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Adverse Birth Outcomes, “Bad Fathers,” and Disciplining Risk:**A Place for a Feminist Voice in Bioethics**

In the past decade, several clinical studies have attempted to identify causes of adverse birth outcomes, such as gestational diabetes, preeclampsia, low birth weight, and preterm birth, by studying paternal race or ethnicity as a risk factor.¹ In US history, mothering, particularly women of color’s mothering, has been scrutinized and regulated.² So, at first, the attention turned toward paternal biology may appear to be a feminist project, drawing attention toward the “other half” of infants’ biological information. However, the conceptual framework of such research implicates ideological notions of race, class, and gender, which discipline how we identify risk, make allowances for medical atrocities and discrimination, and are “inscribed” on the body.³

For centuries, humans have given birth and cared for families, through relationships and communities enmeshed in histories and in institutions, such as family, biomedicine, and education—essentially, forms of biopower. Science and families shape and are shaped by ideological frameworks, notions that are designed to uphold a status quo and dominant ideas about what is good and right in society. Within the relatively young field of bioethics, the care of families as well as mothering has already been named a feminist ethical concern.⁴ I argue that a bioethical voice that is feminist ought not to belittle racial inequalities in birth outcomes by simply looking at biological race and asking “what about the fathers?” Instead, such a voice should look under the surface of the “trending” of paternal race as a risk factor. Here, we can draw deeply from key events in bioethics history that echo into the present fixation on inherited

1 Caughey et al. 2010, 2005; Ma 2008; Getahun et al. 2005; Palomar et al. 2007

2 Roberts 1998; Rich-Edwards et al. 2001.

3 Shim 2002:130; Foucault 1990; Haraway 1991.

4 Tong 1996; Gilligan 1993.

race and risk. “Mechanisms of power,” such as the mobilizing of paternal race as risk, help us understand the temptation to fit paternal race into the “black box” of race and sex difference as biological health risks, as Bruno Latour and later, Janet Shim describe.⁵ I am also led to agree with Mildred Cho that there is “no baby in the bathwater” and racial difference is not an appropriate target for clinical or scientific study of *biological* risk. Instead, I argue a content analysis of such research can redirect us (again) toward a more appropriate target in the search for just beginnings for all children: the impact of racial discrimination and systemic inequalities of power on birth and families.⁶

In this paper, I offer a brief content analysis on the social construction of knowledge about paternal race and adverse birth outcomes. First, I review the relationship my paper seeks to draw between knowledge claims and moral claims, and how Foucauldian biopower and biopolitics position the historical threads of bioethics and the attention to race as a biological risk factor in the study of paternal characteristics and adverse birth outcomes. Then, I summarize how the research objectives, discussion, and conclusions of three recent studies of paternal race as a risk factor position particular social and moral problems.⁷ In consideration of these moral claims, I join an invitation for feminist voices in a clinical-scientific place, consumed by biological difference, and ask about justice-making.

As a student of bioethics and sociology, I am interested in how “knowledge claims” are also moral claims. . Janet Shim explains that in her sociological research on epidemiology that knowledge claims have a “character,” in which we can analyze assertions as “sites where racial,

⁵ Latour 1987; Foucault 1990; Shim 2002:129.

⁶ Cho 2006:499.

⁷ Palomar et al. 2007; Getahun et al. 2005; Ma 2008.

class and gender orderings are visible and constitutive” (Shim 2002:130) Assertions take a moral stance on the relationships among individuals and populations as equal or unequal, as good for us or “risky” for our health.⁸ Claims about biological difference and risk have moral dimensions that draw toward our senses of goodness and danger and arrange racial difference along a range of research objectives and assumptions -- assumptions about social inequalities and the effects of racism on health.⁹ Before, during, and since the drafting of the human genome, an array of theorists has refuted race as a biological classification.¹⁰ This set of theorists agree that “we are not naturally divided into genetically identifiable racial groups.”¹¹ Meanwhile, other scientists also have made claims about innovative technologies that make it possible for them to identify groups whose genetic similarities resemble previously invalidated racial categories and thus, show racial difference as a biological reality.¹² Tethered to this debate over biological race, other researchers have made claims about the effects of racism, social inequalities, and violence on birth outcomes.¹³ The study of adverse birth outcomes and paternal race takes place within this multi-directional research context.

