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The "Primitive Pelvis," Racial Folklore, and Atavism in Contemporary Forms of Medical Disenfranchisement

I FIRST MET SHAUNTAY JOHNSON in the Alpha WHC as she waited for her appointment in the High Risk Clinic. In those first few minutes of meeting her, she struck me as a nice, pleasant woman with a great sense of humor. I immediately asked her if she would like to participate in my study by sitting down with me for an in-depth interview. She seemed happy to agree, and we talked for the next hour-and-a-half about everything that came to mind.

Shauntay, a pretty, twenty-four-year-old Black woman who had lived in Harlem all of her life, was twenty-nine weeks pregnant with twins: two baby boys. Her sons would join Shauntay's already full family: unmarried, she had a set of four-year-old twin girls (whose father had only recently begun to give Shauntay $175 per month in child support) and a three-year-old son (with whose father she was romantically uninvolved, but who remained a friend and active co-parent). While the pregnancy was unplanned, and although she had no intention or desire to involve the father of her unborn twins in their lives, she was more than optimistic about the future: she had the support of her mother, brother, and her three-year-old son's father—who, although biologically unrelated to Shauntay's twin girls, helped to raise them as well as their son. "We were friends before I got pregnant [with our son]. And we are friends now." Indeed, when Shauntay informed him she was newly pregnant, he was disappointed at first. “He said, ‘How can you do this to me? You already have the twins. You got Junior. And now you’re going to have twins again?” But, he quickly changed his tune and reassured her that he would be a presence in all of her children’s lives. “He said, ‘I’m still here. My number hasn’t changed. If you need to me to change diapers, I’ll change diapers. If you need me knock [the new babies’ father] out, I’ll knock him out.’ ”

Shauntay had been receiving prenatal care at Delta Hospital, a smaller public hospital close to her home, but her obstetrician there had recommended that she be seen at Alpha because it had superior ultrasound equipment. I asked her why the ultrasound technology at Delta—where she had delivered her twin girls and younger son—was insufficient. She explained:

SHAUNTAY: Yeah—one of the babies has some type of kidney problem—they couldn’t tell the difference at the other clinic. They didn’t know what it was. First, they were like, “Maybe you have another kid.” The lady was just seeing something different with that machine. So, they sent me here. I guess, I don’t know—I didn’t get to . . . I guess they will see something more, or—maybe it isn’t what they thought it was at the other hospital. Because they thought it was something worse than what it really is. But, still, I have to come here every week.

KHIARA: Now, were you worried when they told you that the baby might have a kidney problem?

SHAUNTAY: No, because they told me that it appears to be hereditary. And I know that it’s from the father’s side—it’s not my side. I mean, it’s not nothing you go home and say, “Oh Lord.” [laughs] I mean, as long as it could be fixed and you catch it at an earlier time than later. . . . I mean, I don’t worry myself about a lot of stuff. Because I have other kids. I don’t have that kind of time to be worrying about everything. . . . It’s better for me to come here because they see more and they are a little more effective. But, the other place, I just couldn’t go.

Shauntay assured me the twin’s condition was “no big deal,” even though the obstetrician at the other hospital informed her that he would have advised her to terminate the pregnancy had he known about the twin’s condition earlier.

> It was a big deal at the other hospital because the doctor, he's not—how do I say this?—sensitive in any way. He was like, "Well, if I would have known this way before, I could have gave you the shot and you could have gotten rid of that one. This kid is going to have a life of going to the hospital. You don't want that—but it's already too late."

She told me that had she had a more vulnerable personality, the doctor's callous prognosis of her twin's condition would have troubled her.

> If I was that type, he would have just—I would have been so sick [upset]. I would have been going through depression. You know what I'm saying? He would have really had my head somewhere. But, like I said, you don't let it faze you. He made me mad, but I wasn't ready to cry or nothing like that. I wanted to fight him, though. [laughs]

When she was called into her appointment with the physician, ending our interview, Shauntay gave me a hug and told me she would see me soon—which pleased me, as I was looking forward to following her throughout the remainder of her pregnancy and meeting her twin boys when they arrived. But, I never saw Shauntay again. Realizing her absence in the clinic one day, I checked her medical records to see if I could track her down. The notes in her chart told a tragic story.

Shauntay had been referred to Alpha from Delta because Delta was unequipped to handle the severity of the condition from which Shauntay's baby suffered. The Delta ultrasound had revealed that one of her twins (referred to as Twin B in her medical records) had anechoic structures overlying both of his kidneys—an ominous finding. Moreover, the ultrasound detected hydronephrosis (a swelling of the kidneys that occurs when the flow of urine is obstructed) as well as hydroureter (a swelling of the ureter). Both conditions imply that the ureter and the connection of the ureter to the kidney have been overfilled with urine. The severity of this condition was exacerbated by Twin B's growth having shown restriction (a condition called IUGR, or intrauterine growth restriction). Moreover, Shauntay's physicians also noted that Twin B suffered from AEDF, or absent end-diastolic flow, indicating that the placenta was not working properly and the fetal heart was struggling. A diagnosis of IUGR with AEDF is a dire one, and most fetuses with the condition do not survive absent immediate delivery.

On the same day I talked to an upbeat, laughing, and joking Shauntay, she was admitted to the hospital for the monitoring of Twin B's condition and given a course of dexamethasone to promote fetal lung maturity in anticipation of a potential preterm delivery. The medical records indicate that because Twin B was only being monitored daily, as opposed to continuously, Shauntay requested to be discharged the following day—most likely because she had three children at home for whom she needed to care. She agreed to return to the hospital daily for her physicians to check on Twin B's status. As planned, Shauntay returned the next day. A sonographic assessment of Twin B revealed his condition had worsened; moreover, although a fetal heartbeat was found, there was no spontaneous movement or breathing. Shauntay was counseled that Twin B would die if he was not delivered immediately. Complicating the matter was the fact that Twin A was completely healthy. If Twin B was delivered, Twin A would have to be delivered also—at only twenty-nine-weeks gestational age. A physician noted in the medical records, "The patient was counseled that if she desired to intervene for the sake of twin B, that intervention should be via immediate cesarean delivery. If she did not desire to intervene for the sake of allowing twin A to have more time to grow in utero, that was an acceptable alternative, but that likely twin B would not survive until a time when twin A could safely deliver."

Faced with such an unthinkable choice, the records indicate that Shauntay "opted to leave to speak with [her] pastor regarding the religious implications of this decision." She was advised against leaving, as the possibility of intervention at that point was still open, but might have closed by the time she returned. She nonetheless insisted on it, promising to come back when she had reached a decision. (Interestingly, a nurse who had cared for Shauntay in the labor and delivery ward told me Shauntay had left that day because "she said someone had been rude to her. I don't know who it was—a nurse or PCA or someone. But, she said that someone was rude and she wanted to leave.")

Shauntay returned the next day, having decided to undergo a C-section delivery of both twins. After delivery, Twin A was placed in the neonatal intensive care unit. Twin B, however, died shortly after being removed from the womb. The records sanitize the horror of the event: "[Patient] was told of Twin B's demise and patient requested time to herself."

RACIAL DISPARITIES IN INFANT AND MATERNAL MORTALITY

At present in the United States, the infant mortality rate for Black babies is nearly two-and-a-half times higher than for white babies. This disparity has persisted despite the overall decline in infant mortality rates over the years. There has not been even a narrowing of the racial gap; although fewer infants died last year, the rate at which Black babies died remained twice that of white babies.

Perhaps it is easy to disconnect these shameful statistics from the experience they quantify and describe. Perhaps the estrangement that numbers produce dulls the senses and prevents outrage. Perhaps this explains the relative lack of public outcry and protest over what can dispassionately be called "racial disparities in infant mortality." But, Shauntay puts a face on the otherwise disembodied numbers and rates. Instead of carrying home two babies wrapped in blue blankets, Shauntay brought home one baby and planned a funeral for the other. An empty crib in her apartment would remind her of the baby who did not live, until she managed to—not quickly enough—give the unused crib to a pregnant friend. She would have to think of a story to tell all her neighbors who knew she was expecting twins; until word got around that one of her infants had died, how would she respond to the inquiry, "Where's the other baby?" Would she ever tell the baby who lived that he had a twin? Would she ever be able to look at her son and not be reminded of the other son who died?

Infant mortality among African Americans in 2000 occurred at a rate of 14.1 deaths per 1,000 live births—more than twice the national average of 6.9 deaths per 1,000 live births. Perhaps these facts and figures alienate those reading them from the human tragedy they condense. Black women experience Shauntay's ineffable pain at twice the rate of their white counterparts. Black women are twice more likely to know what it feels like to give birth, but have no child to mother.

Racial disparities in maternal mortality in the United States are equally lamentable. Black women die from causes linked to pregnancy and childbirth at more than three times the rate of white women. In New York City, the maternal mortality rate for Black women was more than five times that of white women. "In fact, 1 of every 2,500 black women in New York City who becomes pregnant dies. The similar figure for white women is 1 in 14,000" (Fang, Jing, Shantha Madhavan, and Michael H. Alderman 2000, 742). And although New York City's maternal mortality rate exceeded that of the nation as a whole, this excess is due to the elevated maternal mortality rate experienced by Black women. "Indeed, if all New Yorkers experienced the mortality of its white women, the rates for the city would be indistinguishable from the country as a whole" (743).

Fortunately, during my fieldwork I never met a pregnant woman who died during or shortly after her pregnancy; consequently, I cannot provide an ethnographic story that can help to personify the abstract figures. But, "maternal mortality" means a child will grow up never knowing the mother who gave birth to her. Maternal mortality means a husband, boyfriend, or partner somehow will have to balance the joy of welcoming a new life with the devastation of encountering death. Maternal mortality is an event that, despite a cause of death being noted on the death certificate, remains inexplicable to those it affects. And so, when one understands maternal mortality as such—as a personal, indefinable disaster—it seems manifestly unfair that this burden is imposed disproportionately on Black women, Black families, Black people.

