Introduction

ESTABLISHING SHOTS

Diana, Yessica, and Evelyn—all physician assistants, or Patient Care Associates (PCAs)—are chatting in one of the nurses' triage rooms during a lull in a typically chaotic day in the "Alpha" Women's Health Clinic. Diana, an outspoken, funny young woman of Haitian parentage who has been working for over six months in the clinic as a temporary employee, sits on an examination table and plays with the creases in her uniform. On the other side of the cramped space, touching up her carefully applied makeup, sits Yessica, thirty-five and Dominican Republic-born, who has been working at Alpha for close to five years. Evelyn, an older woman who had immigrated to the United States from Jamaica, and who has been a PCA at Alpha for over a decade, leans against a chest of drawers, arms angrily folded over her chest. Evelyn has just finished escorting a patient to the physician for her examination. The patient, in the final months of her pregnancy, had complained loudly and persistently about the long time she had waited for her appointment that day.

The incident with that disagreeable patient has sparked a conversation among Diana, Yessica, and Evelyn about the "problem" with patients generally. Diana brushes a piece of lint off of her shirt and remarks, "They don't even have good insurance. They come in here with their little lousy Medicaid and be the main ones raising up in the hallway."

Yessica and Evelyn laugh, commenting that Diana's statement is "so true." Encouraged, Diana continues, "They have more money than we do. They have two or three baby daddies that they get child support from. They have Section 8, so they pay $100 in rent. They have food stamps; they have WIC. And then they stroll in here with their Coach bags." More laughter, accompanied by a smattering of "I know" and "she's right." Diana continues, "That's why they have kids. For real. That's why they have them. And then us—we bust our behinds working everyday, and we have holes in our socks. Can't even afford to buy a bottle of water if we get thirsty." More laughter, but this time, Evelyn interjects, "But, we have a better quality of life than they do." Yessica disagrees, "No, we don't. That's why they *choose* to live their lives like that. Some people don't like to work." Diana, nodding her head, concurs, "My cousin could have collected welfare and just sat at home. She had two kids. But, she chose not to. She chose to get a job. And now, she's just like us."

In an article written almost two decades ago about Alpha's emergency room, the writer describes the care Alpha gives to its patients as "war-zone medicine":

> It also sees the worst wounds of the city: crack addicts, bullet holes from drug-related assault guns, AIDS patients, the homeless who have no place to go for care, teen-agers who need severed limbs reattached after being run over by subway cars, inmates from city prisons whose manacled ankles protrude from stretchers.
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> At Alpha, battlefield images fit like bandages on a wound.
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> Drugs are found in two out of three patients who are shot, stabbed or hit by a car, doctors say. One-fourth of the trauma cases involve people who have mixed two or more intoxicants, usually alcohol and cocaine.
>
> The homeless seek treatment for such ills as frostbite and rotted feet similar to soldiers who suffered trench foot, a disease caused by prolonged exposure to wet, cold and inactivity. (Dvorchak 1990)

Julie, a twenty-four-year-old, soft-spoken, self-professed Rastafarian who recently moved back to the United States from Trinidad, exits the secured door separating the waiting area from the examination rooms and empties the contents of her bag onto the front desk. "The midwife lost my clinic card!" she cries, referring to the card Alpha issues to every patient stamped with the patient's name, address, and a seven-digit number that identifies the patient throughout every clinic and department in the hospital. Patients must present this card at every appointment. If lost, the patient must get a new one issued in the Business Office located on the lobby floor of the ambulatory care building, a task that could take anywhere from fifteen minutes to two hours depending on hospital traffic that day. "She lost it! I know that she didn't give it back to me! Now she has me looking like I'm crazy!" Julie rustles through the pile of items she has poured onto the desk. "I don't have time to get another card! I have a lot of appointments to go to today! I have to go to Brooklyn. . . . I don't have time for this! The midwife—she's all smiles. But, when I tell her that she didn't give me my card back, all of a sudden, she's like, 'I have to go to lunch.' " Angry tears have begun to stream down Julie's face. "She should just say that she's sorry."

