

‘The opposite of a history’

What substance use in pregnancy can lead to an ethics of accompaniment

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Abstract

Theoretical work in critical medical anthropology and biomedicine on substance use in pregnancy has yet to develop a cohesive framework of the maternal-fetal unit (MFU) as a dynamic object. As a result, patient history, risk, and agency continue to be driven by an Enlightenment-era, monolithic conception of individual will. I use the example of Carla, a young woman actively using heroin in her pregnancy, to illustrate the limits of the MFU as it is currently conceived. By using critiques of subjective utilitarianism, as discussed by Byron Good, and the concept of becoming, as elucidated by Gilles Deleuze and Félix Guattari, this article seeks to articulate an ethics of accompaniment, focused on both individual patient care and wider sociopolitical advocacy. These ethics help to redefine the MFU, and support new and unique ways of providing services to this often marginalized and vulnerable population.

Keywords

substance abuse, pregnancy, becoming, assemblage, prenatal care

Make maps, not photos or drawings.

– Gilles Deleuze and Félix Guattari
A Thousand Plateaus (1987, 24–25)

Clinical epistemology: From critical medical anthropology to physician advocacy in the care of substance use in pregnancy

The importance of anthropological theory in biomedical practice has been a topic of discussion over the past three decades (see, for example, Christman and Johnson 1996; Kleinman 1985; Kleinman and Benson 2006). This discourse has created an epistemological space within biomedicine in which to focus on the social and political construction of care, particularly among marginalized and vulnerable populations. The effect of critical medical anthropology – particularly its primary engagement with biomedical institutions’ power and control – on clinical practice has been felt in a variety of ways, from HIV/AIDS care in Haiti (Farmer 1992) to understanding chronic illness and pain among migrant farmworkers in the United States (Holmes 2013).

In particular, the role of the physician as a ‘public citizen’, engaged in the care of an entire community, rather than only an individual, sheds a new light on the ethical requirements of biomedical care (Gruen, Pearson, and Brennan 2004). Physician advocacy, defined as ‘action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and wellbeing that he or she identifies through his or her professional work and expertise’ (Earnest, Wong, and Federico 2010, 63), is a direct response to the ethical obligations of a physician as a public citizen. Indeed, in line with critical medical anthropology’s goals for creating a new medical order committed to understanding and undoing inequality as experienced through health disparities, physician advocacy takes up this torch on a political, educational, and clinical level (see Metzl and Hansen 2014). Moving towards ‘viable institutional practices’ (Quesada, Hart, and Bourgois 2011, 351) created by structurally competent physicians requires a new form of ethics and new theoretical objects to think with in the clinical encounter. These challenges set the stage for clinically evaluating patients living at the margins of care, particularly those who challenge everyday notions of morality and agency.

In the world of obstetrics, one particular figure emerges: the substance-using, pregnant patient. In this essay, I introduce Carla¹ – a pregnant woman using substances who was

1 All names and locations have been changed in order to protect participants’ confidentiality.

evaluated in the antepartum service of a major hospital in the northeastern United States. Through her narrative, I discuss the maternal-fetal unit (MFU) as a biosocial object to think with in a clinical setting, particularly in relation to the ethical and biomedical concerns surrounding substance use in pregnancy.² I then elaborate on the particular events surrounding Carla's presentation to the hospital for initiation of methadone maintenance in the setting of sexual assault; in particular, how risk, agency, and medical history were structured to impact the moral deservingness of her care (Viladrich 2012; Willen 2012).³ Finally, I turn to the construction of an ethics of accompaniment⁴ – informed by critiques of agency by Byron Good and discussions of becoming by Gilles Deleuze and Félix Guattari – that redefine how a patient's medical history, and therefore agency, is viewed in relation to the MFU.

Introducing Carla

I met Carla in her antepartum room during my fourth year as a medical student. As a sub-intern at a large county hospital in the northeastern United States, I spent a majority of my day taking care of pregnant women admitted to the hospital for a multitude of fetal and maternal medical issues. Many of the women I helped to care for, under the tutelage of an obstetrics and gynecology (OB/GYN) resident, were admitted for safe transition from intravenous, nasal, or oral use of nonprescribed opiates to synthetic opiates, such as methadone or buprenorphine.⁵ Carla's initial story was similar to many women I had seen in

2 As opposed to Paul Rabinow's (1996) discussion of biosociality as the use of disease to create new social groupings or self-perceptions, I use 'biosocial' in this essay along the lines of Bridget Hanna and Arthur Kleinman (2014, 17): 'A biosocial approach posits that such biologic and clinical processes are influenced by society, political economy, history, and culture and are best understood as interactions of biological and social processes'.

3 For the purposes of this paper, I use the term 'agency' to describe the ability of a pregnant woman to make decisions about her life, her health, and her fetus's well being. Though this definition is limited in scope, it stems directly from discussions surrounding moral pioneering, described by Rayna Rapp (2000, 2011) in the context of amniocentesis and genetic testing, and further elaborations regarding its social construction (see Gammeltoft 2007).

