Social Embodiments: Prenatal Risk in Postsocialist Germany

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Abstract: Anthropologists have linked bodies to social histories, events, and structures by way of a presence of illness or physical pathology. The social embodiment of risk evident in a hospital in former East Germany at the millennium was conceptually different: women described bodies marked by absences—of pregnancy, employment and feelings of safety. Central to the theoretical concerns of social embodiment in this article are observations of how the pregnant body embodies competing notions of risk. This article shows how notions of prenatal risk can illustrate the ways in which social embodiment can be not only a presence, but can also manifest as reproductive absence, hesitation and ambivalence.

Keywords: social embodiment, prenatal risk, postsocialist, Germany

Résumé : Les anthropologues ont lié les corps à des histoires, des événements et des structures sociales, au travers de la présence de maladies ou de pathologies physiques. L'incarnation sociale du risque, évidente dans un hôpital de l'ancienne Allemagne de l'Est au tournant du millénaire était différente au plan conceptuel dans la manière dont les femmes décrivaient des corps marqués par l'absence – de grossesse, d'emploi et de sentiments de sécurité. Dans cet article, autour des considérations théoriques relatives à l'incarnation sociale, nous apportons des observations sur comment les corps en gestation incarnent des notions de risque en compétition les unes avec les autres. Cet article montre comment des notions de risque prénatal peuvent illustrer des manières par lesquelles l'incarnation sociale peut se constituer comme une présence, mais peut aussi se manifester comme absence, hésitation et ambivalence à l'égard de la reproduction.

Mots-clés : incarnation sociale, risque prénatal, postsocialiste, Allemagne

Introduction

Risks—and death—come into being in social fields. This articles explores the making of social embodiment through perceptions of prenatal risks in the milieu of postsocialist (former East) Germany,[1] as it was made evident and corporeal during fieldwork in a university hospital. Childbirth has long served as an ontological event marking a person's "first risk," but as a result of prenatal diagnostic technologies like ultrasound, the perinatal interval (Weir 2006) has in some societies superseded birth as the first instance where embodied risk (Kavanagh and Bloom 1998:437) is identified and surveilled in routine ways. Prenatal technologies like ultrasound, fluids screenings and electronic fetal monitoring have made the perinatal interval available as a site not only of biomedical oversight and (sometimes) intervention, but also of socialization, projectification, and identity-making (for example Mitchell 2001; Rapp 1999; Taylor 1992, 2008).

The stories women (some with their partners) told about themselves as former East Germans in interviews about their use of prenatal diagnostic technologies show how biomedical and social domains are mutually constitutive. To be pregnant, to be formerly East German and to participate in the social norms of prenatal care in reunified Germany at the millennium was to embody small, everyday actions infused with post-reunification postsocialist sensibilities. Insecurities and doubts about the future were heightened in the 1990s for former East Germans; daily life changed little for most former West Germans. Some former East Germans described the work and family life transitions as "completely the other way around" (Erikson 2005; see also Beck-Gernsheim 1997; Kreyenfeld 2001). The mutually constitutive aspects of meaning-making within and outside of biomedical domains are framed here as forms of social embodiment, constituted through experiences both endogenous and exogenous to women and the prenatal care setting.

Embodiment as a theoretical construct in anthropology has taken many forms, its use aimed most broadly at overcoming the Cartesian mind and body binary theoretically predominant in biomedicine (Csordas 1990, 1994; Jaye 2004; Scheper-Hughes 1994). Embodiment in pregnancy specifically has tended to be treated by social scientists as an analytic through which to explore processes of women's individual subjectivity and sexuality (for example Lupton 1999; Oliver 2010; Young 1990). Psychologists too have taken up embodiment as a theory to think *with* the body. Social embodiment in the psychological literature has focused on bodily states, postures, movements and expressions evident between people within small social interactions (Barsalou et al. 2003; Niedenthal et al. 2005).

In this article I integrate notions of pregnant embodiment with theories of social embodiment *expanded* to incorporate biomedical and geopolitical sociality. Iris Marion Young provides two important touchstones here: (1) pregnant embodiment involves a reconstituted self, a pregnant woman is "decentered, split, or doubled in several ways," "[experiencing] her body as herself and not herself"; and (2) "[p]regnancy does not belong to the woman herself" (Young 1990:160). A social embodiment of pregnancy is both individual and collective. The pregnancy is the woman's *because it is in her body,* but it also occurs within particular social fields that are beyond her, and, in this case, biomedical, geopolitical and historical in nature. The bodily state of pregnancy, I argue, bears meaning both endogenously—originating internally for women from their bodily state—and exogenously—originating externally from social milieus, not as separate or singular trajectories but in ways that are fluid, shifting and overlapping.

In the decade after reunification, the social embodiment of risk—that is, risk that can be taken measure of in the body—manifested in former East Germany as *absences* in reunified German society. Other anthropologists have linked bodies to histories, events, and geopolitical structures, characterized almost exclusively in poor countries as various expressions of structural violence (for example Farmer 2004; Nguyen and Peschard 2003; Scheper-Hughes 1994). In those cases, bodies emblemize a *presence*, however unwelcome, as people's bodies come to literally embody epidemic and infectious disease, derivative of the inequalities, discriminations and violence of everyday life. In this view, bodies are markers of suffering, social and political oppressions, and human rights violations.

The social embodiment of risk in eastern Germany at the millennium is conceptually different in the way that women's bodies were marked by *absence*. A significant decline in the number of children born in former East Germany after reunification—a fertility rate decline of about 1.5 to 0.5 (Kreyenfeld 2003)—resulted because people were anxious about their futures, interviewees told me. Fertility rates in former West Germany remained steady at around 1.5 from 1980-2000 (Statisisches Bundesamt 2001). In former East Germany, there was a notable absence of pregnant women for about a decade after reunification. Social embodiment, in this case, was marked by a temporary exception to previous (and only recently resumed [Goldstein and Kreyenfeld 2010]) patterns of childbearing.

Women's pregnant bodies emblemize meaning for the women themselves but also for and in relation to others. Central to the theoretical concerns of this article are observations of how pregnant bodies embody competing understandings of risk for different groups. In this article, risk is the common analytic, viewed from the standpoint of multiple interlocutors—women, obstetricians, hospital administrators—in an attempt to unpack the social production of risk, and to illustrate how circulating notions of health risk refract with post-reunification anxieties of the broader postsocialist German culture on personal, individual and societal levels.

