue with refreshments afterwards in the cafeteria. That ceremony was also poorly attended. Since then I surmised that families were not ready or did not want to come back to the hospital where their loss occurred. It might also be too emotionally painful.

(Nurse Manager, In-Depth Interview)

The staff recognized the importance of the memorial service and continued to participate in torrential rain, cold, and oftentimes-windy conditions each fall.

One year, thinking it would be a symbolic commemoration of the lives of the infants, we ordered live butterflies to be released during the memorial service. There were some awkward moments as the nurses encouraged the butterflies to fly up and away while I recited the poem from the end of the program entitled, "Journey of Hearts." Unfortunately, the butterflies fell to the ground flapping their wings. The butterflies were "half-dead" I think they succumbed to the cooler October temperatures. That was the first and last time butterflies were used in the memorial service. I was mortified.

(Nursing Director, In-Depth Interview)

Information about the memorial service was provided in the "support packet" given to each of the women while in the hospital. The RTS bereavement services chaplain or "Perinatal Bereavement Coordinator" as she was sometimes called, also kept track of women who had an IUFD or a newborn loss and personally sent out written invitations to each woman and her family inviting them to the memorial service. While the chaplain maintained good records of families eligible to participate the nurse manager reported ongoing problems:

The chaplain tends to send out the memorial service invitations at the last minute. Families have been known to find out about the service "after the

fact.” Having either read or been informed about the memorial service, families have called the pastoral care department to inquire about the date for the infant memorial service only to find out it had already happened. That’s a huge problem.

(Nurse Manager, In-Depth Interview)

Participants: Health Care Staff/ Women and their Families

Currently, the nurse manager, the nursing director, and the “Perinatal Bereavement Coordinator” active plan and participate in the annual memorial service. In addition, other health care staff that regularly participated in the service was one of the attending obstetricians; a woman from the business office, and a few staff nurses would come if they were available. The physician and the woman from the business office were responsible for singing the hymns solo without accompaniment. In the past cider and donuts were provided for the families although there was no food at this year’s service. Roses and a little memento were given to each of the women who participated in the service. The ceremony, mementos, and food (when available) were paid for with hospital funds.

The Ceremony

Outside the hospital setting, personhood continued to be socially constructed through language, action or non-action, and artifacts.

When each woman came to the cemetery site, either alone or with her family, I watched as the leader of the infant memorial service personally approached the woman, introduced herself, and welcomed her and her family members to the memorial service. Then the leader handed each family member a program with the picture of a white lamb on the front with the Bible inscription: “let the little children come to me . . .the kingdom of heaven belongs to such as these (Matthew 19:14).” Inside the program were the words to the scripture readings, the hymns, and unison prayers.

(October, 2, 2010. Field Note #1)

After introductions were completed, each woman was asked to write her baby's full name down on a sheet of paper. Although it was not required that a woman and her family name their baby, all of them did. Once everyone gathered the leader thanked the women and their families for coming:

It must be hard to come here today. By being here, it might open old wounds; the staff and I hope that in some small way this ceremony brings you closure. We also want you to know that we do care about you, your families, and your babies. We will begin the ceremony by lighting a candle to remember your infant.

(October 2, 2010. The Ceremony Leader)

As the leader lit a candle enclosed in a clear, plastic hurricane cover, (to somewhat protect the candle from the wind) the leader recited from the program:

We will light a candle to remember your infant and others . . .who were not to precede you in death-but did. Who continuously share a special place in your heart. Whom we shall never forget - -in time or space, who will journey with you still.

(October 2, 2010. The Ceremony Leader)

During the service there were several scripture readings, prayers and hymns either said or sung. Then it was time for the rose presentation. Before distributing the roses the leader explained to families how important it was to say their baby's name out loud. She solemnly said,

We remember each baby with love. As I read your infant's names, please come and receive a rose.

(October 2, 2010. The Ceremony Leader)

The women each came forward, some with tears softly rolling down their cheeks, or at times sobbing, and received a rose and a memento of some sort. This year the trinket was an angel pin.