4 I thank one of the anonymous reviewers of this text for coining this phrase.

5 Concomitant with an inpatient admission for titration, such patients would be regularly visited by obstetricians who specialize in the care of women with substance abuse issues, social workers, and psychiatrists. In the outpatient setting, these women are also continually managed by a multidisciplinary care team in order to continue synthetic opioids. They are further subjected to urine toxicology screenings to assess for adherence and the use of other substances. These tests would be used by different bureaucratic agencies, such as Child Protection Services, in their determination of women's fitness to parent and to keep custody after birth (Child Welfare Information Gateway 2012).

the past: she professed a desire to ‘get clean’ during pregnancy after a long history of using narcotics.

Talking to her in her sparsely furnished room, Carla positioned herself upright in her bed, untangling the loose IV lines from the edge of her bedrail. The multiple rings on her fingers clacked gently on her meal table as she spoke. She looked frail and unkempt, with her short, dirty blond hair left uncombed, and her bony frame swimming under the large, white hospital gown. I sat in a chair at her bedside, doing an initial evaluation to understand her history, medical condition, and what brought her in to the hospital.

Carla detailed a long history of abusing oral and intravenous narcotics with intermittent cocaine use, gesturing to the multiple scars on her arms when she would discuss any aspect of her drug use. She did not state when she started using heroin, her drug of choice, but told me that she began using oxycodone from a local dealer over the past few years. I directly asked her about whether she had exchanged sex for money or drugs, and she told me that she never engaged in this behavior. She denied having ever attempted to maintain sobriety through the use of methadone or buprenorphine; however, she was sometimes off of substances for periods of days to weeks while trying to coordinate easy access to both money and housing. Both unemployed and homeless, Carla had been living outdoors in different parks and highway underpasses on the outskirts of the city. Most recently, she was sleeping on one of her close friend’s couches. She had not been in the shelter system in the city, and when pressed, did not give any reason as to why she had not reached out to these programs.

Carla’s pregnancy was not her first, and like her others, it was unplanned, though extremely desired. She was unsure about the timing of her last menstrual period, but felt that she might have been about four to five months pregnant. The father of the baby was not currently involved in her day-to-day life. She had little to say about him, except that he was not supportive of her and that he was also actively using heroin. Her previous viable pregnancies had ended with normal vaginal deliveries. However, due to her active substance use during those pregnancies, CPS was involved and acquired custody of her children. Eventually, the children were placed in her parents’ care; they were located in another part of the state. She told us that she was unable to go to see them due to problems in accessing transportation.

Carla fit into the category of women predominantly seen at the hospital: poor, unemployed, homeless, and actively using substances. Her admission for methadone titration was seen as a way to mitigate the multiple risks to both herself and her fetus brought on by her substance use. However, these clinical concerns, and the subsequent care provided to Carla, bring up important questions about the science of substance use in pregnancy and the

conception of the MFU. Turning to the MFU as an object to think with regarding substance use in pregnancy, I argue that Carla's story introduces important questions about agency, patient history, and risk that are rooted in a static theory of the MFU. By reconceiving the MFU as a dynamic entity, Carla's narrative can take on new meaning within the clinical encounter.

Substance abuse in pregnancy: Putting the 'M' back in the MFU

The MFU is understood by scholars through a variety of lenses, primarily via qualitative understandings of new technologies geared at improving overall fetal and neonatal health. Whether through studying amniocentesis (Rapp 2000, 2011), fetal ultrasound imaging (Gammeltoft 2007), or assisted-reproductive technologies (Inhorn, Shrivastav, and Patrizio 2012), the anthropology of reproduction has examined biomedical practices to chart the construction of both the mother and the fetus. Couched within these analyses is how obstetrics as a field, directly or indirectly, dictates a woman's given role within the biomedical gaze (Foucault 1973). Questions of agency, risk, suffering, and care are evaluated through these frames – and are driven, and ultimately limited, by the biomedical and state apparatus within which women receive care. Discussions of prenatal care and forms of governmentality (Foucault 1991), elucidated by authors like Lealle Ruhl (1999) on risk and care of the self, make important links between prenatal care, public health, and state power. But this focus, I argue, while important in formulating sound public policy, must be accompanied by a thorough examination of how the pregnant woman is constructed in relation to the fetus.

A woman who is simultaneously pregnant and actively using substances is a unique and challenging figure in the world of modern obstetrics. The presence of the 'addict' mother has accompanied multiple discussions within the field regarding adequate health management during pregnancy and effects on the fetus (Finnegan et al. 1972; ACOG 2011). In particular, physicians are concerned with avoiding neonatal abstinence syndrome (NAS), which can be brought on by a lack of exposure to opiates after delivery or placental abruption⁶ in the setting of active cocaine use. These clinical instances dictate important considerations for management options for practitioners in regards to the timing and method of delivery, and the care of both the mother and newborn (Niebyl and Simpson 2012). They also inform a

6 'Placental abruption' is defined as the early sloughing of the placenta from the uterine lining. This directly impacts the maternal-fetal oxygenation system and causes fetal hypoxia and, if severe enough, fetal demise.

significant amount of counseling provided to women who are actively using substances during their pregnancies.