Ethnographic research for this article spanned a time period, from 1998-2008, within which a significant number of German healthcare reforms transpired. Since German reunification in 1990, government, corporations and doctors (see Giaimo 2002) have exerted influence in the reform of Germany's universal healthcare system. Reform efforts have been complex and are not addressed here. This article is based on one stage of research conducted in two German state-funded university hospitals, one in former East Germany, the other in the former West. The hospital-based research design stage was comparative. This article features the East German data, which was collected primarily in a university hospital in a city of about 100,000 residents. The city, categorized as "core" by OECD, was nonetheless located in a county considered rural (OECD 2007). Many of the pregnant women I met were from surrounding small, rural villages. This stage of research included purposeful sampling and semi-structured interviews with women (71 from former East Germany; 51 of the 71 were at East Hospital[2]) and participant observation of a total of 449 prenatal exams (233 were conducted in the former East German hospital). The interviews were conducted by the author in German and translated into English by the author and research assistants who were Germany-born, German first-language speakers.

Relative Risk: Perceptions of Pregnancy and Postsocialist Life

Several patterns were evidenced in women's responses to interview questions about risk. More than half the women (54 per cent) said that pregnancy was not risky. Beatrice,[3] a 27-year-old government worker, was typical when she said, "[Prenatal care], especially ultrasound, is not so much about finding what's wrong as it's looking to see that everything is developing like it's supposed to." Most women expected prenatal scans to confirm that their pregnancy was "on track"; few expected obstetricians to diagnose problems in *their* case. Further, many women articulated that "doing it right," that is, doing their *Aufgabe* (duty) as pregnant women—for example getting regular prenatal *Kontrolle* (surveillance), and following "doctor's orders"—would likely mean that they would not have any complications, as if prenatal care in and of itself provided totemic protection against complications. A number of women responded to the question "is pregnancy risky?" as follows:

> No. If the child's mother sticks to what she is told and if she can think a little, I don't think it is risky. If she sticks exactly to everything and if she doesn't consume huge amounts of drugs or alcohol or smoke a lot ... if the future mother sticks to the rules and keeps a healthy diet and gets some exercise, nothing should go wrong. [Olina, 30, kitchen worker]

> That depends on how you behave. If everything is okay and you behave the way you are supposed to, it is not risky. But when you do not behave the way you are supposed to, it can become risky. [Corina, 30, ceramic artist]

> It depends. If you behave irresponsibly ... I mean I am a smoker, but I reduced it. I didn't stop immediately, that wouldn't have been possible anyway. I have one glass of alcohol every now and then, but not more ... You have to be responsible ... You have to stop doing certain things ... I cannot understand some people who go to parties and smoke pot and things like that. [Christel, 17, unemployment program trainee]

Most of the women interviewed seemed unaware that the vast majority of pregnant women in Germany are considered to have a *Risikoschwangerschaft* ("at risk" pregnancy). Official statistics at East Hospital (n=1061) the year of my fieldwork, for example, identified 88 per cent of the women giving birth at the hospital as at risk. For the greater *Land* (state or province), the percentage was 75 (n=16010). Yet, the criteria obstetricians used to qualify risk[4] were different from those women used to determine risk for themselves. As a group, pregnant women in the former East shared little of their obstetricians' understandings of risk, which were based in clinical and epidemiological standards. More about obstetricians' perspectives follows in the next section, but I turn now to women's characterizations of risk in the interviews.

TABLE 1
Responses to interview question: "Is pregnancy risky?"

	East Hospital (n=54)	
No, pregnancy is not risky	29	(54%)
Depends/I don't know	17	(31%)
Yes, pregnancy is risky	8	(15%)

My question about pregnancy risk was almost always first understood by the women as *fetal* risk rather than *maternal* risk, even though the question did not specify.

> The risk is for both ... For the child [it includes] influences from the outside which you cannot prevent, like illnesses or radiation exposure ... For me, as a woman, there are very big mental and social pressures if there are financial problems or if the environment is wrong. [Helga, 36, university lecturer]

Probing further in an effort to get women to reveal what they understood and meant by risk, however, often led to a *shift* from talking about the fetus to talking about themselves, often in terms of their "bad behaviour," explained below, and also in terms of eastern Germany sociality. Risks and responsibilities were understood foremost as *behaviours*, concrete and observable. Some women identified risks such as age, early contractions and bleeding, but many more women talked about risks as behaviour they were responsible for, or could be held responsible for if anything was or went wrong. Few eastern German women mentioned genetic factors as risks threatening either their fetuses or themselves. The comment below was typical and evident in many of the interview transcripts:

> I need to lead a healthy lifestyle, not lift anything heavy, get a little exercise, not do anything that would harm the child. To be more considerate of my own body, which I might not do in regular life. [Christiana, 32, unemployed worker]

When I asked women at East Clinic if pregnancy is risky, only 15 per cent (see Table 1) said that it was—a low percentage at a clinic providing care for a wide range of pregnancy types. Women tended to define risk in terms of things they could control such as lifestyle choices like

eating right, getting enough sleep, avoiding stress, alcohol and second-hand smoke:

> I have to keep a healthy diet. I have to go outdoors a lot. I have to eat a lot of fish so that the brain develops ... and I must not sit in a room with twenty smokers. I have to have as few stressy people around me as possible, and sleep a lot. [Ute, 25, factory worker]

> I think the responsibility for the child starts with the first day of pregnancy. That means you have to keep a healthy diet, to get exercise. To do everything that is a good pregnancy so that the child does not experience any risk. [Magda, 26, nurse]

There was a marked difference in the interview data from former East and former West Germany about the issue of risk. Notably, the former East German cohort considered risk in ways that were markedly different from their obstetricians. There was far greater commonality between western German women and their obstetricians about what constituted risk during pregnancy. At West Hospital I found a general acceptance of obstetricians' views of pregnancy risk among women, as measured by an absence of challenges to obstetrical authority. A second and stronger difference also emerged between east and west cohorts as well: the most notable difference was the way that more than half of the women at East Hospital described risk in terms of social risk, such as the risks to childbearing when one is unemployed or one's future is uncertain, as was the case for many East Germans at or after reunification.[5]

