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Khiara M. Bridges

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Pregnancy, Medicaid, State Regulation, and the Production of Unruly Bodies

Khiara M. Bridges*

ABSTRACT

¶1

This paper represents a concretization of thoughts generated during a year and a half of anthropological fieldwork in the obstetrics clinic of Alpha Hospital—a large, public hospital located on the island of Manhattan. 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 nutritionists, social workers, health educators, and financial officers—who inquire into areas of women’s lives that frequently exceed the realm of the medical. This paper 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. Further, this paper argues that because the regime of prenatal care provided by the state-qua-Medicaid is one delivered within a highly technological, biomedical paradigm of pregnancy, poor women are produced as possessors of “unruly bodies.” Because the uninsured poor are universally produced as such, I argue that the consequence is a medicalization of poverty. As a result, the poor are treated as biological dangers within the body politic. The paper begins with a presentation of Michel Foucault’s notion of biopolitics and an explanation of its relationship to the regime of prenatal care at operation in Alpha Hospital. A detailed description of the apparatus of professionals that initiates women’s prenatal care at Alpha follows in Part Three. Part Four continues with a description of the highly-technological care that is delivered as a matter of course at Alpha. A brief conclusion follows in Part Five.

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I. INTRODUCTION

¶2 In May 2006, I began fieldwork in the obstetrics clinic at Alpha Hospital¹—a large, public hospital located on the east side of the island of Manhattan. For the first couple of months of my research, I sat in the waiting area and simply observed clinic traffic. I remember thinking that the place 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 that broadcast educational shows about nutrition and exercise, the nurses that call 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 lab coats and stethoscopes. Yet, this obstetrics clinic remained strange—strange because hospital policy was to require 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 one of the places where the indigent, homeless, or otherwise dispossessed go when they are injured or sick. Thus, when at Alpha, one may hold the elevator for a bandaged homeless man on one's way up to the obstetrics clinic. It remained strange because of the sheer diversity of the population that seeks 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. And so, for the first couple of months, I just sat in the waiting room (eventually moving behind the front desk, and later into the nurses' triage rooms and doctors' examination rooms) and scribbled descriptions in my notebook of the strangely familiar place that was to be my field for the next year and a half.

¶3 Over time, I learned that there existed a host of professionals who worked in the obstetrics clinic in addition to the nurses and doctors: there were abortion counselors, health educators, patient advocates, geneticists, nutritionists, HIV counselors, social workers, and financial officers—the duty of the latter being to help uninsured pregnant women apply for Medicaid. I eventually learned that prenatal care patients at Alpha receiving Medicaid coverage of their medical expenses (or who are expected to eventually receive Medicaid coverage of their medical expenses)² are *compelled* to meet with a nutritionist, a social worker, a nurse/health educator, and a financial aid officer.³

¹ Pursuant to a standard ethnographic practice, all names—including the name of Alpha Hospital—and anonymity-compromising details have been changed. In this Article, when I have quoted a portion of a formal interview that I conducted with an Alpha patient or employee, I have indicated the month and the year of the interview. However, when I have quoted remarks that were made in passing or snippets of conversations that I overheard and hastily scribbled into my notebook, I have not provided specific information about the month or year in which the quote was made.

² I met only one woman during my tenure at Alpha who was not receiving Medicaid or any other government-subsidized health insurance of her prenatal care expenses. This woman was ineligible for Medicaid because her income exceeded the income 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 that she had subsequently researched—refused to pay for her prenatal care expenses, claiming that her pregnancy was a “preexisting condition.” Thus, she paid for her prenatal care (and labor and delivery) expenses entirely out of her own pocket. Interview with anonymous obstetrics clinic patient (Jan. 2007).

³ Patients are required to meet with the financial aid officer only if they do not have Medicaid coverage

Because all Alpha prenatal care patients are expected to be or to become Medicaid recipients, *all* Alpha prenatal care patients are compelled to meet with the latter group of authorities. The requirement that women take on a confessional posture with a nutritionist, social worker, nurse/health educator, and financial aid officer struck me as potentially disturbing.

¶4

After a year and a half of sitting in Alpha's bustling obstetrics clinic, I came to believe that by compelling patients to meet with a battery of professionals who inquire into areas of women's lives that frequently exceed the realm of the medical, 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, this article argues that the receipt of Medicaid inaugurates poor women into the state regulatory apparatus. Further, because the regime of prenatal care provided by the state through Medicaid is one delivered within a highly technological, biomedical paradigm of pregnancy, poor women are produced as possessors of "unruly bodies." Because the uninsured poor are universally produced as such, I argue that the consequence is a medicalization of poverty. As a result, the poor are treated as biological dangers within the body politic.

A brief note: When I argue that poor women are "produced" as possessors of unruly bodies, I use the word "produce" in a conscious effort to evoke imagery of manufacture

upon presenting themselves to the hospital for prenatal care. Because a fair number of Alpha prenatal patients have Medicaid insurance coverage prior to the pregnancy that brings them to the Alpha obstetrics clinic, not all prenatal patients meet with the financial aid officer.

Although this Article discusses the specificities of the New York State version of Medicaid, the critique of Medicaid offered within is—with a caveat—democratically available to all states participating in the federal Medicaid program. In 1965, Congress created Medicaid, a federal-state cost sharing program through which states are reimbursed for expenditures for medical services provided to qualified individuals. THE ALAN GUTTMACHER INSTITUTE, THE COST IMPLICATIONS OF INCLUDING ABORTION COVERAGE UNDER MEDICAID, ISSUES IN BRIEF 1 (Oct. 1993). Individuals qualify for the program when their combined incomes and resources are deemed by law to be insufficient to meet the cost of necessary medical care. *Id.* The Prenatal Care Assistance Program (PCAP) should be understood as an expansion of Medicaid coverage, specifically designed to provide pregnant women with medical services germane to their pregnancies. In 1986, Congress established PCAP at the federal level to reimburse those states that offered prenatal care to pregnant women whose incomes exceeded Medicaid eligibility standards. Kelley P. Swift, Hope v. Perales: *Abortion Rights Under the New York State Constitution*, 61 BROOK. L. REV. 1473, 1476-77 (1995). To this effect, Congress amended the federal Medicaid statute and created an optional category of Medicaid-eligible persons composed of pregnant women and infants with family incomes at or below 100% of the federal poverty line. *Id.* at 1477. Under the 1987 amendment to the federal Medicaid statute, Medicaid coverage of pregnancy-related services became mandatory. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4101, 101 Stat. 1330, 1330-1400 (1987). The amendment required each state to extend eligibility to women whose income is up to 133% of the poverty line, but states can opt to extend benefits to women whose income is up to 185% of the poverty line. *Id.*

In 1989, New York State enacted its own version of PCAP, which extended prenatal care services to women with incomes between 100 and 185% of the federal poverty line. Prenatal Care Act of 1989, Ch. 584, (1989) N.Y. Laws 1224 (codified in N.Y. PUB. HEALTH LAW §§ 2521, 2522, 2529, (McKinney 1989) (effective Jan. 1, 1990)). New York's PCAP now offers the maximum coverage allowed under federal reimbursement standards.

New York State elected to fund and administer its PCAP program through the state Medicaid program. Thus, within this Article, I use "Medicaid" as a proxy for "PCAP"—although other states that elect to participate in the Medicaid program may not similarly administer and fund their prenatal care programs. Nonetheless, to the extent that other states, like New York State, mandate the inclusion of the "extra-medical" within the realm of the medical—that is, to the extent that other states require pregnant women seeking prenatal care to meet with nutritionists, social workers, health educators, and the like—the critique offered within should be understood as relevant.

and industrial process. It is an effort to analogize the treatment of women's bodies at Alpha with the methodical creation of a product. In the case of pregnant women's bodies, however, the product that is ultimately produced is an unruly object that is most competently managed by trained professionals. Moreover, to say that pregnant women's bodies are "produced" as unruly—in lieu of describing their bodies as "treated" or "seen" as unruly—underscores that there is more at stake in the Alpha obstetrics clinic than the mere representation of poor women's bodies. That is, women's bodies *behave* as unruly when they are constantly measured, quantified, weighed, gauged, or otherwise assessed within a technology that speaks in terms of normal and abnormal. Variations from the norm become anxiety-marked occasions for further surveillance and the possibility of disciplining the body back to normality. The bodies "produced" by the obstetrics clinic through the nine month gestation of the fetus are not merely "conceptualized" as, or "regarded" as, unruly; they behave accordingly. I take this point up further in Part IV.

¶5 In the following section, I present Foucault's notion of biopolitics and explain its relationship to the regime of prenatal care at operation in Alpha Hospital. A detailed description of the apparatus of professionals that initiates women's prenatal care at Alpha follows in Part Three. Part Four continues with a description of the highly technological care that is delivered as a matter of course at Alpha. A brief conclusion follows in Part Five.

II. ALPHA OBSTETRICS AND THE FOUCAULDIAN BIOPOLITICAL PROJECT

¶6 Much has been written about the state's interest in the production and management of health—both of the individual and of the population.⁴ Foucault most famously, perhaps, elaborated upon this state interest via his notion of "biopolitics": Whereas in the classical age, state power was demonstrated in the exercise of producing death, in the modern age, "this formidable power of death . . . now presents itself as the counterpart of a power that exerts a positive influence on life, that endeavors to administer, optimize,

⁴ Most germane to my project is the literature that discusses the state's interest in reproduction. *See generally*, Paula A. Treicher, *Feminism, Medicine, and the Meaning of Childbirth*, in *BODY/POLITICS: WOMEN AND THE DISCOURSES OF SCIENCE* 120, 120 (M. Jacobus et al. eds., 1990) ("The health of childbearing becomes a signal for the health of the state. Accordingly, decisions about pregnancy, childbirth, and maternity have been concerns of the state as well as of the childbearing woman and her family."). This state interest in reproduction is pronounced during periods in which the birthrate is perceived as either decreasing precipitously or increasing dangerously. *See, e.g.*, Athena Athanasiou, *Bloodlines: Performing the Body of the 'Demos,' Reckoning the Time of the 'Ethnos'*, 24 *J. MOD. GREEK STUD.* 229, 239 (2006) (discussing the "demographic crisis" in modern Greece, and arguing that "[i]n the face of dwindling population, the *self-interest* of individual bodies joins forces with the larger *social good* of the body politic in ways that tacitly bracket the internal differentiation of the national body as such; at the same time, certain marked bodies (i.e., ethnic, racial, or sexual others) are excluded from the definition of the category of 'the people.'"); DAVID G. HORN, *SOCIAL BODIES: SCIENCE, REPRODUCTION, AND ITALIAN MODERNITY* 5 (1994) (discussing the fascist Italian state's concern with reproduction in the 1920s and 30s, as declining fertility and a range of other procreative practices were constructed as social problems; in response, the state developed a range of techniques of management and deployed a program of government designed to know, manage, and promote fertility); Leith Mullings, *Households Headed by Women: The Politics of Race, Class, and Gender*, in *CONCEIVING THE NEW WORLD ORDER: THE GLOBAL POLITICS OF REPRODUCTION* 125, 129 (Faye Ginsburg & Rayna Rapp, eds., 1995) (arguing that "[w]omen as mothers—who are involved in both biological and cultural reproduction—become master symbols of family, race, and civility, and are central to the authorized definition of the national community," and consequently, "[w]hen boundaries are threatened, rhetoric about fertility and population control escalates, and native Euro-American women, preferably those of the dominant class, are exhorted to have children").

and multiply it, subjecting it to precise controls and comprehensive regulations.”⁵ Foucault describes a “power over life” that

focus[es] on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy, and longevity, with all the conditions that can cause these to vary. Their supervision was effected through an entire series of interventions and *regulatory controls: a biopolitics of the population*.⁶

Following Foucault, prenatal care presents itself as an occasion par excellence for the state to “administer, optimize, and multiply” life, to subject the body to “precise controls and comprehensive regulations,” and to ultimately gain a modicum of control over “the level of health” of the population.⁷

¶7 Yet, pregnancy is not a legal event. That is, the fact of pregnancy alone does not put the pregnant woman within the jurisdiction of the biopolitical state. While the state may desire to exercise its “power over life” by submitting the expectant mother and her fetus to “an entire series of interventions and regulatory controls,” the pregnant woman is not compelled to surrender herself to such a state project. Again, this is because, at present, the fact of pregnancy alone does not enable the state to reach the woman and her pregnant body with its biopolitical power.⁸

¶8 The biopolitical state could achieve the regulation of every pregnant woman by creating a law that mandates that women receive prenatal care either from state actors or from persons that must otherwise answer to the state. However, at present, such a law does not exist. Indeed, there is no law in the United States that makes criminal or otherwise penalizes a woman’s failure to submit herself to *any* kind of prenatal care during her pregnancy. That is, should a woman undergo the forty weeks of pregnancy without ever having sought and/or received medical care from a physician, nurse practitioner, midwife, or other professional whose services are intended to ensure the birth of a healthy baby and the continued health of the new mother, I am not aware of any

⁵ 1 MICHEL FOUCAULT, *THE HISTORY OF SEXUALITY* 137 (Robert Hurley trans., 1980).

⁶ *Id.* at 139.

⁷ *Id.*

⁸ Foucault’s theory of biopolitics is remarkably elaborated upon when read in conjunction with historian Barbara Duden’s work on the fetus. Duden’s book, *Disembodying Women*, is a historicization of “life”—the religiously and morally significant notion that is, at present, hegemonically constructed as embodied in the biological fact of the fetus. BARBARA DUDEN, *DISEMBODYING WOMEN: PERSPECTIVES ON PREGNANCY AND THE UNBORN* (Lee Hoinacki, trans., Harvard Univ. Press 1993) (1991). Duden’s work encourages the reader to imagine an alternate place and space where the fetus is understood differently than it is at present; indeed, the fetus might be understood as little more than a “scientific fact” that appears some days or weeks after the union of sperm and egg. However, Duden argues that, presently, the fetus has become simultaneous with “life”; accordingly, the fetus has acquired the same religious and moral significance as “life.” A scientific object, then, has become imbued with devastating import. Moreover, caretakers of the fetus, i.e., physicians, have become charged with the magnificent duty of caring for “life.” *Id.* at 1-4.

Yet, it is instructive to think of Duden’s “life” alongside the “life” that is “administered, optimized, and multiplied” within Foucauldian biopolitics: That the biopolitical state would have an interest in pregnancy and obstetrical practice is a foregone conclusion when the (Foucauldian) “life” in which the state has an interest first manifests itself in the fetus as sedimentation of (Dudenian) “life.” FOUCAULT, *supra* note 5, at 137. Thus, prenatal care, as care of the fetus-cum-“life,” becomes a practice that the biopolitical state would insist upon regulating.

law that punishes such a woman's behavior, or lack thereof.⁹ In Colorado, a woman who exposes her fetus to controlled substances may be found to have neglected her child and, consequently, lose custody of the infant.¹⁰ And, of course, once a baby is born, there are a wealth of laws that punish a woman for directly harming or failing to protect her child. But, prior to a baby's birth, there is no law that penalizes a woman for "failing to protect" her not-yet-born child by neglecting or otherwise refusing to have a medically-managed pregnancy.

⁹ Interestingly, a woman that I interviewed told me that the social worker informed her that a woman will "get into trouble" if she gives birth to a baby at Alpha and there is a record of fewer than four prenatal care appointments for her. When I asked the social worker, in passing, if this was true, she laughed a bit and said:

If somebody comes . . . to deliver and it seems like they haven't been getting prenatal care here or elsewhere, what happens is that they will hold the baby until they can get a nurse to go to the home and see if everything is taken care of there. And once they get clearance, then the lady can take the baby home. It's not like they get in trouble. It's just that we have to clear the air because if she wasn't prepared enough to come to prenatal care, who says that she's prepared enough to take care of a baby? That's neglect. Why haven't you been getting your prenatal care? That's neglect. It can cause birth defects and all sorts of things like that. It's not that they lose their baby. It's just that we hold the baby long enough so that the nurse can check to see if there is a crib and things like that. . . . We want to clear the air. After that, we let them go. But, we don't want Alpha to be on the front page of the paper—saying that some lady took her baby home and bad things happened to it.

Relevantly, many visibly pregnant women present themselves for the first time to the Alpha obstetrics clinic—without medical records of earlier prenatal care. If these women cannot manage to be seen by the obstetrician four times before delivering their babies, then their babies will be held at the hospital until "the air is cleared" at their homes. Although the hospital's intent may be benign in refusing to release these newborns to their mothers, it is difficult to conceptualize the inability to take one's newborn home as anything other than "getting into trouble."

¹⁰ See *People ex. rel. T.T.*, 128 P.3d 328, 329 (Colo. App. 2005) (finding that although a petition for neglect could not be "filed with respect to an unborn child because a fetus is not specifically included within the statutory definition of 'child,'" a pregnant woman who uses drugs can be found to have neglected her "child" if the infant tests positive at birth for controlled substances); see also Me. Rev. Stat. Ann. tit. 22, § 4011-B (2007) (requiring "a health care provider involved in the delivery or care of an infant who the provider knows or has reasonable cause to suspect has been born affected by illegal substance abuse . . . [to] notify the [Department of Human Services] of that condition in the infant," yet clarifying that the statute "may not be construed to require prosecution for any illegal action, including . . . the act of exposing a fetus to drugs"); but see *State v. Luster*, 419 S.E. 2d 32, 34 (Ga. App. 1992) (holding that a pregnant woman "could not reasonably have known that she would be prosecuted for 'delivering' or 'distributing' cocaine to her unborn child if she ingested cocaine while pregnant, and thus she did not receive the 'fair warning' mandated by [Ga. Code Ann.] § 16-1-2(2) [(1968)]").