The leading causes of maternal death have been identified as hemorrhage, pulmonary embolism, pregnancy-induced hypertension (leading to preeclampsia and eclampsia), puerperal infection, and ectopic pregnancy. That these conditions affect Black women with a disproportionate frequency and are more fatal has been attributed to the higher rates among Black women of high blood pressure, preexisting and gestational diabetes, and obesity. Indeed, one study reported that 54 percent of women who died from pregnancy-related causes had a history of chronic disease—among them hypertension, cardiac disease, diabetes, schleroderma, and sickle cell. Obesity was the most commonly identified condition (Campbell 2007). These are all conditions, in addition to decreased health care access (due to poverty), which affect Black women at disproportionate rates. Such information has led some researchers to conclude that to bring white and Black maternal mortality rates to parity, we ought to "eliminate socioeconomic disadvantage" by increasing Black women's access to early prenatal care, then monitoring them more closely for hypertension and diabetes while attempting to control the effects of obesity. This increasingly popular view explains racial health disparities as wholly a function of class and preexisting medical conditions while saying nothing about the individuals under whose care Black women are disproportionately dying.

However, at least one study challenges the conclusion that it is class that is the problem, disputing the claim that Black women are dying because they are poor and not because they are Black. Fang et al. (2000) released a study showing that although socioeconomic factors (such as marital status and educational achievement) were strongly correlated to maternal mortality for non-Black women, such factors had relatively little impact on the incidence of maternal mortality for Black women. The authors report "unmarried non-black women had a maternal mortality ratio more than twice that for married women, and non-black women with less than a high school education had more than six times the mortality ratio that did those with high school education and above." Meanwhile, a relationship between these socioeconomic factors and maternal mortality was not readily apparent for Black women: "[T]he mortality ratio of unmarried black women was indistinguishable from that of married black mothers, and black mothers with less than a high school education had 1.5 times the mortality of blacks with at least a high school education" (739). Similarly, for non-Black women, there was an association between residence in a low income community and higher maternal mortality rates. No comparable association was found for Black women; they were as likely to die from a pregnancy-related cause without regard to the affluence of the neighborhood within which they lived. Accordingly, Fang's study suggests referring to the phenomenon as "racial disparities in maternal mortality" is not a red herring. That is, race has everything to do with why Black women are more likely to die in the path toward motherhood—and not simply because race follows class closely in the United States.

Racial disparities in infant and maternal mortality are part of a larger phenomenon of racial health disparities experienced by Black people in the United States. That Black persons suffer from certain diseases at higher rates and die younger than their white counterparts has been well-documented in the literature (Institute of Medicine 2005; Office of Minority Health and Health Disparities 2009; National Center for Health Statistics 2007). Again, that Black people are disproportionately poorer than white people in the United States—and therefore more likely to be uninsured and lack access to regular health care—does not entirely explain away these disturbing statistics. The Institute of Medicine (IOM), a not-for-profit, nongovernmental organization that is part of the Academy of Sciences, released a report arguing that the poverty in which Black people disproportionately live cannot account for their being sicker and dying younger than their white complements. The IOM found "racial and ethnic minorities receive lower-quality health care than white people—even when insurance status, income, age, and severity of conditions are comparable" (Institute of Medicine 2005). "Lower quality health care" is not an amorphous, intangible concept; instead, it signifies the concrete, inferior care physicians give their Black patients. The IOM reported minority persons are less likely than white persons to be given appropriate cardiac care, to receive kidney dialysis or transplants, and to receive the best treatments for stroke, cancer, or AIDS (6–7). Mincing few words, the IOM described an "uncomfortable reality": "some people in the United States were more likely to die from cancer, heart disease, and diabetes simply because of their race or ethnicity, not just because they lack access to health care" (3).

The IOM gestures toward a phenomenon that, although going unnamed in the literature, could do much to explain racial disparities in health: physician racism. That is, perhaps the racist beliefs of physicians explain why Black persons do not receive the most effective and desirable tests, treatments, and therapies for their conditions. Perhaps physicians' devaluation of Black bodies—for no reason other than the fact that that they are *Black* bodies—explains why Black women die from pregnancy-related causes at three to four times the rate of white women. Perhaps the lesser regard with which physicians hold Black lives explains why Black infants die at more than twice the rate of white infants. Indeed, perhaps racism practiced by the persons who are empowered to care for them partially explains Black people's status as the sickest racial group in the United States.

Other factors named in the literature also contribute to racial health disparities—such as the disproportionate levels of poverty among Black people, which increases the likelihood they will also suffer from poor nutrition and obesity. Moreover, disproportionate levels of poverty increase the likelihood Black people will lack access to regular medical care, which, in turn, decreases the likelihood that medical problems will be caught at an earlier, treatable stage. But, these facts should not be used to argue that physician racism should be dismissed as an impossibility or irrelevancy—as if physician racism exists only in thought experiments (or, if it actually does exist, has no relationship at all to the racial disparities in health that shorten the lives of Black people across the nation).

A caveat: the discussion contained in this chapter may be accused of lapsing into individualism while losing sight of structures of racism. That is, it may be taken to argue that bad, racist behaviors of individual physicians—as opposed to more macro, institutional forces—produce the racial disparities in health that are so well-documented. If racist behaviors are the cause of the phenomenon, the way to eliminate racial disparities in health would be to rid the medical establishment of its bad actors. Once the guilty parties no longer practice medicine in the United States, we can expect parity among the races in all indexes of health. However, the ensuing discussion of physician racism should not at all be taken to advocate this position. Instead, individual racism exists simultaneously to and alongside structures of racism. Accordingly, bad, racist behaviors of individual physicians—in addition to more macro, institutional forces—produce the racial disparities in health. Physicians harboring racist beliefs (and physicians not harboring racist beliefs) practice medicine within institutions that function to both reiterate racial and racist discourses and to maintain racial inequality. Ridding the medical establishment of individual bad actors will not eradicate the large and small structures that are also responsible for racial disparities in health—structures that range from population discourse (which I explore in the following chapter) to a two-tiered system of health care in which people of color are disproportionately relegated to the inferior tier. And so, it is imperative that this chapter's exclusive focus on individual racism is not taken as an argument that it is exclusively responsible for racial health disparities.

NAMING PHYSICIAN RACISM

Cultural critic and race theorist John Hoberman (2005, 2007) has done illuminating work in this area, casting light on the ways in which the phenomenon of physician racism has been denied altogether or capably hidden in research regarding health disparities. Hoberman argues that racism—defined as "racially discriminatory rationing by physicians and health care institutions"—plays at least some role in the health gap between the races. Indeed, there is no reason to believe that a person's decision to become a physician somehow immunizes him or her from the racism, race-thinking, and race-consciousness that pervade the United States. It may be overly optimistic to think physicians' extensive training in the biological sciences in some way cleanses them of the biases and prejudices that run rampant in the social milieu in which that training takes place. Certainly, there is nothing intrinsic about medicine or medical training that should counsel us to believe physicians, as a class, are free from "deep-seated attitudinal biases that parallel those of the general public and the media and [could] confuse [their] best clinical intentions" (Hoberman 2007, 512).

Hoberman argues that when physician racism is invoked in studies of racial disparities, it is never by that name, and it is usually done through a "rhetoric of exculpation" and with "euphemizing vocabulary" in which physicians are excused for the racial biases they may harbor and put into practice. He notes the above-referenced IOM report—in which the authors damningly concluded that a person's ascribed race, independent of class, made it more likely he or she will die from cancer, heart disease, and diabetes—nevertheless expertly uses the "rhetoric of exculpation" when describing its findings: "Survey research suggests that among white Americans, prejudicial attitudes toward minorities remain more common than not, as over half to three-quarters believe that relative to whites, minorities—particularly African Americans—are less intelligent, more prone to violence, and prefer to live off of welfare. It is reasonable to assume, however, that the vast majority of health care providers find prejudice morally abhorrent and at odds with their professional values. But, health care providers, like other members of society, may not recognize manifestations of prejudice in their own behavior" (Institute of Medicine 2005, 10). Here, as throughout the literature, physicians are given "the benefit of the doubt" and presented "as the passive receptacles of powerful stereotypes" (Hoberman 2007, 511–12). When not representing physicians as the unfortunate victims of overpowering racist ideas, the literature presents physicians' racism as a "cognitive shortcut" upon which they rely because of time constraints. "[T]he physician who practices a racially biased form of medicine is not himself a racist, but is simply too busy to behave more carefully. He is distracted rather than negligent or hostile or indifferent" (Hoberman 2007, 511–12).

Hoberman's findings—that the literature has largely denied the possibility that physician racism may contribute to health disparities—hold true in the reports of racial disparities in infant and maternal mortality. Consider an explanation offered by the authors of a study finding that African-American pregnant women were less likely to receive surgical intervention for pregnancy-related hemorrhage, even though the severity of hemorrhage was equivalent between the racial groups studied: "In the case of postpartum hemorrhage, reluctance to report or under-reporting on the part of the patient or difference in history taking on the part of the physician could lead to differences in treatment for the same degree of hemorrhage" (Harper et al. 2007, 184–85). Oddly, the authors partially attribute the disparity between the rates at which physicians surgically intervene in Black women's hemorrhaging episodes to the Black women who are bleeding to death. It seems a bit peculiar to believe that a woman will not inform her physician or caretaker of her massive blood loss. The hypothesis that Black women will silently endure such frightening episodes probably says less about Black women's actions under such circumstances and more about discourses of Black women's fantastical stoicism and strength. Moreover, the authors also partly attributed the disparity to "difference in history taking on the part of the physician"—an obscure phrase explaining very little. It is unclear what the authors perceive as the "difference" in the histories taken of Black and white women. Is it that physicians are not quite as thorough or careful when they take Black women's histories? Why exactly would physicians take different histories of Black women? The authors could be gesturing toward the unnamable—that the personally held racist beliefs of physicians prevent them from providing the same quality of care to their Black patients as they do to their white patients—but the authors are careful to hide such a suggestion behind euphemism.

