

Introduction

SIGHTSEER

I remember my first day of fieldwork at Medical Response and Transport (MRT) very well. A few minutes before 5:00 AM, I walked into the firm's headquarters, sometimes referred to as the "barn." Inside a small office, I met Eric, a white man in his early forties. As one of the company's dozen or so field supervisors, Eric's primary task for the day was to monitor the largest segment of MRT's 911 ambulance fleet, the portion servicing the urban core of what I call Agonia County. However, he also agreed to a secondary task: taking me on a sightseeing journey of sorts. Per the recommendation of upper management, this day with Eric was partially meant to introduce me to MRT before I actually started jotting notes from the backs of ambulances. It also didn't hurt that all supervisors are experienced paramedics, meaning Eric could provide insight beyond his current position as a middle manager. After exchanging a few pleasantries about the weather and my research, we walked out of the barn and headed toward a company-issued SUV known more informally as a supervisor rig.

As we prepared to depart from MRT's headquarters for the day, I took a mental note of Eric's appearance: stocky build, veiny arms, and a high-

and-tight haircut. I thought he looked a lot like law enforcement in his company uniform, which included a shiny supervisor badge. Either due to coincidence or Eric's secret ability to read minds, he told me that he looks especially cop-like when he wears a bulletproof vest under his shirt. He wasn't wearing the vest on this particular day though. It's hot and bulky, but he promised his wife he'd at least put it on during night shifts. Before leaving the barn for the day, Eric told me he'd show me some of the reasons why he protects himself with a vest from time to time.

He drove me through some "ghettos" and "hoods." I'd later learn that these are terms MRT workers and supervisors casually and interchangeably use to identify poor neighborhoods, which are disproportionately occupied by Agonia County's black and Latino residents. Eric first took me to the "killing fields," a predominately black neighborhood with a high homicide rate. From there, we cruised into some nearby "barrios" before we made our way to see some "projects."

Inside the supervisor rig, Eric provided a verbal commentary for the sights outside our window. "There're usually prostitutes here, but not at this time," he said. It was 8:00 AM. I found this to be an odd summary for an avenue that seemed to be better defined by its "Cash for Gold" signs, fast food restaurants, liquor stores, and pay-day loan centers, but I appreciated Eric's spontaneous description of place. In addition to prostitutes, he told me there are lots of "bangers" on these streets. But again, he insisted we wouldn't find such characters at this hour. The wicked evidently rest.

After driving up and down the streets of these neighborhoods, waving to the ambulance crews we saw in the process, we eventually paused at a red light. An older black man in torn clothes lumbered across the street, passing the front of our vehicle. Eric lowered his voice, adding an extra assurance of privacy, "There's a zombie." I chuckled nervously and asked, "What's that mean?" "He's an alcoholic. You can see it in the yellowing of his eyes," he said, describing some jaundice that *could* be associated with liver problems and apparently by extension with the problematic consumptions of this man whom we never actually spoke to. I soon learned that Eric's zombies also include people who use heroin and other "downers," and are distinct from his more animated "tweakers," "crack heads," and "meth heads."

As the tour continued, I asked Eric to tell me about the types of calls his crews run. He didn't know where to begin and, in retrospect, I don't blame

him. I didn't know it at the time, but the hundreds of calls I saw in the months following the tour covered just about every inch and layer of the human body, from the head down to the toe and from the skin into the marrow.

Eric grabbed a protocol book he keeps in the supervisor rig and tossed it into my lap. I skimmed through it as he continued to drive somewhat aimlessly through busy streets. The book is a thick manual, but it fits perfectly in the side pocket of an EMT or paramedic's cargo pants. Almost biblical in its authority, this book is published by Agonia County Emergency Medical Services (EMS), the public agency that oversees MRT's contract with the local government. It outlines a number of protocols from how to manage grieving bystanders to how to work with police during an active shooter event, but it mostly covers treatment procedures for a variety of medical problems. Among other things, these include cardiac emergencies, overdoses, psychiatric crises, pregnancy complications, respiratory issues, strokes, seizures, and trauma (i.e., physical injury).

