
Alpha Hospital: Unique, But Not Singular

ALPHA HOSPITAL: A UNIQUE INSTITUTION . . .

George Washington was only a toddler when Alpha Hospital first opened its doors in the early eighteenth century (Opdycke 1999). Since then, Alpha has become arguably the best public hospital in the country. It is one of the few places in the nation where poor people have access to first-rate, outstanding health care. Indeed, the hospital is one of the most widely recognized medical institutions in the United States. The programs it provides top several lists: emergency medicine, neurology/neurosurgery, cardiovascular medicine, nursing, and, most notoriously, psychiatry. Alpha's reputation as a psychiatric hospital par excellence may be due to its counting many famous figures as former clients, including Edie Sedgwick, Norman Mailer, Charles Mingus, Allen Ginsburg, John Lennon's killer Mark David Chapman, and, more recently, Courtney Love, who was taken to Alpha after she was seen confusedly ambling around her Manhattan neighborhood. She was later photographed handcuffed to a gurney in the hospital—what may be standard procedure for those who resist treatment (*People* 2004). Yet one does not have to be a celebrity to be granted entry to Alpha's psychiatric ward. "If you're in Manhattan and you happen to be unfortunate enough to decompensate in a manner that involves an imminent threat to yourself or those around you," you are

most likely going to Alpha—that “single word that, for more than a century, has told the rest of New York City that there is now one less person on the streets about whom it has to worry” (Harris 2008).

Alpha’s status as a psychiatric hospital is so recognized that it has become embedded as such in the cultural imagination of the nation. This partially explains how Alpha has become a pop culture referent. Alpha was the site to which Barney Miller shipped everyone he considered mentally unstable when he encountered them during his travails in the Twelfth Precinct. In *Miracle on 34th Street*, Alpha Hospital was the temporary home for Kris Kringle as he awaited a court hearing to determine whether Santa Claus really existed. In one, not uncommon, heated exchange between Alice and Ralph in *The Honeymooners*, she tells him, “I’ll go fix my lipstick. I won’t be gone long, Killer. I call you Killer ‘cause you slay me.” Ralph, a jibe always on the tip of his tongue, replies, “And I’m calling Alpha ‘cause you’re nuts!” However, “spokesmen for the hospital will remind you, with the dogged patience of those who have had to say it again and again, that Alpha is much more than a psychiatric center” (Harris 2008). By most accounts, it is an excellent hospital that provides superb, wide-ranging care.

Alpha is unique for two distinct reasons: first, the quality of the medical care it offers in many respects is the world’s best. Alpha’s program for the reattachment of limbs has global renown (New York City Health and Hospitals Corporation 2009). Should the president of the United States or any manner of foreign dignitary require medical care while visiting New York City, he or she most assuredly will be whisked to Alpha Hospital (New York City Health and Hospitals Corporation 2009). When police officers or firefighters are injured in the line of duty, Alpha’s record of offering the best in trauma care assures that they will be rushed to Alpha’s emergency room (Dvorchak 1990); indeed, Alpha’s record of excellence in providing trauma medicine explains why its ER was inundated with patients after the explosion in the basement of the World Trade Center in 1993 (Zuger 2001) and why its ER would have been similarly inundated in 2001 had there been more survivors following the collapse of the Twin Towers. Moreover, Alpha’s history has included pioneering innovations and Nobel-Prize-winning research (Opdycke 1999, 12). The history continues to the present, as Alpha is the site of a number of studies that may very well shape the future landscape of medicine and technology. Accordingly, Alpha is frequently cited in medical journals as the hospital at which research was conducted and important (read: publishable) results were found.

Furthermore, it is a referral center for “high-risk” pregnancies, providing cutting edge maternal-fetal medicine to those who require it (NYC.gov 2010). It also offers women enjoying “low-risk” pregnancies the option of a midwife-assisted, natural childbirth in a picturesque, Jacuzzi-fitted birthing center. Wrote one journalist, “The lavish birthing room hardly squares with the image of Alpha. . . . Luxury and Alpha might never have appeared in the same sentence, but the new birthing center is gleaming, beautiful, and luxurious” (Fein 1998). Between the birthing center and the traditional labor and delivery ward, close to two thousand babies were born at Alpha in 2007 (NYC.gov 2010).

The second reason for Alpha’s uniqueness is that because of the generosity with which New York City’s public hospitals have been funded, it is able to offer the world-class medical care described above to more people who otherwise would have no access to health care at all, let alone state-of-the-art health care. “[N]owhere else in the United States does there exist a public hospital of such scope and generosity” (Opdycke 1999, 12). Indeed, when the federal government began subsidizing health care for the poor via the Medicare and Medicaid programs, millions of persons across the United States gained access to health care that they had been unable to afford in the past. However, this increased access to health care enabled by Medicare/Medicaid was not as dramatic in New York City, in which universal access to health care was already close to being realized—due in part to the city’s expansive network of public hospitals and clinics. (Opdycke 1999, 139). “New York City has provided hospital care in its public hospitals as a mandatory service, not a discretionary service” (*U.S. News & World Report* 1975). Alpha Hospital is a significant part of this story, as it has always been the oldest and largest of all the public hospitals and clinics in New York City, the flagship institution providing care to more of those in need than any other public hospital in the area.