Several women answered the question about risk by emphasizing that life itself was risky. Most of these women emphasized how "natural" pregnancy is for women, describing pregnancy as *Natur*, and using German euphemisms for pregnancy like "*in anderen Umständen*" ("simply other circumstances") or "*Sie im Leben gehört*" ("[pregnancy] belongs in life"):[6]

> I think pregnancy is something beautiful, I mean, after all, it's not a disease. You are just in a different condition. I think it's nice. You don't have to fear anything and you don't have to worry. [Christiana, 32, unemployed worker]

> Living is risky ... it's what women are built for. Everything has risks, so I don't think it's particularly risky ... One should think twice about telling a doctor anything [because] they will put you on tablets. They are afraid of everything. They take it too far! [Nicola, 23, unemployed]

One of the women's partners added:

> [Pregnancy is not risky] if you stick to the rules and don't get out of control. Something can happen at any time. You can cross the street, sprain your ankle and fall in the gutter. [Jahn, 28, financial advisor]

For some women, even when grave risk was diagnosed during a prenatal exam and well-explained to the patient by an obstetrician, risk remained imponderable if the patient felt physically asymptomatic or intuited no threat. In an extraordinary interview with Karolin and her partner, Karolin skipped the typical formal German greeting rituals and started talking about her pregnancy the moment she crossed the threshold into the interview room. She spoke so spontaneously on this point that I had to rush to begin to record the interview, so urgent was her need to *tell* me about her experience. Her pregnancy had been an emotional one because one of the early blood tests (Triple Test—a probability test, not definitive) had indicated a chance, she was told, of Down Syndrome. She described her experience of having "the feeling that it is impossible that things are that wrong":

> When we saw the child on the ultrasound, and everything was perfect, how it was lying there, nice and quiet, and now it is supposed to be sick? That's when I thought that, really, nothing could be wrong ... I was told they could not really tell whether there was something wrong ... But about the Triple Test, I still don't quite understand. The doctors were not able to explain it. I heard it from the first doctor who was still in training and he did not know the details. So he sent me to his supervisor, and she explained it to me again, but I still do not get it. It's a blood test that is not very precise. [Karolin, 21, nursing student]

> She was hysterical for three days after, not well at all. That's when we thought, does this test have to be done? [Karolin's partner, Andre, 30, salesman]

An amniocentesis later confirmed that Karolin's fetus did not have Down Syndrome: "After 14 days I had the final results, but until then I had no peace." Karolin was typical of the women who were unsettled by being told there was a problem that she did not register in her body, a case of *un*embodied risk, if you will. Many of the women interviewed expressed a need to *feel* the risk—a physical or mental discomfort—to perceive the risk as real for them.

When describing serious risks that they did *not* feel, women almost uniformly used "they"—as in "they tell me" or "they say"—referring to the obstetricians who had identified the risk, describing the risk in ways

that were external to the intimate experiences of their pregnancies:

> Risky? Well, yes, there are risky pregnancies. They said mine was one because I'm 33 years old and because of ICSI [intracytoplasmic sperm injection—an in vitro fertilization procedure] ... They said mine was a risky pregnancy, but I feel great ... This pregnancy was ideal! No problems ... and now there are only 2 ½ weeks to go [until the due date]! [Renate, 33, saleswoman]

This "they-ing" of risks was a way women "othered" risks. It was different from how many women characterized the behaviour they themselves "owned," like when they confessed to, for example, having had a glass of beer with last night's bratwurst.

Absence as Social Embodiment

My interviews in eastern Germany followed fieldwork in the former West, and one of the most significant departures the eastern cohort made in comparison to their western sisters was eastern women's references during the interview to endogenous and societal risks as integral and necessary components of their pregnancy experiences. There was no interview question that inquired directly about social risk, yet 30 of the 54 (56 per cent) East Hospital women interviewed *spontaneously* mentioned *in the present tense* various aspects of social life that felt risky during pregnancy. The same questions were asked of women in former West Germany prior to fieldwork in the former East, but the western German cohort spoke almost exclusively about risk during pregnancy as biomedical or corporeal risk.

More than half of former East German women saw the eastern German social milieu at the millennium as risky. The number of children per woman in eastern Germany declined precipitously during the 1990s, as many women throughout the former East simply did not have children at all in response to the social uncertainties of reunification. This dip in former East German fertility—sometimes characterized as "the kink" (Kulish 2009)—was noticeable; several interviewees commented on it. Opportunities for university education, vocational training, gainful employment and daycare had been guaranteed in East Germany. The unsettling of these guarantees for East German women was linked to post-reunification life. Several also mentioned newfound post-Fall of the Wall perceptions of menace and violence, as in the quote below:

> Now you have to be afraid. I didn't used to be afraid, for example, when I was out in the streets at eleven at night, alone, even as a little girl. I would never do that today. I would be afraid. That's the price we've paid. [Odette, 32, physician]

Embodied Risk: Screening for Statistical Norms in Real Women's Bodies

As imaging technologies for looking into the human body have become more sophisticated, there has been a shift away from women as the intimate arbiters of their reproductive experiences. Social historian Barbara Duden (1993) writes incisively about the historical trajectory of women's self-knowledge in Germany, and notes that women were once the sole arbiters of fetal "quickening," that moment when a woman reports feeling fetal movement in the uterus for the first time. In the 20th and early 21st centuries, however, social acceptance of the obstetrician as arbiter of women's reproductive experiences is near complete (see Erikson 2007).

This section focuses on obstetricians' understandings of risk, which were a complex mix of clinical, biomedical, epidemiological and statistical norms and knowledge, and which were quite different from women's understandings of risk. For obstetricians, prenatal risk is writ large into everyday practice and every woman's pregnant body. In Germany, prenatal risk is inextricably linked with ultrasound scanning. Pregnant women have on average 11-12 prenatal exams and an ultrasound scan at every exam.