This same study also found that African-American women delivering preterm were less likely to receive antenatal steroids that could improve perinatal outcomes—a disparity the authors found "disturbing." They explained it as follows: "[D]ifferences in reporting contractions or accurately assessing risk for preterm birth from history could lead to differences in administering antenatal steroids" (Harper et al. 2007, 185). Again, the authors partly attribute the fact that preterm Black infants are more likely to be denied steroids necessary to develop their premature lungs to Black women's silence. Again, Black women are fantasized to be uncannily durable (or daft) women, bearing the pain of contractions without thinking to inform their physicians or caretakers of their premature labors. The other explanation the authors provide for the disparity in the administration of antenatal steroids—that physicians do not "accurately assess[] risk for preterm birth" in Black women—requires much elaboration. What is it about Black women that causes physicians to fail to accurately assess their risks? Could racism be partly to blame for physicians' inability to hear the histories Black women tell them?

The Harper study concludes by offering several ways to reduce the racial gap in pregnancy-related death. Among them, the authors propose that Black and white maternal mortality rates can be brought to parity by "eliminating unequal treatment." Here, the authors might be using "unequal" as a synonym for "racist." Or, they might not. It is unclear, and because of that lack of clarity, physicians who provide racially discriminatory care are absolved from responsibility.

The Harper report is far from the only study denying the role physician racism may play in the persistent disparity in rates of infant and maternal mortality and morbidity among Black and white people. Yet, there are notable exceptions to this practice of obfuscating or denying altogether the operation of physician racism in creating and maintaining racial disparities in maternal and infant mortality rates. One of the most overt namings of racism as an actor in this phenomenon comes, ironically, from a physician who appears to accept some notion of biological race. He argues that investigations that "show the persistence of high African American infant mortality[,] even when African American women enroll in early prenatal care at high rates[,] and that show that college-educated, middle-class African American women still have higher rates of low birthweight and infant mortality than poorly educated, impoverished whites" are "suggestive of genetics being a more powerful determinant" (Parker 2003, 336). Yet, this doctors' belief in biological race does not prevent him from also believing racism plays an indispensable role in creating health disparities:

> Efforts to study infant mortality have continued to trend toward studying the problem at the molecular level: the missing or defective gene, the environmental toxin. Such efforts, while personally rewarding to investigators, risk irrelevancy and unethical indictment when existing solutions operate at the macroscopic level. Group empowerment socioeconomically, health education, and abolition of racism have no gene markers, but they do raise a different issue. When infant mortality and disparity are examined in these contexts, there is no question that we know enough. The question is: as a resource-rich society facing significant health disparities that can potentially be resolved, are we "good" enough? (337)

Although Parker is candid in his articulation of racism as an actor, he notably does not name its perpetrator; he also does not name the physician as being the someone who treats patients differently on the basis of race. Parker's silence allows the subject of racism to be anything and anyone from physicians (in their interpersonal interactions with patients) to more diffuse institutional, cultural, and discursive practices. The hush that surrounds the naming of the physician as the person responsible for racism is echoed in other studies that dare to identify racism as a force in racial disparities in health.[1]

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I met the newly pregnant Rhonda at her first prenatal care visit to the Alpha WHC. Rhonda, a native New Yorker, was a woman of Puerto Rican and African-American heritage who self-identified as Black. Because she appeared to be a friendly, talkative, and open person, I asked her if she would be interested in speaking to me more extensively about her prenatal care experiences. She agreed, and we made plans to talk during her next appointment. She warned me: "We're going to need a lot of time. I have a lot to talk about." Her current pregnancy was her fourth—she had twin sons who were thirteen, a daughter who was twelve, and another son who was seven. She then told me her youngest son was a "survivor": when she had given birth to him at twenty-six weeks, he weighed a little less than two pounds. She spoke about him with so much love that, throughout our interview, I found tears coming to my eyes. Although the medical conditions he would face for the rest of his life were daunting, she described him as a "happy kid":

> It takes him a minute to get it out, but he talks. That doctor said he'd be a vegetable—said he'd never do anything. Said he'd probably have hydroencephaly, he'd be institutionalized. But, he talks—too much, in fact! He doesn't walk—he has some issues. He's a quadriplegic. But, the only way I can describe him is "awesome." He smiles all day where you would be miserable in his condition. Some people say, "I don't understand your son because, if it were me, I'd be miserable—in a chair all day, can't do anything. We literally do everything for him and he still says, "Hi, how are you?" all day. He's a happy kid—happy kid. He loves school, loves his friends, loves his teachers. And they all love him.

It was not until we had a chance to talk again that she revealed the true extent of her choice to call her son a "survivor": he was one of a set of twins, but the other boy had died shortly after birth.

When I met Rhonda, she had just finished settling a lawsuit with the hospital that had delivered her sons—one she says she filed seven years earlier to get the answers the hospital had refused to give her: "Somebody had to tell me why my child was the way he was and why my son died. To be honest with you, I was prepared to lose. But, they still would have had to say something. They would have been forced to say, 'This is what happened.' That was my whole purpose." Over the course of the litigation, she learned she had had a Group B streptococcal infection during her pregnancy—something her physicians knew about, as it was documented in her medical records, but for which she never received treatment.[2] Although she now had the answers she had needed so desperately, they did not dull the pain of having to bury her child.

> When I first gave birth to my sons—when I had them. . . . First, [my husband] came to me. When I first woke up, he was the first person I saw. He said that Yusef, my surviving baby, needed a blood transfusion. Yusef needed a blood transfusion, but Xavier, my son who died, was okay. Um, he needed help breathing, but he was going to be all right. And I'm like, "OK." You know, because my only question was, "Are they okay? I want to see my babies." That was the first and only thing on my mind: "I want to see my babies." And my husband, he said that they need blood. And I said, "OK. Well, call everybody." And he was like, "I called everybody already." He let me know that he called everybody in the family, and my family was coming to donate blood. That was Friday . . . and then my son took a turn for the worse. Just a day later, Xavier died. [pause] I went to the nursery to see Yusef. I just had to be with Yusef. [pause]
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> So, after I left, I came upstairs very emotional. I'm automatically blaming myself, you know—thinking "I killed my son." I was in my room—they gave me my own—I had my own room. Two beds. I'm in my room—hysterical. It was Saturday. It was quiet. And I was hysterical.

She described the death of her son as a heartbreak that threatened her mental health even after the initial shock. In the months after his death, she began collecting stray animals, stopped eating, stopped bathing, and stopped caring for her other children. In fact, she checked herself into the psychiatric ward at Alpha Hospital because she thought she was "crazy." "Losing my son was such a tragedy for me. It was just like . . . that's my baby. That's my son. I wanted those kids so much. . . . I never got over it. I probably never will get over it."

SOME CONTEXT: A LONG HISTORY OF MEDICAL RACISM

I do not tell the stories of Rhonda and Shauntay in order to make an argument that because they are Black women, physician racism contributed to their babies' deaths. This is an argument I am radically incapable of making. Rather, I include their stories to give a human face to a trauma that occurs disproportionately to Black women.

Even if one cannot argue that racism on the part of their physicians played some role in the experiences of Rhonda and Shauntay, those experiences ought to be put in context—embedded in a history in which race had everything to do with Black women's encounters with their physicians. Rhonda and Shauntay's experiences are, in fact, moments in a long history of Black women's contact with medicalized obstetrical and gynecological services. Indeed, one can argue that any ethnography of a clinic that provides obstetrical and gynecological services to large numbers of Black women—and any ethnography that is critical of the services provided—ought to be put in this context. This is important for two reasons: first, with this background, one can ground the present, less overt (yet effective) medical disenfranchisement of women of color that I discuss throughout this book in its more blatant predecessor. Second, this history should not be reified as a snapshot of a distant past that has no effect on the present, but rather can be appreciated as a practice that persists and can inform our understanding of the contemporary. That is, rather than grasping current demonstrations of racism, race-thinking, and disenfranchisement on the basis of race as anomalies, we can appreciate their consistency with the long history of medical racism in the United States.

One of the most salient aspects of the history of Black women's contact with medicalized obstetrics and gynecology is exploitation, unfortunately. In her history of nontherapeutic medical experimentation on Black Americans, journalist and medical ethicist Harriet Washington (2007) recounts numerous occasions of Black women being subjected to horrific experimental gynecological and obstetrical surgeries without their consent, ranging from vaginal surgeries, nontherapeutic hysterectomies, and contraceptive abuses. Another salient aspect of Black women's history with obstetrics and gynecology is the construction of the Black pregnant woman within the discipline as remarkably resilient. Hoberman describes this fantasized trait as "obstetrical hardiness," defined as the belief that Black (and other socially and politically disempowered) women are relatively unaffected by the expected pains of labor and childbirth. "Obstetrical hardiness" is part of a broader philosophy about the primal nature of Black people, who were thought to represent a "primitive human type that is biologically and psychologically different from civilized man" (Hoberman 2005, 87). Variations on the theme of the Black reproductive body as a hardy, primordial type include beliefs in: Black hyperfertility attributed to the truism that "[t]he simpler the organism, the simpler the genesis and the greater the prolificness"; the Black "primitive pelvis," which was thought to be narrower and deeper than the presumably more "civilized" pelvises of white women, and invariably enabled a complication-free passage of the infant during birth;

the absence among Black women of endometriosis, which was thought to be a "twentieth century disease" that only affected "civilized" persons within modernity; and the lessened sensitivity of Black women's vaginal tissues, which was thought to make Black women immune from injuries occasioned during birth.