In a political system, such as the US, which systematically attempts to not “see” race and not acknowledge the impact of racism on communities of color, the re-emergence of biological concepts of race distracts us from social determinants of health, such as experiences of racial discrimination or residential segregation, and may even regard these social demarcations among

⁸ Shim 2002:130.

⁹ Ibid.

¹⁰ Shim 2005, 2002; Epstein 2007; Roberts 2012; Schwartz 2001; Cho 2006; Whitmarsh and D. S. Jones 2010.

¹¹ Roberts 2012:x.

¹² Goldenberg et al. 1996; Goldenberg et al. 2008; Risch et al. 2002; Burchard et al. 2003.

¹³ Nuru-Jeter et al. 2009; Dominguez 2008; Roberts 1998.

racial groups as natural.¹⁴ In her 2012 book, *Fatal Invention: How Science, Politics and Big Business Re-Create Race in the Twenty-first Century*, Dorothy Roberts explains the US moral character of the knowledge claims about biological race re-emerging in terms of “biopolitics”:

the seemingly color-blind regime of coercive surveillance imposed on poor communities of color will seem more acceptable to a majority of Americans as their belief in intrinsic racial differences is validated by genomic science and technologies. The new racial biopolitics obscures the modern form of state brutality at a time when the United States claims to have move beyond violent enforcement of racial hierarchies. As biological theories of race and the technologies it is generating make racial inequality, as well as the punitive apparatus that maintains it, seems perfectly natural.¹⁵

As Roberts’ illustrates, a “new racial biopolitics” has been taken up to address various topics throughout social science, reworking, obscuring, and extending history in service of state domination and constructing good citizens.¹⁶ The interplay of politics of race, technologies of risk, and moral claims of biological inferiority are directed toward the control of society. One can rethink the naturalness of “risk factors” by putting risk into a historical-ethical context: “the idea of inherited predispositions came to the fore, of course, in the second half of the nineteenth century, as all manner of problems of social pathology and danger became understood in terms of degeneracy.”¹⁷ It is not a far leap to see the historical extension of a long trend of mobilizing race as a marker of biological inferiority toward today’s political division of race as risk.

Biological notions of race have long served ideological functions, such as arguing a biological inferiority of particular racial groups in order to attempt to justify slavery or forced sterilization. How does research make families of color the “subject of calculation” in order to

¹⁴ Gee, Walsemann, and Brondolo 2012

¹⁵ Roberts 2012:xii.

¹⁶ Roberts 2012; Rose 2006:22–24.

¹⁷ Rose 2006:19.

intervene upon paternal race as risk and improve the life chances of individuals?¹⁸ How does this research continue notions of a hierarchical worth or “goodness” among groups of families and provide a biological reason for their differences?¹⁹ My hope is that a closer inspection of three recent studies of paternal race as a risk factor might help position the particular social and moral problems that reconfigure race as inherited risk.

My interpretation of the moral knowledge claims within studies of paternal race as a risk factor for adverse birth outcomes is guided by notions of risk as disciplining society and of reproduction as historically regulated. Deborah Lupton proposes that even as clinical studies make an effort to neutralize and render transparent risk factors, risk remains political—a “moral technology” to “discipline the future.”²⁰ Risk factors for adverse birth outcomes are also constructed within a historical and social context of reproduction. Faye D. Ginsburg and Rayna Rapp explain that reproduction is “an entry point to the study of social life,” where we can observe “how cultures are produced (or contested) as people imagine and enable the creation of the next generation.”²¹ Women of color’s reproductive decisions have been the target of media, policies, and mythologies, which have sought to regulate and disparage them; scientists, clinicians, and other researchers have the opportunity to access the contexts of reproduction, race, and risk in order to make claims about the racial disparities in adverse birth outcomes.²²

STUDIES OF PATERNAL RACE AS RISK

18 Rose 2006:19.

19 Roberts 2012:24.

20 Lupton 2012:87.

21 Ginsburg and Rapp 1995:2.

22 Lauderdale 2006; Fried et al. 2008; Roberts 1998.

Darios Getahun and his colleagues (2005), Lisanne Palomar and her colleagues (2007), as well as Sai Ma (2008) attempt to understand the relationship between parental contributions and adverse birth outcomes through the factor of paternal race. They arrange the category of paternity to include or refer to male sexual partners, sperm, and fathers. Each of the studies argues that maternal race still has a more significant contribution to birth outcomes than paternal race, but wish to highlight the point that paternal racial characteristics allow for comparison between maternal and paternal contributions or may explain how offspring of interracial couples have different birth outcomes from couples where both parents are of the same race.²³ Their conceptual effort in these articles is to illustrate that in addition to maternal race, paternal race is also worth investigating.²⁴