In *Killing the Black Body*, Dorothy Roberts gives a history of the punitive response that states have had toward women who use crack cocaine during their pregnancies. DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* (1997). Instead of helping these women gain control over their addictions and lives, many states opted to punish pregnant drug users by prosecuting them for crimes against their born and unborn children. A common punishment for women who abuse drugs while pregnant is the commencement of child abuse and/or neglect proceedings against them, and the subsequent state seizure of custody of their children. *Id.* at 159-60. Roberts recounts the story of the first conviction of a woman for exposing her baby to drugs while she was pregnant: Jennifer Clarise Johnson was convicted of two counts of delivering a controlled substance to her two children after they tested positive for metabolites of crack cocaine shortly after their births. However, because the relevant statute had not contemplated the delivery of a controlled substance to a *fetus*, the prosecution had to prove that Johnson "delivered" crack cocaine to her children after they were born. The prosecution accomplished this strange feat by offering the testimony of obstetricians who presented evidence that Johnson had passed crack cocaine to her children via the umbilical cord; moreover, some forty-five to sixty seconds would elapse between the child's emergence from the uterus and birth canal and the clamping of the umbilical cord. Hence, it was within those seconds that Johnson "delivered" crack cocaine to her already-born children. *Id.* at 162-67.

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Undoubtedly, the power of moral sanctions imposed upon pregnant women who fail to receive prenatal care should not be underestimated. Many of the pregnant women I have encountered at Alpha Hospital are very much aware of the “immorality” of a pregnant body unsupervised by a member of the medical establishment. On the unlikely occasion that a woman is not aware that a pregnancy unmanaged by medicine opens her up to moral condemnation, the employees of the OB/GYN clinic at Alpha Hospital often provide this education. For example: the majority of patients with whom I have spoken at Alpha Hospital’s OB/GYN clinic began their prenatal care shortly after discovering their pregnancies and deciding that they wanted to carry them to term—usually within the first twelve weeks of pregnancy. Then again, many patients decide to come to Alpha Hospital after becoming dissatisfied with the care that they have received at another hospital. These patients—usually quite far along in their pregnancies—are expected to bring along with them documentation of their prenatal care from the other hospitals. This holds true even though Alpha repeats all laboratory tests, ultrasounds, vaginal examinations, and the like conducted by other hospitals. Hence, asking a woman for her records from another hospital frequently functions only to shame those women who cannot produce such documentation and provoke them into defending their documentation-less status. Many times, women in the final weeks of their pregnancies, yet seeking to begin prenatal care at Alpha Hospital, cannot produce such documents because they have not been receiving prenatal care and have asserted that they were in fact receiving care at another hospital solely to avoid moral censure. I have observed on numerous occasions the women who work behind the front desk at Alpha Hospital—two women who greet women arriving for their appointments and take their relevant paperwork, and two other women who solely answer the clinic’s incoming telephone calls—exchange looks of disapproval when a visibly pregnant woman without documents seeks to begin her prenatal care at the hospital.¹¹ On one occasion, a prospective patient (who, I eventually learned, had recently arrived in New York City from the Dominican Republic) saw the disapproving glances and overheard a rhetorically-asked, “She doesn’t have any papers?” In response, the patient answered back defensively and insolently, “I was going to the doctor in my country, so don’t even worry about that!”¹²

¹¹ The phenomenon of requesting documents from patients in order to verify their receipt of prenatal care at another location is interesting when analogized to another issue that impacts the lives of many of the patients seeking prenatal care at Alpha Hospital—immigrant “illegality.” A person with a work or student visa, “green card,” or other paperwork affirming her authorized position within the borders of the United States—that is, a person with proper documentation—is said to be a “legal” immigrant to the United States. Conversely, a person without such papers becomes identified as an “illegal alien.” Thus, the presence or absence of documents determines the “legality” of a person. One might say that a similar operation is at work in the prenatal care context: Those persons who can produce proper documentation of their prenatal care have “legal pregnancies.” Those without proper documentation have “illegal pregnancies.” Of course, the “legality” of a pregnancy just sketched has no relationship to the state and law insofar as a woman cannot be punished by the state even if she is discovered to have an “illegal pregnancy.” However, the “legality” of a pregnancy unquestionably impacts the way a woman is treated when she first presents herself to the frontline at Alpha Hospital.

I intend to explore the larger phenomenon of the fetishization of paper generally in the OB/GYN clinic at Alpha Hospital in a later piece.

¹² Whether Alpha Hospital employees actually *believe* the accounts that women tell to explain their lack of documentation is another story altogether. Minnie, a Patient Care Assistant (PCA, or medical assistant) who often does intake work behind the front desk and has worked at Alpha Hospital for twenty-five years said: “These patients tell you this and they tell you that. Who knows what they did in their country? Who knows how they got here [to the United States]? That’s not my business. My business is to help them.”

¶10 Although such moral sanctions are a powerful and effective force—which, at the very least, inform women that failing to receive prenatal care is commonly viewed as irresponsible behavior, but, more likely, induce pregnant women to actually submit themselves to prenatal care—these moral sanctions are not “law.” Undoubtedly, moral sanctions might and should be understood as assisting the state’s endeavor to encourage poor women to submit themselves to a state-invested prenatal care program: a woman’s feelings of guilt, due to moral condemnation of her medically-unsupervised pregnant body, may cause her to seek prenatal care. If the only medical care she can afford is that which is subsidized by the state, then the state finds itself a new subject upon her acceptance of state-subsidized care, brought forth by acts of extralegal morality. Nevertheless, morality is not law. That is, although moral sanctions may be analogized to the law insofar as both have blanket applications and potentially punitive natures, the state is not invested in moral sanctions and cannot directly use them to comprehensively regulate the pregnant body. Finally, moral sanctions do not allow the state to fill the extralegal, interstitial space of pregnancy.¹³

¶11 While moral sanctions do not create legal subjects located within the state’s biopolitical enterprise, Medicaid might. At Alpha Hospital and other facilities that accept Medicaid insurance coverage for prenatal care, state subsidization of a pregnant woman’s medical expenses via Medicaid functions as a carrot that entices women to submit themselves to state supervision, management, regulation, and discipline. Women are offered a contract where, in exchange for the state’s payment of medical bills, they are

It should be noted that the disbelief of patients’ prenatal care stories is part of a larger phenomenon whereby patients are largely viewed by Alpha Hospital frontline employees as uneducated, yet somehow incredibly shrewd, manipulators of the “system.” I intend to explore the intersection of these contradictions in the fantasy of the patient—that is, the figure of the “wily patient”—in a later piece.

¹³ The state’s interest in pregnancy, and the concomitant creation of legal subjects of pregnant women, might be explained differently—if one begins with the assumption that the state’s power is partially a product of its omnipresence. One could theorize that it is the inability to avoid the law and the consequent potential for state-sanctioned violence that contributes to the state’s strength. Admittedly, this is not a new conceptualization of law: Walter Benjamin theorized a law that sought to be present enough to colonize all acts of violence, which he considered a natural datum that necessarily undermined the state-qua-law. He writes:

[T]he law’s interest in a monopoly of violence vis-à-vis individuals is explained not by the intention of preserving legal ends but, rather, by the intention of preserving the law itself; that violence, when not in the hands of the law, threatens it not by the ends that it may pursue but by its mere existence outside the law.

1 WALTER BENJAMIN, *Critique of Violence*, in *SELECTED WRITINGS*, 1913-26, at 239 (Marcus Bullock & Michael W. Jennings eds., 1996). Because extralegal violence threatens law, law must be present in all places where violence might be exercised: “[T]his legal system tries to erect, in all areas where individual ends could be usefully pursued by violence, legal ends that can be realized only by legal power.” *Id.* at 238. What Benjamin presents is an explanation of law’s ubiquity.

But what about those areas that law has failed to colonize? How does law assert itself in those interstitial spaces that exist between legal power? Does the state-qua-law simply accept a weakening of its strength? Or, more likely, does the state-qua-law attempt to assert itself in those interstitial spaces? When the law cannot colonize by force, does the law then seek subjects who voluntarily submit themselves to its jurisdiction, thereby maintaining law’s ubiquity, omnipresence, and consequent power? It would seem logical that the state-qua-law would want to assert itself in the interstitial space of pregnancy because not only would the state’s absence there weaken law’s power, but also because pregnancy is yet another occasion to create legal subjects of women. Pregnancy is an almost ideal opportunity to entice women—especially poor women—to put themselves within the state regulatory apparatus. So, the infiltration of the law into the interstitial space of pregnancy becomes the state’s goal.

obliged to open their lives to state intervention. A description of the process of initiating prenatal care at Alpha Hospital illustrates the point.

III. PRENATAL CARE ASSISTANCE PROGRAM: INITIATION INTO THE STATE REGULATORY APPARATUS

¶12 At Alpha Hospital, a woman must first take an Alpha Hospital-administered urine test to confirm her pregnancy—without regard to whether she has already confirmed her pregnancy with an at-home test.¹⁴ A woman must then wait for the pregnancy test results to be inputted into her electronic medical records (which usually takes one business day) before she can receive her initial Prenatal Care Assistance Program (PCAP) appointment. A woman can only bypass the additional waiting period generated by the necessity of waiting for the results of the hospital-administered pregnancy test if she has documentation from another hospital or clinic confirming her pregnancy. If she does, then she is immediately given an appointment to return for her PCAP visit.¹⁵

¶13 On the day of her PCAP appointment, a woman meets with many Alpha Hospital employees, each of which is described in the following sections.¹⁶

¹⁴ There was some controversy in the clinic as to whether visibly pregnant women should be required to take an Alpha Hospital-administered urine test to confirm their pregnancies. There was a contingent of staff who believed that all women, regardless of physical condition, should be tested for pregnancy. Another contingent believed that pregnant women need not confirm their pregnancies via urine testing when they were “showing.” Thus, whether a visibly pregnant woman seeking to initiate prenatal care at Alpha had to re-confirm her pregnancy by taking a hospital-administered pregnancy test depended on who was working at the front desk when she first presented herself.

Interestingly, Betsy Gotbaum, the Public Advocate for the City of New York, released a report in May 2007 describing the requirement that a woman re-confirm her pregnancy with a hospital-administered pregnancy test as a “barrier” to prenatal care. BETSY GOTBAUM, OFFICE OF THE NEW YORK CITY PUBLIC ADVOCATE, HURDLES TO A HEALTHY BABY: PREGNANT WOMEN FACE BARRIERS TO PRENATAL CARE AT CITY HEALTH CENTERS 9 (2007), available at <http://pubadvocate.nyc.gov/policy/documents/HurdlestoaHealthyBaby.pdf>. Gotbaum conceptualized the requirement as a “barrier” to care because a woman must be physically present in the hospital to re-confirm her pregnancy in this way; consequently, the requirement prevents women from making prenatal care appointments over the phone. Yet, the problem is even more severe than Gotbaum’s report reveals insofar as women cannot simply make the desired appointment on the day that they physically present themselves to the hospital. Rather, they must also wait another twenty-four hours after submitting their urine for pregnancy testing—when the results are inputted into the computer system—before they can make an appointment for prenatal care. Gotbaum argued that “Requiring a visit to conduct a pregnancy test prior to a prenatal care appointment is an unsound and unnecessary policy.” *Id.* at 12. She recommended that “Instead of requiring an additional visit, clinics should confirm pregnancy at the time of the first prenatal appointment. If the clinic-based pregnancy test produces a negative result, the appointment should be used to provide the woman with preconception or interconception care, or family planning and contraception counseling as appropriate.” *Id.* at 3.

¹⁵ Notably, Gotbaum also described as a “barrier” to prenatal care the necessity that women meet with a registered nurse, HIV counselor, nutritionist, and social worker prior to having a medical examination. She says:

Requiring multiple visits prior to the first prenatal care appointment not only delays entry into prenatal care for pregnant women but also may discourage women already struggling to juggle the demands of work and/or childcare or overcome other barriers to appropriate health care, such as immigration, language, or transportation issues, or stigmatized behavioral issues. While social workers, HIV counselors, and nutritionists provide valuable services, meeting with them should not be a precondition for prenatal care

Id. at 13.

¹⁶ It should be noted that the PCAP appointment day tends to be an extremely long one, principally because the woman must meet for long periods of time with several people. Sometimes “PCAP patients,” which is their moniker on the day of their PCAP appointment, have to wait for one of the people with whom they

A. *Registered Nurse*

¶14

The nurse takes the woman's medical history, asking if she has ever had any of a number of medical problems, e.g., diabetes, hypertension, heart disease, gynecologic surgery, anesthetic complications, and uterine anomalies. The nurse also records information about any past pregnancies a woman has had—whether any were ectopic or multiple, whether she carried the pregnancy to term or had a spontaneous or induced abortion, and whether she suffered any complications during the pregnancy, labor, or delivery. The nurse documents whether the woman has had any history of mental illness, whether she has experienced trauma or violence in the past, and whether she consumes tobacco, alcohol, or any other “illicit/recreational drugs” and, if so, in what amounts.¹⁷ The nurse also provides the patient with what is called “education”¹⁸—involving a number of matters that could conceivably affect the patient's pregnancy, e.g., sexual activity, exercise, travel, domestic violence, seatbelt usage, and the use of any medications (“including supplements, vitamins, herbs, or O[ver] T[he] C[ounter]

must meet to complete other obligations. Additionally, if the patient does not speak English or Spanish (most of Alpha Hospital employees who meet with PCAP patients know enough Spanish to conduct their portion of the PCAP visit with patients who speak Spanish only), this language barrier tends to lengthen the visit. The Alpha Hospital employee must then use the “language line”—a telephone with two receivers that connects the employee and patient to a translator over the phone. The necessity of waiting for a translation of every question and response almost doubles the length of the visit and potentially delays the ability of the employee to begin her session with the next scheduled PCAP patient. Thus, women who have arrived on time for their PCAP appointments may end up waiting another hour or two before they begin their sessions. And again, once begun, their sessions may last two or three hours.

I stress the length of the PCAP day because it might be understood as training women to accept a common characteristic of “public” institutions: hideously long waiting periods. Accordingly, the PCAP day and its length teaches women that public institutions, which Alpha exemplifies, are frequently too understaffed to effectively and efficiently meet the needs of those that depend on them. Insofar as the poor are compelled to rely upon public institutions more than their non-poor counterparts, the length of the PCAP appointment day might be understood as educating PCAP patients about what it means to be poor in the United States, how the poor are commonly treated, and the expectations that the poor should have when negotiating these institutions.

¹⁷ All of this information is recorded on a standardized form produced by the American College of Obstetricians and Gynecologists (ACOG)—the ACOG Antepartum Record. (ACOG is a non-profit organization comprised of physicians that sets standards of healthcare in the OB/GYN specialty.) The form solicits sociological data such as birth date, age, marital status, and, interestingly, race. ACOG Antepartum Record, Form A (on file with author).

¹⁸ The language used by Alpha employees and on Alpha forms is “education”; that is, Alpha employees are expected to “educate” patients. For example, an itinerary of the employees with whom the patients meet on the day of their PCAP appointment is listed on the “Patient Education Flow Sheet”; the matters that they discuss are broken down into “1st Trimester Education Topics,” “2nd Trimester Education Topics,” and “3rd Trimester Education Topics”; further, the Alpha employee must document that each topic was discussed by checking a box marked “health education/literature given.” Alpha Hospital Patient Education Flow Sheet (on file with author). Alpha Hospital's use of the term “education,” in reference to the vast quantities of information given to women during their PCAP appointments and over the course of their pregnancies, mirrors the language of the ACOG Antepartum Record forms, which label the topics that should be discussed with the patients as “Plans/Education.” ACOG Antepartum Record, Form E (on file with author). Then again, ACOG articulates the objective of the organization as the promotion of “patient education and [the] stimulati[on] of patient understanding of and involvement in medical care.” American College of Obstetricians and Gynecologists, <http://www.acogupdate.com> (last visited Jan. 18, 2008). Nevertheless, I find the use of the term “education” problematic insofar as Alpha employees inform their patients about only one—albeit the dominant and most powerful—model of pregnancy and childbirth: the biomedical model. It might be more appropriate to regard the program of knowledge given to the patients by Alpha employees as “training,” as opposed to “education.” Cf. DUDEN, *supra* note 8, at 25 (“Each prenatal visit to the clinic serves as a training session for the forthcoming game.”).

drugs”).¹⁹ Additionally, the nurse draws blood and takes a urine sample from the patient in order to conduct a battery of tests, including blood type, Rh type, and hemoglobin electrophoresis. The nurse’s final task is to refer the patient to the Women, Infants, and Children Program for Pregnant, Breastfeeding, and Postpartum Women (WIC) by completing a medical referral form.²⁰ The patient must take the form to the WIC office in Alpha Hospital to receive food vouchers, which can be redeemed at grocery stores and farmers’ markets that have been approved by the New York State Department of Health (NYSDOH).