(October 2, 2010. Field Note #2)

Following the presentation there was a closing prayer and hymn. After the rose presentation the leader invited the families to share stories during “a time to remember” as written in the program.

No one shared a story in the large group although after the ceremony families seemed to linger. While they lingered I observed that women and their families stayed within their family circle or occasionally spoke with a member of the health care staff. Women and their families may have felt safer staying in their family group or only speaking with health care staff who knew best what they had gone through while in the hospital.

(October 2, 2010. Field Note #3)

Following the ceremony, I took some time to reflect on the ceremony, my surroundings, and how I got to the site. The nurse manager had given me directions to the east side cemetery and the pond where the memorial service was to take place. As I entered the gates of the cemetery I saw the pond to my left and an office building to my right. However, there was no left turn to reach the pond. Passing the office I drove on a narrow lane about one-quarter mile, made a u-turn, and came back toward the pond. It seemed like an older cemetery with mature trees and headstones with faded names carved on the facades. I observed the nursing director get out of her car. I pulled my car in behind hers and parked on the grass just enough to allow other cars to pass me on the narrow lane if necessary. We walked to the pond where the director set up a folding table with the large hurricane candle. She also had the programs to distribute to the women, their families, and health care staff. The nurse manager and two labor and delivery staff nurses arrived with the angel trinkets and a vase with a dozen red roses. It looked as if new grass seed was sprinkled on fresh dirt in front of the pond. The dirt was rather soft. There was no sign welcoming women and their families. The health care staff stood by the pond and the folding table waiting for people to arrive. We seemed to be the only visible group of people in the cemetery. As a result, women and their families gravitated to where we were standing. The pond was at the front of the cemetery. It had a triangular shape bordered by a chain link fence separating the cemetery from a sidewalk and a very busy four-lane highway. Green plants were growing around and in the pond. Some type of plant that resembled lily pads was floating on the surface of the pond. There was a cement bench by the pond if someone wanted to sit and gaze at the pond. This pond is where fetal and newborn ashes are sprinkled over the water three weeks prior to the service.

(October 2, 2010. Field Note #4)

This year three mothers came to the ceremony at the east side cemetery.

One was alone, while the others brought their family members:

I watch as a woman who was crying approached the site where the ceremony was to take place. A family member has her arm around the woman's shoulders. She's giving her tissues. When she joined the group, I noticed that she had shoes on with about a 2-inch heel. She ended up standing on the soft pile of dirt where the grass seed had been laid. Her heels sank into the soft dirt until they were not visible any more. The woman didn't seem to notice. When her baby's name was read, the woman unsteadily walked up to receive her rose and memento from the leader. On the way back to her family, with heels sinking into the ground with every step she fell into the waiting arms of her family member. The woman seemed totally oblivious to what was happening to her shoes, her pain was so acute

(October, 2, 2010. Field Note # 5)

An elderly man, who could have been one of the babies' grandfathers, approached me while I was standing by the pond after the service. He shared with me that he liked the fact that:

My baby's ashes are sprinkled over the water that for me represents life, the bosom of Jesus Christ. My baby has now returned home.

(October 2, 2010, Man at East Side Cemetery)

There were also three families at the west side cemetery. One woman asked if she could videotape the ceremony to send to her sister, who experienced the loss. She had moved out of state and asked that a video recording be made because she could not return for the memorial service. The leader was very glad to oblige her request. At this location there was an actual memorial garden made out of a cement walkway and platform, evergreen trees, grass and mulch. Some years back, a benefactor of St. Grace Hospital had made a substantial donation to construct this memorial garden. Upon further questioning no one knew any more about how this memorial garden came to be.

This memorial garden stood in stark contrast to the non-descript, unmarked pond located at the east side cemetery.