Of course, some calls are more severe than others. Eric explained to me how county dispatchers classify ambulance responses not only according to the type of emergency (e.g., chest pain, headache, and stab wound), but also by the presumed urgency of the problem. In reverse alphabetical order, and from the most acute to the least, there are five primary levels of severity determined by dispatchers: "echo," "delta," "charlie," "bravo," and "alpha." Echo responses include things like cardiac arrests while alpha responses include things like flu-like symptoms. The main point of these classifications is to set guidelines for how fast an ambulance crew should arrive at the scene of a call. For example, crews are supposed to arrive within eight minutes and thirty seconds to most echo responses while they usually have thirty minutes to show up to an alpha response.

Eric warned that these dispatcher-determined triages are usually "good guesses" but they can be misleading. For him and essentially everyone I spent time with at MRT, there is a more informal but a more important distinction in severity. It's determined on 911 scenes and in the backs of ambulances by crews who can see, touch, and speak to patients directly.

There are "legit" calls and then there are "bullshit" calls. Legit calls are the so-called real emergencies that necessitate and justify the craft of paramedicine. These are typically the cases that have crews exercising the

skills that they were taught: intubating breathless airways, compressing lifeless chests, plugging bleeding wounds, and so on. In contrast, bullshit calls are the so-called nonemergencies that involve little more than a collection of vital signs, a ride to the hospital, and maybe some minor interventions like the icing of a sore joint. As I eventually came to understand this distinction, legit and bullshit are not really binary categories but are instead more like poles on a continuum.

During the tour, Eric offered me his thoughts on legit and bullshit ambulance cases. In teaching me about the latter, he depicted two forms of people, what we might call the “selfish” and the “stupid.” Supposedly, selfish people often call 911 because they want a quick painkiller fix, they wish to bypass an emergency department waiting room, or they desire some other convenience provided by the responding ambulance crew. Such people greedily take an ambulance away from a more deserving soul in the area, like a gunshot or heart attack victim. But not everyone who calls for bullshit reasons is seen as selfish. According to Eric, stupid people purportedly call for different reasons. They’re not interested in executing some sinister plan for self-reward. Instead, they lack basic problem-solving skills. They call 911 for nonurgent problems because they don’t know any better. Or at least that’s the impression I gathered from Eric’s impromptu lectures on the tragedy of bullshit.

Luckily for him and his crews, the calls are not all trivial. Eric also told me about some of the “good” and “interesting” calls he had run. As an experienced paramedic, he has certainly seen his fair share of legit calls. He told me stories of how he skillfully brought the dead back to life with a mixture of CPR and drugs. He also told me how he cleverly identified cardiac abnormalities through an electrocardiogram. Eric then provided some gruesome accounts of salvaging flesh and bone nearly obliterated by car accidents and other catastrophes.

This man’s reflections of past calls eventually led him to some “war stories.” As he drove me through more neighborhoods, Eric’s voice sometimes shifted to a somber tone. He told me about finding young bodies pumped with bullets, intestines spilled out of abdominal walls, and the maggot-infested corpses of suicide victims. He told me heartbreaking tales of having to inform children that their parents were never waking up and of patients taking their final breaths under his care. Even though

Eric complained a lot about bullshit, it seemed like every few blocks reminded him of the real-life horror shows he was abruptly cast into during their climaxes or epilogues. Still, Eric said, “It’s not like the movies.” Ambulance operations are not always adrenaline-rushing, and even when they are they can mentally wound providers. Like many of the experienced ambulance workers and supervisors I met, Eric seems to traverse the streets of Agonia with ghosts in tow.

Suddenly, our conversation was interrupted. A short and loud alarm flooded the interior of the SUV. Eric turned up the radio to hear what the dispatcher was assigning him. It was a “GSW,” a gunshot wound. As a supervisor, Eric is frequently summoned to high-profile calls like this one for a twenty-four-year-old black man who was shot in the gut.

However, by the time we arrived at the scene, not much remained but some blood that was splattered on concrete and encircled in crime scene tape.¹ We were left in the dust on this call, but it worked out for the tour. Eric had planned on driving me through this area of town anyway. The blood splatter left on the sidewalk was located almost perfectly at the epicenter of what he described as “a little nexus of evil.” Along with a couple of other locations in the county, this five-or-so-block area is distinctive not only in its intense marginality, but also in its apparent offensiveness to Eric and many others at MRT.² He insisted an open-air drug market was just north of this blood splatter and a homeless encampment was only a few blocks south.