Obstetricians at East Hospital treated the probability of risk as fact as they went about their regular work days, categorizing patient risk in terms of probability based on epidemiological studies. Epidemiological artifacts—like fetal anomalies increasing as maternal age increases, or higher likelihoods of slow fetal growth when pregnant women smoke, or "too much fat" on the back of fetal necks in ultrasound images correlating to a likelihood of Down Syndrome—operated less as possibilities and more often as determinants in the prenatal exam encounter. In everyday practice, epidemiological data became shorthand: anomalies increase with age; size decreases with smoking; neck fat means disability. Competing notions of risk were at work in the prenatal encounter, enlivening the notion that risk is a cultural artifact, not just an epidemiological and clinical fact (Handwerker 1994), but some notions of risk were made by people—the obstetricians—who were deemed more knowledgeable and powerful by the larger society.

One of the first observable differences between women's experiences and obstetricians' experiences of risk and prenatal ultrasound occurred almost every time they looked simultaneously at the ultrasound image on the monitor. The women were looking for their children

and the obstetricians were looking for clinically defined pathologies. Time and again, I witnessed the disconnect between what obstetricians were pointing out on ultrasound images and what women later told me they saw when they looked at the very same image. Visualizing the fetus with ultrasound was not enough for most women to share obstetricians' population health-based conceptualizations of risk to them or their future children.

When I asked the obstetricians at both East and West Hospitals about the disconnect three things became clear: (1) most obstetricians expected patients to already understand how population health statistics work, that is, how habits like smoking are linked to diseases like cancer across a population of thousands of people to produce "standard humans" (Epstein 2009); (2) they expected patients to be able to translate statistical risks to their own embodied experiences; (3) obstetricians generally assumed that once patients had had population health statistics explained and mapped onto ultrasound images of their fetuses, the education was complete and the patients would share the obstetrician's population health perspective posthaste. Except, as I have shown in the earlier section, they did not. This disconnect was not neutral in East Hospital, as in other places. As Kaufert and O'Neil (1993) have also shown, when lay, epidemiological, and clinical languages of risk do not sync, power differentials do not favour pregnant women's perceptions of risk.

Uncertainties and Ambiguities of Risk

Obstetricians sought out prenatal risk expecting to find it. In fact, that is their job. Every day they worked to identify, isolate and name risk indicators, lest they be considered professionally negligent.[7] Even when obstetricians were self-conscious and articulate with patients about the limitations of identifying risk indicators, as some in East Hospital were, they were required to act as if epidemiological-based risk was real in and of itself. After one prenatal exam, as the patient and her partner exited the exam room, the obstetrician turned to me and reiterated that the fetal skull measurements he had just taken indicated that the baby's head was too large for its gestational age. This is an indication of possible hydrocephalous, he said, which he felt obliged to document. As he entered this new data into the patient's computer record, he said, "but did you see how big both the parents' heads were? This baby is fine!"

At East Hospital,[8] not everyone who received prenatal care was a high risk patient. Several people mentioned to me that if you were friendly with your *Frauenarzt/ärztin* (women's doctor), he or she could say you were experiencing *besondere Beunruhigt* (special disquiet) to gain access to hospital services. At East Hospital, 17 per cent of the women whose prenatal exams I observed listed this indicator as justification for hospital services. Typically, by trading on the network of relationships like those so richly documented in Berdahl (1999), women who preferred going to university hospital obstetricians were able to, even when they were not in need of higher specialty care. Many women told me it was very easy to be referred to the hospital for prenatal care. Several said they asked their Frauenarzt/ärztin to write a letter of referral to the hospital because the obstetrician either did not yet own an ultrasound machine in their practice or because the machine was old and the image resolution was poor. With the hospital's newer, higher-quality, clearer-resolution imaging machines, the baby's first (ultrasound) picture was sure to be a good one. Many Frauenarzt/ärztin obliged. It appeared to go without saying that women could easily get access to better hospital machines (and therefore better, higher resolution images) just for the asking.

Easy access to the better machines, however, sometimes had unexpected results. Better resolution meant, obviously, that the obstetricians could see more. One woman, Uli, 26 years old, pregnant with her first child, was unprepared for what her obstetrician found. She admitted during her exam that she had just wanted a good picture and had easily acquired a letter from her Frauenarzt.He had obligingly written something vague about hospital obstetricians needing to check the fetal heart. During the ultrasound scan, after the hospital obstetrician quickly dismissed any medical concerns about the fetal heart, the obstetrician stopped moving the transducer across her bare abdomen and stared intently at the ultrasound monitor. She honed in what she announced was a "clitoris much larger than normal for gestational age." In that instant, Uli's pregnancy and her female fetus joined the already crowded ranks of high-risk pregnancies, and there they remained for the duration of the pregnancy.

For East Hospital obstetricians as well as for obstetricians elsewhere practicing biomedicine, enlarged fetal female genitalia can indicate life-threatening conditions like congenital adrenal hyperplasia, affecting 1 in 15,000 people (see Saada 2004). The diseases, however, are considered so rare they fall into the orphan disease category, a category of conditions for which there are typically few treatments developed or medical resources devoted. The ambiguity of prenatal genitalia begins with the ultrasound image. Real-time 2-D technology, the level of ultrasound device used for prenatal scans at East Hospital, are greyscale digitized translations of soundwaves. The machines were new and the resolution was good, but ultrasound

visuals have limitations. Fetal movement during the ultrasound scan, the shadows between small fetal limbs, the amount of amniotic fluid, the skin and fat densities of the pregnant woman are all variables contributing to the ambiguity of determining prenatal risk with ultrasound. Sorting real threats from inconsequential physiologies is the everyday job of the obstetrician, and at East Hospital, they err on the side of identifying risk, rather than not. Statistically, the risk identified—88 per cent of the pregnancies in the year of my fieldwork—far outstrips the actual fetal anomalies present at birth—2.7 per cent in the same year.[9]

East Hospital's categorization of genital ambiguity exclusively as a medical risk speaks to the global ambiguity of prenatal risk in another way, one in keeping with what women interviewed understood as risk *within* complex and multiple social fields, beyond medical designation. In short, genital ambiguity in Germany has social and political meaning. Statistically, chances are far better that Uli's fetus simply has a large clitoris (ISNA 2010). Over the last two decades, intersexuality advocacy around the world has aimed to educate the medical profession and lay public about the variability of clitoral and penis size across human populations. Medical "regulation" of gender—that is, the neonatal surgeries conducted within days of birth to "normalize" genital size and shape both with and without parental consent—has been taken up by advocacy groups in Germany and elsewhere as a human rights issue (Fausto-Sterling 2000; Hird and Germon 2001; Intersexuelle Menschen e.V. 2010). In the context of the East Hospital prenatal exam, the omission of the social field in identification of the newfound risk for Uli's pregnancy was typical.