History counsels us that the phrase "racial logic" is a misnomer, as the ways in which the concept of race has been deployed to make sense of human difference have not always been logically consistent. Therefore, it should come as no surprise that the belief in Black reproductive primitivity manifested itself in contradictory ways, with Black people being immune from certain types of disorders and diseases (such as endometriosis), yet ironically predisposed to other conditions (such as syphilis and pelvic inflammatory disease). Hoberman explains the incongruous logic of black racial hardiness:

> The discourse that distinguishes between "civilized" and "primitive" peoples has long been characterized by a deep ambivalence on the part of the "civilized" toward the "savage" type. The negative sides of primitive life are the ignorance and unsanitary conditions that threaten good health. In this context African-American women belong to the same "primitive" category as African women, so it is only natural for an American physician to assert that "the Negro's reaction to disease is primitive." On the positive side, the primitive is associated with a biological vitality and a hardiness that is finally indistinguishable from a profound harmony with nature and its mysterious processes. (2005, 94)

Hoberman goes on to argue that, although it has been discredited that people of African descent are a different, primitive type of human (certainly such views no longer appear in medical journals and mainstream media), ideas of black racial hardiness, "adapted to modern circumstances" of course, live on in medical schools, hospital wards, and operating rooms (2005, 97). Ideas endure about the ease of certain racialized women's labors and childbirths, the naturally healthy gynecological and obstetrical lives of other racialized women, and the resistance to infection and disease biologically possessed by other racially gifted women. Hoberman argues that these ideas persist through an oral tradition whereby attending physicians tell racial tales to their students, who pass the tales on to their colleagues, who eventually pass them on to their students, etc. He quotes one academic physician: "There are lots of little stories that physicians believe that are neither scientifically based nor are proven. That's the problem" (97). Hoberman argues that racial folklore may explain racial disparities in health, as "[m]edical personnel who believe in black hardiness may restrict access to certain kinds of surgery on the assumption that black patients have a less urgent need for such procedures. Conversely, the same belief in black hardiness might help to account for the disproportionate frequency with which black patients are subjected to more radical and damaging surgeries than whites: hysterectomies, lower-limb amputations, and bilateral orchidectomies (castration), since medical personnel may assume they are better able to tolerate such trauma" (96).

Consider statements made by one of the most senior attending physicians in the Alpha WHC, Dr. Veronica Rose. Dr. Rose had worked for thirty years in her own private practice in Long Island; after retiring, she was hired by the Omega University School of Medicine as a Professor of Obstetrics and Gynecology—a job she insisted upon calling a post-retirement "hobby." At the time of my fieldwork in the clinic, she had been teaching and practicing in Alpha for three years. About halfway through my interview with her, I remarked that the patients at Alpha experienced extremely long waits for appointments that seemed excessive in their frequency. She responded with her perception that Alpha patients were not scheduled for more appointments than their counterparts in private practice:

ROSE: That's standard. It's once a month from the first visit to twenty-eight weeks. From twenty-eight to thirty-six [weeks], it's every two weeks. And it's every week thereafter. That's standard stuff. And keep in mind that the people here have a lot more pathology than the people in a private setting. In a private setting, you're not going to see all of the hepatitis. You're not going to see the sickle-cell anemia. You're not going to see the . . . you name it. You're not going to see it.

KHIARA: Now, the increased pathology that you see here, what is that based on?

ROSE: It's cultural.

KHIARA: It's cultural?

ROSE: Oh yeah—it's cultural. And it's ethnic. Meaning that if you're coming from a private setting, where 92 percent of your population is white, you're not going to have a lot of sickle cell. You're not going to see a lot of hepatitis in people who live in upscale Long Island. Yeah, I actually had to go back and look some things up when I first got here. Because I hadn't seen them in years. People in a private setting are basically healthy. People here are not so healthy. They have a lot of issues that we're not going to see on a regular basis in a private setting.

KHIARA: Is some of that nutritional also?

ROSE: I'm sure it is. I think it's cultural. Somebody coming from the middle of Africa someplace is going to have a lot more issues than somebody coming from eastern Long Island is going to have. Plus, you're going to have issues of indigency, lack of education, the whole. . . . It's just poor people. Poor people don't have the same level of education obviously. They don't eat as well. They have a lot of obesity because they eat a lot of fast food and things of that nature. These are all things that are built into a clinic setting that you're not going to see elsewhere. But, they [the patients seen in the Alpha WHC] are not seen more often, generally speaking.

There is much to unpack in Dr. Rose's complex declaration. What is most clear is that she believes the "Alpha patient population" differs from the patients to whom she attended in her private practice because of the "increased pathology" present within the former group. Understanding Dr. Rose's philosophy of why the "Alpha patient population" has "increased pathology" is more challenging, however. To begin, she posits the cause as being in part "cultural." Although there is a lot vapidity in Dr. Rose's use of "culture," one can distill that it is not "indigency," lack of education, and nutrition. Rather, "culture" is *in addition* to those things: "I think it's cultural . . . *Plus*, you're going to have issues of indigency, lack of education. . . ." Moreover, place appears to inform culture: "Somebody coming from the middle of Africa someplace is going to have a lot more issues than somebody coming from eastern Long Island is going to have." Although the place of "eastern Long Island" corresponds with the "92 percent white" "private setting," its antipode is the presumably non-white "middle of Africa" represented in public clinics. Which is to say: race informs Dr. Rose's notion of "culture." And it is this notion of culture-qua-race that she views as the cause of the increased pathology among Alpha patients. For Dr. Rose, one will not find sickle cell or hepatitis among white people. Indeed, among white people, one will not find the plethora of diseases Dr. Rose had to "look up" when she was called upon to treat non-white people.

In sum, Dr. Rose explains the higher rates of pathology in public settings as being due in part to the race—the non-whiteness—of the patients managed there. Culture-qua-race also explains the lower rates of pathology in the private setting, which indeed is characterized by its lack: it is a place where the physician is not going to see hepatitis, will not see sickle cell anemia, will not "see the . . . you name it. You're not going to see it." This lack of pathology and "issues" mimics the lack of presumed racial and ethnic particularity—the normativity—in "eastern Long Island," as Dr. Rose is careful to articulate. Although Dr. Rose names neither racial biology nor some notion of the Black human type's primitivity as foundations for her theory of culture, it is not difficult to see that the "culture" she believes is found in the "middle of Africa" is congruent with the "image of the sickly and biologically deficient black person" that is paradigmatic of biological notions of race.

However, many physicians I interviewed disagreed with Dr. Rose's conceptualization of Alpha patients as being sicker than their privately insured counterparts. Indeed, many obstetricians considered Alpha patients, on the whole, to be a healthy group of people. As one resident explained, "We see a lot of young, healthy women. So, I don't find that [the assumption that poor, uninsured people are sicker than their insured counterparts] to be true, necessarily. Because I think a lot of—just by nature of our job—we see a lot of young, healthy, pregnant people." Another physician, Dr. Steven Shander, offered a similar opinion, and in the process, disputed Dr. Rose's construction of the "private population" as the absence of risk, disease, and pathology. I asked him if he found his Alpha patients to be sicker on the whole than their Omega counterparts. He responded:

SHANDER: I think it depends on your specialty, too. We're OB/GYN. We don't see a lot of—I mean, we have a lot of patients that come in for GYN exams with multiple medical problems that we don't primarily manage. Hypertension, diabetes—they are smokers. A lot of things that get taken care of in their medicine clinic. Whereas we primarily do a pap smear and a routine GYN evaluation. And then, of course, obstetrics: you are dealing with generally a young and healthy population. The advantage that we have here at Alpha is that we are the referral center for truly high risk patients. All [New York City public] hospitals have high risk obstetrical service—at least most of them. But, if they are too big to handle . . . for some of these other hospitals, they get sent to Alpha. And so we get to see some of the more interesting, more difficult cases.

KHIARA: And so these are issues that you wouldn't see in the Omega population?

SHANDER: Not necessarily. We have a lot of subspecialties at Omega as well. And so they develop a consultation pool as well. High risk situations. They have oncologists. They have Maternal Fetal Medicine doctors.

It would seem, then, that Dr. Rose's belief in the figures of the pathology-ridden racial minority and the constitutionally durable white person may have made it impossible for her to recognize the actual health states of the persons she attends.

Moreover, Dr. Rose's complex beliefs regarding "culture" speak to the argument I have been developing in this chapter. The scholar interested in locating conduits for the transmission of racial folklore may point to Dr. Rose as a concrete example. Indeed, Dr. Rose told me that she took up the "hobby" of working in the Alpha WHC because she wanted to share with future generations of doctors her accumulated wisdom and passion for gynecological practice. It may be overly optimistic to hope that Dr. Rose did not pass on to her constant coterie of medical students her "knowledge" of the relationship between culture-as-race and pathology. When one considers the danger such racial folklore historically has been to Black patients who have been both subjected to unnecessarily harsh medical treatments and denied essential therapies due to misdiagnosis, Dr. Rose's articulation of the power she has as an attending over her students sounds ominous. I had asked her if her students found the clinic's banal chaos a little unusual. She responded:

> You can't find something bizarre [when] you have nothing to compare it to. [The medical students] are a *tabula rasa*; they have no background against which to make any kind of comparisons at all. To them, they are coming in and they are learning something brand new. . . . They're so busy trying to figure out what's going on and trying to learn how to do stuff. . . . They are happy souls. And they're happy if they walk out of here learning how to do a couple of things.

Again, it may be overly optimistic to hope that Dr. Rose spared her "tabula rasa" the folklore that white people tend to be pathology-free while non-whites tend to be sites of disease, disorder, and "issues."

It is racial biology that unites lore regarding Black women's obstetrical and gynecological hardiness, predisposition toward pathology, primitive pelvises, and hyperfertility. Moreover, it is racial biology that counsels that the "Black race" is a concept referring to a biological entity—one possessing biological processes distinct from the "white race" or the "Asian race." It is racial biology that has created dangerous consequences, providing justifications for treating differently racialized people differently. Arguably, theories of racial biology were enervated by social constructionists who argued convincingly that "races" are the products of *social*, not biological, processes. Sociocultural anthropologist Kamala Visweswaran offers a particularly poignant formulation of this argument: "The middle passage, slavery and the experience of racial terror produce a race of African Americans out of subjects drawn from different cultures. Genocide, forced removal to reservations, and the experience of racial terror make Native American subjects drawn from different linguistic and tribal affiliations: a race. . . ." (1998, 78). However, despite the persuasiveness of Visweswaran's argument and the wide acceptance of the concept of race as a social construction, racial biology has experienced a reinvigoration in recent years.