A middle-aged, African-American woman sits in the bustling waiting area in the Alpha Women's Health Clinic, waiting for a nurse to give her an injection of Lupron©—a medicine her physicians hope will help reduce the symptoms of her uterine fibroids. The physician who had attended to her on this day, Dr. Grenier, a very bubbly, young white resident, had prescribed an additional medicine to be taken orally. The patient attempted to fill the prescription at Alpha's pharmacy, which provides selected medications at no cost to the patient. However, Alpha's pharmacy did not stock the medicine Dr. Grenier had prescribed. And so Dr. Grenier consults with Dr. Ming, the attending physician, about what they can do for the patient. When the apparent answer is "nothing," Dr. Ming only half-mockingly says with a laugh, "We should close Alpha." Dr. Grenier, again only half-mockingly, responds, "Wait until

I finish my residency! But, if they closed Alpha, where would they take all the prisoners who need medical attention? Or all the patients with tuberculosis? Or all the psychiatric patients? No hospital is going to see them. We always say that, after Alpha, if they put us in a *good* hospital, we wouldn't know what to do. But, if they put us in the jungle, we would be fine."

The doctors continue to debate how to treat the patient. Dr. Ming suggests, "We could give her the money to take the prescription to an outside pharmacy and have it filled." By this time, Trisha, a dour West Indian registered nurse not known for her tact has wandered over. She remarks, "Where is that money going to come from? The thing that kills me about these patients is that they don't have three dollars to pay for medication, but then they have Dooney & Burke bags and all this stuff that I can't afford—stuff that, if I bought it, I wouldn't be able to eat. But, they buy it because they think, 'Someone at Alpha will give me money.' " Dr. Ming simply smiles and says, "That's why I like working at Alpha—because it keeps you thinking." Trisha agrees: "You'll never get Alzheimer's here. Because your brain is always working."

In 1964, New York City began constructing a new building for Alpha Hospital. Important people understood the project to be a significant one; a director of the hospital had called the construction of a new building vital, as the hospital's "physical surroundings will match its staff's ambitions for patient service" (Opdycke 1999, 168). In response to the announced plans, a surgeon who had interned at the hospital offers a healthy dose of realism and skepticism by publishing a "tribute" to Alpha in a local paper, affirming his faith that the spirit of Alpha would not be "corrupted" by any expensive, elegant building the city might erect for it:

> She resists improvements as her bacteria resist antibiotics and in the end, virulent, she survives. So let the city fathers move in with their millions of dollars. Let them build new buildings, hire more help, buy more syringes, do their damnedest to destroy her personality and make her a replica of every other white, cold, sterile and efficient citadel of healing. She will resist that standardization. And I am willing to wager that when the last new building has been built, the last technician hired, the last dollar spent, there will still be no scissors on Ward M5. (Opdycke 1999, 168)

Dr. Veronica Rose—an intimidating, older white attending physician whose brashness, rudeness, and insensitivity make it difficult to appreciate that she is probably a very competent OB/GYN—exits her examination room, only to see a pile of patient charts in the box outside. She flips through them and asks Yessica, the PCA assisting her that day, "Who keeps putting all these walk-ins in my box?" Yessica, who was talking to a patient, stops that conversation to respond, "I'm not sure, Dr. Rose." Dr. Rose, dissatisfied, continues, "Is there anyone precepting today?" Yessica answers, "I think Dr. Silverstein is." Dr. Rose thrusts the charts into Yessica's hands and says, "Well then, let Dr. *fucking* Silverstein do them." She marches off, white coat swaying, the sound of her heels against the tile floor echoing. The patient to whom Yessica was speaking before her exchange with the doctor watches Dr. Rose, the

physician she is scheduled to see that day, go around the corner and disappear.

The above vignettes offer a pithy slice of life at Alpha Hospital, a place that is a "legend in American medicine—one of the country's busiest, wildest, most able hospitals, and one of the remaining few where ability to pay is not a prime consideration" (Zuger 2001). In these scenes, one can see the contours of major themes that frame the hospital and will recur throughout the ethnography: an ancillary staff, composed primarily of first-generation immigrants of color, whose distrust and dislike of the patients they serve cause them to echo the arguments made by conservative pundits in favor of dismantling the existing welfare state; well-trained, elite physicians struggling to provide the most technologically sophisticated health care to society's most destitute and most marginalized; patients, predominately poor persons of color, who are both the victims and the beneficiaries of Alpha's underfunded, overburdened nature, struggling to receive that most technologically sophisticated health care; the thinly controlled chaos that threatens to burst forth—and, occasionally, does indeed do so —despite the best efforts of the staff, physicians, and administrators to prevent it.

