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Jailcare: The Safety Net of a U.S. Women's Jail

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Jailcare: The Safety Net of a U.S. Women's Jail

by

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[redacted]

for my parents. . .

ABSTRACT

Institutions of incarceration are widely understood for their punitive, depriving, and at times even violent characteristics. Yet prisons and jails also provide medical care and other services that people marginalized by poverty, addiction, racism, and other forces of structural inequality might not otherwise have. This dissertation investigates the everyday contours of care in an urban women's jail in California. Based on six years of clinical work as an Ob/Gyn in the jail's clinic; ethnographic fieldwork throughout the jail and its surrounding community; and over 40 interviews with jail workers, medical staff and inmates, I describe how this jail was constituted by caregiving relationships which were inextricably linked to disciplinary structures, particularly for pregnant women. Deficiencies in the public safety net, market shifts, and trenchant problems in the criminal justice system meant that cycling between jail and the streets was a normative rhythm of everyday life for many of the urban poor. Recidivism was less a statistic and more an intimate relationship between inmates and jail workers. First, I describe how the medical triage system upon entry to jail diagnosed the deficiencies of people's lives on the streets. Next, I explore the quotidian rhythms of the jail medical clinic, and how health providers cultivated ambiguity as a form of caregiving to a patient who is also a prisoner. I then focus on reproduction as a key site where the deficiencies of public services and their substitution with incarceration were made visible. Custody and medical apparatuses in jail managed the figure of the pregnant inmate, with her gestating fetus, both as worthy of tender care and as a liability threat to the institution. Pregnant women similarly experienced jail with ambivalence, even desiring the relative safety of this punitive space. The ambiguity surrounding pregnant, incarcerated women, combined with their experiences of marginality outside, produced jail as a place—often the only place—where these women could enact a normative ideal of motherhood. Particularly for marginalized, reproducing women, jail has become an integral part of America's social and medical safety net.

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PREFACE

In the early, still-dark hours of a winter morning in 2004, I was in a hospital room preparing to catch the baby of a pregnant woman in the final stages of labor. I was a first-year resident physician in obstetrics and gynecology in Pennsylvania. As a young doctor, I was mostly focused on the mechanics of safely facilitating a birth. I nervously watched the electronic fetal heart rate monitor for signs of fetal distress; I went through in my head the maneuvers I was taught to perform if the baby's shoulder got stuck in the birth canal. With IV poles and monitors, nurses and doctors, and a woman pushing with contractions, it was by most accounts a typical hospital delivery room scene. Except for one detail: the mother-to-be was handcuffed to the hospital bed. She was incarcerated at the local jail. I had no idea what got her there, but I had some idea that it would be unlikely for her to abscond between painful contractions. She pushed her baby out, and cradled it in her one unrestrained arm.

Not surprisingly, I was deeply troubled by this moment, and horrified at my own complicity in the act. Among my many disbelieving thoughts, the simplest one was this: there were women—pregnant women—behind bars. Like most Americans, I had not given much thought, other than what the news media and popular culture had fed me, to institutions of incarceration and the people inside of them. Having come to medicine with a strong sense of social justice, I then became committed to learning about and improving reproductive health services available to incarcerated women.

When I was finished with my residency training, I moved to California, to a city I call Bridgetown, known for its progressive politics and creative, entrepreneurial spirit. I sought out the opportunity to work with women in Bridgetown's jail, and began volunteering intermittently as the jail's only on-site Ob/Gyn (a very skilled women's health nurse practitioner was already providing routine services there). After a few months of doctoring in this setting, I became overwhelmed with the complexities of providing medical care in this charged environment that was both constraining— *it was a jail* —and

enabling— *I provided clinical services that most of these women did not access outside*. The relationships I had with other medical staff, with deputies, and with patients at the Bridgetown jail were, I sensed, telling a larger story about care and inequality in America, one that was different than the standard narratives of mass incarceration. I turned to anthropology for guidance. The material in this dissertation is drawn from my experiences at the Bridgetown jail from 2007 to 2013 as a doctor and an ethnographer, a duality with methodological complexities I explore further.

This dissertation is about how those nuanced interactions around health care in Bridgetown's urban county jail are working through broader social, economic, racial, and health inequalities which are the conditions of possibility for contemporary incarceration in the U.S. I explore this phenomenon through the everyday experiences of those who work (including those providing medical care) and live in jail. This on-the-ground focus highlights routines of caregiving which arise from and exceed the usual disciplinary and punitive dimensions we have come, through hundreds of critical analyses of prisons, to expect. This is not a story of institutional violence, although I do not deny that violence in its many forms is part of the fabric of our country's system of incarceration. Instead, this dissertation sheds light on the human intimacies, even kindness, of jail that do not fit neatly into stereotypical prison-worker/ inmate power dynamics. There are times that my descriptions make jail seem like a safe, nurturing, fun place to be.

Narrative and ethnographic accounts of carceral institutions frequently begin with an entry story: a heavy metal door clanging shut, irrationally long wait times to enter, storing all of one's belongings in a locker, going through a metal detector. Indeed, every time I entered the Bridgetown jail, I walked through a metal door which an all-seeing guard clicked open, and my bag was searched. But my entry was usually unremarkable. I could bring my bag inside the jail (since the deputies knew I had a space in the clinic to store it); my cell phone, usually discretely buried at the bottom of the bag, was never confiscated. I exchanged small talk with the deputy who inspected my bag and looked at my

"permanent clearance" jail identification badge. The ease with which I entered (and exited) the jail was largely due to the fact that I worked there. But it also speaks to the porosity of jail, an institution that is not the same as prison.

The majority of a vast critical literature on institutions of incarceration focuses on prisons. When jails are considered, both in scholarly works and in popular consciousness, they are usually conflated with prisons as interchangeable institutions of confinement; or jails are dismissed as a weigh station along the path to prison. Yet jails are distinctly different from prisons.

Whereas prisons are under state or federal jurisdiction, jails are local, county level. Jails incarcerate people awaiting trial or who have been convicted of minor offenses. People come to jail first when they are arrested. Even if convicted, they may or may not go to prison. As such, jail is often thought of as an entry or re-entry point into the criminal justice system, a holding place before prison, a chaotic, a people-processing site (Wacquant 2002).

In contrast, prison is relatively static. Prisons house people convicted of crimes, mostly of felonies. People generally stay in prison for multiple years, even the entirety of their lives. People may spend as little as four hours in jail, or up to a year (and occasionally longer). Recidivism rates are high for both jail and prison, but the temporal interval for returning to jail is much shorter than prison, since jail is the first stop. I saw people in Bridgetown get released from jail one day only to return the next. Some people never go to prison, but cycle frequently through the local jail. The shorter intervals between and the frequency of jail stays create tremendous opportunities for familiarity between staff and inmates. Recidivism, as this dissertation explores, is much more than a statistic; it is a substrate for the care that emerges in jail.

This more frequent cycling also illustrates that jail is in flux with the larger community. After all, jails are located within the communities where people live—or at least where they commit their alleged

crimes. Prisons are usually far away from people's homes. Jail is interstitial: between mainstream society and the prison. And jail is porous: with its surrounding community.

Despite these differences, there is a notable absence of analysis of jails; John Irwin's 1985 short ethnography of processing into and social life in a jail remains one of the few accounts. This dissertation, then, aims to understand jail as a distinct, though related, phenomenon from prison, connected to the community in ways that make it hard to ignore the relationship between the community safety net and the carceral net.

If it seems unsettling to read an account of a carceral institution that focuses on some positive dimensions to being inside, then you share my anxieties. I am critical of the war on drugs, the abandonment of the mentally ill, and other racially-directed policies which have led to the imprisonment of millions people, most of whom I believe should not be there in the first place. So to write about aspects of jail which seem positive is politically risky for a larger agenda of criminal justice system reform which I support. It also risks perpetuating a "culture of poverty" argument, blaming recidivism on individuals' contentment with the status quo; and it risks having a backlash against providing quality services for people inside jail. I would be devastated if my writing were taken as an endorsement of mass incarceration. But this tension between being critical of our unjust imprisonment practices and seeing the good, albeit contingent good, that jail can do is real. This contradiction is something many jail workers, including myself, grapple with on a daily basis. The coexisting brutality and kindness of jail is also something which many of the incarcerated women I met appreciated. I hope the reader will feel similar ambivalence, for this reflects the reality of how many people experience jails.

Another note on ambivalence. Most of the pregnant women I cared for and came to know in my time at the Bridgetown jail struggled with drug addiction; they injected, snorted, or smoked heroin, crack, or methamphetamines—or combinations of them all— during their pregnancies. Structural violence and abandonment created the conditions of possibility for their addiction. As a doctor and an

ethnographer, I cared for these women through that understanding, rather than one of individual behavioral attribution. Yet in the context of these systemic factors, these women still did things that were harmful to their fetuses and that made them seem ill-equipped to care for a baby. Holding the structural recognition against the consequences that their constrained choices had for their babies is also disquieting, something to which I return in the conclusion.

The racialized dimensions of mass incarceration in the U.S. are impossible to overlook. The statistics are staggering, and repeatedly invoked in attempts to reveal institutionalized racism embedded within the criminal justice system. An abundance of works—too numerous to cite comprehensively—by scholars and activists has justifiably critiqued the racial injustice of mass incarceration, exploring racialization from various political, historical, economic and social perspectives,

These are absolutely essential phenomena to explore, and it is important that such critical inquiry into race continue. However, this dissertation is not about race—at least not explicitly. It is not aimed at generating theories or providing ethnographic descriptions about how race and incarceration are experienced by black women who are targeted by a racist criminal justice system. As legal scholar Marie Gottschalk (2013) has argued, despite the contributions of race-based analysis of incarceration, excessively focusing on the racial disparities of the carceral state elides other processes at work in sustaining this unequal reality.

To be sure, racial dynamics infuse every aspect of this ethnography. Most of the women incarcerated in the Bridgetown jail were black, even though, according to the city's 2012 census, the population of the city of Bridgetown was only 6% black. Deputies and medical staff came from diverse backgrounds, white, black, Latino, Filipino-American, Chinese-American, Korean-American, Indian-American. The contours of race in the jail undoubtedly affected my relationships with informants, especially since I am white. Indeed, after working at Bridgetown jail's clinic for three years, some of the nurses told me that when I first started, the patients were skeptical of me, saying "Who does this white

lady think she is?" It took some time, the nurses added, but eventually the enjailed women began telling the nurses that they trusted me, even though I was white. While those dynamics were certainly pervasive, and will necessarily come up in discussing the formation of relationships of care, I have chosen to center on other aspects of relationality in this analysis.

This dissertation comes at a time when public discourse about our overcrowded institutions of incarceration is beginning to shift. The far-reaching consequences of draconian drug laws, of criminalizing poverty, and of practices which disproportionately target communities of color are being questioned by more than just critical scholars and activists. Bridgetown, where this dissertation takes place, is at the forefront of innovative restructuring of its local criminal justice policies and social services. The Supreme Court in 2011 ordered the state of California to depopulate its over-capacity and under-resourced prisons. And in a widely heralded speech in 2013, Attorney General Eric Holder castigated our current system of incarceration as a moral and economic failure for its destructive, racialized effects on our society; he called for comprehensive reform in drug laws and sentencing practices. It is my hope that this dissertation will provide useful insights into how people on the ground work through these issues that all too often get simplified in policy debates and analyses that do not take into account the daily nuances of care and incarceration.

ACKNOWLEDGMENTS

When I first heard the imposing steel door at the entry to the jail click open six and a half years ago, I could never have imagined that it would lead to such profound professional and personal transformation. I certainly could not have predicted that I, recently finished with my Ob/Gyn training, would return to school and someday write a dissertation about this jail. But the people I met in jail compelled me to do so, and for that I am grateful. To the many incarcerated women who let me into their lives beyond the terms of a doctor-patient relationship, I offer my deepest thanks. With their tenacity, their resilience, their sense of humor, and their self-reflection, these women have profoundly influenced me. The woman I call Evelyn remains in my thoughts daily. These women continue to inspire me to work for reproductive justice and criminal justice reform.

To maintain anonymity, I cannot name the many people who work at the Bridgetown jail who were willing to let me cross the lines of professional, personal and research relationships. I wish to thank Sheriff's Department administrators and deputies for welcoming my research presence. The jail clinic staff, in particular, have been such important presences in my life for the last seven years. They were colleagues, mentors, and friends before they were informants. Conducting ethnographic fieldwork in this setting brought me even closer to these people. I remain inspired by their dedication. I myself get emotionally exhausted from one day a week of doctoring at the jail. They do this work full time. To the director of Jail Health Services and to the nurse practitioner I call Vivian, I am particularly indebted. I have learned so much from the two of them about how to be a better physician, about how to be an unwavering advocate for the most marginalized people in society, while still maintaining a sense of humor about all of the tragedy and complexity we encounter.

I have been fortunate to receive generous financial support for this research from a number of organizations. I wish to thank an anonymous foundation for funding my initial research on emergency contraception access for incarcerated women, and for partial salary support during my first 3 years of

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Having Lorna Rhodes, from the University of Washington, on my committee has made me feel like I hit the jackpot. Not only has she provided critical guidance as a fellow ethnographer of carceral institutions, but she has also offered the kind of writing advice no one thinks to mention. I am also grateful for Cori Hayden's support, particularly in helping to establish foundations of anthropological and feminist theory. I have benefitted tremendously from numerous conversations over my years in graduate school with Lawrence Cohen, Sharon Kaufman, Kelly Knight, Donald Moore, Paul Rabinow, Jonathan Simon, and, especially during our shared time in Washington, DC, Nancy Scheper-Hughes.

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Since my days as an undergraduate, I have long been compelled by anthropological thought. It was ongoing encouragement from my early anthropological mentors which reinforced my desire to return to graduate school. Arthur Kleinman helped me believe that it was still possible for me, entrenched as I was in clinical practice, to be an engaged anthropologist; I am grateful to him for this and for his continued support. Without Deborah Gewertz, who first exposed me to the world of critical anthropological inquiry during my sophomore year in college, I would not have gone down this path. Her comment on my first anthropology paper, “You should write more than prescriptions. . .” has been a mantra of support for the last twenty years. She continues to inspire me with her scholarship, and her heartfelt mentorship.

It is an unusual trajectory for a fully-fledged physician to pursue a PhD. My co-workers, whom I am lucky to call friends, in the San Francisco General Hospital Division of the Department of Obstetrics, Gynecology, and Reproductive Sciences at the University of California, San Francisco have been incredible in supporting me. From their understanding of why medical anthropology and this project matter to our shared mission of serving the underserved, to their flexibility with my constrained schedule in covering clinical work, they have been remarkable. Thanks to Phil Darney and Rebecca Jackson, my bosses and mentors who enthusiastically helped make it possible for me to get a PhD and still grow as junior faculty. Dr. Darney in particular was the first to help me recognize that working with incarcerated women was going to be “my niche,” when he interviewed me for a family planning fellowship position eight years ago. Tracy Weitz remains an invaluable mentor and friend whose

example of incorporating rigorous social science perspectives into reproductive health research and policy has propelled me; her warm encouragement has sustained me.

While they are also medical colleagues, Christine Dehlendorf, Eleanor Drey, Jen Kerns, Sara Newmann, and Jody Steinauer have proven their worth as true friends throughout this process. I am grateful to these and other friends who have provided necessary sustenance in the form of adventures, gourmet meals, witty text messages, and affirmation of the importance of my unusual path. Special thanks to Colin Carter, Angela Garcia, Rachel Harold, Meredith Heller, Thellea Leveque, Christine Marshall, Becky Marshall, Suzanne Peterson, and Rachel Roisman for this and so much more.

To my husband Jacob Harold, I am beside myself with appreciation for his patience and engagement with my work. His insistence on the value of anthropological perspectives in advancing social justice has been a constant reminder for me of why I am doing this work. I feel fortunate to have a partner who can spar with me on critical theory, and keep me honest about the bigger picture of it all.

Finally, after all these years I am still amazed that my parents, Janice and Jerry Sufrin, were right. As an undergraduate, I pondered going to graduate school instead of medical school as my academic version of post-adolescent rebellion. My parents gently redirected me to the pragmatic benefits of becoming a physician—advising me that I could always find a job in medicine and that I could later return to anthropology. Not only was their practical insight true, but being a clinician has been deeply fulfilling and anthropologically inspiring. My gratitude for their pride and unwavering support is deep. It is with respect and love that I dedicate this dissertation to them.

ABBREVIATIONS

ACA	American Correctional Association
CHART	Correctional Health Assessment and Record Tracking
CJ1	County Jail 1 (intake jail)
CJ2	County Jail 2 (women's jail)
CPS	Child Protective Services
DPH	Department of Public Health
DOT	Directly observed therapy
JHS	Jail Health Services
LVN	Licensed vocational nurse
MCR	Medical care request
NCCHC	National Commission on Correctional Health Care
PPD	Purified protein derivative (tuberculosis skin test)
NP	Nurse practitioner
RN	Registered nurse
STI	Sexually transmitted infection
SRO	Single room occupancy

INTRODUCTION

Rescue

"Everyone says I got arrested, but I got rescued." Evelyn was 32 weeks pregnant, although you could not tell that a fetus was gestating beneath the baggy, extra-large, standard-issue orange sweatshirt she wore. She had just arrived at the Bridgetown County Jail five days ago, for the third time this pregnancy, and for more than the twentieth time in her adult life. Evelyn had turned herself into the cops who were patrolling the corner where she regularly sold, bought, and used crack, on a charge of some outstanding warrants. "I was so sick," she explained, "I didn't want to get high no more. I just wanted to be in jail where I knew that I could eat, I could sleep, and that even if it's not the best of medical care, I was going to get some type of care."

This was Evelyn's self-proclaimed rock bottom. She had been addicted to drugs and in and out of jail since she was 18. She was now 29 and pregnant for the third time. She had spent the last six weeks on the streets of Bridgetown, "rippin' and runnin':" barely sleeping, smoking crack, selling any drug she could to make some money, getting into fist fights. This drug- and poverty-induced violent insomnia was familiar to her. But what was new, what made her feel more desperate than ever, was that she had no place to lay her head, not even a dingy single room occupancy (SRO) hotel room. She lay on the hard tile floor in the subway station at 60th and Atlantic, but could not stand the rats running over her feet. Until now, she had never had to eat out of garbage cans, getting excited when people left half-eaten food on top.

I ran into Evelyn one day when I exited the subway station that was the closest thing she had to home right now. She knew me as her doctor from jail earlier in pregnancy, the only obstetrician she had

seen for prenatal care. As we spoke, she kept her head concealed in a hoodie, and her scratched face turned to the ground. She tried, not so subtly, to hide her crack pipe behind her ear. “How are you” seemed too harsh to ask, so instead I offered “It’s good to see you.” Mostly we sat in quiet, sharing the mid-summer sun and the strange recognition of seeing each other outside of jail for the first time. As if a direct confession were too much for her, Evelyn broke our silence with, “I need some more prenatal vitamins. I ran out. Do you know how I can get some?”

Evelyn’s question, amid her current desperation, illustrated a poignant contradiction about women who are poor, pregnant, and dependent on the state for their survival: on the one hand, she was using drugs she knew to be harmful to her growing baby. And, she later explained, “I wasn’t making my prenatal appointments because I didn’t care about anything but getting high.” On the other hand, she was invested in the pregnancy; the night she got into a fight that left her with scratches on her face and bruises on her belly, she got herself to Bridgetown County Hospital a mile away—because she was worried about the baby.

Evelyn had already given birth to two sons, both while in jail. She was raising neither of them. And here she was again, a belly full of baby and in a place that had come to be familiar to her: jail. Jail: a place of punishment; a place where the deprivation of liberty is part of the punishment; a place where guards are constantly watching and ordering their charges into submission. The complex story of why someone like Evelyn, especially in her pregnant state, would desire to enter a punitive institution might seem obvious; but as a predicament for which we all share some responsibility has yet to be fully told.

Maternal Bliss

“Doctor, I just want to know, is it OK if I dance to Beyoncé?” I had not been prepared for pop music to be part of my prescription strategy at a prenatal check-up, but Kima needed to know. Tomorrow was the talent show in the D-pod housing unit at the Bridgetown County Jail, and Kima was used to being the life of the party. She was also 34 weeks pregnant and now that she was sober in jail,

she did not want to do anything to harm her gestating baby. I gladly authorized her performance, and watched the next day as she took the make-shift stage in the common area of her jail dorm. With vigor, she thrust her hips, shimmied her shoulders, bopped her head, and slithered her body in every direction she could as Beyoncé's song "Get me Bodied" played from an old boom box that belonged to the jail. Her thin, standard-issue orange t-shirt was loose, but still clung closely enough that everyone could see her protruding belly, which she rubbed with pride during the performance.

Four weeks later, still in custody at the jail, Kima began having painful contractions. They were familiar labor pains, as she, like Evelyn, had given birth two times before and, like Evelyn, while incarcerated. Also like Evelyn, she did not have custody of her children due to her struggles with addiction. That night, a nurse in the jail evaluated Kima, and decided she needed to go to the hospital. So the deputies in the jail escorted her to a car, and drove her the 10 minutes to nearby Bridgetown County Hospital. Kima arrived at the labor and delivery unit with the conspicuous fanfare of a jail inmate—bright orange clothes and a uniformed officer at her side. After a nurse checked her in, Kima shed her orange garb in exchange for a drab blue and white checkered hospital gown. The sartorial shift transformed her from a prisoner to a patient, albeit with a guard sitting idly outside her room to ensure she wouldn't escape between contractions.

With her orange clothes balled up discretely in a corner, the birthing room was like any other. The room was filled with excitement and anticipation, even a few family members during designated jail visiting hours. To a cheering crowd of doctors (including myself), nurses, and a doula, Kima effortlessly pushed her baby out. From incarcerated womb to ostensibly "free" newborn existence, baby Koia was placed into her mother's arms. The guard outside heard the unmistakable cries of new life. He popped his head into the delivery room, his black uniform reminding us briefly of Kima's incarcerated status. Gently, respectfully, he said, "I just want to wish you congratulations, Kima." A quick glance at the babe in arms, and then he was back to his post outside the room. Kima basked in the attention. She had a

blissful look on her face as she held her newborn against her chest, completing a romantic portrait of new motherhood—an unexpected portrait for a prisoner.

Kima was optimistic for a new start. Finally being able to be a mother, to stay clean. She only had two more weeks in jail and then she was going to a residential treatment program for moms and babies. Her sister would take care of the baby for the next two weeks, and then, Kima dreamed, the maternal bliss she felt at childbirth could resume. Kima desired for childbirth to be an escape route for her present life of drugs and petty crime. The normative and exceptional experience of being pregnant and incarcerated suggests that in our contemporary moment jail accomplishes more than discipline and punishment.

Jailcare

Jail, and the carceral system more broadly, have become an integral part of our society's social and medical safety net. Evelyn's and Kima's lives, including their pregnancies, have been shaped by a historical trajectory that is peculiar to the United States and that defines one of its greatest tragedies. The whittling away of public services for impoverished people, coupled with the exponential escalation in the number of jails and prisons serving as sites for the care of the indigent, define this American tragedy. The poorest of the poor in America have come to expect that they will go to jail. While there, they know that they will not only be subjected to a regimented, disciplinary environment, but that they will also receive certain services. For the worst off in America, jail is the new safety net.

The emerging equivalence between the carceral net and the safety net has created opportunities for care and discipline not only to coexist, but to shape each other in unexpected ways. My title, "Jailcare," suggests the disturbing entanglement of carcerality and care. "Jailcare" is also evocative of "health care,"[1] one of the services which the public safety net struggles to provide amid ongoing national debate about who deserves health care and who should pay for it. This dissertation

examines how this intertwining unfolds every day among the guards, medical providers, and women who cycle through jail.

The Perfect Storm

Evelyn's and Kima's pregnancies precipitate from a perfect storm of two deeply entrenched crises[2] in US society: mass incarceration[3] and disparate health care access. Since the 1980s' initiation of "the war on drugs", the US has seen an exponential rise in the number of people behind bars, from 501,886 in 1980 to 2,238,751 in 2011 (Glaze et al 2012). Phenomenal overcrowding, stark racial disproportionality, and a cost of billions of dollars characterize our modern day carceral institutions. Most of the people suspended in the criminal justice system will continue to cycle through, with recidivism, poverty, racism, and drug addiction inextricably linked.

Marginalized by poverty, under-education, and the siphoning of public resources from their communities, this is the same segment of the population who also experiences disparities in poor health and health care access. Those who cycle through our institutions of incarceration suffer from higher rates of HIV, hepatitis C, sexually transmitted infections, tuberculosis, chronic illness, drug addiction, and mental illness, to name a few (Rich et al 2011). More than half of the people who come into jail or prison are among the 44 million Americans without health insurance (although this number is poised to change dramatically with the recently enacted Affordable Care Act).[4] And yet, when they enter into a carceral institution, they gain a constitutional right to health care. In the 1976 landmark Supreme Court case *Estelle v. Gamble*, Chief Justice Thurgood Marshall declared that *"the deliberate indifference to the serious medical needs"* of prisoners is a form of cruel and unusual punishment, resolutely prohibited by the 8th Amendment (US Supreme Court, 1976). Prisons and jails are thus legally and constitutionally required to attend to their inmates' "serious medical needs."

While mass incarceration has generated innumerable problems, it has thus also, partially and perversely, remediated problems of access to health care for millions of Americans. Jails and prisons

have notably become the country's largest provider of mental health care services (Kristof 2014). Kima and Evelyn have been inculcated into the disciplinary apparatuses of the jail, and this, paradoxically, enables them to access certain kinds of citizen rights and certain kinds of care.

The predicament of health care provision in a prison or jail setting poses a set of apparent contradictions. First, incarceration is a deliberate technique for suspending most rights of prisoners (Foucault 1977; Goffman 2007); deprivation of liberty is an intentional mode of punishment.[5] And yet, prisoners gain a constitutional right to health care—something which non-incarcerated US citizens cannot claim. Although as a pregnant woman in the community Evelyn qualified for Medicaid, it was not guaranteed as a right. Moreover, she was accustomed to getting free care in jail. So the only prenatal care Evelyn sought during her pregnancy was while she was in jail.

The second contradiction is the presence of curative medicine in an institutional state setting where punitive, dehumanizing repression is the norm (Watterson 1996; Goffman 2007; Fleury-Steiner 2008). The punishment mode through which incarceration currently operates in the U.S. makes prisons and jails sites of physical violence—the harshness of daily deprivations of comforts of living, the belt of weapons on the prison guard. Jails and prisons are also enmeshed in structural violence, as evidenced by the disproportionately poor population of color, which further oppresses these communities. And yet, amid this state-sanctioned violence, a mandate to care exists. Medical activities, with commitments to the intimacy of caregiving, seem to challenge the logic of institutional violence. For instance, pregnant inmates like Evelyn and Kima become medically authorized to receive privileges like a bottom bunk, an extra slice of bologna, and an ice pitcher to ensure their safety and to optimize the health of their fetuses. These luxuries become symbols of care only because they are prescribed within a milieu in which care is presumed to be lacking.

These dual ironies speak to the intersection of two powerful loci of power in our contemporary moment: prison and medicine. The ironies also suggest tensions in the ways care unfolds in a

constrained environment. The pervasiveness of regimes of knowledge and power, emerging with the Enlightenment in the 17th Century, was a component of modernity. The transition of punishment from public, physical torture to the enclosed, regimented space of the prison involved a strategy of knowing bodies and producing subjects whose behavior would be governed by disciplinary strategies (Foucault, 1977). With the emergence of the penitentiary in the 18th century, punishment assumed a higher, moral purpose of transforming the souls of criminals through a lengthy imprisonment; the prison now had the ambiguous function of caring for the prisoner during this time of transformative punishment (Prout and Ross, 1988: 11). Punishing criminals also became the terrain of professional experts, whose techniques helped to shift punishment from the body to the mind, from physical violence to regulatory control. Discipline is the subtle management of modes of living, through which normative behavior is modulated with "discreet surveillance and insistent coercion" (Foucault 1977: 299); timetables in prison are tools of behavioral governance.

Foucaultian discipline is an important component of the daily managerial and safety tasks of what is known as "custody" in prisons and jails. Disciplinary regimes have been internalized broadly beyond the prison, Foucault argued, for they are how we organize ourselves as rational, modern beings. Disciplinary power requires no force, although in the prison force may be an accoutrement. Foucault provided a critical insight into punishment, but the punitive aspects of contemporary prisons and jails are not exclusively disciplinary; treatment of prisoners still includes unpredictable physical brutality that is far from the subtle control of disciplinary regimes.[6]

With the prison's exemplary disciplinary regime, Foucault further elaborated, the clinic became iconic of the prison. Medicine became a key instrument of social control, maximizing the health and therefore productivity of the population (Politics of Health). The health of individuals and of the population became an object of governance in much the same way that the behavior of prisoners was. Just as the prisoner was to be known through constant surveillance, so too was the patient known

through visual signs perceived by the medical gaze (Foucault 1975). Just as the prisoner comports herself through expected norms of behavior, so too does the patient make choices about health-related behaviors through normative medicalized regimes (Horton and Barker 2009). For Foucault, care is organized by disciplinarity.[7]

Jail does remain for Evelyn and Kima, at least partially, an experience of regimentation of everyday living, of being subjected to the whims of those with institutional power. But what Evelyn and Kima show us is a different relationship between carceral and medical institutions: a relationship where care is reliant on and arises out of punishment, where care can flourish as affective relations which are generated through disciplinary arrangements. This is a different kind of intertwining of care and discipline than Foucault described, different than this configuration of power which was central to subject formation. The connection is not simply regulatory, as Foucault would have us believe. Rather, it is laden with the intimacies of everyday human relations. These relationships develop in an institution designed for harshness, where punishment can still exceed the subtlety of disciplinarity. As a result of the totalizing nature of the institution and of the anemic welfare state, the prison can also nourish. For Evelyn and Kima, incarceration has become an experience of health care services, of caregiving relationships, of safety from the streets, and of potential maternal transformation. The prison is iconic of the clinic.

The stories of Kima and Evelyn form part of a larger tapestry of stories about how jail workers, medical providers and inmates are all working through the repercussions of broader structures of inequality in our country. That tapestry depicts the ways that care can emerge within the compromised milieu of a jail enmeshed in the forces of political, economic, racial and medical marginality. In this context, pregnancy, marked by the gestational potential for change, is an exemplary moment in how such care transpires. The delivery of reproductive health care within the apparently constricted milieu of a jail can elucidate what it means to care and be cared for when the fundamental conditions of

generating new life (through pregnancy) and restricting the lived experience life (through incarceration) are brought into contact. Being attentive to the granular aspects of everyday relations around these phenomena in a jail and its medical setting reveals that these contours are not simply about structural violence, or the oppressive nature of the carceral state. Rather, they tell us about ways that jail practically and intimately can be a normative and unsettlingly caring institution amid precariously lived lives.

Disarray of the Safety Net, Expansion of the Carceral Net

Evelyn was born in 1983 to poor, black parents who held no steady employment and who struggled with drug addiction. Her mom used phencyclidine (commonly known as PCP) while she was pregnant with Evelyn. By that point in time in the U.S., a major shift was well underway in how the state dealt with such segments of the population, and the cultural imaginary of what they morally represented. Put simply, where the state once had a strong moral and financial investment in robust services for the poor, it now invests in an increasingly large and punitive penal system to manage them. Rather than addressing problems of poverty through social services, the state instead incarcerates millions of people whose poverty may have led them to petty theft or drug addiction. Of course, public services for the poor have never been available equally, as segregationist policies of Jim Crow excluded many black families from state-sponsored benefits. But the general shift in how the state engages the poor is still salient.

When Evelyn was 5 years old, her mother was murdered. Evelyn was variably cared for by her father and a cousin, whom she referred to as Aunt Vera. When it was discovered that her father was molesting her, the state removed Evelyn from Aunt Vera's custody. Instead of providing mental health and trauma services for Evelyn and keeping her with her nurturing aunt, state agencies funneled her into a series of group homes, foster care, and, because of anger precipitated by her unaddressed

trauma, eventually into juvenile detention. Her entry into adult correctional facilities was early and, ultimately, not surprising.

The historical arc from the social to the "penal treatment of poverty" (Wacquant 2010: 97) in the US has been well explored by a number of scholars (see, among others, Tonry 1995; Davis 1997; Wacquant 2002, 2008, 2009, 2010, 2012). With the New Deal of the 1930s, the US government sought an expanded role in assisting wage earners and those who were financially distressed. The Social Security Act of 1935 established, among other things, unemployment insurance and Aid to Families with Dependent Children (the predecessor to what we now call "welfare"); such programs implied that taking care of the poor was under the purview of the state, and comprise what we now think of as part of a "safety net" for the poor.[8] This spirit continued through the 1960s with Lyndon Johnson's commitment to winning the "war on poverty" through a variety of expanded government services, including food stamps and federally funded medical care for the poor (Medicaid) and elderly (Medicare).

These programs also came at a time when civil rights activism was at its zenith, when the trenchant, unequal effects of racial segregation—including the unequal availability of safety net services for African Americans—were at the forefront of national dialogue. Progressive social activism in this decade spilled into civil unrest in urban centers in the 1970s, which in turn generated a new public fear of crime (Simon 2007); this panic contributed to turning to incarceration as an anxiolytic, to isolate groups perceived to threaten the dominant moral order (Freely and Simon 1992; Simon 2007). Not coincidentally, this supposed "dangerous underclass" was poor and black, located in the abandoned urban ghettos (Wacquant 2001).

At the same time, there were dramatic shifts in the skilled labor market in the US and in the deregulation of the market economy, generating a surplus of unemployable, superfluous laborers. Those who were already disenfranchised, particularly in urban ghettos, were made more so by neoliberal economic policies and the retrenchment of the safety net (Wacquant 2004), which began in

the 1970s and culminated in President Bill Clinton's famous Welfare Reform Act. In 1970, the median amount given to a family of four by Aid to Families of Dependent Children (AFDC) was $221/month. In 1990, adjusted for inflation, that amount was $128/month (Wacquant 2009: 49). The Federal Housing Budget declined by 80% from 1978 to 1988 (*ibid:* 52). Other public aid programs were eliminated, as the poor were left to turn to precarious wage opportunities and illicit markets, notably the drug economy. As many inmates at the Bridgetown County Jail told me, selling drugs remained the only reliable way they knew they could make money, and more than they would make at a minimum wage job.[9] A history of incarceration further prevents people from legal wage earning because of widespread restrictions which employers place on hiring those with felony convictions.

Another notable retreat of public services in the 1970s was the national closing of state-run mental hospitals, thought to be rife with inhumane and coercive treatment. While motivated by humanistic desires to deinstitutionalize the mentally ill, the promise of more community-based mental health treatment services was never fulfilled (Estroff 1981; Brodwin 2013). Without adequate support, many suffering from mental illness found themselves incarcerated for a variety of petty and non-petty crimes, largely precipitated by social abandonment. Jails and prisons have now become the largest provider of mental health services in the country (Kristof 2014).

While the federal government invests a considerable amount of total dollars in programs intended to aid the poor— $607 billion in 2012—these services remain uncoordinated, disorganized, and weighted by numerous stipulations for enrollment.[10] Amid this disarray of the safety net and the economic shifts which have further marginalized the poor, the US has seen a spectacular and unprecedented rise in the number of people behind bars. There has also been an astounding increase in the amount of money spent on managing and building state prisons—from approximately $16 billion in 1982 to $40 billion in 2010 (adjusted for inflation) (Kyckelhahn 2012); when combined with local expenditures, the US spent $76 billion on corrections in 2010 (Kyckelhahn 2012 and 2013). This growth

has flourished without a preceding or concomitant rise in crime rates (Tonry 1995; Wacquant 2009b). Instead, mass incarceration resulted from "a politics of resentment toward categories deemed undeserving and unruly, chief among them the public aid recipients and street criminals [who] came to dominate the . . . debate on the plight of America's urban poor" (Wacquant 2010: 1).

Incarceration and the safety net are also linked in that coming to prison or jail suspends any publically-funded benefits someone receives through programs like Supplemental Security Income, Temporary Aid to Needy Families, food stamps, or disability benefits;[11] when released, that person must go through the process of signing up again. This is also notably true for health insurance benefits from Medicaid or Medicare.[12] That incarceration disrupts these public health care coverage programs and then furnishes a legal mandate for the prison to fill in this gap suggests a substitution role of the carceral apparatus for the public safety net.

Inextricably linked to this inverse relationship between the social and penal management of poverty is the so-called "war on drugs," launched in full force the 1980s[13] under President Ronald Reagan, as he moved to privatize and cut public sector services; although drug crime was declining (Maurer 2006), states ramped up incarceration for drug crimes in part through increased policing and draconian sentencing laws such as mandatory minimum sentences and California's notorious "Three Strikes" law.[14] Although rates of drug crimes among people of all races have remained equal, blacks are 13 times more likely to be incarcerated for drugs (Dumont 2013), leading scores scholars and activists to point out that the war on drugs and mass incarceration are distinctly racially directed phenomena (see especially Gilmore 2007; Alexander 2012).