As I arrived I observed a bronze sign, with the hospital's name printed on it, at the entrance of the memorial garden by the cement block walkway. Walking on the cement blocks I walked toward a bronze cherub that stood on top of a block of granite holding an infant. As families and the health care staff arrived they followed the same walkway that I did, then stopped and gathered at the foot of the cherub statue for the ceremony. Prior to the service I watched as a cemetery employee placed a lectern in front of the cherub for the leader's use. It felt like the cherub was presiding over the ceremony because of the statue's height. The cherub towered over me as I stood next to the statue. As I stood there I looked around and noticed that there were two granite benches to sit on. Some family members sat during the ceremony while others stood. A row of well-trimmed hedges bordered the area where the ceremony took place. Grass, evergreen trees, a well-manicured lawn, and mulch landscape surrounded the garden. Behind the bronze statue was a row of evergreen trees that marked a large grassy area. At the base of the trees there were small, square granite grave markers placed in a straight line parallel to the trees. They were about the size of a brick that would be used in constructing a home. Individual years from 2002-2010 were etched on each one of the granite grave markers. Babies' ashes were buried underneath the grave markers. This year was especially poignant for all of us because there was a pair of baby booties by the 2009 grave marker, faded, and worn from being out in the elements. It made me wonder about the woman or man who placed the booties by the granite grave marker. Did the person come alone? How often? Did the person find peace in these surroundings? All unanswered questions.

(October 2, 2010. Field Note #6)

On the last page of the memorial service program was the following poem entitled, "Journey of Hearts" that the leader recited:

A butterfly lights beside us like a sunbeam and for a brief moment its glory and beauty belong to our world; but, then it flies on again. And though we wish it could have stayed, we feel fortunate to have seen it.

The poem signaled the end of the memorial service. The leader solemnly said, "thank you for coming today, our thoughts and prayers are with you all."

(October 2, 2010, The Ceremony Leader)

Ella and Andrew Wright, who had their ritual expectations met in the hospital also commented on the memorial service and its meaning for them:

We needed the ceremony to be Christian based for ourselves. It was so wonderful that it was just from the Bible and hymns that everybody loves and associates with comfort and joy, it was simple and it was, you could hear the voice of God speaking through the heart of it.

(Ella, Interview, 3 Months Post-Hospitalization)

Discussion

Ritual Constructs Personhood

The yearly infant memorial service provides a woman and her family an opportunity to commemorate their deceased fetus. In addition, the memorial service further constructed fetal personhood, parenthood, and creation of family. In the context of the memorial service a fetus was referred to as a “baby” or by the name provided by the mother rather than the clinical marker of fetus.

Ritual and personhood are interrelated and mutually co-constructed. As introduced in Chapter 1, social birth in the United States was noted to be synonymous with physical birth. In the hospital setting a woman’s cultural expectations for the physical birthing process figured prominently in either the success or failure of the construction of personhood during IUFD ritual. However, physical processes were conspicuously absent at the infant memorial service because there were no medical procedures to perform or medications to be administered. In the community setting social processes trumped the physical processes. Similar to the Wari or infants born in Ecuador whereby personhood is socially constructed in increments over time through ritual activities, the memorial service continued the construction of social personhood, parenthood, and creation of family that was initiated in the hospital (Conklin & Morgan, 1996; Scheper-Hughes, 1992).

The yearly infant memorial service provides a woman and her family an opportunity to commemorate their deceased fetus. The memorial service can also be the start of an ongoing tradition. In the hospital setting, fetal personhood was created through IUFD ritual such as language, actions or non-action on the part of the staff, and the collection of artifacts. These rituals became an extension of the labor and delivery as ritual continued to create personhood for a fetus and construct parenthood for a woman. As such, these rituals are significant to the participants of the memorial service. In addition, Ella and Andrew Wright who participated in the memorial service ritual and in a post-hospitalization interview were recognized as bereaved, childless parents.

The memorial service is conducted once a year during pregnancy loss awareness month. In addition, the ceremony is conducted at the same cemeteries every year. The characteristics of repetition and invariance are illustrative of ritual. Rituals were also formal and created order in the cemetery setting.