THE ROAD TO ALPHA

My path to the Women's Health Clinic (WHC) at Alpha Hospital had been quite circuitous. My first contact with Alpha was through an article in the "Sunday Styles" section of the *New York Times* about the author's struggle to be correctly diagnosed with (and ultimately treated for) Lyme disease (Cooper 2003). After having been seen by some of the most esteemed and status-rich physicians in Manhattan, none of whom could identify the origin of the "high fever, headache, generally altered consciousness, and . . . large necrotic wound" (Cooper 2003, 3) on the back of his leg, Cooper became desperate:

> In August, I started calling City Health Department numbers and ended up at the Poison Control Center, somehow persuading the operator to connect me with an actual doctor. I told him my story, and just when I thought the nice man on the other end of the phone was humoring me, he told me to meet him at Alpha's emergency room so he could take a look.
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> Alpha? As in, leather restraints on the gurneys?
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> Indeed. I endured a line 20 people deep just to see the triage nurse.
>
> Alas, it took a public city hospital like Alpha to cure me of the exotic ailment I had picked up outside of New York. (Ibid)

After being tested for Lyme disease at Alpha, and after the disease had been positively identified, Cooper continued his treatment there and was ultimately cured. He wrote of the irony that the most acclaimed of Manhattan's physicians could not do what a lowly staff doctor at the city's much maligned public hospital could. How peculiar, he wrote, that in a place evoking images of straitjackets and urban decay he found the cure that previously eluded him.

When I read this article that introduced me to Alpha, I had been living in New York City for several years, and had long thought of myself as a *New Yorker*. I remember feeling a bit

ashamed after reading this piece, as it challenged that status: a "true" *New Yorker* would not have been oblivious to Alpha Hospital and the images it ought to conjure. While it was difficult to adjust to the idea of thinking of myself as merely *living in New York*, the article had appropriately introduced me to Alpha, which I now understood to be: 1) a psychiatric hospital, 2) a paradigmatic beleaguered public/poor person's hospital, and 3) a place where one received quality health care only after having endured bureaucracy and excessive wait times alongside the "tired, poor, huddled masses."

My second encounter with Alpha came a couple of years later. I was in midtown Manhattan on a Saturday evening, having just celebrated a college friend's birthday, when a young man who looked no older than sixteen approached me and asked, "Which way is Ninth Avenue?" Pleased that I could demonstrate my knowledge of all things Manhattan and help someone out in the process, I pointed a deft finger westward and said, "Cross the street, walk another block. You'll see Ninth Ave." Smiling and thanking me, the kid took off across the street. Moments later, a livery cab running a red light struck him. In shock, I saw his body flying through the air, the sound of metal hitting flesh and bone seeming louder than anything I had thought possible. Some onlookers ran to his aid; others called 911 from their mobile phones. I could only stand motionlessly on the sidewalk. Eventually, I began to cry. I wept until the ambulance arrived minutes later, wept as I asked the paramedic where they were taking him, wept as he responded, "Alpha."

I did not know at the time that it was a foregone conclusion that he would be taken to Alpha, as the hospital received the bulk of trauma-related injuries that occurred in Manhattan. All I knew was that I could not free myself from the image of the airborne kid or the memory of the sound. In the cab on the way to Alpha, I tried to steel myself for the news he had died, that I was the last person who had heard him talk and seen him smile. I do not remember arriving in Alpha's emergency room, although I do have vague recollections of being told that because I was not a relative, the staff was prohibited from giving me any information regarding the boy's status. But I refused to leave without knowing if he had lived or died, and so I sat, defiantly, in a waiting room chair, hoping one of the workers would have pity on me. I would have sat there forever, but there was no need: an hour or so later, I saw the kid limping down the hall in a hospital gown, still smiling, but this time missing a front tooth.

On that first visit to Alpha, I bore witness to the hospital at its best—an institution that stood ready and able to put the pieces of an unlucky young man back together. I also bore witness to sights that might be anticipated (but for which one is never really prepared) in an emergency room of a public hospital on a weekend night: a man handcuffed to a stretcher, eagerly eating a mystery meat sandwiched between two pieces of white bread; another man sitting on a gurney with cuts all over his face, being interviewed by a policeman; an elderly man, completely and utterly alone, sitting in a wheelchair facing the wall. I do not remember witnessing the stepped-up security that has come to be a sign of the times since September 11, 2001 in New York City public institutions. One hospital administrator remarked that since that day, the hospital has hired more security officers and has restricted points of entry. She feared turning the building into "a fortress," saying "I still want to maintain this as a place you want to come to if you are sick. I still want that fuzzy, patient-centered feeling" (Becker 2002). On that first visit, I did not

get the sense that the hospital had achieved that coveted "fuzzy, patient-centered feeling," but neither did I feel I had entered a fortress. (That only came after I began my research there and had to flash hospital identification every day when I came into the building.)