That prisons and jails disproportionately house African Americans is a social and statistical fact: blacks comprise 13% of the overall US population, but 38% of the prison population (Carson and Golinelli 2013); 54% of jail inmates are people of color (Minton 2013). The numerical face of racialization of mass incarceration represents a number of complex, underlying forces: the production of

symbolic imagery which equates criminality with blackness (Davis 1997); the intersection class control and the crumbling urban ghetto with race control (Wacquant 2001); and the historical continuity of targeted black imprisonment with slavery and Jim Crow (Davis 1997; Wacquant 2001; Alexander 2010). Importantly, the convergence of governance of the poor and racialized strategies in the age of mass incarceration should not be taken as the interchangeability of race and class, but of their intersection through a broad range of policies and structures.

The cultural narrative around crime and drug use escalated in its moralizing tone during this era, fueled in part by fear and deeply entrenched racial prejudices.[15] Pregnant, black women like Evelyn and Kima are particularly vulnerable to moralizing convictions that incarcerate them for using drugs in pregnancy and endangering their fetuses (Tsing 1992; Roberts 1999; Paltrow and Flavin 2013); nonetheless, the state remains poorly committed to adequate educational and social services for this next generation.

Women in particular have been notably affected by the war on drugs and shifting welfare policies; there was a 646% increase in the number of women in prison between 1980 and 2010, a rate 1.5 times that of men (Sentencing Project, 2012). Most of the 207,000 women behind bars are there for non-violent crimes (Carson and Golinelli 2013; Minton 2013), and as many as 60% of them struggle with addiction (Fazel et al 2006). Nearly two thirds of them are mothers (The Rebecca Project, 2010). More than half have experienced physical or sexual abuse as children or adults (Harlow 1999). Symptoms of a mental illness are present in close to three quarters of women who are incarcerated (James and Glaze 2006). These women have high rates of sexually transmitted infections, and higher than incarcerated men, with up to 14% being diagnosed with Chlamydia upon entry (Willers et al 2008) and 49% reporting a prior history of a sexually transmitted infection (Clarke et al 2006). The majority of incarcerated women are younger than 50, with 63% of female prisoners between the ages of 18 and 39 (Carson and Sabol 2011). Many women begin their time in the criminal justice system as girls in juvenile detention.

Kima, 31, and Evelyn, 29, fit into all of these epidemiologic descriptors. Women's paths to incarceration and their gender-specific health needs have nonetheless been neglected, because overall they comprise only 9% of the incarcerated population (Covington 2007; Carson and Golinelli 2013; Minton 2013).

The prisons and jails in this era of mass incarceration are, as many have documented, characterized by harsher living conditions and a more punitive sentiment than the previous decades. These are the "warehouse prisons" (Irwin 2005), where people are extracted from society to linger in idleness with little to no preparation for re-entry, dooming them to recidivism and perpetuating their marginality. The pervasive nature of imprisoned abandonment and the structural forces encouraging return to prison are different than "discipline" in the classic Foucaultian sense, for they are not simply about normative regimes. The expansion of the carceral system has not only meant a sheer increase in the numbers within its walls. It has also had increasing reach into communities, in part through probation and parole terms and in part through the repercussions on families when individuals are removed from the community.[16] With its wide reach, the carceral system has thus come to structure social and economic relations for all of society. Wacquant (2001; 2010) has emphasized this reality by examining the continuities between the urban ghetto and the prison.

The absence of rehabilitative programming and the presence of cruelty are well and perpetually documented in academic and journalistic accounts. But alongside the reality of severe deprivation, there exists a twisted paradox. Prisons and jails provide shelter, clothing, food, and medical care for millions of people whose outside lives are characterized by homelessness, addiction, poverty, malnutrition, and trauma. Moreover, there is tremendous local variability in the extensiveness of services available to those inside the walls of prisons and jails. Bridgetown County Jail, for instance, is notable for having a plethora of programming. Kima was part of an in-house, comprehensive drug treatment program, which linked her to residential treatment facilities in the community. She and other women were encouraged into artistic expression as part of their healing, showcased at intermittent

talent shows, such as the one where Kima danced to Beyoncé. Some of the women complained to me that there was actually too much going on and that they wished they had more unscheduled time in jail.

While the jail in the adjacent county had little to compete with the Bridgetown jail's services, Bridgetown was by no means unique in offering of an eclectic variety of programs even beyond the basic needs which a total institution is expected to provide. The corollary to the twin demise of the public safety net and the criminalization of poverty is that Evelyn knew, at her rock bottom on 60th and Atlantic, that she could turn to jail for help. Jail was her safety net. As Wacquant has astutely noted, "the US carceral system has become a perverse agency for the delivery of human services" (Wacquant, 2002: 388). What has yet to be examined is how this continuity between the safety net and incarceration unfolds inside a jail, as those employed and confined inside work through this tremendous, consequential paradox.

Jail versus Prison

As I mentioned in the Preface, jail and prison have important administrative, geographic and criminal justice differences. Despite similarities in the punitive, poverty-managing, racializing techniques between the two institutions, jails are distinctly different social worlds. The short and frequent intervals of recidivism contribute to this. For women like Evelyn and Kima, coming to jail is not a life altering event; rather, it is a normative, anticipated experience. The physical embededness of jail in the surrounding community (see photo) makes it hard to ignore its connections with the outside world, including the safety net.

The uneventfulness of recidivism in jail is exemplary of Gilles Deleuze's point that we have shifted from a strictly disciplinary society to a more dispersive society of control: "Control is short-term and of rapid rates of turnover, but also continuous and without limit, while discipline was of long duration, infinite, and discontinuous" (1992: 6). A recent scandal at the Baltimore jail where a jail gang leader impregnated four female guards—some of whom were recruited by gang members to apply for

jobs in the jail, and who smuggled cell phones and drugs into the jail—illustrates the complexities of control societies, as well as the extent of connections between the community and jail (Toobin 2014).

Neither jail nor prison can be thought of as isolated institutions, nor do the people confined inside disconnect themselves from their outside lives. As Mahuya Bandyopadhyay (2010) has shown in her ethnography of a prison in India, prisoners actively reflect on the similarities between the state's repressive management of their lives in prison and before prison. Her argument appropriately shows that inside and outside life cannot be separated analytically. But her ethnographic insight of the continuities between prison and pre-prison life imposes a temporal distinction that does not exist for most people who go to jail. Kima and Evelyn did not have a pre-jail life and a jail life, for they were constantly cycling between the two such that they were both part of the same life for them. The temporality and geography of jail are thus important windows into the realities of carceral continuities in the lives of those marginalized by structural forces of inequality.

The Right to Care

Understanding the relationship of care between the state and incarcerated women cannot be limited to the realm of policy analysis or the courts, but these nonetheless provide important background for the everyday instantiations of the state's responsibility to care which occur in the jail. After all, as I will describe throughout this dissertation, Bridgetown jail staff engaged on a daily basis in adjudicating what kind of care is warranted for people who are being punished through incarceration. Their everyday crafting of care must be situated in an active legal context in which the courts have become deeply involved in defining the conditions of incarceration (Schlanger 2003; Reiter 2012) and, more broadly, prisoners' rights and the prison's responsibility to care. A brief look at some of the key cases reveals the essential ambiguity around discourses of rights and, in turn, the emergence of care in a punitive setting.

Estelle v. Gamble came in the midst of a surge in prisoners' rights lawsuits in the 1970s (see Reiter 2012).[17] In 1975, prisoner JW Gamble injured his back while doing labor on a prison farm in Texas. He alleged that the medical care he received was inadequate and that he was further punished for not working due to back pain. The Supreme Court disagreed, and Gamble lost the case. However, they took his instance and the precedents before them exposing medical atrocities as a platform to establish, through reference to the Eighth Amendment, health care as a right for prisoners. It signaled, along with other key prisoners' rights cases of the time, that the punitive suspension of rights which characterized incarceration must be selective. The case put medical care under the realm of what legal scholar Sharon Dolovich (2009) has called "the state's carceral burden," its duty to provide for prisoners' basic needs and protect them from harm.

The majority opinion of the court is replete with appeals to rationality and to sympathy for human suffering. It is worth citing at length:

> These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or a lingering death," (*In re Kemmler, supra*), the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. (*Cf. Gregg v. Georgia, supra,* at 182-183 [joint opinion]). The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common law view that "it is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself" (*Spicer v. Williamson)*.

By giving regulatory and rights-based force to prisoners' states of health, *Estelle* made medical care integral to the everyday experience of incarceration. "Evil," "decency," "pain and suffering," are evocative phrases that imbued care for prisoners with moral and sentimental weight. As I will discuss in this dissertation, the staff at the Bridgetown jail, though they did not mention rights or *Estelle*, worked within these moral and affective dimensions of care established by the Supreme Court's affirmation of

rights. Since *Estelle*, there have been tens of thousands[18] of lawsuits[19] to challenge and define the scope of "deliberate indifference"[20] and "serious medical needs" (see Rold 2008).[21]

The scope of judicial involvement in care must also be measured not by the extraordinary number of cases filed, but also the depth of involvement of the courts, such as court orders for individual prisoner medical care and, most recently in *Brown v. Plata* (2011), ordering the state of California to depopulate its prisons by 46,000 people in 3 years because the health conditions were so abysmal.[22] Locating prisoners' right to health care in the domain of ethics, the Supreme Court argued that the risk of suffering due to inadequate medical and mental health care was "incompatible with the concept of human dignity and has no place in a civilized society" (*Brown v. Plata* 2011: 13). Such extensive litigation of prisoner health care has contributed to the judicialization of care (Biehl et al 2012) as well as to the medicalization of the prisoner (Simon 2011: 253).

In this rights-based rationale for prisoner health care, medical needs take on an ontological, naturalized status. The prisoner's needs are envisioned as external to the goals of punishment (their denial serves no "penological purpose"). When a prisoner's health care is cast as a human right, the circumstances leading to her incarceration are made irrelevant; for even a prisoner is still human enough to be entitled to this right to have her biological needs fulfilled.

Medical care, accordingly, is imagined as an unquestioned good or a "meta-right" (Greco 2004: 1), as something to be achieved in the face of potential deliberate indifference and of the coercive structures of unfreedom of the prison. In this scheme, "serious medical needs" have a taken for granted quality. A correctional health care administrator I met at a conference provided me with his practical explanation of this term:

> *Estelle v. Gamble* sets up both a platform for what must be provided and sets ground rules for what you don't have to provide. Basically, if it's a serious medical condition, you need to address it. If it's not a serious medical condition, you don't. And while there is always a gray area where, you know, some people may legitimately say it's serious, and others may legitimately say it's not serious, the deliberate indifference standard is pretty much the Bible that ought to guide what you do.

This is the balance between the entitlements of rights, which establishes the minimum of what must be provided,[23] and the moral articulation of what health care prisoners' deserve.

With this essentialized biological basis of health rights, we might then examine post-*Estelle* activities as exercises in actualizing prisoners' health right. Nancy Stoller (2003), for instance, provides a sophisticated spatial analysis of health care in a prison. Despite her social and political reading of how clinical spaces are constructed within the prison, she depicts health care as something static, a service to be accessed in the face of barriers posed by the prison. Stoller's ultimate conclusion is that the punitive, disciplinary structures which interfere with obtaining health care in prisons preclude the possibility of relations of care.

The juridical preoccupation of linking medical care for prisoners with rights attempts to answer the question "what is the prison's responsibility to care for its charges?" This question of obligation to care has its roots in what Foucault described as pastoral power. Pastoral power was exemplified by the ancient shepherd, who exercised power over his flock of sheep through the benevolent provision of subsistence for them, looking after them, and tending to their injuries (2007: 127). For Foucault, "pastoral power is a power of care" (*ibid)*; it is the pre-cursor to the modern state's welfare activities, where seemingly compassionate intentions produce power effects. In the prison, an institution of the state, we might locate this pastoral impulse as "the state's carceral burden" (Dolovich 2009); in other words, the state has removed prisoners' ability to care for and protect themselves, to sustain their lives, and so it must fulfill those roles. Care would seem to be an endpoint of duress. Even if this is the case, it does not necessarily mean that health care providers and guards who are on the ground in prisons are providing care under duress. We must instead look to the everyday social translations of pastoral care, for this is where the benevolence of pastoral power can be more than regulatory, can even instantiate an ethical ideal of caring (Garcia 2010: 31).

A deeper understanding of health care rights is in order. For if it is merely thought of as a meta-right, then the analysis of health care in jail is limited to an examination of how access to this right is enabled or prevented, in an inevitable demonstration of structural violence (see Willen 2011). This compartmentalized view of a right to health and health care overlooks the ways that so-called medical needs have become dynamic terrain for relationships within the carceral milieu. Rights are not pre-political entitlements, waiting to be attained, but are configurations of social, political, and institutional arrangements (Somers and Roberts 2008: 407, 413), made meaningful through human interaction. Prisoners' health care rights are thus better understood through the everyday encounters in which caregivers and patients articulate what Sarah Willen (2011) calls "health related deservingness." That is, a prisoner's constitutional right to health care, though it may be continually contested in the courtroom and policy arenas, is realized through the nurses, doctors, and guards who make decisions everyday on what kind of care people who are incarcerated deserve.

Nurses at Bridgetown did not speak in the judicial language of "serious medical needs" and "deliberate indifference." In fact, many of the medical staff had not heard of the *Estelle v. Gamble* case, or that the Supreme Court mandated correctional facilities to provide health care as a matter of constitutional right. I once heard a patient in the waiting area of the jail clinic threaten to sue the jail because she had to wait two weeks for a gynecologic exam. The medical staff hardly gave her notice, and the ones who did mocked her threat. Perhaps they, like I, assumed that this was merely a complaint expressed as a legal threat, that the patient was unlikely to pursue legal action, and that even if she did she was unlikely to win. What is clear is that health care rights for prisoners are not only adjudicated in courtrooms and activist circles, they are given form through everyday human relationships and micro-practices of care. Ethnographic inquiry provides a critical window into care and rights that exceeds the juridically-oriented conversations about prisoner health care.

Professionalization of Correctional Health Care

In addition to the courts, health care professionals, too, have contributed to the historical trajectory of articulating "the state's carceral burden" to care for prisoners. Doctors and nurses have long been present in prisons and jails. In 18th century England, the Prison Medical Service was created, largely in response to reformer John Howard's report of gruesome health conditions. [24] Howard's activism helped to incite a "modern humanitarian consciousness" (Simon, *in press*: 8) around the management of people in prisons, a spirit which would resurface in U.S. courts' involvement in prisoner health care. In the U.S., The National Prison Association (now known as the American Correctional Association) formed in the reformist era of prisons in 1870, and asserted in its foundational document, "Declaration of Principles,"[25] that the prison has a role in caring for its inmates: "The hospital accommodations, medical stores and surgical instruments should be all that humanity requires and science can supply; and all needed means for personal cleanliness should be without stint" (American Correctional Association 1870: 33). There was little specificity of how medical services should be administered, but this statement nonetheless implies that prison leaders believed inmates should have medical care equivalent to what would be available to them outside of the penitentiary.

Literature on the structure and availability of medical care in prisons in the days before it was legally mandated is sparse. Some prisons hired community doctors to come to the facility, others sent inmates to local hospitals, but details on what conditions would merit attention are lacking. Doctors presided over electric chair executions as early as the late 1800s (Conover 2001), and participated otherwise in the management of prisons (Simon, *in press*: 7). One exposé of Arkansas prison farms suggested that sections of the on-site prison hospital served as a torture chamber, with assistance from prison doctors (Murton and Hyams 1969). Alongside medical atrocities in prisons, the post-World War II era of penology aspired to rehabilitate prisoners using a medically-influenced curative model of criminality. As Foucault noted, this therapeutic dimension of care in prisons was tightly aligned with the project of transforming the criminal into a proper citizen.

As the courts secured prisoner health care in the sacred domain of the constitution, the medical community was beginning to organize a professionally unified approach to the medical care of inmates. The first organized effort came in 1972 in the form of a report on medical care in US jails. The American Medical Association surveyed 1159 sheriff's jurisdictions, finding a systematic and egregious absence of adequate medical care in jails (American Medical Association 1973).[26] This prompted the American Medical Association in 1975 to undertake a pilot program at 30 jails to systematize health care provision, which later became the basis for a national accreditation program (Anno 2001: 23).

This program led to the 1983 formation of the National Commission on Correctional Healthcare (NCCHC).[27] The NCCHC now accredits over 500 jails, prisons, and juvenile facilities across the US that have chosen to meet its nationally-accepted standards of care and to go through the accreditation process. The Bridgetown jail clinic was not accredited by the NCCHC. A medical administrator explained to me that accreditation was an expensive, logistical hassle; since the services provided at Bridgetown exceeded the NCCHC standards, he did not think going through accreditation was a worthwhile process.

Although the NCCHC is not a legal organization, the juridical framework established by *Estelle* nonetheless gets played out through the organization's regulatory guidance for prison and jail clinics. Standardizing clinical care offers jails and prisons a road map for avoiding deliberate indifference, for providing what the NCCHC deems a "constitutionally acceptable level of care" (NCCHC website).[28] I met a jail nursing administrator from Arkansas at NCCHC's annual conference who told me that her facility's accreditation has saved them from several lawsuits. "It's an assurance," she told me, "that you're not showing 'deliberate indifference.'" She rolled her eyes with disdain as she uttered those constitutionally bound words. The legal mandate was imbricated into her sense of professional obligation.

The NCCHC's 200-page book of standards translates the vagaries of the "constitutional" standard of serious medical needs into specific logistics and services, from personnel and administration to medical diets and health care services (NCCHC 2008). Most of the NCCHC standards are designated

"required" for an accredited facility, but a few are optional. Such a taxonomy parallels the central tension between the minimum care to which prisoners are entitled—rights and constitutional requirements—and the moral vernacular of their deservingness, or what some view as an excess of care.

Though its initial activities focused on accreditation, NCCHC has grown over the past three decades to be a vibrant professional society for nurses, doctors, administrators, and mental health workers in prisons and jails. The NCCHC now holds educational conferences, publishes an academic journal and textbooks, and examines individuals to award them the title "Certified Correctional Health Professional."[29] NCCHC representatives are currently working on creating a medical board-certified specialty for physicians. What all of this standardization and organizing has amounted to is the professionalization of health care provision in prisons and jails, the emergence of a field of practice known as "Correctional Health Care."[30] These forces of professionalism try to normalize the work of health care providers in an area that continues to be marginalized by mainstream professional circles. The majority of the correctional health care workforce is comprised of nurses, followed by mental health workers. Nurses are in the trenches in jails and prisons, interfacing with inmates more frequently than physicians.

The business of correctional health care is also noteworthy. Hundreds of jails and prisons (though not Bridgetown) contract out the provision of health care services to a handful of private corporations which are centrally headquartered far from the prisons and jails they serve. The county or state pays a lump sum to the company for an agreed upon list of services. The prison health company then has an incentive to keep its medical costs as low as possible. Market forces and the companies' profit motives, not surprisingly, often encourage cutting corners and providing negligent, dangerous care, as media reports continue to highlight (von Zielbauer 2005; Leonard and May 2013; see also Fleury-Steiner 2008). Corizon, the largest private prison health company, earns an estimated $1.5 billion in profits annually (Segura 2013).

I spend this time describing some of the national landscape of correctional health care to highlight the ways that attention to the health of prisoners has taken on the character of regulated practice, communal practice, and market capitalism.

Public Health and Prisoner Health Care

Two other overlapping dimensions which are central to how prisoner health care has been addressed in the US are public health and social justice. Academic researchers, administrators, jail providers, public health workers, and prisoner activist groups alike have emphasized the population level considerations of health care for prisoners. For one, prisons house large numbers of people in common space, creating a reservoir for the transmission of infectious diseases. Health care infrastructure within prisons, public health advocates have argued, should work thus to prevent disease inside.

The second public health perspective understands that most incarcerated people have poor indices of health and access to health care pre-incarceration. Incarceration then becomes an opportunity, albeit an unfortunate one, to work with populations who already have a high prevalence of mental illness, addiction, chronic disease, sexually transmitted infections, hepatitis, HIV and other conditions. In this opportunistic orientation, incarceration may exacerbate those conditions or, when care and re-entry services are provided, incarceration may ameliorate people's health. The fact that jail has become a primary health care provider to women like Evelyn and Kima from Bridgetown is well known in public health circles, and among people working in jails and prisons. A third public health perspective on prisoner health care builds on the reality that, ultimately, most incarcerated people are released into mainstream society. Tending to inmates' health while they are incarcerated also benefits the health of the communities to which people return (Dumont 2013).

These opportunistic public health approaches coexist with a social justice imperative in certain circles of activists and medical academic researchers. That is, many researchers and people who provide

care to prisoners—myself included— are motivated by a humanistic desire to help individuals they see as marginalized by broader structures of poverty, racism, and inequality. For instance, there is an active "Prison Health Care" subsection of the American Public Health Association (APHA); many of the members were once radical civil rights activists in the 1960s and 1970s, and see health advocacy as one way to improve current prison conditions. Angela Davis, the famous prison abolitionist, was fiercely welcomed as the keynote speaker at the 2012 APHA annual meeting. These activists even liken mass incarceration itself to a public health epidemic, a scourge on our society as destructive as any infectious disease (Drucker 2011).

Human Rights Watch, Justice Now, Legal Services for Prisoners with Children, California Coalition for Women Prisoners, these are but some of the hundred or so non-profit groups in the US[31] who advocate for health care improvements in prisons. Indeed, there is much to improve. Contemporary examples abound of prisons with gravely dangerous or absent medical services, a confluence of budgetary constraints, overcrowding, and the normalization of preventable suffering by prison medical workers who are overwhelmed by their duties (Fleury Steiner 2008: 5). Frequent media exposés report egregiously inadequate and incompetent medical care at many prisons and jails across the country, such as a doctor not wearing gloves when doing pelvic exams on women prisoners (Johnson 2014). Such extremes were absent in the Bridgetown jail clinic, but it is important to keep in mind the tremendous variability and potential for abuse in the quality of medical services across jails and prisons in the U.S.

As I delve deeply into the everyday realities of care within an institution of confinement in Bridgetown, these three macro level forces—legal, professional, and public health justice—must be kept in mind. These perspectives all take form in the unique circumstances of carcerality: punishment, normalizing regimes, restricting liberty, inequality, and, ultimately, relations among humans. If we left the analysis to an exploration of these three intersecting spheres of prisoner health care, we would have an interesting story of how policies, regulations, and calls for change converge to define who and under

what circumstances people deserve health care. Instead, we must look to the ways that health and care are made meaningful on the ground as individuals contemplate in action the complex moral terrain of entitlements and deservingness of health care.

Bridgetown Jail

There were six jail units across Bridgetown, managed by the Bridgetown Sheriff's Department. I spent most of my time in County Jail 2 (CJ2), the only jail which houses women. The nearby intake or "booking jail," County Jail 1 (CJ1), where I also conducted fieldwork, was the reception unit where police officers would bring in newly arrested people (men and women) to be processed into the jail. CJ1 and CJ2 were located in the same five-story building in downtown Bridgetown, which stood adjacent to a major highway. Thousands of Bridgetown area residents passed the jail every day on their way to and from secure jobs and homes. Yet few living in Bridgetown would be able to identify what the rounded-walled, concrete building with art-deco frosted glass window panes was.

The Bridgetown jail, in the midst of the city and adjacent to a highway

The building was rounded to the contours of the "pod style" housing units, circular dorms in which the guard tower of each housing unit was panoptically in the middle and the "cells" were arrayed

around the periphery. These were not the long hallways of cubic cells with iron bars, vividly represented in popular media. The pods were built in Bridgetown in the early 2000s with the hopes that open architecture would facilitate a more positive, rehabilitative environment. Most of the cells in the pods did not have doors; they were open to the common area where inmates ate, exercised, socialized, and attended classes, among other activities. Each cell had 2 bunk beds and a narrow space between them. Shared toilets and showers were in individual stalls on each level of the pod. A single iron door at the entrance to the pod provided security. It slid open and closed when an unseen deputy at the central control tower in another part of the jail saw who was at the door and pressed a button. The upper-level cells in the pods had locked glass doors, for people classified as needing higher security; these cells were euphemistically called "ad seg," for "administrative segregation."

The midyear count at the Bridgetown jail in 2013 was 1445, down 29% from 2029 in 2007.[32] Women were 9% of the total jail population in 2013. The number of women incarcerated in Bridgetown dropped dramatically by 45% in my time there, from 251 when I first arrived in Bridgetown in 2007 to 137 in 2013.[33] Reflecting national trends in racial disparities, 58% of these women were black. The majority of these women (76%) were arrested for non-violent crimes, with drug-related offenses being the most common. The median length of stay for women in 2012 was 82 days, and the recidivism rate hovered around 70%. The decline in Bridgetown's jail population since 2010 is notable. In fact, most other jails in California have seen an increase in their population since the 2011 "Public Safety and Realignment Law," known as "Realignment" was passed in response to the *Brown v. Plata* mandate to depopulate California prisons.[34] Those convicted of non-violent, non-serious, non-sexual crimes are now to be managed at the local level, in the communities from which people come.

Most counties in the state have responded to this mandate by incarcerating more people in jails (and even building more jails, presaging the possibility of the same problems that plagued the prisons) (Grattet 2013). But Bridgetown has not incarcerated more people, and has continued its commitment

to alternative, community-based sentencing for low-level offenders, as well as to expanded probation and drug treatment programs. Funds from the Realignment law have only bolstered Bridgetown's ability to do so. One of the pods in CJ2 even closed in early 2013, because the population was so low.

Bridgetown's Jail Health Services (JHS) operated inside the jails, but was a branch of the city's Department of Public Health (DPH), not the Sheriff's Department which ran the jails. As such, JHS was oriented toward a broader vision of what health care inside the jail can do than at some jails where the services are contracted out to a profit-driven private corporation. JHS employed doctors, nurse practitioners (together, these two groups were usually referred to as the "clinicians" by Bridgetown staff), registered nurses (RN), licensed vocational nurses (LVN), pharmacists, clerks, and administrators. Nurse practitioners (NPs) have training which enables them to evaluate, diagnose, and treat patients. Though they are always under the supervision of a physician, they function relatively independently; such was the case at the Bridgetown jail clinic, where there were more NPs than there were physicians. Nurses, including RNs and LVNs, comprised the bulk of the clinical workforce of JHS, both in number and in their 24-7 presence at the jail. During the weekdays, there were 5-10 RNs and LVNs staffing the clinical duties in CJ2, as well as 2-5 clinicians seeing patients for routine and emergent clinic visits.

Medical care was free for inmates at the Bridgetown jail, but at many jails and prisons, inmates must pay a fee, usually around five dollars, in order to see a physician. Such a policy attempts to deter inmates from unnecessary use of the medical system, but also places an unnecessary barrier to services for people who already have limited means and to whom the prison is required to provide health care.

A parallel organization, Jail Psychiatric Services (JPS), provided psychiatric care, group and individual therapy, case management, and addiction treatment, among its many services. Both JHS and JPS had linkages with community providers to whom they attempted to connect inmates while they were in custody. The burden of mental illness among incarcerated populations in general is tremendous and this was true for the people I studied. While psychiatric diagnoses and psychological trauma are

surely integral to the lives of the women I describe, the carceral management of mental illness is not the subject of this dissertation (for a harrowing analysis of this, see Rhodes 2004).

The Bridgetown Sheriff's Department's primary responsibility was to run the city's jails, to watch over the people who are made to go to jail, a task often referred to as "custody." As I explore throughout this dissertation, the daily tasks of custody provided a structure for caregiving relationships that exceeded the predictions of disciplinarity. Sheriff's Department employees did not generally arrest people— police officers did— nor did they determine whether or how long someone will be in jail—that was the purview of the courts.[35] The workers who were in the pods, 24 hours a day, 7 days a week were typically the lowest rank officers—deputies. The chain of command continued with senior deputies, lieutenants, sergeants, watch commanders, captains, and chiefs. Unless the distinction in rank is necessary, in this dissertation I refer to all of these Sheriff's Department professionals as deputies (in other settings, they might be called guards or correctional officers). At the top of the hierarchy was the sheriff, an elected official who spent most of his time in city hall. The Sheriff's Department also worked closely with the probation department and community agencies to try to ease re-entry and curb recidivism.

Bridgetown's Progressive Politics and Anthropological Lessons

This jail field site and its surrounding urban community are, on the one hand, somewhat exceptional. The city is known for investing in social services, enacted through a variety of innovative programs for the poor, marginally housed, sick, unemployed, malnourished, and drug addicted, who are primarily comprised of racial and ethnic minorities. So while the broader political narrative in the U.S. and in the state of California is one of a reduction in social services for the poor, Bridgetown tries to work within these constraints to fill in some of the gaps created by depleted state and federal funds. And yet these services in Bridgetown remain under-funded and under-utilized by those who need them most—women like Evelyn and Kima.

These city-wide commitments to helping the poor could also be found in the philosophy of Bridgetown's Sheriff's Department. Despite an overall arc in the US's management of criminals from social isolation and repentance to rehabilitation and now to the harsh punitive sentiment of mass incarceration (Simon 2007), Bridgetown's jail maintained a coexisting commitment to helping people with successful re-entry. This, along with a willingness to invite creativity into the jail, was evident in the large amount and wide variety of scheduled activity that existed in the jail: a charter school, yoga and meditation classes, health education, drug treatment programs, Alcoholics Anonymous and Narcotics Anonymous, providing opiate overdose kits for use in the community, guitar and bongo lessons, poetry workshops, religious services, doula support for pregnant women, to name only a few. These daily activities were collectively called "programming" by jail staff and inmates, and by prison and jail administrators more broadly.[36]

While programming inside a jail and efforts to link women with community resources are not unique to Bridgetown, they are worth noting. So are Bridgetown's extensive public services. So is the liberal-minded DPH, the umbrella agency for the jail's health services. These factors did not necessarily translate into "success" by metrics of recidivism, addiction recovery, or stabilized housing. The Sheriff's Department did not, after all, control the drug sentencing laws or build public housing. Rather, these resources are worth highlighting, in part, as a prelude to describing life inside a jail that is not as desolate as monolithic representations would have it.

I also describe this active landscape to signal the tremendous variability of jails and prison throughout the U.S.; some jails may have elements of Bridgetown and many do not. This is a key point. Every jail, every prison, though they may share a certain modus operandi, similar architecture, may even be accredited by fulfilling the same set of national standards, is its own ecosystem. I have visited several other jails and prisons in different geographical regions, and have spoken with people who work at facilities across the U.S. As one prison nurse I met at a conference told me, "we are all in our own silos."

In my capacity as an obstetrician, I have served as an expert witness in lawsuits involving jails in other states where pregnant women are so categorically mistreated with substandard medical care that it has made me doubt whether the stories of reproduction and health care at the Bridgetown jail—where basic standards of medical care were well in place—are worth telling. In the records I have reviewed from these legal cases, pregnant women are rarely seen by a qualified health care provider, even when they report concerning symptoms like bleeding or contractions. These women have delivered babies in the toilets of the jail; they have experienced the trauma of miscarrying five-month pregnancies at the jail, despite pleas to be transported to the hospital where their physical and emotional pain, not to mention their safety, might be tended to. These accounts are appalling, and remind me of how much work there is to be done. They graphically illustrate that incarceration can involve reproductive and medical suffering that seems out of place in our contemporary world.

The fact that such fundamental departures from standard medical care are not present—or at least not systematically so—at Bridgetown does not preclude us from learning about care and carcerality in this setting. We would hear a different story from these other jails where obviously substandard medical care is the norm, where documentation of overt cruelty would demand an urgent ethical response to improve conditions. But the institutional setting of a jail requires a more nuanced engagement of the multiplicity of power and care than a response that we simply need a more humane carceral system with better health care.

The variability among jails and prisons does not mean that what happens in Bridgetown can only tell us about Bridgetown. Indeed, one of anthropology's central tenets is that we can look to the particular to learn about the general (Durkheim 1982). And so Bridgetown's notable progressive politics and innovative spirit which seep into the jail and the jail clinic serve as a particular backdrop to the story I tell of the equivalence of the carceral net and safety net in our society, and how they are both suspended by interwoven threads of discipline and care.

Methods

I lived in Bridgetown for five-and-a-half years. During that time, I worked once a week as the obstetrician-gynecologist consultant at Bridgetown's women's jail, and also provided medical care at Bridgetown County Hospital, Bridgetown's public safety net hospital. I had worked in CJ2 for over four years when I officially began ethnographic research there and in Bridgetown's surrounding community. For ten months, I inserted myself into spaces and routines of the jail which I had previously not entered as a physician.[37] This involved spending time observing the clinical area which I already knew from a doctor's perspective. I accompanied nurses as they carried out their tasks, and took note of interactions among my fellow clinicians, nurses, and patients in the open areas of the clinic. I observed the nurses in CJ1 assess the medical stability of new arrestees.

These clinically oriented experiences were the foundation of how I saw care as part of the fabric of the entire jail, not only the clinic. While in my analysis of care I focus heavily on the voices of providers, I do not discount that care is a collaborative endeavor which also includes patients' perspectives. Indeed, patients do appear throughout, for it is through interactions with patients that we see what constitutes care for the providers, in their responses to patients. But seeing the practices and preoccupations of those who, by professional definition, inhabit the clinical space helps us begin to understand the contours of institutionalized care—and how care in the jail confronts critical issues around the broader safety net and deservingness of care.

Beyond the clinic, I also chatted with deputies as they watched over their charges, day and night. I was present with incarcerated women in the housing units during their day to day activities. Some of these nurses and deputies I spent time with outside of the jail, sharing a meal or other social activities. I also followed some women into the community when they were released, tracking them down on street corners, at drug treatment programs, or at the county hospital. I chauffeured them to court appearances and to supervised visits with their babies. And I spent time with them when they

returned to jail. I also continued to work as an Ob/Gyn at the county hospital, where many of these women were patients, either still incarcerated or released in the community.

This methodological continuity between the jail and the community is in part an intervention on the existing ethnographic approaches to the prison, where fieldwork takes place only in the institution. The majority of these accounts focus on the social worlds inmates create inside (Sykes 2007; Clemmer 1958; Ward and Kassebaum 1965; Owen 1998); they take the social control of prisons as the primary force of life inside, where the task has been to find examples of inmate agency and resistance. There are notable exceptions to this tradition, of course, such as Rhodes' (2004) ethnography of a maximum-security prison, in which prisoners, mental health workers and guards are all working through in their daily interactions existential questions of what it means to be human (see also Bandyopadhyay 2010). But what this spatial confinement to the institution in the current body of prison ethnography does is to reinforce the myth that the prison is a site detached from mainstream society. Even ethnographies which offer insight into the connections between inside and outside do so through the prisoners' narrative reflection on their lives outside of prison (Bandyopadhyay 2010). In my fieldwork approach, I was privy to parts of women's actual lives in the community, and how those lives had fluidity with the jail.

I had intended, during those ten months of dedicated fieldwork, to compartmentalize my roles at the jail: Mondays would remain my doctor days, when I would still run the reproductive health clinic that I had built over the previous four-and-a-half years at the Bridgetown jail, and all of the other days I would be an anthropologist. This sounded easier, less messy, and with less risk of violating HIPAA.[38]

But I was never just an anthropologist at the jail, and never just a doctor. On Mondays, I was part of the triaging and care system that is the subject of this dissertation, adjudicating decisions about how best to help people in this constrained and enabling environment. I heard women's heart-wrenching stories of violence, manipulation by their boyfriends, addiction, and dreams to transform

with intimate detail that was enabled by privacy of the doctor-patient relationship. Patients who had heard about my research would take the clinic visit to tell me stories they thought were relevant to the study. I was both a practicing clinician and an attuned ethnographer.

And on Tuesdays through Sundays, while inserting myself in situations outside of the clinic exam room, I also answered medical questions from nurses, inmates, and even deputies. My status as a doctor, and one who had worked at the Bridgetown jail for the prior five years, enabled me to access sites and situations I would not have been able to if I were "just an anthropologist," for the staff had come to trust me. I also knew how to navigate the rules and spaces of the institution. This insider status enabled me to eschew, to a large degree, the surveillance of the researcher which other prison ethnographers have experienced from prison workers (Bandyopadhyay 2010).

When Evelyn had painful contractions one Sunday afternoon while I was at the jail, instead of transporting her to the hospital, I was able to examine her cervix at the jail, and determine that it was false labor. I experienced a meshing of my identities. But my patients and co-workers—also my informants—were not concerned with compartmentalizing my roles. They facilely absorbed me as a practitioner and a researcher.