The use of urine toxicology screens and women's admission of active substance use can activate the involvement of CPS; due to the presence of CPS, pregnant women actively using substances have been found to both fear and curtail their involvement in biomedical care (Roberts and Pies 2013; Sharpe 2001; Schempf and Strobino 2009). Adherence and toxicology tests, as is well documented in the social-scientific literature (Knight, forthcoming; Murphy and Rosenbaum 1998; Sufrin 2014), are both a mechanism of enforcing sobriety and judging the deservingness of women in regards to custody over children. The work of the National Advocates for Pregnant Women (NAPW), particularly Jeanne Flavin and Lynn Paltrow (Flavin 2009; Flavin and Paltrow 2010), has documented the effects of prosecution and imprisonment of pregnant women using substances and put forth important critiques of misogynistic and unjust state laws. The logic behind the legal apparatus focused on pregnancy outcomes lies in the biological relationship between woman and fetus, with the ability of chemical intoxicants that pass across the placenta to affect the growth and well-being of the fetus. This perceived one-way biological relationship is translated into social and moral codes regarding motherhood and fitness for custody; ultimately, the MFU is writ into governmental and clinical apparatuses focused on promoting the object on the receiving end of any given maternal action: the fetus.⁷

However pronatalist the legal system is in America today, the method in which a clinician provides prenatal care and counseling to a woman actively using substances does not focus solely on the fetus.⁸ The reorientation to the maternal aspect of obstetrics has been a major

7 In her discussion about the sociopolitical construction of risk, Mary Douglas (1990, 15) contextualizes the attribution of risk as primarily involving a concept of justice. Her argument about risk as a combination of ancient understandings of taboo and danger, imbued with scientific validity (via probability and other forms of statistics), finds itself expressed through concerns about the stigma, class, and 'undesirability' of certain populations. In this vein, Vania Oka-Smith (2012) writes about the construction of bad motherhood in Oaxaca, Mexico; her analysis has, at its heart, the attribution of risk by biomedical providers to women deemed as indigenous. Substance abuse in pregnancy brings these concepts to the fore with regard to how risk is understood within this population as a function of marginality and class. For further discussion on substance use in pregnancy, see Fordyce and Maraesa 2012 and Hamilton 2012.

8 The focus on the fetus within the realm of state law has led to the passage of SB 1391 in Tennessee, which criminalizes substance use in pregnancy (McDonagh 2014a, 2014b), leading to the arrest of twenty-six-year-old Lacey Weld. She was given more than twelve years in prison for distributing methamphetamine; however, the federal judge in the case stated that she was given an additional six

component of the field since the mid-1980s, when Allan Rosenfield and Deborah Maine (1985) wrote ‘Maternal Mortality – A Neglected Tragedy: Where Is the “M” in MCH?’ in *The Lancet*. Their focus on maternal mortality in developing countries, and their critique of the technology-driven aspects of modern obstetrical care, pushed many in both biomedicine and public health to realign their focus on the mother. More recently, Mary D’Alton, a perinatologist, has argued that an emphasis in clinical care on decreasing both maternal morbidity and mortality should be a component of modern obstetrical practice and training (D’Alton 2010; D’Alton et al. 2013). This prioritization of the mother moves away from analyses devoted solely to neonatal and fetal outcomes, and, as a result, forces clinicians to rethink the tripartite relationship of the caregiver-woman-fetus, and to see it as dynamic.⁹ For the purposes of this paper, putting the ‘m’ back in ‘maternal-fetal unit’ requires a theoretical model that privileges the voice and, most importantly, the actions of the pregnant woman as not only tied to the fetus. A woman who is pregnant has a biomedical and social trajectory that overlaps with, but does not necessarily adhere to, a particular definition of motherhood and health, one that is driven by a highly racialized, classist, and misogynistic conception of self-care (see Bridges 2011; Foucault 1988; Ruhl 1999). Clinicians and researchers need to account for the aforementioned assumptions if, for nothing else, one is to avoid the reductionist model of caring for the woman or the fetus – as if each were isolated in their own silo – rather than caring for both at different periods in time.

Ethnographic studies and philosophical works have already engaged in redefining the MFU, particularly in relation to abortion (see Thomas [1971] 2010; Marquis [1989] 2010), genetics (see Buchbinder and Timmerman 2011), and surrogacy (Malm [1989] 2010). Most recently, Nancy Scheper-Hughes (2012) has examined the role of immunology in regards to rethinking maternal well-being and motherhood. By discussing fetal incompatibility from a maternal point of view, she creatively begins to question the core components of motherhood and maternal love:

years of incarceration due to ‘perceived use’ of the drug captured on surveillance footage while she was visibly pregnant (Gwynne 2014).

⁹ Epigenomics, or the study of gene regulation and modification, has added to this discussion by attempting to account for the impact of environmental and social determinants on health. In particular, studies in both public health and the biomedical sciences have focused on the long-term effects of the in utero maternal environment on health outcomes. The most well known of these discussions, elucidated by David J. P. Barker and colleagues (2007), focuses on the impact of low birth weight on cardiovascular risks later in life. However, critics note the focus on the maternal body alone as the nidus (site of origin) for improvements in health outcomes as constituting a form of somatic determinism, emphasizing the immediate social realm of the mother instead of wider public and social policy (Lock 2013; Richardson 2015).