In sum, from the obstetrician's point of view, pregnancy is foremost embodied risk of the first instance. "At risk" is what a pregnant woman and fetus *are*.[10] This is different than how eastern German women in this research project experienced pregnancy, which was more broadly inclusive of family, employment and security concerns. It turned out, though, obstetricians themselves also experience risk in non-medical ways. As the section below details, an unexpected fetal death illustrated how risk for East Hospital obstetricians as a cohort was also institutional, juridical, and even, by small degrees, nostalgically national.

Risk Business: Managing the Uncertainty of Pregnancy in Transitional Times

"There is some trouble," the midwife said quietly to the obstetrician. Accompanying the midwife was Simone, a 23-years-old two weeks shy of her due date, and her husband. They walked into the prenatal ultrasound exam room on my first day of fieldwork at East Hospital, a Tuesday. Simone made her way over to the exam table, slipped off her shoes, and with her hand underneath her belly, holding it up the way very pregnant women do, she lifted herself from tip-toes up onto the table. In retrospect, it is remarkable that there was not more alarm in the air, not on her face or her husband's or in the manner of the midwife who had walked Simone from *Kreissaal* (Labor and Delivery) to *Ultraschall* (Ultrasound Department). The midwife turned to Dr. T., the obstetrician on duty, "the fetal heart tones aren't showing up. Will you give a look?"

Simone had been to the hospital on Saturday too, three days before, driving the 30 minutes from her home in a picturesque village known for its piano factories and quiet vacation retreats. This was Simone's first baby, and throughout her pregnancy she had seen several doctors, though not because she was experiencing complications. She came from a relatively wealthy family who, I was told, wielded a fair bit of power in their village. She had shuttled from doctor to doctor seeking "the best possible care" with a detectable sense of entitlement uncommon in most of the people I met while working in eastern Germany. When Simone found out she was pregnant, she had first gone to her local Frauenarzt for care, as is the usual first step for prenatal care. But her mother knew a doctor in a small city hospital, and trading on the informal network of relationships in former East Germany, Simone began going to the small city doctor as well, even though she was young and healthy and by all accounts experiencing a low risk pregnancy. On Saturday, Simone had felt more anxious than usual—the baby wasn't moving much, she said. "Pregnancy anxiety" is named in Germany: in West Hospital, the term was *Mütterlicheangst* (motherly anxiety); in East Hospital, the term was besondere Beunruhigt. These terms are more than descriptors of how a woman is feeling. It was also a legitimate diagnostic condition covered by health insurance. Simone did not manifest the risk factors that would have been predictive of fetal disability or death, and her prenatal care record included several mentions of besondere Beunruhigt. Based on my own observations during 233 prenatal exams at East Hospital, some obstetricians included besondere Beunruhigt in patient records with marked degrees of patronization.

The small city hospital doctor had sent Simone to East Hospital because it was considered the best hospital in the region. It was a university research hospital with a reputation based on a centuries-long legacy of high quality care and cutting-edge health research. Since re-unification, the hospital also had the best and newest

diagnostic technology, better in many cases than what was available at comparable hospitals in western Germany. On Saturday, Simone had an ultrasound scan, and her fetus was deemed to be fine. The East Hospital doctor on call Saturday night took a lot of still-images of the fetus, 14 in all. Simone had also been hooked up to an electronic fetal monitoring machine, and from the elastic belt sensors strapped across her belly, fetal heartbeats had appeared fine. Simone was sent home Saturday evening.

On Tuesday morning, Simone was back at East Hospital because she had not felt any fetal movement for over 24 hours. In the exam room, Dr. T. looked for three long minutes. Then he said gravely that he was so sorry but there was no heartbeat. Then he sat completely still, this normally bouncy jovial man, as a wave of deep sadness washed over everyone in the room. So many tears. Simone and her husband sobbed, separately at first, she on the exam table, he standing near one of the ultrasound monitors, face in hands. As Simone curled up on the exam table into a fetal position, her husband went to her and folded himself over her body. Her big belly, still bare and sticky from the ultrasound transducer gel, lay huge beneath their tangle of arms, heavy with a new meaning. In the next moments, the rest of us slipped out of the room, leaving Simone and her husband alone.

Institutional Risk Management

Every morning at 7:00 I joined the East Hospital doctors for *Hörsaal*, referring to both a daily conference and the lecture hall in which it was held. The rest of the hospital had been renovated since reunification, but this room had not. The room looked like it could have hosted Vesalius' anatomy classes with its tiers of old wood chair-desks, stacked steep, focusing attention on the speaker at its deep centre.

Thursday morning after Simone's tragedy, the Hörsaal filled up with white coats, senior doctors, as well as the freshly-minted medical students. I saw Dr. T. conferring quietly with colleagues at the room's lecture centre. Hovering on the front wall high above them was a slide of Simone's baby. Her son lay still before us, huge, about 50 times larger than life. In the picture he was covered with vernix and framed in the slide by Simone's bare legs, the whiteness of her legs made all the more stark by bright smatterings of blood. Cause of death was obvious: the umbilical cord, wrapped around the baby's foot three times, ran diagonally across the torso and up and around the neck. Each time the baby had kicked, the umbilical cord tightened around his neck, acting as a noose in utero.