On that first visit to Alpha, I also do not remember bearing witness to the other aspect (besides legendary medical care) for which Alpha's emergency room is known. As one journalist put it, Alpha's "admirable characteristics, however, do not always translate into smooth or serene health care delivery, a fact well known to both Alpha's staff and its patients. The ground floor emergency area can be a sea of confusion and flaring tempers—doctors hollering at doctors, nurses at nurses, both of them at aides, at one another, at patients, and patients right back at everyone else" (Zuger 2001). Although I would witness countless verbal and near-physical confrontations during my fieldwork in the WHC, on my first visit to Alpha, the ER was fairly tranquil.

The next time I set foot in Alpha was in the early summer of 2005—this time with the purpose of studying race as a process. At some point during my studies in law school and graduate school, I had grown impatient with what had become a mantra within academia: "race is a social construction." I stood in complete agreement—of course race is a social construction. The truth of the definition of race offered by the American Anthropological Association (1998) seemed indisputable to me: surely race was a biologically arbitrary, socially constructed ideology about physical differences among humans, with a "race" being a socially salient, hierarchically ordered category. However, what bewildered and frustrated me was the absence of studies demonstrating *how* race was socially constructed. I wanted to know by what processes race had endured as an omnipresent social fact with powerful material repercussions despite its lack of moorings in biology (Crenshaw et al. 1995). And so, I dreamt up the present research project as an investigation of the construction of race during the event of pregnancy—an event that continues to engage racial discourses. In short, I wanted to write an ethnography of pregnancy as a site of racialization.

What I discovered when I finally began ethnographic research in the Alpha WHC exceeded my carefully crafted research questions. Indeed, when I began my fieldwork, I had to reformulate all of them. Initially, I had imagined that I would conduct my fieldwork for the project in Delta Hospital, a smaller public hospital located in central Harlem. Because I had envisioned the project as an ethnography of pregnancy as a site of the racialization of African American women specifically, Delta Hospital (which because of its location attends to large numbers of African and African-American people) was an ideal site. I spoke with the director of the Obstetrics and Gynecology clinic at Delta six months or so before I was to begin fieldwork, and he affirmed his commitment to providing Delta as my field. However, when the time arrived for my fieldwork to actually begin, he stopped returning my phone calls. I found myself field-less (and devastated). Six months later, after sending my research proposal to every director of obstetrics at every private and public hospital in Manhattan, Brooklyn, Queens, the Bronx, and eastern New Jersey, I still had not found another site. On a whim, I sent an e-mail to Rayna Rapp,[1] who I had never met, but whose acknowledgements in her book *Testing Women, Testing the Fetus* revealed her to be well-connected to those with the power to grant a humbled anthropologist access to that which lies behind hospital walls. To my utter

surprise and delight, Professor Rapp responded and put me in touch with Dr. Christina Johnson, the Director of Ambulatory Care at Alpha Hospital. Dr. Johnson responded positively to my research proposal, and so began my extended love affair with Alpha.

And so also began the rearticulation of my research questions. The sheer racial and ethnic diversity of the patients seen within the Alpha WHC made insincere and artificial any insistence upon focusing on the racialization of African Americans alone; the heterogeneity of Alpha's patients forced me to broaden my project from one inquiring into the racialization of Black women to one inquiring into racialization processes more generally. Moreover, that which was common to the subjects of my study would no longer be race—as it would had I conducted fieldwork at Delta—but rather socioeconomic class, as all Alpha obstetrics patients came within Medicaid income limits. If the Alpha obstetrics clinic was to be my field, I had to directly confront the Medicaid apparatus. Additionally, it foregrounded my consideration of the relationship between race and class, as I found that to "get to" questions of race, I had to "go through" issues of class. This is not to say that class always precedes race, that race must come subsequent to class in every instance, or that race is an epiphenomenon of class; however, to pursue my investigation, the analytic of race had to be folded into an analysis that began with class. Thus, class is the point of entry for the first three chapters of the book, thereby enabling me to address questions of race in the last three chapters.