In my dual roles as physician and anthropologist, I became involved in some of these women's lives at very intimate and vulnerable moments. When Kima pushed her baby out, I was there to catch baby Koia in my own gloved hands. Because I wore scrubs and a hospital ID badge, I was able to be there in the hospital with her the next night, after official visiting hours, when a Child Protective Services worker unexpectedly put a police hold on Kima's baby.

This meant that for the two days in the hospital before she returned to jail, she could no longer have her newborn with her in the room. She could only visit her in the nursery, accompanied by a guard and walking in shackles. As Kima grasped these new limits on her already truncated ability to bond with

her baby, her maternal bliss was shattered. Out of sight of the guard outside her hospital room, I hugged Kima—prohibited contact with a prisoner—as she wailed.

I was on call at the county hospital the night that Evelyn was transported from jail to the hospital because she thought her water had broken; it had not. While she was in the triage area of labor and delivery, she had a seizure. It was not the first she had had in her life, or in this pregnancy, but it was concerning nonetheless. I was her doctor that night as I decided to admit her to the hospital. I had already come to know Evelyn well, both as an anthropologist and a doctor at the jail, and felt we had become close. Evelyn also felt we had become close: a few weeks later, when she gave birth, she named her baby Carolyn, partly after her deceased mother and, so she told me, partly after me.

Eventually, it became evident that it was impossible to distinguish my roles and insights gained from being a doctor and an ethnographer. I began to see my work at the jail more as "observant participation" (Chang 2008; Barton 2011; Wacquant 2011) than as participant observation. I was already enmeshed as an integral actor in the phenomenon I was studying, making direct contributions in real time.[39] And so, the data in this dissertation reflect an entanglement of my perspectives as a practicing physician and as an engaged ethnographer. The material comes not only from my ten months of focused fieldwork, but also from the concurrent time and prior five years in which I practiced as a physician, with an anthropological lens. Where the stories I share include medical information about people, I have either been given permission to do so, or have changed identifying details. In some cases, I have merged information about people to further make them unidentifiable. In all cases, I have changed names to pseudonyms. When I speak generally about the medical providers at the jail, I write in third person for grammatical ease. But I use that pronoun understanding full well that I too was one of those clinicians at the jail.

Observant participation at the Bridgetown jail and its surrounding community comprised the bulk of my methodological approach. I also conducted interviews with incarcerated women, jail medical

staff, deputies, and administrators. For some of the women in jail, sitting in a semi-private room in the housing units was the only way to be able to talk to them. A few months into my research, word got around the jail about my study, and women came to me with the idea that they wanted to share, in writing, their experiences accessing medical care in jail. Their writings are also data in this dissertation. Finally, I attended national meetings of the NCCHC and the ACA to gain insight into the national conversations about health care for incarcerated populations.

While overlapping data from being a doctor and an anthropologist in the same place may seem messy at best and risky at worst, I see analytic richness and an ethical imperative in doing so.[40] After all, anthropologists and doctors both deal in messiness. It is existential to the human experience we seek to understand and to heal. The interweaving of information gleaned from my dual roles also reflects another major argument of this dissertation, that we are all implicated in this reality in which jail has become a site where the disenfranchised must turn to for care. Whether we are struggling to make ends meet without a safety net, or whether we ourselves benefit from the scales of racial and economic inequality, we are all one step removed from jail; we are all part of the systems which have made certain groups more likely to have to step inside jail.

Ethnography of the Obvious

A goal of ethnography is often cleverly summarized "to make the strange familiar and the familiar strange, all the better to understand them both" (Comaroff and Comaroff 1992: 6). Prisons and jails in the US in one sense occupy the 'strange' category: although 2.2 million Americans are incarcerated on any given day, many millions more will never set foot in one of these institutions and can only imagine them through media and political representations.[41] Indeed I hope this dissertation will make them seem a little more familiar, and make readers more aware of our collective complicity with mass incarceration. But I also seek to make strange the familiar, monolithic representations of prisons as sites where only discipline and punishment occur, where individuals are churned through

regulatory structures that at once dehumanize them and at the same time make them into properly governable subjects. These representations of the prison are so predictable in critical scholarly and activist literature that they have come to be obvious readings of the carceral state. Such an interpretation of the medical care in a jail would be easy, and not altogether inaccurate on some days. But it would be dangerously incomplete.

Accordingly, I see this project as "an ethnography of the obvious,"[42] not merely of the familiar. An ethnography of the obvious signals an intervention on the obvious and fetishized representations of "The Prison." It also means looking to obvious phenomena which have been eclipsed by dominant narratives.[43] In the jail clinic, there are doctors and nurses practicing their healing arts with patients. Obviously, this is a type of caregiving. And it leads us to the rest of the jail, where deputies are managing the intimate activities of daily living for a group of women—eating, sleeping, bathing, socializing. On the surface, this too is care. It is also mixed, of course, with discipline. Overlooking one obvious—the intimacy of jail—for another—its repressive violence—may yield a coherent story, but it would not capture the complexity of everyday realities.

A Note on Terminology

The words used to signify a person who is incarcerated are many: inmate, prisoner, offender, criminal, convict, felon, and even, as used in prison corporate speak, client. Each of these has an array of connotations, a linguistic history, and political signification. Choosing one of these terms to use in a work that features these people so prominently is a tricky task. I would prefer to use throughout this dissertation "incarcerated woman" or "person who is incarcerated." Incarceration would thus remain an adjective, a descriptor of a current state, but would not imply a more permanent position by using a noun. However, this would be cumbersome. I have chosen to use the term most frequently used by the people themselves who animate these pages: inmate.[44] Sometimes I substitute it with prisoner, for stylistic variation and to suggest the instability of these categories.

Jail as Intimate and Institutional Safety Net

Each chapter of this dissertation considers how, for certain people whose street lives are characterized by social and economic marginality, jail acts as a safety net, providing medical and other supportive services that are generally lacking from their lives outside of jail. Within this unsettling reality, care emerges in multiple and often contradictory ways that are inextricable from the structures of carcerality which paradoxically enable caregiving. Part I focuses on the medical apparatus within the jail and how the routines of providing clinical services, as animated by clinic staff, grapple with questions of people's deservingness of health care. In Chapter 1, I describe the initial processing task applied to all new arrestees in the booking jail, medical triage. This clinical assessment represents the interface between life on the streets and life in jail, where medical staff triage the deficiencies of the street and make decisions about which ones should be remedied while here in jail. Because recidivism engenders familiarity between the triage nurses and patients, sociality and intimacy infuse the triage interactions which adjudicate the health care someone entering jail is deemed to deserve.

Chapter 2 continues to explore the jail health care providers' routine clinical practices as negotiations of health related deservingness for women who are both inmates in a jail and who live lives of chronic marginality on the streets. I take the reader through a typical day in the clinic which is embedded within the jail. Caregivers in this setting must confront the obvious reality that they are working inside a regimented, carceral setting and treating patients who are also prisoners. Rather than enacting care that is an express antidote to the punitive measures of incarceration, or subsuming medical care into these disciplinary structures of jail custody, jail medical staff instead cultivate ambiguity amid all of the contradictory figures and forces before them. This commitment to not resolving ambiguities is itself a form of care, imbued with affect and intimacy made possible by the routine medicalization of life in jail.

In Chapter 3, I examine two paper objects which have critical currency in the practical delivery of health care services and in the affective ties care in jail invites: the "refusal of care" form and the "medical care request" form. Rather than being the predictable distancing accoutrements of bureaucracy, these forms enable varied relationships between medical staff, inmates, and even deputies. Questions of what constitutes deservingness of care and what is an excess of entitlement—questions posed by the vague terms "deliberate indifference" and "serious medical needs"—coursed through the daily engagements with these forms. These chapters in Part 1 bring the rights-based language of the prisoner health care mandate into the realm of the everyday enactments of the paradoxical health care mandate.

Part 2 builds on these notions of the intimate ambiguity of care arising within a carceral setting, and considers these in aspects of daily life in jail beyond ones that are officially medical. Here, I focus more on the perspectives of the incarcerated women themselves and of the deputies who are charged with carrying out the tasks of custody which make the jail run on a day to day basis. I return to the stories of Kima and Evelyn, as well as other pregnant enjailed women, in Chapter 4 to explore how reproduction both is and is not an exceptional process to be occurring in a jail. Instead of analyzing incarcerated women's miscarriages, abortions, prenatal care, and childbirth experiences solely as instances of the state's coercive management of poor, predominantly black women's reproduction, I look again to the ambiguous interdependence of tender caregiving and carcerality. Chapter 5 then continues with how being in jail while pregnant cultivates certain forms of normative motherhood, enabling women to desire the carceral environment.

From these ideas of normative reproduction in jail and pregnancy's magnified opportunities to care and regulate, Chapter 6's description of jail as home makes sense. Here, I delve more deeply into the concept of custody, showing that the constant interface between inmates and deputies in the name of jail custody is imbricated with care. Recidivism means that jail is a routinized part of these women's

lives, and a place they expect some forms of material and relational nurturance. This, contrasted with the precarity of their street lives, makes jail a place of refuge and dwelling.

Finally, the conclusion provides an update on Kima, Evelyn, and the children they gestated while they were in jail. I contextualize their institutionalized lives within broader recent policy discussions in Bridgetown and nationally about the responsibility of the state to care, especially through the recently enacted health care law the Affordable Care Act and through the privatization of prison health care. Throughout this work, it is my aim to show how jail is a safety net not only because of its services, but also for the tragic ways that its care, even amid carceral violence, can exceed the safety and care available outside its walls.

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[1] The term "health care" itself has been critiqued because it implies that the US system actually delivers health. As journalist Walter Cronkite once pithily declared, "America's health care system is neither healthy, caring, nor a system."

[2] In 2006, California's Governor Arnold Schwarzenegger declared that the state's prison system was in a "state of emergency" because severe overcrowding had created risks to the health and safety of prisoners and prison workers (See Simon 2013: 253).

[3] "Mass incarceration" is a widely used term to reference the vast rise in the numbers of people imprisoned over the last 30 years. Loïc Wacquant (2010) offers a revised term, "hyperincarceration," to clarify that the surge in incarceration has not involved the masses. Rather, it disproportionately targets poor, black men. Other critics have noted that the descriptor "mass," along with extensive critiques, suggests that incarceration is worse if more people are involved; the implication is that the days of 500,000 inmates were better, when poor conditions and unequal justice were also rampant common (Lorna Rhodes, personal communication, 12 December 2013).

[4] The hopes that the Affordable Care Act (ACA) will substantially reduce the number of Americans who do not have health insurance are also tempered by Congressional and state-level efforts since the bill was passed to curtail the expansion of coverage. As of 2014, twenty-four states declined the offer of federal funds in order to expand their Medicaid programs (Source: State Forum, available at: https://www.statereforum.org/Medicaid-Expansion-Decisions-Map?gclid=CPaEuY20zLwCFcdQOgoduVUANQ, accessed February 14, 2014). The alternative ways these states are dealing with the ACA's health care mandate threaten to leave millions of people without health insurance, perpetuating the situation the ACA hoped to ameliorate.

[5] The court system has been involved in a large number of court cases which have sorted through the rights that prisons and jails must ensure are maintained despite the liberty-depriving confinement of incarceration. Civil litigation has insured that prisoners have a right to a certain amount of space, to food, to religious freedom, for instance—in addition to the right to medical care which is focused on here. Laws enabling or preventing prisoners from voting vary from state to state, but only 2 states, Maine and Vermont, allow currently incarcerated prisoners convicted of felonies to vote. In California, people convicted of a felony have their right to vote restored once they have served their prison and parole time. I was present at the Bridgetown jail during the fall election season in 2012, and saw deputies provide and then collect absentee ballots for the women in jail who were eligible to vote.

[6] Pat Carlen's (2008) concept of "imaginary penalties" connects the notion of prison's disciplinary regime to society's expectations of prison. That is, prison workers try to satisfy society's demand that prison can make the public safer, but they know that the disciplinary practices of custody cannot achieve this, so imprisonment becomes an imaginary penalty focusing on the processes of incarceration rather than outcomes.

[7] In his "Hermeneutics of the Subject" lectures at the Collège de France, Foucault (2005) explores a different kind of care, care of the self, which was valued in ancient Greek times but displaced by a Cartesian focus on knowledge of the self. Care of the self is an active practice, doing things to tend to oneself. It is the foundation for accessing the truth, and therefore spiritual transformation. Care of the self is also a foundation for relations with others, for it allows the self to care for others. This kind of care is different than the regulatory care of governance which arises out of disciplinary regimes.

[8] The origins of the term "safety net" are not clear, but historian Guian McKee's search through newspaper archives determined that the first reference to the term was in a 1966 New York Times article quoting Franklin Delano Roosevelt in a campaign speech for his race for New York governor: "public assistance will be envisaged as a safety net on the one hand, and as a transmission belt to productive employment on the other." The phrase "safety net" was not widely used until President Ronald Reagan used the phrase to reassure the public that his widespread government spending cuts would supposedly not impact the social safety net for those with "true needs." See "How did the social safety net get its name?" by Krissy Clark, April 2, 2013, Marketplace. Available at http://www.marketplace.org/topics/wealth-poverty/show-your-safety-net/how-did-social-safety-net-get-its-name, accessed February 13, 2014

[9] See Philippe Bourgois and Jeffrey Schoenberg (2009) for a rich, ethnographic account of the relationship between shifting market forces, urban poverty, drug addiction, and illegality.

[10] See http://federalsafetynet.com/safety-net-programs.html (accessed 17 April 2014) for details. "Safety net" programs included in this $607 billion are the Earned Income Tax Credit, Supplemental Nutrition Assistance Program, Housing Assistance, Supplemental Security Income, Pell Grants, Temporary Assistance for Needy Families, Child Nutrition, Head Start, Job Training, Women Infants and Children (WIC), Child Care, Medicaid, Low Income Home Energy Assistance Program, and phone subsidy.

[11] Supplemental Security Income and Disability Income benefits are discontinued after 1 month of incarceration.

[12] If a prisoner has to be hospitalized while incarcerated and if that hospitalization exceeds 24 hours, then Medicaid and Medicare can be reinstated to cover those health care costs. Although in some circles this is being identified as a result of the Affordable Care Act, this was actually the case before the law was passed, but officials at most prisons and jails were not aware of this benefit.

[13] New York state led the way in the harsh policies of the drug war when in 1973 then Governor Nelson Rockefeller signed into law a series of statutes that would punish people who sold as little as 2 ounces or possessed 4 ounces of drugs with long-term prison sentences. This was an unprecedented punitive turn to manage non-violent crimes in a manner similar to violent crimes like murder.

[14] Passed in 1994, this law meant that after being convicted of two felonies, if a person was then convicted of a third crime, even a minor non-violent one, she would spend the rest of her life in jail. Similar laws were adopted in two dozen other states and by the federal government.

[15] The myth of the "crack baby" was born in the 1980s. Popular media exaggerated shoddy scientific claims that babies born to women who smoked crack in pregnancy were neurologically damaged. Although the scientific evidence has since been discredited (Ackerman 2010), the moralizing myth persists.

[16] Megan Comfort (2009) has identified the impact that incarceration has on families of those who are in prison as "secondary prisonization." She provides a rich account of how romantic relationships between male prisoners and their non-incarcerated female partners are often enhanced by incarceration. Visitation rituals, the amnestic effects that separation has on the negative parts of relationships, these are some ways that prison enables some couples to create ideals of domesticity they never had outside of prison. For those with partners who are incarcerated, relationships, flow of daily life, and household finances become shaped by the rules and emotional distress of imprisonment. Comfort calls this reach into non-prison life for the women as "secondary prisonization," building on Robert Clemmer's idea that inmates become inculcated into the world of prison so that it reaches every aspect of their existence.

[17] Federal court cases from the 1950s and 1960s established the prisoners did indeed have the right to bring forth lawsuits against the prison based on conditions which would then be judged for their constitutionality against the 8th Amendment standard. Keramet Reiter (2012) and Margo Schlanger (2003) both provide detailed accounts of court cases which enabled the courts to have a role in determining the day to day conditions of living in and managing prisons. In Reiter's case, she argues that the litigation around the occasional use of solitary confinement

in prisons in the 1960s and 1970s set the stage for the building of exceedingly punitive Supermax prisons of long-term solitary confinement now widely used to confine prisoners deemed by the prison to be threats. In the earlier solitary confinement cases, Reiter argues, the courts concerned themselves with the constitutionality of the conditions, such as space, food, access to daylight; but they did not deem the existence of solitary confinement and its sensory deprivation to be unconstitutional.

[18] There is no central, or even de-centralized, database of prisoner health litigation cases. This estimate was extrapolated from legal scholar Margo Schlanger's compilation of prior articles tabulating the type of prison litigation brought against the facility. In Schlanger's 2003 article, the estimate was that roughly 15% of prison litigation pertained to medical care (see footnote 48, p. 1570), with close to 40,000 federal civil lawsuits filed by inmates in one year.

[19] Media and academic reports of some of these cases reveal a wide array medical conditions that have been litigated; to name only a few: untimely or absent distribution of critical medications for heart disease, diabetes, asthma; incompetent health care providers who neglected worrisome symptoms like shortness of breath, weakness, pain; suicides which could have been prevented with more clinical vigilance and appropriate psychiatric care; shackling of pregnant women in labor; women seeking abortions who were prevented from accessing the procedure by the facility.

[20] The 1994 case *Farmer v. Brennan* clarified that to demonstrate "deliberate indifference," the burden of proof is to show that a prison worker knew that there was a risk of harm to a prisoner and then actively disregarded that. *Farmer* set the standard that deliberate indifference cannot be prosecuted as cruel and unusual punishment if someone was ignorant to the dangers of a particular condition or act. Dolovich (2009) has critiqued the *Farmer* decision for its narrow concept of punishment at the individual level, from a guard who may or may not know about the risks of something, rather than holding the institution and state accountable, which she argues is more consistent with the 8th amendment. *Farmer* also creates incentives for officers and institutions not to notice potentially dangerous conditions. Notably, the *Estelle* mandate did not make medical malpractice alone in prison a constitutional violation; instead, it put medical care (or its absence) in the realm of intentionality.

[21] Three basic "rights" have been clarified in these cases: a prisoner's right to access care; a prisoner's right to receive treatment that was ordered; and the right to professional medical judgment (Rold 2008).

[22] The *Brown* decision amounts to a medicalization of mass incarceration; that is, the hypertrophy of incarceration has resulted in an excess of suffering visible as poor physical and mental health outcomes among prisoners. Evidence of health-related suffering has, as Jonathan Simon (2011 and *in press*) has astutely argued, put "mass incarceration on trial."

[23] *Estelle* did not provide a list of conditions which constitute serious medical needs; for this administrator, that lack of detail was minimized as a "gray area," incidental to what he appreciated as "ground rules." Court cases since *Estelle* have applied the following logic to deem a medical need "serious:" if it "has been diagnosed by a physician as mandating treatment or. . . is so obvious that even a lay person would easily recognize the necessity for a doctor's attention" (*Duran v Anaya* 1986; *Ramos v Lamm* 1980); and if conditions "cause pain, discomfort, or threat to good health" (*Dean v. Coughlin* 1985).

[24] Joe Sim (1990) has written a detailed historiography of the Prison Medical Service in England from 1774-1989. Social reformers in 18th Century England like John Howard advocated for systematic provision of health care for prisoners. This was only partly a humanistic drive, for it was also tied up in an understanding of criminality as disease. Medical disciplinary techniques in the Prison Medical Service sought, in classic Foucaultian fashion, to modify prisoners' behavior into normative morality. There was no organized analog to the Prison Medical Service in the United States, but the philosophies integrating the therapeutics of medicine (and psychiatry) with the moral transformation of the criminal were (and are still) prominent in the US.

[25] This document reads almost like a passage from Foucault's *Discipline and Punish*. The Principles very explicitly emphasize the purpose of prisons as reforming the soul of the prisoner. Article IX: "Of all reformatory agencies, religion is first in importance, because it is most potent in its action upon the human heart and life." Article XV: "In prison administration, moral forces should be relied upon, with as little admixture of physical force as possible, and organized persuasion be made to take the place of coercive restraint, the object being to make upright and industrious free men, rather than orderly and obedient prisoners. Brute force may make good prisoners; moral

training alone will make good citizens. To the latter of these ends, the living soul must be won; to the former, only the inert and obedient body."

[26] This 51 page report documented that 25% of jails had no medical facilities on site, 31% had no physician available, 66% had first aid supplies as their only medical care, and a plethora of other statistics to document the absence of medical care.

[27] Accreditation involves site visits, with NCCHC consultants visiting jails and prisons to review protocols and infrastructure, interview staff and inmates, and inspect the clinic facilities. The certification is voluntary, yet there are many unaccredited prisons and jails which also use the NCCHC standards to help guide their practice. The touted benefits include prestige, decreased liability costs from law suits, promoting a well-managed system, legitimizing budget requests. Accreditation does not, however, putatively mean "good" care, nor does its absence signal "bad" care.

[28] On the NCCHC website's overview of accreditation, five paragraphs extol the legal benefits of accreditation, including that court cases have held up NCCHC standards as the benchmark and that compliance with the standards will ultimately save money by avoiding litigation. Available at www.ncchc.org, accessed February 1, 2014.

[29] Some health care professionals are also active in the American Correctional Association (ACA), the largest (and oldest, since 1870) professional organization for people working in any capacity at jails and prisons.

[30] The modifier "correctional" derives from the general term "correctional facility" which came out of the rehabilitative era of penology when prisons were rooted in a therapeutic ideology; incarceration was hoped to be able to *correct* a criminal into an upstanding citizen. Applying "correctional" to health care should not be taken as a commitment to this therapeutic model, but rather as a convenient adjective for the health care provided in jails and prisons, collectively called correctional institutions.

[31] This estimate was obtained from the non-profit search engine www.guidestar.org.

[32] Although it is a major urban center, Bridgetown's jail population is overall relatively small. Los Angeles County Jail houses an average of 22,000 inmates daily (ACLU, https://www.aclu.org/la-county-jails, accessed February 18, 2014). The average daily population at New York City's Rikers Island Jail is nearly 12,000 (http://www.nyc.gov/html/ops/downloads/pdf/mmr2013/doc.pdf, accessed February 18, 2014), and at Cook County Jail in Chicago is 9,000 inmates (http://www.cookcountysheriff.org/doc/doc_main.html, accessed February 18, 2014).

[33] These number were provided to me by the Bridgetown Sheriff's Department. The "midyear count" is a metric used by the Department of Justice Bureau of Justice statistics, with census taken on June 30 every year.

[34] For an excellent discussion of the litigation events culminating in the Supreme Court decision, see Simon (2013). Enacting mandates of *Brown v. Plata* are ongoing. California's Governor Jerry Brown has been involved in ongoing disputes with the courts claiming that the prison problems are fixed, something with which the courts disagree. With Realignment, people convicted of non-serious, non-sexual, non-violent crimes now serve their time in county jails instead of state prisons, regardless of the length of their sentence. This could mean some people could be in jail for years, despite the fact that these facilities are not set up for long-term incarceration. In addition, people who have violated their parole will also be managed by local jurisdictions rather than be sent to state prison.

[35] Probation and Parole departments are also involved in deciding who should be incarcerated. People who are released from jail or prison are often released under conditions of probation or parole, with rules to follow and appointments to report to. Violations of the terms of one's probation or parole, even technical violations of traveling even just a short distance outside of one's restricted geography, may lead to re-incarceration.

[36] Programming is a convenient shorthand for all of the activities, and makes it sound like a summer camp. At one level, programming is a simple, gentle term for the scheduled events. "Programming" also conjures a site where many inmates are sent when released from jail, a drug treatment program. Indeed, some of the events which comprise weekly programming are related to treatment; most of them also have some goal for the inmates to acquire a skill or knowledge. At another level, then, programming in jail might also be understood as program's sense of providing coded instructions (as in programming a computer) in how to be a proper, un-jailable citizen: someone who is healthy, drug-free, self-respecting, and educated.

[37] I received approval from the Committee on Human Research at my home institution to conduct this research, as well as approval from the Bridgetown Sheriff's Department and Jail Health Services.

[38] I considered withdrawing from my doctor duties at the jail while I was doing fieldwork, and I also considered finding a new site where I was not known as a doctor. But both of these seemed like undesirable options. If I stopped working at the jail, I would lose my deeply insider perspective. Moreover, my informants would still see me as a doctor. Additionally, I had established a referral level ob-gyn clinic at the jail which provided important services on site, and at the time I was officially beginning my fieldwork, there was no one able to take this over. I was not willing to let this service for women in jail wither. As far as finding a new field site, I could never have had the access, trust, and intimate relationships which I had built over the previous 5 years at the Bridgetown jail.

[39] For other examples of observant participation, see Michael Oldani's (2004) analysis of the pharmaceutical industry's gift economy, based on Oldani's own experience of being a Big Pharma drug rep. Loïc Wacquant (2011) trained at a boxing gym to write about the habitus of prize fighters in Chicago's ghetto; Bernadette Barton (2011) was a lesbian in conservative Kentucky, and wrote about the experiences of being gay in the Bible Belt.

[40] I am certainly not the first physician anthropologist to write ethnography in a place where she has practiced medicine. Arthur Kleinman (1981, 1995) has developed many of his theoretical contributions to medical anthropology through his work as a psychiatrist, both in Boston and China. Paul Farmer (1992, 1999) has famously done so in Haiti. Vinh-Kim Nguyen (2010) cared for AIDS patients in the Ivory Coast, where he also wrote about the therapeutic sovereignty exacted by the ways these people had to transform themselves in order to access AIDS care. Clare Wendland (2006) delivered babies as an obstetrician in Malawi where she also wrote about the training of Malawian doctors in an age of "global medicine."

[41] Of course for these millions behind bars, and their families and communities, prisons and jails are all too familiar.

[42] This term emerged from a personal communication with Lawrence Cohen on April 24, 2013.

[43] "Surface reading" is an interpretive approach which does not privilege the deep, latent meaning buried in a text, as "symptomatic reading" does (Best and Marcus 2009). Surface reading recognizes that "as much as our objects of study may conceal the structures that give rise to them, they also wear them on their sleeves" (Best and Marcus 2009: 18).

[44] The word "inmate" applies to someone confined to living in an institution; it has been used especially to signal people housed in asylums for the mentally ill and in prisons. Robert Clemmer (1958) increased the usage of this term to describe those in prison in his influential book The Prison Community, first published in 1940, in which he provides ethnographic descriptions of inmates' code of conduct. Erving Goffman highlighted the congruence between mental asylums and prisons by using "inmate" for both of these settings in his call for deinstitutionalization of the mentally ill in Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (1961). Some incarcerated people prefer "prisoner," as a more political term. No one term is sufficient to represent the person who is incarcerated.

Part I

CHAPTER 1
Triaging the Everyday, Every Day

"One keeps on emerging from a phase, but it always recurs. Round and round. Everything repeats. Am I going in circles, or dare I hope I am on a spiral?"

-C.S. Lewis, A Grief Observed

The Triage Door

The door to the intake jail, CJ1, opened. Two police officers escorted a thin, bearded, handcuffed man through the entry. He wore a dirty shirt, ripped pants, and worn down sneakers; he wreaked of the mixed scent of alcohol and urine. This particular door, which opened to a wide alleyway, was the only direct interface between the outside world and the actual space populated by inmates and staff. The other door to the jail was the entrance to the adjacent main jail building, CJ2, around the corner. At CJ2's door, the inside world of incarceration was buffered from the outside by a public lobby, black and white linoleum lined hallways, elevators, and a series of metal doors; this was the entrance used by jail workers, attorneys visiting their arrested clients, and by civilians visiting inmates on designated visiting days. But in CJ1, there was just one set of doors separating—and connecting—the streets from the jail. This singular boundary obliged CJ1 to confront elements of the outside reality which accompanied people on their entry into jail.

When CJ1 the door slid open, nurse Charlie welcomed the police officers and their handcuffed charge from behind a desk that faced the entrance. The officers motioned to the man they had just arrested to sit down in front of Charlie. The police handed Charlie a beige card with the man's name on it, then Charlie asked the man a series of standardized health questions. This was medical triage. It inaugurated the classificatory rituals of the jail, and was the first thing to happen when a person was

brought through the doors of the Bridgetown County Jail. Before any criminal processing could occur, before the person's body was transferred from the custody of the police to the custody of the Sheriff's Department, and before the person went through the socialization procedures of degradation so vividly described by Goffman (2007) and Irwin (1985), a nurse routinely evaluated the person's physical and mental stability. If the nurse detected any urgent conditions, then the need for medical (and often psychiatric) intervention diverted the jail processing to attend to the person's health. Nurses might detect a wound—perhaps acquired during the event that led to arrest, or perhaps festering for weeks on the streets. They might identify a person with diabetes who had not taken insulin for days and was therefore at risk of going into a coma. They sorted these new arrestees into various categories of health and disrepair.

This triage has certain hallmarks of decision-making and prioritizing need for intervention that typically characterize the rationality of medical triage seen in emergency rooms and disaster zones.[1] These processes rely on the distribution of limited resources to those who are deemed to have the greatest need. Triage is about balance between resources and people. Likewise, Bridgetown's JHS had an allocated budget from the city health department which set the material terms for how staff decided on the appropriate level of diagnostics and therapeutics to patients. In jail, these triage processes also operated through tensions between three intersecting macro-level commitments which hold the jail triage accountable: legal mandates, professional medical standards, and a sense of social justice. But it is the people working in the trenches of jails and prisons who make the terms of the larger debates meaningful or even irrelevant in everyday practice.

With the punitive space of the carceral ever-looming, jail medical staff enacted their triage, often consciously, as a moral calculus of "health related deservingness" (see Willen 2011, 2012). Deservingness is something that is reckoned and experienced in the everyday; people make judgments about whether someone deserves health care based on what matters for them and for the people

whose deservingness they are assessing. The balance characterizing this kind of triage is between providing enough care to bodies deemed to be deserving while avoiding an excess of care to undeserving bodies.

CJ1 nurses triaged with a conscious awareness of the insidious structural forces outside of jail which contributed to the often neglected health conditions they saw. The criteria for this calculus of health-related deservingness in jail were guided in part by official protocols, but also by the triager's moral experience of what was at stake for her and for her patient in administering care at the interface between the streets and the jail. Attention to the everyday interactions of triage reveals that these moral stakes were infused with a rhythm of chronicity, fostered both by the repetition of certain clinical scenarios and by triaging the same patients who constantly cycled through the jail. The recurrence facilitated triage as a social process, and recidivism as an intimate relationship. Triage staff came to see themselves as being on the frontlines of diagnosing the deficiencies of their patients' lives outside of jail. Jail triage then, becomes a triage not only of individuals, but of the inequalities outside of jail which are constitutive of mass incarceration.

The Angry Chair

"I call this 'the angry chair'," Charlie told me one night in CJ1. He pointed to the powder blue plastic chair in front of him, currently empty, in which new arrestees sat when the nurse performed the triage assessment. The chair looked rather benign, the kind of stackable chair you might see at a church luncheon. Charlie called it "the angry chair" because he acknowledged that the people who had just been arrested were not typically in the most jovial of moods. "Everyone's angry when they first arrive," he explained in a generous tone. That triage chair was the first point of arrival for all men and women brought to the Bridgetown County Jail.

Around us in CJ1, there was constant movement and a charged energy. The background noise fused the rhythm of deputies tapping on computers and socializing with co-workers, and was

punctuated by sounds from new arrestees in holding cells: anguished sobs, moaning calls for help, angry insults directed at no one in particular. Likely in the throes of psychosis, a woman in a group cell fifteen feet from where Charlie and I sat was shouting nonsensical phrases and banging her head against the door. The jail deputies aggressively grabbed her out of this holding cell. She started screaming in protest, as each arm was clenched by a different deputy. The men in black uniforms then dragged her to a "safety cell" with padded walls, pushed her inside, and closed the heavy iron door.

Meanwhile, next to the triage area where Charlie and I sat, a deputy's iPod lightly blared the 1980's pop song "Close to Me" by The Cure, accompanied by his keyboard typing as the work of processing was being done. Another deputy arrived to start his shift and cheerfully greeted me and nurse Charlie. "I brought some cookies from my favorite Polish bakery. You should have some," he offered, pointing to the break room down the hall. For a place taking in people in all kinds of intoxicated, violent, and tired states from the streets, CJ1's atmosphere, from the perspective of the staff, had a notably light and social dimension to it.

CJ1 was a busy place for a nurse to be stationed. In one year, there were 24,233 triage encounters,[2] an average of 66 per day, mostly concentrated in the late afternoon and nighttime shifts. Since CJ1 was the point of contact with the outside world, people were constantly entering—police officers bringing in people they arrested, inmates returning to jail from a hospital visit—and exiting—people released from jail, those being sent to prison for a longer sentence. The triage nurse had to assess everyone who entered. Some arrestees stayed in CJ1 only for a few hours and were then released. Others, by virtue of the charges of their arrest, stayed in CJ1 up to 24 hours, until they were sent to a housing unit in CJ2. Circuitous hallways and an elevator outfitted with an internal security gate connected CJ1 and CJ2. These two jails were technically in the same building, but they administered different tasks of custody. CJ1 was for initial processing and sorting into and out of jail. CJ2 was where

inmates lived for days to weeks to months (and, rarely, years) under constant regulation and surveillance.

Deputies moved these people wearing their street clothes from holding tanks to curtained dressing rooms, where they "dressed in" to standard issue orange pants, shirts, socks, shoes and undergarments. People were shuffled in and out of holding cells to have their mug shots and fingerprints taken. Nurses, jail psychiatric workers, and deputies walked around to check on people with severe mental illness or who were withdrawing from alcohol and drugs.[3] Some arrestees lay on the floor or the wooden bench in their cells, while cellmates around them paced angrily. CJ1 was anything but stagnant.

Facing the CJ1 door and the angry chair, the desk at which Charlie and I sat was contiguous with the large, U-shaped Formica counter, behind which the Sheriff's Department staff milled about—completing paperwork to process people into or out of jail; chatting casually with co-workers; calmly watching the CJ1 action, ready to yell and restrain anyone who "acted out." This position of the nurse's triage station within the U paralleled the integrated nature of medical triage in jail processing.

The centerpiece of the triage routine was a 17-item health screening questionnaire and visual assessment. The interaction was guided by the jail's electronic medical record system, called CHART. The triage questionnaire programmed into CHART required the nurse to enter a response for each of the following prompts, a grammatical mix of yes/no, fill-in-the-blank, and questions:

Refuse to answer triage questions
General appearance
Urgent medical condition
Fever, cough, sore throat
Prescription medication brought in with patient
Primary care provider
Recent injury or trauma
Current abscesses or infestations
PPD status
Night sweats
Recent weight loss
ETOH [alcohol] use

History of diabetes
Are you suicidal
Drug use
Women specific questionnaire
Last menstrual period
Are you pregnant

These were the initial questions. Nurses asked a much more detailed set of questions later in the CJ1 processing, for people who were going to be staying in jail, during the "intake assessment." This occurred in a semi-private, glass-walled room in a different part of CJ1. Both of these initial evaluations in the intake jail "differentiate people into groups based on specific criteria" (Nguyen 2010: 109); here in jail, the node of differentiation sorted people into groups meriting different degrees (including none) of medical intervention before incarceration could proceed.

This medical triage as a condition for entry is not unlike what happens in refugee camps. Refugees have been displaced by natural disasters, wars, or other large-scale traumatic events which often cause bodily and psychological suffering. Peter Redfield (2005) has explored how triage upon entering refugee camps focuses on the physical manifestations of trauma, such as using color coded bracelets to denote a person's degree of malnutrition, in order for humanitarian workers to help maximize people's survival. Triage in this form acts on life at the level of what Giorgio Agamben (1998) has called "bare life," the basic biological processes of being. Redfield argues that this survivalist mode of triage masks the broader context of suffering which then produced the need for intervention in the first place. He calls this a "minimalist biopolitics: the temporary administration of survival within wider circumstances that do not favor it" (2005: 344).

On the surface, jail medical triage also looks like a minimalist biopolitics. Triage nurses screened patients for acute and serious medical ailments as a condition of entry to the jail. They discovered patients with lacerations, HIV, asthma, diabetes, or other chronic conditions. Often, the patient would then reveal, either through by direct admission or by a sign like a dangerously high blood sugar or severe difficulty breathing, that she had not been taking her medication; on many occasions, the last time

patients had taken medications was their last incarceration. The triage nurse would then intervene with the appropriate therapeutic, which would then continue throughout the jail stay. Blood sugars were managed with insulin and acute complications from diabetes were avoided; wheezy lungs were loosened with inhalers; and CD4 counts raised with anti-retroviral medications.