I didn’t know it at the time, but I ended up frequenting this “little nexus of evil” a lot during my fieldwork. Beyond encountering people whom Eric would probably consider bangers, zombies, and tweakers, I experienced some memorable “firsts” in this area. This place not only included my first gunshot scene; it also included my first death, my first overdose, and the first time I saw bone cut through skin.

I also encountered plenty of low-priority calls in this particular area of the county: people needing prescription refills, clinically stable people requesting or perhaps even “seeking” pain medication, and people looking to sleep in a bed at a hospital. While in this five-or-so-block area, I frequently shadowed crews who were more or less just “taxiing” people to the emergency department for seemingly nonurgent reasons. And, when I worked as an EMT, I drove those who supposedly misuse the ambulance

to the hospital myself. Eric's voice popped into my mind nearly every time I stepped out of an ambulance in this part of Agonia. "This place is a little nexus of evil." I started to think he was sort of right.

But true wickedness probably comes from outside the nexus, from those nefarious human systems that pack suffering into places like this. Eric and I witnessed the aftermath of an attempted murder here, but we may have also witnessed what Friedrich Engels calls "social murder," capitalism's inevitable wasting of human life.³ The market yields and necessitates exploited (e.g., workers), excluded (e.g., jobless), and precarious (e.g., temporary employed) populations that are all exposed to an array of bodily risks.⁴ Systemic racism is also suspect, from the continued legacy of Agonia County's segregated neighborhoods to the casual "color-blind" biases that help maintain white supremacy across market, state, and civil society.⁵ Public health scholarship is actually pretty clear on this point: risks for illness and injury increase toward the bottom of the American racial hierarchy.⁶

As such, it's not very surprising that poorer people and people of color are more likely to experience what Eric considers to be "legit" emergencies. This is true not only for things like gun violence, but also for intense traffic accidents and other sources of severe injury.⁷ It's also true for heart attacks, strokes, drug overdoses, seizures, breathing difficulties, psychiatric crises, and essentially every emergency listed in Eric's protocol book.⁸ For many social scientists, these patterns are indications of a society that concentrates vulnerability on down-and-out populations.⁹

Structural forces seem to also account for all the so-called bullshit that Eric's crews are responding to. Persistent barriers to primary care likely motivate many people to turn to emergency medicine for an array of problems.¹⁰ Changes to the American social safety net during the past couple of decades have probably had an effect as well. A neoliberal shift toward market-based policies has made traditional welfare programming more disciplinary and arguably more stingy for vulnerable populations at a time when their economic and social precarity has increased.¹¹ One of the effects of this transformation seems to have been a "medicalization" of public aid, meaning people are turning to medical entitlements like public disability benefits and emergency care for more generalized assistance.¹² From this point of view, it's not the selfishness or stupidity of individuals

that is to blame. It's the selfishness and stupidity of a society that pressures legions of people in need to turn to one of the few institutions that are promised to them, the ambulance.

Ultimately, an expansive library of sociological thought tells us there's little reason to doubt that my sightseeing tour brought me very far "downstream" in a causal river linking macrostructural conditions to personal hardship. It was never very obvious to me where all these bodies Eric described floated down from, but float they did. My objective is not to follow the stream up, but to make sense of the workers who are waist-deep in the water trying to pull people out. Such an objective, however, necessitates that we first break from some common assumptions of ambulance operations in the United States.