The book proceeds from the assumption that race is a discursive phenomenon; race is ideas about difference that become visible and tangible as they are made to be reflected in the material conditions within society (Haney-López 1996). Material and societal conditions appear to affirm the veracity of ideas about race. And the unfortunate dialectic continues. I wanted to examine this dialectical process of race formation *as it occurs during women's pregnancies* because pregnancy engages racial discourses to such a dramatic extent that pregnancy can be described as a racially salient event. Roberts (1997) has made such an argument. Noting that scientific racism's primary supposition was the genetic basis of race and, consequently, superiority and inferiority, she argues "[b]ecause race was defined as an inheritable trait. . . . [r]eproductive politics in America inevitably involves racial politics" (9). Further, pregnancy has remained racially salient even though, prior to the recent reinvigoration of biological notions of race, there was a waning of ideas about racial biology; this is because Black mothers are thought to transfer to their children the "deviant lifestyle" that explains their persistent social inferiority. Expounds Roberts:

> As both biological and social reproducers, it is only natural that Black mothers would be a key focus of this racist ideology. White childbearing is generally thought to be a beneficial activity: it brings personal joy and allows the nation to flourish. Black reproduction, on the other hand, is treated as a form of *degeneracy*. Black mothers are seen to corrupt the reproduction process at every stage. . . . They damage their babies in the womb through their bad habits during pregnancy. Then they impart a deviant lifestyle to their children through their example. This damaging behavior on the part of Black mothers—not arrangements of power—explains the persistence of Black poverty and marginality. (1997: 9)

That white women are largely exempt from discourses that censure and condemn their reproduction *on the basis of their race* increases the racial salience of the event of pregnancy. Moreover, pregnancy is a focused occasion to interrogate racial processes because it directly implicates the material bodies of women. This is important because, historically and presently,

the material body has been understood as the primary sign of racial difference (Schiebinger 1993; Wiegman 1995).

Although pregnancy is fairly described as a racially salient event, one of the greatest ironies I encountered during my fieldwork with pregnant women at Alpha was the absence of explicit discussions of race—even though it was obvious to me that race was essential to any explanation of *why* Alpha is the way it is and *how* it persists as such. That race is a powerful organizing principle at Alpha was suggested by the racial geography of the WHC: although several of the providers who worked in the clinic can be described as persons of color, most of them were white. Yet, the providers were assisted by a support, or ancillary, staff that was entirely composed of women of color. Moreover, during the period in which I conducted my fieldwork, most of the ancillary staff persons were first-generation immigrants to the United States. Thus, there was a fascinating, racially significant chain of command in the clinic: white persons, with the most power and prestige in the clinic, sat at the top of the clinic hierarchy with their non-white assistants populating the ranks below them. Furthermore, the racial dynamic within the clinic was made even more fascinating by the racial composition of the patients served there; although many white patients sought obstetrical and gynecological care at Alpha, the large majority of Alpha patients were racial minorities. This meant a predominately white group of providers practiced medicine upon a largely disempowered, disenfranchised, marginalized, and importantly, non-white group of patients. Although it was difficult to ignore or dismiss the racial geography of the clinic, very few of the persons with whom I spoke during my fieldwork actually commented upon it. Indeed, I was frustrated for many months by the refusal and/or inability of any of my interlocutors to offer race as a relevancy—despite the fact that race could not and should not be ignored as a salient category that has produced Alpha as the underfunded, discursively maligned, frequently polemical space that it is.

THE QUESTION OF PSEUDONYMS

In the final months of my research at Alpha, another anthropologist previously unknown to me also began fieldwork in the obstetrics clinic. Although I was initially apprehensive about the prospect of sharing "my" field with a "competing" anthropologist, she eventually became a valued colleague with whom I could compare notes. One afternoon, we began contemplating life after Alpha and the practicalities of writing up our research. I asked her if she would employ a pseudonym when she referred to Alpha in her scholarship. She replied that she probably would not, as she did not believe her argument to be hypercritical of the hospital such that a pseudonym was warranted. Then she smiled and said, "But, I think *you* should definitely use a pseudonym for Alpha in the stuff that you plan to write."