However, Alpha’s status as a (if not “the”) premier institution of public health in the nation and perhaps the “best shot” the poor have for obtaining quality health care raises the stakes of the critique that is to come. In the following chapters, I will argue that the institution (and the services it provides) demeans its patients and perpetuates racial and social inequalities. In the process of supposedly equalizing the poor and their non-poor counterparts, Alpha nonetheless pathologizes and stigmatizes the former. Indeed, because the program of universal prenatal care offered within Alpha Hospital may be the best version available, and Alpha may be the

closest the nation has come to universal health care, the critique of U.S. political economy and racial politics I offer becomes all the more critical.

. . . BUT NOT A SINGULAR ONE

Though the uniqueness and extraordinariness of Alpha Hospital should be recognized, the hospital ought not to be understood as singular. Which is to say, to the extent that Alpha is a site where poor, pregnant women's bodies are excessively problematized and racial inequities are reiterated, this is a product not of some peculiar quality of Alpha, but rather a product of an institution that 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.

Alpha is a site of racialization—a racialized and racializing institution—because it is a hospital that is firmly located on the second tier of the U.S. two-tier health care system, a second tier disproportionately populated by poor people and people of color. “For years, New York City’s public hospitals have been known as health care outposts of last resort. If the Health and Hospitals Corporation, which runs them, had advertised their medical services, it would have been considered akin to Albania hawking its tourist attractions: they may exist, but who would want to go there?” (Steinhauer 2000). While we may see within Alpha “the contrast between public care and private at its purest” (Opdycke 1999, 12), this is a contrast that is present throughout the nation. Alpha is unique in that it does an exceptional job of providing medical services to a large group of persons who must rely upon public health care, but the hospital is far from singular: numerous institutions throughout the United States replicate the job that Alpha endeavors to do for the poor. In every major city in the United States, one will find a relative of Alpha, a distant cousin perhaps—a public hospital existing alongside its private counterpart, providing the care the latter either cannot or will not provide. And so, the ethnography I offer might have been written about any of these other laudable institutions of public health.

Further, although Alpha is world renowned for its research and innovations, such achievements do not exempt it from its status as a public hospital; Alpha must still depend on government dollars, which seem to always be in short supply. The result is that Alpha is plagued by problems affecting many public institutions: it is underfunded and understaffed.

Moreover, the equipment that the staff and physicians use may be in short supply, or may have been superseded by newer, better versions—versions that remain out of the hospital’s fiscal reach due to budget constraints. A chief resident, Gloria Vance—a soft-spoken, pleasant white woman who was looking forward to finishing her residency and beginning a new position as a general OB/GYN at a large private hospital in Boston—explained it to me in the following way:

Anywhere from the actual machine for a CAT scan to the X-ray machine is better at Omega [the private hospital with which Alpha is affiliated] than it is here. It has a higher resolution. So, for example, if we’re ruling out a pulmonary embolism—which we do a lot, because in pregnancy, people are at an increased risk for getting blood clots—they will often call it a poor study here, whereas, at Omega, they never do. One time, I asked the radiologist why that was so, and he just said that the actual scanner [at Omega] is a better quality machine. So, there is just the equipment level. And then there’s the number of scanners and the number of staff—so that makes it easier to scan, or MRI, or whatever, over at Omega than to do it here. And it’s not always true that one is going to be better than the other. It’s just that, in terms of the overall, it’s easier to get a scan there. And it’s better quality. . . .

[Alpha] is a teaching hospital. And for somebody who has no insurance, it’s a tough world. And they feel like this is a place where they can come. But, if you compare what is here versus what is at Omega, there are just more restraints here—because it’s all based on budgets.

Another procedure, for example, that we could do at Omega is a procedure called endometrial ablation. There are all different types of techniques to do it. And we don’t have all that technology [at Alpha] to do that.

These challenges, which may affect the quality of health care that Alpha can deliver to a patient on any given day, are mirrored in the experiences of other public hospitals throughout the nation.