The nurses screened for the downstream, medically-legible consequences of "wider circumstances" which related to untreated medical conditions in the community. Ultimately, even with some valiant efforts, they could offer only band-aids, in the metaphoric and actual senses of the term, for they could not address the systemic factors which coalesced in the ill health of the patient before them, a patient who was entering jail. If we stopped there with the basic conditions of jail medical triage, this would indeed seem to be a minimalist biopolitics, acting on a biological version of life. But this is why it is necessary to ethnographically enter the jail, to see beyond an institutional level analysis that presumes the medical-carceral apparatus to be a biopolitical strategy.

Charlie's moniker "the angry chair" reveals that the triage interaction was anything but minimalist; the patient's affective state and the nurse's interpretation of its etiology were part of triage too. During the triage interview of a patient in the angry chair, nurses would adeptly switch back and forth between looking at a computer screen into which they were typing in the electronic medical record, and looking at the newly arrested person in the chair in front of them. There were times when I observed nurses, depending on their mood, avert their eyes completely from the patient and towards the computer screen. When I was with Charlie, who had worked in the jail for over 20 years, he paraphrased the standardized questions and went out of order, trying to make it sound like he had not asked the same series of questions thousands of times. Nancy, another longtime CJ1 nurse, did her triage assessment by reading through every question, in order, with a detached, monotonous tone. With gentle chastising, Nancy firmly redirected any patients who provided her with information out of sequence from the computer prompts she was following.

Medical Clearance and the Assumptions of Triage

The express purpose of this initial triage was twofold: to identify people who had urgent medical or psychiatric needs that required attention before they could be processed further into the jail; and to identify people with non-urgent medical or mental health issues who would, once admitted to jail, warrant medications, testing, or detailed clinical care. The NCCHC (2008) requires that the facilities it accredits have a medical screening upon intake. Likewise, this assessment is generally accepted as standard practice for any jail or prison in the country. Jail's universal medical triage upon entry presupposes ongoing danger. It presumes that the outside world can be dangerous for bodies which therefore need medical assessment before entering the institution; it presumes jail may be dangerous for the person inside, if she has medical conditions that are untreated; and it presumes that the inmate may be dangerous for the institution, if a medical lawsuit charging "deliberate indifference to the serious needs of prisoners" ensues.

Two key health-based assumptions underlie the existence of this medical classificatory ritual in jail. The first is that the everyday outside lives of most of the people cycling through jail are "unhealthy." Bridgetown jail health care providers saw this embodied as people first walked into the triage door: emaciation, obesity, lacerations, abscesses, track marks from injecting drugs, high blood pressure, bloodshot eyes, dirty clothes; these were some of the familiar signs which marked many of these bodies as unhealthy. Being confronted with such stigmata of social suffering and structural violence was routine. Nonetheless, nurses often attributed these visible signs to individual irresponsibility. "They just don't take care of themselves," a nurse told me after triaging a woman with scabbed-over bug bites on her face and the darting eyes of someone high on crack. Medical staff typically presumed, mostly correctly, that people cycling through the jails did not routinely access health care outside of jail.[4]

Amid this derision, nurses simultaneously held the understanding that "their lives are hard." Not infrequently, nurses would reflect on this to me, listing things like homelessness and poverty as

other reasons why the people in front of them appeared "unhealthy." Jail medical triage thus offered medical recognition of conditions of the outside world. It also intimated the possibility of intervening on outside suffering, with jail as a remedy or salve. Nurse Stephanie, who had worked as a CJ1 triage nurse for over fifteen years, told me with pride that she saw herself as being "on the frontlines of public health." To identify conditions for which patients needed treatment which did not arise in the triage interview, Stephanie would meticulously go through someone's electronic medical record from the jail system and the community health system (to which all jail health workers had access). On a number of occasions, she had discovered reports of chlamydia infections or other sexually transmitted infections (STIs) that had yet to be treated.[5]

This perspective on street life and the limited ways patients were presumed to access medical services created a sense that jailcare could be a healthy antidote for them. Jail triage provided an interface with a health care system that could detect, and potentially remediate—at least for the short term—unhealthy conditions from the streets. For the nurses and other jail clinicians, what to do with the health conditions detected in the bodies before them, the operative work of triage, was always something to be negotiated: providing care that was deserved or care that was not deserved, given the constraints and possibilities of CJ1. For example, a chlamydia infection, which is often asymptomatic, is not a life-threatening situation, so treating it in jail triage might seem like an unnecessary excess. But if untreated, chlamydia could lead to adverse health consequences in the future[6] and could be spread to others. It is also simple to treat, with a single dose of an inexpensive antibiotic. For triage nurses like Stephanie, treating this infection— acquired on the streets, tested for outside of jail, but noted upon entry to jail— was a reasonable triage intervention.

The second health-based assumption behind the existence of medical triage upon entering jail and prison is that incarceration itself does things to people's bodies and psyches; therefore, people must be screened before entering the institution as a way, in theory, to make incarceration proceed "safely."

If someone has asthma or is pregnant, for instance, these are things worth addressing so that shortness of breath or labor pains do not then significantly disrupt the work of punishment and confinement. It is not unlike health screening to enter another total institution, the military, which assesses fitness for the violence of combat. A major difference, of course, is that a health condition may preclude someone from entering the military, but an illness can only delay (if a person is sent to the hospital) or qualify the conditions of incarceration.

This perspective on jail medical triage as readying someone for incarceration was not actively acknowledged by the medical staff at Bridgetown. But the language used to describe the outcome of the triage process in Bridgetown is revealing: "medical clearance." If someone had an acute condition detected in triage, the nurse would send her to the hospital to be "medically cleared." If nothing acute was detected, the nurse would sign his or her name on the new arrestee's custody card (the piece of cardstock with select information that followed a person through the jail), and jail processing could proceed with medical collusion; people were implicitly "cleared" as suitable to undergo the procedures of incarceration.[7] This is part of the other side of the triage balance between providing too much care and just enough, where the decisions fall in the realm of the minimum care necessary to make incarceration safe. These two stances of jail triage—screening the deficiencies of the streets and screening to further the carceral process—played out practically in the first decision which triage nurses made: to send someone to the hospital or not. In this capacity, the triage nurse had a notable, albeit short-lived, authority of decision-making. The nurse was able to arbitrate, if not override, criminal processing by ordering hospital level care.

There were certain conditions which, by JHS policy, required transport from the jail to the nearby county hospital.[8] That is, protocol mandated certain responses, regardless of the opinions of the police officers or deputies. For example, if a woman reported using opiates (heroin or prescription pain killers), then the nurse performed a urine pregnancy test (if the woman consented to it). If the test was

positive, or if the woman was already known to be pregnant, then the opiate-using pregnant woman was immediately sent to the hospital for "medical clearance." The reasoning was that withdrawal from opiates in pregnancy can be associated with miscarriage or other adverse outcomes. Standard obstetrical practice recommends avoiding withdrawal in pregnancy by placing a woman on methadone or buprenorphine therapy (ACOG 2012). The observation and initiation of these medications in pregnancy could not be done at the jail, especially in busy CJ1, so women had to be sent to the hospital. The protocol for medical clearance helped to make the medical decision making seem objective, as though the same standards were applied equally to all.

At the same time, while some of the decision-making in sending people to the hospital was protocol-driven, much of it also relied on the nurses' independent clinical judgment. CJ1 was entirely staffed by registered nurses, with a doctor always on-call for phone consultation but not present in CJ1. An example of the interplay between nursing judgment and triaging the embodied effects of poverty was skin abscesses. Many people came off the streets into jail with skin abscesses, a consequence of certain injection drug use techniques and bacterial colonization.[9] For small abscesses, a nurse practitioner or doctor in the CJ2 clinic could treat it the next day once the person became an inmate in jail. But if the abscess was large or had worrying signs of a systemic infection, the nurses had to decide if it was urgent enough to send someone to the hospital for treatment.

One Sunday morning, nurse Stephanie was confronted with this dilemma from a quiet, unassuming man who answered "yes" to the "current abscess or infestation" question. Stephanie noticed a few small abscesses on the man's neck as they walked to a nearby exam room. When he removed his shirt, Stephanie saw his left armpit was full with a hot, red abscess the size of a grapefruit. It was not an emergency, but, she thought, it looked painful. It was too big to resolve on its own, too big to manage in CJ2, and would eventually need to be opened with a scalpel to drain the pus. Stephanie shared with me her reasons for sending him to the hospital at that moment. She was worried that if he

got released from CJ1 back to the streets, he would not get it tended to, since he had not sought medical care for this outside of jail. She worried that if he went to the jail housing unit, there would be a delay in arranging for a hospital transport (having to see a nurse practitioner in clinic, arranging Sheriff's Department staff to escort the patient). It was easier here in CJ1 to send someone to the hospital, in part because of the single door to the outside world, and in part because the police officers were still in charge of the arrested patient. It was they who would have to accompany him to the hospital, not Sheriff's Department staff.

Deciding to send someone to the hospital for medical clearance was not only a matter of clinical judgment. It was also, to some degree, an emotionally-laden decision, asking nurses to manage the difficult job of caring for people who were normally marginalized by the medical system as a gesture of affective caregiving. The grapefruit sized abscess was not a life-threatening emergency, Stephanie assessed. But her triage algorithm was laced with empathy for the pain the mass was causing; she was aware of how the structural forces of the streets and the jail would influence the likelihood that this man's abscess would not get drained.[10] She also had to balance her compassion with the affective responses her decision might generate among police officers who had to accompany arrestees to the emergency room, Sheriff's Department staff ready to process people, and the patients. Patients had varied reactions to being sent to the emergency room. Some were excited to be in the hospital instead of jail; others were humiliated to be publically handcuffed in the emergency room.

The Anxiety of Gatekeeping

There were many ways in which the nurses invested considerable and varying types of emotion into their triage interactions. The emotional stakes did not just play out through interfacing with patients, whom they might judge harshly for their lack of self-care, or for whom they might extend compassion for the ravages of their street lives. Interactions with police officers and deputies were also heavy with affect: sometimes from collegial banter, and sometimes from conflicts over their respective

professional obligations. The police officers' carceral intentions to deposit people in jail and then leave were often at odds with the caregiving intentions of the jail triage nurses. Triage evaluations of patients thus always had the potential to expose this conflict, made most tangible when nurses ordered hospital transports. This arrangement formed a subtle battleground between nurses and police officers, fought with emotions, affect, sidelong glances, and competing assertions of expertise.

The potential for such conflict to materialize made anxiety a common experience for triage nurses, stemming from the intermediary role they had between the caregiving they performed and punitive confinement they implicitly permitted. As the sole clinical decision-makers in CJ1, the triage nurses had independence which they found both rewarding and stressful. They feared "missing something" that would then cause further suffering in the patient, and invite reprimand from their supervisors (the nursing administrator and the medical director); for the administrators above the triage nurses, too, had to contend with this conflict of interest at an institutional level when it led to a poor health outcome.

Adding to this anxiety was the fact that their professional conduct was on public display. Deputies walked by or sat near the triage area, and the police officers who arrested the person being triaged stood only a few feet away from the angry chair. This looming proximity was a source of anxiety for the triage nurses, although it was something they grew accustomed to. How they conducted themselves with patients, the degree of sympathy they showed for them, how much time their evaluation took, extraction of personal details from the patient, these dimensions of triage put the nurses and their competency under personal scrutiny from both police officers and deputies.

A third source of triage anxiety stemmed from the short-lived yet determinant power the triage nurses had over the police officers' work. The triage nurses in CJ1, after all, were the gate-keepers between police officers' responsibility for the arrestee and jail deputies' responsibility for the soon-to-be inmate. It was the triage nurse's medical approval which allowed the police officers to transfer custody

to the jail staff, and which allowed the officers to leave jail and return to their usual patrol. Triage nurses did not relish this position of temporary authority, for police officers could retaliate against nurses with public insults and other forms of harassment during the current or future interactions in CJ1.

Police officers did not want to linger in the intake jail, or, what they bemoaned was even worse, to escort someone to the hospital for medical clearance; they wanted to get back to the streets. Their desire to leave jail and avoid the hospital was such that some police officers, nurse Charlie shared, had tried to conceal injuries—dragging a person to the triage chair to mask a limp, for instance. Charlie once triaged a man who had a small bandage sloppily placed on his forehead. As Charlie gently peeled off the gauze, he noticed that the police officer, who had placed the bandage, looked down in shame. Underneath the bandage was deep laceration that clearly needed to be sutured in the emergency room, where the police officer should have taken this man before coming to jail.

The tension of triage as a moment of exchanging a body from one law enforcement domain to another meant that the angry chair was not just for the fury of the person just arrested. Officers too could become angry as nurses made clinical decisions. One afternoon in the triage area, a fight erupted between a plain clothes police officer and a jail deputy. This officer had returned to CJ1 from Bridgetown Hospital with a man whom nurse Charlie had diverted to the hospital because his pulse in triage was 200 (normal is less than 100). Emergency room staff evaluated him, and eventually his pulse normalized so they sent him back to jail, escorted the entire time by the police officer. But when the patient sat in the triage chair for the second time, Charlie touched his wrist and again felt a rapid pulse. The patient was quiet and calm, which made it hard to attribute his tachycardia to anxiety.

Charlie proceeded hesitantly, knowing that his clinical inclination to send this man back to the hospital would be met with resistance. He brought the man into the small exam room and checked his blood pressure and heart rate with a machine, which confirmed a pulse of 170. They returned to the open triage area and Charlie looked through the hospital paperwork again, confused at why he was sent

back to jail. Charlie turned to me. With our eyes, we both affirmed what was obvious to us as medical professionals: he needed to return to the hospital. We sighed, and then Charlie apologetically informed the police officer of the need to return. The officer's face turned red, and frustration quickly grew into anger. "Come on! He was just cleared at the hospital!" He was pressuring Charlie.

As a medical professional with expertise on this matter, I felt bullied by the officer's protest; I second-guessed our shared decision, wondering if there was some cardiac monitoring we could do in the jail (there most certainly was not). Although Charlie was sure of his decision, he was also tentative as he explained his reasoning to the officer. "It's protocol. I'm sorry, but it's protocol." Charlie's appeal to the officer, like others I observed, was not delivered as compassion for the patient's well-being, though I had no doubt Charlie was concerned. Rather, Charlie articulated his decision to the police officer as a professional duty, just following protocol.

Despite the appeal to protocol, this officer could not be placated. He sarcastically sneered and rolled his eyes at Charlie as he told another officer "Yeah, he's gotta go back to the hospital." Charlie continued with his work, calling the medical director to let him know about the transport. Meanwhile, an uproar broke through the baseline chaotic noise of CJ1. The angry police officer and a jail deputy were in a shouting match, swearing so much at each other I could barely make out the content of their conflict. "You need to know where you are!" the deputy yelled at the officer, poking his extended index finger into the officer's shoulder. The deputy was sticking up for Charlie and his medical decision making. The CJ1 lieutenant approached the scene and separated the two, who then stewed in their own corners of the hallway. "Supercop over there doesn't know where he is. It's not my problem this guy's not medically cleared," the deputy growled. And that was the crux of the conflict, and triage in general. Whose responsibility was it to care for this person, plucked from the streets where a cardiac arrhythmia, cocaine, dehydration, alcohol withdrawal, or some combination of these made his heart contract faster than it should have?

Deservingness: Beyond the Politics of Triage

The very existence of medical care for the incarcerated foregrounds this question of whose responsibility it is to care with the notion of health related deservingness. How much and what kind of care do people arrested for allegedly committing a crime deserve? Does their transgression of the law and perhaps of society's moral norms mean that they do not deserve medical care? The courts have affirmed that even criminals are deserving of health care, or at least that their "serious medical needs" warrant attention. Deservingness is, Willen (2012) has argued, the "flip side of rights," for rather than being grounded in universal truth claims or legal assurances, deservingness claims are negotiated in moralistic and relational terms. Certain groups are constructed as worthy of public support and others unworthy, such as classic representations of "the deserving poor" versus groups deemed undeserving because of their marginality and moral inadequacy (Sargent 2012). Being deserving correlates to a sense of commensurability between a particular service and the moral value ascribed to the person whose deservingness is in question.

For instance, Willen analyzes how health-related deservingness among unauthorized immigrants in Israel is premised on the fundamental terms of citizenship, where immigrant non-citizens are excluded from the political communities; they are seen as non-contributing members of society and economic burdens. This perception excludes them from the local moral communities and thus they are deemed to be less worthy of concern (Willen 2012). In the age of mass incarceration and the war on drugs, most imprisoned criminals are likewise understood in mainstream representations as undeserving figures, for they have violated social and legal norms, and exemplify the popular moral imagination of evil. They are sent to prison to exclude them from society. And yet this exclusionary practice becomes the focal point not for declaring undeservingness, as with unauthorized immigrants, but for emotionally-laden processes of triage which conceptualize their worth as humans.

An arrestee's or inmate's deservingness of basic conditions of living is constantly negotiated in jail. Accordingly, the work of medical triage is deeply involved in adjudicating arrested people's health-related deservingness. Supreme Court decisions and a professional regulatory apparatus may be conditions of possibility for jail medical triage. But in the everyday interactions of triage, it is the moral register of deservingness which is at play. This perspective allows us to consider that triage is saturated with sentiment, and it should not be sidelined as accessory or political. Nurses' awareness of the marginal circumstances of arrestees' outside lives was not a putative correlate to sympathy for deservingness, just as being arrested was not an automatic exclusionary force of undeservingness. Instead, triage animated these and other points of reckoning deservingness into social interactions.

As nurses carried out their duties to patients and crafted their professional composure in the face of CJ1's fusion of criminal and medical processing, they contemplated what these handcuffed patients before them deserved. CJ1 triage was the interface between the state's abandonment of people on the streets and the coalescence of institutional state power. Triage nurses could not help but bring to their work of triage their own affective and moral stance on the state's responsibility towards the criminal body before them and the worthiness of that body. As I sat at the triage station with Lenny, another longtime nurse in CJ1, he reflected on the work of triage precisely through these tensions of responsibility and deservingness. He told me stories of a diabetic patient who had slashed the tires of a parked car in plain view of a police officer, so that he could come to jail to get his insulin; of patients who asked for "my Percocets" as soon as they sat in the angry chair.

As he reminisced, Lenny's smile and tone conveyed both humor about the situation and annoyance with what people demanded of the jail. "I don't know if we should be pampering them like this. You know, in [adjacent county] they have to pay a fee every time they request medical care." Lenny presented this fact to me as a good idea, to discourage people asking for too much.[11] From this disparaging stance, Lenny then looked around at the processing scene around us in CJ1, the interface

between street life and jail life. He fluently transitioned from his critique of pampering to a different moral stance. "I like working here. After years of ICU [Intensive Care Unit] nursing, of med-surg at [a private hospital], here I feel like I'm serving the community." He gestured with his chin at the arrested people around us. "These people are social outcasts," he said with compassion. "At the end of the day, I know I've done something for the people in my community. I'm a Christian, and caring for these people is in line with my Christian values." With this mix of cynicism over people getting too much care in jail and his sense of moral commitment to help, Lenny enacted his nursing duties in triage. He also articulated, on his own religious scale, broader policy debates on the negatively viewed "entitled poor" and the sympathetically understood "deserving poor," and the ambivalence that they generate.

People like Lenny were constantly confronted with the question of society's responsibility towards marginalized "social outcasts" and, consequently with questions of how to distribute medical care. Should they continue to dose insulin to a returning arrested patient with a dangerously high blood sugar, knowing he did not use it on the streets? The answer to this was always yes. Untreated hyperglycemia can lead to coma and death. But should Lenny order "Percocets," implicated in opiate addiction and an underground economy in jail, for someone who reported chronic pain syndrome? That answer was less clear. Lenny and other nurses attributed the insulin (and other health) neglect on the streets to a combination of "lack of access" and having access but not prioritizing health on the streets. For something with immediate physical consequences like high blood sugar, the triage reasoning prioritized biological disease pathways over the moral judgment of irresponsible self-care (Metzl 2010). When it was a condition whose lack of treatment was perceived to have less acute physical consequences, like chronic pain, then the balance of deservingness was filtered through sighs and an affect of annoyance. Biologically verifiable facts, along with the bureaucratic register of protocol, entered into the equation as a way to navigate the moral uncertainty surrounding the care that marginalized, criminalized bodies warranted.

The dynamics of health-related triage have been the subject of much recent anthropological inquiry. What unites these analyses is the argument that triage is fundamentally a politics of life, played out through explicit or veiled hierarchies of moral value (Redfield 2005; Fassin 2010; Nguyen 2010). In this framing as a political technology, triage becomes a technique, they argue, for contemporary societies to act on "the value they attach to life in general and on the worth they attach to lives in particular" (Fassin 2009: 58). In the jail medical setting, these politics of value are made meaningful through affective ties and conflicting sentiments that are uniquely generated in response to the punitive processing.

The anthropology of triage has exposed it to be a biopolitical strategy, reinforcing and creating anew configurations of power through choices about which lives are worthy recipients of life-sustaining interventions. This is not only a biopolitics of normalizing practices, but of reckoning the value of lives (Fassin 2010: 241-2). Redfield (2005; 2013) and Didier Fassin (2010) have deepened our understanding of the politics of life at work in triage through the paradigmatic medical humanitarian organization Médicins Sans Frontières. Appealing to an abstract notion of common humanity, Médicins Sans Frontières actively refuses to take sides in conflict zones where they administer medical relief services; all lives are equally valued, the organization espouses, and equally deserving of rescue. The paradox of this apolitical stance, Fassin and Redfield have argued, is that it is itself a politics of life. The triage that Médicins Sans Frontières must do to prioritize the timing and type of intervention on suffering bodies creates a necessary hierarchy in order to equitably distribute resources.

Beyond this functional establishment of disparity in a field of triage, inequality of lives is at the core of such medical humanitarian projects: there is always an asymmetry between workers and sufferers in their risk of dying (Fassin 2010). Jail medical triage likewise starts from a presumption of inequality. Its existence implicitly recognizes the conditions outside of jail which make some bodies healthier or sicker than others, and which jail must confront as it prepares to take in these people.

Triage in jail serves not as an arm of "prison as the great equalizer,"[12] to put everyone no matter their crime, race, or status in society on the same level; rather, jail triage makes legible the unequal conditions structuring our world, manifested in, for example, an abscess. Medical triage in jail is there to screen and sort the effects that structural violence has had on people's bodies and (via mental health screening) their psyches. At a basic level, CJ1 triage nurses operated according to the standard logic of medical triage: prioritizing who, in the face of finite resources and of entering into the potentially dangerous experience of incarceration, must receive medical care immediately and who can wait (or who does not need intervention at all).

The Intimacy of Recidivism

Every jail medical staff person I spoke with at the Bridgetown jail was keenly aware of the medically restorative role of jail, that many of their patients did not tend to their bodies outside of jail. One prominent infectious disease doctor in the community who was also the head of the city's Department of Public Health had declared publically a number of times that some of his patients with HIV would not be alive if they were not cycling through jail.[13] After all, in jail they had a nurse hand them anti-retroviral medications,[14] along with a comprehensive HIV treatment and prevention division of JHS. I cared for a woman in jail who had not had a pap smear in many years; a routine pap smear and subsequent biopsies done in jail detected early cervical cancer, which was then treated at the county hospital. The patient told me that without jail, she would have continued to not seek medical care, and would not have known about the cancer—perhaps, I speculated, until it was advanced enough for treatment to be ineffective.

In these and other cases, jail was life-saving. However, the jail's medical survivalist interventions were temporally limited. They offered a brief interruption in a life that was largely medically bereft. Most people returned to the streets and the conditions of chronic marginality which compromised their health and limited their access to health care. Despite efforts to connect jail patients to community

care, there was little the jail medical apparatus could do to alter the broader context of inequalities which sustained these people's poor health and churned them through the realities of mass incarceration. This reality may seem to be a "minimalist biopolitics," akin to the limited scope of alleviating suffering of lives enacted by Médicins Sans Frontières.

What is different about jail's version of this limited scope of ameliorating life is its chronicity in people's lives. Recidivism rates at the Bridgetown jail were around 70%, which meant that most people who left jail also returned. Kima, for instance, would get released from jail and usually return within a few months—sometimes even just a few days. Recidivism is a key concept in criminal justice and policy circles. From the Latin *recidīvus* for "falling back" or "recurring," recidivism refers to the process of a previously incarcerated person getting rearrested. In these uses, recidivism is a statistical signifier of failure—failure of the individual and failure of the criminal justice system to reform prisoners into law abiding citizens. Of course, as Foucault (1977) noted, the prison sets up conditions for further "delinquency" of prisoners upon return to society; likewise, the warehouse prisons of mass incarceration are largely devoid of rehabilitative and re-entry services which might help people avoid re-arrest.

But the medical triage of jail as intervention on people's lives urges us to re-think recidivism beyond its numerical representation. For it is through recidivism that people cycling through jail have their bodily and mental states tended to by professional caregivers on a somewhat regular basis. Recidivism means that these band aid moments of healing are recurrent and, in fact, as the public health director acknowledged, it is by the logic of recidivism that jail can be a life-sustaining safety net. In other words, recidivism becomes a key ingredient in the survival strategies of the urban poor.

Current anthropological analyses of triage interventions delve into how these actions are profoundly political, into the power configurations involved in deeming whose life is valuable and worthy of saving. In this framework, sentiments like compassion for the sufferers (Ticktin 2006) or fear

that aid workers will be killed (Fassin 2010) get imbricated into larger political strategies of regulating lives. For instance, Miriam Ticktin explores the illness clause in French law which grants undocumented immigrants the right to reside legally in France and receive free medical care if they suffer from serious illness. This policy, informed by humanitarian compassion, makes sickness interchangeable with political recognition from the state, vis-à-vis a medical and legal apparatus which creates an incentive for suffering. This ostensibly compassionate and apolitical policy, Ticktin argues, is actually a deeply political technology in which someone's biology is remodeled into a category worthy of state intervention. In this understanding of humanitarian interventions, care and concern are reduced to strategies of governance rather than intersubjective relational engagements. This view limits what we can say about the affective dimensions of triage decisions, if they are only meaningful as political processes for the unequal access to citizenship (Ticktin 2006) or for the differential valuing of lives worth saving (Fassin 2010; Nguyen 2010).

In contrast, understanding the interactional nature of triage in jail allows us to see how emotion and politics are wrapped up in intimate sociality. Triage interactions in jail were repetitive, not only in the patterned states of disrepair in which people appeared to the nurses, but also in the actual people involved; that is, recidivism created a chronic triage of the same questions, the same nurses, and the same patients over a long and potentially unending period of time. The familiarity generated by this chronicity resists any simple politicization of the affect involved in jail triage interactions.

The story of triaging Kima demonstrates the intimacy of recidivism. On one of her many arrivals to jail, nurse Charlie was at the triage station to welcome her. They had known each other for many years and had been in this configuration before. As Kima told me, being in a clinically-focused moment forced her to admit to the fact that she suspected she was pregnant. When Kima saw Charlie, "I was crying, but I was like, 'Charlie, I think I'm pregnant.'" She was scared, she explained, because she had been using drugs she knew were harmful to pregnancy. At Charlie's prompting, Kima gave a urine

sample, and Charlie confirmed her suspicions that she was pregnant. Again, she said, "I burst into tears." Kima felt familiar enough with Charlie that she could be emotional, and that she could welcome Charlie's comfort. In this moment, we see again the limits of a narrow understanding of recidivism as a statistic.

Care is thus sutured to recidivism. People enter jail, they leave jail, and then return. Within that cycle, the jail is mandated to provide care. With this kind of chronicity, imagining patients' lives outside of jail is necessary to triage, to the task of understanding what has happened to bodies and diseases in between one incarceration and another. This is not the "minimalist biopolitics" Redfield (2005) ascribes to the triage of people entering refugee camps, where suffering bodies are treated as an assemblage of decontextualized biological needs; Médicins Sans Frontières' mode of triage makes it unnecessary to imagine refugees' lives before the event which displaced them. When Charlie triaged Kima and decided he should run a pregnancy test on her urine, he was partly guided by protocol that directed him to offer the test to a woman whose last menstrual period was over one month ago. But in this case, Kima indirectly asked him to run a test as she shared her anxieties with Charlie. He imagined, informed by what he already knew about Kima from past triage encounters, that Kima's life involved unprotected sex with multiple partners on a regular basis and that she could be pregnant, even if she had recently had bleeding she thought was a period.[15]

Kima and Charlie had a relationship built over recidivism's repetitive temporality. Charlie noted that he sometimes saw his recurrent jail patients on the street, since the five block walk from the jail to the subway station traversed drug corners where many people released from jail spend their time. Some people greeted Charlie with a smile, he told me, and even escorted him to the subway station. I too experienced this gesture and warm recognition from some jail patients on the street. "Hey!" one shouted excitedly when she saw me. "You put that IUD thing in me when I was in jail!"

The familiarity that enabled some triage moments to be intimate interactions like the one between Kima and Charlie was also evident in the relationship arrestees had with the institution itself. People who had spent time in jail before came to expect certain things from the institution. One man who sat down in Charlie's angry chair one day gruffly answered his questions with mostly monosyllabic responses. When Charlie asked if he had any medical conditions, the man grunted "back pain." "Any medications?" "Hydrocodones," the patient responded. "And I need a bottom bunk." New arrestees' memory of the institution was reciprocated in the memory the institution had for individuals; this came in the form of computerized records and of interpersonal familiarity. So when this man requested his pain medication and a bottom bunk, Charlie checked in the jail medical record system to see that in past incarcerations, this man had indeed been prescribed a bottom bunk and pain medication; later, Charlie would also call this man's pharmacy to confirm whether he also was prescribed pain killers in the community.

Triage nurses looked up information about the patient in the "Longitudinal Clinical Record," the electronic medical record system used by Bridgetown's network of clinics and the county hospital run by the Department of Public Health, since this was the system most people cycling through jail would access if they did seek medical attention in the community. Because Bridgetown's JHS was a branch of the DPH, the jail clinic staff had access to this computer system; triage nurses used this often to help complete their medical understanding of a patient before them in the angry chair.

Again, recidivism becomes animated as more than a statistic; in the medical triage moment, recidivism was also a cumulative electronic narrative about someone which complemented the interpersonal familiarity between triage nurse and the patient before them about to re-enter jail yet again. Computer technologies in jail cannot be simply understood as impersonal strategies of knowing subjects, as I discuss further in Chapters 2 and 3. In the criminal justice system, electronic records can be distinctly personal, compressing information about individuals into selective stories which authorize

new ideas of punishment and justice (Aas 2005). The familiarizing role that CHART played in triage interactions prompted triage nurses to recall and learn details of someone's prior incarceration. The longer title of the computer program which the CHART acronym represented was telling: "Correctional Health Assessment Record and Tracking." Tracking implies following someone, a temporality for something that is ongoing; for CHART, that ongoing event included both the occurrences of a current incarceration and the recurring ones. CHART thus partially encoded the intimacy of recidivism which the entire triage evaluation initiated.

The conditions of recidivism, the physical embededness of jail within the community, and electronic records thus all fostered personal and institutional memory for the people who cycled through the jail. Intimacy, Lauren Berlant writes, "involves relations that largely proceed by way of what goes without saying" (2011: 264). It is an unequal intimacy, to be sure, for the jail patients did not know nurses with as much detail as the nurses knew the patients. But the rhythm of recidivism and the predictable practices of medical screening anchored jail staff and newly arrested people into familiar ways of relating. These elements generated comfort enough that Kima could let her guard down and cry with nurse Charlie about her pregnancy fears. We might assume that Kima's closeness to Charlie has its cathartic power only by way of its contrast to uniformly antagonistic, distrustful and abusive relationships with deputies; however, as we enter further into jail and its relationships in subsequent chapters, we shall see that the avenues of intimacy are part of the fabric of the institution itself, and inextricably woven into elements of institutional violence.

For Kima, it was not only Charlie as a representative of the jail, but also the institution itself which lent itself to intimate attachment. Similarly, the man described earlier had a certain relationship with the institution in which he expected the prescribed comforts of a bottom bunk and pain killers. It was a common experience, as another triage nurse told me, that "as soon as they get in that triage chair, some of them act entitled, asking for blankets or a sandwich, because they know they can."

People's chronic familiarity with jail and recognition of what it provides cultivate a relationship not only with the people who work in jail, but also with the institution itself. Ian Whitmarsh (*in press*) makes a case for seeing institutions as we see kinship, as a basis for foundationally ambivalent sociality. The meaning people make out of their relationship with the jail is not reducible to the punitive aspects of the institution, but arises precisely because it is a place from which they expect a peculiar ambivalence of harshness and care which is animated in the social engagements of care.

Triage's Public Privacy

It is notable that Kima displayed emotional vulnerability during triage, and even more so given the public nature of the interaction. Charlie and Kima were stationed, nurse and patient facing each other, right amid the chaotic flux of CJ1; there was no screen, no door around them (except when the urine test was done). Deputies walked by, or leaned against the adjacent counter filling out paperwork as the patient in the angry chair had to answer personal health questions. Two plain-clothed police officers who arrested Kima hovered only a few feet away, as was standard practice, since they were still "in charge" of this person. The police officers' proximity to the triage interview made it impossible for them not to hear the conversation. Most of them I observed made no pretense of discretion, turning their eyes and ears directly to the triage interaction. I wondered whether patients feared that their answers to the "drug use" question could incriminate them, with the police officers hovering.

This lack of privacy from police officers and deputies encroached on the usual expectations in western biomedical practice of confidentiality between the caregiver and patient, codified in the US in regulatory codes of the Privacy Rule of the Health Information Portability and Accountability Act (HIPAA), which grants medical privacy as a patient right. In non-jail settings, health care providers are constantly reminded of their obligations to the regulatory specter of HIPAA, that people not involved in the patient's medical care are not to be privy to a patient's private medical information (without permission from the patient). In jail triage, being arrested hardly serves as implied "permission" for an

officer to listen, but that was functionally what happened. In some jails and prisons around the country, especially small jails with limited nursing staff, the triage is even done by a correctional officer. One justification given for the visibility of the nurses' triage work was for police officers and deputies to be able to protect nurses from a potential assault by an arrestee, a legitimate concern. An administrator told me that there has been one serious assault on a triage nurse, and several other attempts.

When I began working at the Bridgetown jail's clinic, I assumed that there was an official guideline on how to navigate HIPAA in this site where non-medical personnel loomed over medical encounters. Instead, I learned that patient confidentiality was something to be negotiated, to be worked at in the face of constant surveillance. If a patient needed to be transported to the hospital, jail health workers relied on deputies to make that happen, but had to be deliberate not to mention why; sometimes, deputies would push providers into telling them. This issue came up at a joint staff meeting I attended between Sheriff's Department and JHS leadership. From the custody side, Sheriff's Department leaders argued that transporting deputies needed to know in case something happened to the patient en route to the hospital. Health care administrators pointed out that if it was an unstable patient at risk for something happening on the way to the hospital, the patient (and accompanying deputy) would be in an ambulance anyway. After much debate, prioritizing patient privacy prevailed. Regardless of what transpired in this conference room, it was the health care providers and deputies on the ground who managed the disclosure of information.

Deputies were privy to certain pieces of medical information which jail medical staff disclosed to them, by protocol. For instance, an inmate's "housing card," a five by eight inch piece of beige cardstock, had a section to denote if the person had certain "high risk" medical conditions: tuberculosis, pregnancy, diabetes, detoxification from alcohol or opiates. Certain degrees of information on mental illness was also disclosed to deputies. This was done both formally, by deputies having to check in every

15 minutes on an inmate put on “suicide watch” in a safety cell, or informally as the deputies observed which inmates were visited by jail psychiatric staff.

The negotiation of patient privacy in the midst of an all seeing carceral institution was magnified in CJ1 where medical triage and jail processing were spatially and procedurally intermingled. To adapt to this exposure of the clinical ritual, triage nurses proceeded with a variety of approaches. Sometimes they passively acquiesced to the subtle intrusion, proceeding as usual with the routine question-answer triage performance. This could cause some patients discomfort. Nurse Nancy, for instance, had learned from the electronic CHART that a man she was triaging had a history of syphilis. She asked him, “other than the STD, any medical problems?” The man gestured toward the police officers with embarrassment. “Jeez lady,” the arrestee said with anger towards Nancy. He was, after all, sitting in the angry chair.

Other times, nurses and patients spoke in code to create some elements of secrecy. With another patient, Nancy could see from the woman’s electronic medical record that she was HIV positive. Instead of using that exact diagnosis in her triage questions, she asked the woman indirectly “do you take anti-virals?” This attempt to protect the patient from the police officer learning about a condition that carries tremendous stigma, HIV, required an active but subtle recalibration of the terms of clinical communication. This was a caring gesture. In CJ1, the sacredly private valence our biomedicalized society ascribes to health information was systematically displaced by the ostensible need for police presence at this initial processing moment. Criminal surveillance inserted itself into medical surveillance. Caregiving involved the moment to moment adaptation to this carceral presence.