And so, my colleague interpellated me as the author of a work offering a relatively unforgiving critique of the Alpha WHC and the legislation and policies it is compelled to effect—the author of a critique so trenchant that, to protect the hospital (as well as my relationships with the people who enabled me to conduct my fieldwork there), I should employ a pseudonym when referring to it in my scholarship. However, I have also been identified previously on numerous occasions as a person whose politics lie far left of center. Thus, I

recognized the contradiction: I am the author of a work that relentlessly critiques a generous, laudable moment in this country's "safety net": a moment of universal health care, no less. On other occasions, this is a moment I would vociferously defend. Therefore, I must recognize and concede the contradiction resulting from my reproving a place and policies whose nonexistence I would also reprove with the argument that the lack of commitment to state-subsidized or universal health care leaves the most vulnerable most exposed.

I insist the New York State Prenatal Care Assistance Program (PCAP), the Medicaid program upon which the overwhelming majority of pregnant Alpha patients rely, is an example of universal health care because its relatively high income limitations (a woman can earn up to 200 percent of the federal poverty line and still qualify for the program) and its availability to undocumented immigrant women enable health care to be provided to a significant number of persons who would not otherwise have access to it. Moreover, PCAP mimics universal health care insofar as the health services available under it are not limited to obstetrical care. Medicaid/PCAP-insured women can avail themselves of dental, optometric, dermatological, and general medical services (among others) should the need or even desire arise. However, the Medicaid/PCAP program should be considered a limited instantiation of universal health care, mainly because men and nonpregnant women are excluded from its ambit, but also because the generous insurance coverage given to the pregnant woman terminates just eight weeks after she gives birth. As I thankfully acknowledge the radical nature of the PCAP program—one midwife I interviewed insisted upon characterizing the program as "revolutionary"—I find myself in the awkward position of criticizing the revolution.

Now, one of the reasons the revolution has been launched in the obstetrics clinic of New York public hospitals is because the uninsured, pregnant poor have been conceptualized by decision makers as an "at risk population." That is, the "at risk population" served within the Alpha WHC would not have access to the health care I critique if those who are responsible for implementing Medicaid/PCAP had not imagined the "population" served by the program as having characteristics that demand a state response in the form of government-subsidized health care. Despite the failure of the United States to commit itself to providing medical services to the other millions of "medically indigent" individuals who are unable to afford private health insurance, there was something about this "at risk population" served by Medicaid/PCAP that produced results. Ironically, the racism, xenophobia, classism, and sexism that inform discourses about "risk" and "populations" in effect enable the realization of a universalized, though circumscribed, system of health care within a country that presently stands uncommitted to implementing a program of universal health care.

However, a problematic "state of exception" results from the engendering of this finite moment of universal health care, a moment that is designed for and only accessible to a bounded group. Which is to say: although one could make a persuasive argument that everyone should receive government-subsidized health care, the group of individuals that does, in fact, receive state-funded care becomes exceptional. When a radical moment of universal health care is realized within an otherwise privatized system, the group that benefits becomes understood as radically in need of the exception—they become particular, peculiar, unusual. They also become discursively constructed as even more likely vectors of disease and

pathology. Significantly, the construction does not exist only at the level of discourse alone; it is made material through the manipulation of the physical bodies of Alpha patients. The production of the poor, PCAP-insured/uninsured pregnant women as exceptionally pathological would not necessarily occur if the United States actualized a system of unbounded, unlimited, and universal health care. Within a system of nationalized medicine, there would be no need to imagine a segment of society as somehow being more "at risk" for certain lamentable outcomes (and, therefore, uniquely deserving of the suspension of the system of privatized medicine) before health care is provided for them; the state's subsidization of their health care would be the expectation, not the deviation.

THE QUESTION OF METHODOLOGY

For the first couple of months of my fieldwork, I sat in the Alpha WHC waiting area and simply observed clinic traffic, attempting to make sense of what appeared to be barely controlled bedlam. I remember thinking this place that was to be my field for the next year-and-a-half was incredibly familiar, yet undeniably strange. It was familiar because, in many respects, it resembled the numerous doctors' offices I have frequented over the years—with the televisions broadcasting educational shows about nutrition and exercise, the nurses calling out names in the waiting area, the magazines sitting on tops of tables with the addressee information scribbled out with black marker, and the friendly, though intimidating, doctors with their white coats and stethoscopes. Yet, the WHC remained strange because hospital policy required identification upon entry. Thus, one got the distinct feeling after passing through security that one was entering into a potentially dangerous, but secured place—like a courthouse or airport. It remained strange because Alpha is *the* place in New York City where the indigent, homeless, or otherwise dispossessed go when they are injured or sick. Thus, on the way up to the WHC, one may hold the elevator for a bandaged homeless man. It remained strange because of the sheer diversity of the patients who seek prenatal care there. Thus, on any given day, one can overhear patients in the waiting area speaking English, Spanish, Mandarin, Cantonese, Polish, Arabic, Bengali, Urdu, Hindi, and French.