B. HIV Counselor

¶15 As per NYSDOH guidelines, all patients must receive counseling as to the “benefits of HIV testing as early in pregnancy as possible to reduce perinatal transmission” and the “meaning of the test results for both mother and newborn.”²¹ Further, all patients receive an “explanation that all cases of HIV infection and names of all partners known to the provider will be reported to the NYSDOH for epidemiological and partner/spousal notification purposes only.”²² Hence, all PCAP patients meet with a counselor who discharges this duty. If the patient assents to the test, the blood drawn by the nurse is tested for the presence of HIV-antibodies. If the woman does not assent to the test, the counselor must document the articulated reasons for declining testing.²³

¹⁹ ACOG Antepartum Record, Form E, *supra* note 18. At a prenatal care visit that takes place later in the pregnancy, patients are counseled on the “signs and symptoms of preterm labor, anesthesia/analgesia plans, fetal movement monitoring, circumcision, breast or bottle feeding, postpartum depression, and newborn car seat.” Interestingly, patients are also counseled on “postpartum family planning/tubal sterilization.” At the bottom of the form is a place where the nurse should indicate whether the “tubal sterilization consent [has been] signed.” *Id.* My initial query is to wonder whether the concern with contraception—especially permanent sterilization—would hold true for patients whose pregnancies are not problematized, i.e., non-poor, non-immigrant, “non-raced” (read: White) women.

²⁰ WIC is a federal program, administered by the New York State Department of Health (NYSDOH), whose mission is “to safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.” Women, Infants, and Children Program for Pregnant, Breastfeeding, and Postpartum Women, About WIC, <http://www.fns.usda.gov/wic/aboutwic/default.htm> (last visited Jan. 14, 2008). WIC participants receive food vouchers for “foods [that] are high in one or more of the following nutrients: protein, calcium, iron, and vitamins A and C. These are the nutrients frequently lacking in the diets of the program’s target population. Different food packages are provided for different categories of participants.” UNITED STATES DEPARTMENT OF AGRICULTURE, WIC FACT SHEET 2 (2006), *available at* <http://www.fns.usda.gov/wic/WIC-Fact-Sheet.pdf> (last visited Jan. 18, 2008) [hereinafter WIC FACT SHEET].

²¹ This language is taken from the “Alpha Hospital HIV Pre-Test Counseling” form, which is not a form prepared by NYSDOH. Alpha Hospital HIV Pre-Test Counseling Form (on file with author).

²² *Id.*

²³ Because I have never observed an HIV counseling session (for confidentiality reasons), I am not aware to what extent and how the counselor encourages the woman’s acquiescence to HIV testing. A denial of testing by the patient appears to be disfavored, although the fact that a positive test result is shared as a matter of course with the patient’s partner may represent a massive deterrent to a woman’s consent to testing. One patient, with whom I developed a friendship over the course of her pregnancy, declined testing at Alpha because, since becoming aware of her pregnancy, she had been tested twice for HIV at other healthcare facilities. From notations made in her chart, it appears that employees at Alpha asked the patient for consent to HIV testing at every prenatal care visit—that is, until she produced documentation of the negative test results from one of the other facilities at which she was tested. This patient’s experience makes it appear that HIV testing is highly encouraged at Alpha.

C. Nutritionist

¶16 Each patient must meet with a nutritionist who documents the patient's diet, records any known food or non-food allergies, notes whether the patient has had any difficulty eating due to nausea or vomiting, and provides information to the patient about the nutritional needs of women during their pregnancies. During the meeting with the nutritionist, patients are asked to record what they ate for breakfast, lunch, and dinner the day before. Afterwards, they are given a chart with an itemization of foods (e.g., milk, cheese, meat, eggs, fruit, cereal); then they are asked to circle the number of times per day (or alternatively, per week) foods are consumed. After the assessment, they are given information about the prenatal diet's relationship to a "healthy baby," dietary recommendations for pregnancy, and "tips" on how to increase or control weight gain, as needed. Should the nutritionist find the patient's diet unsatisfactory, she checks a box labeled "inadequate/unusual dietary habits" and asks the patient to make a verbal commitment to meet the nutritional needs of herself and her fetus.

¶17 Interestingly, the nutritionist's assessment of the patient's diet has a direct relationship to a woman's eligibility for WIC. Because, by statutory caveat, WIC food vouchers are only available to those pregnant women who are at "nutritional risk," it is in the patient's interest—that is, if she is interested in receiving WIC vouchers—that the nutritionist find fault with her diet and, concurrently, enable her eligibility for WIC.²⁴ In fact, most of the pregnant patients at Alpha with whom I have spoken had been approved for WIC and were receiving food vouchers.²⁵ This leads me to believe that, as a practice, the nutritionist summarily deems a patient's diet insufficient in order to qualify her for WIC. An example from a patient's chart: After assessing the patient's diet, the nutritionist wrote, "Diet needs improvement—limited intake [of calcium] food, protein food, fruits and juice." However, the patient appeared (to the lay observer) to have an adequate diet and a healthy appetite: the previous day, the patient drank tea for breakfast, ate a sandwich with turkey, cheese, lettuce, tomatoes and mayonnaise for lunch, ate rice with broccoli in garlic sauce for dinner, and snacked on a banana post-dinner. Moreover,

²⁴ The statute specifies that in order for a woman to be certified as eligible for WIC, she must be "determined to be at nutritional risk. . . . This determination may be based on referral data submitted by a competent professional authority not on the staff of the local agency," e.g., a nutritionist employed in the clinic where a woman receives her prenatal care. 7 C.F.R. § 246.7e (2006). A woman should be deemed eligible for WIC if she has "[d]etrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements, such as anemia, underweight, overweight, abnormal patterns of weight gain in a pregnant woman," "[o]ther documented nutritionally related medical conditions, such as clinical signs of nutritional deficiencies, metabolic disorders, [or] . . . a history of high risk pregnancies or factors associated with high risk pregnancies (such as smoking; conception before 16 months postpartum; history of low birth weight, premature births, or neonatal loss; adolescent pregnancy; or current multiple pregnancy)," "[d]ietary deficiencies that impair or endanger health, such as inadequate dietary patterns assessed by a 24-hour dietary recall, dietary history, or food frequency checklist," or "[c]onditions that predispose persons to inadequate nutritional patterns or nutritionally related medical conditions, such as homelessness or migrancy." *Id.*

²⁵ There was one patient with whom I built a rapport who declined to receive and redeem the WIC food vouchers for which she had been approved. Her reason for declining state aid in the form of subsidization of her food expenses was her belief that if she could afford to bear the expense on her own, she should. She said, "I'm okay [financially] for now. When the baby comes, I'll use it—but, not really for that [the milk and cereal that WIC provides women]. Just for, like, formula, because that's expensive." Interview with anonymous obstetrics clinic patient (July 2007). There seemed to be a shame associated with the receipt of food vouchers that this woman wanted to avoid for as long as she could. I intend to explore issues of welfare, shame, and race in a later piece.

although the nutritionist had noted that the patient had a “limited intake” of calcium, protein, fruits, and juice, the patient had indicated that she consumed milk, cheese, eggs, and beans more than four times per week, drank juice as often, and ate fruits and vegetables at least twice a day. Nevertheless, per a notation in her chart, the patient was referred for and enrolled in WIC.

¶18 The one patient that I met who did not receive Medicaid and was paying for her prenatal care out-of-pocket, Irina, is a revealing outlier. Irina had refused to enroll in WIC, and in her chart, the WIC medical referral form was blank, save for the nurse’s scribbling of “PT REFUSED.” Nevertheless, the nutritionist had indicated that the patient’s “diet needs improvement . . . Limited in protein food, fruits, juice and vegetable. Eats sugar cereals.” The nutritionist had also checked a box indicating that the patient was at “moderate risk” due to her “inadequate/unusual dietary habits.” Like the case cited above, Irina had consumed an ostensibly healthy amount of healthy foods over the course of the previous day: Cheerios with soy milk, orange juice, a roll, an egg, two servings of cheese, several glasses of water, beet soup, bread, avocados, bean sprouts, lettuce, a glass of soy milk, vegetable soup, yogurt, peach cobbler, decaffeinated tea, and Corn Pops.²⁶ Irina’s case would seem to indicate either that the nutritionist deemed her diet insufficient only because the nutritionist did not know that Irina was uninterested in enrolling in WIC and, otherwise, would not have found fault with her diet as she did, or alternatively, that the nutritionist summarily disapproves of every patient’s diet. Either way, I find the presumptive condemnation of women’s diets a bit disturbing as a moralistic gesture—even when done with the design to enable WIC eligibility. One could imagine an alternate space where WIC eligibility is not endangered by a nutritionist’s honest and reasonable finding that a woman’s diet is indeed healthy.

¶19 I would like to stress that while many women with whom I have spoken welcome their meetings with the nutritionist and appreciate the information given to them, just as many women found the coerced consultation offensive. For example, when I asked Willa about her meeting with the nutritionist, she said, “I get really uncomfortable talking to nutritionists.” When I asked her why, she said:

Willa: I don’t like to do it. It makes me really uncomfortable.

Khiara: Really? Why is that—do you think? Has it always been that way?

Willa: Yeah. Because it’s always been such an issue of tension. And my family has always been so much about healthy eating—but, we’re all fat. So, it really stresses me out. Like, we’re all overweight. Yet, we’re always so educated. So, it makes me angry. . . . And I always feel like I’m not really eating the way I should. . . . No—it’s true. I don’t like talking about it. It’s weird. Can we change the subject, please? [Laughs.]²⁷

²⁶ During our interview, this patient provided more color to her session with the nutritionist during which she received her nutritional assessment: “The nutritionist told me that I wasn’t eating enough dairy or something and I was like . . . Cottage cheese has been my craving and that’s my—really, my first trimester craving was cottage cheese with Thousand Island dressing on it. Now I’d probably vomit if I ate that. But it was delicious at the time.” Interview with anonymous obstetrics clinic patient (June 2007).

²⁷ Interview with anonymous obstetrics clinic patient (June 2007).

¶20 While I was happy to oblige Willa by immediately asking her a question about a different topic, I imagine that she could not so easily “change the subject” during her requisite meeting with the nutritionist.

¶21 Another example: I made polite conversation with a woman, Gladys, whom I had interviewed earlier in her pregnancy. She told me about recent developments in her life and her excitement about her baby’s upcoming birth. She also told me about a conversation with the nutritionist that she had had at her last prenatal care visit two weeks prior. She said:

She [the nutritionist] was trying to tell me that I had gained too much weight. Just a couple of weeks ago, they were trying to tell me that I wasn’t gaining enough weight. Now, she’s trying to tell me that I’m overweight. I’m not overweight; I’m normal. Hello? I’m Black. I have hips. I have a butt. [Laughs.] I’m supposed to go back to see her today, but I’m not going to.

I cite these examples to emphasize that coercing a woman to confess her dietary habits to a nutritionist is not always a benign affair.

D. Social Worker

¶22 Although oddly paired, the screening that the nutritionist performs is identified as a “Nursing Nutrition/Psychosocial Assessment.” Thus, after the nutritionist asks the patient questions about food allergens, diet, and eating problems, she then determines whether the patient has any of the “risk factors” identified on the “Alpha Hospital Psychosocial Screening” form. These factors are the following: “unwanted pregnancy; teen pregnancy; foster care/surrender for adoption planned; HIV positive; [history of] or current substance abuse; high risk medical problems/poor [obstetric history]; anxiety; lack of familial/environmental support system; marital/family problems; domestic violence; depression; concern [regarding] capacity to care for a newborn; retardation; [history] of psychiatric treatment/or current emotional disturbance; lack of entitlement/benefits; homeless/shelter resident.”²⁸ There is also a box to check if “no referral [is] necessary at this time.” If the nutritionist deems a social work referral appropriate for a patient, she escorts the patient to the social worker’s office. The social worker then acquires more information from the patient about the “risk factor,” and if necessary, puts her in contact with additional professionals who can assist her.

¶23 In practice, the above mentioned list of risk factors is not exclusive, and the expectation is that the social worker will see *all* of the PCAP patients who come through the obstetrics clinic. As explained to me by one of the social workers, Medicaid eligibility is sufficient to establish the woman as “at social risk,” thereby making a social work referral apt and appropriate. Accordingly, all PCAP patients are compelled to meet with a social worker and encouraged to divulge personal information.²⁹ To a pregnant

²⁸ Alpha Hospital Psychosocial Screening Form (on file with author).

²⁹ It should be noted that although all Alpha patients are required to meet with a social worker, the social workers are not always successful in meeting with all of the patients. Tina, one of the social workers, explained to me (with a great degree of frustration) that this is primarily because Alpha PCAP patients must meet with a number of staff members on the day of their PCAP appointments. Meetings with the social

woman solely expecting routine prenatal care during her visit to the hospital, it may seem a bit *odd* that prior to having a standard and routine medical examination by someone qualified to do so, she must meet with a social worker and be expected to take on a confessional posture.³⁰

¶24

The invasive nature of a coerced confessional may be somewhat mitigated by the fact that many patients' meetings with the social worker are uneventful.³¹ When a

workers are commonly viewed as less important than the numerous blood and urine draws, the nutritional assessment/WIC referral, and the Medicaid subscription process with the financial officer. Hence, the requisite meeting with the social worker is often bypassed if time limitations compel it. Tina explained, "Yes, we miss a lot of people, which is a problem, because we're supposed to see one hundred percent. It's a really bad situation because everyday there are PCAPs. Everyday, there are new patients. So, it's difficult as it is to catch all of the new ones each day. So, if you miss one, well—you may catch her at her next visit. But, on her next visit, there's a whole set of new patients, which you have to see all of. So, missing a patient—yeah, it's a bad situation." Interview with anonymous social worker (Jan. 2007). She added that she and the other social worker were not penalized—"other than the embarrassment"—for failing to see all of the PCAP patients.

However, all women who deliver at Alpha Hospital are required to meet with a social worker prior to being discharged from the hospital and taking their babies home with them. Tina stated that as a result, "if there isn't already a database on them, then they'll create one then." *Id.* Accordingly, it appears difficult for a patient to avoid the compelled confession that is simultaneous with a required social work consultation.

³⁰ Undoubtedly, the assistance given by the social worker is desired by many patients. I have encountered many patients who, during subsequent visits to the clinic for prenatal care, request to speak with the social worker with whom they met during the initial PCAP visit. For example, one patient, who had become homeless and was consequently placed in temporary/emergency housing by the New York City Department of Human Services ("DHS"), had been transferred to another shelter that she believed was unsanitary and located irresponsibly far from Alpha Hospital. She sought out the social worker, who documented that conditions at the shelter were unsatisfactory, with "bedbugs and poor kitchen amenities in which to refrigerate the milk she receives from WIC and to cook and adequately feed herself/baby." Time was of the essence, for if the patient stayed in the shelter for more than 48 hours, it was to be deemed a "permanent placement," thereby making it incredibly (read: bureaucratically) difficult for her to be reassigned to another DHS shelter. To assist the patient, the social worker obtained a letter of "Medical Necessity" from the patient's provider—a midwife—stating the midwife's request that the patient "be transferred for medical necessity and the health of her child to a facility suitable for a pregnant women [sic] and closer to our facility." Due to the assistance of the social worker, the letter was obtained on the day the patient requested it, and the patient was moved to a more hygienic shelter that was, indeed, closer to Alpha Hospital.

³¹ The following record of a patient's meeting with the social worker is similar to many of the social worker's notations made in patients' charts, and is, therefore, characteristic of the exceedingly mundane quality of a large portion of the social worker's interactions with patients:

Pt [patient] is a 29 y/o, Polish, married, female who is pregnant [. . .]; EDD [expected date of delivery] 7-3-07. Pt was referred from HRC [High-Risk Clinic] to be seen for a routine psychosocial assessment. Pt is seen in High Risk clinic diagnosed with Thyroid since two years ago. Pt uses Thyroxin 125mg. Pt states her mother has High Blood Pressure. Pt has Medicaid and Metro Plus number [. . .]. Pt states that she and husband [. . .] 28 y/o are happy about this unplanned pregnant [sic]. Pt cell phone number is [. . .] and home phone number is [. . .]. Pt reports a stable marriage for five years. Pt lives with husband and he is only support system. Pt is alert and participated. Parents are in Poland with one sister. Pt is the youngest child in the family, born and raised in Poland. Pt completed 5 years of college education in Poland, can read and write in English and Polish. Pt is employed part time as a Bookkeeper [sic] and earns \$128.00 [per week]. Husband work [sic] as an electrician his salary is \$400.00 a week. Pt. denies any history of substance and sexual abuse, arrest, psychological problems or domestic violence.