If human life at the cellular level is dependent on creative risk, gradual incorporation of difference, misrecognition of self, the mother–fetal relationship is founded on the suppression of rejection for nine months of pregnancy followed by a dramatic ‘expulsion’ of that same alien material. How might this understanding affect the way we conceptualize ‘maternal thinking’ and the politics of peacemaking after the tiny enemy is expelled, captured, swaddled, and ‘adopted’ by the stranger, the other who is also the (m)other? (Scheper-Hughes 2012, 165)

The important question within the aforementioned analyses, as it relates to substance use, is not simply the (de)personification of the fetus or neonate as it relates to maternal behavior (Scheper-Hughes 1992; McDonough 2014a, 2014b) or the relationship between mother and fetus, but how clinicians understand the complex biological phenomena of the MFU and the sociopolitical space that pregnant women inhabit. The conception of the MFU as it relates to substance use echoes back to the need for clinical praxis in caring for marginalized and vulnerable populations, like pregnant homeless women who are using substances. As a physician, this disconnect is felt most importantly in the space of the clinic. Counseling and caring for these women well demands a clinician to be savvy about biomedical, legal, social, and political structures that impact access to care while simultaneously navigating those barriers to provide compassionate and individualized care. Existing alongside the ever-expanding biosocial framework of pregnancy are the personal experiences of agency, violence, and suffering of individual women. How clinicians and substance-using pregnant women interact, disperse, collide, and adjust beckons those with one foot in research and the other in clinical practice to think about a more fluid conceptualization of the MFU. Elaborating on Carla’s narrative illustrates the need not only to reframe the clinician’s gaze towards the assemblage of the MFU, but also how public policy can be structured to render better care to an often-marginalized and vulnerable population.

Truth, deservingness, and care of the MFU

After Carla talked about her current use of heroin and oxycodone, she explained what brought her to the hospital. She initially began speaking of her need to withdraw from opiates because she had recently begun using them again. When pressed about why she relapsed or what conditions precipitated her relapse, she began describing the physical, sexual, and emotional violence she experienced over the previous three days. Though she initially stated that she was sleeping on her friend’s couch, she confided that over the past few days she had been camping underneath an underpass on the outskirts of the city. She was attempting to travel into the city, and was hitchhiking on the side of the road. An unnamed man, who had promised her that he would drive her into the city, picked her up. Carla said he took her to a rural cabin off of the main highway, where she was locked up

without food or means of contact for three days. She related stories of being tied up and burned with cigarettes, and being injected with some form of narcotic against her will. She described the lull, akin to a high, she felt after the injection, and was convinced that the abductor had administered some form of an opiate. She also described being sexually assaulted multiple times, but would not elaborate as to whether or not he used condoms. She displayed scars on both thighs, which she described as remnants of the burns she sustained from his cigarettes. Finally, Carla stated that after three days, she was driven to the edge of the city and let out on the side of the road. She made her way to our local emergency department for evaluation and admission.

As the medical student on the team, I visited her daily throughout her inpatient stay as part of my rounds. Like many clinical encounters, her narrative came in fits and starts, whether by describing her story to me from different temporal perspectives or by revealing her signs of abuse during daily physical exam procedures. During her initial evaluation, Carla had requested a complete physical examination, including a genitourinary exam, and police presence in order to file a report; she rescinded both requests almost one hour later. One of the resident physicians with whom I worked was called in to help counsel Carla about undergoing a post-assault evaluation and filing of police charges. After almost forty minutes in the room, she stepped out with a look of confusion on her face. The resident explained that she had counseled Carla both about the safety of the mother and the fetus, particularly regarding sexually transmitted diseases, and also emphasized that it was her right to file a report with police services. The resident stated that she was caught off-guard by Carla's demeanor in the room, which she described as appropriately concerned, but reluctant to ask for help. Her attitude, considered peculiar by the care team, was contextualized after a brief review of her previous admission: almost two months prior, Carla had been admitted for buprenorphine titration and evaluation after an alleged abduction, assault, and torture. She had not disclosed these facts to the care team during our initial examination.

For the care team, Carla's previous history complicated her current hospitalization and care needs. Had she actually ever been abducted, tortured, and assaulted? Thinking, for a moment, that the revelation of her past history constituted another instance of violence, Carla's pregnancy and her associated substance abuse could be contextualized in a framework of risk. The fact that she was subjected to abduction, rape, and torture twice in the past few months attested to her embodied vulnerability as a homeless, pregnant, substance-abusing woman. Alternately, if Carla was, in fact, fabricating the details of her recent abduction, perhaps she knowingly described such sexual violence in order to gain access to housing, food, and opiates from a sympathetic staff. Relying on the stereotypes surrounding opiate addiction and homelessness, especially in the context of gender inequity, the tropes of violence and pregnancy could engender more sympathy for Carla, and thus

give her a better chance of acquiring needed goods and services. This viewpoint, held by many of the care staff, aroused feelings of outrage.¹⁰ Statements made in workrooms and at nursing stations on the ‘danger’ Carla was placing her fetus in, particularly in regards to her homelessness and active IV-drug use, were ways of questioning the deservingness of her care. One of the ancillary staff questioned why she was taking up a bed when another, ‘sicker’ patient could use it. Others commented on how ‘demanding’ Carla was, as manifest in the frequent need to assess her opiate withdrawal via the clinical opiate withdrawal score (COWS) to adequately transition her to methadone. The MFU, in this circumstance, was divorced into a binary: on one hand was Carla the homeless, heroin-addicted woman, perceived by much of the medical staff as exploiting the hospital for easy access to housing, food, and opiates; on the other hand was Carla the pregnant woman, putting her fetus at risk for poor outcomes by engaging (willingly or not) in a ‘dangerous’ and violent lifestyle, wherein the use of street (as opposed to synthetic) opioids was an integral part of the narrative (see Bourgois 2000). The biosocial landscape that framed Carla’s narrative – namely how agency and risk are impacted by substance use, homelessness, and a poor social safety net – is conveniently left out of the aforementioned false dichotomy.