Moreover, if I had not had the good fortune of stumbling upon Alpha in New York but instead ended up patrolling the halls of the obstetric clinics at Chicago’s Cook County Hospital, Los Angeles’ County General, or Atlanta’s Grady Memorial Hospital, I would have still been able to write some version of the ethnography of pregnancy as a site of the racialization contained within. That is, because public hospitals serve those marginalized elements of society private hospitals can refuse, public hospitals have in turn

become marginalized (Opdycke 1999, 194). It is the Alpha Hospitals of the nation that have served those groups that the vicissitudes of history have marked with stigma: individuals dying from tuberculosis, babies born with crack cocaine metabolites in their bodies, gay men and intravenous drug users suffering from AIDS, and so on. During the mid-1980s, when ignorance of HIV and AIDS caused “the fear of contagion” to grip the United States, Alpha treated more people suffering from AIDS than any other hospital in the country; this was not because the providers and staff at Alpha were exceptionally heroic or courageous, but that “the city’s municipal hospitals, and Alpha in particular because of its location in Manhattan, must accept any AIDS patient, many of who are referred by private hospitals” (Sullivan 1985). At the time, many were aware of the stigma that AIDS patients brought to the institution that cared for them. “Faculty members expressed concern that treating a disproportionately large number of AIDS patients could stigmatize Alpha and upset an overall patient mix that traditionally has offered Omega-Alpha residents a classic postgraduate training in medicine in a major big city hospital.” (Sullivan 1985). Yet, there was nothing Alpha could do to avoid its patients and the stigma they brought; as the hospital of “last resort,” it admitted them and cared for them in the best way it could. That public hospitals serve the stigmatized in part explains their continued existence; Alpha and like institutions survive because they meet “social needs that private providers have been unable or unwilling to address” (Opdycke 1999, 10).

THE ROLE OF MEDICAID

Medicaid and Medicare threatened to undermine the segmentation, and simultaneous racialization, of the U.S. health care system by allowing for the integration of the two tiers. When Medicaid and Medicare were first introduced in 1965, many commentators believed public hospitals would find themselves invigorated as they would no longer have to absorb the health care cost of the previously uninsured who now had Medicaid/Medicare. Other commentators believed public hospitals would find themselves deserted in the advent of Medicaid/Medicare, as the formerly uninsured who depended on them would take their Medicaid/Medicare insurance to more prestigious private hospitals. (Opdycke 1999, 140). Many of them did. However, public hospitals—and Alpha Hospital specifically—did not find themselves deserted wastelands as every indigent former patient flocked to the more privileged private hospital down the block. This was because there

still remained a large number of persons who did not qualify for Medicaid or Medicare and, uninsured, would continue to depend on public hospitals for their health care. One can still find stories of uninsured patients who were turned away from private hospitals only to end up at Alpha Hospital and have their lives saved there. The *New York Times* reported the story of a French woman who had sought care for abdominal pain from one of the more prestigious private hospitals in Manhattan.

Pelvic cancer was suspected, and she was admitted to the obstetrics and gynecology floor, where the diagnosis was confirmed. A private doctor, along with the house staff, attended to her. The doctor concluded that she needed surgery within several weeks followed by chemotherapy. The woman had no insurance. The senior physician discharged her, and left a note on the woman's chart saying that she had instructed her to obtain health insurance or go to a public hospital.

Investigators determined that when the woman left the hospital, on Manhattan's West Side, she had barely been able to walk. That same day, she went to Alpha Hospital, a city facility, where surgeons operated immediately. (Kleinfield 1999)

Moreover, private hospitals are still able to choose which services they will provide and which they will deny. Accordingly, "the exodus to the private sector did not represent a cross-section of the municipal caseload—more white patients than black found a welcome in the private system, more Medicare than Medicaid, more acutely ill than chronic, more expectant mothers than drug addicts, more sober employed than homeless derelicts." (Opdycke 1999, 146). Instead of undermining the segmentation that characterizes the U.S. two-tiered health care system, Medicare/Medicaid actually functioned to exacerbate the polarization. "[T]he arrival of Medicare and Medicaid had further narrowed the circle of New Yorkers who had to depend on public care, leaving behind, once again, the people with the least choices and least resources." (Opdycke 1999, 146). These people are, for the most part, Alpha's patients.

Further, private hospitals not only could select which services to provide, but also choose whether they would accept Medicaid/Medicare insurance at all. When reimbursements offered by private insurance companies, especially managed care plans, were cut and became comparable to those paid by Medicaid/Medicare, many private hospitals were happy to open their doors to the publicly insured (Steinhauer 2000). The president of

the Health and Hospitals Corporation, which manages the public hospitals in New York City, described the situation: “Right now, Medicaid and Medicare are like gold cards in every hospital in the city. They all are trying to attract those patients” (Steinhauer 2000). Indeed, part of the motivation for the construction of the birthing center at Alpha was to stem the exodus of Medicaid patients from the public hospital to their private counterparts. The former director of obstetrics and gynecology at Alpha said upon the opening of the center, “We’ve got to dispel that *Midnight Cowboy* image of Alpha. People are going to see this center, they’re going to stop and say, ‘This is Alpha?’ And they’re going to look at the whole hospital in a new way.” (Fein 1998). [Dustin Hoffman’s character in *Midnight Cowboy*, Ratso, was a poor, likely uninsured street hustler who refused to seek medical care for what was probably tuberculosis. He tells his friend, “Just get me on a bus. You ain’t sending me to Alpha.” He ultimately dies on the bus, having avoided at all costs the stigma attached to being an “Alpha patient.”]