RETHINKING THE AMBULANCE

Thousands of local agencies and organizations form a complex web of 911 ambulance operations in America.¹³ In the space between federal regulation and the ambulances that roll past you in traffic, state-level emergency medical services authorities (e.g., California Emergency Medical Services Authority) charge local bureaucracies—often divisions of county health or public safety departments (e.g., Agonia County EMS)—with assuring ambulances to citizens. Some of these agencies deploy 911 ambulances directly, such as in Pittsburgh and New Orleans. However, it's more common for them to delegate these operations in portion or in full to fire departments, such as in Dallas, or to private firms like in San Diego. In California, it's estimated that less than a quarter (22 percent) of ambulance-providing agencies are private, yet over three-fourths (76 percent) of 911 calls are responded to by crews working for private companies.¹⁴

Buried somewhere in this web, we find MRT. As previously noted, MRT is a large for-profit firm that provides 911 ambulance services in several locations across the United States. I focus on MRT's operations in Agonia County. There, the company employs a few hundred frontline workers and effectively monopolizes ambulance operations through a contract with the local government.¹⁵ MRT primarily secures revenue from ambulance patients and personal health insurance providers

(overwhelmingly public ones like Medicare and Medicaid) under a fee-for-service model. In billing people or their insurance providers, MRT is similar to essentially all 911 ambulance operations in the country, be they private or public.¹⁶

My time at MRT taught me the ambulance is an institution that in many ways fulfills its formally articulated mission to provide timely and consequential care to “anyone.” Similar to the emergency department, the ambulance cannot deny services based on a person’s ability to pay. As such, the provision of paramedicine cuts across divisions in class, race, citizenship, age, and gender. By and large, people just need to ask for an ambulance or somehow imply that they need one (e.g., by lying unconscious in the street).

In fact, if you’re reading this book somewhere in the United States, you can have an ambulance right now if you want one. Just pick up a phone, dial 911, and tell the operator you need some medical aid. The state, at multiple levels, promises you an ambulance in a somewhat timely fashion. More times than not, it will deliver on this promise.

Of course, there are some caveats. While you probably won’t get a busy signal when you call, you shouldn’t be totally surprised if you do.¹⁷ Still, I’d bet it’s more likely you’d have to wait longer than expected for an ambulance because there are few to none currently available in your area.¹⁸ Yet, even this is exceptional. Perhaps there are some legal reasons that make you hesitant to dial 911. The police may very well show up along with ambulance crews, especially if you call for something like an assault, an overdose, or a psychiatric emergency.¹⁹ So, if you want to avoid law enforcement, you’ve been warned. Maybe it’s not so much the police that scare you from calling, but the invoice. You should be scared. Even if you have insurance, you may get stuck with a bill well over a thousand dollars in a few weeks.²⁰

With these conditions in mind, concerns over ambulance accessibility for poor people and people of color are certainly reasonable. Indeed, a number of researchers have pointed to help-seeking reluctance and thinned emergency services toward the bottom of class and racial hierarchies in the American city.²¹ We must nevertheless be careful not to write the ambulance off as an institution that is absent in oppressed and marginalized communities.

Paramedics and EMTs respond up and down the polarized city and there are people toward the bottom who choose to avoid it, but neither of

these facts negate an important feature of the ambulance: it's an institution that's disproportionately utilized by destitute and otherwise vulnerable populations.

This isn't a particularly new pattern either. From the horse-drawn buggies that were run by hospitals after the Civil War to the motorized vehicles that were run by police departments, fire stations, funeral homes, and small companies after World War II, the ambulance has long been present in the lives of the urban poor.²² Moreover, civil rights activists in the 1960s and beyond helped expand ambulance accessibility to racial minorities, and particularly to blacks in large cities.²³ The ambulance's gravitation toward the bottom of the urban hierarchy held during the national expansion and standardization of paramedicine during the 1970s, the partial federal withdrawal in ambulance operations during the 1980s, and the rise of national ambulance corporations during the 1990s.²⁴ Today, ambulance crews working for both public and private entities continue to disproportionately treat and transport relatively disadvantaged populations.²⁵

What does this look like for MRT specifically? Well, over half the firm's invoices are billed to either uninsured or means-tested Medicaid patients. And, as Eric told us, MRT's crews are disproportionately sent into Agonia County's poorer neighborhoods, where a large share of the county's black and Latino residents dwell. I was able to confirm this not only through my fieldwork, but also through my analysis of several thousand medical records completed by crews.