Pt was referred to social work from PNC [Prenatal Clinic] to be seen for a routine psychosocial assessment. Pt is domiciled and undocumented. Pt was alert and oriented. Pt has an [sic] limited support system. Pt was receptive to social work intervention and answered all questions asked. Pt will breast and bottle feed the baby. Pt will think about contraceptives and CNS for

woman has “no issues,”³² such social work referrals may be perceived as just another bureaucratic hurdle a woman must overcome before having a medical examination. Tina, one of the social workers, explained that a patient with “no issues” simply will be given a packet of information on physiological changes she can expect during pregnancy and social services available to pregnant and parenting women. Even so, Tina acknowledged that the intervention that she is required to make by Medicaid has a strange location within the obstetric clinic:

Tina: A lot of times, the patients don’t know why they have to see a social worker. It’s really strange. But, it’s required by PCAP—their insurance.

Khiara: Most of the time, do patients volunteer—well, let’s say that [the nurse] brings [a patient] over. Would she be receptive to social work? Most of the time, do you find that?

Tina: Very rarely—usually when they decline, there’s something to hide. But generally, even if they’re not thrilled—if they didn’t come to the hospital and say, “OK, I want to see a social worker!” . . . Even if that’s not how they’re coming, once they are here, they participate. And then once you give them the packet of information, they’re appreciative. Even the experienced mom is appreciative of the information packet.³³

¶25

Alternatively, social work referrals may be perceived as a gross, unwelcome imposition into matters seemingly irrelevant to the desired prenatal medical examination, which, it should be underscored, is the principal reason women present themselves to the

well care baby. Pt was counseled on the importance to comply with appointments and preparations for the birth of baby such as crib, car seat and clothing. This interview was conducted in English. Pt will continue [prenatal care] at Alpha Hospital.

³² Tina gave me an exhaustive list of the questions that she asks patients during their social work screening:

Was this pregnancy wanted and do you want to have this baby? Do you have any experience? . . . If you’re a first-time mom, do you have anybody who can teach you how to take care of a baby? Is the father involved? Do you have a place to live? Money to buy things for the baby? A social support system? Do you have anything in your history that might make the parenting difficult? There might be things that surface for you at a time when you need to be at your best for your baby. Is there any child abuse, sexual abuse, domestic violence? . . . Is there any substance abuse? Does she consider it a problem? Is she in a program? Has she been arrested? Has she ever had any children taken away from her—which means that she has a history of poor parenting? Are you breastfeeding, bottle-feeding? Did you apply for WIC? . . . After you deliver this child and are taking care of a newborn, do you plan on having another baby right away? If you’re not, it’s easier to not [become pregnant again] if you [choose a contraceptive that you could leave in place for long periods of time]. Do you know what options are out there? Are you going to breastfeed? If you are, there are [contraceptives] that are better while you’re breastfeeding. Do you have everything that you’re going to need to know? Do you want parenting classes? Yes—you can go here for them. Do you have everything that you’re going to need for the baby? No—try going to this place. Maybe they can help you. You have to be in the best condition that you can be in for your baby. So, maybe you should get counseling. Here are some places that you can go.

Interview with anonymous social worker (Jan. 2007).

³³ *Id.*

obstetrics clinic at Alpha Hospital. One patient's file revealed such a polemical encounter, per the social worker's notation recorded in the medical record:

Pt [patient] is a 32 y/o Hispanic, single, female who is pregnant . . . ; EDD [expected date of delivery] 6-10-07. Pt was seen for a follow up on ACS [Administration for Children's Services] cases. This worker tried to get information from patient regarding the new case that ACS worker Mr. Jones mention [sic] to this worker but patient just stated that there is nothing new to report. Mr. Jones did not allow Ms. Jane Doe the new worker on the case [to] talk to this worker. Ms. Doe's tel. Number is [. . .] Mr. Jones telephone number is [. . .]. This worker discuss [sic] the case with Supervisor, Hannah Williams who is going to follow it.

¶26 In this instance, the patient was discovered to be the subject of an investigation by ACS, the bureau of municipal government responsible for protecting children from abuse and neglect. The patient appears to have viewed the compelled meeting with the social worker as an undesired and undesirable imposition and, consequently, refused to cooperate with the social worker. The social worker, in turn, contacted the ACS caseworkers directly, and, failing to acquire their cooperation, referred the matter to her immediate supervisor, who "is going to follow it." This is a remarkable sequence of events when considered in context—a woman's presentation at a hospital for routine prenatal care.³⁴

¶27 Furthermore, obligatory social work consultations are potentially less problematic when they are designed to empower the woman by providing her with information and services of which she may avail herself. Yet, on many occasions, it becomes obvious that the social worker is instead situated antagonistically to the woman; that is, the social worker reveals herself to be acting as the agent of a potentially punitive state.³⁵ Below, I quote at length a portion of an interview that I conducted with a patient, Ashley, and her boyfriend, Paul:

Khiara: And you spoke to the social worker. How was that meeting with the social worker? Uneventful?

³⁴ I had the pleasure of speaking with this patient, Rhonda, at length during an in-depth interview. She explained to me that she had become the subject of an Administration for Children's Services [ACS] investigation as the culmination of a succession of events. Her youngest son was born at 24-weeks gestation, and as a result, is severely physically and mentally disabled. He is seen by a specialist in Alpha Hospital, who as Rhonda explained, is committed to seeing her son walk. (At present, he is confined to a wheelchair.) When Rhonda became ill due to her pregnancy, and was unable to take her son to one of his regularly-scheduled doctor's appointments, the physician reported her to ACS—the rationale being that she was "neglecting" her son by failing to bring him to his physical therapy. Rhonda was not angered by having been reported to ACS by her son's physician. She says that her son's physician jokingly told her, "You know I called the peoples [sic] on you. But, it's because I want to see my boy walk." She also says that the visit to her home by ACS investigators was uneventful; they "looked around and left." But, she was fearful that the social worker from the obstetrics clinic would reactivate ACS's interest in her by making unnecessary inquiries into a matter that had already been resolved. Interview with anonymous obstetrics clinic patient (Jan. 2007).

³⁵ I do not mean to argue that the social workers are *always* acting as agents of a potentially punitive state. Instead, they always have the potential to *become* agents of that state. Accordingly, it appears rather invidious to compel a woman to confess information about herself to an individual who has the option of using that information against her.

Ashley: Yeah. I didn't like her. . . .

Khiara: What didn't you like about her?

Ashley: I thought she was very forceful. And I didn't like her attitude. They were like—I have some mental health issues And I told her about them—just being honest and everything. And she was like, “You know, you're going to have to go see the psychologist. And if the psychologist thinks—recommends drugs, you're going to have to take them or else your baby's going to be taken away.” I was like, “Don't scare me like that!”

Paul: Total scare tactics.

Ashley: Total scare tactics. And I didn't appreciate it. And she was, like, pushing, like If I don't want to take Prozac, I don't have to. I can do without it during my pregnancy. But, she was so, like, forceful. And then, Paul was sitting outside. [Initially], she didn't want him to be there. And then she was like, “Do you want me to bring him in? Do you want me to tell him?” What? [Laughs.]

Paul: “You have to take your medicine!” [Laughs.] . . .

Khiara: The interesting thing is that, had you not mentioned—because you volunteered the information and the mental history that you have. And because you volunteered it, she sort of ran with it. You know?

Ashley: Yeah, it was very strange because I volunteered it because—because I wanted help and I wanted to do this properly. But, I don't want to be pushed drugs and pushed someone else—encourage someone else to push drugs on me. That's one of the reasons why I came here: because I didn't want the epidural! [Laughs.] I don't want it pushed on me.

Khiara: Ironically.

Ashley: I didn't appreciate her. It left me feeling very sour that day.

Khiara: That's too bad. Because you shouldn't have those experiences, you know? Did she actually force you to go see the psychologist?

Ashley: I wanted to. That's one of the things I wanted to do. Yeah, she did set that up for me.

Khiara: And have you met with that person?

Ashley: Yeah, I see her every week.

Khiara: Does she push drugs?

Ashley: No! Not at all. No.

Khiara: I wonder why that is that [the social worker] felt compelled to be heavy-handed. . . .

Ashley: She was quite heavy-handed. I just don't—I didn't understand. But, like, at first I was fighting with her. I was like, "No!" You know? Like, I was coming up with all these arguments about why it's not right. And then I was like, "Oh, just shut up! She's not going to get it."³⁶

¶28

Now, one may find the social workers' interventions with Rhonda and Ashley unproblematic—even laudable—understanding it as indicative of Alpha Hospital's commitment to all aspects of the health of their pregnant and unborn patients. The theory might be that prenatal care involves more than ensuring that the pregnant woman's amniotic fluid level remains stable and the fetus grows at a consistent rate; prenatal care also involves ensuring that the social environment into which a woman brings her newborn is healthful and life-affirming.³⁷ However, one must bear in mind that this "holistic" approach to prenatal care is made compulsory for patients who do not have private insurance and made optional for their private insurance-holding counterparts. That is, while private insurance-holding expectant mothers can forego the requirement of a social work assessment by electing to receive prenatal care from a private hospital or physician that eschews such a requirement, the poor-qua-public-insurance-holders are

³⁶ Interview with anonymous obstetrics clinic patient (Mar. 2007).

³⁷ This argument might be read as asserting that the "private spheres" of public insurance-holders at Alpha Hospital are opened up to surveillance, management, and regulation. When considered in this manner, Horn's work on the state's concern with reproduction in Fascist Italy becomes relevant. Horn examines the re-imagination in 1920's and 30's Italy of what is presently considered the dichotomized public and private spheres. He writes that in that space and place, individuals were conceptualized as having "social bodies," "located neither in 'nature' nor in the private sphere—but in that modern domain of knowledge and intervention carved out by statistics, sociology, social hygiene, and social work." HORN, *supra* note 4, at 4. He notes that during this time, a school of interwar jurists argued that the family should not be regarded as a "natural institution" that preceded society and eluded the purview of the state. "It was instead to be imagined as a social institution, open to and perhaps requiring state intervention and therefore transcending the domain of private law." *Id.* at 66. Against Catholic and liberal thought of the era, there was a collection of thinkers who contended that the family was a "social formation" that functioned in the national interest. One scholar, Cicu, maintained that "the family was not a social entity but also a *governmental entity*. The family carries out a state function, and it is this juridical end that justifies the vigilance and intervention of the powers of the State." *Id.* at 68.

It would appear that the social workers at Alpha Hospital, who must inquire into "private" elements of patients' lives in order to better ascertain the nature of the families into which the patients' fetuses will be later born, are charged with the duty of enacting these patients' families as "public" and/or governmental institutions—analogueous to the work that was done in interwar Italy. If public insurance-holding patient families may be conceived of as a "public" or governmental institution, even liminally so, how does this impact the meaning of the "right to *privacy*" as a guarantee of reproductive freedoms? Historically, this right was designed to protect families as private institutions from public intervention. However, what is the meaning of that protection for families that are conceptualized and treated as *public* institutions? Moreover, if it is true that the right to *privacy* has transformed over time into an individual-inhering right, does it still protect individuals who are members of "public" families, i.e., poor individuals? I intend to explore all of these questions and more in another piece.

compelled to undergo such interventions. They have no choice in the matter, which can be understood as extremely unjust.

E. Medicaid Financial Officer

¶29 In the state of New York, Medicaid coverage is available to all pregnant women, regardless of immigration status.³⁸ Those pregnant women who do not have any health insurance at the time of their PCAP appointments are instructed to meet with the Medicaid Financial Officer stationed in the Alpha OB/GYN clinic.³⁹ The financial officer explains to the patient that she needs to submit documents establishing proof of pregnancy, identity, address, and income in order to qualify for Medicaid and, thus, have her medical expenses covered by the state.⁴⁰

¶30 Needless to say, the process of applying for Medicaid can be stressful and anxiety-producing, especially for those patients who are residing in the country “illegally,” i.e., without proper documentation.⁴¹ Establishing proof of income may be nearly impossible for those women who either work “off the books” at businesses, or who receive cash as payment for work performed informally, like babysitting or housecleaning.⁴² A woman

³⁸ Medicaid in New York State, http://www.health.state.ny.us/health_care/medicaid (last visited Jan. 14, 2008). Eligibility for coverage commences at the beginning of the pregnancy and continues until sixty days after the woman gives birth. The child—having been born within the borders of the U.S.—is a citizen and therefore eligible for continued Medicaid coverage. If the mother was not a citizen or permanent resident before the birth of the baby, she so remains after giving birth; consequently, eight weeks after delivering, she is no longer eligible for Medicaid and finds herself, once again, without health insurance.

³⁹ Because the PCAP appointment day can be extremely lengthy, patients sometimes do not have the opportunity to meet with the financial officer before the end of the business day. These patients are instructed to meet with the financial officer whenever they are in the hospital during regular business hours, e.g., at subsequent prenatal care appointments. The expectation is that all of the prenatal care patients seen in the OB/GYN clinic will have Medicaid during their pregnancies. To meet this expectation—that is, to identify all those patients that have somehow slipped through the cracks—several times throughout the day, a financial officer makes the rounds through the Alpha Hospital OB/GYN clinic waiting room, asking patients, “Do you have insurance? Are you pregnant?”

⁴⁰ Proof of pregnancy is established by the submission of an Expected Date of Confinement [“EDC”] Letter—a letter stating the woman’s projected delivery date, calculated based on the date of the woman’s last menstrual period. This letter is usually given to the patient after she meets with the nurse. Proof of identity may be established by the submission of a state driver’s license or ID card, school identification or other photo identification, birth certificate, United States or foreign passport, or a permanent resident alien card (“green card”). Proof of address may be established by the submission of a post-marked envelope, utility bill, or rent receipt, complete with the patient’s home address and signature from the landlord. Lastly, proof of income may be established by the submission of two pay stubs, a signed and dated letter from the employer on company letterhead, or a 1040 form with wage statement. If, conversely, the patient has no income, she must submit a “Letter of Support” with proof of address from the supporter. Alpha Hospital, Frequently Asked Questions about Applying for PCAP (on file with author).

⁴¹ I established a rapport with one patient who was a Polish woman residing in the United States without documentation. She tearfully approached me one day after meeting with the Medicaid Financial Officer, showing me the list of the documents that she would have to submit in order to receive Medicaid coverage for her prenatal care medical expenses. She said, “I don’t have these papers! It’s too complicated! Too much!” I could only assure her that every patient with whom I had spoken had managed to get Medicaid coverage, and I insisted that she would not be the exception.

⁴² One encounter with a patient underscored for me that the patient population of Alpha is largely comprised of the underserved masses who supply cheap, often undocumented, labor to their enfranchised counterparts. I was walking by an examination room in which a very pregnant woman with a bandage around her wrist sat, waiting to be seen by a physician. She handed a cell phone to me and said, “*Habla español, ¿sí? Dígale en inglés.*” “You speak Spanish, right? Tell her in English.” She then told me a story in Spanish about how she was trying to clean the top of a bookshelf, but could not reach it. She found a ladder, but even with the ladder’s help, she still could not reach the top of the bookshelf. Finally, she

in such a situation must then acquire a letter from a person who she can claim financially supports her—although she very well may financially support herself. Moreover, a requirement as simple as establishing proof of address may be difficult for those patients and families that have recently moved or expect to move within the upcoming weeks or months. One patient explained to me that she had all the paperwork in order that she needed—except for the proof of address; she had been staying with her sister and knew that her tenure residing there would have to come to a close soon.

¶31 The Medicaid application process is an important part of the day for both the pregnant woman seeking prenatal care *and* the hospital. For the patient, Medicaid coverage means that she can receive healthcare during her pregnancy at no cost to her. For the hospital, Medicaid coverage held by its pregnant patients means that the hospital will not have to assume the loss created by patients who cannot pay the cost of services rendered. As a public hospital and member of the New York City Health and Hospital Commission,⁴³ Alpha Hospital is required by legislative mandate to provide services to any patient who presents herself at the hospital.⁴⁴ Therefore, Medicaid coverage means that the state and federal governments will reimburse the hospital for the cost of those services it is required to provide anyway. Accordingly, it is in the hospital's financial interest to ensure that all the patients that it serves have Medicaid insurance.

¶32 Moreover, before the hospital can be reimbursed by the state for the services it renders to patients with Medicaid, the hospital itself must be qualified as a "PCAP provider"—meaning that the state has approved it to provide prenatal care services to

stood on a wet bar that was nearby, and, unfortunately, the corner of the bar on which she was standing could not sustain her and broke under her weight. It took me a moment to realize that the patient wanted me to translate this story to the person on the phone—someone who employed her as a housekeeper or maid. I immediately went into advocacy mode and translated the story as sympathetically as I could for the patient. I am not sure whether I saved the patient her job—the employer sounded irritated and only said to me, "I don't know how much it is going to cost to repair [the bar]." The precariousness of this patient's position in the world—being obliged to crawl on top of furniture during her last trimester in order to clean the house of someone with whom she could not directly communicate, *and sustaining an injury for which no means were available to compensate her*—resonated with me. That incident struck me with the realization that Alpha is the place where the most exploited go when they have to "go to the doctor."

⁴³ The New York City Health and Hospitals Commission (NYCHHC) is a public benefit corporation, created in 1970 for the purpose of overseeing New York City's public health care system in all five boroughs. "The Corporation consists of 11 acute care hospitals, 6 Diagnostic and Treatment Centers, 4 long-term care facilities, a certified home health care agency, and more than 80 community health clinics. . . . Through its wholly owned subsidiary, MetroPlus, NYCHHC operates a Health Plan which enrolls members in Medicaid, Child Health Plus, and Family Health Plus." New York City Health and Hospitals Corporation, Frequently Asked Questions, <http://www.nyc.gov/html/hhc/html/about/faq.shtml> (last visited Jan. 14, 2008).