Triage nurses could also choose to escort a patient from the angry chair to a small room a few feet away. This room resembled a storage closet more than an exam room, but it offered a little bit of privacy from the rest of CJ1. If a nurse had to do an evaluation that involved touching the patient, such as examining a wound or an abscess, or collecting urine for a pregnancy test, she would take the patient

to this room, shielding the patient from the gaze of police officers and deputies. As Charlie told me, nurses also learned to defer some health questions for the more detailed "intake evaluation" that they would do later in CJ1, after the initial triage moment in the angry chair. This nursing interaction happened in a different part of CJ1, on the side of the unit where people who would be staying in jail waited to be sent to the housing units. The office where this second, more thorough phase of the health evaluation took place in a room with glass walls; the nurse and patient were still visible to deputies , but at least the walls gave the nurse-patient interaction some audio privacy. Charlie knew that the public triage of the angry chair was awkward. He accepted that "sometimes the patients lie" because of this lack of privacy, and that they were usually more forthcoming in this glass room.

This work of negotiating privacy with the patient was a notable gesture of care, for it contradicted the usual erasure of privacy that is characteristic of incarceration's panopticon. These moments where triage nurses crafted some elements of privacy—whether through secret code language or by taking the patient to a small enclosed room—created space for intimacy, a sense of shared experience (Berlant 2000) that was, at least temporarily, exclusive to others surrounding the intimate subjects. What enriched intimacy in CJ1 was this very attempt to create privacy, the willingness to create a shared, private connection in a publically-given encounter within an institution of incarceration. Intimacy, Berlant (2000) notes, encompasses the "range of attachments" people make in mediating the forces of collective experience in public and private domains. The everyday work of triage in the jail created such opportunities for intimacy, a connection where Kima could cry to Charlie about her pregnancy suspicions while sitting in the publically exposed angry chair.

Kima was certainly used to the relative lack of privacy in CJ1. And she was also used to Charlie. So her emotional display of her reproductive anxieties during triage was easy and unexceptional for her. Charlie's warmth with Kima during this triage process of finding out about a pregnancy is hard to reduce to a biopolitical technology. This is not to say that Charlie's actions did not have strategic dimensions, for

testing Kima for pregnancy was part of a larger triage project of patching deficiencies from the outside and make incarceration safer for poor, unhealthy (sometimes pregnant) bodies. But the exchange between Charlie and Kima reminds us that triage moments cultivate emotional connections.

Moral Technologies of Triage

Jail medical staff thus reckoned their decisions to care as "situationally specific, vernacular *moral* arguments about deservingness" (Willen 2012: 812). This everyday reality of medical, procedural, and moral decision-making contrasts with universalizing arguments about rights-based entitlements, for those with authority to care in the jail think about entitlement in terms of the people before them. As Willen contends, the moral domain in which deservingness claims are articulated are deeply relational. That is, they are based on "one's sense of actual or presumed social connection to those whose deservingness is in question" (Willen 2011: 3). The moral assessments which nurses made as they decided care were indeed relational in this sense. The nurses' triage decisions were substantively informed by the carceral environment and the outside conditions often precipitating incarceration.

It was often multiple threads of Bayesian reasoning which infused the moral probabilities in triage: given that this person may have committed a crime; given that I work in a jail and not a community clinic; given that health care may be elusive for this person in the community, what medical care does she deserve right now? The answers to these conditional questions were answered individually by whatever nurse was at the triage desk. Protocols and medical facts may have partially guided the triage responses, but so did the interpersonal interactions between nurse and the patient in front of her. Understanding triage in this context of the relational nature of deservingness rather than only as a biopolitical strategy allows us to see triage as a technology of sentiment and sociality.

Interacting with patients at this social rather than just procedural or political level of triage has implications for the kinds of subjects the nurses perceived their patients to be. Recall that nurse Lenny acknowledged that the people cycling through jail were part of the "community." He framed his

compassionate stance in contrast not to a perception of these people as criminals, but more as nuisances. Another CJ1 nurse James echoed this comparison. “You know, people say these jail people are ‘throw-aways,’” furrowing his brow. “They’re not throw-aways, they’re people.” The care of triage brought nurse and patient together at a moment which, under the watchful eyes of law enforcement, put inequalities of poverty and bodily and mental health into stark relief.

The triage nurses were savvy in deciphering numerical codes for the arrest charges on a person’s jail card, yet this was usually a point of interest, not a reckoning point of their patients’ health-related deservingness. This was apparent to me as nurse Nancy looked at the back of a patient’s jail card before triaging a patient. “5143-2, that’s for theft. But see this—“ Nancy pointed to a few other numbers on the card. “That means she has some outstanding warrants. She’s going to be here a while,” she said nonchalantly. And then Nancy moved on to ask the patient the standard triage questions. Nurses in triage could hold this information about the arrest charges without crossing over to the law enforcement side. Instead of the transgression of the law contributing to a moral assessment of deservingness, sympathy for patients’ marginality as well as the intersubjective nature of the triage relationship went into the metrics of health related deservingness.

Demureness, like the patient quietly suffering with a large armpit abscess, elicited sympathy for the patient’s difficulties on the street and was one element of the caregivers’ calculus of deservingness. But a patient with immediate, multiple micro-demands for a bottom bunk, a no peanut-butter diet, light work duty, and Benadryl, those patients might have been granted those requests if they were in line with standard protocol, but nurses might have simultaneously sighed or rolled their eyes at patients who acted entitled. The social and emotional engagements of triage which factored in life on the street in one way or another superseded perceived criminality in how health related needs and deservingness were negotiated. It was not merely a matter of counterbalancing the law enforcement context of CJ1, of medical triage opposing the criminal assumptions that were the raison d’être for CJ1. Rather, it was the

unique way that triage nurses were directly confronted with the ravages of street life and with people's social, attitudinal engagement with the institution they were about to enter. This criminal sidelining work which allowed the sociality to exist was part of the care of triage.

Triage nurses were in a crucible of human emotion as they sorted through triage decisions of what kind of care the newly arrested patient needed and deserved. Despite this and the occupational stresses of the job, the nurses liked working there. Most of them had worked at this job for over fifteen years. They liked the independence of their clinical decision-making; they liked the collegiality of working with the deputies in CJ1; and some felt gratification from helping those society treats as disposable. A few nurses even identified the constant action and interaction of CJ1 as "entertaining." Indeed, there were times in triage when I had to suppress laughter I felt ashamed to be forming when patients who were psychotic or high on a cocktail of drugs would answer triage questions with elaborate non-sequiturs. The chaos of the intake jail could, disturbingly, be fun.

Triage in the jail was permeated with sentiment; it was an emotionally-laden task that is not reducible to politics, although the political dimensions of inequality and marginality do help to shape the triagers' affective approaches. This is in contrast to the notion that sentiment gets subsumed into regulatory practices which ensure the functioning of power and hierarchical relationships, as Ann Stoler (1995, 2002) has written about European colonial projects. Stoler analyzes how intimate relationships between the colonizer and colonized were something to be managed, how critical it was to shape affective ties between the two for the making of colonial categories. In jail triage, the multiplicity of sentiment exceeded the power arrangements expected of health care provider-patient, of carceral institution-subject.

Berlant's conception of compassion is useful here to recognize that affect can be both political in its operational effects and intersubjective as a process. Both nodes are connected by the moral weight behind decisions about whether to act or to withhold action. Berlant writes: "in context [compassion's]

power involves myriad anxieties about who among the sufferers deserves to be positively or negatively judged, and why, and whether there is any adequate solution to the problem at hand" (Berlant 2004: 6). For the nurses working through the constant balance of triage, the solution to the individual "problem," the arrested patient in the triage chair, entailed ongoing anxiety.

Taking Care of Triage

Triage was central to the jail's everyday rhythms of processing new arrestees and of tending to inmates living in the jail. Triage was a task-oriented practice, what nurses assigned to be in CJ1 did as part of their job. It was also a process of negotiating what kind of care was deserved by a person enmeshed in the poverty of the streets or the rigidity of a jail system. These elements of affect and power in triage were not accessory to the technical decisions health care providers made in jail. Nor were they reducible to a broader political strategy of how triaging arrested criminals sustains subject positions in which inmate bodies are valued in limited ways. Triage diagnoses the deficiencies of the streets and offers a temporary yet—because of the chronicity of recidivism—sustaining salve. These triaging endeavors themselves require taking care of, in the ongoing implicit commitment to working through and within the realities of caregiving in a space of confinement. The task is full of uncertainties and contradictions in who deserves what kind of care. In triage, ambiguity shows itself to be the cornerstone of care.

[1] From the French verb *trier*, to separate or select, the triage concept emerged on the battlefield to classify wounded soldiers into those who were likely to die regardless of intervention and those who might live—and therefore return to battle—if their wounds were treated (see Nguyen 2010). The military rationale has mutated into many forms, from the routinized triage of hospital emergency rooms, to medical humanitarian relief efforts during war or natural disasters (Redfield 2005; Fassin and Vasquez 2005; Ticktin 2006) or the distribution of HIV treatment (Nguyen 2010).

[2] Data come from Bridgetown JHS annual audit report.

[3] There were detailed protocols to guide the care of people withdrawing from alcohol and opiates, recognizing that alcohol withdrawal in particular can be fatal. The protocols included not only frequent visual and vital signs assessments, but also benzodiazepines (for alcohol withdrawal) and medications to relieve the symptoms of diarrhea and restlessness of opiate withdrawal.

[4] Those who worked in the jail had employer-based health insurance, with a choice of several plans including California's well-known, comprehensive managed care organization Kaiser Permanente. This is not to say that deputies and jail medical staff all "took care of themselves" in the idealized way our culture represents "good health." Some were overweight, ate high fat foods at work, rarely exercised, smoked, drank excessive alcohol, and other things characterized as "bad health behaviors." Also notable about the contrast between health insurance that jail workers had and that most inmates did not have outside of jail is that they too may have been surrounded by friends or relatives who themselves did not have health care benefits.

[5] These reported STIs might have been tested for in the community at one of the DPH clinics, or during a person's previous incarceration in jail. In addition, at one point in time the DPH had a worker stationed in CJ1, usually during the high volume evening and night shifts, specifically to test new arrestees for STIs.

[6] The potential consequences of untreated Chlamydia infection for women include pelvic inflammatory disease (more widespread and serious infection of the reproductive organs that can require hospitalization and in some cases surgery), infertility, ectopic pregnancy, and chronic pelvic pain.

[7] Jong Pont and colleagues (2012), who work in prison medicine in Europe, have commented on the risks that prison health care providers have of cultivating dual loyalty to both the patients and the interests of the prison. It is an unethical stance, they affirm, to compromise professional duties to the patient with acquiescence to compromising requirements of the prison. The intake medical examination, they argue, "should not issue certifications that prisoners are fit for imprisonment" (2012: 476). The authors' ethical stance is valid, but inherently unrealistic. Whether or not an official certification is given, the presence of medical authority at prison or jail intake, followed by the turnover of the prisoner from medical examination to prison examination is a subtle affirmation that incarceration can continue.

[8] The Policy and Procedure for "Receiving Triage and Intake Screening" instructed triage nurses to send patients with the following conditions to the hospital and not to "accept" them into the jail until "medically cleared": "1. Signs, symptoms, or history suspicious for active TB. 2. Lacerations requiring suturing. 3. Unresponsiveness. 4. Injuries which require X-ray evaluation. 5. Serious head injuries. 6. Pregnancy with: signs and symptoms of opiate withdrawal or regular and recent use; history of alcohol addiction and pulse above 100 and hallucinations, tremors, sweating, anxiety or irritability; history of crack/cocaine addiction and pulse above 120 and/or blood pressure above 140/90; history of daily benzodiazepine use of 60mg or more of diazepam or equivalent and pulse is above 100 and hallucinations, tremors, sweating, anxiety, or irritability; cramping or vaginal bleeding; pulse above 100; blood pressure above 140/90 x 2 and no known history of hypertension. 7. Unstable cardiac chest pain. 8. Severe cellulitis, abscesses requiring I&D, infected human bites. 9. Inability to walk or stand unassisted. 10. Peritoneal dialysis. 11. Respiratory distress of unknown and/or unmanageable etiology. 12. Reporting to have ingested narcotics or cocaine. 13. Reporting to have been raped within the last 72 hours. 14. Requiring life sustaining medical equipment not available in the jail. 15. Imminent danger to self or others. 16. Any other serious medical condition requiring emergent care.

[9] See Bourgois and Schonberg (2009) for detailed analyses of the political economy and social life of abscesses among homeless drug addicts in San Francisco. The authors show how poverty and its medical management are inscribed graphically onto bodies through abscesses.

[10] It is not uncommon for people to attempt to drain their own abscesses with whatever sharp objects they can find, although this often leads to worse infections. Bourgois and Schonberg (2009) explore some of these self-therapeutics as "techniques of the body."

[11] There is much debate around charging a co-payment for medical care in jails and prisons. It is common practice to charge a fee, usually around $5, for inmates to see a doctor for a non-urgent complaint that was not initiated by the health care provider (prenatal care, for instance, does not typically have a co-payment). The idea, as Lenny corroborated, is to discourage people from abusing the ready and otherwise free access to medical care which they have. Most inmates have some money "on their books," from family members or friends, to buy things at the commissary. So the assumption is that if they can afford to buy Cheetos, they can afford to pay $5 for a clinic visit.

Those who do not have money on their books are exempt from the co-payment. There was no co-payment for any medical service at the Bridgetown County Jail. The medical director was vehemently opposed to this practice which he considered unethical and dangerous; the financial burden in this already coercive environment would prevent too many people who needed care from coming to the clinic. Medical care should not be monetized as a means to regulate behavior.

[12] This colloquial phrase is a mutation of Horace Mann's famous quote that "education is the great equalizer." The irony of the substitution is that prison and schools are linked in myriad ways. There is the disparity in spending on prisons over schools, which only furthers the likelihood that children attending underfunded schools will end up in prison. And, as Foucault noted, schools and prisons are modeled on the same disciplinary structures.

[13] The public health department's director's comment about jail caring for his patients was invoked at public hearings I attended two years in a row when the Bridgetown's city council considered contracting JHS to a private corporation. In this scenario, it was the quality of jailcare that was emphasized, to save jobs and a public health infrastructure at the jail.

[14] Being reliant on jail for HIV medications was problematic at a clinical level for those patients who had difficulty continuing them outside of jail. With only sporadic treatment, the HIV virus can mutate and develop resistance to anti-retroviral medications, making the drugs ineffective. Because of this, HIV specialists at Bridgetown jail were careful in their decisions about whom to give anti-retrovirals to in jail. The specialists also established a clinic outside the jail where their patients could follow-up upon release.

[15] Twenty percent of women will experience bleeding in the first trimester of pregnancy. This bleeding may seem to women like a period, and so they may not realize that they have missed an actual menstrual cycle.

CHAPTER 2
Cultivating Ambiguity: Routinzing Care in the Jail Clinic

"Let us try to assume our fundamental ambiguity. It is in the knowledge of the genuine conditions of our life that we must draw our strength to live and our reason for acting."

-Simone de Beauvoir, The Ethics of Ambiguity

Court order for Care

Nurse Practitioner Vivian stepped into the exam room where I would soon start seeing patients for the morning. It had become somewhat of a ritual for her to do so with me, an opportunity for her to tell me a little about some of the patients she had referred, to vent frustrations about co-workers and patients, and to tell exceptional stories of things that only happen in jail. Vivian had been working at the jail for 13 years. She was the jail's women's health nurse practitioner who provided the bulk of the routine gynecological and prenatal care to the women of the Bridgetown jail. Vivian came to her profession with a deep desire to help those at the bottom rungs of society. Although she now lived in the suburbs, Vivian had grown up in the same urban Bridgetown neighborhood as many of the women cycling through jail. She attributed her divergent pathway from theirs in part to her parents, especially her mother, who fiercely promoted her education, as opposed to the other women's mothers whom she knew abandoned them for drugs, prostitution, and prison. Also like most of the women in jail, Vivian identified as African American, and took pride in being an example for them. Vivian saw her work in jail "as a kind of ministry," to serve and ameliorate the lives of women who came from her own community.

This particular morning, Vivian was visibly exasperated. She gesticulated, she shook her head, she stopped and started her sentences a few times while narrating her frustration with patient Kima. Kima was now 32 weeks pregnant. She had been back in jail for over two weeks, for the third time this pregnancy. This was a point in pregnancy when women have prenatal visits every 1-2 weeks, to screen

for pre-eclampsia (a condition of high blood pressure in pregnancy which is more common in the third trimester), to check the fetus' growth, to make sure there were no signs of preterm labor. But, except for one initial visit, Kima had repeatedly "refused" to come down to clinic to see Vivian for a prenatal visit. Vivian kept her on the "sick call" list every day, hoping Kima would come down to the clinic. "Sick call" is the standard vocabulary used throughout correctional medicine to denote daily clinic sessions, not so subtly implying that medical care in jail or prison is there to deal with sickness as it arises, rather than to have a preventive focus. This was the spatialized routine for clinical care in the Bridgetown jail, which I discuss further below: patients were brought by deputies from the housing units to a separate clinic wing of CJ2.

Vivian was at her wit's end over the fact that she had been unable to provide prenatal care for Kima. Despite her frustrations, Vivian's first impulse was to frame Kima's recalcitrance as a set of explanations that made it morally tolerable and emotionally explicable for Kima to refuse prenatal care. Vivian told me that Kima was particularly upset about being in jail this time, because she was not arrested for her usual drug-related charges: it was a simple shoplifting charge, a bar of nice smelling soap from Walgreen's that Kima had a weakness for. Kima could not cover her bail, and the penalty seemed out of proportion to the crime. Kima was more angry about this incarceration, so she was refusing everything offered to her in jail. Vivian also suspected that Kima was angry with her for not giving her special treatment, given that Vivian had known Kima's aunt in the community for a long time. "She expects personal treatment but I can't do that. I have to be professional and treat her like a patient." Vivian was so exasperated with the obstacle of Kima's medicalized autonomy to refuse care for her pregnancy that she half-joked: "I'd like to get a court order for her to come down here for to prenatal care!"

From Coherence to Ambiguity

Vivian's threat to get a court order to provide Kima with prenatal care might seem coercive, paternalistic, even punitive; on the surface, it is consistent with a carceral mindset, and with an insidious version of reproductive control through incarceration (Flavin 2009; Paltrow and Flavin 2012).[1] But Vivian's comment was a joke. It arose from the fact that the courts were part of Kima's life and also part of regulating jail conditions; the joke also emerged from the tensions between Vivian's desire to make Kima's pregnancy as healthy as possible, with Vivian's respect for Kima's patient autonomy. The fact that it was in jest speaks to the contradictory nature of the work of providing care in a jail.

This care is infused with what Paul Brodwin (2013) calls "everyday ethics," in which frontline caregivers' ideals are constantly questioned and articulated through reflections of their everyday encounters with patients. This is not the abstract terrain through which bioethics is typically debated. "Everyday ethics is a matter of second thoughts and fleeting moments of self-doubt" (Brodwin, 2013: 4), and, I would add, reflective jokes like Vivian's. "People reflect in passing on what they just did or witnessed someone else doing, and why it disturbed them. Afterward, they plunge back into the usual routines" (*ibid*). This active ethical engagement was a part of the disposition of jail health care providers, a reflective stance elicited by the strangeness of folding medical routines into custody routines.

The challenges that brought ethical questions into transient focus for jail health providers relate to two realities I introduced in Chapter 1: the structural inequalities characterizing inmates' lives—and health—on the streets, and the constraints of the carceral environment. Jail's constitutive outside and its carceral structures infused how health care workers in the jail clinic carried out and reflected on their day to day work, which included judgments of deservingness. These dimensions to everyday ethics in the jail clinic index a form of care that necessarily had to incorporate the unique tensions and congruities between the realities of jail custody, clinical caregiving, and street life. This form of care

required clinic workers to cultivate ambiguity amid the apparent certainties which the carceral environment provided.

It would be easy to imagine that a biomedical clinic embedded within a jail would reproduce the normalizing, controlling processes which Foucault saw as the interdependence of regimes of discipline in the prison and of care in the clinic (see Sim 1990). Indeed, some of these carceral elements, as I will describe, seeped into jail clinical practice. Simultaneously, jail health providers also worked to distinguish their care in the clinic from the punitive practices of the deputies. As one nurse told me: "There is that dichotomy that still exists. . . . They [the deputies] think of them [the inmates] as being less of a deserving person in terms of that we [clinic staff] are really spoiling them [with medical care]."

This presumed dichotomy resonates with what some scholars have emphasized as the oppositional and seemingly incompatible goals of medical care and incarceration, to simultaneously heal and punish (Prout and Ross 1988; Anno 2001; Stoller 2003; Pont et al 2012). Such writings about "correctional health care" consistently emphasize how caregiving in this setting is fraught with constraints from the institution and with potential conflicts (Prout and Ross 1988; Anno 2001; Stoller 2003; Jorg et al 2012). Providers have to work within the limits of the schedule of the institution; the clinic has to control access to health resources like over-the-counter medications which creates high demand for medical attention and overburdens the system; following the rules and logics of the institution gives providers a "dual loyalty" problem between the patient and the prison (Pont et al 2012); professional medical standards are secondary to prison security administrative considerations and the minimum care necessary standard established by the *Estelle v. Gamble* case.

These issues were certainly relevant macro-level structural forces on the ground for Bridgetown jail health providers. They demand ethnographic interrogation to how these tensions are managed and nurtured in the unique forms of care which arises in the carceral setting. Such discussions of conflicting logics and Foucaultian discipline are detached from on-the-ground realities, and leave little room for

affect. Jail health workers were constantly confronted with the incoherence of the seemingly coherent domains of carcerality and biomedical care. They constantly tended to and fused the apparent oppositions, bringing discipline and care together in more ambiguous ways than what Foucault established. They did this through their expected daily clinical duties, through the work of defining the inmates as patients and not prisoners, through the medicalization of life in jail, and through the aspirations of equivalence between care in jail and care outside of jail. Care arose as clinic providers sorted through the inconsistencies they encountered in punitive discipline and compassionate caregiving.

The everyday contradictions jail clinic staff negotiated largely traced back to questions of whether these patients in a jail were morally deserving of care, or whether they were receiving excessive entitlements. Such attention to ambiguity in clinic workers' actions and relationships is itself the very essence of care, a kind of care that can grapple with inequality writ large. Ambiguity is not the same as vagueness, for ambiguity resides in tension, not the lack of clarity; it is about polyvalence, uncertainty, coexistence of contrasting interpretations (see Whitmarsh 2008). The ambiguity of jailcare specifically involves fundamental questions around the moral worthiness of prisoners receiving care—figures who, on the one hand, have ostensibly violated legal-social norms and may thus be seen as less deserving of services; and who, on the other hand, are marginalized by poverty, addiction, and racism and especially deserve care because of their structural vulnerability (Quezada et al 2011). I write "ostensibly" and "allegedly criminal" because at least half of the people in jail are pre-trial and have not been convicted of a crime for their arrests.

Scrutinizing the Assumptions of Care

Care is an elusive word. It is frequently invoked as a word to describe what health professionals do and provide, but its meaning is infrequently specified. Doctors and nurses use the word routinely: "I'm taking care of this patient." This lack of specificity when describing care is also true in the literature

on care across several disciplines. Most people subscribe to a definition of care that is broad, yet incorporates a range of assumptions of what care is and what care is not. In its most basic use, it may conjure compassion, intimacy, affective qualities of human connection. Care may signify services rendered, especially in biomedical institutions. It may also signal moral responsibility to others: children, family members, citizens, the recipients of humanitarian interventions.

Care cannot be distilled to a singular definition or practice, nor should it be. Neither should it be deployed casually, taking for granted that its ephemeral and practical qualities will speak for themselves. Care must be understood as "a problem in everyday life, rather than a category with defined borders" (Han 2012: 24). In describing the mundane intimacies of care in the jail, I expand on three particular dimensions: care as concern, as relationship, and as practice. The first two build on Heidegger's delineation of *sorge,* care that is existential to being in the world. This care entails concern, anxiety, and attentiveness, in which one's own existence is always oriented toward and entangled with another (Heidegger, 2010). Vivian perseverated on Kima's pregnancy health. She put Kima on the clinic list every day, she was anxious about her role in caring for Kima, and was concerned enough to enlist another provider in persuading Kima to receive services. Vivian's attentiveness was itself a form of care. In the jail clinic, care involved such constant attention not only to people, but to the certainties—such as health care refusals being oppositional— prescribed by the carceral institution, whether they were reinforcing, critiquing, or disregarding them; this attentiveness was constitutive of how staff tried to connect with patients.

Sorge is also about relationships. The existential qualities of care are premised on our shared vulnerability, that as humans we all have the potential to suffer and to die, albeit an unequally distributed potential shaped by structural forces (Quezada et al 2011). Judith Butler extends human vulnerability to "precariousness," since sustaining life is dependent on certain economic and social conditions (Butler 2009: 14). Such precariousness is what opens us up, in part, to governance and to

regimes of care such as humanitarianism which produce further political struggles (Ticktin 2011). It is what makes a total institution like the jail legally responsible for caring for its residents, "the state's carceral burden" (Dolovich 2009) to protect its charges from harm since they are stripped of their ability to protect themselves.

Beyond the institutional registers of vulnerability-rooted care, care is also deeply intersubjective: "precariousness implies living socially, that is, the fact that one's life is always in some sense in the hands of others" (Butler 2009: 14). The relations of care that ensue might be hierarchically organized, as with healer and patient who give care and receive care; but they are always interpersonal. Angela Garcia takes sociality at the heart of care one step further to acknowledge that we have unshared vulnerabilities which, by their very singularity, necessitate "remaining close to one another" (Garcia 2010: 68). Those who work in the jail and who are incarcerated in its walls remain close to each other in a myriad of ways. Vivian's desire to care for Kima arises from and creates anew affective ties—some of them filled with anger—between them.

Care, especially when attached to "medical care," is also a technical practice. For Foucault, techniques of care in the clinic are fundamentally disciplinary practices to normalize bodies, specifically into healthy bodies that can be more productive and ideal citizens. Care in this sense is an arrangement of power relationships.[2]

In contemporary biomedicine, the practice level of care usually corresponds to the aspiration that the practical acts of giving a medication or performing a surgery will cure an illness or alleviate suffering. These material aspects of giving care have become increasingly technological and, to some, have displaced the romanticized relational aspects of care (Kleinman and Hanna 2008). This displacement also indexes another distinction in conventional understandings of the professional domains of care. Historically, doctors have often been understood as emotionally distant technocrats, with nurses as the agents of tender caregiving to patients. While this simplified caring dichotomy is

perhaps more attenuated now, the professional identity of nurses as caring remains strong; in fact, Vivian, herself a nurse practitioner, bemoaned the laziness and detachment of some of the LVNs and RNs at the jail: "Whatever happened to the 'care' in nursing care?" she vented to me on several occasions.

Ann Marie Mol (2008) has argued for an understanding of the practice of care as a collaborative relationship between clinicians and patients who, together, navigate through the uncertainty of disease and treatments to resolve their disarray.[3] In contrast to this foundational chaos arising from illness and therapeutics, the jail clinic begins with the certainties of its surrounding jail architecture: regimentation of time and space, housing people who have been arrested for allegedly committing a crime and who have been convicted of a crime. Medical providers in the jail, I will discuss, do not resolve biomedicine's messiness in their practice; rather, they tap into this messiness. Care emerges through practice, through attentiveness, and through relationships precisely in the engagements with ambiguity.

Julie Livingston (2012) describes an oncology ward in Botswana as more than just a clinical space where suffering bodies are tended to. Rather, the cancer ward is part of the country's political narrative of participatory democracy and universal health care, for staff and patients seek out opportunities for equality in the care of cancer patients. These egalitarian notions are the larger stakes for the patients and practitioners in this clinical space imbued with these moral commitments, and get enacted in the daily intimacies of cancer care, what Livingston calls "moral intimacies of care." In the jail clinic, politics and moral sentiment are also instantiated in the quotidian rhythms of deciding who should be seen in clinic, who should receive a treatment; of wondering if a patient would tend to this outside of jail, if she is manipulating the clinic system. The moral framework here is an extension of what the triage nurses worked through in Chapter 1, health-related deservingness (Willen 2011), the kind of human that is registered to be worthy of care. This has played out in the courts, starting with *Estelle* and following from scores of lawsuits and, more recently, *Brown v. Plata*. In the daily routines of the jail clinic, the

moral sentiment of deservingness plays out the macro-level drama of the state's responsibility to care for its citizens.

Although I have highlighted three dimensions of care, I do not intend to identify it as a stable, locatable phenomenon. Nor do I wish to set the stage for a treasure hunt to find these aspects of care amid the presumed cruelty of the jail, a trite exercise. Concern, relationship, and practice are merely three organizing entry points into the ways that care is an ongoing, emergent phenomenon in the jail clinic. Scrutinizing the assumptions of care in the jail clinic means looking critically at nurses and clinicians and the circumstances which produce or preclude tenderness typically thought of as care; it means questioning the assumption that deputies are an obstacle. Often they are. And often it is the nurses who are the obstacles. As this chapter highlights, care, in its many contradictory contours, is ubiquitous in the jail.

Patient-prisoners

The space of the clinic in the jail offered the possibility of transforming, albeit temporarily, a prisoner into a patient. When patients entered the jail clinic, spatially distinct from their housing units, nurses, LVNs, doctors and NPs were ready to take temperatures, auscultate lungs, palpate masses, and ameliorate aches and pains. Behind the closed door of an exam room, the patient shed her orange pants and sweatshirt in exchange for a standard flimsy white paper patient gown, momentarily making the space of incarceration look and feel like a clinic in the outside world. There was no guard in the room, no barking of orders. The only routine was the biomedically familiar, the eliciting of a "history of present illness" and the physical examination.

This one level of clinical routine corresponded to the staff's frequent affirmations that they were there to treat patients, not inmates. This was an often repeated sentiment in casual conversations, in interviews, and especially when conflicts with deputies arose. Vivian had, several times, relayed with pride to me the story of her job interview:

> The last question I was asked was 'So, how do you feel about taking care of inmates?' And, I told him, 'Well, they're not inmates to me. They're patients to me. I'm here to provide medical care. I'm not here to police them, judge them, that's something that's left to the legal system. I'm going to provide care to them whether they've committed a petty theft or they committed murder. If they're a serial killer, my job is to provide medical care to them, and do it efficiently, and provide good care to them So, what[ever] their offense [was] that caused them to be incarcerated, that's not my concern. I'm not going to be naïve and think [otherwise], because I know I'm in jail because they're inmates and I'm *in jail*. But, they're patients to me. So, their *medical issues* are my concern. . . . And I tell the patients "you're a patient to me, you're not an inmate."

The need for jail-based health care professionals to reaffirm that the subject before them was a patient suggests that the reverse, that they could slip and treat their patients as inmates, was an ever-present possibility. For this reason, the inmates in clinical configurations are better understood as patient-prisoners.[4]

This looming threat of treating a patient as a prisoner arose from the simple inescapable reality of being in a place that houses people accused or convicted of committing crimes. So clinic staff spend time figuring out how to navigate the jail's punitive and custodial missions, which were seen as contrary to nursing and medical care: "Their [goal] is law enforcement [referring to the deputies], and they don't see that we have different principles we care about. We don't care what [the patients] are here for, and [the deputies] are just convinced that they are making our streets safer," a nurse commented to me while waiting for patients to be brought to clinic. The distinction between patient and prisoner, healing and custody, us (clinicians) and them (deputies) was formalized in orientation for new staff in the jail clinic. Practitioners[5] were conditioned not to ask why patients are in jail. This instruction served dual purposes of managing patient perceptions— so that patients did not think providers were judging them for their alleged crime or offering to assist their criminal case—as well as the clinical perceptions of the patient—so that clinicians did not view the patient before us as a murderer, and invoke moral judgment as to her deservingness of care.

At the same time, as clinic staff carried out their daily work, they were constantly sorting the people before them along a continuum between patient and prisoner subject positions. While patients

were waiting on the bench, nurses would not ask directly the reason someone was in jail, but they often made small talk which acknowledged patients' criminal status: "You back so soon? You just got out of here!" More pointedly, there were many ways that clinic workers would hear about the details of someone's arrest charges—from deputies, from the local paper's police blotter, or from the inmates themselves. Often, the criminal stories would become a fun, voyeuristic fascination, something nurses could fill their idle time with.

One day I watched the staff gather around a computer screen to read about the patient who was just seen in clinic, who was arrested for allegedly robbing *Jeopardy!* host Alex Trebec in a Bridgetown Hotel Room. After another patient disclosed, unabashedly, to staff from the waiting bench that she had stolen a $20,000 purse from Barney's, clinic staff searched the department store's website for an online photo of the bag. Michael Jackson's song "Man in the Mirror" gently timbered from the small radio at the nurses' work station, keeping the atmosphere light. In these moments, alleged criminal acts were sources of gossip and humor for the staff, a way to minimize—but not dismiss—the prisoner identity; this playful treatment of criminality allowed the clinic staff, in theory, to transform morally culpable criminals into patients who deserved the health care they were providing.

Although she never asked, Vivian often heard the arrest stories from patients who, over the thirteen years she had worked there (and the years the same women had cycled through the jail), had come to see Vivian as a confidante. Most of the criminal stories disclosed to Vivian contained complicated but predictable elements of drug addiction, sexual violence, low self-esteem, unemployment, and lack of social support. Vivian took a therapeutic stand in order to sort these self-declared criminals as patients, offering life lessons about making better choices that sometimes sounded like a mother disciplining her child into proper behavior. Other clinical exchanges could also temporarily disrupt the efforts to see someone as a patient and not a prisoner or criminal. For instance, I have known clinicians who, upon placing a speculum in a woman's vagina to test for STIs, have discovered an

unexpected finding: plastic baggies of drugs. At such an exceptional moment where criminality and health intersected, clinicians would quietly dispose of the stash, and treat the woman's vaginal infection with an antibiotic. Clinicians remained actively faithful to their mission to care for a patient, and actively rejected the opportunity to punish a prisoner.

There were times when inmates themselves played with this patient-prisoner continuum, reinforcing stereotypical prisoner identities while they were in clinic, such as by manipulating staff, stealing an item from clinic, or even referring to themselves as criminals. I once caught a patient of mine, Nina, stealing a dispenser of liquid antibacterial soap. When I noticed the soap was missing from the exam room after I had seen her for a clinic visit, I chased her down in the hallway and asked her to return the soap. She weakly denied the theft. Then I noticed a hint of threat growing in my demeanor, as I motioned with glaring eyes toward the deputies—a suggestion that I had the power to get Nina in trouble. She sheepishly pulled the elastic waistband on her orange pants, reached in, pulled out the soap and handed it to me. I chuckled at her concealment tactic, not knowing what to do with this item stored in a less than sterile place. The deputies were barely watching our interaction, but checked in "Everything ok, doc?" I looked Nina in the eye as I covered for her. "Yep, all set thanks."

Clinicians working in jails must navigate these territories of culpability, criminality, moral judgment and custody on a daily, moment-to-moment basis. I did not want to get involved in any formal disciplinary process or punishment of Nina, and yet I felt compelled to warn her, in sotto voce, "don't do this again." Moments like these challenged clinic staff to sort their own role in the system, to navigate their roles as patient advocate, disciplinarian, and sometimes both. Clinicians had to cultivate a heightened sense of equal amounts of skepticism and compassion toward their clients, which became particularly visible in exceptional moments like theft.

Filtering Manipulation

Such moments of medically-inflected criminality were not infrequent in the Bridgetown jail (and jails and prisons in general), such as when inmates were found to be hoarding narcotic pain medications that nurses dispensed, and selling them to other inmates. Dramatic attempts to escape jail were sometimes staged through clinical routines, like one time when patient-prisoner Connie tried to fake a miscarriage by smearing strawberry jam on a menstrual pad. She had hoped for a medical transport to the hospital, where she could then, the nurses told me, try to escape. These kinds of shenanigans got coded into the category of "manipulative." Prisoners, after all, were presumed criminals, had done something deceptive to end up in jail. It was easy for this assumption to seep into the clinic, sometimes bolstered by patient behavior.

Clinicians were subtly primed to suspect lying from the patient-prisoner. This was a perennial topic of discussion at national professional meetings and in textbooks on correctional health care. In Connie's case, like detectives, the nurses tested her pad for blood (it was negative) with the same reagent used to check for blood in someone's stool. The nurses even saved the jam-filled pad in a biohazard bag as evidence for me, since I would be seeing this patient the next day in clinic. It was moments like these which challenged jail clinic staff to see their patients as only patients, to wonder if their patients' symptoms were being fabricated for secondary, perhaps even criminal, gain.