In their study, “Adverse Perinatal Outcomes Among Interracial Couples In the United States,” published in *Obstetrics and Gynecology*, Getahun et al (2005) are interested in the relationship between parental race, particularly paternal race, and adverse perinatal outcomes as well as stillbirth.²⁵ They relied on two previous studies (1992, 2004) that identified pregnancies of interracial parents to be at higher risk for low birth weight than same-race parents.²⁶ To analyze the records, Getahun et al (2005) re-categorized the self-reported maternal and paternal races as black or white, “irrespective of Hispanic origin,” obscuring some forms of racial difference in an attempt to explain black-white difference at a desirable level of confidence.²⁷ They controlled for some potentially confounding variables, such as maternal age, parity, and

23 Caughey et al. 2010:156.

24 Getahun et al. 2005; Ma 2008; Palomar et al. 2007.

25 Getahun et al. 2005:81.

26 Parker and Schoendorf 1992; Tan et al. 2004

27 Getahun et al. 2005:82, 86.

prenatal care, but they did not include socioeconomic status or other behavioral factors.²⁸ Their results suggest, “the frequency of preterm births was considerably higher in both black and mixed race parents as compared with both white parents.”²⁹

Getahun et al (2005) direct their study toward the opportunity for clinical intervention. They acknowledged the potential for social disparities as contributing factors, but concluded that identifying high-risk groups based on race, such as interracial couples, “may help clinicians in designing interventions at an earlier stage in pregnancy.”³⁰ The discussion of the study results begins with a historical comment on the rise of interracial marriage and births to mixed race parents in the prior two decades.³¹ Getahun et al (2005) imply that a social trend of interracial relationships might render more births with adverse medical conditions and there may be something inherently risky about the “essence” of interracial couples.

In 2007, *American Journal of Obstetrics* published a study on paternal race as a risk factor for preterm birth (<37 weeks of gestation), written by Lisanne Palomar, Emile A. DeFranco, Kirstin A. Lee, et al (2007). Palomar et al (2007) are interested in the racial disparity in risk of preterm birth between black women and white women in the United States. They reference studies that “have suggested social aspects of race, such as inequality in the prenatal treatments and medical technologies that black women receive, compared with white women, can explain this disparity.”³² However, Palomar et al (2007) prefer to follow the path of potential genetic causes for preterm birth among black women. To do so, they rely on earlier studies that

28 2005:82.

29 2005:86.

30 Getahun et al. 2005:87.

31 2005:87.

32 Palomar et al 2007:152.e1.

“demonstrated that this difference in risk on the basis of ethnicity is not explained adequately by medical, social, or behavioral risk factors.”³³ Palomar et al (2007) wish to fill in the gap of knowledge about “paternal and therefore fetal genetic influences” on preterm birth.³⁴ They hypothesize that “there is a genetic basis” for the timing of birth “by examining the effect of paternal race on the occurrence of preterm delivery.”³⁵ In other words, Palomar et al (2007) mobilize paternal race as a representation of fetal genetic makeup in order to illustrate the presence of genetic mechanisms influencing birth.³⁶ They conclude, “genetic determinants, as reflected by race, may influence birth timing,” after adjusting for a selection of “sociodemographic factors.”³⁷ They found that the pregnancies of same-race couples who were black fared much worse than white-white couples, but white mothers whose infants had black fathers had higher risks of preterm birth than the white-white couples and infants who had black mothers and white fathers were at higher risk than all white mothers.³⁸ In pursuing the identification of these racial trends, the Black mother remains in the same problematic position as studies on race as risk that ignore paternal race; shifting the focus to paternal characteristics maintains the position of Black mothers as inherently risky, and possibly even further “inscribes on the body” the notion that Black women possess a “natural riskiness” in their sexual and relational partner choices. Palomar et al (2007) admitted that race is not an “ideal index of genetic composition,” but argued it “reflects geographic ancestry, as implicated by genetic

33 Palomar et al 2007:152.e1

34 Palomar et al 2007:152.e2

35 Palomar et al 2007:152.e2.

36 2007:152.e2

37 2007:152.e5

38 2007: 152.e5.

markers” and go on to offer extensive comments on the racial expression of gene variations, linked to preterm birth.³⁹ They send the message that racial difference, even within a couple, should matter to us in how we approach the biology of childbirth, and as Getahun et al (2005) looked toward clinical interventions, it is not over-reaching to suggest that Palomar et al (2007) might also see a public health importance to choice of partner race, based on their assertions and data.