⁴⁴ A fact often quoted in Alpha Hospital pamphlets and advertisements is that "more than 80 percent of Alpha's patients come from the city's medically underserved populations." Alpha Hospital Fact Sheet (on file with author). This fact is often followed by the statement: "No one in need is ever turned away from Alpha." That Alpha Hospital cannot refuse service to any patient who presents herself at the hospital is a fact known by many patients that I have met while working behind the front desk of the OB/GYN clinic. For example, one woman approached the front desk and said, "I'm pregnant. . . . I don't have insurance. . . . I need prenatal care. . . . Did I mention that I don't have insurance?" In response, Minnie, a PCA who frequently conducts intake behind the front desk, explained to her the PCAP process and how to begin it. Coincidentally, I ran into the prospective patient that evening on my walk to the subway station. She recognized me from the hospital, and we made polite conversation as we walked. Eventually, we began talking about her pregnancy, and I asked her, "So, what made you come to Alpha for your prenatal care?" She responded, "I was laid off from my job last month and I lost my health insurance. My friend told me that I should go to Alpha because they have to see you. Even if you don't have any health insurance, they have to see you. They can't turn you away."

Medicaid recipients.⁴⁵ And Medicaid Policy Guidelines mandate that a patient meet with a nurse, nutritionist, HIV counselor, social worker, and a Medicaid financial officer.⁴⁶ That is, in order for the hospital to be reimbursed through Medicaid for the prenatal services that it provides, it must guarantee that the patient meets with the above professionals. Hence, the entire apparatus described above is mandated by the state. The state essentially says to poor pregnant women, “We will pay your bills in exchange for, at the very least, state surveillance of your pregnant body and the private arena in which it exists.” It is quite an exchange to make—considering that women with private insurance are not similarly compelled to cede access to their private lives. Indeed, government subsidization of medical service becomes a kind of recruitment device that enlists poor women into the welfare bureaucracy’s subjection. Again, some may find state intervention into women’s private lives completely unproblematic and potentially desirable—understanding it as a laudable effort to provide pregnant women with a wealth of information that they could use to make their pregnancies healthy events on multiple levels.⁴⁷ However, it is not all women whose private lives are intervened upon; indeed, it

⁴⁵ “A PCAP provider is an Article 28 approved hospital outpatient department or freestanding diagnostic and treatment center (D&TC) that was approved by the NYSDOH to provide prenatal care in accordance with Part 85.40 of Public Health Law at 10 NYCRR.” OFFICE OF MEDICAID MGMT., N.Y. STATE DEP’T OF HEALTH, PRENATAL CARE ASSISTANCE PROGRAM (PCAP): MEDICAID POLICY GUIDELINES MANUAL 3 (2007) [hereinafter GUIDELINES]. “If the application review process indicates the provider is qualified and the Department approves their enrollment, the provider is reimbursed at an enhanced Medicaid rate for the enriched package of services delivered.” *Id.* at 4.

⁴⁶ The Guidelines explicitly delineate that all PCAP providers must provide “[n]utrition services including referral to the Women, Infants and Children (WIC) Program, [p]sychosocial services, HIV counseling and testing, [p]renatal diagnostic and treatment services, [h]ealth education, [and s]creening for presumptive eligibility for Medicaid and assisting pregnant women complete the Medicaid application process.” *Id.* at 3.

⁴⁷ Indeed, this is the rationale given by some of the Alpha Hospital employees who actually provide the services mandated by the state. Social worker Tina enthusiastically describes her job as that of providing valuable services to women who need them. She argues that pregnancy might be an ideal time to make interventions in women’s lives. She says, “There may be child abuse, sexual abuse, domestic violence. For a woman in an abusive relationship, she could be raped by her spouse and wind up pregnant. The pregnancy is a good reason to leave the house and come to the hospital. For a woman in that situation, this [the meeting with the social worker] could be an opportunity to get help.” Interview with anonymous social worker (Jan. 2007). Even for women “without issues,” the social worker thought her role remained important and useful nevertheless, as she could ensure that women are connected with all the social services of which they may avail themselves.

However, subsequent to all meetings with patients, Alpha Hospital employees must make a written notation inside the patient’s medical record of the topics discussed. Upon review of these notations, it is difficult to squelch skepticism towards optimistic articulations that Medicaid-mandated services are provided for the benefit of the woman alone. A common notation reads as follows:

Information delivered: 1st Trimester: orientation to facility, rights/responsibilities of pregnant patient, pregnancy danger signs, common discomforts, drugs/ETOH/smoking OTC drugs, enrolled in WIC, occupational concerns, contacts after clinic hours (emergency), domestic violence, toxoplasmosis[;] 2nd trimester: pregnancy danger signs, common discomforts, sexuality, fetal movement, physical activity/exercise, signs/symptoms pre-term labor.

Patient Response: PT VERBALIZED UNDERSTANDING.

Another example from a patient’s encounter with the “Breastfeeding Teaching Protocol”: Within this protocol, the nurse is required to articulate to the patient the benefits of breastfeeding—among them, “economic, convenience, safety, health . . . , nutrition[al], immunity, [and] development[al]” benefits. The “outcome” of the meeting: “The patient will verbalize commitment and desire to meet her infant’s nutritional and nurturing needs via breastfeeding.” Alpha Hospital Breastfeeding Teaching Protocol (on file with author). Indeed, all documentation of employee meetings with patients is punctuated with a statement attesting to the fact that the patient verbalized an understanding of, or commitment to follow, the

is only poor, uninsured women's private lives that are rendered accessible to state intervention, regulation, and management. As a consequence, Medicaid coverage of prenatal care could be construed as a carrot that attracts poor women into the state regulatory apparatus.

¶33

Furthermore, even if a woman has no interest in applying for Medicaid—opting to use her own private insurance or pay out-of-pocket for her prenatal care⁴⁸—she must still meet with the nutritionist, social worker, HIV counselor, and nurse before being scheduled to see a provider for a medical examination. This policy is effected because the hospital chooses to err on the side of fiscal caution—presuming that every patient receiving healthcare within the obstetrics clinic will eventually become a Medicaid recipient. In the event that a patient ultimately receives Medicaid coverage, the hospital can be reimbursed for the services it provides—as it has satisfied all the PCAP requirements for Medicaid reimbursement for that patient. Alternatively, in the event that the patient ultimately does not receive Medicaid coverage and, instead, pays for prenatal services through private insurance or out-of-pocket, the hospital is not disadvantaged in any way; the only consequence would be that the PCAP services would have been rendered unnecessarily. As a result, all Alpha Hospital pregnant patients—without regard to whether they receive Medicaid—are compelled to expose themselves to state

information delivered.

An observer with a healthy dose of skepticism could reasonably understand these notations as doing nothing more than offering written proof that the hospital provided the meeting pursuant to the requirements of Medicaid. Indeed, if the services were provided for the benefit of the woman alone, there might be no reason to document that they, in fact, were delivered; as long as the pregnant woman received the information, then the hospital's mission would be accomplished. Or, documentation that the patient verbalized understanding or commitment might be read as protecting the hospital from future litigation initiated by the woman. For example, a woman who smokes cigarettes during her pregnancy and subsequently gives birth to a low birth-weight baby would have a difficult time suing the hospital for failing to inform her about the causal relationship between smoking and birth weight if she had “verbalized understanding” about the matter early on in her pregnancy. The same might be said about a range of other issues that endanger the health of the fetus.

Remarkably, this skepticism about the hospital's program is shared by some Alpha employees. On one occasion, I saw a patient's medical record sitting on a chair in one of the triage rooms. I picked it up and, noticing its volume, remarked to one of the nurses in the room, “It's so thick! That's a lot of paperwork.” She said, “You know why, right? Litigation. Patients can't sue us.”

⁴⁸ As stated earlier, I met only one uninsured patient who, because her income exceeded the income limitations set by Medicaid, elected to pay for her healthcare out of her own pocket and to receive prenatal care from Alpha Hospital. Moreover, I never met a patient who had private insurance, yet nevertheless elected to receive her prenatal care at Alpha Hospital. However, one of the midwives informed me that she had encountered some Alpha patients who had private insurance, yet chose to apply for and receive Medicaid because their private insurance required exorbitant co-payments. As an example, she offered the experience of her friend, whose private insurance required a co-payment of over \$3,000 for her labor and delivery expenses. She explained that some patients are similarly-situated and therefore elect Medicaid coverage in order to avoid the astronomical out-of-pocket expenses that are attendant with some private insurance.

Interestingly, the midwife related this story to me as an illustration of how the “system” does not work. That patients may have private insurance, yet receive Medicaid reimbursement for medical expenses nevertheless, was offered as a case in point of a shortcoming of the welfare state. Yet, patients who elect to receive Medicaid in order to avoid excessive private insurance co-payments seem, to me, to be underinsured. Medicaid *should* be available to those whose private insurance fails to sufficiently cover the costs of their medical expenses. In other words, the example given by the midwife should not be understood as a failure or abuse of the welfare state; rather, it ought to be understood as one of its successes insofar as it enables women with insufficient and inadequate private insurance to bear their prenatal care expenses.

intervention, regulation, and management by providing information about the minutiae of their private, intimate spheres.

¶34 To distill the central theme of the above exposition: for the uninsured poor, state regulation is simultaneous with prenatal care. Foucault’s theorization of the carceral is helpful in understanding the significance of this fact. In *Discipline and Punish*, Foucault argued that the classical-era scaffold, which could demonstrate the immense power of the sovereign only by destroying the body of the prisoner, was replaced by the instrument of the modern-era prison—the consummate vehicle for acting on the heart, thoughts, will, and inclinations of the prisoner. It produced docile bodies through a technique that combines constant surveillance with the precise management of the prisoner’s body in space—both physical and temporal. The Panopticon, the prison par excellence, dramatized and epitomized the operation of power in the modern age: the prisoner, whose body is always capable of being seen, bears this knowledge and, in turn, becomes the agent of his own discipline and oppression.

¶35 In the final chapter of this seminal tome, Foucault explained that the work accomplished by the prison has been disseminated to a range of institutions:

[M]oving still farther from penalty in the strict sense, the carceral circles widen and the form of the prison slowly diminished and finally disappears altogether: the institutions for abandoned or indigent children, the orphanages . . . , the establishments for apprentices. . . . And then, still farther, there was a whole series of mechanisms that did not adopt the “compact” prison-model, but used some of the carceral methods: charitable societies, moral improvement associations, organizations that handed out assistance and also practiced surveillance, workers’ estates and lodging houses⁴⁹

¶36 The result of this dissemination was the creation of a “carceral archipelago,” which “transported [the technique of the prison] from the penal institution to the entire social body.”⁵⁰ Indeed, “this great carceral network reaches all the disciplinary mechanisms that function throughout society.”⁵¹ Thus, bodies incarcerated in penal institutions are not the only bodies subjected to constant surveillance and management, performed with the intent to “correct” the desires of the subject; rather, all bodies caught within the “carceral net”—usually indigent, disenfranchised, and importantly, female (a point, unfortunately, ignored by Foucault)—are thus subjected.

¶37 In this way, one can understand Medicaid coverage of prenatal care as an apparatus that attracts poor, pregnant subjects into the carceral archipelago. That the state pays the medical bills accrued by pregnant women for their prenatal care is benign, in and of itself; however, the endeavor appears more disciplinary and surveillance-intensive when one considers that the state first requires the woman to meet with a nutritionist (who constructs a chart quantifying, and frequently censuring, her diet), an HIV-counselor (who attempts to gain her consent to an HIV-antibody test, the results of which will most assuredly be sent to the proper authorities and become the stuff of citywide, statewide,

⁴⁹ MICHEL FOUCAULT, *DISCIPLINE AND PUNISH* 298 (Alan Sheridan trans., Pantheon Books 1977) (1975).

⁵⁰ *Id.*

⁵¹ *Id.*

and nationwide statistics), a social worker (who compels the women to divulge intimate details about her life), as well as nurses, health educators, and financial officers. All of this is to say, the pregnant woman who has decided to attempt prenatal care at a public hospital like Alpha finds herself most decidedly within the state apparatus.⁵²

¶38 In sum, the fact of pregnancy alone does not bring a woman within the jurisdiction of the state. Yet, the fact of pregnancy combined with the woman's attempted receipt of state aid not only brings a woman within the state's jurisdiction, but also becomes an opportunity for the state to create a legal subject whose private life is exposed to state supervision and surveillance. In this way, Medicaid and PCAP programs function to create legal subjects of pregnant women—bringing them within the jurisdiction of the biopolitical state, making them and previously invisible (some would say “private”) elements of their lives visible, exposing them to state oversight, and ultimately barring them to the potentiality of state-sanctioned violence.⁵³

IV. BODY MATTERS: THE PRODUCTION⁵⁴ OF “UNRULY BODIES”

¶39 I have hoped to demonstrate that attempting prenatal care with the assistance of state aid initiates women into an expansive state regulatory apparatus that far exceeds the purview of that care. This is significant because it demonstrates how class operates to differentially produce populations—generating the poor (not infrequently composed of people of color) as a group whose private lives are not respected as spheres into which the state ought not to tread.⁵⁵ Additionally, the simultaneity of prenatal care and state management, intervention, and oversight is also significant because Medicaid coverage arguably produces the bodies of poor women—as a class—as problematic entities. That is, Medicaid coverage produces poor, pregnant women as possessors of unruly bodies.

⁵² Notably, the male partners of women attempting prenatal care at a public hospital like Alpha also find themselves decidedly within the state apparatus. This is because the nurses taking the initial medical history and social workers seek to elicit information about the fathers of patients' babies. Accordingly, after a woman has been thoroughly interviewed by the social worker, she would have identified the father of her baby, his telephone number and address, his race and citizenship status, his place of employment and salary, whether he is supportive of the pregnancy, and if he has ever abused her physically or otherwise. Hence, women's extraordinary visibility before state authorities effects the extraordinary visibility of the males with whom they have relationships.

⁵³ By “state-sanctioned violence,” I refer to violent acts committed by the state—acts that are only understood as legitimate because they are perpetrated by the government through “legal” means. So defined, I view the ability of the state via ACS to demand entrance into a woman's home and survey its contents as an act of state-sanctioned violence.

Moreover, I view the ability of the state to take custody of a woman's children as a gross act of state-sanctioned violence. I spoke with a postpartum patient who recounted an example of this unfortunate demonstration of state-sanctioned violence: When she went into labor, she brought her two children—ages seven and twelve—with her to the hospital. However, because no other adults were present with her, and because minors are not allowed entrance into the Alpha Hospital delivery rooms, her five year-old and twelve year-old were placed in a foster home while she delivered. It was only after she was discharged from the hospital that she able to regain physical custody of her children. Interview with anonymous obstetrics clinic patient (Nov. 2006).

⁵⁴ See *supra* Part I for a discussion of the use of “production” and “produce” in this context.

⁵⁵ A related question is whether the Medicaid-enabled intrusion by the state into poor women's private lives merely demonstrates how socioeconomic class produces a population whose privacy rights are nullified by state interference. Or rather, does it demonstrate how the state is directly and actively involved in producing class inequalities and subjugation, generating a population with no privacy rights that the state is bound to respect? I intend to explore this question in a later piece.

¶40

To begin, Medicaid coverage produces the pregnant body in a very specific, highly-medicalized way. Per the protocol that PCAP providers must follow, the pregnant body whose prenatal expenses are paid by the state is one that:

- (1) Should be monitored every three weeks during the first two trimesters, every two weeks during the first two months of the last trimester, and every week during the final month of pregnancy; should be weighed at every visit to the clinic, and the body's blood pressure ratio should be measured and recorded;
- (2) Can benefit from prescribed prenatal vitamins;
- (3) Requires the visualization of its interiority via ultrasound between twelve and twenty-four weeks, a procedure during which all parts of fetal anatomy are identified, amniotic fluid levels are checked, and other physical abnormalities which can be seen, e.g., placenta previa, vasa previa, are detected;
- (4) Demands urine testing for glucose and albumin at each visit;
- (5) Should be given a "Group B streptococcus culture at 35-37 weeks, as indicated per the Centers for Disease Control and Prevention (CDC) guidelines";⁵⁶
- (6) Should be hailed back to the clinic within eight weeks after giving birth in order to be given a final medical exam, be assessed for any additional "medical, psychosocial, nutritional, alcohol treatment and drug treatment needs of the mother or infant that are not being met,"⁵⁷ and be given information on family planning and/or actual contraception if the preferred method has been identified;
- (7) Should be given a referral enabling the woman's enrollment in WIC;⁵⁸
- (8) Requires the "glucose challenge test" at the woman's initial visit and again at 28 weeks, which necessitates the woman having her blood drawn, then consuming a sugary beverage ("Glu-cola") and having her blood drawn three more times every subsequent hour in order to test how well the woman's body metabolizes glucose, and as a consequence, whether the body is diabetic;

⁵⁶ The creation of a requirement from a guideline proposed by the CDC should dispel any doubts that the pregnant patients at Alpha Hospital reside squarely within the state's biopolitical project. The prevention and control of epidemic and pandemic health threats to the population, which is the concern of the CDC, is practiced on the bodies of the individuals within the obstetrics clinic at Alpha. Said differently, the individual bodies within the hospital become the stuff upon which the state can act on the population. To borrow an argument made by Duden in a different, but related, context: The enactment of CDC guidelines on an individual is to apply a policy that "make[s] sense only for groups"—insofar as it is done with the health of the population, and not the woman, in mind. She, consequently, "is transformed into a crumb of the population." DUDEN, *supra* note 8, at 18.