Figure 2 summarizes the neighborhood-level response rate for MRT in the year 2015, which I have age-adjusted and averaged across poverty concentration deciles. The pattern is clear: ambulances are rolling into poorer neighborhoods at a relatively high rate. Look at the bar farthest to the right, the one with the highest mean rate of MRT responses. It captures the thirty poorest neighborhoods in the company's jurisdiction and includes the "killing fields," "barrios," "projects," "little nexus of evil," and other areas that I encountered during my sightseeing tour with Eric. While not evident in this simple figure, these neighborhoods capture less than a tenth (9 percent) of the people living within MRT's market, but they account for nearly a fifth (19 percent) of the firm's responses. Perhaps unsurprising to most readers, these neighborhoods also contain a high proportion of Agonia County's black and Latino residents (64 percent on

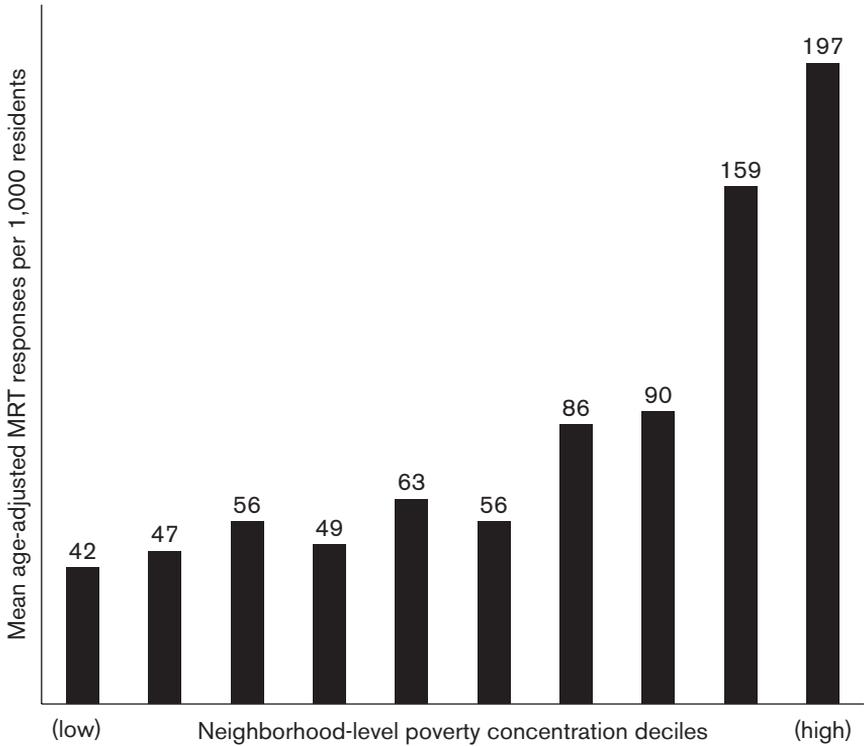


Figure 2. Mean age-adjusted ambulance responses by neighborhood poverty concentration. *Source:* MRT deidentified patient care reports, 2015; American Community Survey Five-Year Estimates, 2011–2015. *Notes:* Observations = 300. Neighborhoods defined as census tracts. Records geocoded by author using QGIS 2.14.6 (92 percent success). Excludes MRT responses to highways and bridges.

average versus 36 percent of MRT’s jurisdiction overall). The ambulance is not limited to poor or minority neighborhoods, but something seems to push or pull it toward these areas.

Not long after my introductory tour with Eric, I led a research team that included a couple of emergency room physicians and a paramedic to further examine this association between neighborhood poverty and ambulance responses. Drawing on the same medical records used to construct figure 2, we found evidence suggesting that a ten-percentage-point

increase in neighborhood poverty is associated with a 45-percent increase in ambulance responses.²⁶ We even controlled for geographic patterns in race, gender, age, citizenship, and other factors. This pattern held for all the major call types listed in Eric's protocol book and for what he would probably consider to be both legit and bullshit calls.²⁷ In a subsequent study, we also found evidence suggesting that MRT ambulances are *not* relatively tardy in poor neighborhoods.²⁸

None of this is to suggest that ambulances don't ever "no show" or show up devastatingly late in disadvantaged neighborhoods. They absolutely do. For example, once a crew I shadowed didn't arrive on scene until thirty or so minutes past the time a 911 call was placed. This wasn't particularly unusual except that it was for a preschool-aged girl who was shot during a drive-by. We rolled up to a street corner to find a reasonably angry group of people. "You're too fucking late!" one man yelled before somebody else explained to us that a cop took the girl to a hospital. I don't intend to conceal or trivialize tragedies like this or similar ones published in the news.²⁹ But, just as we should be careful not to assume the ambulance is an institution that's evenly spread across the polarized metropolis, we should be careful not to conclude that it's absent in poor and nonwhite neighborhoods when the evidence suggesting so is often thin.