In 2008 *American Journal of Public Health* published an article by Sai Ma on paternal race and mixed-race couples. Ma suggested “prenatal interventions need to pay more attention to the disadvantaged mothers within all racial/ethnic groups, even when the particular race/ethnicity is normally not considered at risk.”⁴⁰ Ma appeared to support future research that would investigate the social and economic determinants of prenatal health and birth outcomes. However, her conclusion was wed to her conjectures about the absence of paternal demographic information from birth data, as related to social dimensions of women’s life and partner choices.

Ma feared that the habit of ignoring paternal race would “treat infants of mixed-race parents and those of same-race parents *equally*.”⁴¹ Without remarking what would make mixed-race couples unequal to or different biologically from same-race couples, it becomes clear that Ma assumed marriage is the framework for the study of paternal race/ethnicity and birth outcomes. She explained that her study follows up on hypotheses that interracial marriage is less ideal socioeconomically and less desired socially. In order to justify the research objective of her

³⁹ 2007:152.e5. As for limitations, Palomar et al (2007) concede that much of the racial information was collected through mothers’ self-report and that some sociodemographic variables were beyond their reach, “such as psychosocial stressors that are experienced by biracial couples” (152.e6). Nevertheless they maintain their conclusion that parental race is a risk for preterm birth, “independently of maternal race or common sociodemographic factors” (152.e6).

⁴⁰ Ma 2008:2291.

⁴¹ Ma 2008:2285, italics my emphasis.

current study, she cited an analysis of 1990 US census, where investigators surmised that the white wives of men of color were found to have less education (making them “less desirable” spouses) than the white wives of white men, indicating a form of status exchange, and that “people prefer members from their own group, and thus, intermarriage is the less desirable scenario.”⁴² Here, she has reinvigorated American eugenic notions of multiracial birth as countering the reproductive discipline of “bettering” the white race. She lamented the frequent exclusion of biracial infants from many studies of adverse birth outcomes when paternal data is not available, despite worse outcomes for these infants, especially for infants of Black mothers.⁴³ While she maintained the commonly held thesis that mothers or pregnant women play a more important role in pregnancy and delivery than “fathers,” she hypothesized that paternal race/ethnicity might affect the birth outcome and concluded that it was infants with unreported paternal demographic data, “missing fathers,” who were most at risk for adverse birth outcomes.⁴⁴ She then suggests that births without documented paternal data might possibly have resulted from “unintended” pregnancies, which pose additional health risks to the birth mother and child.⁴⁵

Getahun et al (2005), Palomar et al (2007), and Ma (2008) extend the trend toward biological or genetic race as risk and also restrict or discipline our view of vision for risk and birth to biological notions of Black and male sexual contributions to offspring, failing to reconceive of women’s role in “bad” outcomes in any manner remotely feminist. While holding several important components in common, the three studies vary in their rationales for their

42 2008: 2285

43 2008:2285.

44 2008:2286

45 Ma 2008:2291.

starting point of race as a risk factor. How and why does this set of research studies “discipline” risk in this powerful way? These authors implicate several reasons, which map onto moral claims about race and risk and form “mechanisms of power.”⁴⁶ First, they operate within a widening research trend of investigating race as biological risk, which brings its own objectives and intended as well as unintended consequences. Secondly, these authors find it reasonable to overlook or bypass social or psychosocial conditions. Lastly, they use race *as if* it were itself a genetic or biological risk factor.