However, this is where Alpha’s story diverges from the stories of other public hospitals with affiliations with private hospitals: the private hospital with which Alpha is affiliated, Omega Hospital, refuses to accept Medicaid insurance. As a consequence, there is no blending of patient populations between Alpha and Omega as there might be between public and private hospitals that both accept Medicaid. The segregation of populations accomplished by Omega’s refusal to accept Medicaid insurance increases the likelihood that the Alpha patient will be poor and, consequently, a racial or ethnic minority.

THE EXOTICIZED PUBLIC SIBLING

That Alpha has an affiliation with a private hospital attached to a private medical school is not unique. Alpha’s affiliation with the elite Omega University School of Medicine (OUSOM) is an example of the relationships between private medical schools and public hospitals that can be observed throughout the nation. In literature made available to the public, Alpha boasts that its half a century-long academic affiliation with Omega enables Alpha patients to receive cutting-edge care from the most select of medical experts (NYC.gov 2010). This was a relationship the city brass actively sought, believing that an official relationship between Alpha and OUSOM would be desirable because the “private affiliates would help attract top-level physicians; at the same time, the private institutions would bring to the public sector the same disinterested commitment to excel-

lence that they were thought to pursue in their own facilities” (Opdycke 1999, 111). From OUSOM’s perspective, a relationship with the public hospital was beneficial because the latter offered greater opportunities to its faculty for teaching and research and its students for observing pathology they might not see within private hospitals. Many physicians I interviewed commented positively on the fact that due to the lack of regular medical care brought on by the absence of health insurance, patients seen at Alpha tend to present themselves to the hospital with disorders and diseases that are in more advanced stages than their privately insured counterparts. Comments made by Dr. Renee Escueta, a young but senior attending physician who began her medical career as a resident at Alpha, exemplify this. When I asked her why she chose to work in Alpha as opposed to a more prestigious private hospital, she responded, “The patients are very interesting. They are much more interesting than private practice. Because of the level of pathology in them. You don’t see. . . . A lot of it is unfortunate because they haven’t taken care of themselves. So, things that can be caught early, or things that can be treated go many steps further. So, by the time they get here, it’s a big deal. But, you can learn from it.”

The result is that public hospitals in symbiotic relationships with private medical schools offer themselves as the “very interesting,” exoticized complements to private teaching hospitals. Moreover, within the racial logic of the United States, exoticization is simply a degree or two removed from racialization. The relationship between exoticization and racialization is made explicit in a *Los Angeles Times* article written about Alpha almost two decades ago. The journalist quotes an ER physician, “We’re kind of a field hospital. This is war-zone medicine.” He continues, “We see everything here. We are the window to the world. You will never go anywhere else in the world and see something we haven’t already seen at Alpha. . . . It’s like a Third World situation.” (Dvorchak 1990). Alpha’s status as a site for the observation of the exotic, the rare, and the unusual is evident in the doctor’s first comments; the seamless addition of the descriptor “Third World” in his final comment expertly exemplifies that exoticization is not far removed from racialization. To the extent that Alpha’s status as the exoticized antipode to Omega Hospital’s norm set in motion the processes by which Alpha and the patients it serves are racialized, variations on these processes are likely evident in the scores of other public hospitals across the nation with academic affiliations with private medical schools.

Before I dive into an analysis of these processes, however, I must provide a bit more background to the place and the people who are the substance of the ethnography.

THE CAST

The Alpha WHC is housed in an aesthetically pleasing, recently constructed ambulatory care building that was annexed to the primary hospital building—an older, visibly more decrepit structure that can be fairly described as having passed through “obsolescence into decrepitude” (Shonick and Price 1977, 236). The ambulatory care building boasts an eight-story skylight and glass walls, which allow each of the five floors to be flooded with natural sunlight. The WHC, located on the top floor, shares its waiting area with the dermatology clinic, ultrasound clinic, and financial services desk—at which every patient must check in before seeing a doctor in any of the clinics located on the floor. There is a lot of open space in the connected waiting areas; at times, that open space is put to good use as it accommodates long lines of patients. Because the building is open and airy, sound travels easily; a person on the top floor can hear everything occurring in the spacious lobby on the ground floor, from a symphony playing classical music to commemorate the events of September 11th to an argument between a security guard and a distressed woman attempting to visit a loved one who has been rushed to the emergency room.