I do not argue that Medicaid-recipients are transformed into "crumbs of the population" while their privately-insured counterparts wholly escape such transformation. This is because screening for Group B streptococcus at thirty-five to thirty-seven weeks gestation has become the standard of care, meaning that all providers of obstetrical care are encouraged to screen their patients for the infection.

⁵⁷ GUIDELINES, *supra* note 45, at 14.

⁵⁸ In fact, the Guidelines presume that all women submitting themselves to PCAP services *should* be enrolled in WIC. In the description of the PCAP program, the Guidelines include within the list of "comprehensive services that are included in the enhanced Medicaid clinic visit rate . . . [n]utrition services including referral to the Women, Infants and Children (WIC) Program." *Id.* at 3. It should be noted that the Guidelines do not specify that this referral is "as needed" or "as indicated"; instead, it is a blanket referral given to all women seeking Medicaid coverage of prenatal care services.

- (9) Should be given a “repeat gonorrhea, chlamydia, syphilis and HIV screen during the third trimester, as clinically indicated,” and once again at the post-partum visit; and
- (10) Should be vaccinated for Hepatitis B and screened for tuberculosis.

¶41 Items one through five of the above list are not particular to Medicaid-subsidized prenatal care; the privately-insured should expect similar treatment. The rest of the items differ from the care given to privately-insured patients in the following ways:

- (1) While privately-insured women commonly receive a medical examination six to eight weeks after giving birth, their doctors do not assess their “psychosocial, nutritional, alcohol and drug treatment needs” unless given a reason to do so; neither do I expect that providers attending to privately-insured patients provide information on contraceptives to women at their postpartum visits—that is, unless women specifically request it;
- (2) Women with private insurance most likely will not receive a referral for WIC;
- (3) Administration of the “glucose challenge test” at the woman’s initial prenatal care visit and again at twenty-eight weeks is reserved for Medicaid recipients. The privately-insured receive the test only once, when they are twenty-eight weeks pregnant;⁵⁹
- (4) While all pregnant women—with or without private insurance—should expect a test for gonorrhea, chlamydia, and syphilis during the Pap smear that they receive during their initial prenatal care visit, only Medicaid-recipients are tested for these sexually-transmitted diseases again during their third trimester, and once again during their post-partum visit;⁶⁰ and
- (5) The privately-insured are not commonly vaccinated for Hepatitis B or screened for tuberculosis.

¶42 Nevertheless, the general structure of privately-insured women’s prenatal care does not greatly diverge from that of women with Medicaid; frequent doctor’s visits during which the body and its functions are measured, examined, and manipulated within sterile,

⁵⁹ I never received a satisfying explanation as to why Alpha patients were doubly administered the glucose challenge test. All of the providers to whom I posed the question were similarly perplexed by the protocol requiring the test for women at their first visits to the clinic. One attending physician responded, “I don’t know why they do it here. It’s not really valid. If it’s positive, you can’t call it gestational diabetes because they’re not even eight weeks pregnant. I think they do it early here because of compliance problems. They also do it because a lot of people are borderline diabetic before their pregnancies. But, out in the real world, they don’t do it.” Interview with anonymous attending physician (Aug. 2007).

⁶⁰ Most of the Alpha providers with whom I spoke knew that Alpha patients were screened for these sexually-transmitted pathogens more than their private insurance-holding counterparts. However, most insisted that they were comfortable with the protocol because the “patient population” at Alpha is purported to be at a higher risk for sexually-transmitted diseases. One nurse practitioner elaborated that she found no ethical dilemma with repeating these tests, which require vaginal examinations, because she would be conducting vaginal examinations at those times anyway—at thirty-six weeks gestation for the Group B streptococcus culture, and at six weeks postpartum to check the health of the cervix. The provider that most closely approximated outrage over this policy was a physician in the second year of his residency. He stated, with some degree of distaste, “They have a gonorrhea/chlamydia screen when they first come here. Then, they have another one done at 36 weeks. So, why do they need one now—six weeks after delivery? It’s silly.” Interview with anonymous second-year resident (Apr. 2007).

white-walled spaces are as common for wealthier pregnant women with private insurance as they are for women with Medicaid. Hence, I do not argue that the course of general treatment mandated by Medicaid is altogether unique to government-subsidized insurance or that it is otherwise reserved for poor, uninsured women. Thus, I do not contrast the Medicaid-mandated regime of care with that regularly offered to and accepted by most private insurance-holders. Rather, I contrast the Medicaid-mandated regime of care with that which is not available to Medicaid-recipients: prenatal care offered within a paradigm that does not understand pregnancy as always and necessarily a medical event.⁶¹ That is, while women with private insurance may elect to receive prenatal care that is premised on the constant surveillance and measurement of the pregnant body, women with Medicaid do not make such an election; it is elected by the state on their behalf.

⁶¹ I compare the Medicaid-mandated course of treatment with the experience of Kamilah, a woman with private insurance that I interviewed two weeks after she had given birth at her home to her third child:

Khiara: So, did you have to go to, like, a clinic for your prenatal care appointments?

Kamilah: For my appointments? No, I just went to [my midwife's] home.

Khiara: So, you never had to go into a medicalized environment?

Kamilah: Well, I went to a clinic the first couple of times. And when she referred me for sonograms, I did that. But, other than that, it was either in her home office or in my house. It's great because in your last month . . .

Khiara: Because you have to go more often.

Kamilah: Yeah, more often. Thirty weeks—once you pass that, it's twice a month. And once you're thirty-six weeks, weekly. And those weekly visits, she comes to you. Partly to familiarize herself with your home. I mean, she knows my stuff because this is her third [child that she has delivered in my home]. But, you know, [she comes to your home in order] to familiarize herself with your home. And also, so that you don't stress getting to her. So, we had our visits here.

Interview with privately-insured new mother (Jan. 2006). Kamilah did not recall being weighed at every visit with her midwife—especially the weekly visits that she had during the last month of her pregnancy. Neither did she recall having her blood pressure taken repeatedly. While her urine was tested for the presence of glucose and albumin at every prenatal care appointment, Kamilah herself would do the testing by dipping a pH stick into urine that she had collected; she reported to the midwife whether the pH stick revealed anything abnormal. Kamilah was never prescribed prenatal vitamins; rather, her midwife recommended a vegan prenatal vitamin that she could take if she felt that she was not consuming healthy amounts of the recommended foods. Additionally, Kamilah reports that her midwife did, in fact, conduct a vaginal examination during the thirty-sixth week of her pregnancy; but, she denies that she was tested once again for sexually-transmitted infections during that examination. *Id.*

Kamilah gave birth to her third child in her bedroom while her two young children slept. Her labor and delivery represented the final episode of an ideology of pregnancy as an event that need not be sequestered away into sterile environments. Rather, it was treated as an occasion that can and should be built into the fabric of a woman's extant life. Notably, Kamilah does not describe herself as “anti-medicine” or avow the outright rejection of medicine. When I asked Kamilah if she was “opposed to medicine,” she said, “I'm opposed to unnecessary medicine . . . But, I'm not one of those people who would be dying, talking about, ‘No, I don't want the surgery.’ You know? But, I don't even take aspirin. I feel like, if you have a headache, get to the root of the headache . . . Like, around here, we do herb tea and just natural tinctures and that sort of thing. When we're dealing with a fever—especially with the kids—usually we do fevergrass for it. But if it's bad—I don't know if you remember what it's like to have a fever: the headache and just everything hurts. Just to relieve them, I'll give them some IB Motrin. Within reason. Within reason. I think that we're an overly-medicated society. So, I'm kind of careful about that.” *Id.*

Kamilah—and probably more than a few public insurance-holding women, if given the option—preferred to receive a course of treatment that refuses to understand pregnancy as an ailment and that simultaneously empowers the pregnant woman to care for her own body.

¶43

Women receiving Medicaid cannot enjoy prenatal care delivered outside of a paradigm of pregnancy as a medical event requiring medical intervention. The prenatal healthcare provided by Medicaid, by statutory mandate, is premised on constant surveillance of the pregnant body—a body whose health appears to be capable of failing at any given moment. This is in line with what medical anthropologist Robbie Davis-Floyd termed the “technocratic model of childbirth”—within which “the female body is viewed as an abnormal, unpredictable, and inherently defective machine.”⁶² I would like to expand Davis-Floyd’s argument to encompass the nine months that precede labor and childbirth; hence, I argue that the regime of prenatal care described above is a function of a “technocratic model of *pregnancy*”; accordingly, Davis-Floyd’s “technocratic model of childbirth” would represent the final stage of a larger ideology of the pregnant body. It is a body whose ability to process sugar may suddenly disappoint, whose blood pressure may dangerously climb, and whose weight gain (or lack thereof) may indicate some unspecified complication. It is a body that is deficient in nutrients, for both itself and the body of the fetus that it carries within; hence, prenatal vitamins are prescribed to it, and it is enrolled in WIC to enable its acquisition of “iron-fortified adult cereal, vitamin C-rich fruit or vegetable juice, eggs, milk, cheese, peanut butter, dried beans/peas, tuna fish and carrots.”⁶³ It is one that is always already susceptible to pathogens in the form of bacteria and viruses; hence, it must be screened for their presence. Indeed, the pregnant body produced by Medicaid is so greatly susceptible to sexually-transmitted pathogens (i.e., gonorrhea, chlamydia, syphilis, and HIV) that it must be doubly screened for their presence during pregnancy, and once again six weeks after the woman gives birth. The body produced by Medicaid is one whose interior should be made visible to the naked eye via technological interventions;⁶⁴ subsequent thereto, women are rewarded with fuzzy black-and-white images of their insides.⁶⁵ Lastly, the look of the place should not be

⁶² Robbie E. Davis-Floyd, *The Technocratic Body: American Childbirth as Cultural Expression*, 38 SOC. SCI. & MED. 1125, 1127 (1994).

⁶³ WIC FACT SHEET, *supra* note 20, at 2.

⁶⁴ Interestingly, many of Alpha patients’ interiors are made visible via ultrasound several times over the course of their pregnancies. This is because, invariably, the fetus is not in a position within the uterus that enables the ultrasound technician to acquire images of all relevant parts of the anatomy. Accordingly, if the technician cannot acquire a satisfactory image of, say, the fetus’ femur, the woman must return to the clinic to have a re-scan. Additionally, if there is a discrepancy between the woman’s asserted date of last menstrual period (LMP) and the size of the fetus as indicated by the ultrasound, the woman must return to the clinic to have a “growth scan”—during which the technician determines how much the fetus has grown between the growth scan and the previous scan: If the sonogram indicates that the fetus is smaller or larger than it should be based on its LMP, the physicians and technicians have to determine whether the LMP is incorrect or if there is a problem with the fetus. For example, it would have to be determined whether a small fetus is really 12 weeks gestational age as opposed to the 16 weeks that it would be based on the date of the woman’s LMP, or if, alternatively, the 16 week-old fetus is just abnormally small. Most of the time, the woman has simply miscalculated the date of her last menstrual period and there is nothing wrong with the fetus. Nevertheless, I can imagine the anxiety produced in a woman who is told preliminarily, “Your fetus is too small.”

The result of suboptimal fetal positioning and LMP discrepancies is that patients find themselves with several ultrasound scans over the course of their pregnancies. This may serve to reiterate woman’s dependency on medical technology as well as the fact of the “unruliness” of their bodies. I discuss this notion of the “unruly body” later on in this section of the paper.

⁶⁵ Although I endeavor to problematize the staggering and ostentatious technology—including ultrasound imaging—that is used to manage women’s pregnancies as a *matter of course* inside of Alpha Hospital, I would be remiss if I neglected to report that many of the patients with whom I have spoken absolutely adore the fuzzy black-and-white images of their fetuses with which they are rewarded after their ultrasound scans. See Rosalind Pollack Petchesky, *Foetal Images: The Power of Visual Culture in the Politics of*

disregarded: that is, the Medicaid-produced pregnant body is one that is appropriately treated in antiseptic examination rooms by physicians, nurse practitioners, and midwives who wear white lab coats.⁶⁶ This body should be led down white-walled, white-tiled corridors by gloved and uniform-wearing medical assistants.⁶⁷ The body should be exposed, unavoidably, to the smell of disinfectants, cleaning solutions, sanitizers, and sterilizers.

¶44

In essence, the body produced by Medicaid is one that is insistently and tenaciously medically managed. While one can make a persuasive argument that the course of treatment mandated by Medicaid exceeds “normal” medicalization insofar as Medicaid

Reproduction, in REPRODUCTIVE TECHNOLOGIES: GENDER, MOTHERHOOD, AND MEDICINE 57, 72 (M. Stanworth ed., 1987) (“Women frequently enjoy seeing pictures of their fetuses, citing that it creates a feeling of intimacy, as well as a sense of predictability and control”). At Alpha, the ultrasound technicians usually give the women at least two images of the profiles of their fetuses’ faces. While I found many of the ultrasound images indecipherable, I could usually relate the fuzzy images of a fetus’ profile with that of a baby; *but see id.* at 62 (“[T]he photographic image . . . obscures the fact that that image is heavily constructed.”). I have been present on numerous occasions when women create a scene of sorts when they are told by the technician that they would not be receiving ultrasound pictures, usually because the fetus was not in a suitable position for its profile to be “photographed.” Additionally, I know many women who have created photo albums from their sonogram pictures and several women who have put the ultrasound images of their fetuses on their cell phones as screensavers. Nevertheless, patients’ joy in the acquisition and possession of ultrasound images should not serve to diminish the critique of fetal imaging, nor should it serve to mitigate the critique of the high (some would say excessive) amount of technology that is used to manage all women’s pregnancies at Alpha. As Petchesky noted, women’s ways of seeing their ultrasound images may be affected by public images of fetuses. *Id.* at 73. Similarly, patients’ excitement over their ultrasound images, and enthusiasm about the medical management of their pregnancies, is far from a “natural” response; rather, it is a response that is a product of a culture (perhaps coinciding with what can be identified as a “U.S. culture”) that, for the most part, fetishizes the fetus and venerates medical science. On the latter point, see LESLEY A. SHARP, STRANGE HARVEST: ORGAN TRANSPLANTS, DENATURED BODIES, AND THE TRANSFORMED SELF 238 (Univ. Cal. Press 2006) (discussing Eleni Papagaroufali’s study of perceptions about organ transfer in Greece, and noting that Papagaroufali was “struck especially by how readily Americans embrace biotechnological answers as solutions to human suffering,” and observing that “Greeks, in contrast, are far less committed to this paradigm, given that their nation remains peripheral to the scientific realm, one whose values are otherwise deeply entrenched in American society.”).

⁶⁶ One of the first observations that I made upon beginning fieldwork in the OB/GYN clinic at Alpha Hospital was how simple it was to identify a staff member with his/her occupation in the clinic. The staff is structured according to the following hierarchy: The medical assistants are the women of color who wear beige nursing uniforms. (Indeed, all of the medical assistants are women of color.) The women of color who wear white lab coats are the registered nurses. (Again, all of the registered nurses are women of color.) The residents are the relatively young persons, usually White, who wear white lab coats. The nurse practitioners and midwives are more easily confused; they are all young, White, well-dressed women who do not wear lab coats. Finally, attending physicians are the older persons who wear white lab coats. The exception to this schema is the lone male midwife, Mark—an older, stately gentleman who opts to wear a white lab coat. Had I not had the pleasure of meeting Mark on my first day at the clinic and having a long, enjoyable conversation during which he described his occupation and background, I would have wrongly assumed—due to his age, gender, and lab coat—that he was an attending physician.

⁶⁷ Biologist Lynda Birke has written thought-provoking work regarding how standard practices of Western medicine—including the *look* of the facilities in which Western medicine is dispensed—may alienate women of color. She writes, “In hospitals particularly, whiteness can seem to predominate . . . which, in the experience of one patient, felt at odds with her black identity. White is the colour (or its lack) of hospital spaces (and thence represents the disempowerment of the patient in the hospital bed, especially if she is not white).” LYNDY BIRKE, FEMINISM AND THE BIOLOGICAL BODY 82 (Rutgers Univ. Press 2000).

Birke’s observation reveals a glaring absence from the present discussion thus far; that is, an explicit analysis of the role of race in the Alpha obstetrics clinic is conspicuously absent. But, I have not yet worked through the problem of how race complicates what has been presented here as an issue of class. I am still struggling with how to answer the question of how patients’ races engage with the above-described state/Medicaid apparatus and the biomedical delivery of prenatal care.

recipients are doubly and trebly tested for conditions for which the private-insured are screened only once, that is not my interest. I believe that even if one assumes, for argument's sake, that Medicaid-recipients' prenatal care is not medicalized beyond the extent to which privately-insured women's care is medicalized, the intersection of this "normal" medicalization with a population entirely composed of poor women generates especially disempowering effects. In the following section, I discuss Barbara Duden's scholarship on the fetus and her critique of the medicalization of pregnancy, generally. I then explore her critique in the context of the poor women that it affects at Alpha Hospital.