The discussion amongst the doctors that followed was at first clinical—"...uncommonly long umbilical cord...," "...asphyxiation..."—then the discussion became defensive—"there was nothing that could have been done," "this was a rare occurrence," "we have no control over something like this." The discussion then shifted again and stayed focused on the juridical implications of the case. Simone's mother had reportedly filed a lawsuit. There was, however, a question of jurisdiction; the small city hospital may have been at fault first. The director of obstetrics, a stalwart and gentle man, repeated several times in vain that the hospital's focus needed to be on the woman and her family, not on defending the hospital for a death they could not have prevented. But his comment was largely unacknowledged as tasks were delegated in preparation for a hospital defense. A senior obstetrician strode to the front of the lecture hall, taking loudly and gesturing as he made his way forward. He had reported two days earlier on how good the hospital's infant mortality statistics were. Now he was mobilized, lawyer-like, energetically elaborating at some length on the case East Hospital could make in its defense. Electronic fetal monitoring strips as well as the 14 ultrasound images the physicians had taken on Saturday night would all be used as evidence to prove that East Hospital was not at fault. Many physicians in the Hörsaal were aware of the 1999 landmark "wrongful birth" ruling in Austria (followed three years later by a similar ruling in Germany) that set in motion legal precedents for claims of "wrongful pregnancy," "wrongful life," and "wrongful death" (Brezinka 2000, 2006).[11]

When I saw Dr. T. later that morning, he told me how exasperating he found this case. East Hospital doctors had done "everything right," he said. Simone's mother must have filed the lawsuit out of unbearable grief, he added compassionately. Simone's situation was tragic and terrible, but Simone's had been "a no-risk pregnancy" and, he said with great passion, there was just *no way* the obstetricians could have prevented what happened.

Tragic Paradox: Risk and No-Risk in Postsocialist Germany

Simone too had done "everything right." She had sought and received early and regular prenatal care, replete with lots of ultrasounds, as is the norm in Germany. During her pregnancy, she did not smoke or drink alcohol; she had gained the "right" amount of weight. At 23, she was young and healthy, and physiologically speaking, she was considered at the prime and "least risky" of her reproductive years.

When the fetus of a healthy woman dies in Germany, people assume something has gone terribly wrong and

that something could have been done. Perhaps not (see Enkin 2006). Still, a woman "like Simone" was considered unlikely to experience a problem pregnancy. The paradox of Simone's case is tragic: Simone was not considered at risk, despite the increase in screening, diagnostic testing, and epidemiological indicators that categorized the vast majority of pregnant women in Germany each year as potentially at risk. Simone's case was especially troubling to many obstetricians because, epidemiologically, her baby was not supposed to die.

The physicians on duty Saturday night may have missed whatever brief window of opportunity existed to rescue the fetus when Simone came in complaining that her fetus' movements were "strange and different." There was no evidence that the physicians were medically negligent. Still, on a Saturday night, Simone went first to the obstetrical hospital's Emergency Room, where an experienced obstetrician was likely on call but not present. Talk after Thursday morning's Hörsaal was that two young, relatively inexperienced physicians were on duty that night. They took 14 ultrasound images, but a question quietly circulated about whether or not they would have known what an umbilical cord around the neck looked like in an ultrasound image. In Germany, physicians conduct and interpret ultrasound images; sonographers as a separate class of medical professionals do not exist. Physicians of any specialty can legally conduct ultrasound exams without a single day of ultrasound training (though few do). The question remained however whether an experienced obstetrician would have seen that Simone's fetus was distressed.

Simone's loss affected the hospital administrators and obstetricians in ways that were not only professional but deeply social. The loss brought to the fore insecurities about the quality of eastern Germany's medical care that lay just beneath the veneer of everyday interactions. On the one hand, in East Hospital I witnessed hard-earned and well-deserved pride in the excellent health research and provision of patient care, as well as occasional declarations of unchecked bravado. In my everyday interactions at the hospital, there were many expressions by many different kinds of people—patients, physicians, administrators—of confidence in the hospital system and East German medicine generally as well as regular mention of East Hospital's historical legacy of providing first class medical care, dating back to the 16th century. On the other hand, there were also moments when it was clear that physicians and administrators felt continual pressure to meet or, better yet, exceed West German standards. During a coffee break, when I asked a group of obstetricians why a former West German physician was director of East Hospital's *Frauenklinik* (Women's Hospital) when there were so many qualified former East Germans, the general consensus after lively discussion was that East Hospital, like so many others in eastern Germany, needed a former West German at its head to be taken seriously as a university hospital. During a 2005 visit to East Hospital, I learned that the beloved director of the obstetrical department, a former East German, had just announced he would be stepping down from his position. The talk of the obstetricians and nurses centred on his reasons why: He had lived all of his adult life in East Germany and he simply "couldn't take" any longer the pressures from management to think of healthcare primarily in terms of profits. The mental shifts required to administer the hospital—from "solidarity to profit," they characterized it—were demoralizing to him.

The tensions arising from the threat of a lawsuit, the question of physicians' inexperience and possible error in judgment on Saturday night, and the doubts that more could have been done to prevent Simone's stillbirth played out against a social backdrop of a lingering anxiety that former East Germany had not quite yet arrived. Over the ten years I conducted the larger research project informing this article, concluding in 2008, I continually witnessed actions, events and attitudes that conveyed the sense that eastern Germany remained backward. Oft-quoted exceptions of former East German cities like Dresden, Jena, Leipzig and of course Berlin did not overcome prevailing linguistic chauvinisms that *all* of former East Germany was behind. With the passage of time, these sentiments lessened. But since reunification, there have been and remain marked policies that build East-West inequality into the German medical system, starting with obstetricians working in the former East earning about 80 per cent less than their western German counterparts. Right after reunification, West German domination of reunification processes—some have said colonialization (Stack 1997)—contributed to widely acknowledged competitions and antagonisms between the two Germanys (for example Azharyahu 1997, Boyer 2001), and sometimes resulted in new cult and cultural forms (for example Berdahl 2000). But in medicine, the West's advantage was not subtle. At East Hospital, for example, one of the obstetricians was within months of finishing her Doctor of Philosophy in Medicine degree when the Berlin Wall fell. Her degree was awarded four years later after she re-took coursework originating in former West German universities; her former East German coursework was inadmissible for requirement fulfillment. She described the coursework as virtually identical.

This was the backdrop against which lingering doubts about the death of Simone's baby found traction. On a day-to-day basis, the not-subtle markers of presumptive East German inferiority—for example, less pay, preference for West German-trained heads of hospital and West German medical coursework—were mostly ignored. But events like the death of Simone's baby brought to the surface individual and institutional desperation for an irreproachable medicine in eastern Germany, lest the event be used as proof of ongoing and systemic deficiencies.