A Widening Trend

Research studies discipline risk by aligning their objectives of a study on risk with particular intended consequences, ignoring other feasible goals and implicating other unintended social and political consequences. Getahun (2005), Palomar (2007), and Ma (2008) conduct their research within a broader and rapidly expanding regime of science investigating race as biological risk. Research on race as biological risk for preterm birth or other adverse birth outcomes has far-reaching intended consequences. Robert Goldenberg et al (2008) list several reasons it would be advantageous to identify risk factors for preterm birth: locating women with risk factors so that they might be offered “risk-specific treatment;” defining “a population useful for studying specific interventions;” and discovering characteristics that might reveal “mechanisms leading to preterm birth.”⁴⁷ The goal of looking at paternal race as a risk factor might then be identified as offering risk-specific treatment to pregnant women with male partners of particular races, defining racial groups of male partners of pregnant women who would be

46 (Tan et al. 2004; Parker and Schoendorf 1992)

47 Goldenberg et al. 2008:76

useful for further study, and reveal characteristics of some men that are “mechanisms” of adverse health outcomes for the entire family.⁴⁸ However, reactions to one of the studies’ objectives have addressed the echoes of American eugenics and revealed the potentially unintended, yet dangerous consequences of research programs, such as Palomar et al (2007) as well as Ma (2008) and Getahun et al (2005). A letter to the editors shared in distress that some of this type of research “points toward the objectionable policy of controlling population reproduction according to so-called race.”⁴⁹ In reply to these reactions, Palomar et al (2007) acknowledges that they anticipated their paradigm would draw some “controversy,” but failed to actively engage their critics.⁵⁰

Paternal race as a risk factor is also part of a debate on “race-based medical research.”⁵¹ Esteban Burchard, a geneticist and his colleagues (2003) argue that the “evaluation of whether genetic (as well as nongenetic) differences underlie racial disparities is appropriate in cases in which important racial and ethnic differences persist after socioeconomic status and access to care are properly taken into account.”⁵² Palomar et al (2007), Getahun et al (2005) and Ma (2008) also shared this perspective. On the other side of the debate, are critics who address the reluctance of studies of race as a risk factor to prioritize social inequalities related to racism and discrimination. In their letter to the editors of the *American Journal of Obstetrics and Gynecology*, Michael Montoya, an anthropologist, and Benjamin Howard (2008), a physician and medical educator, argue Palomar and her colleagues made “unsound” and “potentially

48 Goldenberg et al. 2008:76.

49 Montoya and Howard 2008:483.

50 2008:483.

51 Schwartz 2001.

52 Burchard et al 2003:1174.

harmful inferences” about race, genetics, and risk.⁵³ Montoya and Howard (2008) wrote that “assessing such preterm labor outcomes as racial and thus genetic, reinforces racial stereotypes about the black body.”⁵⁴ Palomar et al (2007) emphasize the goal of discovery of genetic risk factors over the search for policies that would address the equitable treatment of particular communities and improve birth outcomes through social change.⁵⁵ Montoya and Howard (2008) name Palomar et al (2007) an example of research that “reduces health disparities to isolated race-specific traits” and through their unintended consequences, stand to be a “bioethical problem and a public health shame.”⁵⁶

Omitting the Social and the Psychosocial

The complex interplay of social conditions, behavior, and race are partially addressed in the background and discussions of studies of adverse birth outcomes. Goldenberg et al (1996) had studied low birth weight among black women, and argued that maternal characteristics labeled medical, psychosocial, and behavioral risk factors did not explain the differences in birth weight of Black infants and white infants. They stated, “it is unlikely that continued study of the demographic, medical, psychologic, or social conditions we studied will substantially add to understanding the large differences in pregnancy outcome between the races.”⁵⁷

Goldenberg et al (1996) advised terminating the study of social conditions related to the racial disparities in adverse pregnancy outcomes, as “analysis of the contribution of ‘known’ risk

⁵³ Montoya and Howard 2008:483.

⁵⁴ 2008:483.

⁵⁵ Montoya and Howard 2008:483.

⁵⁶ 2008:483.

⁵⁷ Goldenberg et al. 1996:1324.

factors for preterm birth will probably provide little new knowledge.”⁵⁸ However, in a paragraph earlier, Goldenberg et al (1996) remarked that in their study, “other potential causes for the [racial] differences in outcome [rates of preterm birth] may include variation in nutritional status, access to medical care, stress, and other psychosocial constructs and intergenerational effects not measured with the scales used” (Goldenberg et al. 1996:1324). Their own study did not measure a set of social conditions that they concluded have been exhausted. The three studies of paternal race as a risk factor echoed this contradictory set of attitudes: they provided commentary on the limitations of their study regarding potential social factors and, simultaneously, declared such social conditions as inadequate or unconstructive in explaining racial disparities in birth outcomes. In pursuit of their goals to improve the health of families and offer treatment based on risk and given the complex and rich context in which race, reproduction and risk intertwine, it is difficult to imagine how such social and psychosocial conditions and factors could be omitted or resisted.