In 2005, BiDil—a combination of hydralazine and isosorbide dinitrate that, among other things, widens blood vessels in the heart and could prevent death in people suffering from congestive heart failure—was the first drug approved by the FDA for the treatment of persons belonging to a specific race. The manufacturers and marketers of BiDil argued that clinical trials had proven the drug could successfully treat heart failure in Black persons, but could not produce similar results in non-Black patients.[3] However, the clinical trials forming the basis for these claims of BiDil's race-specific efficacy were poorly constructed, arguably proving only that BiDil was an effective drug, not that its effectiveness was unique to Black persons. In the clinical trials, BiDil reduced the mortality of persons with heart failure from 10 percent to 6 percent, giving those taking the medication a 43 percent survival advantage. However, all of the persons who enrolled in the clinical trials were self-identified African Americans. Accordingly, the trials could not and did not demonstrate BiDil would not produce similar results for members of other racial groups. Nevertheless, the FDA approved BiDil's race-based labeling. Consequently, if a physician prescribes it to a non-Black person, insurers do not have to cover the cost of its "off-label" use (Washington 2007, 322).

Biological race in the form of "genetic factors" was offered to explain the efficacy of BiDil for self-identified Black persons. BiDil's patent holder produced scholarship hypothesizing that heart failure in Black persons was primarily due to a genetic cause, excluding the plethora of nongenetic contributors. For these racial scientists, genes that were unique or restricted to Black people produced "a pathophysiology . . . that may involve nitric oxide insufficiency." One cardiologist explicitly disputed the relevance of nonbiological causes of the increased rates of heart failure among Black persons, arguing that data "do not support socioeconomic factors as important contributors to the excess mortality rate seen in African Americans affected with heart failure." This cardiologist avowed "[h]eart failure in blacks is likely to be a different disease." Moreover, the difference was all in the genes: "[T]he emerging field of genomic medicine has provided insight into potential mechanisms to explain racial variability in disease expression" (Washington 2007, 322).

The reaction to BiDil was complex. Supporters of the drug ranged from the politically conservative to the politically liberal. BiDil worked well with conservative political ideology because it offered a genetic, not social, explanation for racial inequalities (Roberts 2008). BiDil also worked well with liberal political ideology, as it is consistent with identity politics and demands for inclusion by historically disadvantaged groups (Roberts 2008). However, other progressives reacted with horror to the arrival of BiDil and the resurgence of racial biology that it heralded. They feared BiDil would encourage people to conceptualize race as a biological entity, undoing decades of progress made by scholars and activists who had argued (and persuaded many) that race was a social construction. Many were concerned that the nuance involved in using race in biomedical research—that is, race as a simultaneously overinclusive and underinclusive concept allowing researchers to get an imperfect hold on genetic variation among human beings—would be lost with the advent of BiDil. A contingent of scholars who have thought extensively about BiDil's problems (and benefits, inasmuch as BiDil represents a concerted effort to confront the racial disparity in mortality from heart failure) wrote hopefully, anticipating that, in the future, physicians will be able to easily divine the genetic makeup of any individual who presents herself for treatment (Tutton et al. 2008, 466). In an era of pharmacogenomics, the use of a social construct such as race in a biomedical research would be obsolete, as "it will be possible to treat every patient based on her specific genetic traits rather than on the genetic traits she is presumed to have on the basis of her affiliation to a particular racial/ethnic group" (466). In the present, however, using race may be an important interim measure as it allows "geneticists and biomedical scientists [to get] some purchase, however crude, on genetic variation amongst different human populations" (466). It is worth noting, however, that BiDil can not be understood as a step towards pharmacogenomics because "the mechanism of action by which it appears to have a beneficial effect on heart failure patients is unknown" (Kahn 2008, 742).

Unfortunately, the nuance the use of race in biomedical research involves is frequently lost, as "biomedical differences between racial groups are routinely misinterpreted as evidence of innate genetic differences" (Ellison et al. 2008, 449). Moreover, the marketers of BiDil, as well as the FDA committee that recommended approval of the drug, disavowed the relevance of nuance—making the stark claim that a *biological* difference in white and Black persons explained BiDil's unique efficacy for the latter group. The committee's chairman, Steven Nissen, contended that African-Americans have inherited genes from African forefathers that affect salt retention and the ability to coagulate blood. For Nissen, the difference was genetic and, literally, all in the blood of Black people: "Respecting biological differences, based on selective evolution, is not racial bias" (Reverby 2008, 481). Nissen articulated his sentiment that "there were enough differences in self-identified African Americans' responses to this and other drugs to satisfy what he called 'biological plausibility' " (482).

In the end, BiDil was approved and marketed as a drug tailored to the unique physiology of Black persons. Accordingly, every advertisement of BiDil that features a smiling Black woman—smiling because, as an African-American woman who has been prescribed BiDil, she is confident that she enjoys a greater chance of surviving a diagnosis of congestive heart failure—makes the argument that Black people possess a distinct genetic composition. Every pamphlet distributed that shows a concerned Black man, who, clearly, wants to learn more about how BiDil could help him, makes the case that races are biological categories and all arguments to the contrary are fallacies. Moreover, these problematic, potentially dangerous arguments are likely to become more ubiquitous: since the FDA approved BiDil, there has been a dramatic upsurge in the number of race-based patent submissions to the Patent and Trademark Office (Dorr and Jones 2008).

Although BiDil makes a strident case about the biological reality of race and racially specific responses to pathogens and disease, these arguments have been heard throughout history. "In this country physicians have long assumed that different races . . . experienced diseases differently and required distinctive therapeutics. As recently as the 1940s, physicians debated whether or not treatments for tuberculosis would work as well in American Indians as they did in whites" (Dorr and Jones 2008, 443). Racial biology formed the foundation for the "Study of Syphilis in the Untreated Negro Male" at the Tuskegee Institute, as physicians sought to finally answer the question of just how differently syphilis coursed through Black bodies as compared to white ones (Duster 2006, 491). Although syphilis was thought to do most of its damage to the neurological systems of its white victims, for Blacks the cardiovascular systems were thought to be the principal targets of its ravages. Indeed, one Johns Hopkins physician asserted "syphilis in the negro is in many respects almost a different disease than syphilis in the white" (Reverby 2008, 480)—a statement that echoes the BiDil proponent's assertion that "heart failure in blacks is likely to be a different disease."

Even after Nazi Germany took racial biology to the most horrific of its logical conclusions, theories of racial biology and investigations into racial therapeutics did not completely fall into disfavor. "In the 1940s and 1950s, medical researchers described a series of racial variations in drug response, most famously the increased incidence of hemolytic anemia seen in black soldiers given malaria prophylaxis during World War II" (Dorr and Jones 2008, 443). Indeed, the Tuskegee syphilis study did not end until the 1970s, representing forty years of applied racial science. Which is to say: BiDil is no anomaly, but rather a consistency—in harmony with the history of medical racism and biological notions of race.[4]

Most importantly, at the very crux of theories of biological race is the belief in fundamental difference. When difference is at the molecular level—that is, when it is the product of simple genetic expression—it becomes insurmountable. Biological race argues that dissimilarity is intractable and undefeatable. When the difference is in the chemistry, there is nothing one can posit that can negotiate the divide. There is also nothing one can do to avoid the construction of the divide; its construction is predetermined. Indeed, the form the divide will assume is determined by molecules and genes. Accordingly, someone from a "different" race represents radical alterity. When faced with a racial Other, one is looking at another who is, at his or her most basic, *not like* oneself.

Accordingly, biological race Others racialized people and groups, and radically so. However, recent scholarship has demonstrated biological race does not have a monopoly on the process of Othering. Indeed, the concept that had been proffered and developed as an antipode to race and biological determinism has come to represent insurmountable basic difference. I am speaking about culture, a topic I will return to later in the chapter.

RACIALIZED OBJECTS OF CONTEMPT

Thus far, I have proposed that racial health disparities may also be explained by physician racism, and I have proffered physicians' faith in enduring theories of racial biology as the substance of that racism. However, I would like to push the argument a step further by contending that racial health disparities may also be explained by looking to a more crude form of physician racism: the plain, deep-rooted contempt for a racialized group harbored by a medical provider. As Hoberman writes, "[T]here is no reason to believe that medical personnel enjoy any sort of immunity to societal ideas about race" (2005, 86). And there is no reason to believe physicians are immune from making certain racialized groups and persons the objects of race-based derision. Hoberman recounts an incident at the University of Alabama at Birmingham where three medical students wore blackface to a Halloween party, making themselves caricatures of Stevie Wonder, Fat Albert, and an unspecified black woman. It is not unreasonable to argue that some form of contempt—some disdain—for Black people had to have informed their decisions to make Black bodies into objects of entertainment and mockery. And it is not unreasonable to have little faith that people (including doctors) who feel this way could bracket it when called upon to provide care for the subjects of their contempt. Health disparities between Black and other racial groups may also be explained by looking to physicians' simple devaluation of the lives of their Black patients.

Consider another portion of my interview with Dr. Rose. After she had spoken fondly of her medical students (who observed her intimate examinations of her patients as part of their instruction), I asked if her patients ever objected to having students in the room during their gynecological examinations. She responded:

ROSE: Yes. They do consistently.
KHIARA: Really? How do you feel when that happens?

ROSE: My feeling is . . . I have a number of feelings. I think there should be a sign out there that says, "Turn your cell phone off"—just like there is in a movie theater. [pause] There should be a sign out front that says: "This is a teaching institution. You are getting world-class care for nothing. Suck it up." And that's it. And that's an ethnic thing also. Spanish, the Hispanic crowd are much more compliant to that kind of thing. Whether they like it or they don't like it, they seem to be okay with it. The Bangladeshi crowd, they're not—if there's a male involved, he has a big problem with that. That's a cultural thing. You can't do much about it. Interestingly enough, the biggest ones that complain the most and refuse are the African-Americans.

KHIARA: Really?

ROSE: Absolutely. I can't—I don't know why. I just think it's sort of an entitlement thing that comes with being a New York Medicaid recipient. They sort of figure that they're special. I don't know. I can't figure it out. And that's not a racist remark; it's an observation. They are the ones that most likely say, "No. I prefer not." You have a certain number of people in the older age groups who are very modest. They are going to say no. Your best bet is a young Hispanic girl who has a bunch a boyfriends and who doesn't care. If you get one of those, you're in pretty good shape.