Carla’s care on the inpatient ward was ultimately successful; her pregnancy continued without complication, and she was safely transitioned to methadone. Upon leaving, she promised our care staff that she would follow up both at the local methadone dispensary and in prenatal care. Later in the year, after rotating off service, I was told by both the OB/GYN attending physicians who were staffing a prenatal clinic devoted to caring for women who were using substances during pregnancy that Carla never returned for follow-up care. Looking back, I ask: how did the structuring of narrative (intake history) and the staff’s ideas about the MFU, expressed in terms of deservingness, contribute to the type of care Carla received? I contend that reconstructing Carla’s admission through the guise of Byron Good’s discussion of subjective utilitarianism and Gilles Deleuze and Félix Guattari’s concept of becoming can create an ethics of accompaniment, and that this can be used to advocate for patients like Carla in both the clinical and policy environment.

10 Reviewing the case among psychiatrists, family medicine physicians, psychologists, and OB/GYNs almost three years after the incident, many individuals described this very same phenomenon. One physician exclaimed, ‘Well, Carla may know us better than we know ourselves!’ indicating that Carla may have known how to elicit a sympathetic response from the staff in order to fulfill her material and medical needs. Another physician described a ‘scarcity model for compassion’, meaning that many in the biomedical field require a dramatic show of suffering in order to create a compassionate connection with a patient. For further discussion regarding the demonstration of the suffering body and the provision of care in the American context, see Crane, Quirk, and van der Straten 2002.

Subjective utilitarianism and becoming in the clinical encounter

Carla's narrative seats maternal agency as a nidus for discussions on moral deservingness and the biomedical analysis of risk for the MFU. Maternal agency has famously been described in the anthropology of reproduction, particularly as it relates to engaging with reproductive technologies. Rayna Rapp (2000, 2011) describes 'moral pioneering', or how women make sense of new reproductive technologies using their experience in a variety of domains – social, gender, generational, and religious:

Women and their supporters may be forced to confront and opt in or out of new and quite invasive medical technologies, but they do not do so on “virgin territory.” Rather, they use available and long-standing resources to reason their way through a fraught and seemingly radically new situation. In a sense, they become “moral pioneers” by using comfortable resources to decipher uncomfortable situations, a form of constrained but real agency. (2011, 11)¹¹

Tine Gammeltoft (2007), in her analysis of prenatal diagnosis of fetal malformations in Vietnam, reorients the notion of agency to include biomedical and familial structures. Rooting her critique in a response to Rapp's work, she argues that moral pioneering is indicative of a particularly Western form of the subject. For Gammeltoft, it is the relationships an individual has with family and biomedical structures, rather than an individual's moral compass, that impacts the decision to continue or terminate a pregnancy. In both circumstances, maternal agency is constructed in the realm of the care of the self (Foucault 1988; Ruhl 1999), with a heavy reliance on subjective utilitarianism. Though a primarily economic term, Byron Good (1994, 47) critiques subjective utilitarianism in the context of patient care-seeking behavior: 'The analytic conjunction of the utilitarian actor, instrumental beliefs that organize the rational calculus of care-seeking, and ethnomedical systems as the sum of strategic actions is uncomfortably consonant with neo-classical economic theories of the utilitarian actor, the market place, and the economic system as precipitate of value-maximizing strategies'.

11 However, this relationship is not merely a one-way street, as Rapp suggests in her analysis; both the lives of reproductive technologies and those of the individuals that use (or desire to use) them are contextualized and impacted by each other. In the context of my argument, this becomes important for understanding not only agency, but also how assemblages of care create new trajectories for pregnant, substance-using women.

In subjective utilitarianism, the maternal subject exists in an unhindered world of choice; moreover, the rationality employed by a given individual is rooted primarily in a cost-benefit analysis. Concepts like moral pioneering, situated within the complex social and political relationships forged by a given pregnant woman, are stripped from any construction of maternal agency. This ‘impoverished conception of human symboling, of meaning made servant to the biosciences and to practical reason’, as Good (1994, 47) puts it, undergirds the discussion of Carla’s deservingness for care. Her admission to the hospital, then, would be seen as a utilitarian act driven by a desire for food, clothing, and easy access to opiates, with the potential for engaging in prenatal care for her fetus. This reductionist view disengages Carla from a wide variety of other motivating and competing factors that might drive her into care, such as her proximity and potential engagement with violence, her desire to care for herself and her fetus, and her overall concerns for her safety and well-being. All of the aforementioned factors are expressions of wider socio-structural inequalities, linked with homelessness, substance use, and the status of women within marginalized social groups (see Bourgois, Prince, and Moss 2004; Bourgois and Schonberg 2009).