Religious and secular rituals are important to the conduct of the memorial service. During the memorial service, the religious rituals were comprised of a variety of scripture readings, Christian church hymns, and prayers. Religious rituals were formal, repetitive, and ordered the memorial service. Ella and Andrew Wright, because of their church ministry, were very familiar with the religious rituals that brought them comfort as they mourned Joel's loss. These rituals promoted social connections to the living and to the deceased that

fostered a sense of stability and continuity for all participants. For families in particular, they learned how to continue on despite loss.

Each of the health care staff had a specific role in the service. The nursing director was also the facilitator of the memorial service. The chaplain presided over the religious rituals that consisted of prayers and Bible readings. The obstetrician and woman from the business office were soloists singing the various hymns of remembrance while the women, their families, and health care staff participated, as they felt comfortable. Participants recited prayers out loud, listened respectfully with heads bowed as the soloists sang, and prayed together as if they were in a formal church setting. In addition to the formal, repetitive, and ordered characteristics of these religious rituals, language and actions by the participants were indicative of a performance.

Secular rituals consisted of presenting a rose and an artifact or memento to each woman at the memorial service as the leader read her baby's name aloud. A rose has long been recognized as a symbol of love. The memento consisted of a small angel pin given to each woman as a token of remembering her infant. This artifact is a symbolic representation of angels as ethereal beings who transcend the physical body. During this solemn part of the ceremony, ritual was highly stylized, "acted like a part in a play" and commanded attention of participants (Moore & Myerhoff, 1977, p. 7). These rituals communicated messages that a fetus was indeed a baby, and a woman was a mother, a childless mother. Ella and Andrew Wright were transformed into bereaved, childless parents.

Naming has been shown to initiate social birth and personhood (Morgan, 1996). Naming that began in the hospital was reinforced during the infant memorial service. Layne (2001) reported in her research that names have a heightened significance in the construction of personhood particularly when there are no physical remains. For the women and their families who attended the memorial service no physical remains were evident as only ashes were available to either be sprinkled over a pond or interred at the hospital's memorial garden.

All women who attended the memorial service had a first, middle, and last name chosen for their infant. When the leader read each baby's name slowly and deliberately as a woman came forward to receive the rose and a memento as tokens of remembrance, the ritual process was formal, orderly, and very solemn. Reading the baby's name aloud was a symbolic activity that acknowledged the baby's personhood. These religious and secular rituals offered evidence to women and their families that each woman did give birth to a baby worthy of being remembered.

The infant memorial service is one example of a periodic commemoration that is specified by the calendar. Nature, symbolized through the conduct of the ceremony outdoors, a picture of a lamb on the memorial service program, a poem about butterflies, and images of flowers have become symbols of a deceased infant or child (Layne, 2003). Although a cemetery can be considered a place of death, it is also a place where social and ritual processes take place that communicate rebirth of a fetus and social recognition of a woman as a bereaved, childless mother.

Personhood and Anthropology

The memorial service clearly illustrated the key characteristics of ritual theory that are congruent with the literature. Religious and secular rituals were formal, stylized, performative, invariant because they occurred at special places such as cemeteries, at fixed times on the clock and calendar, and as a result of specific circumstances (Rappaport, 1999; Moore & Myerhoff, 1976). The memorial service had special words that combined with a sensory experience made for a more complete ritual performance (Rappaport, 1999). Participants heard the words, hymns, and readings structured within the memorial service. Feeling the breeze, smelling the fresh air, and being out in nature added additional meaning to the ritual.

Layne (2003) noted in her research that nature themes were prominent in parents' stories describing their loss. Likewise in this memorial service the inclusion of pictures of a lamb and butterflies, a poem, and the nature setting were key themes that are congruent with her research.

In line with the literature is the notion that personhood is a cultural attribute that is supported by specific social rituals, one of which is naming. The hospital's infant memorial service at the cemetery and its attendant rituals is an example of the social construction of personhood sans excessive medicalization. In the United States, biological birth and social birth are often intertwined when the construction of personhood is discussed in the literature. But it is important to recognize that biological death is also distinct from social death and can result in the transformation of a living person into a non-person or spirit (Kaufman &

Morgan, 2005). This idea is somewhat of a contradiction when considering a fetal death. A fetus may be transformed into an angel, spirit, or an image found in nature. In a fetal death, a once viable fetus did not live outside the womb so biologically death has occurred; yet as we have seen above the situation of socially becoming dead can be more complicated. Therefore, it is possible in such situations to consider from an anthropological vantage point how a fetus can be a person, yet not really.