The default presumption that "they're manipulative" was so pervasive in the jail clinical milieu, that it had a life cycle. Julie, the clinic clerk, told me that when new clinic staff would come to the jail, they naively believed anything a patient told them, fulfilling every request: "Even the inmates, they say, 'Oh, yeah. [That nurse] is new. I'm going to manipulate her. I've got me one.' They'll say it out loud! . . . That's all they know how to do." And then, Julie continued, the new person either learned to manage this element of work in the jail, or left the job.

Nurse practitioners and doctors also carried assumptions of manipulation but worked to resist this derogatory classification of patients as manipulative liars. Clinical screening became a kind of filtering process that enabled clinicians to decipher how to do morally-neutral, good medicine, even while anticipating the worst from patients. Clinicians sorted through countless examinations for knee pain, pelvic pain, back pain, and the concomitant pleas for pain medication—medication stronger than ibuprofen. In the non-jail setting, Megan Crowley-Matoka and Gala True (2012) have explored clinicians' subjective experiences of dealing with requests for painkillers from patients at veterans' hospitals. The metric to sort through pain pill requests used by many of the doctors they studied often relied on distinguishing medical necessity from pleasure-seeking. This calculus also existed for jail clinicians, and was often discussed at staff meetings. But it was secondary to the framework of honest versus manipulative intent of the patient, who was being seen in a jail, for allegedly transgressing legal norms. Criminality, despite clinic workers' morally-guided attempts to cordon off the caregiving space of the clinic as separate from the punitive space of the jail, always loomed. The intimacy that arose from moments of caregiver empathy were thus more pronounced precisely because they were achieved in a milieu where patient-prisoners were read, more generally, as criminals.

For the RNs and LVNs, who interfaced with patients more frequently than doctors and NPs, the concern for being manipulated was a routine part of care: does this person really need this or is she merely manipulating me? As one nurse told me, "You have to take everything into consideration like huh, because at times, a lot of them will manipulate a lot that you're like, 'Oh.' But you can't brush things off like that in the jails." This ubiquitous suspicion for fakery was something the nurses especially had to manage when the clinic walkie-talkie crackled with the emergency call from the deputies in the pods, "man down." [6] Seizures were the most common call for a man down, yet one nurse speculated that only 30% of the seizures were real. [7] "Here, they're going to go man-down. They do all of this to manipulate the system," often times to get pain medications, remarked an LVN matter-of-factly. But

some “man-down” calls were serious, like when the nurses did life-saving CPR until an ambulance came for an inmate having a heart attack. Clinic staff responded to the background of presumed manipulation—partly informed by patient behaviors and partly sustained by clinic staff’s meta-narrative about them— as part of the job. Maintain your suspicion— they are prisoners after all— but take everything seriously—they are patients with the potential for suffering.

Lorna Rhodes (2004) describes how prison workers are trained to presume that inmates in a maximum security prison are manipulative. The baseline of suspicion corresponds to how staff view the very personhood of their charges, and of the impossible task of discerning potentially non-existent truth from the inmates. In this inverted configuration where the inmate has power over the guard, empathy is an occupational hazard (Rhodes 2004: 184). In contrast, nurses and doctors are expected as part of their professionalism to develop empathy for their patients. Bridgetown jail clinic workers’ responses to patient-prisoners’ manipulations, then, were central to how they cared. When Nina stole the soap, I scolded her, trying to discipline her into a properly-behaved patient and prisoner. In the very same breath, I assured the deputies, who wield punitive power that “everything was fine” — a protectionist gesture of concern for my patient. Care is not simply that gesture, an apparent contrast to the punishment of a manipulative patient-prisoner. Care emerges precisely in these moments of ambiguity, when disciplinarity involves human connection, intimate concern, and suspicion in the same moment.

The figures before clinic staff were thus both patients and prisoners, or patient-prisoners. Clinic workers had to attend to the messiness of these two subject positions, without ever needing to settle on one. It was fundamental to how they enacted care in this setting. Patient and prisoner were not fixed identities, nor were they spatially dependent on where a person was in the jail, in the clinic or the housing units. Rather, both identities were unstable possibilities along a continuum which jail medical staff were constantly sifting through as they calibrated their job duties and orient their affective registers of care toward the figure in front of them.

Looming behind this patient-prisoner continuum is the question of deservingness of care. What kind of care does someone who hides narcotics in her cheek, who fakes a miscarriage, or who feigns back pain deserve? Clinic staff both resisted and incorporated this criminal suspicion of their patients as they strived to be just caregivers, and to simply do their job.

Equivalence of Care

The tensions of the patient-prisoner continuum index a spatial framing of the world inside a carceral institution—where prisoners live—and the world outside—where patients are not presumed to have committed a criminal offense. This relationship between inside jail and its constitutive outside is not a neat separation, a clean spatial break, for inmates' lives—and their health—outside of jail are constant referents while inside. This dynamic gets played out in the field of correctional health care in discussions of "equivalence" in health care services between the community and the facility; contestations over equivalence are moral ones (Fassin 2010), and work through an individual's health related deservingness inside with respect to their health and health systems outside. Quoting the ACA from the pre-*Estelle v. Gamble* days, the NCCHC's widely used book Correctional Health Care: Guidelines for the Management of an Adequate Delivery System states: "Medical care for prisoners must be equivalent in quality to the care which is available in the community" (ACA 1966: 436, in Anno 2001: 20); the NCCHC's published book of Standards for Health Services in Jails (2008) grapples with this equivalence in 200 pages of detail.

Regardless of providers' own beliefs about the comparative quality and quantity of services inside and outside jail, it was nonetheless an inevitable dynamic that Bridgetown jail health care providers contemplated as part of their "everyday ethics." Equivalence was reckoned both in terms of individuals' degree of self-care and in terms of access to health care systems. Vivian expressed frustration with the lack of equivalence between the high quality care women access inside jail, and their lack of health attentiveness outside of jail:

> We get them healthy, we get them a nice little plan, and now we get you an IUD [intrauterine contraceptive device]. You can come to any of the [community] clinics and continue their care [outside]. And then they leave and they forget about it all. "I have CIN3 on my pap [pre-cancerous changes of the cervix] and I need to get a biopsy." And they forget it all [when they get out]. And then we make an appointment all over again and the appointment is April 28 and they get out April 27. Then they come back [to jail] and we start it all over.

Clinic workers critiqued patient-prisoners for not continuing on the outside the health improvements that were begun on the inside. Structural barriers and assumptions about patient-prisoners' street lives thus got collapsed into a moral judgment that they did not know how to take care of themselves. The lingering, usually unspoken follow-up questions to such narratives of clinical futility, which were common among jail health providers, were "If they don't take care of themselves outside, should we . . .?" "Do they deserve. . . ?" And yet clinic workers did. Sometimes staff did such tasks as a matter of routine, and sometimes the acts were infused with compassion for how hard people's lives were outside of jail. Frequently, recognition of the marginality of patient-prisoners' lives outside of jail led clinic providers to want to exceed what they received outside of jail, to get their health improved in ways they did not our could not in the community—the opportunistic potential of jail to ameliorate health. Here again is the ambiguity which constitutes the very texture of care.

In other scenarios, the inside-outside equivalence dynamic was compared to an ideal of community standards. This was true when Vivian, a jail medical services administrator, and I petitioned the Bridgetown DPH to start routinely covering prenatal genetic screening tests for pregnant women who opted for this service; previously, each request required approval from a special DPH committee which could cause a delay in obtaining this time-sensitive test. To make the case, we emphasized the community standard of prenatal care and national guidelines. The proposal was approved. Here, the equivalence dynamic was to make care in jail comparable to the community standard, even though many patients might not access the health care system outside of jail.

The Clinic Routine: Contradictions as Care

The daily rhythms of the jail clinic were organized by routine; clinics in the community are too, with opening hours, a schedule of patients, and usually a lunch break. But the routine in the jail clinic was much more involved, for it took form through the regimentation of its host, the jail. In Foucault's rendering of the clinic as a site of disciplinarity, this routinization is paradigmatic of caring relationships that are rooted in configurations of power. This intense bureaucratic structuring of a clinic is also, on the surface at least, a departure from the compassion and empathy which we expect to characterize the caregiving of a clinical space (Hanna and Kleinman 2008). But we cannot take bureaucratic routines at face value as sites of emotional detachment, for as Rhodes has aptly argued, to take too seriously the "administrative schemes for the prison [would miss] the extent and implications of slippage away from them" (Rhodes 2001: 70). Moreover, the bureaucratic organization of the clinical routine creates gaps and possibilities for creative enactments of care.

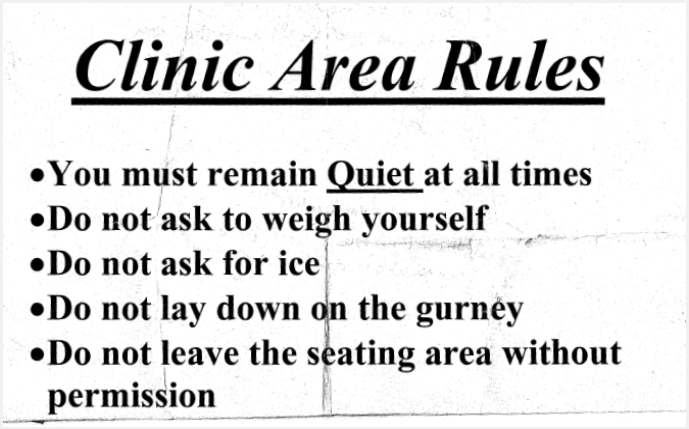
A closer look at the routine in the Bridgetown jail clinic reveals that the rote rhythms and tasks were punctuated by what Livingston (2012) has called "the moral intimacies of care." That is, the interactions around caregiving among nurses, LVNs, doctors, NPs, deputies, and patient-prisoners work through the personal and intimate stakes of living and being for these people: in terms of desire for recognition, easing the discomforts of daily living, professionalism, sociality, and the shoulds and shouldn'ts of worthy distribution of resources. The seemingly impersonal, disciplinary dimensions of care and the compassionate intimacy of care become mutually constitutive. As discussed in Chapter 1, intimacy is cultivated through attachment and shared experience; the chronicity of recidivism and the potential for health care services to contrast the punitive actions of the jail nurture these possibilities for intimacy between jail inmates and health care providers. To further understand how this moral intimacy of care emerges as ambiguity in a carceral environment, I will describe an aggregate of a 24 hour time period from the perspective of the clinical world of the jail.

First, a brief orientation to the material aspects of the jail clinic. The clinic area was in a separate wing of CJ2, located on the second floor in the south end of the building; thus clinic and jail staff called the area "2 south." To get from the housing unit pods to the clinic, one had to exit through the sliding metal door of the pod, walk to an elevator at the end of a long hall lined with old institutional gray carpet, get out on the second floor, and walk through another hallway. Inmates then had to walk through a metal detector, and then they were in the holding area. Staff who passed this way to the clinic either walked around the metal detector or walked through it and set it off; it was not intended for staff surveillance. In the holding area, there were 3 dank cells for containing groups of inmates as they waited to be sent to clinic or court. With a hard wooden bench, a single toilet shielded only by a 3 foot high cement wall, and stark cold air, the holding cells were uncomfortable places to be for longer than a few minutes. The team of deputies assigned to guard the holding area and who moved inmates from the pods to the holding area were called "movement deputies." Depending on the security level of the inmates or on the deputies' moods, they sometimes left the glass doors of the holding cells ajar, sometimes they locked them.

The holding area led to a wide hallway, at the end of which was the main clinic area. Along this hallway was the entrance to the dental clinic, where a dentist and hygienist saw patients for basic dental care several days a week. Anyone walking down that hallway could peer into the clear glass walls and watch as an inmate had a tooth extracted. The hallway then opened into a large open area brightly lit with fluorescent bulbs: the clinic. A wooden bench and a few plastic chairs lined the walls at the entry to the clinic area; there were health education brochures for patients on a variety of topics. The focal point was the nurses' work area, which was bordered by a long, elevated, counter-like desk which they sat behind as they completed certain tasks. There was also a parallel long desk against the wall, creating an aisle in between the two counters, space for personnel to sit, stand, or pass through as a thoroughfare. The area was brimming with binders of protocols and shift schedules, medical reference

books, stray papers from patients' paper medical records, a fax machine, stacks of blank forms (some of which were mimeographed copies of forms that had not been used in over 10 years). To the right of the nurses' area, there was a copy machine and a large metal file cabinet that contained, among other things, paper prenatal charts for the pregnant women—in the same format as the prenatal charts used at Bridgetown DPH community clinics.

The white walls had dulled with time. In a few places, flyers were stuck to the walls with tape, many of them mundane announcements from the department of public health. Near the patient waiting area, prescriptive flyers reminded patients that they were still in a jail: "Remain seated until called. Getting up, being loud, or being verbally abusive will result in disciplinary action." Adjacent to the "rules of the clinic" flyer (see photo) was another notice, in English, Spanish, and Cantonese, informing patients that they have the right to medical care.



Sign posted in clinic waiting area

Along the periphery of this central, open area of the clinic, there were 7 doors. One door was to a locked medication room, where narcotic pain medications were stored and tracked. Another door opened to a large "treatment room," where there was a stretcher, a ceiling-mounted exam light, an EKG machine, equipment to take X-rays, and cabinets full of various medical supplies. There was a lab room

behind another door, where nurses drew blood from patients for various screening and diagnostic tests. These specimens were then brought by courier to the Bridgetown County Hospital lab once a day. The bathroom for patients in the clinic was the only bathroom they used in the entire jail which had a full door for privacy, as opposed to a concrete block or a bathroom stall door. The remaining three doors were to examination rooms where doctors and NPs evaluated patients in private, alone. These rooms were well stocked with adjustable exam tables, a microscope (most commonly used to examine women's vaginal discharge for signs of infection), and many other supplies.

I spend this time describing the lay-out of the clinic in part to set the scene, but also to establish that, aside from a few regulatory flyers, the clinic in some ways looked and felt like any other. It was spatially, administratively, and financially (since it was a branch of the health department, not the Sheriff's Department) separate from the rest of the jail apparatus. This separateness should not be taken too literally, as some scholars have (Prout and Ross 1988; Stoller 2003), as the symbolic distinction between the goals of incarceration and the goals of medical care. Rather, the maintenance of the distinction between the clinic and the rest of the jail, and the moments when that distinction falls away, these are the moments of ambiguity in which providers work through their "everyday ethics" (Brodwin 2013) to craft a form of care that works in this particular setting and with these particular patients. I now turn to the routine of the clinic to explore the rhythm of this ambiguity.

6:30am: Quiet

The day shift arrived to relieve the night nurses at 6 in the morning. Julie, the unit clerk, and Katie, a nurse, sat at the nurse's station desk. There was an empty quiet in the air, which would soon be filled with the noise of patients and deputies, clinical services and conflicts. But for now, they enjoyed the calm. Julie alternated between checking Facebook, organizing papers, and just sitting. Katie also sat in front of a computer. She stared at the turquoise screen, the ubiquitous glow of the jail's electronic medical record system, CHART. Katie typed in her responses to Medical Care Request (MCR) forms that

inmates had submitted, and read internal emails from her supervisor about scheduling. Becky, the LVN who would be coordinating clinic that day briefly reviewed the "Sick Call" list which the night nurse had typed, based on the rolling list of patients waiting to be seen. The names were grouped on the list by housing units into categories of: "Clinic," "Ob/Gyn", 'High Risk," "Treatment," "Lab." Then Becky started to get ready for "noon" pill call, still four hours away, by printing out the list of patients who were to receive medications, ice, or warm compresses.

There were lists everywhere. The "alpha list" enumerating every person incarcerated at all of the Bridgetown jails that day. The list of County Hospital appointments for the day. The "high risk" list of diabetic patients and pregnant women. Pill call lists. Sick call list. Max, the charge nurse for the day, assembled copies of these lists and deposited them in the morning muster room where the deputies would soon be gathering to receive their work assignments for the day.

After muster, the movement deputies for the day arrived at the holding area. Deputy Gibson started to organize the tasks for moving inmates from the pods to clinic, by neatly highlighting some of the names on the sick call list, color-coded to those who would potentially not get seen today: "NIC" (not in custody), "Ct" (court), "Ad seg" (administrative segregation), and "Ref" (refused). Although he could see the clinic desk down the hall, Deputy Gibson picked up the phone and called Becky. In a momentary but daily reverse of the expected authority in a jail, where deputies dictated most of the logistical decisions, Becky told him it was now OK to bring patients from the pods to the clinics, the clinic staff were ready for them. Other times, the movement deputies might tell the clinic staff that no inmates could be moved in the jail right now: if deputies were on lunch break and there were not enough escorts, clinicians and patients would have to wait. A patient who was on administrative segregation, a higher level of security, had to be escorted to clinic with her own guard, and no other patients around. Every patient from one housing unit group had to be finished in clinic and escorted

back before another housing group would be brought down. These institutional constraints meant that clinicians sometimes sat idle, waiting to see patients for even as long as two hours.[8]

That control which deputies had over clinic flow was a major factor clinic staff cited as "an obstacle" to caregiving, and one of the constraints widely acknowledged in the correctional health literature (Anno 2001). Bridgetown jail clinicians became accustomed to this limitation by choosing carefully when to accept the movement deputies' constraints, and when a patient's medical condition was serious enough to insist on immediacy. Caregiving was thus layered with negotiating lists, deputies' authority, and categories of prisoners. Navigating these regimented structures in which the clinic existed produced clinical routines which sutured the practical tasks of caregiving to custody routines.

8:30am: Action and Waiting

The 6:30am quiet was gone. The waiting area and clinic desk bustled. To the right of the clinic desk, seven or eight patients, all from B-pod, sat on a wooden bench mounted to the wall, or on two plastic chairs. Becky wrapped a blood pressure cuff around a woman's arm and stuck a thermometer under her tongue, mostly watching the machine for the numbers and not the patient's face. Becky scribbled the vital signs on a scrap of white paper, and then taped it, face down, to the plastic bin next to Vivian's exam room door.

This haphazard scrap, an artifact of bureaucratic clinical protocol, signaled to Vivian that her patient was ready to be seen. Vivian stood in the arch of the door, and called out the name scrawled on the paper, extracting the woman from the undifferentiated noise of the waiting area. Vivian and this patient knew each other from multiple prior incarcerations, and there was a familiarity as Vivian smiled, greeted her and said "come on in." Inside her exam room, so many of the patients had come to trust her with the most intimate details of their lives.

Meanwhile, LVN Mariella called other patients into the lab room to have blood drawn for a workup: HIV and hepatitis tests; cholesterol levels; prenatal tests; and anything else the doctors and NPs

might have ordered. As women waited to be called and as nurses and LVNs completed their tasks, numerous conversations ensued.

The clinic was an intensely social space. Patients talked with each other—about the food in jail, about pop culture, about people they know in common, about their case and when they might get out. Julie, the clerk, had a small radio next to the computer she sat in front of, and on this day it was playing smooth R&B music. A patient heard it as she exited the exam room and started dancing to the slow beat. "This is one of my favorite songs!" she exclaimed. Julie barely looked up, but met her smile as the woman swayed her way down the clinic hallway. "This is the closest we get to the outside, here in the clinic. Yeah. You ladies have a blessed day. Don't work too hard," she said to the lot of us sitting behind the clinic desk. With this casual reflection, this inmate summarized the clinic workers' efforts to create a space that was separate from the punitive, disciplinary structure of the jail world, a space that was "closest to the outside" world—filled with music and familiarity instead of deliberate deprivation. The routines of the clinic, and even the clinic's mere existence as part of the jail routine, allowed for this intimacy.

Another patient-prisoner, Quiana, was on her way to give a urine sample for a pregnancy test before she saw Vivian, a routine procedure for all patients in clinic for an Ob/Gyn related visit. Quiana sauntered up to the counter to talk to Julie, behind it at her usual perch. I listened to Quiana say, "Guess what Julie, they're going to drop my charges! I mean, I still have probation, but they're going to drop these charges." Julie smiled, with friendly, casual interest. "Oh really? That's good." Julie knew Quiana well, since she had been cycling through this jail every few months for over a decade. I too knew Quiana, as a patient from a year ago, and from seeing her in the hallway a few weeks ago. Her hair was now fuchsia colored. I assumed that she had found a way to dye her hair in jail, but when I asked her, she corrected me, noting that she did it outside of jail. Julie pointed out, with Quiana still part of the conversation, that she had been out of jail and then back in already.

Quiana then recognized me and declared, in full volume to all in the waiting area, “You took out my IUD! Or put it in. I can’t remember.” Julie responded as though she was talking with a girlfriend over coffee: “Girl, why don’t you still have that IUD?” Quiana admitted that “I didn’t like the bleeding. I took it out!” Julie lightly chastised her for her impatience: “What’s wrong with you girl?! That is all psychological. You can deal with that.” At that moment, LVN Becky who was trying to keep clinic flowing, looked at Quiana and the empty urine cup in her hand, and gestured her head toward the bathroom. Quiana took the hint and said farewell to me and Julie, so she could dutifully pee in a cup.

This level of familiarity and intimacy between jail patients and clinic staff was pervasive. As in Chapter 1’s description of triage, this intimacy was partially facilitated by recidivism, the routine way jail was part of the rhythm of many of these women’s lives; as we shall see in subsequent chapters, the familiarity was not limited to the clinical space, but it was notable nonetheless. Moreover, it was by no means present between all staff and all inmates at all times, but this tone of conversation and even personal content between Julie and Quiana was exceedingly common. It animated the routine space of the clinic waiting area, or while an LVN was drawing blood or taking vital signs.

This personal intimacy infusing the relationships of care in the jail clinic should not be taken to signal equality. Of course, there was still an element of authority in these relationships. Common sense customs of health care professionalism meant that staff were much less likely to disclose personal information about themselves, though that too happened on occasion. Quiana would not ask Julie “girl, what’s wrong with you?” Or if she did, it would be considered inappropriate. Nonetheless, this implicit hierarchy did not negate the personal intimacy. In fact, the medical authority relation was part of the intimacy, even enabled such a connection with someone who was incarcerated.

These moments of familiarity are not exceptional in the jail clinic. But in a clinic outside of jail, this familiarity, as though talking with a friend, would be unusual. In the jail, repeat and frequent visits are marked by a different type of familiarity than clinic staff-patient relationships in the outside world.

One reason for this difference is that, in jail, the chronicity of recidivism creates a space for intimacy in care-giving routines that surpasses that of non-jail clinics. Quiana, like so many of the other patients in the clinic, had been in the Bridgetown jail 40 times in the last decade, staying a few days or up to a few months. She had given birth more than once while incarcerated at this jail. Other women were part of inter-generational cycles of incarceration, so clinic staff know knew, cousins, mothers and daughters. Of course Julie, Vivian, Mariella and other staff were familiar to Quiana, and vice-versa. Jail was a chronic part of Quiana's life.

In some cases, these loose personal affiliations of the jail clinic may have even been informed by connections outside of jail. Kima's aunt, for instance, used to braid Vivian's hair, a contentious connection for Kima's expectations of Vivian. Moreover, Vivian, Julie, and Mariella were all black women who acknowledged that they grew up in the same neighborhood as some of the inmates; in a few cases, they may have even gone to school with them.[9] This point of common history was rarely discussed, but when it was, it took on several sentiments. For some staff, it signaled that although clinic staff may have come from similar backgrounds as their incarcerated patients, they did not end up destitute and criminal. There may have been pity, as I have heard from Vivian, for the circumstances like absent, drug-addicted parents which then led many of these women to their current jail-cycling, drug-addicted, absent parenting lives. Vivian incorporated this awareness of a common narrative for these women into her approach to caregiving:

> So they never had an adult figure or a parent. And they say "I've never had anybody who listened to me. I never had anyone who cared. So for you just to listen to me." And you can see their faces, I approach them and respect them because I'm treated that way when I go to see any of my doctors. And they'll say "Hi Vivian," or Miss Carter, or they'll hug me because I'm a hugger. . . . Shake my hand when they meet me. You have to earn respect. The way you earn respect on the streets is you curse someone out or you fight 'em. So I'm not using profanity. So they learn some socialization, just in the little time that they see us.

Despite her empathy for her patients' early childhood experiences, Vivian also disparaged them, to me and to the patients themselves, for making bad choices. "It's always people, places, and things, I tell

them," her way of talking to patients about breaking bad habits. "There are people here now I grew up with who made different decisions." This combination of relief, empathy, and individual responsibility were representative of the ambiguity clinic staff cultivated in how they approached care for their enjailed patients.

Another reason intimacy was amplified differently in the jail clinic than an outside clinic pertains to the more frequent opportunities clinic staff have to interface with patients than in the community. Some of these opportunities were initiated by patients (in the form of MCRs) and others by the clinic (for screenings, follow-up visits). When in jail, women came to clinic for a variety of things they would not otherwise go to a health facility for, such as headaches, rashes, minor scrapes or other things they might ignore or would be able to self-remedy by going to a drug store. They also came to clinic to tend to more serious issues, such as HIV care, hypertension, STI screenings, prenatal care, contraception and more, issues which many patients *only* addressed—as patients and providers alike acknowledged—in jail.

In jail, convenience and free cost circumvented structural barriers that are often articulated as the major contributor to why marginalized, uninsured populations do not access health care in the community. For instance, Evelyn, the pregnant woman I presented in the introduction, desired jail time in order to get prenatal care: she turned herself in. This phenomenon is a blatant example of jail, with its free and ubiquitous medical care, filling in the holes of the safety net, an "opportunity" for care which is not lost on public health advocates (see, among many, Glaser and Greifinger 1993).

The gaps in receiving health care in the community and in jail were not only a matter of differential access, geographic and financial, at least according to clinic staff. Providers noted that patient-prisoners' perceptions of health, health care, and embodiment seemed to change from the community to jail. Their entire frame of everyday life had been reorganized from the streets, where medical care may just not be a priority for them. But when in jail, their relationship to health care could

be different. For instance, nurses going through the daily stacks of MCRs would sometimes complain about how frequently the inmates requested health care services. A common interpretation of this which clinic staff told me was that there were few activities filling inmates' time in jail (although the Bridgetown jail actually did have many scheduled activities for women on most days). So coming to clinic was something to do, a way to break up the monotony.

Moreover, in the community, more than half of these women used drugs on a regular basis. In jail, they were sober.[10] Jail clinicians spoke with me about their interpretation of the effect that these relative states of street intoxication and jail sobriety had on women's perceptions of their bodies. They offered an interpretation similar to Drew Leder's (1990) about the phenomenological dynamic between the experience of the body's presence and absence. The body often recedes from its own conscious perception, usually when it is functioning unproblematically. At times of dysfunction, such as pain or a broken limb, we then notice the body as present; it is present through the absence of an ordinary state. Leder's dynamic of embodiment is what jail clinicians were articulating when they surmised that, when sober in jail, women were more aware of certain embodied sensations that they did not notice outside; women's perceptions of new things , clinicians further speculated, then led them to seek medical attention for the presence of embodied symptoms which seemed to these women a departure from their ordinary non-jail state. Jail and substances like drugs and alcohol mediated embodied urges to access care, or so clinicians thought.

One example on which Vivian frequently remarked was the most common chief complaint of women coming to the clinic: vaginal discharge. This was in contrast to community clinics, where discharge may be one reason some women come to a women's health clinic, but is not the predominant reason. Every day, Vivian saw women who complained about discharge. Sometimes she diagnosed them with STIs. Sometimes the discharge was a non-sexually transmitted vaginal infection, like bacterial vaginosis, whose high incidence in this population may be related to storing drugs in their vagina.[11] And

frequently, the discharge was just normal, physiologic secretions. Whichever the etiology, Vivian ascertained that most of these women were too high to notice such bodily sensations on the streets.

The jail clinic thus filled in health care where the forces of the streets— whether structural or phenomenological— created holes. This was true not only because of the broader context of differential access to care inside jail where it was guaranteed versus outside of jail where women like Quiana were marginalized by non-inclusive health care systems. It was also true because there was an intensity of managing lives and health in jail, organized by protocols and necessitating constant human interaction. The intimacy of caregiving exceeded that of the normal outside clinic, enabling even minor hygiene to become medicalized and thus part of the care and disciplinary apparatus of the jail system.

The regular and routine testing helped configure this management: tuberculosis skin tests (called a PPD) for all people arriving in jail; vital signs every few hours for new arrestees withdrawing from alcohol or heroin; blood sugar checks for inmates with diabetes; administering individual pills which patients would normally take on their own at home. Moreover, by virtue of the jail's fundamental deprivation of liberty and of independent access to resources, the clinic stepped in to provide—or deny—things which these women could obtain in the community without any health professional's assistance: an ice pack or a warm compress to soothe a wound; foot powder for itchy feet; bed rest; Vaseline for dry skin; a peanut butter-free diet for someone with an allergy; Tylenol for a simple headache. Then again, many women did not buy Tylenol or foot powder at the drugstore when out of jail. Some could not afford it, or instead spend their money on vials of crack. And for others, tending to their bodies with salves and health care systems was not a priority, as clinic providers frequently complained. Jail and the accoutrements which the clinic provided offered a temporary reconfiguration of what aspects of women's bodily experience were at the forefront.

10:30am- Peddling Pills

A warm smell of food wafted through the air. A nurse had zapped a Lean Cuisine frozen lasagna in the microwave of the staff break room, and the aroma travelled to the clinic area. Although 10:30am seemed early for lunch, when your shift starts at 6am, hunger sets in earlier than noon. I wondered how this smell affected the patients sitting on the bench in the clinic waiting area; they were missing their 10am lunch of bologna sandwiches in the pod. There were 5 women waiting to see a clinician. Some of them looked bored. Since there were no appointment times in jail, just a group of women escorted to clinic en masse, each woman had to wait her successive—and surprisingly arbitrary—turn. Some might be on that bench for 2 hours. The idleness which was built into the management of time in jail, and the presumption that prisoners must endure it, existed in the clinic, too.

One woman asked Julie "how much longer do I have to wait?", not hiding her accusatory annoyance that she was tired of waiting. "What else do you have to do?" Julie retorted with sarcasm. Another asked Becky "Can I have some water?" Someone got up from the bench and walked to the scale to weigh herself, while another woman jumped up to peek her head into NP Andrew's open exam room, to ask him to refill her Benadryl.

Becky tried to stay on course with her tasks and documentation, but the patients' requests from the waiting bench were diverting her attention. Sometimes staff responded to these moments by ignoring them, sometimes by interrupting what they were doing to fulfill a patient's wish or to answer a question, and sometimes by exasperatedly telling them no. These low-level irritants of movement from the bench, requests and complaints were finally too much for Julie one day. With a roll of her eyes, she declared "These people get on my nerves!" And then the kind Julie who had so casually chatted with Quiana disappeared. "You people need to sit down and be quiet! This is not a playground!" she ordered. Julie turned to me, shaking her head, and told me what I have heard her say numerous times: "It is not my job to regulate these inmates!"

Ironically, when I later asked Julie what her role was in the jail clinic, she summarized it as "keeping order in the clinic." Julie indeed took on a regulatory role in the clinic, through threats of punishment and by enforcing behavioral norms. As she explained in more detail in an interview:

> They would just like jump up and run into the clinic, you know? You know, run into the clinician's room. And I have to tell them. And then they want to go back and forth, back and forth, and I'm like, "okay, I have power in this pen. If anybody gets up and goes in that room again, I'm going to write you up." I had just got to the point where I'm done talking; I'm going to start writing each and every one who gets up when they're not called, I'm going to write you up, and I'm not playing. You have to be very firm. And it's kind of like you almost have to talk to them like they're children. You know what I mean? And they don't like that because they consider themselves as adults. My thing is you consider yourself as an adult. Act like an adult. Sit down, behave like an adult and no one would have to—I shouldn't even have to say anything to you. You don't like the way I'm talking to you, but I shouldn't have to say anything to you because you are an adult. You should know how to conduct yourself as an adult.

She saw her orders as a justified response to what she identified as rudeness from their unruly behavior. Julie's infantilizing admonitions came from someone with power over these patient-prisoners, in a pre-determined relationship where the prisoner is always the object of governance. And yet, she still listened to Quiana. The continual presence of disciplinary power did not preclude the possibilities for humor and intimacy that Quiana and Julie engaged in. In a clinical space which grapples with the figure of the patient as someone worthy of compassion and of the prisoner as someone worthy of punishment, intimacy and discipline coexist.

While Julie was "keeping order," Becky was putting the final touches on her pill call cart. Four times a day, every day, an LVN or nurse pushes a medication cart through each housing unit to deliver medications: everything from over the counter pills like Tylenol to controlled substances like methadone, and other accoutrements of healing, such as an ice pack or a warm compress. It was a ritualized process, which each nurse adapted to her own style: from the printing and exchanging of lists to the electronic charting of medications dispensed and everything in between. Pill call had a routine and was an integral part of the daily routine of the entire jail; pill call was a mobile extension of the clinic into the housing units.

Suddenly, I was startled by a loud hammering sound from the medication room. Becky was using a hammer to pulverize Vicodin and Percocet, still in their plastic blister packs, into a powder. Once in the pods for pill call, Becky will empty opioid powder into a cup of water when the designated recipient is standing before the pill cart, dissolving the powder to ensure that the prisoner-patient cannot store the narcotic in her cheek to use for other purposes, also known as "cheeking." Becky taped every prescribed medication, in its packet, to the paper pill call list, next to the name of the intended recipient. She filled a few plastic pitchers with water, stacked Dixie cups and small white paper baskets (the kind you might put condiments in at a fast food restaurant), and loaded a few small plastic biohazard bags with ice. She was ready, she just needed permission from the pod deputy that now was a good time to come. A quick phone call to B-pod, and permission was granted.

Becky expertly maneuvered the cart, which was nearly chest high, through a series of locked doors and an elevator. The heavy door to B-pod magically whirled open—someone at the far away central the command panopticon could see us, via video camera, standing in front of the door. The pod deputy had already called out the women on the pill call list, and they were dutifully lined up along the upstairs railing, the deputy standing by.

Pill call was the essence of directly observed therapy (DOT), a classic biopolitical technique popularized in the treatment of tuberculosis in the 1940s (Bayer and Wilkonson 1995).[12] With infectious diseases, DOT aims to put microbes and patients into biomedical submission by enforcing consistent medication use; it regulates individual behavior for the benefit of the vitality of the population. In the jail, pill call's DOT was a naturalized function of incorporating biomedicine into institutional life. Pill call solved a practical problem of distribution of pharmaceuticals to many inmates, for it was much more efficient to send one nurse with a cart to patients in their pods, rather than sending many patients to one nurse in the clinic. It also reflected the intensity of managing lives in the jail, for it was not only pharmaceuticals which were dispensed, but warm compresses, ice packs, Vaseline and other personal

remedies that become medicalized in an institution of deprivation. One of the most notable aspects of pill call was just how many people received narcotic medication—crushed and dissolved in water, of course.

People came to clinic complaining of all kinds of aches and pains. Some took prescribed opiates in the community, others did not, some bought them on the streets. Some of the pain narratives evoked the uncomfortable living conditions in jail—the hard metal bed frame and thin foam mattress which caused back pain. Patients cited that they received pain medicine last time they were in jail; some cried as they described their physical pain. Clinicians were taught to take pain seriously, that on a national scale it is undertreated. And yet jail clinicians also knew that some of the patient-prisoners were performing in order to extract opiates for pleasure, for trade, or just to make the time in jail pass a little more easily. Or that opiates were not the best remedy for their particular pain. Triaging complaints of pain and distributing carefully pulverized pills were recurring, daily activities in the jail clinic.

The work was never done, the issue was never resolved. For as soon as a clinician resolved to order, increase or deny opiates, another patient appeared, another MCR was submitted to double the dosage. Many clinic staff identified pain medication management as the most difficult issue they were faced with, in part because of its frequency and in part because of its challenges to their sense of professional duty and moral judgment of patients. Managing patients' subjective reports of pain was more than a Sisyphean task for jail clinicians. It was a process of managing their own ambivalence over the incomplete and ineffective medicalization of pain, and of not wanting to get duped by patients who, medically, did not "need" opioids (Crowley-Matoka and True 2012). Their dilemma also stemmed from the common knowledge that many people were addicted to these drugs in the community—which may have related to their criminal charges and was likely tied up in a complex history of social trauma. Clinicians did not want to be complicit with these trajectories, but they did also did not want to under-treat "real" pain.

Thus, on pill call, these contested interactions of pain management were represented in long lists of recipients and pulverized pills. Becky parked her cart in front of the line of inmates in B-pod who were ready for their pills. The protocol dictated that she check the wrist ID band of every woman in line, and then administer the medication or ice pack according to her list. In practice, every LVN performed pill call with his or her own modifications. Some LVNs knew these women's names and faces so well that they did not bother confirming identity; others asked the patient-prisoner to state her name; and more rarely, usually with a new LVN, they checked every ID band.[13]

After a woman swallowed a medication at pill call, she knew to turn away from the nurse and toward the deputy. She would then open her mouth wide, lift her tongue, and prove that she was not hiding anything—although people found ways to conceal even with an open mouth. Some women turned this into a childish performance, sticking their tongues out in contempt like they might at a playground. In this adaptation of pill inspection, performing women remained docile in their prisoner duty while mocking the presumptions of distrust which were ascribed to them.