After I had familiarized myself with the space and the staff—and, importantly, after the staff had familiarized themselves with me—I eventually moved behind the front desk and began the "participant" portion of my participant-observation of the clinic. On those days, I worked behind the front desk and did intake—answering telephones and questions, greeting patients, making appointments, administering urine pregnancy tests, etc. About a year into my fieldwork, I moved to the nurses' triage rooms where I observed women's preparations for their medical examinations. After some time, I "participated" in these rooms by taking and recording women's weights and blood pressures and by testing the pregnant women's urine for the presence of glucose and protein, dipping a pH stick into the tube of collected urine they provided at the beginning of each visit.

Over time, as the required female presence in the room, I was able to observe patients' examinations by male providers. I also observed patients' consultations with social workers, nutritionists, Medicaid financial officers, health educators, geneticists, and nurses. I watched

several ultrasound scans and several more labors and births in the labor and delivery room. Moreover, I conducted over 120 hours of in-depth interviews with eighty patients—something I was able to do while the women waited inordinately long periods of time to see their providers during their scheduled appointments—and fifty hours of in-depth interviews with thirty providers and staff persons. As a counterpoint to my fieldwork in Alpha Hospital, I also spent several weeks observing the obstetrics clinic in Sigma Hospital, a smaller public hospital located in the Lower East Side of Manhattan. Moreover, my research led me outside of institutional walls as I attended baby showers thrown in honor of the women I met at Alpha, audited birthing classes offered by non-hospital-affiliated organizations, interviewed women at their homes, and volunteered at a nonprofit organization dedicated to lowering the maternal and infant mortality rates in Northern Manhattan.

THE ARGUMENT TO COME

Chapter 1 provides a robust description of Alpha Hospital's location within the larger public health context. Alpha Hospital is a distinctive institution with a long and colorful history within New York City and the nation. This chapter provides that color. In truth, Alpha Hospital is arguably the best public hospital in the country; moreover, it is one of the few places in the nation where poor people have access to first-rate, outstanding health care. A vigorous acknowledgment of the uniqueness of Alpha Hospital—as an institution impressive in light of both the quality and breadth of the services it provides to the poor—raises the stakes of the critique that is to come. Given this institution is, perhaps, the best shot the poor have at getting quality health care, what does it mean that it (and the services it provides) can nevertheless be criticized as excessive in its technology, intrusive in its demands for knowledge, pathologizing as an equalizing move, demeaning to its patients, and perpetuating of racial and social inequalities? A vigorous acknowledgment that the program of universal prenatal care offered within Alpha Hospital may be the best version available makes more trenchant the critique of the U.S. political economy and racial politics that follows. But although Alpha Hospital is unique, it should not be understood as singular: to the extent that Alpha is a site wherein poor, pregnant women's bodies are excessively problematized and racial inequities are reiterated, this is a product not of some curious quality of Alpha, but rather that Alpha as an institution depends upon public dollars to deliver health care to uninsured, marginalized persons in the United States. Consequently, the critique is not of Alpha as such, but rather of the nationally circulating discourses, politics, policies, and practices that also affect Alpha and the people who populate it.

As mentioned earlier, the large majority of patients who receive their prenatal care from Alpha rely upon Medicaid/PCAP to cover their medical expenses. As a condition of receipt of this aid, women were required to meet with a battery of professionals—namely, social workers, health educators, nutritionists, and financial officers—who are legally obliged to inquire into areas of women's lives that frequently exceed the realm of the medical. This fact, coupled with interviews I conducted with women who described their experiences with this inquisitive apparatus, led me to conclude that Medicaid mandates an intrusion into women's private lives and produces pregnancy as an opportunity for state supervision, management, and

regulation of poor, otherwise uninsured women. I explore this aspect of Medicaid in Chapter 2.