URBAN SUFFERING

We know the ambulance is generally a present and busy institution in the oppressed and marginalized territories of urban America. Yet, why and how this institution churns through people in these areas remain somewhat of a mystery. The professional literature on paramedicine offers simple explanations for the heavier utilization of ambulances among down-and-out populations: high rates of morbidity and mortality, detachment from primary care, lack of transportation, and shared misconceptions of emergency.³⁰ However, this literature tends to ignore the structural conditions of paramedicine and says very little about how ambulance crews are dealing with a disproportionately poor and nonwhite clientele. Meanwhile, the limited sociological research on the ambulance offers some rich insight into crew-patient interactions but says effectively

nothing of the ambulance as an institution that manages hardships toward the bottom of the polarized city.³¹

To help solve such a mystery, this book rethinks the ambulance as a frontline institution for governing urban suffering. MRT crews traverse a large and densely populated place I call Agonia County, where plenty of people exist in temporary and enduring agony. Agonia is a playful Spanish-word pseudonym I use for a particular area in California, but it's also a kind of generalized description of urban life in advanced capitalist societies. Of course, urban dwellers, be they in the dense core or the sparse periphery, do not live in absolute misery. But all human settlements contain suffering. It's simply the more agonizing side of urban life that paramedics and EMTs frequent most. From stab wounds to strep throat, ambulance crews are dispatched to handle an array of suffering bodies.

As such, it's not that surprising that ambulance crews tend to work toward the bottom of the economically and racially polarized metropolis. Suffering is certainly not limited to poor people, people of color, or other structurally disadvantaged groups, but it generally intensifies on them.³² As anthropologist Seth Holmes puts it, suffering is "roughly cumulative from top to bottom."³³ We can see this in the anxiety and torment linked to precarious shelter and so-called bad jobs.³⁴ We can also see it in the pain associated with high rates of street crime, high school incompleteness, and predatory lending. These are all conditions that disproportionately afflict people toward the bottom of a complex urban hierarchy.³⁵ And, as already detailed, the downward intensification of suffering is also apparent in the concentration of illness and injury among the city's oppressed and marginalized people. In short, suffering tends to obey a kind of social gravity. Something in the cosmos pulls it toward the city's destitute and stigmatized populations.

There are a number of institutions that handle people who carry the brunt of suffering in the American city. Be it by protecting them, punishing them, or simply processing them into objects to know and direct, such institutions essentially "govern," "manage," or "regulate" these populations at ground level. This can be seen in the way welfare offices distribute and withhold cash assistance, food stamps, means-tested health insurance, and related forms of aid.³⁶ It can be seen in the way criminal justice institutions collect, isolate, and surveil a disproportionate number of poorer

and darker-skinned bodies.³⁷ Nonprofit and for-profit organizations that are contracted and subsidized by governments to deliver public goods and services are also important.³⁸ And, despite reasonable concerns over access to care, medical institutions must also be included in a discussion of how suffering populations are managed by street-level institutions. Often tasked explicitly by law or contract to aid indigent populations, emergency departments, community clinics, and similar sites constitute some critical front lines for managing the city's most pained people.³⁹

We should keep in mind that welfare offices, prisons, hospitals, and related institutions are generally disinterested in eradicating the root causes of suffering.⁴⁰ The reasonable assumption here is that oppression and marginality—and the suffering that tends to map onto such conditions—are incurable in a capitalist and racist society like the United States. While the frontline institutions that tend to handle people toward the bottom of the urban hierarchy may certainly alleviate (or even exacerbate) suffering, they are not generally oriented toward abolishing its fundamental causes and indeed they're not really expected to be oriented as such. Thus, we're left with a fragmented, and often a contradictory, mess of institutions for handling suffering populations but not for terminating the root sources of their agony.