While pill call was rife with regimentation, it was also an intensely interpersonal exchange. Pleasantries of "Hi, how you doin'?" were exchanged. There was joking, like when an LVN greeted a patient by calling her "klepto," because she was caught stealing stray soy sauce packets from the nurse's lunch in clinic a few months ago. The patient smiled at this inside joke. Some nurses passed the pills with a "feel better," or a smile, inserting an affective dimension to the rote ritual.

In a non-incarcerated clinical setting, the nurse's smile would be unremarkable. But in jail, it was notable. The sympathetic smile which accompanied her rule-governed pill pushing unsettled any apparent division between a nurse's compassion and penal discipline. This is precisely the nature of care that emerges in this charged environment. Even in its affective, intimate dimensions where a nurse delivers a pill with a tender smile, care is always premised on an authority relation. Indeed, this

hierarchical foundation of care then creates possibilities for affective connection being a transgressive element of care.

Other nurses did not even look patients in the eye on pill call, burying their heads in the pill-taped list. Bureaucratic ritual provided a crutch for avoiding the intersubjective nature of nursing care, despite pill call creating face to face interactions. It was a strategy for avoiding the onslaught of complaints from patient-prisoners, for pill call was an opportunity for them to voice their medical concerns to an agent of the jail health apparatus. "I was supposed to get my pain medication increased, why am I only getting one?" "Why am I not on the pill call list?" "I have this discharge and it itches real bad." "I put in a slip for medical 3 days ago, when am I going to be seen?" Most of these questions were ones the LVNs and RNs were unable to answer on the spot, for they often stemmed from actions taken (or not) by the doctors or NPs, not the nurses. But to the patient-prisoners, the pill call brigade was the front line of the medical establishment of the jail. Inmates held pill call nurses accountable for all of the clinic staff and systems. The nurses may have responded with a "I'll look into it," or by looping them back into the bureaucratic circle, "put in another slip for medical."

Depending on the individual nurse involved, the "I don't knows" may have been delivered with an affect of apology, of distraction, or of annoyance. There may not have even been a verbal response to someone's plea, just a glance at the list and the scribbling of a reminder note. This silence was a tactic some nurses had developed, to keep their cool amid the barrage of requests. But their quiet and facial expressions could be perceived as rude by patient-prisoners, who at times while in the pill call line have hurled insults to the nurses about their incompetence. LVN Becky explained how she coped: "Under my breath I'm like, you know, like I'll say something back, just to keep myself sane."

As pill call's DOT suggests, disciplinarity in the jail clinic milieu took several forms. It drifted between the infantilizing punitive regimes of incarceration, of which Julie's waiting area admonitions were representative, and the medicalized, microtechniques of care: directly observing medication

swallowing, being diagnosed in the clinic, and asking to be diagnosed. These moments all worked to discipline the women as patient-prisoners. But these moments were also the very same ones which invited intimacy and compassion.

Pill call was a ritual of care. It was a technical practice and an opportunity for sociality. Patient-prisoners sought recognition as bodies in need of pharmaceuticals or medical evaluation, acknowledging their vulnerabilities and their dependence on these gatekeeper nurses. From the gentle smile to an annoyed shrug of the shoulders on pill call, the nurses and LVNs cultivated ambiguity precisely as a form of recognition.

12pm: The Tedium of CHART

Deputies were cycling through their lunch breaks, so there was not enough staff to coordinate the movement of inmates to and from clinic. This gave the clinicians, nurses, and LVNs a chance to document all that they had done with patients this morning. LVNs charted their pill call activities—who received medications or an ice pack and who "refused." Nurses narrated their responses to MCRs, a process I will describe in more detail in the next chapter. Clinicians wrote their progress notes about patient visits; typed their review of hospital visits or requests for medication renewals; and ordered medications, laboratory tests, wound care, or referrals to the county hospital. All of these moments were recorded in CHART. The CHART system also allowed jail medical staff and administrators to communicate with each other through an internal email system—about patients, about work schedules, about incidents that arose with co-workers or patients.

With its turquoise background, all capital letter typing, and lack of computer mouse compatibility, it appeared as a relic from 1980s DOS-style programs. In fact, it was introduced to the Bridgetown jail in 1996 as a response to a court order to have better continuity of care when inmates were transferred from one Bridgetown jail to another. CHART was much more than a repository of electronic medical information. It was an ongoing professional task, a medically narrated representation

of a person's times in jail, and the instrumental arbiter of who was prescribed pills or ice or a visit to clinic; every pill given at pill call, every MCR submitted, every visit with a clinician, every blood pressure checked, these were all logged in CHART. Information about a patient could be sorted and viewed categorically, such as all clinic visits with a doctor, "stacking" bits of knowledge in ways that made the information strategically useful for subsequent action (Aas 2005: 85-86).

Because every patient's intake medical evaluation in the booking jail was charted, one could view how many times a person had been admitted to jail. Eighteen CHART entries fit on one screen view, so the number of screens to toggle through reflected the volume of interactions a person had with jail medical staff over time. Notes from jail psychiatric services were often direct quotes of the patient-prisoner's emotional state and response to being in jail. Entries from other staff may also have included direct quotes of colorful patient language, in-their-own-words descriptions of symptoms, complaints about or refusals of medical care. These quotes served in part to justify a medical provider's actions (or inaction), creating evidence should accusations of inadequate care arise.

The ubiquity of CHART as part of medical caregiving in the jail cannot be overemphasized. Clinicians and nurses spent many hours of their days sitting in front of the turquoise screen of CHART, tapping on the keyboard. While it may seem an obvious sign of how technology has depersonalized medicine, an act of neoliberal efficiency, CHART is a dynamic interface through which scripts about patients are narrated. The difficult patient, the pain-medication seeking patient, the psychotic patient, the irresponsible patient who does not follow-up outside of jail, the "needy" patient with a multitude of minor complaints, the noteworthy first time or occasional entry into jail, these figures got codified in official documentation. These "stacks" of CHART knowledge, as Rhodes suggests about prison computer systems, could depict patient-prisoners as "carriers of needs and dangers, each with its own institutional response" (Rhodes 2007: 555). Subsequent providers could then read others' CHART interpretations of patients and calibrate how they framed an encounter with a patient. CHART enabled this kind of

"institutional memory" which was only partly about the past, for it also projected future action (Linde 1999).

For instance, before I saw Connie as a patient, the woman who tried to fake a miscarriage with strawberry jam, I read the night nurses' account of the events, already including at that point their diagnostic suspicion. Despite the caregiving imperative to listen to the patient, CHART predisposed me to distrust Connie, even the ostensibly objective findings of pelvic tenderness I found on her physical examination. Tenderness in a woman with an early pregnancy can be a sign of a pregnancy in the fallopian tubes, a potentially life threatening condition. But to take the possibility of this diagnosis seriously would require transporting this woman to the county hospital, a logistical and bureaucratic hassle for all.

I had to sort through these realities made possible by the double disciplinary space of a clinic in a jail, where the figure before me was a patient and a prisoner. Was she an unhealthy patient, constituted by abnormal signs on physical examination? Or was she a manipulative prisoner, creatively feigning pathology as the CHART description scripted her to be doing? Each of these figures corresponded to different degrees of health related deservingness. When I spoke with the patient in front of me and asked her about the strawberry jam, she nonchalantly admitted to the shenanigans. There was no formal punishment for her medically-based fakery. Little was at stake for her in admitting the truth the nurses had already discovered. What was at stake for me in weighing the CHART script of manipulation (and the patient's own corroboration of this script) and the physical examination signs was either looking foolish for unnecessarily transporting a patient to the hospital, or missing a dangerous diagnosis if I dismissed her physical signs.

Ultimately, fear of missing a serious condition tipped the balance, and I had Connie transported to the hospital—an action which I had to initiate in CHART, choosing option "M" under the category "disposition": transfer to emergency room. But this was not a clear resolution of opposing narratives,

the malingering prisoner or the pathological patient. For I remained begrudging in my actions, and felt foolish for deciding to send a scripted manipulator" to the hospital. It was this unsettling of any clear boundaries between diagnosing disease or manipulation, even in the acts of medical decision-making in the jail, which is central to the caregiving in this enjailed space. CHART was a critical mediator of these engagements with ambiguity.

3:20pm- Afternoon Clinic

The morning shift of nurses had been replaced by the afternoon shift, except those who were working a double. "PM clinic" was the daily afternoon clinic session when patients came down for routine checks that did not require a doctor or nurse practitioner. Although it was the clinicians or established written protocol which determined the surveillance or treatments, it was the nurses and LVNs who carried out the tasks in PM clinic: blood sugar checks for diabetic patients, placing PPDs for new arrivals in jail to screen for tuberculosis, blood pressure monitoring, dressing changes for wounds, lab draws, vaccinations, weight checks, to name a few. These orchestrations could only begin once the deputies had changed shift at 3 o'clock, and once the afternoon "count time" of inmates in CJ2 was complete.

The atmosphere was decidedly more relaxed than the morning clinic. In the morning, nurses scurried about getting patients ready for the clinicians, and serve as an intermediary between clinicians and the deputies who control the flow of patients to clinic. The doctors and NPs were generally not around—gone for the day or busy entering information and ordering medications in CHART from the morning group of sick call patients.

In PM clinic, patients, nurses, and deputies chatted even more casually in the waiting area than in the morning. Unlike morning clinic when the deputies stayed in front of the holding cells, the PM deputy escorts would hang around in the clinic, as they were always supposed to do, in order to make sure the inmates behaved in clinic. They all joked about nothing in particular. The nurses made small talk

with the patients, asking “You back again?”; or talking about food—“You gotta try the barbeque from T-Dubs when you get out! It is sooo good.” Laughter, bored silence, and, on occasion, yelling cycled through the soundtrack of PM clinic. Regardless of the content, there was a routine familiarity in the air.

Angela was in PM clinic for her daily dressing change. The left side of her face was raw and seeping, a few sutures from the emergency room holding the skin back together. She and LVN Mariella walked back into the treatment room, where Angela then reclined on a stretcher. As Mariella peeled off the old gauze, Angela told us the story of the high-speed car chase with the police which sent her face through the glass windshield, and which got her arrested. She was lucky her injuries were relatively minor, we all remarked in various permutations. Angela winced as Mariella gently cleaned the wound and applied antibiotic ointment. Mariella shook her head with sympathy for how painful these abrasions must be. She also made the assessment that her dressing should be changed three times a day, but she could not make changes to the wound care routine without a clinician’s order in CHART. She vowed to schedule Angela for a “chart review,” so one of the NPs could enter this order.

This moment of classic nursing care, the intimacy of a dressing change, gave Angela a reprieve from the daily grind of the jail routine. Her wound also evoked concern from the pod deputy later that evening. The deputy was concerned that the environment of B-pod was not healthy for a gaping wound, given all of the people fresh off the streets who arrive in B-pod. So the deputy called the night nurse and made an appeal for Angela to be transferred to C-pod, the infirmary pod where there were nurses present 24/7. The night nurse rejected the suggestion, protecting the bed space in C-pod for potentially sicker patients. The nurse retorted to the advocating deputy that Angela was already “medically cleared” at the county hospital, and she did not need any higher level care. Nurse and deputy switched their expected roles as patient advocate and rule enforcer. Varying and conflicting registers of concern for Angela as a patient and an inmate coalesced on her abraded cheek.

Another woman on the clinic bench got called back to the lab room to get blood drawn for an HIV test, and to give a urine sample for a pregnancy test she has requested. While she was waiting, the supervising deputy hovered by the bench, fidgeting with a set of handcuffs that made a rhythmic ratcheting sound. He was trying to banter with her, with nosiness and insults: "Are you pregnant?" "You just a dopefiend." The woman responded "Hey, that's not nice. That's not good for someone's self-esteem." The deputy gave her a look that said "Can't you take a joke?" His position of authority made him feel entitled to joke with her, in the form of harassment, and to pry into her medical history. She revealed herself not as a hardened prisoner resisting authority and not as a silent subject; she showed herself as a vulnerable human whose feelings could be hurt. There was intimacy in her admission of vulnerability, even in the midst of a disciplinary relationship with the deputy.

So when the LVN beckoned the patient to the lab room, she begged to stay there even after her blood had been drawn, while the pregnancy test was running for 4 minutes. In that time, the LVN tried to soothe her, as she tightened a tourniquet around the patient's arm. The LVN tenderly soothed the patient's wounded emotions, a moment made possible in part by the chronicity of jail in the patient's life and in part by the hurtfulness of the deputy's harassment. The woman then talked about her last few weeks on the streets since her previous incarceration, about her children not in her custody, and about her hopes to get her life together this time. More than four minutes had passed. She was not pregnant. Here in the clinic's lab room, under the burden of prescribed biomedical diagnostic practices, one finds intimacy emerging between the LVN and patient.

4:00pm: Down Time

The patients were gone, the clinicians were gone, and the RNs and LVNs sat in front of computers at the long clinic desk. They were charting the tasks from PM clinic, reading and sending emails in CHART, fielding phone calls, surfing the internet, and talking amongst each other—about some of the patients, about their families, about frustrations with the schedule or with their boss. Sometimes

there was a quiet tension in the air, strife over a co-worker's laziness, not following protocol, or calling in sick and making everyone work that much harder. Whatever unfolded during these unscheduled times, it marked the clinic space as an intensely social world.

Once dinner time in the pods was over at 4:30, the pod deputy called clinic and told the staff they could come for pill call. The LVNs rolled their prepared carts in the familiar routine. Mariella finished distributing pills to the line in general population of B-pod—those "free" enough to stand in a line. Then the deputy escorted her to each "ad seg" cell where the patients on higher level security resided in a cramped room behind a locked door. Mariella passed the pills and a cup of water through a small trap door-like window in the glass door. The patient-prisoner showed her mouth, and handed the empty cup back. One of the ad seg rooms had a large clear garbage bag filled to the brim with Cheetos, popcorn, M&Ms and more junk food. Today was commissary day, when people buy food with money from their accounts. When Mariella saw this full bag, she joked with the patient-prisoner, "Looks like you bought the whole commissary!" Guarding deputy, patient, and LVN all laughed together.

6pm: Night Shift

The scheduled tasks of the day were almost complete—only one more round of pill call before bedtime, around 8:30pm. The overnight crew of two RNs and an LVN arrived, overlapping for a few hours with the 2p-11p shift nurses. The night team was there to respond to any urgent overnight needs for all of the pods. A "man-down" emergency or a phone call from a pod deputy, these moments would break up the monotony of the twelve-hour graveyard shift. Such moments were also filled with the diffident anticipation of gravity: was it an emergency or not? The night nurses in particular were charged with a high level of independence of clinical judgment, since there was no clinician on site to arbitrate triage for the skeleton crew. Although a doctor could always be reached by pager for a middle of the night consultation, just like in the hospital, the night shift nurses in the jail were isolated from a full-fledged medical apparatus.

As midnight marked the halfway point of the shift, the nurses readied the lists for the next day's sick call and transports to the county hospital for specialist appointments. After their 4am wake-up call and breakfast, patient-prisoners with hospital appointments would be called out and escorted from the pods to a Sheriff's Department vehicle. Nearly every day, someone refused to be transported—not wanting to give up getting back into bed for a few hours, not understanding why they were going, being humiliated to be seen in public in orange clothes and chains, or having a court date that may have hopes of getting them released. Whatever the reason, the night nurses had to manage these refusals of specialty care. This was routine for the nurses. It was also routine for them to sigh in moral reflection. "They take this for granted. Do they know how long it would take *me* to get an appointment like this?" Such pauses were laced with subtle judgments of these patient-prisoners as ungrateful, as not caring about their health. These "everyday ethics" (Brodwin 2013) reflections connect to larger questions about inmates' health-related deservingness while in jail, the terrain of ambiguity which could never be completely resolved.

Morning pill call at 4:30am was the same routine as the others, except that patients were bleary-eyed and less talkative. Several missed their morning pills because they wanted to stay in bed. Later, when the nurse documented her pill call activities for each patient in CHART, she would enter that those who stayed in bed refused their medications. The morning crew arrived, and it was time for another day of care to begin.

Care in the Routine

Describing the jail clinic through an extended, temporally demarcated structure offers several insights. One is that the jail and, by association, its clinic organize their duties to punish and to heal by marking time. It is a predictable illustration of the lived experience of Foucault's observation that disciplinary power regulates individual bodies by managing relations of time. But to limit the interpretation to a predictable example of regulatory, governing power inside a clinic inside jail would

miss how humans actually manage the constraints and tensions imposed by the intersecting regimes of medicine and carcerality. Instead, what the routine of the jail clinic opens up is the possibility of intimate caregiving arising from bureaucratic routine.

A second insight gained from this descriptive structure emphasizes how care, in its multiple forms, is enabled precisely by this temporal regime and the very structures of carcerality. It is not that caring relations are ontologically prior to discipline, that their grounding in mutual human vulnerability precedes the power arrangements superimposed on humans. Rather, *care emerges within and in response to discipline*. It may not always take the romanticized, compassionate form of a doctor or nurse holding a patient's hand amid grave physical and emotional suffering. Importantly, it is a willingness to sift through the ambiguity of a mandate to tend to the needs of women who, by virtue of being in jail, are categorized as socially deviant, and who may tend towards certain behaviors that reinforce that characterization.

At every level of the jail clinic's routine, health care providers were confronted with the morally ambiguous question of worthiness—did inmates deserve this HIV screening test? Did they deserve to be in jail? Was it fair that the health care services inmates received in jail was more extensive than what many people sought in the community? As one nurse asked rhetorically, "How you going to think you deserve this, but you done killed somebody?" The clinic in the jail had to confront both the facts that their patients were arrested for committing a crime and that tremendous health inequalities existed outside of jail. Ambiguity flourished within these conflicting questions of who deserved medical care and how much.

Clinic staff sometimes suppressed these undercurrents of deservingness by perceiving their routine and their patients like any other clinic, like any other patient; or they may have enlivened the ambiguity with shoulder shrugs as they dispensed a pill, with casual critical conversation amongst themselves. These small gestures within the routines of medical care became important opportunities

to negotiate the ambiguities. A shrug, a tender smile, a side comment, a joke, these became ways that clinic staff diffused tensions they felt in deciphering patients' worthiness of care. These same unsettled ambivalences enabled clinic workers to care for patients in ways that exceed the punitive dimensions of the carceral milieu.

Much of the negotiation over the moral status of the patient and the moral position of the caregiver was made possible by the very biomedical reductionisms that have, in the past, been a source of criticism among social scientists. The reliance of biomedicine on diagnostic technologies is critiqued by those who lament its displacement of the intimate exchange of caregiving relationships (Kleinman and Hanna 2008).

The jail clinic set up a counterpoint to this. It was rife with elements of bureaucracy and technical diagnostics that might be seen as departures from this romanticized human connection found in caregiving. Goffman identified a similar, broader tension in total institutions where there is "constant conflict between humane standards on the one hand and institutional efficiency on the other" (Goffman 2007: 78). Instead, what I hope the routine at the Bridgetown jail clinic has shown is that rote technical practices and the human intimacy of caregiving are not divergent. They are mutually enabling. They allow an ethos of compassionate care not to contradict an ethos of punitive discipline, but rather to form within it.

Cultivating Ambiguity

Understanding the jail clinic is not a matter of naming care when we see it, a surprise gesture of kindness amid a typically cruel place. Instead, it is about seeing relationships, affects, gestures, and routine procedures in their often contradictory forms. These everyday human engagements in the jail clinic wrestle more broadly with what it means to care for another person. Being open to seeing intimacy and human connection in rote bureaucratic acts or in the constant sorting through the

ambiguity of subject positions and places enables possibilities of care even within larger systems which sustain hierarchy and inequality.

As this description of the temporal routine and bureaucratic practices of the Bridgetown jail clinic has revealed, the affective dimensions of caregiving are not inconsistent with the punitive and regimented aspects of discipline. Rather, intimate care arises from and within disciplinary routines. Angela Garcia develops an expansive view of care as being with another even amid incommensurable experience, "in which the parameters of the clinic and of the patient are not so easily defined. Perhaps *we* are the patient, and the clinic—intended as a space for healing—is all around us" (Garcia 2010: 68). Similarly, perhaps the ethos of the jail clinic that is embedded within and arises from an oppressive system of mass incarceration marks the care that is all around us.

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[1] Court-ordered intrusions into pregnant women's ability to make autonomous decisions occur not infrequently in the US. Physician and legal scholar Julie Cantor (2012) has written about the exceptionalism which the desire to protect the fetus interjects into scenarios of patient-refused care which otherwise would remain at the bedside and would not invite legal arbitration.

[2] Foucault even commented on the figure of the prison doctor as the ideal agent of creating transformation in the prisoner (Foucault 1977: 270). The doctor, in the intimacy of the medical exam, can gain the trust of prisoners better than any other staff, and therefore wield great influence over the prisoner's transformation.

[3] This logic of care is opposed to the logic of choice which involves rationally sorting through uncertainties by making informed, consumer-oriented decisions. In the case of Vivian's care of Kima, Vivian deems Kima's "choice" to refuse prenatal care—a choice partially based on Kima's dissatisfaction with Vivian and with the jail-- an unhealthy choice. But the care Vivian then proceeds with is not a collaborative sorting through a range of uncertainties about prenatal care. It instead begins with the certainty that because Kima is pregnant, she should receive prenatal care, and because she is in jail, there might be space to mandate prenatal care.

[4] Angela Garcia (2010) uses the concept of "patient-prisoner" in her work on addiction and loss in rural New Mexico. For Garcia, the patient-prisoner is the subject that gets produced by juridical, medical, and carceral regimes which govern the drug addict through the dual logics of recovery and punishment. This patient-prisoner also exists in the Bridgetown jail. But the patient-prisoner I discuss here, from the perspective of medical providers in the jail, is a figure enmeshed in relationships of care, where the attention to the continuities and contradictions of the patient and the prisoner are part of what care means. Just as jail is an interstitial space, so is this continuum between patient and prisoner.

[5] Throughout, I refer to clinicians, nurses, jail clinic staff, clinic workers, practitioners and providers in the third person. Importantly, I am also one of these clinicians. For clarity, I continue to use the third person, but am aware of my position in this milieu.

[6] The emergency clarion call was called "man down," even in the women's jail.

[7] Seizures are recognized as a challenging diagnosis in correctional settings in general. The NCCHC has sessions at its annual meetings which help guide clinicians through the real and the fake. Inmates may have a higher risk of true seizures, because of prior head injuries, which up to 60% of prisoners have experienced (Shiroma et al 2010); prior abuse and violence may manifest as physical symptoms while incarcerated. But at the same time, seizures with their dramatic physical display, can be easy things to perform.

[8] Making people wait is a well-known power of custody routines in general in prisons and jails. Visitors, for instance, must wait at entry gates to enter. Custody staff might be checking visitors' security clearance, but they also can extend this process to take as long as they want it. This power to control time in prison and jail is specific to custody staff. The idleness Bridgetown jail health staff might feel has similarities with the idleness some inmates feel over the way their time is controlled and emptied.

[9] These kinds of community overlaps would be less common in a prison setting, compared to a jail. In prison, inmates come from all over the state, and the workers are usually local. In jail, both inmates and workers are local. It depends—not all prisoners are relocated from the city, some are from the same rural towns as the staff. The general point is probably true though.

[10] Although illicit substances were hard to come by in the Bridgetown jail, they most certainly were used. Smuggled in by visitors, by hiding drugs in one's vagina. People found ways to disrupt the sobriety of jail.

[11] Bacterial vaginosis is an infection caused by a disruption in the normal bacterial flora that colonize a woman's vagina. Douching and inserting objects into one's vagina can cause such an imbalance, leading to symptomatic infection. Vivian and I diagnose a large number of women in the Bridgetown jail with bacterial vaginosis. That many of these women stored drug stashes in their vagina was likely no coincidence.

[12] Direct administration of pharmaceuticals has also long been used in the psychiatric setting, where nurses directly administered psychotropic medications to inpatients in mental institutions.

[13] This time-consuming part of the protocol may also be used as a subtle weapon against the deputies, as LVN Rakeema did one day. There was a dispute on a previous shift between a deputy and another LVN over not giving a patient her pill call medications three hours late (she was in court and missed pill call distribution of an ibuprofen, which she would be getting anyway at the next pill call). The tension spilled over to the afternoon shift as the deputy standing next to Rakeema made rude comments about her colleague. Rakeema erupted into an angry tirade, defending her colleague and protocol. When she resumed pill call, Rakeema reverted to checking every woman's ID band, just to annoy the deputy who had to stay with her the entire time.

CHAPTER 3
Documents and the Intimacy of Bureaucracy

"To critique bureaucratic processes for the way they assert agency over us, and for the limitations they place on our own creativity and agency, would miss the very means by which bureaucratic processes compel others' creativity in the first place."

-Annelise Riles, Documents

Scraps and Half Sheets

Clinical care at the Bridgetown jail relied heavily on bureaucratic practices. The incessant documentation in CHART, the following of guidelines and protocols, the circulation of various half sheet, carbon copy pieces of paper to request and deny medical care, these were routine and integral parts of medical care in the jail. In the clinic, to notify a clinician that her next patient was ready to be seen, the nurse would scribble the patient's name and vital signs on a carefully torn scrap of paper and tape it to the exam room door.

Paper, carbon paper, electronic records—that these hallmarks of bureaucracy were interwoven with the tasks of medical care in the jail clinic should not be surprising. Documenting the clinical record has become important to the biomedical project of knowing and representing the patient in certain, formulaic ways (Holmes and Ponte 2011). Moreover, prisons and jails are classic state institutions and, as such, operate through the rational techniques of bureaucracy which Weber (2006) identified as central to the state's power. In the prison setting, Katja Franko Aas (2005) has explored how the increasing use of guidelines and computer technology in the contemporary penal system allows people to construe prisoners as disjointed bits of information, making them targets for new forms of technologically-justified punishment.

Typically, bureaucracy is related to indifference, as it supplies the "moral alibi for inaction" (Herzfeld, 1992: 33). Hannah Arendt (1976) saw the mundane, repetitive nature of bureaucracy as fundamental to the state's potential for violence, for bureaucracy's focus on tasks and not humans could lead to detachment and to appreciating the individual as superfluous; the individual could then be destroyed without any concern. Likewise, bureaucracy and technology, Zygmunt Bauman (1989) argues, create physical distance in social relationships and therefore generate indifference to those others from whom one is distanced. Anthropologists have examined the "social production of indifference" through processes which decontextualize suffering into sterile bureaucratic tasks (Scheper-Hughes 1992). What these perspectives on the state and bureaucracy share is that bureaucracy's rational technologies of control are technologies of power which remove affect from certain types of human interaction.

In contrast, in the Bridgetown jail clinic, bureaucratic artifacts are better understood through the rich social networks which these practices cultivate (Riles 2001), and through the meaning people invest in documents (Das 2004; Gordillo 2006). I follow Rhodes' (2004; 2007) extensive explorations of bureaucratic routines in a maximum security prison as sites where fundamental questions of human rationality and relationality are worked through. This is not to say detachment and disregard were categorically absent from the rote bureaucracy of the Bridgetown jail clinic. Rather, the paper-pushing and rule-following of the jail clinical apparatus were active terrain for emotionally invested caregiving relationships. Here, I take seriously Begoña Aretxaga's assertion that rational technologies of control are "practices of legibility [that] are not detached but invested with affect" (2003: 204).

In this chapter I examine three forms which were in constant circulation in the jail clinic milieu: medical care request forms (MCRs), refusal forms, and "chronos" (special privilege forms). Converging on these forms are themes of triaging the interface between the violence of the streets and the harshness of jail from Chapter 1, as well as the ongoing, unresolved uncertainties between care and carcerality from Chapter 2. Through these forms, health care providers and patient-prisoners

continually cultivated ambiguity in caregiving as they negotiated the unclear, morally-inflected terms of deservingness of health care. Bureaucratic tasks were substrates for such intimate engagements of care.

Magic of Paper

While CJ1 was the first point of contact of soon-to-be inmates with the jail medical apparatus, as described in Chapter 1, the logic and practices of triage were by no means limited to this bustling intake space. In fact, triage was ubiquitous in the everyday routines of the entire jail. This was true both at the practical level of identifying acute medical needs as they arose and at the moral level of negotiating what care people deserved while in jail. Such negotiation was routinized in the form inmates filled out in order to access clinical care, what inmates and workers facilely referred to as "MCRs." These 5 inch by 8 and ½ inch sized pieces of paper were such an integral part of daily jail and clinic life that, when I first asked what MCR stood for, many people could not tell me. The MCR template included space for the date, a person's name, date of birth, housing location, what kind of service they requested, and lines for explanation. Two lines at the bottom of the form were for nurses to complete their decision on "action taken" and to whom the patient was referred. The form reminded patients that "You will be triaged or seen within 24 hours," and that "if you need to be referred to an MD/NP you will be seen within 10 days."

It would be hard to underemphasize the importance of MCRs in the daily life of the Bridgetown jail. A stack of them lived at the guard tower in the housing units so that inmates could fill out as many MCRs as often as they desired in order to communicate symptoms or other requests to clinic staff. If a woman was illiterate, then other inmates would help her by filling out the form. Nurses then collected MCRs four times a day when they came to the pods for pill call. The MCR then circulated back to the clinic, to the hands of the designated "MCR/assessment" nurse for the day. This person was tasked with sorting through these MCRs and then making house calls in the pods (what I call a "pod call") to assess

the urgency of a complaint someone communicated on the form. From July, 2011 to June, 2012, 3,929 patients at all of the Bridgetown jails submitted 22,529 MCRs.[1] In CJ2, this could mean 20-50 MCRs a day that a nurse would have to triage.

Every nurse had her own system for dealing with MCRs. The standard elements included reading the amassed forms one or more times a day, looking up medical information about the requestor in CHART to put the MCR in context, and deciding what to do: make a "pod call;" send a message via CHART to a clinician asking to refill a patient's medication; consult with a clinician about an intervention; schedule a patient for a clinic appointment; or deem that no further evaluation is necessary. In theory, the assessment nurse was supposed to see every person who submitted an MCR. In practice, the decision to see was at the discretion of the individual nurse.

Whatever their determination, the nurses had to document their reasoning and decision in CHART. They also had to hand-write the basic information of each MCR—patient name, date, complaint, response, and nurse initials—in a black binder log book. If a patient was not satisfied with the MCR decision, if a response took longer than she deemed appropriate, or if the nurses communicated nothing about their decision, then it was common for a patient to submit another MCR with the same request. Nurses knew that CHART's transparency left their MCR management open to surveillance from their boss, the nurse manager. No one wanted to be called into his office to be reprimanded, but the threat was always there.

On the surface, MCRs seemed like a classic paper trail of bureaucracy: audit culture (Strathern 2000) at its finest in one of the most classically regimented spaces, a carceral institution. It would be easy to read MCRs as an expected technology of modern medical and carceral apparatuses. Indeed, there were elements of this in how MCRs made patients legible to the clinic staff in certain ways; for example, a person who submitted multiple MCRs a day was viewed by the nurses as needy, insatiable, and a nuisance. Bureaucratic crafting of health care access is not unique to a jail, for things like health

insurance company rules and overbooked schedules in the non-jail world of health care mediate people's ability to receive medical care. But what is different here is that the conditions of carcerality simultaneously restrict access to care—a patient could not simply walk into a clinic to see a doctor—and enable access—by virtue of the MCR triage system, interacting with the nurse was available at the scribe of a pen.

MRCs were thus imbued with what Michael Taussig (1997) calls "the magic of the state." As he elaborates, power structures and regulatory forces we have come to associate with the state are made meaningful not simply through laws and institutions, but as people invest sacredness into things that would otherwise be without value —the policeman's badge, for instance (Taussig 1993: 243), a passport, or a mailbox. On such fetishized objects the fantastical, excess qualities of the state are performed in people's everyday lives. People come to desire the magic of the state, even in its mundane, bureaucratic formations. For as Aretxaga adds, "[rational technologies of control] are animated by a substrate of fantasy scenes that betray complicated kinds of intimacy, sensualities, and bodily operations" (2003: 403). Similarly, MCRs circulated through the jail with this kind of magical quality, where inmates and clinic staff endowed the forms with a spectacular amount of value. Inmates' fantasies of recognition and care were enacted through these forms, which then generated a basis for social ties between caregivers and incarcerated patients; through MCRs, nurses then connected to broader moral concerns of adjudicating what kind of care a medical care requestor deserved. MCRs were a nexus of the desire to be cared for and the desire of the state, with its carceral burden to care (Dolovich 2009).

Seeking Recognition

The content of MCRs from the Bridgetown jail reveals a rich and diverse array of concerns that women wanted to communicate to medical staff. I reviewed MCRs from a one month time period, which revealed patterns in the types of requests made. Some MCRs indicated specific symptoms such

as heavy periods, headache, vaginal discharge, or a stuffy nose. Other MCRs requested ameliorations to daily life in jail which happened to fall under the clinic's purview. Most of the MCRs included a directive or anticipated outcome, such as seeing a doctor or nurse practitioner, or having a medication prescribed. In addition to the individually specific symptoms, there were several consistent patterns of issues raised in MCRs: pain symptoms or pain medications; constipation; dental issues; Benadryl (typically prescribed for allergies and itching, but also known medically and by women in the Bridgetown jail for its mildly sedating properties); psychiatric help; routine health check-up; Boost nutritional shakes; changes to medication delivery logistics, such as time of day, refill, "self-carry" instead of distributed at pill call, prescribe medications that someone takes outside of jail; placement on a special diet, such as vegetarian or peanut allergy; creams for dried skin, dandruff, and itchy feet; change in housing placement; asking to be weighed in clinic; vaginal discharge or STD check; and more generically stated requests just to see a clinician.

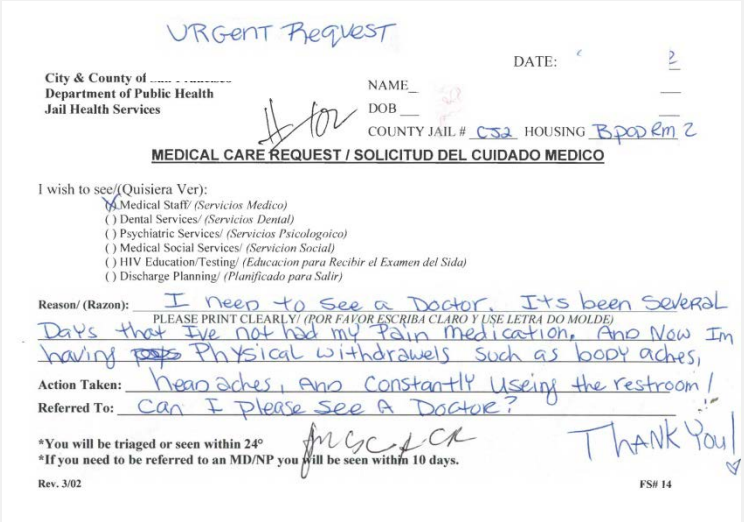
The minutiae and breadth of requests to the clinical apparatus revealed the medicalization of daily life in the jail. Inmates knew the extent to which clinic staff controlled access to certain resources, and they tapped into this through MCRs. What is immediately apparent is that MCRs were vital means of seeking recognition of experiences of bodily and psychic life in jail. Whereas the intake triage in CJ1 responded to the effects of life on the streets, the everyday triage of MCRs responded more directly to the carceral environment, the discomforts of daily living which medically-prescribed salves could potentially soothe.

A closer look at the actual words used in some of these requests further reveals that MCRs played a role in the moral economy of triaging people's deservingness of care. Many MCRs were crafted as letters to health care providers, with pleas and detailed explanations which served, so the inmates hoped, to buttress their request for medical attention. Here are some examples, with original capitalization, spelling, and punctuation included:

> Att: Adrian [worker from Jail Psychiatric Services]. Can you plese [*sic*] come see me ASAP. I really need to talk to you. I feel like I am going crazy!
>
> ATTENTION MEDICAL EMERGENCY 911. Need to see Vivian [women's health nurse practitioner] because my monthly is irregular and she told to put the slip and I'm bleeding realy heavey. [*sic*]
>
> Urgent Please. I would like to know if you can up my meds to a higher does and also could you please house me by self because I am tired of smelling ASS ALL DAY and all night and it is getting to the point where I am getting sick to my stomach
>
> URGENT!! Attn: NP Please evaluate me for stronger pain meds for my lower back pain. I am in a lot of pain most of the time and Motrin is not strong enough. Thank you for your consideration.
>
> Can you please refill my ibuprofen. I really do need it. Can you please reinstate my stool softener. Thanks.