In Chapter 3, I direct my attention to the medical technology provided to indigent pregnant women as a matter of course within Alpha Hospital—a teaching hospital renowned for the highly sophisticated medical care that it can and does deliver to its patients. This chapter describes the prenatal health care that poor, pregnant women receive and notes that it is delivered within an abundantly technological, biomedical paradigm of pregnancy. I argue what Medicaid-insured, pregnant women's bodies receive is excessive in the sense that it goes beyond any necessary and appropriate medicalization, as well as that offered to privately insured women. This chapter concludes that the result of this excessive medicalization is that poor women are produced as possessors of "unruly bodies." Because the uninsured poor are universally produced as such, the consequence is a medicalization of poverty, with the poor being treated as biological dangers within the body politic. The excesses of Medicaid's medicalization, which can be understood as a suspicion of poor women's bodies as especially "at risk," provides an important basis for the argument that the "high risk" the patients receiving prenatal care from Alpha are thought to embody coalesces them into an apprehensible "population"—the interpretation offered in Chapter 5.

Prior to making that argument, however, Chapter 4 takes up the question of how the personally held racist beliefs of physicians may contribute to health disparities between racial groups. In essence, this chapter grounds the less-overt medical disenfranchisement of women of color discussed in the book with a robust discussion of its more-overt predecessor. It begins this task by discussing the largely unrecognized, yet still influential, racist oral tradition in medicine. This "racial folklore"—notably consisting of beliefs about the obstetrical and gynecological hardiness of Black and other purportedly "primitive" women—has long conditioned the reception of pregnant Black women in the United States. This chapter argues that notions of the obstetrical and gynecological hardiness of the marginalized have exhibited a remarkable hardiness of their own as they have managed to persist over the decades. This chapter demonstrates this persistence of racial folklore by offering observations and stories culled from ethnographic fieldwork alongside interviews conducted with obstetricians practicing in the Alpha clinic. The chapter then puts the ethnographic data in conversation with the literature documenting the persistence of racial disparities in health. It goes on to offer the personally held racist beliefs of physicians as an explanation. Physician racism has been shielded from critique, largely as a consequence of notions of the personal privacy of physicians. This chapter will attempt to continue to explode notions of doctors' personal privacy—notions that have functioned to hide the racism that may contribute to health disparities in the United States.

Chapter 5 investigates the use of the term "Alpha patient population" to refer to the individuals who received Medicaid-subsidized prenatal care from the clinic. This chapter considers how it is that the vastly heterogeneous group of women who seek prenatal health care from Alpha can be referred to as a single "population." The chapter argues that the shared poverty of the pregnant women who become patients at Alpha Hospital enables them to be seen as "high risk"; further, it is this imagined shared risk that enables the elision of individual differences and the apprehension of a unitary "population." The chapter then juxtaposes "Alpha

patient population" with a figure that staff, providers, and administrators offered when speaking about the imagined "average" Alpha patient: that of the undocumented, uneducated immigrant. Several interviews with staff and physicians are reported in which the implicitly racialized, undocumented, uneducated immigrant is offered as a representative of all women who receive prenatal care from the hospital. These interviews support the conclusion that "Alpha patient population" operates as a deracialized racialist discourse that allows the providers, staff, and administrators who evoked it to speak race tacitly, yet avoid its explicit mention.

Chapter 6 begins with an examination of the acrimony characterizing the relationship between the clinic staff and their pregnant patients, suggesting that the acerbity of this relationship is rooted in employees' perception of the patients as uneducated. yet somehow incredibly shrewd, manipulators of the Alpha "system." It explores this construction of the health care-seeking subject—a figure I call the "wily patient." The chapter argues that the "wily patient" parallels the figure of the "welfare queen," similarly constructed as an uneducated, yet again somehow incredibly shrewd, manipulator of federal and state governments. It compares the figures of the wily patient and the welfare queen and notes a departure between the two: although the welfare queen is implicitly racialized as Black, the wily patient appears to be un-raced. A genealogy of the welfare queen is conducted to discover the origins of her Blackness. The chapter discusses the genesis of the stereotype of the "welfare queen" at the hands of Ronald Reagan in the 1980s and analyzes why he was able to get so much mileage out it. This history, which explores the racialization of categories of the deserving and undeserving poor, enables the argument that the wily patient also possesses an implicit racialization: one that is thoroughly nonwhite. The argument is that the operation of race successfully produced an entire population of women as racially Other-ed possessors of despised fertility. The chapter concludes with a discussion of how the discursive non-whiteness of the wily patient affects the experiences of those material wily patients who are racialized as white. This chapter is followed by a brief epilogue.