CHAPTER 9

CONCLUSION

Whereas the last chapter discussed the hospital's annual infant memorial service, this chapter concludes the research. This discussion summarizes the cultural construction of personhood: (1) during IUFD; (2) how this research extends the work of several anthropologists including van Gennepe, Rappaport, Geertz, and Layne; (3) limitations of the research; (4) and concluding thoughts.

Construction of Personhood

A fetus becomes a person and woman becomes a mother through birth rituals that are typically situated in the labor and delivery unit of an American hospital setting. Furthermore, in America biological and social birth are considered synonymous. At the time of birth personhood is initiated through assigning a name, a birth certificate, and social security number to a newborn. However, it is only in adulthood that full personhood is achieved through the assumption of adult roles such as spouse, parent, or community member. The cultural significance of birth and the construction of personhood through ritual has received extensive consideration in the anthropology literature.

Life's transitions such as birth and death have also been classic topics for ethnographic research. Although there are other transitions or life crises worthy of merit and discussion, birth and death are most relevant to this research. These transitions have been categorized as rites of passage and further subdivided into rites of separation, transition, and incorporation. In early

ethnographies, birth was recognized as a rite of passage that transformed a fetus into a person and a woman into her role of mother. In death, a living person was transformed into a different entity such as a nonperson, spirit, or ancestor. Rites of passage illustrate the social process that is culturally defined and results in a transformation of individuals, groups, or communities. Historically birth and death have been considered as distinct rites of passage.

Construction of Personhood During IUFD

Rites of Passage

During IUFD a woman and her family must undergo simultaneous rites of passage that relate to birth and death. This study provides a deeper understanding of IUFD whereby birth and death merge in a blended rite of passage that extends the anthropology literature in this area. Rites of separation during death rituals are relatively short with isolation as a key characteristic. A woman becomes isolated once she is admitted to the labor and delivery unit as a patient. Concurrently with receiving the medical diagnosis of IUFD, a woman begins to separate and grieve the loss of her dream “baby.”

A woman must also labor and deliver a deceased fetus. As described earlier, biological and social birth rituals are considered synonymous in the United States cultural context. A woman participates in transitions rituals, both secular and religious, that characterize the boundary between rites of separation and rites of incorporation. It is during transition rituals where fetal personhood is created. A woman is elevated to a new role as a mother, and a man is elevated to a new role as a father. Together, they become parents and family is created.

Findings of this study demonstrated how fetal personhood for a fetus was alternately constructed during IUFD rituals that took place in the labor and delivery unit. Personhood was created through practice of naming, supported or undermined by action or non-action on the part of the health care staff, and collecting mementos or artifacts to be placed in a memory box. Mementos consisted of various items such as pictures, footprints, a “baby” bracelet, tape measure, and clothing worn by the fetus. Artifacts, as meaningful ways to construct personhood during IUFD, are consistent with the anthropology literature.

Findings also suggested that a woman and a man could be transformed into bereaved, childless parents. Further, their family and community would recognize their parental status during rites of incorporation. Participation in the annual infant memorial service and its social rituals also reaffirmed connections to the living, creation of family, and the start of an ongoing tradition.

Ritual Succeeds or Fails to Construct Personhood During IUFD

This study specifically explored how personhood and ritual are interrelated and mutually co-constructed when women and their families experience IUFD with medical intervention in the labor and delivery unit of the hospital context. Because IUFD is both a birth and a death, there is a heightened level of complexity not found when examining each one as a singular process or discreet rite of passage. A description of such complex IUFD rituals also adds value to the anthropology literature.