The large majority of the patients seen within the WHC are poor women of color receiving Medicaid/PCAP insurance to cover the cost of their prenatal care. I met only one woman during my tenure at Alpha who was not receiving Medicaid or any other government-subsidized health insurance. This woman was ineligible for Medicaid because her income exceeded the limits set by Medicaid guidelines. Since becoming pregnant, she had become a full-time employee at her place of employment (as opposed to a “contractor” to the business that she had been in the years preceding her pregnancy), and had signed up for the health insurance offered by her employer. However, the employer-based health insurance—and the other private insurance plans she had subsequently researched—refused to pay for her prenatal care expenses, claiming her pregnancy was a “preexisting condition.” Thus, she paid for her prenatal care (and labor and delivery) expenses entirely out of her own pocket. Save for this relatively unlucky woman, all other patients I encountered at Alpha relied upon Medicaid for their health insurance during their pregnancies.

Moreover, the majority of patients attended to within the WHC are Latina—many U.S.-born, many others documented and undocumented immigrants. The WHC also sees many women hailing from other parts of the globe such as South Asia, Africa, Asia, and Europe. Finally, although they are a minority, there are still quite a number of U.S.-born Black and White patients. Accordingly, the Alpha “patient population” is comprised of a diverse group of women in terms of ethnicity, racial ascription and identification, level of educational achievement, health status, history of substance abuse, prior relationship to the state and its regulatory apparatuses, familiarity with the biomedical establishment and biomedical discourse, ideas held about pregnancy and childbirth, desire for medical intervention, etc. And while all were poor (with the exception of the unlucky outlier mentioned above), it is also imperative to note that some were poorer than others.

The WHC offers three categories of medical providers of gynecologic and obstetric care: 1) medical doctors, 2) midwives (certified nurse practitioners who have completed midwifery training and certified nurse midwives), and 3) nurse practitioners (nurses whose extensive training qualifies them to perform a host of medical procedures—including Pap smears, vaginal examinations, biopsies, and insertion of laminaria as part of a pregnancy termination procedure). Medical doctors working in the Alpha obstetrics clinic can be divided into two categories: attending physicians and residents. Between the attending physicians and the residents, the approximately twenty-one residents who rotate through the Alpha WHC throughout the course of their four-year residency provide the bulk of services to obstetric and gynecologic patients. The residents are also present in Alpha’s labor and delivery ward and thus care for women during labor. Residents split their highly coveted residency between the public Alpha Hospital and the private Omega Hospital—a split that, along with the perceived camaraderie among residents, is cited by the residents as the Alpha-Omega residency program’s primary draw. Indeed, the Omega University School of Medicine advertises: “Alpha is a large municipal hospital with a diverse patient population; Omega is a large private university referral center drawing patients from a wide geographic area for all of the divisions in our department and the medical center. The combination provides an enviable mix of medical, surgical, sociological, obstetrical, and gynecological problems that cannot be found under the roof of any single institution.”

Because the attending physicians at Omega deliver prenatal care to their patients in private offices outside of Omega Hospital, the residents

do not attend to Omega's patients during their prenatal care. The first time a resident usually meets a pregnant Omega patient is when the patient arrives at the hospital to deliver her baby. However, at Alpha, the residents provide prenatal care to the patients as there are no "private offices" to which Alpha patients can go. Alpha attending physicians, who are Omega faculty or fellows undergoing postgraduate training in gynecologic oncology, maternal-fetal medicine, or reproductive endocrinology and infertility, also attend to patients; however, because there are fewer attending physicians than residents, patients assigned to a medical doctor as their provider (as opposed to a midwife or nurse practitioner) are more likely to see a resident than an attending physician. Attending physicians also perform an oversight function to the extent that they are consulted by residents about patient cases, and they authorize the courses of treatment the residents recommend.

While many of the residents and several attending physicians are racial and ethnic minorities, it is not incorrect to state that most of the providers working in the Alpha WHC are White. Indeed, all of the midwives and nurse practitioners during my fieldwork were White.

Assisting the providers is the "ancillary staff," a term used in the hospital to describe those categories of employees whose purpose is to support the providers by performing auxiliary but essential tasks. Included within the ambit of ancillary staff are: 1) Patient Care Associates (PCAs) who take the patients' vital signs, draw blood and collect urine samples, make follow-up appointments upon the request of the provider, and shuttle the patients in and out of examination rooms; 2) frontline staff, who from their post behind the front desk greet patients, take all relevant paperwork and distribute it to the relevant providers/PCAs, and make appointments; and 3) registered nurses, whose training allows them to provide some health care services to the patients—namely administering injections, dispensing prescriptions and other medications, taking medical histories, and performing colposcopies and other noninvasive procedures. Ancillary staff also includes nutritionists, social workers, HIV counselors, and financial aid officers—staff whose purpose and function I will discuss in greater detail in the following chapter.

The WHC is an extremely frenzied, oftentimes chaotic, not infrequently confused space. And it is the ancillary staff who are compelled to manage the bulk of this confusion. Accordingly, the job of the ancillary staff worker is a stressful, frequently thankless one. One journalist wrote that "[o]n a hectic Saturday night at Alpha, the staff can often be heard to

wonder out loud just what it was that drove them into the so-called caring professions, dooming them to wade through the endless insoluble miseries of their fellow citizens, all the while entangled in an urban health care system seemingly tattered beyond repair” (Zuger 2001). In my experience, the ancillary staff in the WHC does not wait until a hectic Saturday night to engage in such musings; they tend to wonder about their lot daily—and for good reason.