Here, Dr. Rose articulates her contempt for three racialized groups: the "Hispanic crowd," the "Bangladeshi crowd," and African Americans. Within Dr. Rose's schematization, Latinas are a sexually dissolute bunch whose promiscuity—their sexual availability—informs their willingness to have student onlookers observe their gynecological examinations. History counsels us that the stereotype articulated by Dr. Rose is a particularly insidious one, as the belief in the sexual licentiousness of racially minoritized women (specifically Black women) made it more likely that physicians would attribute any pelvic pain or gynecological discomfort these women experienced to sexually transmitted infections. Writes Hoberman, "Socially conditioned to regard all black women as promiscuous, 'gynecologists would almost automatically diagnose a black woman with symptoms of endometriosis as having pelvic inflammatory disease' as a consequence of her sexual behavior" (2005, 92). He cites the work of Dorothy Roberts, who has argued that "rather than think of black women as vulnerable to endometriosis, 'gynecologists are more likely to diagnose

Black women as having pelvic inflammatory disease, which they often treat with sterilization' " (quoted in Hoberman 2005, 92). Accordingly, if history is a teacher, Dr. Rose's conception of her Latina patients' sexual lives may have led to misdiagnoses of gynecological conditions, willful blindness to others, and demonstrations of tactlessness to those Latina women actually saddled with a sexually transmitted infection.

Bangladeshis are also articulated as subjects of Dr. Rose's contempt. Although it is probably true that any patient who refuses to allow Dr. Rose's students to observe her examination incurs Dr. Rose's wrath (in the form of rudeness, insensitivity, or a disturbing lack of "bedside manner"), the woman presenting the phenotype or other characteristics of what Dr. Rose believes to be "Bangladeshi" probably incurs that wrath to a greater degree as her refusal would be based on an "irrational" "cultural" belief and not a perceived more legitimate personal circumstance. That Dr. Rose does not think highly of "Bangladeshis" was made apparent in another portion of our interview. Lamenting the transformation of the practice of medicine from one grounded in interpersonal relationships to a less relationship-focused, profit-driven enterprise, Dr. Rose spoke about the inability of patients with private insurance to enjoy continuity with their physicians throughout their pregnancies:

> When I did my private practice, I was solo. But, there are no more solo practitioners. They don't exist anymore. Just financially. You now have groups of three, four, and five. But, they're starting to be towards six, seven, eight, nine, and ten. And they're adding another concept, which has been called a "hospitalist": a lot of hospitals are hiring someone to work the labor room 24/7—[someone] who has nothing to do with the patients that we're seeing in prenatal care. So, you walk in [to deliver] and it will be Dr. Gupta from Bangladesh who is moonlighting at the hospital; you've never seen this person. All that is changing.

In Dr. Rose's race fantasy, the figure of "Dr. Gupta from Bangladesh" stands for all that is wrong with the current, rapidly altering practice of medicine. "Dr. Gupta's" parasitic opportunism operates to the "detriment of the patient—both physically and emotionally . . . because pregnant women like to bond" with their caretakers. Moreover, because it is reasonable to doubt Dr. Rose's ability to accurately identify someone from Bangladesh (or to identify others who are *not* from Bangladesh), her uncomplimentary opinion of "Bangladeshis" as unfortunate interlopers in the "American" system of health care who are, in another circumstance, revealed to posses regrettable, fixed, "cultural" ideas is apt to work to the detriment of all South Asian women who find themselves in the unlucky circumstance of being one of Dr. Rose's patients.

Finally, it appears transparent that Dr. Rose's unflattering description of her African-American patients, who are most likely to "complain the most and refuse," is informed by discourses of the "welfare queen"—the always Black woman whose receipt of government assistance as an entitlement has corrupted her work ethic, values, and sense of responsibility. Reminiscent of the welfare queen who believes she should not have to engage in labor outside of the home in order to support herself (as those making up hard-working America must do), Dr. Rose believes that the African-American New York Medicaid recipient thinks she is "special" and her body is not the stuff on which professors should teach and students should learn. In Chapter 6, I will explore more expansively the dangers and consequences of suspecting that entire groups of people are welfare queens; it should suffice to observe at this point that the low regard with which Dr. Rose holds her Black patients might not translate into the provision of quality health care for them. In sum, Dr. Rose allows us to see what plain racial contempt looks like and how it may lead to racial disparities in health.

Unfortunately, Dr. Rose was not the only physician I met who demonstrated some contempt toward her racialized patients. Another attending lamented to me "Spanish-speaking patients take it for granted that everyone will speak their language. They expect you to speak Spanish with them. That's the problem: they come here and expect everything to be given to them." It was unclear whether the "here" to which this attending referred was Alpha Hospital or the United States more generally, but what was clear was the disgust that provided the texture for understanding her comments. This attending, like Dr. Rose, also had a reputation among the staff for being tactless, impatient, and occasionally rude to her patients. Such data may lead us to wonder about the way her beliefs about race may influence the quality of the health care she provides.

RADICAL OTHERNESS: THE CORE OF RACIAL BIOLOGY, RACE CONTEMPT, AND CULTURE

I have argued above that racial biology is an idea about the fundamental *dissimilarity* of racialized persons. Furthermore, what is racist contempt for other racialized persons but a hatred for those who are thought to be deeply and basically unlike the racial group to which the racist belongs? When one distills that ideas of radical difference are the foundations of all of these concepts that have operated to shorten (and diminish the quality of) the lives of racially dominated persons, one can see that the danger lies not in the specifics of the concepts but in perceptions of insurmountable difference. Now, although Dr. Rose's conception of "culture" is nothing more than a euphemistic turn of phrase for traditional notions of "biological race," I now argue that more conventional usages of the culture concept are just as deterministic as biological-race determinism. Accordingly, when "culture" is revealed to signify radical Otherness, one can see that cultural stereotypes and beliefs in the way people from certain cultures "just are" can be just as dangerous—and just as racist—as racism.

In a seminal article, "Race and the Culture of Anthropology," Visweswaran (1998) traces the deployment of the culture concept by Franz Boas, largely considered the father of modern anthropology. She writes that, due to his commitment to racial equality, Boas situated race and culture in an antipodal relationship. Indeed, culture was defined through a process of negation. "Culture was expressed through the medium of language but was not reducible to it; more importantly, it was not race. Culture became everything race was not, and race was seen to be what culture was not: given, unchangeable, biology" (Visweswaran 1998, 72). Although, progress-oriented scholars of today lament the biologization of race, Boas' argument for race as a biological category was part of a two-part case for racial equality: the second movement in the case was to argue that the biological nature of race made it value-neutral, having "nothing to do with the superiority and inferiority of given races," to quote his student, Ruth Benedict (73). Boas was arguing against a conception of race in which biology determined the lives and livelihood of people or groups of people. His intervention was to argue that biology-qua-race explained nothing about the potential of people or groups of people: it was simply an insignificant description or possession of a person, having no fundamental relationship to the life a person is capable of living.

Boas and his students contended that the stuff of human difference was not in the "biologically transmitted traits" that constituted race, but rather found in race's antonym—culture. "Culture, not race, was a more meaningful explanation of significant differences between groups of people" (Visweswaran 1998, 75). Race's consignment to the realm of irrelevance forced culture to become *all* that was relevant about a person or group of people. Moreover, because the problematic assumption that biology could determine a person's or a people's life was never questioned, this determinism lived on in the culture concept. Racial determinism simply became a rapidly more ubiquitous "cultural determinism," defined as "the emphasis upon cultural differences for determining outcomes to the 'neglect of normative and political aspects of a cultural process' " (76). And although the intent behind Boas' and his students' deployment of the culture concept was an anti-essentialist one, it has come to freeze "difference possessed by concepts like race" (76). That is, although culture is understood as something that "is learned and can change," as Abu-Lughod (1991) has written, very rarely in its myriad deployments has it been described as changing. A "culture" is static and rigid or, alternatively, it is destroyed and replaced by a new one.

This deterministic, unalterable notion of culture has become common currency. In this way, culture has come to do the work that race is no longer capable of doing; as a consequence, we witness more and more of what I call "culturalist racism," wherein culture is used to condemn persons or a group of people as effectively as did the race concept of yore.

> [B]ecause everyone "talks culture" (that is to say, has access to the concept of culture), its relativist outlines have been increasingly filled by racist content. But does that not illustrate how culture has come to stand in for race? Without a way of describing the sociocultural construction of race, culture is asked to do the work of race. This is perhaps what Walter Benn Michaels means by the title of his essay "Race as Culture." He writes, "Our sense of culture is characteristically meant to displace race, but . . . culture has turned out to be a way of continuing rather than repudiating racial thought." When race functions at all, "it works as a metonym for culture; and it does so only at the price of biologizing what is culture or ideology." (Visweswaran 1998, 76)

Now, culture need not acquire a biological connotation for it to operate as a deterministic concept, although examples of the biologizing of culture surface frequently. Consider an interview I had with a chief resident, Rhea Waxman, who expertly demonstrated the substitution of biological race for biological culture. Dr. Waxman, a white woman in her mid-twenties, spoke openly about her conviction that all patients should be screened for genetic conditions based on their racial background (and her consequent habit of encouraging her patients to test their fetuses for certain conditions depending on their race). Although she believed all patients "regardless of where they are from" should be tested to determine whether they are carriers of problematic genes, "African Americans" and "Asians" were the racial groups that raised the most red flags for her, as those were the only racial groups she named to justify her practice of interrogating her pregnant patients regarding their racial backgrounds: "African Americans are more associated with sickle cell disease [and] Asians with thalessemia." She explained, "Certain ethnicities have certain conditions that are kind of inherent to them due to old, old, old mating habits of people—where you don't mate outside your comfort zone. So, that's the reason why I ask." Although Dr. Waxman clearly subscribed to some notion of biological race, further elaboration revealed her to also subscribe to a notion of biological culture.