A. *The Dudenian Fetus*

¶45 The possibilities and problems associated with the biomedical paradigm of pregnancy are invariably at work in the Alpha Hospital obstetrics clinic. The understanding of the pregnant body within biomedical discourse has been convincingly described as disempowering to the woman upon whom it is enacted. Historian Barbara Duden's work in this area is instructive. She argues that women's experiences of pregnancy in the modern era are held hostage by the "fetus"—a biological fact that is taken to be best administered within the biomedical paradigm. A woman's fetus, however, is only accessible to her via technological processes that are held in monopoly by medical professionals. Thus, the fetus "disembodies" a woman's perceptions and "forces her into a nine-month clientage in which her 'scientifically' defined needs for help and counsel are addressed by professionals."⁶⁸ Duden compares this experience of pregnancy with those of women who have been protected from the "fetus" by historical happenstance and/or their subordinated socioeconomic positioning within global capitalism. She describes the pregnancy of the mother of a poor, recent immigrant living in Harlem as much more "sensual, warm, touchable, familiar."⁶⁹ Pregnancy—before the advent of photogenically-produced fetuses and tests that can detect the presence of Human Chorionic Gonadotropic [HCG] hormone—was a more embodied, personal event. Knowledge of it resided with the woman who *sensed* it; further, a woman's pregnancy was only made known to others through her announcement of it. Duden argues that "the fetus" has altered this. Pregnancy was once an intensely intimate, bodily event about which the pregnant woman knows best—a publicly recognized, haptic state of woman known essentially through her testimony.⁷⁰ It is now a condition that professionals first confirm, then manage, for a woman.

¶46 On the issue of tests that can detect the presence of the HCG hormone in urine and, therefore, determine the fact of a woman's pregnancy, Duden writes: "Today when I do not get my menstrual period, I wait a week, perhaps a few days more. Then I face a decision. I can cross a historically unprecedented threshold and enter the world of scientific 'facts' by obtaining a kit for a urine test. Seeing the result, I conjure up a fetus, and with it the abstraction 'life.'"⁷¹ She then goes on to say that once the fetus is thus conjured, submission to the biomedical establishment closely follows. Duden's narrative

⁶⁸ DUDEN, *supra* note 8, at 4.

⁶⁹ *Id.* at 27.

⁷⁰ *Id.* at 81.

⁷¹ *Id.* at 53.

about the closure of the universe of possibilities a woman can imagine about her pregnancy and pregnant body upon the acquisition of a “kit for a urine test” is particularly relevant at Alpha Hospital. Indeed, a caricature of Duden’s scenario is performed numerous times a day at the obstetrics clinic: Prospective prenatal patients must submit urine to be tested for HCG in order to begin the PCAP process at Alpha—this despite the fact that the large majority of prospective patients have already confirmed their pregnancies with at-home urine pregnancy tests prior to setting foot inside of Alpha. Accordingly, if Duden is correct in that the performance of a urine pregnancy test inscribes women within a specific model of pregnancy and the “fetus,” then Alpha’s requirement of its repetition serves to reinscribe and reiterate this model and its power. It educates women about the nature of the enterprise (i.e., one that is scientific and medicalized) into which they are entering by receiving their prenatal care from Alpha.

¶47 In sum, Duden’s argument is that a woman, now, must depend on technically-trained professionals to care for her during an event that she is intellectually and technically unprepared to manage for herself. Thus, pregnant women are disempowered and made dependent.⁷²

B. *The Dudenian Fetus at Alpha*

¶48 Duden’s argument is applicable to all women living within the era of the fetus. Accordingly, all women, without regard to class, would be equally disempowered and equally made dependent. However, I would like to extend her critique to the women that it affects in Alpha Hospital—poor women. That is, a poor woman may experience the disempowering and dependency-producing effects of a medically-managed pregnancy as yet another demonstration of her powerlessness within society. Indeed, prenatal care so delivered may be understood as a disciplinary mechanism that educates poor women about their status within society and the behavior expected of those that so occupy that station. Specifically, being poor is about being dependent on others, about submitting oneself to surveillance, about being problematized. Being poor is about putting oneself within the charge of someone who can meet the needs that one lacks the ability to satisfy for oneself.

¶49 Indeed, for non-poor women, the element of choice may temper the effects of the disempowering aspects of the Dudenian fetus and the concomitant medical management of pregnancy. Duden speaks of electing to put oneself within the charge of medical

⁷² Davis-Floyd describes the “technocratic model of childbirth” as similarly disempowering. She argues that standard procedures during medically-managed childbirths “enact the view that the female body-machine is inherently defective and generally incapable of producing perfect babies without technological assistance from professionals.” Robbie E. Davis-Floyd, *Obstetric Training as a Rite of Passage*, 1 MED. ANTHROPOLOGY Q. 288, 292 (1987). Upon a woman’s admittance to the hospital, she is shaved, given an enema, dressed in a hospital gown, and tagged with an identification wristband. This, she says, “symbolically strip[s her] of her individuality, her autonomy, and her sexuality.” *Id.* at 293. Moreover, “the internal monitor, attached through electrodes to the baby’s scalp, communicates the additional message that the baby-as-hospital-product is in potential danger from the inherent defectiveness of the mother’s birthing machine.” *Id.* Finally, the physical posture that the woman is compelled to assume during labor, the lithotomy position, puts the woman in a position of “complete exposure, expressing and reinforcing her powerlessness and the power of society (as evidenced by its representative—the obstetrician) at the supreme moment of her individual transformation.” *Id.* at 294. This experience as described by Davis-Floyd might be understood as an unsurprising culmination—a concluding demonstration—of nine months of dependency and disempowerment during prenatal care within the biomedical model of pregnancy.

professionals by accepting discursive constructions of the fetus. She argues that women must “decide” whether to understand their pregnancies as the production of a fetus with needs only medical science may satisfy. Alternatively, women may reject this fetus and choose “aliveness”—a presumably more sensuous, corporeal embodiment outside of the biomedical construction of pregnancy. If the woman chooses the former, “she becomes the subject of a series of needs—for counseling, prenatal testing, diagnosis, prognosis, and management.”⁷³

If a woman does not eschew the series of powerful suggestions that stamp her as the reproducer of a life, she cannot avoid patienthood under the gynecologist, sharing with him the social responsibility for the future of the life within her, including the decision about whether to remain its uterine environment or not. Once she consents to cooperate in prenatal testing and the biotechnological care and management of her insides, she is caught in a series of unavoidable “decisions” that lead from amniocentesis to the interiorization of eugenics to the scientifically guided care of a modern infant.

But a woman can refuse to accept this state and put herself outside the framework that imposes such needs. Inevitably, she then exposes herself to a series of criticisms. Some will see her as a “primitive” who deprives herself and her infant of the benefits of modern medicine. Others will see in her the romantic who places good will, emotions, and irresponsible trust above the certainties of a modern institutionalized reality. And others will dismiss her as utopian.⁷⁴

¶50 Yet, the poor, uninsured patient at Alpha Hospital does not have the option of rejecting a scientific, technological model of pregnancy and putting herself “outside the framework that imposes such needs.” She does not have the luxury of being viewed as a romantic or being dismissed as a utopian. She cannot even elect the title of “primitive.” Insofar as no options outside of an intensely medically-managed pregnancy exist for poor women accepting Medicaid, they are forcibly conscripted into the regime of biomedically-produced-and-satisfied needs.⁷⁵ I do not read Duden as arguing in favor of

⁷³ DUDEN, *supra* note 8, at 54.

⁷⁴ *Id.*

⁷⁵ It is important to note that, if given the choice, many poor women would elect to have a medically-managed pregnancy. I have talked to many Alpha Hospital patients who are enthusiastic in expressing their happiness with the care that they receive from the obstetrics clinic. Indeed, many women choose to receive their care from Alpha Hospital—as opposed to hospitals that are located closer to their residences—because they have heard that Alpha offers the “best” [read: most technologically-intense and scientifically-advanced] prenatal care.

This is in line with anthropologist Gertrude Fraser’s study of obstetric and midwifery practices in the South. Gertrude J. Fraser, *Modern Bodies, Modern Minds: Midwifery and Reproductive Change in an African American Community*, in *CONCEIVING THE NEW WORLD ORDER: THE GLOBAL POLITICS OF REPRODUCTION*, *supra* note 4, at 42, 57. Her study can be read as a response to Davis-Floyd’s work—which may be accused of promoting natural childbirth as the “good” or “right” childbirth experience. Fraser’s work cautions that race complicates the narrative told by those scholars who conceptualize midwifery and natural childbirth as unitarily desired and desirable and medically-managed pregnancy and childbirth as unitarily undesired and undesirable. *Id.* at 55. Fraser shows that in the impoverished,

women foregoing medical treatment entirely—and neither would I suggest it. Rather, I read Duden as acknowledging that a continuum of prenatal care exists: one may conceptualize the woman who refuses all manner of prenatal care on one end of the spectrum. On the other end, sits the woman who is the incubator for a fetus whose needs are satisfied only by the most relentless medical science. Medicaid recipients are forced to sit with the latter or forego prenatal care altogether. I understand such circumscribed choice as hardly a choice at all.

¶51

Moreover, I am reminded of a woman, Summer, who was pregnant with her first child when I met her. I was sitting behind the front desk when she approached me and explained that she had just returned from an extended trip to visit her family in Israel. She said that she had gone to the doctor while in Israel and he had given her and her fetus a number of tests. She asked if she would have to repeat those tests at Alpha Hospital. I responded, “Probably. Alpha likes to do all the tests themselves.” Later on, while she waited for the midwife to call her, I asked if she wanted to be interviewed more formally for my research. During the interview that followed, I learned that she was one of many women who preferred prenatal care far away from the extreme end of the medicalization continuum at which Medicaid recipients are necessarily situated:

Summer: Here it is different because in America, they are so fanatic. So, here you have to do all the tests. So, I kind of go with it. If I was in Israel, I wouldn't know if it was a boy or girl. I would just go into labor and that is it. Here it is impossible. That is why I told you in the beginning that I did some tests in Israel and didn't want to do it again. I am probably going to have to do everything again.

predominately African-American community in which she did her fieldwork, medically-managed pregnancies and childbirths were considered highly desirable. *Id.* This was a community that, due to classism and racism, had largely been ignored by the medical establishment. That the women in this community now had the choice of receiving their prenatal care from obstetricians and delivering their babies in hospitals with the aid of anesthesia “signaled a symbolic if not fully realized inclusion in the field of vision of a health-care bureaucracy that had until then largely ignored the health needs of African Americans.” *Id.* at 57. Fraser notes that present-day critiques of medicalized pregnancies and childbirths, and the simultaneous lauding of midwifery and natural childbirths, have “emerged with the growth of a consumerist, choice-oriented social movement influenced in large part by middle-class (white) feminist theory and praxis.” *Id.* at 55 (referencing Margaret Nelson, *Birth and Social Class*, in *THE AMERICAN WAY OF BIRTH* (Pamela Eakins ed., 1986)). Poor women of color—who previously have been excluded from both obstetrical practice and the generation of the feminist critique of that practice—might disagree with the problematization of the biomedical paradigm of pregnancy and childbirth and, indeed, *want* pregnancies administered in line with it. *See also* Davis-Floyd, *supra* note 62, at 1137 (noting that many women feel empowered by technocratic births); Ellen S. Lazarus, *Falling Through the Cracks: Contradictions and Barriers to Care in a Prenatal Clinic*, 12 *MED. ANTHROPOLOGY* 269, 271, 280 (1990) (noting that the poor, Puerto Rican women she interviewed, without regard to whether they were born on the island or on the mainland, accepted the biomedical model of pregnancy as a pathological condition, and consequently, wanted prenatal care that was delivered in line with it); Ellen S. Lazarus, *Poor Women, Poor Outcomes: Social Class and Reproductive Health*, in *CHILDBIRTH IN AMERICA: ANTHROPOLOGICAL PERSPECTIVES* 48 (Karen Michaelson ed., 1988) (noting that all the women who participated in her study wanted their births to be medicalized procedures, as they ascribed to a view of pregnancy and birth as possessing inherent biological risks).

I, nevertheless, view the forcible conscription of poor women's bodies into the biomedical paradigm of pregnancy as unjust because of the element of choice: Non-poor women with private health insurance may elect this construction and administration of their bodies, while non-poor women with state-subsidized health insurance may not so elect.

Khiara: So, in Israel, your doctor has a different approach?

Summer: It is very alternative. You can do whatever you want. You can refuse. I went to the doctor, but the only thing I did was give blood and [listen to the fetal] heart[beat]. No sugar test or ultrasound. She told me if I wanted to do it, I can, but, it is not mandatory.

Khiara: You feel that they compelled you to do the ultrasound here?

Summer: Yeah. Otherwise, I wouldn't have done it.

Khiara: So, I know that every time you come, you have to do the urine testing. . . .

Summer: Yeah. But, I wouldn't do that if I didn't have to.

Khiara: Then, why don't you refuse?

Summer: To me it is not a choice. . . .

Khiara: I think that when you have a problem in your pregnancy, it is great that you have all these things—all these tests and scans. But, when you don't have a problem, it is—

Summer: —unnecessary. But what can we do? I guess saying nothing is better than having somebody come to see your house and all that kind of stuff. I am just going to keep my mouth shut for now.⁷⁶

¶52 Interestingly, Summer understood the difference between the more “alternative” approach to prenatal care that she enjoyed in Israel and the highly-medicalized approach that she endured at Alpha in terms of the hospital’s “American”-ness. She did not realize that the absence of choice—that is, her inability to opt for an “alternative” approach to prenatal care—is a burden only poor women are forced to bear. Also noteworthy, she believed that the price to pay for arguing against the medicalization of her pregnancy and refusing to submit to the myriad tests that were prescribed for her was state scrutiny and possibly regulation—“having somebody come to see your house and all that kind of stuff.” Concluding that such a price was too high, she opted to submit to the medicalization of her pregnancy and “keep [her] mouth shut for now.”

¶53 Moreover, insofar as the model of prenatal care enacted at and by Alpha Hospital—which is administered pursuant to Medicaid guidelines—is one premised on surveillance of a body that is always capable of failing at a moment’s notice, one may argue that the foundation of this prenatal regime is the *unruly body*. The construction of the pregnant body as an unruly body occurs whenever it is intensively medically-managed; consequently, the pregnant bodies of the non-poor may be thus constructed and treated.

⁷⁶ Interview with anonymous obstetrics clinic patient (Feb. 2007).

This is to say that the unruly pregnant body is not specific to the uninsured poor; rather it is characteristic of the body of any pregnant woman who *elects* (insofar as any woman, living within a society in which the medicalization of pregnancy is the norm, can conceive of their being any choice at all) to be treated within and subjected by the standard, biomedical paradigm. But, as discussed above, therein lies the fundamental difference between the unruly bodies of the poor and the non-poor: the non-poor may *elect* to have their bodies administered in such a fashion. To the extent that Medicaid coverage of prenatal expenses is concomitant with a pregnancy administered squarely within the biomedical paradigm, then poor, uninsured women do not *choose* in any sense to have their bodies constructed as unruly. It is a construction that is foisted upon them.

¶54 Furthermore, the unruly bodies constructed by Alpha rarely disappoint. That is, anomalies, disorders, abnormalities, and malfunctions are regularly and relentlessly found within the pregnant bodies of Alpha patients; yet many of these anomalies, disorders, abnormalities, and malfunctions “resolve themselves” or otherwise have no effect on the health of the fetus or the mother. For instance, on several occasions, I have translated explanations by the ultrasound technicians to Spanish-speaking patients that placenta previa⁷⁷ was detected during their sonograms; however, the ultrasound technicians always assure the women that they should not worry because the placenta usually moves away from the cervix over the course of the woman’s pregnancy. Thus, the potential issue is resolved.

¶55 On these occasions, I imagine that the effect of a diagnosis of placenta previa merely serves as a reminder to the woman that she occupies an unruly body that may fail at any given moment; she is thereby warned that her submission to the biomedical paradigm and the physicians that perform it is required if she hopes for the health of her baby.⁷⁸ That patients are frequently diagnosed with conditions that proceed to no effect might be explained as a failure of a medical technology that “sees too much.” Or, it might just be the effect of screens, tests, and examinations that speak in terms of probability, risk, and likelihood: all patients are rendered at risk for *something*—even if that risk is one in one million.

⁷⁷ Placenta previa is a condition in which the placenta partially or completely covers the cervical os. Patients with placenta previa are advised to undergo a Caesarian section, as they are at risk for massive hemorrhaging if the placenta covers the cervix when the latter begins to dilate in preparation for the birth of the baby. American College of Obstetricians and Gynecologists, Bleeding during Pregnancy, http://www.acog.org/publications/patient_education/bp038.cfm (last visited Jan. 14, 2008).