During the course of my fieldwork, I was able to work behind the front desk and perform the tasks the frontline staff generally performed—answering incoming telephone calls, making gynecology and obstetrics appointments for patients who presented themselves at the desk or called the clinic’s main telephone number, providing pregnancy tests to women who sought them, taking the relevant paperwork from women with appointments and making sure the providers with whom their appointments were scheduled received such paperwork, and doing whatever running around the clinic was required to ensure that patients’ expectations were managed and the clinic continued to function. On the days I worked as a frontline staff person, I would leave for home at 6 p.m. completely exhausted, sweat staining my shirt—the smile and pleasant demeanor with which I tried to greet patients having disappeared hours beforehand. My feet would be sore from the incalculable number of occasions that called for me to run from the front desk to the back examination rooms. I would swab my hands with hand sanitizer, hoping that the ritual would somehow undo the countless times a patient had greeted me with an uncovered sneeze or cough instead of “hello.” Yet, the women who perform this job—the job I volunteered to do for research purposes, a job from which I could throw up my hands and vow never to do again because it is “too much”—resided at the bottom of the clinic’s hierarchy.

There was one occasion on which I did, indeed, vow never again to work as a frontline staff person. It occurred during my first month of conducting patient intake. By that time, I had observed innumerable belligerent interactions between staff and patients and had placed the blame for any and all hostility in the hospital squarely on the shoulders of the ancillary staff workers. I felt that if the staff were more patient and explained more things more carefully to the patients, tempers would not flare. So, on this day, I sat behind the front desk, indirectly offering myself as a model of how staff *should* treat the patients they serve.

All went well during the morning. During the afternoon, however, I was approached by a relatively nondescript, racially and ethnically ambiguous

young woman who said that she needed prenatal care. Beginning prenatal care at Alpha was a complex procedure: A woman had to first take a hospital-administered pregnancy test. The following day, she would call for her test results; if positive, she would then schedule a Prenatal Care Assistance Program (PCAP) appointment, during which she met with a nurse, health educator, nutritionist, social worker, and financial aid officer. It was only after meeting with those professionals on that day that she was given an appointment to *return* to see a physician, midwife, or nurse practitioner. As a result, on the whole it usually took two to three weeks after a woman first presented herself at the hospital before she really “began” prenatal care by getting a physical examination. I started to explain the procedure to the patient—confident that if she were informed about the hospital requirements, she would not become angry at some point down the line when her expectations were not met. However, I did not have a chance to go through more than half of the procedure when the patient interrupted me: “I’m not stupid. Just give me the pregnancy test.” Taken aback, I recovered quickly and handed the woman a test tube, rubber stopper, paper cup, and plastic bag. I began explaining that she should urinate into the cup, pour the urine into the tube, firmly plug the tube with the stopper, place the tube into the bag, and bring the bag back to me. She interrupted me again: “Are you an idiot? I know that already.” She stalked off toward the restroom. Five minutes later—during which I had replayed the scene over and over in my head, trying to figure out where I had gone wrong—she returned with the plastic bag, shoved it across the front desk, and asked, “Am I going to get my prenatal care today?” I said no and told her that she had to call back the following day to confirm her test results. Displeased, she called me a bitch, told me, “Your fucking system is stupid,” and sauntered away.

A former chief psychologist at Alpha once said of the staff who worked beside him in an “emblem of urban government’s catastrophic inattention to its own public institutions” that “I don’t know if it was a kind of masochism or a kind of macho—and that applies to the women as well—a sense of pride in being able to do the most difficult jobs in the most difficult place and do them well” (Harris 2008). The ancillary staff who worked in the WHC did possess a sense of pride born from having endured the daily disorder and occasional abuse that can be expected in the clinic and from having acquired a certain competence regarding how to manage a far-from-ideal situation. It is the ancillary staff women who are simultaneously pushed and pulled in varying directions, who are called upon to assuage the tempers of both the patients

and the providers to whom they must answer, and who are regularly faulted for the clinic's shortcomings. Comments made by second-year resident Dr. Francie Howard are representative of many:

There are many days when the ancillary staff is not doing their job. And you're like, "You're not doing your whole job. I'm doing my job and your job." And it causes some tension.

When I think about the labor floor [at Omega], you have young—not just young—but, young, motivated, committed, energetic people who are really good at their job and take pride in their work. And here at Alpha, a lot of times, you have people who don't take pride in their jobs, don't want to be there, don't feel committed to it. And it ends up that they are. . . . I hate to use the word "lazy," but I'm going to have to say "lazy."

A chief resident articulated a similar sentiment during another interview. An intern present in the room during the interview felt so strongly about ancillary staff incompetence that she interjected herself into the conversation.