How, then, to conceptualize the MFU, both bereft of subjective utilitarianism and with the room to account for the social and political construction of the unit itself? I argue that we can start this arduous task with Deleuze and Guattari’s notion of becoming, which is rooted in classical cultural anthropology. Contrasting Victor Turner’s discussion of liminality along with Edmund Leach’s writings on Kachin sorcery, Deleuze and Guattari (1987, 247) write of an ambiguous ‘politics of becoming’:

There is an entire politics of becomings-animal, as well as a politics of sorcery, which is elaborated in assemblages that are neither that of the family nor of religion nor of the State. Instead, they express minoritarian groups, or groups that are oppressed, prohibited, in revolt, or always on the fringe of recognized institutions, groups all the more secret for being extrinsic, in other words, anomic.

Most recently, João Biehl and Peter Locke (2010, 317) describe ‘an anthropology of becoming’ that focuses on ‘those individual and collective struggles to come to terms with events and intolerable conditions and to shake loose, to whatever degree possible, from determinants and definitions’. Basing such a theory on the importance of ethnography at the margins of life, Biehl and Locke (2010, 336) seek to combine other social theories with a sense of flux:

We work to understand the macro without reducing or bounding the micro, accounting for the effect of structural violence, power, expertise, and the embodiment of sociological forces while still crediting the against-the-odds openness and ambiguity of individual lives and interpersonal dynamics—upholding, that is, the value of people’s drive to singularize out of populations and categories, to take themselves out of the stream of history and social destiny.

The importance of becoming in caring for pregnant women who are actively using substances has to do with the heuristic use of a patient’s medical history. This primarily is related to challenging preconceived notions of the will and causality, and questioning the assumption that a patient’s history can be used to advocate for, and thereby change the social and political suffering of, a given individual. In the clinical encounter, patient history, especially one charged with as much political, legal, and social weight as a pregnant substance-using woman, is neither monolithic nor archeological (see Holmes and Ponte 2011). The moral and legal construction of the pregnant, substance-using woman tightly constrains both the disclosure of substance use by the patient and the use of such history by the physician in the medical record and in the monitoring of substance use through urine toxicology screens. Therefore, patient history is constantly changing as a relationship with a patient grows and as old understandings of illness and health are re-analyzed in different time periods. Substance use during pregnancy entails not just the obvious legal ramifications (affecting custody of children, and, depending on the state law, leading to criminal prosecution¹²), but also how the patient history is constructed in line with different apparatuses of control.

I contend that the ideas of Deleuze and Guattari allow us to envision an ethics of accompaniment, one that allows patient histories to be re-analyzed as cartography (see Biehl 2013). Similar to a rhizome (Deleuze and Guattari 1987), the primordial construction of history leaves one not with a deterministic, predestined view of what will or what did happen, but simply beginnings without end. They write, ‘History is always written from the sedentary point of view. ... What is lacking is ... the opposite of a history’ (1987, 23). This statement has, at its heart, a reorientation of cause and effect, particularly as it relates to how patients present their illness and the means by which they are treated. The notion of causality, described by Enlightenment philosopher David Hume (2007), is the root of all matters of fact, or statements that individuals take for granted. Matters of fact are inferred by experience. For example, if a stone or piece of metal is lifted into the air and then released, it will fall time and again. However, Hume (2007, 31–32) asks a more radical question about

12 See McDonough 2014a, 2014b; Gwynne 2014.

matters of fact: if we ‘consider the matter *a priori*, is there anything we discover in this situation which can beget the idea of a downward, rather than an upward, or any other motion, in the stone or metal?’ Accordingly, is there anything inherent in the MFU or its activity (in other words, substance use) that dictates a certain outcome, a particular clinical or social course?

The idea that there may be unlimited possible outcomes for women actively using substances while pregnant does not discount the neurobiological construction of addiction. Though the concept of addiction was redefined in the twentieth century as a chronic, relapsing brain disease (see Campbell 2013), how this idea maps onto the everyday care and understanding of substance users is varied. Indeed, as E. Summerson Carr (2013) describes in his evaluation of motivational interviewing, the rescripting of the addict’s language from denial (itself a component of addiction) to self-transparency begs important questions about how the biomedical fields are conceptualizing addiction. More specifically, as J. T. Braslow (2013) indicates in his review of the history of recovery, addiction is constructed as a reflection of neoliberal ideologies about self-care and individual drive within the confines of the pharmaceutical industry. Therefore there is an inherent tension between neurobiological determinism and individual choice in the modern-day concept of the addict that offers the possibility for different, creative futures for subjects.