The lived experience of two women and their families during IUFD was described in detail with the inclusion of supporting data from interviews and field notes. IUFD rituals were experienced on a continuum from a case where ritual expectations were met and ritual successfully created personhood to a case at the opposite end of the continuum. The latter case demonstrated how expectations for culturally appropriate behavior, practices, and interactions with health care staff did not signal to this particular woman and her husband that she had given birth to a baby, albeit a dead baby. Therefore, ritual expectations were unmet and ritual failed to create personhood. During participant observation I recognized that IUFD rituals happened somewhere between these two ends of the continuum. The significance to participants when ritual expectations were either met or unmet also affected whether a woman and her family experienced an “uncompleted” or “completed” rite of passage.

This study supports Layne’s assertion that when ritual fails to create fetal personhood or recognize a woman and a man as bereaved, childless parents a woman can become mired in a liminal state. Therefore, rites of passage and cultural expectations for birth that do not come to fruition result in an uncompleted rite of passage (van Gennep, 1909/1960).

A failed IUFD ritual is also congruent with the Javanese funeral example described by Geertz (1957). The ethnography is still relevant into today’s cultural climate. Like the Javanese example absence of a ritual specialist, improper conduct of post-mortem rituals, and lack of a meaningful framework to face fetal death are contemporary characteristics of a failed ritual.

The antithesis of a failed ritual is a successful ritual. The presence of ritual specialists, proper conduct of post-mortem rituals, and a meaningful framework to face death inform a successful ritual. Expectations for culturally appropriate behavior, practices, and interactions surrounding birth also signal to a woman and man that they had given birth to a baby, albeit a dead baby. Additionally, during successful IUFD rituals a woman and her family experience a completed rite of passage. Rites of incorporation took place at the annual infant memorial service whereby fetal personhood was affirmed through ritual and recognition as bereaved, childless parents continued to be constructed.

Religious and secular rituals are illustrative of the essential characteristics described by Rappaport and other anthropologists. Ritual is a mode of communication. Communication is in the form of verbal and non-verbal aspects that become more complex with the addition of sensory elements like seeing, smelling, and hearing. Together these aspects work together to identify the deeper meaning of ritual.

While Rappaport and other anthropologists have put functionalism aside, Rappaport in particular was interested in how the performance of ritual communicated and conveyed meaning. Formality, stylization, and repetition are other key characteristics of ritual that have been identified. Ritual tends to occur at special places under special circumstances, and uses special words. Ritual takes place at specific times as determined by the clock or calendar. Rituals were invariant remaining constant over time.

Religious ritual performed in the labor and delivery unit consisted of blessing a woman during labor and blessing a fetus after birth. Religious ritual appealed to a woman's emotional or affective side. Although religious ritual were brief, ritual did communicate feelings of peace and serenity particularly those who participated in the memorial service.

Although Layne is considered one of the most prolific writers on the topic of pregnancy loss, her research focused on pregnancy loss support groups (1996, 1997, 2000, 2003). The participation observation component of my dissertation research adds value to the anthropology literature particularly as it relates to the in-depth case studies that describe the lived experience of two women and their families. Available research like Layne's does not examine IUFD rituals within the labor and delivery unit and hospital setting.

Kaufman & Morgan (2005), considered the boundaries of life and death in their literature review and how personhood is negotiated and redefined at his juncture. My research adds to this available anthropological research that actually illustrates how fetal personhood and parenthood during IUFD is negotiated at the boundary of life and death in the labor and delivery unit.

Limitations

I was able to gain access to a labor and delivery unit to ethnographically explore the highly sensitive topic of IUFD. I was able to fulfill my research goal of being present with ten families during the IUFD process although only two of the ten families agreed to a post-hospitalization interview three months after IUFD. The two couples I interviewed were older, had other children at home, and were

married. They were in a good position to compare and contrast their IUFD experience with their previous births and were glad to share their stories. The valuable data I received during those post-hospitalization interviews assisted me in validating what I observed during my participant observation activities related to the lived experience of IUFD. Likewise, data from the rest of the families would have also been of interest.