The ambulance is somewhere in this mess and probably has been for some time. Paramedicine may never become the quintessential case for understanding how suffering populations are governed at ground level, nor is it an institution that exclusively handles people toward the bottom of the urban hierarchy. Nevertheless, I argue the ambulance is parked at a couple of really important intersections that can help us understand the regulation of urban suffering more generally. On the one hand, it's frequently interacting with two larger institutions that also disproportionately handle poor people and people of color in the United States: the hospital emergency department and the police squad car. As such, the ambulance offers a unique view into the intersections of the welfare state and the penal state. On the other hand, those who control and coordinate ambulance fleets often meet at the intersection of bureaucracy and capital, where public and private distinctions are increasingly blurred by the delegation of governmental functions to third parties. In this regard, the ambulance is not unlike the many "private" for-profit and nonprofit

agencies that handle suffering populations on the ground (e.g., transitional housing facilities and corporate security firms). As such, the ambulance is not just a suitable case for studying the street-level governance of urban suffering; it's also a *strategic case* for doing so. However, to make the most of this case, I argue that we need to tweak how we typically see and study the regulation of urban suffering.

ON THE FRONT LINES

Beyond providing some insights into the world of the ambulance, this book develops a broader understanding of how suffering bodies are governed at street level. I advance a labor-centric framework to make sense of how frontline institutions handle a variety of problems that disproportionately torment down-and-out populations.⁴¹ Perhaps the true promise of this framework stems from its ability to illuminate significant blind spots in existing social theories. Next, I briefly detail some of these blind spots before outlining the general theory that organizes this book from start to finish.

Forgetting the Workers

As already noted, social scientists examine a range of institutions when considering how economically and racially oppressed populations are governed. These include institutions that can alleviate, maintain, or exacerbate suffering. To help make sense of this variation, a simplified but useful distinction is sometimes made between the protective and the repressive functions of state power. This is most notably accomplished by Loïc Wacquant, a sociologist who offers an analysis accounting for prisons, welfare offices, and seemingly everything in between.⁴² He details a horizontal struggle between the “Left hand” of the state, which steers the welfare institutions that protect and extend life chances, and the “Right hand” of the state, which directs the penal institutions that impair them.⁴³ According to Wacquant, the state's Left hand is weakening, shrinking, and losing autonomy under neoliberalism. This helps explain why welfare programs like cash assistance for poor parents are often becoming more temporary

and parsimonious. Meanwhile, the operations of the state's Right hand are strengthening, broadening, and encroaching on operations traditionally exercised by its Left hand. This is most evident in the United States by a near-simultaneous ascension in criminal justice and in the various welfare reforms that have made public assistance more disciplinary and punitive (e.g., requirements to work in order to receive benefits).⁴⁴

While certainly useful, this kind of framework tends to direct our attention away from the front lines. It glosses over the face-to-face interactions between suffering populations and the workers they interact with in welfare offices, courtrooms, homeless shelters, community clinics, and related spaces. The result is a generally passive and overly macro theory that risks fogging potentially critical activities at ground level. Indeed, people are not passively arrested, hospitalized, or fed by the policies of an ambidextrous state. Others actively arrest, hospitalize, and feed them. People on the front lines do the actual labor of classifying, assisting, and punishing subjects, be they patients, inmates, or some other human category to be processed.

Ignoring the Sides

Luckily, there are scholars who can help us make sense of the front lines and the people who work on them. There's probably no better example of this than Michael Lipsky and his illustrious writings on "street-level bureaucracies."⁴⁵ For this political scientist, the policies that most affect disadvantaged populations are "made" at ground level by social workers, police officers, nurses, and other frontline workers.⁴⁶ These are the people who execute the delivery of public goods, services, and sanctions, and according to Lipsky they have a fair amount of discretion in doing so (e.g., when a police officer decides to arrest someone or not). Still, these workers don't have absolute agency. Their decisions are hindered and enabled by their relations with management from above and with clientele from below. Ultimately, through examining governance at "street level," Lipsky and his interlocutors reveal the management of vulnerable populations as both a "top-down" and a "bottom-up" process.⁴⁷

Such a basic framework is useful for understanding the institutions that directly handle suffering populations. However, in detailing the