⁷⁸ There are countless anecdotes that I could recount concerning the plethora of diagnoses made by Alpha providers that served little purpose beyond reiterating the fact of patients’ unruly bodies. I will offer only one more: I remember having a long conversation and/or in-depth interview with one delightful patient while she waited over two hours for an ultrasound scan. After she was finally called and had completed her scan, I asked one of the nurses if the patient had left for home yet, as I wanted to exchange contact information with her. The nurse replied, “No; she’s talking to a doctor. They saw something with the baby’s heart in the ultrasound.” I became distraught, imagining the patient’s own distress at receiving news of a problem with her fetus. In response, the nurse said, “No, no, no. Don’t worry. It’s no big deal. They see this all the time. It usually goes away.” I looked at her skeptically. She laughed at my continued distress and said, “It’s nothing to worry about. Really. It usually goes away.” Indeed, when I talked to the patient after her meeting with the doctor, she said, “They want to run some sort of blood test. If it comes back negative, then there really is nothing there. But, if it comes back positive, then they would just have to monitor me to make sure that the heart thing goes away.” Again: such an anxiety-producing diagnosis for a “heart thing” that would go away with or without a medical intervention probably did little more than to produce anxiety (in her and me) and reiterate the unruliness of this patient’s body.

¶56 It should be noted that Alpha Hospital offers women the choice of receiving their prenatal care from midwives. In spite of this, this choice does not usually offer women an exit from a medically-managed pregnancy and consequent construction of their bodies as unruly ones.

¶57 First, many women do not know that the choice among the physician, the nurse practitioner, and the midwife exists. On the day of the PCAP appointment, after meeting with the host of staff members discussed above and completing all the urine and blood tests requested of them, women are given an appointment to return to the clinic and have a medical examination. This appointment—ironically called a “doctor’s appointment” by Alpha staff—is the woman’s first meeting with the physician, nurse practitioner, or midwife. Whether the woman is assigned to a physician, nurse practitioner, or midwife is a matter of chance; the woman receives the next available appointment in the schedule. If the next available appointment is with the midwife, the patient is so assigned and will continue to be seen by the midwife for the duration of her pregnancy (unless a medical problem is later detected and she is transferred to the High Risk Clinic to be attended by a physician). Few patients know that there exist three categories of providers in the obstetrics clinic at Alpha Hospital.⁷⁹ Further, if patients are aware of the three varieties of care, few of them know that they can request one of the three.⁸⁰ And further still, of the small group of patients who know that they can make a choice among a physician, nurse practitioner, and midwife, very few of these know the differences in the manner of care offered by midwives versus physicians or nurse practitioners. That is, very few appreciate that midwives ascribe to a paradigm within which the pregnant body is not constructed as unruly.

¶58 Second, and crucially, women who choose to receive their prenatal care from midwives still undergo a medically-managed pregnancy because the care provided by midwives at Alpha Hospital is not qualitatively different from the care provided by physicians and nurse practitioners. This similarity in care is due to the fact that the midwives, like the other categories of providers at Alpha, must comply with the Medicaid protocol for PCAP providers. Undeniably, many patients who have had experiences with both the midwives and physicians appreciate that the midwives take a different approach to women’s healthcare. The patients with whom I have spoken frequently describe their midwives as “nice”; they say that the midwives “take their time” during their meetings with the patients; many patients say that the midwives ask more questions and try to get them to talk more about their pregnancies.⁸¹ This is to be contrasted with patient

⁷⁹ In fact, when I ask women with whom I conduct in-depth interviews if they are seen by a doctor, nurse practitioner, or midwife, I am usually met with bewildered expressions and/or attestations of “I have no idea.” To clarify, I am not arguing that these Alpha patients are somehow irresponsible for not having discovered the training and qualifications of the providers of their prenatal care; instead, I am emphasizing that many Alpha patients have not been given enough information to know that the discovery of the training and qualifications of their providers is a relevant inquiry.

⁸⁰ It would appear that even the Alpha employees are surprised when they are approached by a patient who requests a certain quality of provider. Natalie, a former eleventh grade English teacher who was pregnant with her second child when I met her, told me that during her initial PCAP visit, she requested a midwife as her prenatal care provider. She says, “I remember [the nurse] telling me, ‘Well, you’re lucky that you ended up here, because we have a midwife program and you’re interested in that.’ And I’m like, ‘I’m not lucky. I picked it.’ [Laughs.] . . . ‘This is why I came here. ‘Cause that’s what I wanted.’” Interview with anonymous obstetrics clinic patient (Jan. 2007).

⁸¹ One patient’s midwifery encounter exemplifies many of the stories women have shared with me about their experiences with the Alpha Hospital midwives: Before this patient had her first official meeting with,

encounters with physicians, who are described as “rushed” and “fast,” or alternatively, “unremarkable.”⁸² Nevertheless, patients who are seen by the midwives must submit urine to be tested at every visit. They must endure the “glucose challenge test,” the triple screening for gonorrhea, chlamydia, syphilis, and HIV, and all required vaccinations. Their fetuses are screened for genetic abnormalities when clinically indicated. Their bodies are constantly weighed, blood pressures systematically checked, and interiors regularly made visible via ultrasound and vaginal examinations. This program of prenatal care is mandated by Medicaid. So, essentially, the unorthodoxy, or “alternative-ness,” of any midwifery practice reimbursed by Medicaid—without regard to whether the midwife practices within a public hospital or outside of one—is severely constrained by the necessity of delivering care in accordance with the dictates of being a Medicaid “PCAP provider.”⁸³

¶59

The result is that poor, uninsured women in the state of New York are compelled to live unruly bodies and the medically-managed pregnancies that are their cause and effect. This is significant because in the absence of a choice of a low-intervention prenatal care

and examination by, the midwife, she had been informed that the midwife whom she would be seeing that day was male. She was wary of receiving her examination from a male and told me that she would probably switch to a female physician for her subsequent visits. At her next appointment, I saw her in the waiting room and asked how her visit with the midwife had been. She said, “He is so amazing! I love him. I went in there [the exam room] and told him that I was worried about the baby because I’m not showing that much. And I wanted to know if he thought that I was too small. And he says, ‘You’re just falling in love. And you’re going to be doing this over the next thirty years. And you’re just going to have to let go and stop worrying and enjoy the experience.’ It was so unexpected! I totally didn’t expect him to say that—to respond to my question in that way! I loved it.” Indeed, patients often describe the midwives in much kinder terms than they do the midwives’ counterparts with medical degrees.

⁸² The adjective that is most frequently proffered by patients describing their physicians is “fine”—as in: “How do you like your doctor?” “She’s fine.” Or, “How was your visit with the doctor?” “It was fine.”

⁸³ One profound difference between the midwifery practice and that of the physicians and nurse practitioners is that only the midwives’ patients can deliver in the birthing center at Alpha Hospital. Meanwhile, the patients of the physicians and nurse practitioners must deliver in the standard labor and delivery rooms. In the latter, patients must remain in a hospital bed, connected to an IV and external fetal monitor. Only two persons, both over the age of 18, are allowed to join the laboring woman in the delivery room. Once the woman delivers, she and her newborn are transferred to a different postpartum room where they remain until they are discharged from the hospital.

In contrast, a patient who delivers in the birthing center is not confined to the bed. Because she has neither an IV nor fetal monitor, she may move freely within the room—which is equipped with a kitchen, Jacuzzi tub, large screen television, private bathroom, and expansive views of the East River. Moreover, there are no limitations on the number of persons (and the ages of those persons) who may join her in the birthing room while she is in labor. Finally, the woman may remain in the same birthing center room until she is discharged from the hospital. If, on the other hand, a woman desires an epidural, or if a C-section becomes clinically indicated, the patient must deliver in the standard labor and delivery rooms.

I should also note that when there is actually a *choice* between proceeding within the biomedical paradigm of pregnancy, labor, and delivery, and an alternative one, midwives choose the latter. One pregnant patient gave me an account of the birth of her son, whom she had delivered at Alpha. She says that the umbilical cord was wrapped around her son’s neck for much of the last trimester of pregnancy. However, instead of undergoing a C-section, her midwife heeded her wishes and attempted a vaginal delivery. Once her son’s head was delivered, the midwife removed the umbilical cord from his neck. The rest of the delivery proceeded without incident. The patient said, “The only reason why I was able to avoid a C-section was because of the midwife; if I had had a doctor, they would have done the C-section. No questions asked.” Interview with anonymous obstetrics clinic patient (Jan. 2007).

This is an assessment with which I wholly agree. (In fact, I believe that most *midwives* would have advised this patient to undergo a C-section.) This patient’s experience demonstrates that the Alpha midwives may elect to perform fewer medical interventions than the physicians and the nurse practitioners. But, again, this offer is only available when the midwives have a *choice* to do so; and, for the majority of patients’ pregnancies, the midwives have no such choice.

program, Medicaid—and the state that administers it—enacts the poor, pregnant body as one that can only and should only be treated medically, scientifically, and therapeutically. Prenatal care within the Medicaid regime can be understood to proceed from the assumption that the errors and risks within the poor, pregnant body (which are invariably “there” and must be detected via constant screens and tests) can only be remedied by medical science. The poor body, then, is one that is exposed to bacteria and viruses; hence, antibiotics, antiviral medications, and vaccinations are administered. The poor body is one that is malnourished; hence, WIC, and the concomitant prescription of prenatal vitamins and recommended consumption of meat and dairy, are provided. The poor body is one whose reproduction is dangerously unrestrained and, yes, unruly; hence, the parade of contraceptives placed in front of the post-partum body⁸⁴—ranging from the lower-intervention condoms to the intensely high-intervention Depo-Provera injection.⁸⁵

¶60 The consequence, I believe, is a medicalization of poverty. Poverty is treated as a condition that produces ailments and disorders all rectifiable, or at least managed, through the application of medical science. In this way, the poor are treated as biological dangers—to themselves, to their fetuses, and to the society within which they exist.

¶61 Indeed, Medicaid’s profoundly medicalized management of pregnancy, and the simultaneous production of poor, pregnant women as biological dangers, might be understood as an admission by the state of the unjust nature of capitalism and the class structure that is its *sine qua non*. Essentially, the state assumes that the poor, pregnant body that presents itself to the obstetrics clinic is one that has not had the benefit of regular (or, even irregular) medical check-ups—an assumption that is especially true for the “undocumented” pregnant bodies that present themselves at Alpha. The battery of tests to which patients must submit themselves might be understood as a corrective to the years of medical inattention that poverty and the absence of health insurance compel. The function of every organ and every system is assessed because class inequality dictates that their health would not have been established previously via periodic evaluations—a comfort that the insured enjoy. Indeed, it is not entirely unreasonable to assume that an aggressive medical gaze is appropriate for the uninsured. These are women who do not have the benefit of annual Pap smears to detect abnormal cervical cell

⁸⁴ The matter of encouraging Alpha patients to select a method of contraception is complex. On the one hand, providing information about contraceptives and the actual devices to Alpha patients is valuable insofar as some of the women may, indeed, desire the service. On the other hand, for those women who happily greeted their present pregnancy and will happily greet the next, the parade of contraceptives retrospectively demeans the pregnancy and birth itself, by implication; the abundant message that is communicated is that such an event should be prohibited from being repeated.

⁸⁵ Expectedly, the Depo-Provera injection (which consists of a high dose of progesterone, thereby preventing the woman from ovulating for three months at a time) is the birth control method that comes most highly-recommended by Alpha providers and staff. See Sheldon Segal, *Contraceptive Update*, 23 N.Y.U. REV. L. & SOC. CHANGE 457, 461 (1997) (“Depo-Provera, an injection of the progestogen medroxy-progesterone acetate that lasts for three months, finally was approved for use as a contraceptive in the United States in 1992, after having been used in over ninety other countries for decades.”). It should be noted, though, that there is dissension within the Alpha obstetrics clinic concerning how soon after giving birth women should be offered the Depo-Provera injection: The obstetrician that heads the Labor and Delivery ward [L&D] has created a policy whereby women are asked whether they would like to receive the Depo-Provera injection *before* they are discharged from the hospital—that is, within three days after giving birth. The breastfeeding educator informed me that she, along with another nurse in L&D, is lobbying to change the policy. Their objection to it is that they believe that the high dose of medroxyprogesterone acetate in the injection may decrease the woman’s ability to produce a sufficient amount of breast milk for her newborn.

growth. These are women who do not have the luxury of having a urinary tract infection diagnosed before it becomes asymptomatic and manifests itself as kidney malfunction. These are the women who do not have the advantage of being told if that lump in the breast really is nothing to worry about.

¶62 All of this is to say that Medicaid's tenacious management of pregnancy performs a confession: it confesses that capitalism and the poverty that is its effect create a state of affairs inside of which common and curable ailments within the poor body go undetected. The insistent medical manipulation of the pregnant body mandated by Medicaid can be understood as an attempt to rectify that situation; however, within that attempt is an implicit acknowledgement of the unjust nature of the class structure of this capitalist society.

V. CONCLUSION

¶63 In conclusion, it should be noted that many of the poor women that I have encountered do not passively accept state regulation of their bodies, nor do they submissively accept conscription into a biomedical model of pregnancy and the concurrent construction of their bodies as unruly. I am constantly made aware of discrete acts of resistance. Such acts may be as minor as a woman lying to the nutritionist about the frequency of her cheese consumption—as did a clever patient, who simply wanted to avoid being “hassled” about her vegan diet and shorten the length of her requisite session with the nutritionist.⁸⁶ Other acts of resistance are bolder, as when a patient refuses to answer the inquiries of the social worker, or avoids meeting with the social worker altogether by ignoring her when she calls out the patient's name in the waiting room. Additionally, a patient's refusal to be seen by a resident obstetrician and her demand of care from an attending might be interpreted as a bold act of resistance. This patient's mother, who had prompted the patient to insist upon an attending physician as her provider, told me, “I said to her [the patient, her daughter], ‘You're not a guinea pig.’ I know this is a teaching hospital; but, they need to find someone else to learn on.” Indeed, the very selection of Alpha Hospital (in lieu of another as the site of prenatal care) should be understood as an act of resistance for many women who do not blindly go to the nearest public hospital, but instead travel far to Alpha because they believe that it has an excellent reputation.

¶64 Conceivably, some of the myriad medical problems with which Alpha patients are diagnosed—ranging from gestational diabetes, to excessive weight gain, to placenta previa—might also be understood as discrete acts of resistance. As medical anthropologists Lock and Schepher-Hughes argued some time ago: “The medical gaze is, then, a controlling gaze, through which active (although furtive) forms of protest are transformed into passive acts of ‘breakdown.’”⁸⁷

⁸⁶ Analogous to the way that I see resistance in (some would say) minor acts of Alpha obstetrics patients, historian/anthropologist Robin D. G. Kelley similarly describes behavior of some employees who worked in a McDonald's restaurant in which he did field research. Following James C. Scott's notion of “hidden transcripts,” Kelley argues that the employees' “infrapolitical tactics” included wearing their McDonald's baseball caps to the side, turning the music that played over the speakers in the store from easy-listening to Rick James, and extending fifteen-minute breaks by another fifteen minutes. ROBIN D.G. KELLEY, *RACE REBELS: CULTURE, POLITICS, AND THE BLACK WORKING CLASS*, 8-10 (1994).

⁸⁷ Margaret Lock & Nancy Schepher-Hughes, *A Critical Interpretive Approach in Medical Anthropology: Rituals and Routines of Discipline and Dissent*, in *MEDICAL ANTHROPOLOGY: CONTEMPORARY THEORY*

¶65 In fact, I would like to imagine the very act of being pregnant as an act of resistance for many of the poor, expectant mothers who are served in the obstetrics clinic at Alpha Hospital. I am always moved whenever I see in the waiting room a pregnant nanny with her White charge. I think of Ginsberg and Rapp's formulation of "stratified reproduction"—a term used to "describe the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered."⁸⁸ Ginsburg and Rapp explain:

Low-income African American mothers . . . are stereotyped as undisciplined 'breeders' who sap the resources of the state through incessant demands on welfare. But historically and in the present, they were good enough nurturers to work as childcare providers for other, more privileged class and ethnic groups. . . . The concept of stratified reproduction helps us see the arrangements by which some reproductive futures are valued while others are despised.⁸⁹

¶66 Accordingly, I see resistance whenever I see in the waiting area pregnant women of color employed as nannies, who not only value their own reproductive futures, but *insist upon them*—even while enacting an employment that recognizes their ability to nurture other women's children and simultaneously disregards or demeans their competency to nurture their own.

¶67 Indeed, resistance might be seen in the fact of many other of these poor women's pregnant bodies. That is, in the face of the discursive problematization of their fertility, despite polemical attestations that their reliance on governmental aid is "un-American" and figures them outside of the deserving body politic, notwithstanding that mythical and fantastical ideas of their children exist in the national imagination as the future scourges of society, the patients at Alpha Hospital embrace their fertility and have and love their babies. This, I believe, can be a powerful, material act of resistance.

AND METHOD 68 (Carolyn F. Sargent & Thomas M. Johnson eds. 1996).

⁸⁸ Faye D. Ginsburg & Rayna Rapp, *Introduction* to *CONCEIVING THE NEW WORLD ORDER: THE GLOBAL POLITICS OF REPRODUCTION*, *supra* note 4, at 1, 3.

⁸⁹ *Id.*