There were several factors that could have affected the number of women who consented for a post-hospitalization interview three months after IUFD. The nurse manager was the designated person to call a woman and inquire about her willingness to participate in a follow-up interview. In this capacity the nurse manager acted as an intermediary between the women and me. She reported that it was difficult to reach women by telephone because the phone numbers obtained from the chart were either non-working numbers or there was no answer when the number was called. Since I had been with the family during labor and delivery I may have had different result if I was able to call and speak to a woman directly rather than the nurse manager.

Another factor was the length of time that elapsed between a woman's hospitalization and the follow-up phone call. The timing of the phone call six weeks post-hospitalization may have been less than ideal. At around six weeks post-hospitalization women may be returning to their place of employment and other activities of daily living. At that time, it is also possible women are ready to distance themselves from their IUFD experience.

I conducted ten in-depth and ten follow-up interviews with staff at one hospital. It would be interesting to compare and contrast IUFD rituals and the construction of fetal personhood between two hospitals. Despite the limitations I cannot minimize the deep understanding of IUFD that I did obtain through my participant observation activities and interviews with women, their families, and health care staff alike.

Concluding Thoughts

Through this research I was able to more meaningfully understand how life, death, and personhood issues are culturally handled during IUFD in labor and delivery of an American hospital setting for women, families, and health care staff. It was an honor and privilege to be with women and their families experiencing IUFD. It was a most difficult time for these vulnerable women especially the long hours of a painful labor and birth process. Yet, the women and their families welcomed me in to their labor rooms and for that I am very grateful. I believe my presence made a difference for those women and their families.

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ABSTRACT**IT'S A BIRTH NOT A PROCEDURE: AN ETHNOGRAPHIC STUDY OF AN
INTRAUTERINE FETAL DEATH IN A LABOR AND DELIVERY UNIT OF AN
AMERICAN HOSPITAL SETTING**

by

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Pregnancy loss is a lay term that describes a fetus that dies while in the womb. In the hospital setting, a reproductive loss at any gestational age receives the medical diagnostic label of intrauterine fetal death (IUFD). An IUFD is a both a physical and social process that is medically managed in a labor and delivery unit. In a death adverse American culture there is not enough known about the loss process when women and their families experience an IUFD with medical intervention in the labor and delivery setting. Consequently, there is a need to more meaningfully understand how life, death, and personhood issues are handled during this difficult event for women, their families, and the health care staff. The pregnancy loss (IUFD) process, staff caring practices, and meaning making can be anthropologically viewed as a ritualistic process. In anthropology life's transitions such as birth and death can be considered rites of passage (van Gennep 1909/1960). An IUFD is a unique rite of passage that is a juxtaposition of a birth and a death event. IUFD rituals are investigated within the social and

cultural context of a labor and delivery unit of an American hospital setting to better understand the organization of life, death, and personhood. Ten women and their families, and 20 health care staff participated in this yearlong ethnographic study. Qualitative ethnographic methods included engaging in participant observation and conducting in-depth and follow-up interviews. Data were coded and analyzed. The theoretical framework of Geertz (1957) informs the analysis of two exemplar case studies that illustrate how ritual either successfully creates or fails to create fetal personhood and parenthood. Findings suggest that women and their families experience IUFD as a birth rather than a procedure and recognize their fetus as a person. Women and their families assign personhood to a fetus during post-birth rituals such as naming, receiving a memory box with mementos, and having unrestricted time with the fetus. These findings contribute to a better understanding of how the categories of life, death, and personhood are culturally made in the labor and delivery unit of an American hospital setting.

AUTOBIOGRAPHICAL STATEMENT

Catherine Griffin is a PhD candidate in the Department of Anthropology at Wayne State University in Detroit, MI. She received her M.S. in Nursing from the University of Michigan, Ann Arbor, MI. Ms. Griffin has many years as an experienced maternity nurse, specializing in labor and delivery. In addition to graduate school Ms. Griffin is an Associate Professor of Nursing responsible for teaching undergraduate and graduate nursing students in a faith-based university.