Applying the theory of becoming to substance use, Deleuze and Guattari devote a few pages of *A Thousand Plateaus* to discussing addiction and its ethical ground. For both philosophers, the use of drugs and the assemblage such drug use creates boils down to ‘the hit and the dose, the dealer’ (Deleuze and Guattari 1987, 284). The highly individualized focus of substance use ultimately is characterized by an empty body, unable to be primed for connection with other assemblages (Deleuze and Guattari 1987, 285). Deleuze and Guattari’s description of the addict’s body, as bereft of any social connection, has come under critique by both philosophers and anthropologists. In Peta Malins’s (2004, 96) reading of *A Thousand Plateaus*, the end-point of drug use should not amount to simply pre-judging the assemblage created by a substance user and the substance, but should be seen as an event in itself – a moment when different actors come together to create a specific ethics, spatiality, and above all, subjectification. Malins (2004, 90) writes:

A body does not inject drugs in a social vacuum: it may become subject to the physical intervention of the law, the coercive force of medicine, the reductive classification of psychiatry, the intervening categorization of public health, the disapproving gaze of moral reasoning, the restrictions of spatial planning. ... It may suddenly find itself a ‘risky’ body; a ‘dirty’ or ‘polluted’ or ‘criminal’ body.

The multiplicities provided in different assemblages allows for a new form of agency to take hold, and with it, a new form of ethics. In this framework, good and bad are not simply linked to a moral action (the act of using a substance or not using a substance), but to the possibility of connecting with other assemblages.¹³ An anthropology of the good, namely how ‘people organize their personal and collective lives in order to foster what they think of as good’ (Robbins 2013, 457), can be seen as a natural corollary to Malins’s interpretation. As opposed to a pre-conceived good/bad (or moral/immoral) dichotomy, Robbins (2013, 457) calls for an ‘imaginatively conceived’ good that allows subjects to act in a world that does not necessarily correlate to what is empirically derived. In this manner, the creativity at work in structuring an anthropology of the good is akin to what Deleuze and Guattari call for regarding the notion of becoming – an unending sense of possibilities, connections, and futures.

An ethics of accompaniment – Carla’s narrative reimaged

Deleuze and Guattari attempt to break the rigidity of macro theory by focusing on a rhizomatic, undifferentiated concept of the individual through their discussions of becoming. However, their analyses do little to connect the potential of an assemblage in becoming with the potential of an individual using substances. Critics of these texts and recent research in both substance use and reproductive health point out a new direction for those involved in clinical care; I propose that by incorporating an ethics of accompaniment into encounters with pregnant women using substances, clinicians and researchers can begin to reconcile the issues surrounding agency and the MFU.

An ethics of accompaniment redefines what ‘cause’ and ‘time’ actually mean in the clinical encounter. For many in the biomedical field, a given patient’s actions are deemed good or bad (from a health perspective) based on the construction of a deontological categorical imperative – an action whose philosophical basis is good in itself, rather than good because

13 Jarrett Zigon’s ethnographic study of drug rehabilitation in Russia poses unique questions regarding the creation of moral and ethical assemblages within seemingly unchanging structures. Examining treatment for HIV-positive individuals who are intravenous drug users, he posits that the site of rehabilitation within the Russian Orthodox Church does not necessarily institute a ‘totalizing moral discourse’ (Zigon 2011). Instead, the sociohistorical and political changes that have undergirded Russian life create new assemblages within the shells of deterritorialized spaces. Echoing R. K. Merton (1936), Zigon argues that the unintended and unexpected moral and ethical consequences of this program are felt at the level of recovering addicts’ subjectification – in particular, the institution of a conflicting dynamic of neoliberal self-care and orthodox penance.

it is a means to something else (see Kant 2002, 31).¹⁴ Using substances chronically in pregnancy has multiple neonatal and maternal risks, including neonatal abstinence syndrome (NAS), fetal alcohol syndrome (FAS), fetal growth restriction, mental disabilities, placental abruption, and preterm labor (ACOG 2011; Niebyl and Simpson 2012, 155–57).¹⁵ For an individual woman, active substance use has well-known documented risks: possible liver failure, contraction of infectious diseases like HIV and hepatitis, endocarditis, permanent neurological damage, and death (Maeda et al. 2014; Niebyl and Simpson 2012). Therefore, from a clinical perspective, there is an ethical obligation to inform and help women who are actively using substances to detoxify or move towards replacement therapies, such as methadone or buprenorphine in the case of opiate use.¹⁶

Indeed, from the clinical perspective, the trouble with the categorical imperative has little to do with Carla's narrative. Though some health care providers attempted to use a risk-based counseling methodology in light of Carla's disclosure of active substance use and recent sexual violence, the persistence of deontological thinking became highlighted when her actions were interpreted beyond the immediate physician-patient encounter – when care providers looked to her history to qualify her present and to assess her future. The discussion surrounding deservingness of care is one small example of how the categorical imperative can be used to morally judge vulnerable, marginalized individuals without any attention to sociopolitical context. Judging the rightness or wrongness of substance use in pregnancy is the very type of thinking that informs pronatalist and disciplinary policy today in the United States, in both state legislatures and federal policy. The dynamics and longitudinal aspects of biomedical care, so crucial for understanding a patient's actions and barriers, are lost in the translation to public health policy and criminal law.

14 As opposed to a hypothetical imperative, defined as the practical necessity of a possible action (for example, 'I take your food because I am hungry'), the categorical imperative does not treat human beings as means to an end. The act itself is a mirror of rule-based action (deontology), and is summarized by Kant (2002, 38) in this way: 'So act as if the maxim of your action were to become through your will a universal law of nature'.