Conclusion: Social Embodiment as Constitutive Praxis

In a postsocialist German hospital, we see how varying conceptualizations of risk—personal, clinical, scientific, institutional and geopolitical—make particular kinds of claims about women's pregnancy experiences, naming for women what they are not authorized to name for themselves. In this article, social embodiment has been used to explore the interrelationships between a corporeal condition—in this case pregnancy—with an unsettling of a "state body," as was the case in former East Germany. The upending of the East German social order meant new and differential meanings of family, work and, in this case, risk, were evidenced after German reunification. Risks are historically and culturally constituted phenomenon (Handwerker 1994; Zola 1972), and here we see this manifested in the everyday, ongoing co-habitations of different perceptions of risk, replete with historical referents and social exegeses. Women's endogamous and exogamous understandings of risk co-existed with the operative epidemiological standards used by their obstetricians. The epidemiological construction of risk superseded embodied and social conceptualizations of *what* about being pregnant is risky. Women, though, articulated how pregnancy seemed risky (and not risky) to them nevertheless, and, in so doing, interrupted biomedical constructions of risk so that such constructions were never complete.

In postsocialist Germany, as in other places, risk is presumed during pregnancy; there is no such thing as a no-risk birth. But, as we have seen, prenatal risk does not originate exclusively with the body. Prenatal risks, because they are both corporeal and social, refract; they were not discrete. The social embodiment of prenatal risk can mean that women's bodies reflect for individuals and a wider society biomedically-anticipated threats to bodily maternal and fetal health, but, moreover, can provide insights into collective sentiments of social well-being.

It has been theorized that bodies remember criticism, resistance and delegitimations resulting from political violence (Kleinman and Kleinman 1994). In postsocialist Germany, during the perinatal interval, women likewise registered—with both newfound presences and absences—social criticisms, resistances, and delegitimations resulting this time from a (mostly) peaceful political transition. Women's pregnant bodies became marked in new ways when the whole of Germany made its postsocialist turn, embodying some of the unanticipated social risks of German reunification.

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Notes

1 Throughout the text, capitalized *East* and *West* refer to the two countries before reunification. Lower case *eastern* and *western* refer to the now reunified sections of Germany that fall within former East and West German boundaries.
2 For anonymity and ease of reference, I refer to the hospital in former East Germany as East Hospital and the hospital in former West Germany as West Hospital.
3 All names are pseudonyms.
4 See Stahl 2002 for discussion of German risk indicators.
5 The effects of unemployment and feelings of future uncertainty are also discussed in Erikson 2005.
6 A reviewer kindly and rightly pointed out that these terms are grammatically incorrect. Because they are direct quotes from interviewees, I leave them intact.
7 I have argued elsewhere that this reflects an overproduction of risk (Erikson 2008).
8 This was also true at West Hospital.
9 Some have questioned this well-established practice (Jahn 2002; Stahl and Hundley 2003).
10 As opposed to risk *done* to a person (for example industrial waste) or a person's risky actions (for example drinking alcohol and driving) (Kavanagh and Broom 1998:442).
11 These legal categories have been anticipated in North America and Europe for about a decade. See Macones et al. 1989.

References

Azaryahu, Maoz
1997 German Reunification and the Politics of Street Names: The Case of East Berlin. Political Geography 16(6):479-493.

Barsalou, Lawrence W., Paula M. Niedenthal, Aron K. Barbey and Jennifer A. Ruppert
2003 Social Embodiment Psychology of Learning and Motivation 43:43-92.

Beck,-Gernsheim, Elizabeth
1997 Geburtenrückgang und Kinderwunsch—die Erfahrung in Ostdeutschland. Zeitschrift für Bevölkerungswissenschaft 22:59-71.

Berdahl, Daphne
2000 "Go, Trabi, Go!" Reflections on a Car and Its Symbolization Over Time. Anthropology and Humanism 25(2):131-141.

1999 Where the World Ended: Re-Unification and Identity in the German Borderland. Berkeley: University of California Press.

Boyer, Dominic
2001 The Impact and Embodiment of Western Expertise in the Restructuring of the Eastern German Media after 1990. Anthropology of East Europe Review 19(1):77-84, 2001.

Brezinka, Christoph
2006 Training, Certification and CME in Obstetric Ultrasound Scan in Europe. European Clinics in Obstetrics and Gynecology 1:223-226.
2000 Obstetrical Ultrasound and the Many Faces of Obstetrical Lawsuits. Ultrasound in Obstetrics and Gynecology 16:207-209.

Csordas, Thomas, ed.
1994 Embodiment and Experience: The Existential Ground of Culture and Self. Cambridge: Cambridge University Press.

Csordas, Thomas
1990 Embodiment as a Paradigm for Anthropology. Ethos 18(1):5-47.

Duden, Barbara
1993 Disembodying Women: Perspectives on Pregnancy and the Unborn, translated by Lee Hoinacki, Cambridge, MA: Harvard University Press.

Enkin, Murray
2006 Beyond Evidence: The Complexity of Maternity Care. Birth 33(4):265-269.

Epstein, Steven
2009 Beyond the Standard Human? *In* Standards and Their Stories: How Quantifying, Classifying, and Formalizing Practices Shape Everyday Life, Martha Lampland and Susan Leigh Star, eds. Pp. 35-53. Ithaca, NY: Cornell University Press.

Erikson, Susan
2008 "'Wer sucht, der findet: Die Überproduktion von Risiko': Deutsche Ultraschallpraxis in der Schwangerschaft." (Seek and Ye Shall Find: German Ultrasound Praxis in Pregnancy) Conference Proceedings. Da stimmt doch was nicht ... (Something is not quite right ...). Pp. 44-47. Düsseldorf, Germany: Bundesverband für Körper- und Mehrfachbehinderte e.V.
2007 Fetal Views: Histories and Habits of Looking at the Fetus in Germany. Journal of Medical Humanities 28(4)187-212.
2005 "Now It Is Completely the Other Way Around": Political Economies of Fertility in Re-Unified Germany. *In* Barren States: The Population "Implosion" in Europe, Carrie B. Douglass, ed. Pp. 49-71. Oxford: Berg.