As If Race Were Genetic

Notions of race and gender are embedded as forms of biopower through the use of paternal race as a proxy for genetic and biological factors; these conceptual placeholders “discipline the future” by propping up race and gender as risk for genetic or biological factors not directly tested. Getahun (2005) and Palomar (2007) conceptualize race as genetic, but their studies do not look at genetic data. Instead, they use self-reported race as a proxy, because it “reflects geographic ancestry, as implicated by genetic markers.”⁵⁹ In clinical research, race as a

⁵⁸ Goldenberg et al. 1996:1324.

⁵⁹ Palomar 2007:152.e5.

proxy factor has been maintained through relying on the assertion that there are genetic and biological differences that correspond to distinct racial categories, rather than highlighting disparities in social conditions of racial groups.⁶⁰ Particular to our U.S. cultural and political notions of “bad fathers,” Ma’s remarks that unreported paternal race is socially meaningful (such as her reading of “unintended pregnancy” as categorically bad for health) etches upon bodies of color her notions of undesirability and calls them risky. Somehow, unreported or missing paternal race stands in for moral claims that Ma relies on, about interracial marriage, or unintended pregnancy, and then these are labeled as risky, reinforced by her assertions for couples where paternal data is available. However, it seems deeply problematic to critique the high numbers of missing paternal race data in birth records as matters of individuals’ undesirable choices. In response to the lack of paternal race data in birth records, it seems equally fitting to ask: what do we know about the impact of U.S. mass incarceration of males of color on pregnancy and the reporting of paternal characteristics on birth certificates?⁶¹ Or, how do we account for the erasure of same-sex couples in the collection of parental characteristics in discussions of sexuality and data collecting?⁶² Lastly, how do we understand missing paternal data in light of the fragmenting of immigrant families through deportation and displacement? Ma (2009), Palomar et al (2007), and Getahun et al (2005) discipline risk in “constructing good citizens” by ignoring the potential social, institutional or political reasons that paternal data might be missing in preference of equating missing paternal data with undesirable choices -- “missing fathers,” bad fathers, and “bad mothers” with unintended pregnancies.

60 Shim 2002:130; Foucault 1990; Haraway 1991.

61 The Joint Center for Political and Economic Studies 2010.

62 Bernard 2012

As clinical studies make an effort to neutralize risk factors and render them transparent, risk remains political, and a “moral technology” to “discipline the future.”⁶³ As I have discussed earlier, such studies operate within a broader trend of investigating race as biological risk, overlook or bypass social or psychosocial conditions, and use race as a proxy for genetic or biological risk factors. These studies are constructed within the context of reproduction and families, a place where we can observe “how cultures are produced (or contested) as people imagine and enable the creation of the next generation” and invite feminist voices in bioethics.⁶⁴ Women of color’s reproductive decisions have been the target of media, policies, and mythologies, which have sought to regulate and disparage them. “Bad fathers” has been a cultural trope just behind in popularity of the racialized and controlling images of “bad mothers;” nevertheless, attempts to raise awareness of biological notions of paternal race and missing paternal data is not or should not be considered a feminist move to biologize “bad dads.”

This is not to say, of course, that racial difference does not matter. As Audre Lorde writes, “difference is that raw and powerful connection from which our personal power is forged.”⁶⁵ Difference is also a lens through which discrimination and systemic injustice can be analyzed in the interest of improving all children’s life chances and pursuing just social conditions for all families. Luckily, women of color’s resistance to systemic oppression and movement building has taught those of us concerned with racial disparities in health outcomes that the surveillance of the biology of maternal and paternal life and the regulation of families need not have the last word.⁶⁶

63 Lupton 2012:87.

64 Ginsburg and Rapp 1995:2.

65 Audre Lorde, “The Master’s Tools Will Never Dismantle the Master’s House,” in Charles Lemert, ed. *Social Theory: The Multicultural and Classic Readings*. Boulder, CO: Westview Press, 2009, p.450.

66 Roberts 1998:3.

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