15 Niebyl and Simpson (2012) note that while marijuana has no significant teratogenic (developmentally disruptive) effect on the fetus, data is limited in this regard. Moreover, the authors discuss the confounding factors of polysubstance abuse, sociostructural inequality, and poor health access in regards to analyses of neonatal outcomes, particularly in relation to cocaine use.

16 For a discussion regarding the ethics of maintenance substances, please see Bourgois 2000, Lovell 2013, and Saris 2013.

In the United States today, seventeen state governments actively prosecute pregnant substance-using women for child abuse (Guttmacher Institute 2013; Child Welfare 2012; McDonough 2014a); but, as seen in states like Tennessee and Texas, limited access to treatment and maintenance means that prosecution ultimately commits pregnant or newly delivered women to (re)incorporation into the prison-carceral system with little hope for support or help (see Wacquant 2001). The reduction of maternal substance use to child abuse, itself rife with contradictory and complex definitions (see Scheper-Hughes 1992, 340–343 and 446–431; Finerman 1995), wipes out the complex biosocial interactions of the MFU, subsequently focusing the breadth of intervention on punishment rather than adequate care and support of the MFU across space and time. Physicians are locked into this framework when it comes to provision of and access to care for substance-using pregnant women. Self, agency, and structural inequality are bracketed and left unaddressed by such policies and such clinical responses.

For Deleuze and Guattari, individual actions themselves are not the core components of concern; the focus is rather the impact of connectivity, the territorialization/deterritorialization of new assemblages, and the creation of new methods of becoming. The obligation to inform and counsel women who are actively using substances must always be couched within the assemblage of biomedical care, and specifically how it can improve connections and beget new forms of becoming. Put another way, exposure to substances by the MFU is a present problem with the potential for future change. Maternal-fetal outcomes in the case of substance use cannot be predefined; allowing for a sense of flux, of the unknown, is the backbone of modern clinical care. Rather than focusing on an individual's action – Does a woman use substances? – the question must be: 'How does a woman's substance use help or hinder her attachment to systems of support and care?' The role of the clinician must be to accompany the patient in her history and her present, in order to tease out this complex biosocial reality and tailor the response in a way that maximizes the possibility for care both immediately and in the long term.

Since the primary issue of concern is not an individual's singular action, but the web of interconnectivity and the patient's ability to create new assemblages, clinicians and patients must walk together in order to maximize these possibilities. Counseling and care provided within the prenatal and postpartum arenas must engage women in care not only for the benefit of their pregnancy, but for their health and social well-being overall. Our understanding of agency within structurally violent situations, then, can move away from notions of subjective utilitarianism. Doing so in this case, Carla's narrative loses the murkiness surrounding the validity of her claims of sexual assault and abduction. The disclosure of such violence, though disturbing on both a clinical and moral level, is no longer couched in the guise of whether or not she is using the staff for access to methadone and

shelter. The fact that Carla showed up to care at all becomes the primary motivator for how the team can best serve her health and social needs in both the short and long term.

With an ethics of accompaniment, a woman's continued use of substances, whether new or relapsing, is not subject to a moral dichotomy of good and bad actions or to a crude, reductive neurobiology. Rather, the clinician is able to evaluate her agency in the context of the assemblage that substance use and pregnancy creates in relation to biomedical care, the legal system, and the prison-carceral complex. An ethics of accompaniment, then, is a method of solidarity, one that forces clinicians to realize both the inequality present in these complex encounters and biomedicine's responsibility to agitate for sociopolitical change (Earnest et al. 2010; Farmer 2003; Scheper-Hughes 1995). By structuring the clinical encounter with Carla to promote connectivity within her community by helping her reach out to different methods of care – through social workers, Narcotics Anonymous, or other support groups – rather than focusing solely on the cessation of her substance use and the truthfulness of her claims, clinicians can extend one arm in an ethics of accompaniment. Furthermore, by using stories of women like Carla to lobby against policy and law that simultaneously targets pregnant women while gutting adequate social provisions for care, care providers and researchers can enter into the advocacy realm, another way to practice an ethics of accompaniment, thereby influencing the biosocial realm that the MFU inhabits.

In summary, authoritative knowledge is redirected as the clinician works with a substance-using pregnant woman; care is not solely directed toward immediate maternal-fetal health outcomes, but also toward increasing the ability of the woman to ground herself in a wider structural net and build towards sustained and reproducible changes in maternal and fetal trajectories. This is not to discredit the known risks of using substances in pregnancy, but rather, like harm reduction modeling, to clearly state that in environments where suffering and structural violence shape daily life, a woman's everyday decision making may be impacted by more than her fetus's health. This is putting the 'm' back in the maternal-fetal unit, pushing the clinician to align him or herself with the assemblage of the MFU, rather than the woman or her fetus alone. Choices made by women actively using substances are not those of a flawed subjective utilitarianism in regards to health-related behavior, but are rather tied to a particular time and place, a particular assemblage. Becoming, then, allows for the possibility of change and a new trajectory with different conceptions of agency and effect. The MFU is allowed to traverse through a given biosocial space without presupposed notions of its beginning and end. The cartography is undefined, yet clinician and patient move forward, together, constantly changing and creating new methods of care.

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