CHIEF: For them [the ancillary staff], it's just a job. And they don't have any repercussions. I mean, how often do nurses get sued? They don't. If anything happens to the patient, they don't have any accountability. And they don't care. For them it's a paycheck, and there's a union. And it's like: "I have my job. I have to work 9 to 5. I have to take my break! I have to take my break! Wait! Lunch! I can't go without lunch!" Yet, all these patients are supposed to get seen and we [the doctors] are still working. But, you know, it's lunchtime! [laughs] Like, I said, it's just—you know, they don't care about the patients like we do.

INTERN: The problem is that we don't pay them that well, so we don't hire good people to begin with.

CHIEF: Well, you'd be surprised at the benefits that I think they have. So, I don't know how much they get paid or not. . . . When I talk to [other physicians], our job is not just a job. For me—and I think it's the same for most of us—we don't say, "I want to make this money." I mean, we're here for a different reason; because we actually care about the patients. Because we can put—we make a lot of sacrifices. We put aside this, put aside that. . . . But, the ancillary staff—they don't care at all! They don't. Of course not. They don't care. It's just like I said: It's because it's just their job.

Not only is the ancillary staff faulted for most things that go awry in the clinic, but it is also on their heads that the curses and threats hurled by frustrated patients first land. And it is the ancillary staff who has only an hour-long lunch break during which they may step away from the bedlam and disorder and re-center themselves, finding comfort in a lunch brought from home and a salary that just barely separates them from the maligned, problematized, and marginalized women they serve.

The ancillary staff's proximity (in terms of racial ascriptions, immigration histories, and socioeconomic status) to the stigmatized and scorned patients they assist—patients whose receipt of government assistance during their pregnancies causes them to be apprehended within political and popular discourse as “lazy” welfare recipients growing fat off of government largesse—goes a long way toward explaining the ancillary staff largely figuring in the ensuing ethnography as overwhelmingly negative forces with which patients must contend. However, it is important to argue at an early stage that the ancillary staff ought not to be unfairly condemned. Yes, many of these staff workers were rude and tactless; several of them uttered lamentable racial and ethnic stereotypes of the diverse group of patients they served. At many times, they expressed a plain contempt toward their indigent charges. These bare facts should not be ignored. But, the staff's bad behavior should not be conceptualized as unfortunate peculiarities of the individuals—as bad people behaving badly. In truth, much of their bad behavior ought to be understood as structural: a response to their duty to perform jobs that are highly stressful, yet for which they receive very little compensation. Furthermore, that behavior should be understood as a rational mechanism that distances the actors from the discursively maligned patients they serve.

Consider a story Yolanda told me approximately a year into my fieldwork. Yolanda was a heavyset woman in her fifties when I first met her, someone who had immigrated from Jamaica decades before. She was an Alpha veteran; not only had she been employed by the hospital for over thirty years, but she had given birth to her two now-grown children there. During my time at the hospital, she conducted patient intake at the front desk—taking paperwork from patients who were scheduled to see a provider that day, creating new patient charts, making appointments, dispensing urine tests, answering phones, etc. Although she laughed and joked with her colleagues, she rarely smiled at anyone else. Her reputation for being impolite, brusque, and downright mean to pa-

tients was known throughout the obstetrics clinic. Whenever a staff person leaned over and whispered to a colleague, “Guess who got into a fight with a patient this morning?” more often than not, the colleague would guess in response, “Yolanda?” And more often than not, that person would be right.

Even though it frequently infuriated me to observe Yolanda’s hostility to patients, and although I remain convinced that she should never have been given a job that required her to interact with them, I grew quite fond of her over time. And, eventually, after more time the feeling became mutual. So, one afternoon when the clinic had slowed considerably, Yolanda turned to me as I sat next to her behind the front desk and said, “I tried to get food stamps yesterday.” I laughed: I thought she was kidding. This was the same woman who would look with disgust at a pregnant woman approaching the desk and say contemptuously (and not entirely out of the woman’s earshot), “These women here are too busy. Too too busy. And me and you both gotta pay for their babies.” So, when Yolanda told me that she had tried to get food stamps, I thought that she was joking—that she would never accept the government assistance I believed to be the fuel behind her antipathy toward Alpha’s patients. When I realized she was serious, I tried to save myself by asking, “What did you say? You went where yesterday?” She continued, “I went to the old building [the primary Alpha Hospital building] and asked for food stamps—because, you know, Alpha doesn’t pay me nothing. And you know how they say that you can have a house and a car and a train and you can still qualify for food stamps? Well, they wouldn’t give it to me. They said I earned too much.”