Farmer, Paul
2004 An Anthropology of Structural Violence. Current Anthropology 45(3):305-325.

Fausto-Sterling, Anne
2000 Sexing the Body: Gender Politics and the Construction of Sexuality. New York: Basic Books.

Giaimo, Susan
2002 Markets and Medicine: The Politics of Health Care Reform in Britain, Germany, and the United States. Ann Arbor, MI: University of Michigan Press.

Goldstein, Joshua, and Michaela Kreyenfeld
2010 East Germany Overtakes West Germany: Recent Trends in Order-Specific Fertility Dynamics. Max Planck Institute for Demographic Research, Working Paper WP 2010-033, November.

Handwerker, Lisa
1994 Medical Risk: Implicating Poor Pregnant Women. Social Science & Medicine 38(5):665-675.

Hird, Myra J., and Jenz Germon
2001 The Intersexual Body and the Medical Regulation of Gender. *In* Constructing Gendered Bodies, Kathryn Backett-Milburn and Linda McKie, eds. Pp. 162-178. New York: Palgrave.Intersexuelle Menschen e.V. XY-Frauen [Association of Intersexual People/ XY-Women]
2010 Parallel Report: To the 5th National Report of the Federal Republic of Germany On the United Nations Covenant on Social, Economical, and Cultural Human Rights (CESCR). http://intersex.shadowreport.org/public/Association_of_Intersexed_People-Shadow Report_CESCR_2010.pdf, accessed January 17, 2011.

ISNA (Intersex Society of North America)
2010 How Common is Intersex? http://www.isna.org/faq/frequency, accessed January 17, 2011.

Jahn, Albrecht
2002 Screening—The Trojan Horse in Preventive Medicine? Tropical Medicine and International Health 7(4):295-297.

Jaye, Chrystal
2004 Talking Around Embodiment: The Views of GPs Following Participation in Medical Anthropology Courses. Journal of Medical Ethics: Medical Humanities 30: 41-48.

Kavanagh, Anne M., and Dorothy H. Broom
1998 Embodied Risk: My Body, Myself? Social Science & Medicine 46(3):437-444.

Kaufert, Patricia, and John O'Neil
1993 Analysis of a Dialogue on Risks in Childbirth: Clinicians, Epidemiologists, and Inuit Women. *In* Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life. Shirley Lindenbaum and Margaret Lock, eds. Pp. 32-54. Berkeley: University of California Press.

Kleinman, Arthur, and Joan Kleinman
1994 How Bodies Remember: Social Memory and Bodily Experience of Criticism, Resistance, and Delegitimation following China's Cultural Revolution. New Literary History 25(3):707-723.

Kreyenfeld, Michaela
2001 Employment and Fertility—East Germany in the 1990s. Unpublished Ph.D. dissertation. University of Rostock.
2003 Crisis or Adaptation—Reconsidered: A Comparison of East and West German Fertility Patterns in the First Six Years after the "Wende." European Journal of Population 19(3):303-329.

Kulish, Nicholas
2009 In East Germany, a Decline as Stark as a Wall. New York Times. June 19, A6.

Lupton, Deborah
1999 Risk and the Ontology of Pregnant Embodiment. *In* Risk and Sociocultural Theory: New Directions and Perspectives. Deborah Lupton, ed. Pp. 59-85. Cambridge: Cambridge University Press.
Macones, Alexander J., Anna S. Lev-Toaff, George A.
Macones, James W. Jaffe and Valerie B. Williams
1989 Legal Aspects of Obstetric Sonography. AJR 153: 1251-1254.
Mitchell, Lisa M.
2001 Baby's First Picture: Ultrasound and the Politics of Fetal Subjects. Toronto: University of Toronto Press.
Nguyen, Vinh-Kim, and Karine Peschard
2003 Anthropology, Inequality, and Disease: A Review. Annual Review of Anthropology 32:447-474.
Niedenthal, Paula M., Barsalou, Lawrence W., Piotr Winkielman, Silvia Krauth-Gruber and Francois Ric
2005 Embodiment in Attitudes, Social Perception, and Emotion. Personality and Social Psychology Review 9(3):184-211.
OECD (Organisation for Economic Co-operation and Development)
2007 Rural Policy Reviews: Germany. France: OECD Publications.
Oliver, Kelly
2010 Motherhood, Sexuality, and Pregnant Embodiment: Twenty-Five Years of Gestation. Hypatia 25(4):760-777.
Rapp, Rayna
1999 Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America. New York: Routledge.
Saada, Julien, Anne-Gaëlle Grebille, Marie-Cécile Aubry, Arash Rafii, Yves Dumez and Alexandra Benachi
2004 Sonography in Prenatal Diagnosis of Congenital Adrenal Hyperplasia. Prenatal Diagnosis 24: 627-630.
Scheper-Hughes, Nancy
1994 Embodied Knowledge: Thinking with the Body in Critical Medical Anthropology. In Assessing Cultural Anthropology. Rob Borofsky ed. Pp. 229-239. New York: McGraw-Hill.
Stack, Heather M.
1997 The "Colonization" of East Germany?: A Comparative Analysis of German Privatization. Duke Law Journal 46(5):1211-1253.
Stahl, Katja
2002 Risk and Risk Assessment in Pregnancy—Do We Scare Because We Care?M.A. thesis (MSc Midwifery), University of Aberdeen.
Stahl, Katja, and Vanora Hundley
2003 Risk and Risk Assessment in Pregnancy—Do We Scare Because We Care? Midwifery 19(4):298-309.
Taylor, Janelle S.
2008 The Public Life of the Fetal Sonogram: Technology, Consumption, and the Politics of Reproduction. New Brunswick: Rutgers University Press.
1992 The Public Fetus and the Family Car: From Abortion Politics to a Volvo Advertisement. Public Culture 4(2):167-183.
Weir, Lorna
2006 Pregnancy, Risk and Biopolitics: On the Threshold of the Living Subjects. London: Routledge.
Young, Iris Marion
1990 Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory. Bloomington: Indiana University Press.
Zola, Irving Kenneth
1972 Medicine as an Institution of Social Control. Sociological Review 20:487-504.