When I pressed Dr. Waxman about the fact that, due to centuries of slavery, colonialism, imperialism, global capitalism, and other macro processes, genes that may have been common to one region or group are likely to be found in people of various ascribed and self-identified races, she responded: "You can stand there and tell me that you're White. I'm going to argue a little with you. I'm going to say, 'Are you sure somewhere around there, somebody is not from Africa or the islands?' . . . There's been a lot of press about people's admixture. I'm probably part African somewhere around there. But, I don't associate with that culture or that way of life or anything. So, I don't say that I'm African American." Dr. Waxman appears to admit that a certain irrationality governs her practice of encouraging race-based genetic screening: although she avows that all African Americans ought to be screened for the sickle cell trait and sickle cell disease at birth, she personally would not be screened for the gene or condition, as she does not "say that [she's] African American"—although she is "probably part African somewhere around there." Yet, in Dr. Waxman's wrestling with the illogic of race-based genetic screening, she begins to articulate an interesting conception of "culture." For Dr. Waxman, there is an "African [American] culture" and an "African [American] way of life"—homogenous entities that, when an individual "associates" with them, allow that person to say he/she is "African American." Dr. Waxman appears to suggest that if she did associate with "that culture or that way of life," she could indeed say she is African American. So, at first blush, there appears to be electability to "culture"; one could choose to be or not to be a member of any given culture. Yet, Dr. Waxman's ability to elect membership in a culture is not similarly available to me, as I "cannot stand there and tell [her] that [I'm] white"; she would argue against such an avowal without having queried whether I "associate" with "white culture" or "the white way of life." Accordingly, for Dr. Waxman, it would appear culture is as much of a biological entity as her conception of race. Implicit in her reasoning is that the ability to "associate" with a culture depends upon one's genetic (that is, racial) constitution, buttressing Visweswaran's observation that because "the dominant view of race is a biological one, when this substitution of [culture for race] is effected, culture and ethnicity are themselves essentialized or biologized" (Visweswaran 1998, 76).

Visweswaran's article, first published before the turn of the century, was prescient, as demonstrations of cultural determinism and culturalist racism have multiplied dramatically in recent years. Even when culture is understood as learned (as opposed to biologically inherited) behavior, it still is thought to overdetermine outcomes. Culture has been offered as that which explains everything, including the centuries of violence between "the West" and "non-Westerners"—an argument the late Harvard professor Samuel Huntington parlayed into an influential, best-selling book, *The Clash of Civilizations and the Remaking of World Order* (1996). Huntington posited that cultural difference (i.e., fundamental, nonnegotiable difference) would be the origin of future conflict in the world arena. Civilizations, understood as culture-writ-large, would clash because of the radical alterity they posed to one another. Huntington hypothesized "the fundamental source of conflict in this new world will not be primarily ideological or primarily economic. The great divisions among humankind and the dominating source of conflict will be cultural" (1993, 22).

Nor should culture be understood as deterministic only in world politics; it determines the success and failure of racialized peoples within nations as well. Whereas race used to explain Black people's poverty and disenfranchisement in the United States, culture does so now, as when Harrison (1998) argues, "[H]ere in the United States, we find ourselves debating whether current political discourses on, in one instance, welfare reform and, in another, criminal justice encode race and reinforce racial domination by pathologizing what are being represented as irreconcilable sociocultural differences" (610). When exploring culture's role in explaining racial stratification in the United States, Chang (2002) echoes Visweswaran's findings: "While scientific racialism is generally not a defensible position, there remains what might be described as a social or cultural racialism that attributes certain characteristics to racial groups and explains racial differences as the natural outcome of meritocracy and the free play of the market." (88). Culture has become the entirely defensible position to which dispossession in a "post-racial America" can be ascribed. "This new racialism, which may not be so different from the old racialism, is necessary to maintain the widely held belief among Whites that race has little if any effect on one's life chances in a country where the average wealth of a White household in 1993 was more than $45,740 and the average wealth of a Black household was $4,418" (Chang 2002, 88).

I posit that physicians' belief in "culture" could contribute to racial disparities in health in the same way Hoberman believes physician racism (understood as physicians' beliefs in racial biology and/or the physicians' plain racist contempt) has contributed to racial health disparities. Interestingly, culture has already been offered by many scholars to explain racial disparities in health, as commentators relate the higher morbidity and mortality of Black people to African-Americans' (indelibly cultural) fear of the medical establishment (in the wake of the Tuskegee syphilis study) or Black people's eating habits (common to an entire "culture" and impossible to change). Here, however, instead of replicating this problematic scholarship by looking at how some notion of the "culture" of the victims of health disparities produces different rates of mortality and morbidity, I question how physicians' ideas about the "cultures" to which their patients belong may contribute to health disparities when "culture" is understood as a signifier of fixed alterity.

That is, if at the crux of biological notions of race and racial hatred is the perception of (or desire to believe in) insurmountable difference between racialized persons and groups, the modern concept of culture shares that foundation of radical, unchangeable, nonnegotiable, and deterministic alterity. When we understand that culture can be used to signify fundamental, insurmountable difference (i.e., radical Otherness), then cultural stereotypes and assumptions about the way people from/with certain cultures "just are" may produce the same effects produced by racial discrimination. Hoberman may be correct that physician racism has been an as-of-yet unnamed contributor to racial disparities in health, but he may appreciate only part of the phenomenon by excluding culturalist racism from the ambit of physician racism. When writing about the incident in which three University of Alabama medical students wore blackface to a Halloween party, Hoberman notes it "raises the question of where cultural stereotyping ends and biological race fantasies begin" (2007, 508). For Hoberman, the danger lies only in the physician's harboring of biological race fantasies. And so, I would enhance Hoberman's account of physician racism by including cultural stereotypes within the concept: physicians' beliefs in cultural stereotypes can do the work that beliefs in racial biology have done to shorten (and diminish the quality of) the lives of racially dominated persons.

Consider in this regard a quotation in the aforementioned report concerning racial disparities in health issued by the Institute of Medicine. The report quotes an "African American patient," who says:

> I've had both positive and negative experiences. I know the negative one was based on race. It was [with] a previous primary care physician when I discovered I had diabetes. He said, "I need to write this prescription for these pills, but you'll never take them and you'll come back and tell me you're still eating pig's feet and everything . . . Then why do I still need to write this prescription." And I'm like, "I don't eat pig's feet." (Institute of Medicine 2005, 6)

This physician need not have harbored any beliefs about Black people's biological inability to process sugar or genetic predisposition to retain salt. This physician's cultural assumptions were as total (because all Black people eat pig's feet, the Black person sitting in front of him eats pig's feet) and deterministic (Blackness causes a person to eat pig's feet and fail to fill prescriptions, despite having been diagnosed with diabetes) as is biological racism. Beliefs in Black "culture" could be as harmful as antiquated beliefs in Black primitive pelvises, obstetrical hardiness, or hyperfertility.

Accordingly, one need not look only for physicians' articulations of their beliefs in biological race, as one can look also for their ideas about the way people belonging to certain cultures think, feel, and behave. Such attitudes about culture can be appreciated as "data about individual racial thoughts and fantasies" insofar as culture and race have begun to proceed to the same effect. Indeed, one will find articulations of "cultural thoughts and fantasies" easier to find, as it is still quite acceptable to "talk culture," whereas "talking race" has fallen into disrepute.

My interviews with physicians underscore that culture is understood to be an indicator of difference that is both immutable and impossible to negotiate. It is a wall that—independent of and unrelated to language differences, which can be overcome—prevents communication and mutual understanding between cultural Others:

> DR. CATHY ORVILLE, A WHITE SECOND-YEAR RESIDENT: There are cultural barriers. Like, I had a woman from Tibet the other day who was basically having a miscarriage. I spent 45 minutes on the phone with her being as direct as I could: "You're

having a miscarriage. The pregnancy is not growing. It's not living. That's why you're bleeding." But, at the end of the conversation, she said, "Oh, so the baby will be okay, though?" And I just don't think—her culture—she just couldn't understand because of her culture. Sometimes the difference is too big.

KHIARA: What did you do?

ORVILLE: I talked to her for another thirty minutes. I have no . . . you just do your best.

* * *

DR. PHILLIP VINCENT, A WHITE SECOND-YEAR RESIDENT: In terms of general health, definitely they are healthier at Omega than at Alpha. And a lot of that is a culture thing. It is just my own personal experience. [At Alpha,] I have had problems getting people off fatty diets and they are diabetics. It is very hard because that is what they eat and their whole family eats it and everyone in their neighborhood eats it. It's their culture. They can't cook any other way.

* * *

DR. SARA TRIPP, A WHITE THIRD-YEAR RESIDENT, REMARKING ABOUT THE LARGE NUMBERS OF CHINESE PATIENTS WHO RECEIVE PRENATAL CARE AT BETA HOSPITAL, A SMALLER PUBLIC HOSPITAL ON THE LOWER EAST SIDE: It would be interesting to do something down there, too. It's such a lot of Chinese women. For them, [childbirth education] classes really don't matter. Honestly, Chinese women and Bengali women have a very hard time sometimes, I feel like. I'm just not—even if I have the interpreter phone and somebody who speaks Bengali, I feel like sometimes, we're just not getting through to each other. There are some cultural difference that I just don't get, or they are unable to tell me about something. So, that would be an interesting place.

For these young physicians, culture is used to signify a radical, fixed Otherness; accordingly, the cultural Other comes to represent an alterity that is evocative of the racial Other. Cultural difference of today becomes akin to racial difference of yesterday.

On Chinese-ness

Consider another portion of my interview with Dr. Waxman, in which I asked her if her patients were receptive to her suggestion that they screen their fetuses for genetic conditions based on race. She responded in cultural terms:

> I've found that the Chinese population—they have a lower level of tolerance for difference and disability. So, they almost all test, and they almost all terminate if the results are abnormal. I think that just culturally, there's a lot of pressure. This is what I've experienced. . . . I don't have a lot of background, so much of this is just anecdotal. But, I've found that the women that [immigrate to the United States] have had one child and then two abortions. And when I take the family history, I always ask people, "Were your terminations personal or were there problems with the baby?" Because it's helpful for me to know that. And everyone is very free: "No, they were government [due to the One Child Policy in China]." So, people come here [to the United States] presumably because there are no government restrictions and it's a better life. But, they still want totally normal, healthy babies. So, even though no one is imposing that, they will still have an abortion even though they *had* to abort their last pregnancy. I would think that people would latch on to this pregnancy, like "I can have it. So, I will." But, I think that culturally, it's just acceptable—in that culture—to terminate the pregnancy. And disability is not widely accepted on a stereotypical level.