In this two-minute aside, Yolanda revealed just how close she was to being one of the patients she assisted everyday. She was needy enough to at least *believe* that she might qualify for government assistance; further, her circumstances were such that she actually *acted on* that need by inquiring into the program. Moreover, had Yolanda been thirty years younger and pregnant, there is no doubt that she would have qualified for all the government assistance that most Alpha patients receive, because, as mentioned earlier, the income limitations in New York State for Medicaid insurance during pregnancy are quite high. So, while Yolanda might have “earned too much” as a single woman to qualify for the food stamp program, she likely would not have earned too much as a pregnant woman to qualify for Medicaid (and the Women, Infants, and Children (WIC) vouchers that provide pregnant women and mothers with children under

the age of five with milk, cheese, cereal, fruit juice, and the like). Accordingly, Yolanda's poor treatment of Alpha patients must be accounted for with a measure of interest in her specific subjectivity and subject position. She was called upon to serve—under impressively stressful conditions and with a professedly unimpressive compensation packet—a group of patients whose races, ethnicities, nationalities, and socioeconomic statuses closely mirrored her own. As such, I suspect that Yolanda's animosity (and the staff's animosity more generally) is intensified by a recognition of her own similarity to the patients' profile and her desire to disavow the discursively disparaged patient as an abject version of herself.

In such a light, consider a story told to me by Minnie, a middle-aged woman born in Puerto Rico, who had been working at Alpha Hospital for twenty-seven years at the time of my fieldwork there. Minnie was trained as a PCA and therefore could work more closely with providers "in the back" as she prepared patients for their examinations; however, she tended to be at the front desk, conducting patient intake alongside Yolanda. Minnie was a pleasant, jovial woman whose ability to speak Spanish was greatly appreciated by both the Spanish-speaking patients and her non-Spanish-speaking colleagues. I was quite fond of Minnie, who took to calling me *nena*, a term of endearment in Spanish that literally translates as "doll." Although Minnie was exceptionally nice to me and, for the most part, kind to the patients who sought her assistance, she could also be very nasty to patients when she was frustrated, tired, or annoyed.

A couple of months after I began fieldwork, Minnie became ill and was unable to come to work for several days. When she returned, I asked her if she was feeling better. She said yes and continued,

I have been taking medicine for my high blood pressure for four years, *nena*. I take the same medicine—it hasn't changed. Now, when I went to get my prescription filled the last time at the pharmacy, I noticed that the medicine they gave me dissolved really quickly when I put it in my mouth. And it left a bitter aftertaste. And then, *nena*, I started getting these terrible headaches. Really terrible. So, you know, I figured that the pharmacy had made a mistake and gave me the wrong medicine. So, I went back there and I told the pharmacist that, you know, they had made a mistake. And do you know what he says to me, *nena*? He says, 'It's probably all in your head. How often do you go see the doctor? Maybe you don't go often enough.' I was shocked. He didn't know I was a nurse—that I've been working in the hospital since before he was born.

I asked him why he was getting an attitude with me. And he says, “Well, it seems that you are just repeating yourself.” And I said, “Well, that’s because you don’t seem to be understanding me.” So, I left. I wasn’t going to stand there and argue with him all day. I went to another pharmacy and I had the prescription refilled there. The pills they gave me there were like the ones I’ve been getting for years now. And the headaches went away. So, I’m feeling much better now.

The incredible irony of Minnie’s story was that the rude pharmacist treated her in a manner similar to the way she has treated more than a few patients at Alpha. I have observed her become aggravated on innumerable occasions by patients who seem to be repeating themselves pointlessly, but who are actually trying to reiterate a complaint that appears to be falling on unhearing ears. *She* has been the rude pharmacist who is unable or unwilling to understand the difficult patient who will not just go away. I have no doubt the pharmacist Minnie encountered had dismissed her as an irritable old lady with a Spanish accent who stalked into his pharmacy with an attitude, erroneously believing that her Medicare card entitled her to make unlimited demands on his time. Differently stated, the pharmacist saw in Minnie a version of what Minnie sees in Alpha patients. Like Yolanda, at least some portion of the hostility Minnie demonstrated toward her patients can be explained as an attempt to create distance between herself and them such that they could not, or no longer, be considered abject forms of herself.



Having provided what I hope is sufficient background information about the place and the major players who populate it—and having hopefully exonerated, to some extent, the ancillary staff from being unfairly blamed for the unfortunate role they play in the analysis that is to come—I now turn to the critique. In the next chapter, I begin by exploring the deluge of requirements that follow a woman’s receipt of government subsidization of her prenatal health care costs. That is, as a condition of receipt of Medicaid coverage of prenatal care expenses, poor, uninsured pregnant women are compelled to meet with a battery of professionals—namely nurses, nutritionists, social workers, health educators, and financial officers—who inquire into areas of women’s lives that frequently exceed the purview of

their medical care. This chapter argues that, as a result, Medicaid mandates an intrusion into women's private lives and produces pregnancy as an opportunity for state supervision, management, and regulation of poor, uninsured women. In essence, the receipt of Medicaid inaugurates poor women into the state regulatory apparatus.