Dr. Waxman describes a highly durable conception of culture. To her, one result of governmental policy is that Chinese culture is averse to disability and difference while being amenable to abortion. Accordingly, Chinese people, who are bearers of the culture, are similarly averse to disability and difference and amenable to induced terminations of pregnancy. Chinese people's relationship to disability and difference is not contextual; it does not depend upon the social or political milieu in which they live. Rather, it is cultural. And as culture, it is static, unalterable; once formed, the bearers of it will carry it around with them. Their culture determines their beliefs and actions. Moreover, Chinese people and the culture they inhabit (and that inhabits them) are to be counterpoised to a figure that operates only implicitly in Dr. Waxman's narrative: the noncultural woman, historically racialized as white, whose relationship to abortion is based on noncultural reasons: financial, religious, or personal. In Dr. Waxman's narrative, Chinese women and Chinese culture are the Others to implicitly white women and their cultural lack.

What is the relationship between Dr. Waxman's confident views about Chinese-ness and physician racism—the anonymous and largely unacknowledged process that likely contributes to racial health disparities? I offer that Dr. Waxman's ideas about Chinese-ness are also the stuff of physician racism. Although Hoberman may concede only that her views raise "the question of where cultural stereotyping ends and biological race fantasies begin," Waxman's "culture" can have the same effects as biological race fantasies. That is, Dr. Waxman need not believe Chinese persons possess a distinct genetic or biological constitution for her to assume a Chinese patient sitting in front of her will tolerate an induced, or even spontaneous, abortion better than a non-Chinese patient. As beliefs in the biological hardiness of Black patients may cause physicians to recommend more invasive surgeries, beliefs in Chinese women's permissive attitude toward abortion may cause physicians to recommend abortion for difficult or high-risk pregnancies.

Moreover, Dr. Waxman's theory regarding the Chinese demonstrates just how easily beliefs in radical, fundamental difference inform plain (race-based or culture-based) hatred. If one despises laziness, violence, criminality, and materialism, then one would despise the racialized individuals (i.e., Black persons) whose "culture" ("Black culture," "culture of poverty") causes them to be lazy, violent, criminal, and materialistic. Similarly, one can see how contempt for abortion bleeds easily into contempt for the racialized individuals whose "culture" counsels them to conceive of abortion as an "acceptable" practice.

On Mexican-ness

Perhaps one of the most apparent and ubiquitous cultural stereotypes in the Alpha WHC was the assumption that Mexican origin corresponded with prenatal and postpartum health. In truth, there has been some research showing Mexican immigrants, in spite of poverty and a lack of access to regular health care, show relatively good health indicators (Gálvez 2007, 1). However, this consequence is a result of particular practices—"practices associated with diet, physical activity, social ties, and preparing for the arrival of a child" (2)—that are not intrinsic to Mexican origin, but the result of behaviors that are learned and mutable. The stereotype that Mexican women receiving health care from the Alpha WHC are in excellent health and have very few gynecological or obstetrical problems—and "that's just the way they are," with any nuance regarding the necessity of engaging in particular learned behaviors having been lost—was articulated frequently and shamelessly. Consider an interview I had with Hannah Ferguson, an amiable, talkative white woman in the second year of her residency. Dr. Ferguson was commenting on her desire to impress upon the "Alpha population" the importance of getting yearly gynecological screenings. She related a story of having done a Pap smear on a woman who was fifty, with the test being the woman's first. Dr. Ferguson elaborated:

> She had, like, never seen a gynecologist before. I mean, there was nothing big that I could see on her cervix. But God forbid that she had a really horrible strain of HPV. I could have found a really advanced cervical cancer that could have been treatable if only she had come earlier. So, that's one of those things I find to be frustrating because I feel like we do see more advanced GYN cancers sometimes. And if women had more education about that, then we could maybe help. But I feel like a lot of our other patients are really very healthy. Especially the little Mexican women that come in to deliver. I think they've never seen a doctor before they come in at like, you know, nine centimeters. And they're like—they're perfectly healthy and they look. . . . There was one woman who came in here who was—she was in her late nineties. And I was like okay well, so you know, do you want to come back in a couple of months. Because she had never had a colonoscopy and I was like, you know, maybe she should have a colonoscopy. . . . And I was like, "Do you want to come back and talk about having a colonoscopy?" And she says, "Well, I'm going to Mexico for a couple of months. . . ." Good for you, man! See the world! So, you know—I mean they're—she's seen precious few doctors in her life, but she's in perfect health.

Mexican-ness was thought to imbue Mexican women with an enviable and inexplicable level of health. This natural—almost preternatural—healthiness was usually accounted for in cultural terms, as when one resident remarked to me, "Mexicans just have this healthy culture; you can't explain it." The vitality that flows to Mexican women by virtue of their culture—a cultural vitality—is reminiscent of the construction of Black women as biologically sturdier than their white counterparts. As Blackness was thought to immunize Black women from endometriosis and to endow them with "tough" vaginal tissues that would not tear during birth, Mexican-ness is thought to make it less likely that Mexican women would suffer myriad gynecological and other medical problems. A midwife's remark to Gálvez, an anthropologist who conducted fieldwork research in the Alpha WHC with a specific focus on the experiences of Mexican immigrant women, accurately summarizes the general attitude toward Mexican culture and the people who bear it: "We love the Mexican patients. That's why we love working here. They're so healthy" (Gálvez 2007, 2).

As discussed earlier, the biological hardiness of Black women was thought to be manifested in the effortless and painless labors and births "primitive" Black women experienced. "The easy labors of primitive women' are made possible by the simplicity of their lives, while 'our present civilization with its artificial refinements and customs has made women less able nervously and physically to stand the strain of a hard, prolonged labor' " (Hoberman 2005, 95). Compare this narrative of Black women's simple and trouble-free labors with a story related to me by Gálvez. She had been in the delivery room with a Mexican woman during her extremely painful labor. When the woman lay in the hospital bed, the pain was intolerable; accordingly, she preferred to stand. However, because hospital policy was to maintain the patient in a prone position, the nurses and the woman's obstetrician insisted that she remain in bed. Thus, there began a dance wherein the woman would stand, furtively, when alone in the room with Gálvez and, when any of the staff or her physician entered, attempt to rapidly lie down in bed. After some time, the pain became unbearable, and the woman opted to have an epidural. Once the epidural had been placed and the woman's misery subsided, one of the nurses, perplexed, remarked to Gálvez, "This is so strange. The Mexican women usually don't have such a hard time." Although the nurse did not explain to Gálvez precisely why she believed Mexican women do not "have such a hard time" during their labors (i.e., whether biology or culture was at play), the assumption that Mexican women will have easy labors could have the same consequence for them as assumptions about Black women's immunity to pain: the denial of analgesia and anesthesia or delay in administering them, the insistence that women undergo vaginal deliveries when a C-section may be indicated, or the failure to take the precautions to prevent trauma and infection that the physician might take with other racialized patients. (Hoberman 2005).

Unfortunately, I was not privy to many physician ruminations about "Black culture" or "African-American culture," save for the aforementioned comments by Drs. Rose and Waxman. This could be for any number of reasons: physicians' discomfort with describing to a Black woman their beliefs about Black people, the care taken by most when making generalizations about Black people as a consequence of this country's long history of anti-Black racism, and/or the smaller numbers of Black patients (relative to Chinese and Mexican women) seen in the Alpha WHC. As a result, I am unable to track the function of the culture concept as it specifically relates to Black women. But, given the evidence that "culture" does a lot of work to legitimize the problematic assumptions physicians make about Chinese and Mexican women, there is little reason to doubt it has the same effect as it relates to Black women.

SOME CONCLUDING THOUGHTS

The Prenatal Care Assistance Program and sites such as Alpha Hospital are fairly understood as efforts to ameliorate the effects of this country's history of racism and racial inequality by ensuring that an individual's ascription as a racial "minority" or "Black" does not determine whether she lives or dies or whether she is healthy or sick. And so the program, and the hospital that effects it, should be celebrated for its laudable purposes. But, at the same time, it must be recognized that such programs and institutions are not self-effectuating; *people* give them life. Moreover, people who harbor problematic ideas about race and culture can undermine the goals of these programs and institutions. If we are really committed to ensuring that a person's racial identity does not overdetermine her health status, we must demand that the persons caring for them do not harbor dangerous beliefs. Accordingly, physicians and other health care providers ought to be interrogated about their ideas concerning race and culture.

This suggestion will be met with resistance, as it has become acceptable to conceptualize physicians' personal beliefs, harmful or otherwise, as somehow protected by notions of privacy. But, when we acknowledge that "'doctors' 'private' moral dilemmas involving their patients are actually interpreted and resolved according to relationships of power in the larger society" (Roberts 1996, 118), we understand the relationship between the physician and her racialized patient is far from a "private matter." Because this relationship is informed by the problematic macro processes that we are ethically charged to investigate and scrutinize, we are, similarly, ethically charged to investigate and scrutinize the "private" thoughts that have helped to overdetermine the life chances of racial minorities in the United States. Literally it is a matter of life and death.

In this chapter I have explored medical disenfranchisement in its most evident and recognizable forms: racial disparities in health, physician racism, and theories of racial biology and culture-as-race. In the subsequent chapters, I turn to more discreet demonstrations of medical disenfranchisement—deprivations that begin at the level of discourse. Although I describe these discursive processes as discreet, they operate to devastating effect, functioning to reiterate race and racial inequalities in the United States. Accordingly, in no way should their subtlety—that is, their discursive nature—be used to argue against the profundity of their material impact. That said, I next examine the curiosity that is the phrase "Alpha patient population."