This sampling of MCR text provides insight into the ways that people scripted themselves as deserving of care. Calls of urgency attempted to appeal to the nurse's sense of time which inmates knew was part of the triaging process—some people's requests were addressed immediately, some within two weeks, and others, it often seemed to the women, not at all.

Vivid explanations like the putrid smell in someone's cell were evocative attempts to garner sympathy. Directly addressing the MCR to a particular provider could potentially signal to the triage nurse that the requesting inmate had a relationship with that provider, hoping that the reminder of an interpersonal connection would enhance the chances of being seen. "Please," "thank you," and other pleasantries of polite address appeared as attempts to depict oneself as reasonable and courteous. Asterisks, underlines, and other crafted pen marks animated the MCRs as personalized pleas for recognition, embellished attempts to persuade the MCR nurse of the worthiness of requests (see photo).[2]



URGENT Request

DATE: 2

City & County of ..... -----
Department of Public Health
Jail Health Services

NAME_
DOB__
COUNTY JAIL # C52 HOUSING B pod Rm 2

MEDICAL CARE REQUEST / SOLICITUD DEL CUIDADO MEDICO

I wish to see/(Quisiera Ver):
(X) Medical Staff/ *(Servicios Medico)*
( ) Dental Services/ *(Servicios Dental)*
( ) Psychiatric Services/ *(Servicios Psicologoico)*
( ) Medical Social Services/ *(Servicion Social)*
( ) HIV Education/Testing/ *(Educacion para Recibir el Examen del Sida)*
( ) Discharge Planning/ *(Planificado para Salir)*

Reason/ (Razon): I need to see a Doctor. It's been several Days that Ive not had my Pain Medication, And Now Im having ~~pain~~ Physical withdrawels such as body aches, headaches, and constantly Useing the restroom!

PLEASE PRINT CLEARLY/ *(POR FAVOR ESCRIBA CLARO Y USE LETRA DO MOLDE)*

Action Taken:
Referred To: Can I please see A Doctor?

THANK You!

You will be triaged or seen within 24
***If you need to be referred to an MD/NP you will be seen within 10 days.**

Rev. 3/02 FS# 14

A medical care request (MCR) form

However, the efficacy of the personal testimonial qualities of these scribed requests for care was limited. When nurses went through them, they worked to distill the decorative pleas to their essential clinical need. The inmate women crafting the requests were themselves cynical about the MCR process. I asked some of them about MCRs one day, and they offered their downstream interpretation of how the forms were triaged:

> Evelyn: It's just like, sometimes I feel they look at the MCRs and they pick which ones they want to deal with, which ones they don't want to deal with. It's like, I've put in a MCR for my tooth that has a huge hole in it that—Before I left, they put a temporary filling in my tooth, and I was eating Tic-Tacs, and I ripped the temporary filling out again. And they never came to—they came to assess me for that MCR, but they never—I talked to the dental assistant that I always talk to, she said that they never got a referral. They [nurses] said they referred me to the dentist, but she said that that paperwork and my name isn't on any list. Like, they never referred me. They said they were going to, but they never did. Like, I don't know if they get too busy or they just tell you anything so you can stop putting in a request. Everything's put in a request. Like, I was complaining of upper right pain in my stomach. And I told one of the new nurses — I forget his name. And he said: Write it on a medical request. And I wrote it on a medical request, and I watched him put it on the counter and walk away from me, and then I watched the porter later on that day come and clean it up and throw my medical request away.

> Tanisha: When I start bleeding heavy [with my period], it frightens the hell out of me and I'm like up all night, all that. So when I put in a form, I don't care if I put one in every night. If I put in a form, it's something. It's not for nothing.
>
> Lizzie: I've put in request forms and it's taken a long time to get heard or I don't know. I don't know if they [nurses] feel like they see my name too much down there but it ain't right. They'll keep putting me not as a priority. They pick who they want to prioritize so I have to at times also lie on my request form and say my situation is extreme or yeah, I'm damn near dying or I'm in so much pain to make sure I get down to that doctor office to the doctor to see.
> CBS: And when you do that do you feel like you are seen?
> Lizzie: Yeah, I get results

Lizzie felt that it was wrong for the nurses to "pick who they want to prioritize," the essence of the sorting logic of any triage system. Embellishing and even fabricating symptoms was thus an adaptive response to what these women experienced as unjust and arbitrary decision-making.

Another woman explained that a sympathetic LVN, who collected but did not adjudicate the MCRs, suggested adding descriptors of severity in order to get seen:

> The nurse even told me that it's better that you put that you're burning or your discharge is brown, green or whatever, 'cause those are things that are abnormal. And like they say, the priority goes first but the less significant takes forever and sometimes they don't even get seen at all. So that is crazy that you have to say a little white lie to get seen or you know, even for the small things. So what may be serious to us, may be less pertinent to them.

For these women, the mere fact that they were requesting medical care was serious enough, sufficient to make their concern something to be prioritized. While women knew the procedural response to MCRs— that a nurse went through the forms, assessed people, and decided on an action— the logic of the process remained opaque to them. They knew they were limited by the MCR system, so they crafted what they could out of the system. For the most part, though, there was a disconnect between the imagined value of personalizing the request into a testimonial of deservingness and its power to persuade the triage nurse. Nurses tried to approach MCRs objectively, as much as they could, by bracketing or laughing at the embellishments.

Everyday Triage Ethics

One nurse liked the intellectual challenge of MCRs: "Oh I like doing MCRs. I learn a lot figuring out how to deal with the requests, and sometimes I have to look things up." She gestured to a blue cloth shopping bag on the desk, inside of which was a stack of nursing reference handbooks. The MCR nurses often worked hard to apply a clinical logic to their paperwork triage, to not get drawn in by the testimonial or personal aspects. Other nurses found that MCRs tried their patience: "These people think that the more MCRs they submit the more likely it is they will be seen! It's just annoying." After all, it created more work for the nurses, to have to manage the repetitive requests. The narrative appeal of deservingness which patient-prisoners crafted into their MCRs was translated into medical language as a matter of the clinical bureaucratic routine. Juxtaposing an MCR from patient Nina, alongside the nurse's documented CHART response illustrates how jail triage attempted to make inmates' desires for recognition and clinical care commensurable:

> **From Nina's MCR**
> Att: to Dr. David [nurse practitioner]. Please—> I need to be put back on my Boost treatment because of my weight NOT being where it should be. Also I am NOT eating as much due to me having SWOLLEN INFLAMED GLANDS in MY THROAT. It hurts to swallow [*sic*] and it is causing for my left ear to hurt when I try to swollow [*sic*] my food. So it has caused me not to consume the amount of food I should be intaking [*sic*] to gain my weight. So I need to be put back on my Boost treatment. Please acknowledge my pleas in concern of my condition. Thank you! Thank you so very much! [*Signed with Nina's signature*]
>
> **From CHART**
> Nurses Assessment
> Reason for visit: MCR Request Boost and T3 [Tylenol #3, with codeine]
> Subjective: Pt submitted multiple MCR req to get Boost and T3 because she has trouble swallowing due to painful swollen glands on back of throat. Also that she is underweight. Respiratory Rate 17 [normal] Temperature 98.2 [normal]
> Objective: Seen pt in Pod, A&Ox3 [alert and oriented to person, place and time]. Ambulates with steady gait. No OSB [unknown acronym]. Speaks in full sentences. NAD [no acute distress]. Throat with some redness but no swelling noted. Afebrile. Per CHART, pt already seen for throat problem and throat swab/culture has already been done. Results came back negative. Consulted with onsite clinician, gave V.O. [verbal order] for T3 1TAB TID [three times a day] x 5days. Per CHART, pt has been refusing weight checks. Will inform pt to agree so Boost can be reordered if indicated.
> Assessment: Req for T3 and Boost

The translation from patient testimonial to a triaged and documented clinical decision involved paraphrasing Nina's words into the "subjective" report, subtracting the subjective details of the patient's emotional state that came through even in her MCR. It also involved a pod call, measuring normal vital signs, a limited exam, research into previous evaluation for this problem, and consultation with a nurse practitioner.

On the surface, this process has the hallmarks of any translation of a patient's illness experience into a more sterile clinical representation (Kleinman 1981; Holmes and Ponte 2011). Seth Holmes and Maya Ponte (2011) have argued that the coherent, predictable structure of a clinical note, as in the nurse's note above, serves to recast the chaotic and ineffable dimensions of human suffering as recognizable and discrete patient problems. Such is the classic work of biomedical techniques of knowing. MCRs at one level inscribed patients in a regime where patients' abilities to access health care was dependent on those with power to adjudicate the forms—a replication of the controlling processes of imprisonment.

What is different is that these codified medical responses were part of a rhythm of daily life in a jail. They did more than just turn the sufferer into a generic patient. Rather, these formulaic MCR triage operations also put caregivers and patients into chronic relations around the contestations of recognition and deservingness. The nurse who triaged Nina and her MCR knew her from multiple prior incarcerations and from her frequent MCRs—five for the same reason in the preceding week. There was no limit to how many MCRs a patient could submit, and so the volume and record of them in CHART served instrumental roles in providers knowing patients. For Nina, repeated submission was a conscious strategy to bypass the nurse. She told me, with anger,

> My thing is about a lot of times the assessment nurse tries to tell you what they feel might be wrong with you and don't want to put the request in to the doctor. When I put a request in and say I need to see the doctor, that's what I mean. They come and do the assessment or whatever they do or they check me. I don't feel like I should have to continue to put paper in, paper in, paper in to see the doctor because they can't analyze what's wrong with me.

Nina's emotion was not captured in the repeated CHART nursing notes responding to her MCRs, for the genre has limited ability to convey emotion. But nonetheless, the MCR was the locus for managing Nina's affective disposition. This was the "magic of the state" (Taussig 1997).

Organizing numerous, often messy, handwritten forms into a coherent clinical narrative of the CHART note was a strategy for nurses to actively reckon someone's health related deservingness, filtering the emotions of the paper through an ostensibly neutral lexicon. Vivian denied Nina's Boost requests through her aspiration of equivalence in medical necessity between inside jail and outside on the streets. Trying to maintain a clinical tone was one way in which providers clarified the moral uncertainties of what kind of care a person in jail, and a person who came from harsh streets, merited. Nina was quite thin, after all, her face gaunt from her inconsistent food supply outside of jail. But at 5 foot 7 inches tall and 120 pounds, her body mass index (BMI) of 18.8 did not classify her as underweight; nor was she losing weight in jail, and neither did she have a diagnosed chronic medical disease which would merit nutritional supplements. There was a limited supply of Boost shakes, and the clinic had to distribute them to those who most needed them. Triage.

Nina's chronic condition which kept her thin (but not thin enough) was poverty and the structural violence of her street life as a drug addict. A few weeks after Nina's multiple MCRs for Boost, I passed her on the street. Her eyes had the alertness of someone high on crack. Bundled in a black hoodie, I could just make out her sallow cheeks. Was she thinner than she was in jail, where she had 3 meals a day delivered to her? Possibly. Did she buy Boost from the Walgreens around the corner? Unlikely. Jail clinic staff, like the CJ1 triage nurses, were aware of the conditions of food scarcity in which many lived; "I know it's tough out there," I heard some say. That recognition elicited sympathy from medical staff at times, and at other times it was considered less emotively as a matter of fact.

In Nina's case, there were broader questions of care which loomed in the background as clinic staff decided how to manage her MCRs for high calorie shakes: what was the jail's responsibility to tend

to Nina's thin bodily state? In this case, nurses smoothed the rough edges of her outside life into a neat story of BMI and weight stability, which served to document that she did not deserve nutritional supplementation. Triaging the medical needs of people in jail entailed managing—either by centrally acknowledging or by sidelining—the knowledge of patients' broader life circumstances along with a commitment to practicing reasonable medical care. Triaging MCRs gave nurses opportunities to contemplate such "everyday ethics," where the universalisms of ethical norms "get mobilized only when people start to figure their responsibility . . . in concrete circumstances" (Brodwin 2013: 17).

Patients attempted to make their case for deserving medical care on MCRs by appealing to triage's concern with acuity. But nurses filtered patients' written insistence of urgency through the shared knowledge of the way things worked in jail. Nurses knew that patients knew that if they had a genuinely acute condition, they would bypass the MCR system and notify the pod deputy, who would then summon a nurse to the pod. Still, the MCR nurse was supposed to see and assess the requestor in person, within 24 hours of the MCR submission. Some nurses decided that certain requests, like refilling medications, could be handled by transferring the request to a clinician, who was authorized to do so in CHART. However, without an in-person visit or paper notification in which a clinic worker conveyed the next step to the patient, the patient was left wondering, with another MCR her only channel of communication. David was one of the nurse practitioners in the clinic, beloved by the patients who often requested or addressed him by name in their MCRs. David expressed frustration one day with the nurses' inconsistent approach to MCRs:

> Some [nurses] do the minimum. I see the way they make notes for the referral. I could see that they didn't even see the patient. They're just doing the charting based on the MCR, just repeating what they're complaining. . . . That's why the MCRs are being generated so much. Because if they would only talk to the patient again, because they [patients] don't know if it's been addressed. But if nobody talks to them, they will make another one and another chart review. So, it keeps on piling up.

I agreed with David, and still do, that every patient should be seen, to animate the paper triage with the reality of an actual person, and to close the loop of communication. But I also spent time with nurses

when they were assigned to be the MCR/assessment nurse of the day and could appreciate the frustrations of the onslaught of MCRs.

Pod Calls

Seeing a daily average of 25 patients, whose MCRs came in at different times, in the pods was logistically challenging. Count time, programming, and needing permission from the deputies to travel to the pods—these routines constrained the time available for nurses to make pod calls. I saw nurses deal with MCRs from patients whom I had just cared for as their doctor, who made requests which signaled they were not satisfied with my clinical assessment. The barrage of requests was relentless, and many of them were for minor things which, outside of jail, would require no clinical curating. There were elements of the MCR assignment which made it understandable that nurses would try to resolve some of the issues remotely, through the computer system. At the same time, the mundane and repetitive nature of the task, the representation of a wide range of complaints on a simple half sheet of paper, these bureaucratic hallmarks threatened to homogenize urgent pleas for dandruff shampoo with the more vague but potentially more consequential "I have pains in my stomach." Seeing the patient via a pod call was thus a critical piece to animating the paper and electronic record as the nurse triaged the response which each MCR merited.

If they relied solely on an inanimate piece of paper, nurses, on the surface, would risk appearing to display what the courts would call "deliberate indifference." This is not to say that an in-person assessment is immune to demonstrating the "conscious disregard of a substantial risk of serious harm" (*Farmer v. Brennan 1994*), nor is it to say that the legal standard makes any comment about the necessity of in-person clinical evaluation. What it calls our attention to is the notion that indifference is an affective stance. It is infused with sentiments of disregard, of diminution of an other's existence. The common sense understanding of indifference is not caring what happens to a person or a situation. Michael Herzfeld has described this as a "rejection of common humanity" (1992: 1), signaling

indifference not as a passive lack of concern but an active act of rejection. This understanding makes Justice Marshall's phrase "deliberate indifference" redundant. Moreover, following Rhodes' application of Bauman's assertions on indifference to the prison setting, I take indifference to be a "matter of social relationships" (Bauman 1989 in Rhodes 2009: 204). The fluctuations of producing indifference in the jail clinical setting were central to caregiving in this environment where conventional wisdom expects inmates to be treated as inhuman.

MCRs, even in their seemingly impersonal paper form, exemplify the coexisting emotions which surround the work of triage. Triaging the MCRs was replete with affect, from annoyance with the litany of requests to Katie's excitement with the intellectual challenge, from moments of sympathy for suffering to amusement at the craftiness of requests, and even, at times, to mundane detachment. That an in-person visit was technically required for all MCRs indicates the interpersonal investment in ethics which made meaning out of the distantly legal trope of deliberate indifference. The face to face encounter, as Emmanuel Lévinas (1969) emphasized, is an ethical pre-condition for sociality. For it is in seeing the other's face that we can apprehend her as a different human being, one who thus has "an ethical claim on us" (Casey 2006: 79). The face-to-face encounter of an MCR assessment deepened the ethical obligation of jail medical staff to triage inmates' health related deservingness.

Pod calls for MCRs were fraught with the ambiguity of navigating the intersection between a system of caregiving and a system of punishment. One afternoon I spent with nurse Eileen as the MCR/assessment nurse was typical. I watched as she did her preliminary MCR research sitting in front of a computer in the work area of the CJ2 clinic, cross checking the half sheets of paper with the requestor's documented clinical history in CHART. She made a handwritten list of the patients she was going to see, and then gathered up the stack of MCRs along with a tackle box containing a few diagnostic tools- blood pressure cuff, thermometer, stethoscope, pulse oximeter, glucometer, a flashlight, band aids, and other medical sundries. Once we entered D-pod (with permission), Eileen gave

the deputy the names of the people for us to see. The deputy then directed us to an empty classroom on the second floor of the pod, where we could talk in semi-private with the patients.

We arranged 3 plastic chairs in a triangle, and then the first patient, who had complained of leg pain on her MCR, ambled in with a limp. She explained to us that she injured her hip in a fight outside of jail a few months ago, and the pain got worse yesterday after working out. It was a friendly and business-like exchange. The limp and the story were sufficient for Eileen to offer to renew the woman's prescribed Naproxen (a non-narcotic pain medication), to order ice packs, and to schedule her an appointment in the CJ2 clinic. The patient was content with this plan, and limped out of the room. Eileen scribbled some notes on this woman's MCR, to remind herself to execute and document all that she had promised once she returned to the clinic home base.

The next patient was more agitated, and walked in breathless and insistent. She animated her MCR request for pharmacologic relief of her chronic back pain with a circular story about all the medications she consumed for her pain in the community. Eileen got caught up in the circles as her clarifying questions focused on peripheral details. Even with my clinical background, I was confused about what the woman's complaints of ill health were. Eventually it seemed she felt she had had an allergic reaction to the Vicodin the jail had prescribed; she wanted long acting morphine pills, in limited supply at the jail, instead. Eileen thought she auscultated some very faint wheezes in the patient's lungs, a possible sign of allergy. After pausing to re-center herself after the confusing conversation, Eileen then instructed the woman not to take Vicodin, just in case it was causing a reaction; she informed the patient that she would consult with the nurse practitioner about other medications. The patient's cadence changed and she begged Eileen not to stop the Vicodin, perhaps because it might leave her without any opiate medication.

When we returned to clinic and consulted with NP David who knew this patient well, he wanted to see her in person for a clinic visit. Based on prior experience and the nature of the patient's request,

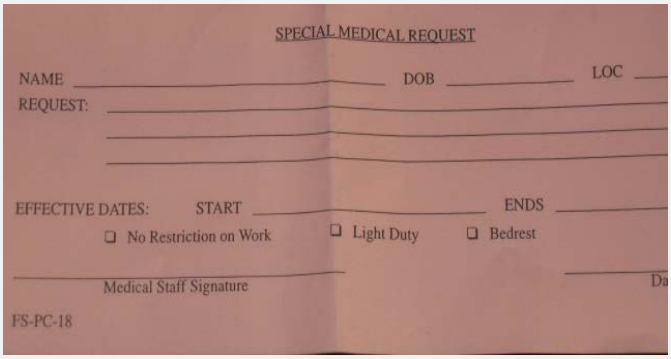
he speculated that the patient might be selling the Vicodin instead of consuming it for her pain. Eileen was not surprised by the suggestion. She laughed as she recalled the patient's circular narrative, and told me "Yeah, it's harder for people to store and sell Vicodin, since it has to be crushed. Morphine pills can't be crushed." So this, Eileen and David suspected, may have motivated the patient's impassioned pleas to change to morphine. These moments of possible trickery were central to the MCR nurses' continual interpretations of the MCRs. Eileen then dutifully charted her visits and decisions in CHART. These examples of pod calls which adjudicate MCRs illustrate how the routines of a bureaucratized system of care involve constant social engagement—even as those socialities are mystified by electronic documentation.

Nurses never referenced the constitutional mandate from *Estelle v. Gamble*, and in fact when I asked them about it, most had never heard of the case. "Oh, is that like Title fifteen stuff?" Title XV is the official California state code of regulations which jails and prisons must follow, and includes basic rules of health care provision which surely derive from *Estelle's* mandate. Despite being unaware of the *Estelle* case, in sorting through MCRs, nurses were effectively making their determinations of what counted as a "serious medical need."[3] This was not a straightforward yes or no, serious or not serious verdict; rather, the vernacular of "serious medical needs" was expressed through ongoing, human interactions in which professional judgment was laden with questions of the shoulds and should nots of the institution. The writing and triage of MCRs were at the heart of such an everyday and socially situated ethics. In this seemingly mundane bureaucratic artifact, frontline jail health workers and inmates worked through the ethical entanglements of courtroom mandates.

Medicalizing Life: The Privilege System

A second key form which circulated through the intimate medical economy of the Bridgetown jail was the "chrono" (see photo). This was a quarter sheet of carbon copy paper upon which a jail clinician would hand-write a number of medically-authorized "privileges" (often requested on an MCR).

The patient-prisoner recipient would then hand the chrono to the pod deputies to materialize the prescribed amenity. Bed rest, a bottom bunk, a water pitcher, these were just some of the items granted through on the chrono form. I asked nurses, clinicians, deputies and patients, but none could tell me the social etymology of "chrono" in the Bridgetown jail. It is hard to ignore the potential symbolic meaning which might derive from its Greek root "chron," meaning time, or the Greek god Chronos, the personification of time. Perhaps the connection is that the privilege granted on a paper "chrono" interrupts the standard routine. [4] Chronos, like MCRs, were invested with inmates' desires for care and recognition from the institution. Moreover, the protocols and interactions surrounding the granting of chronos provide a window into the intense medicalization of daily life in the jail.


SPECIAL MEDICAL REQUEST

NAME _____ DOB _____ LOC ____

REQUEST: _____

_____

_____

EFFECTIVE DATES: START _____ ENDS _____

☐ No Restriction on Work ☐ Light Duty ☐ Bedrest

_____ _____

Medical Staff Signature Da

FS-PC-18

A blank chrono form

Chronos permitted inmates to have special privileges, items beyond the standard inclusions that come with entry into jail. Goffman argued that it is the "privilege system" of a total institution which sustains the norms of inmate behavior, by enticing them with the promise of something extra. In a total institution, privileges are not indulgences in the conventional sense. Rather, they are rewards for appropriate behavior, and ensure that inmates remain governable, self-regulating subjects. Moreover,

these privileges are usually minor things which, on the outside, a person would take for granted: "the absence of deprivations one ordinarily expects not to have to sustain" (Goffman 2007: 51).

In a similar vein, the jail clinic staff controlled access to a number of privileged items which, outside of jail, were unremarkable, that a person would be able to obtain without a third party (if they could afford it): over the counter medications like Tylenol or Benadryl, nutritional supplements, peanut butter-free diets, hummus-filled diets, a plastic pitcher to hold water, Vaseline, a bottom bunk bed, a warm compress. Providers had to order all of these items in CHART, and many of them also required a hard copy chrono. Chrono-granted privileges like medically-authorized bed rest also offered reprieve from the jail's standard routine. Only a doctor's note could excuse someone without repercussion from classes, programming and other required activities—ironically, activities meant to fill the monotonous repository of idle time in jail; without a chrono, if a woman stayed in her dorm bed area when there were required classes, she could get "written up" by the deputies . These are some examples of how aspects of daily life in the jail were highly medicalized because of the background standard of deprivation. Unlike the economy of total institutions which Goffman described, in the clinic, privileges were not rewards for good behavior; they were accoutrements added, especially when a patient-prisoner requested recognition as a patient.

Patients knew to ask clinicians for chronos. When I first began providing care at the jail, I willingly granted chronos to women whenever they requested something. I scribed on the triplicate form just about anything they asked me for, not even knowing whether such things were possible: a pillow, an extra mattress, a second blanket (years later, I learned that these items were not fulfilled). I knew that some women exaggerated their symptoms and, as other staff would label it, "manipulated" me, but I did not take it personally; I presumed that they saw me as someone with power to distribute resources the jail deprived them of. I unselectively wrote chronos partly as a gesture of compassion, a conscious effort to try to soften the rough edges of institutional living for my patients. And I also saw my

strategic use of white coat capital as a subtle act of subversion against the larger system of mass incarceration. But over time, I began to realize the complexities of indiscriminate chrono-granting, and tried to be more judicious.

One day in clinic, in the midst of my chrono transformation, a patient whom I had seen to inform her of Pap smear results asked me for a chrono for a "lay in," bed rest, for the day. She had a stomach ache, she said, but I could find no other symptoms or signs, no tenderness when I pressed on her abdomen; she had walked comfortably and smiling into the exam room. "No, I'm sorry, I can't do that." Invoking the logic of my authority, she pointed out, "Yes, you can, you're allowed to write on these." I tried to explain to her that I had no medical indication to do so, but she persisted. She eventually accepted my rejection and left the room. I was proud that I stood my ground.

Moments later, she returned and stood in the open doorway of the exam room to ask again, this time with a wince on her face. As I started to fold and reach for a chrono slip, I saw Julie, the clinic clerk, in the background, waving her arms and mouthing "NOOOOO!" Julie's gesture was enough to remind me where I was, in a jail. I had heard rumblings from deputies that chronos were logistical hassles for them. Each chrono item created more work for them to accommodate, and though I wanted to believe I could practice medicine in a vacuum, I still felt cautious about getting on the deputies' bad side. Chronos also undermined a generalized motto of incarceration of treating all inmates equally, though of course much about the jail structure differentiated inmates unequally. I came to appreciate that my chrono writing was facilitating downstream inequalities within the jail, whereby the women who knew to come to me would have comforts that other equally deserving—or undeserving, depending on your perspective—women would not have. And so I said no to the patient for a final time. Instantly, her tone of voice and pained facial expression gave way to a smile. "OK. Truth be told, I just didn't want to go to class today." This interchange went beyond hustling and privilege—it was infused with humor and familiarity, and a mutual awareness of the conditions which made our relationship even possible.

There was no algorithm for dealing with chrono requests. Chronos were dependent on clinical judgment. So there were no rules to transgress or uphold, only individual decisions to arbitrate. In this arbitration, the medicalized privilege system challenged what it meant to care. Sometimes providers caved into requests out of sympathy, or fatigue from the persistence of the requests. Frequently, the chrono decision weighed medical necessity against what would happen in the outside world. For instance, at home, a woman could choose to stay in bed with a heavy, painful monthly period. Was it not reasonable, clinicians asked, to allow her to rest during her period in jail? Then again, the female clinic staff noted that they themselves would not take a sick day for menstruation, and thus they had little sympathy for women who ask for a "lay in" for this in jail. Through fulfilling or denying privileges, providers could inflict their own medicalized version of punishment, withholding amenities they deemed the patient-prisoners did not deserve.

At the same time, constructing complete equivalence between inside and outside medical standards in deciding when to grant special privileges risked eclipsing the inequalities which characterized the outside world in which most of these women lived, a reality in which a woman might not have a bed on which to rest during her period. Many clinic staff knew that for many of these women, the care they received in jail, bed rest, nutritional supplements and all, could help smooth over—at least temporarily—inequalities from the streets. Medicalized privileges, solidified on the chrono form, were thus a moral endeavor, a convergence of the institutional logic of punitive depravity, of medical power, of revealing societal level inequalities, and an individual's desire to be recognized.

The story of ice, regular old ice, illustrates the ambiguity of care contained in chronos and medical privileges. Ice was a contentious item in jail. They only way inmates had access to ice was if a clinician ordered it for a medical indication. The carceral milieu of scarcity medicalized ice into a prescription only item. Ice incited enough controversy that it was an agenda item one month at a staff meeting for the clinicians. Apparently, the deputies were getting frustrated with how many women

were receiving ice. They felt that it had "gotten out of hand," making the pill call lines longer, creating a frenzy of inmates coveting others' ice and complaining to deputies, and women exchanging their prescribed ice for commissary items like a bag of Doritos.

At the staff meeting, clinicians all offered medically-grounded reasoning for the ice they had ordered: a woman with menopausal hot flashes; another withdrawing from heroin; those who needed to stay hydrated, like pregnant women, but would not drink the jail's metallic-tasting water at the standard room temperature[5]; people with nausea. Vivian chimed in that it was absurd in the first place that they did not just have an ice bucket in the pods. "It's just ice, people!" Perhaps with an easy supply, there would be less demand. There was no resolution to the ice issue at this staff meeting, but clinicians had all been notified of the deputies' annoyance. "It's cyclical what the inmates ask for," said one of the doctors dismissively; another added "yeah, and it's cyclical what the Sheriff's Department cares about!"

While the clinicians could dismiss the ice cube controversy and go about their business, the nurses had to prepare it in baggies, deliver it at pill call, and withstand the glares from deputies who deemed ice an indulgence. One nurse tried to diminish the ice supply chain by asking me to change a menopausal woman's ice order to cold compresses, because these did not have value in the pod's informal economy. LVN Danitra saw a pregnant woman, Shante, sharing her ice with others, and it frustrated her. If she was not using it, Danitra reasoned, then she should not get it within the privilege system. Danitra reported her observation to me and Vivian, who were providing prenatal care for Shante. "So whaddya gonna do about it?" she asked us expectantly. We had a hard time getting concerned about Shante's ice generosity. Eventually, Vivian conceded that she would talk to the patient and warn her that she would discontinue the ice if she continued to offload it to others.

Later that afternoon I went on pill call with Danitra. Shante came up to the cart for her thrice daily bag of ice. Danitra averted her eyes down to her list as she confronted Shante. In a nonchalant tone, belying how much she cared about the ice shenanigans, Danitra told her, "The deputy called me

because you gave away your ice yesterday." Shante spoke like she barely remembered yesterday, and then recalled, "Oh, yeah, I didn't use it all." To Shante, it was not a big deal, just part of the social network of living with other women in jail. To Danitra and the deputies, it was not just ice. It proliferated unregimented behavior. "Well I'm just telling you that they called me about it, so . . ." Shante left the pill call line with her bag of ice.

The contentious circulation of ice illustrates how the medical privilege system allowed for slippages from and reinforcement of the disciplinary aspects of life in the jail. On the one hand, medical providers granted mundane privileges which further medicalized everyday life in the jail. On the other hand, the comfort items that eased life for patient-prisoners were symbols of care. The caregiving interactions about chronos were also sources of routine anxieties and conflicts among inmates, deputies and clinic staff.

"I refuse"

In Chapter 2, I described an episode in which Kima "refused" prenatal care in jail. While prisoners may have a constitutional right to receive health care, they also have a procedural right to refuse evaluation or treatment from the jail without being punished, something which is codified in NCCHC standards (2008: 129).[6] Patients being seen in non-incarcerated settings also can refuse medical care; but what is different about a jail setting is that the categorical absence of autonomy turns a refusal of even the most mundane medical acts into an event, something worth documenting. On the surface, an event in a jail called a refusal seems like it might be confrontational, like it might incite stereotypical roles of the jail worker with power and the inmate resisting. An obvious interpretation would see refusals as enabling patient-prisoners a brief moment of agency and freedom in an environment where those are intentionally lacking. But to read refusals in such a formulaic way would miss the nuanced ways care and discipline are entwined in the jail clinic.

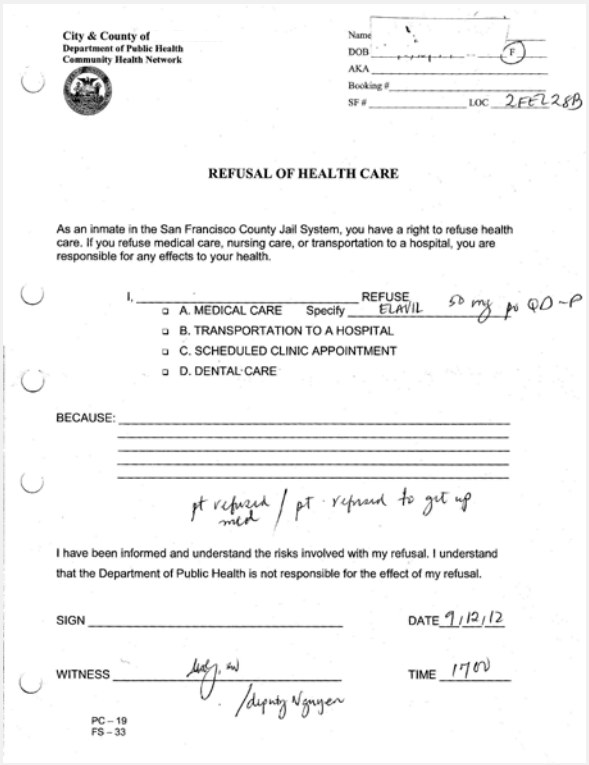
While there were rare occasions when a refusal involved confrontation,[7] for the most part, deputies, clinic staff, and even patients treated refusals as a matter of procedure. Refusals were daily occurrences. That single word, refusal, was an integral part of the daily lexicon and routine for patients, clinic staff, and deputies; refusals were common and staff expected them. Like every medical interaction in the Bridgetown jail, refusals of care had to be documented. It was unremarkable, then, when one woman sitting on the clinic bench casually asked LVN Danitra "Can I sign a refusal form?" Another woman followed her cue. "Yeah, me too." And another. "OK," the LVN responded with a shrug of the shoulders, "It's up to you." There was no anger or threat in Danitra's voice. Just an equivocal response to a routine gesture.

One woman said she wanted to refuse because a nurse yesterday poked her arm 4 times and still could not draw blood for an HIV test. Again, Danitra shrugged with apparent indifference. She did not try to convince the patient to rescind her refusal. Perhaps it was this lack of authoritative insistence which invited the patient to reconsider, for she then asked Danitra, "Well, is it going to be you drawing my blood? Because if it is, then I'll do it." The two walked from the waiting area to the lab room, and Danitra removed a few milliliters of blood from the patient. Although this woman had no reason to believe to believe Danitra would be any more successful at phlebotomy, her decision to get tested for HIV or to refuse hinged on her interaction with and perception of Danitra. Amid its frequent and facile use in the daily world of the jail, the word "refusal" homogenized a complex range of divergent reasons, actions, sentiments, and relationships.

At its most basic level, the refusal form served to document that the clinic recommended a particular evaluation or treatment, and that the patient made the choice to decline. It explicitly shifted medical responsibility from the jail clinic to the autonomous patient, should any adverse health outcome or litigation ensue. The template on every form read (see photo):

> As an inmate in the Bridgetown County Jail System, you have the right to refuse health care. If you refuse medical care, nursing care, or transportation to a hospital, you are responsible for any effects on your health. I, _____, REFUSE."

The form then has check boxes and a fill-in-the-blank area to explain what is being refused and the reason. The patient and a witness made the refusal official with a signature and date, just below the attestation "I have been informed and understand the risks involved in my refusal. I understand that the Department of Public Health is not responsible for the effect of my refusal." Patients were supposed to be given the yellow carbon copy of the form, but sometimes the nurses did not bother, and sometimes the patients, well, refused to take the form. Sometimes they even refused to sign the refusal form.



City & County of
Department of Public Health
Community Health Network

Name
DOB
AKA
Booking #
SF # LOC 2EE28B

REFUSAL OF HEALTH CARE

As an inmate in the San Francisco County Jail System, you have a right to refuse health care. If you refuse medical care, nursing care, or transportation to a hospital, you are responsible for any effects to your health.

I, _____ REFUSE
- ☐ A. MEDICAL CARE Specify ELAVIL 50 mg po QD-P
- ☐ B. TRANSPORTATION TO A HOSPITAL
- ☐ C. SCHEDULED CLINIC APPOINTMENT
- ☐ D. DENTAL CARE

BECAUSE: _____

pt refused med / pt refused to get up

I have been informed and understand the risks involved with my refusal. I understand that the Department of Public Health is not responsible for the effect of my refusal.

SIGN _____ DATE 9/12/12

WITNESS _____ TIME 1700

/deputy Nguyen

PC – 19
FS – 33

A refusal form

It was such a matter of routine, such a mundane occurrence for the nurses and LVNs, that as soon as a patient said "I don't want to see the doctor;" "I'm not getting my blood drawn;" or, knowing the standard procedure from their years of being in the jail, "I'm refusing," the immediate action was to reach for the form. Every day I observed refusal interactions. Yet rarely did I observe attempts to explain or persuade, or even to inform the patient of "the risks involved with my refusal." The nurses would just casually go through the motions. "Sign here," with the classic banality of a bureaucratic task. It was the form that seemed to matter, not the patient.

To see how refusal interactions were textually represented, I collected all of the refusal forms in CJ2[8] for a one month period of time. There were 83 of them from women (an average of almost 3 refusals per day).[9] It would be impossible to calculate the denominator of every clinic visit, hospital transport, medication delivered, PPD placed, blood sugar checked to know what proportion of health care offerings were refused. Furthermore, based on patterns in the forms by date and individual nurses, it is likely that 83 forms did not reflect every instance of a refused service; indeed, based on how frequently I heard deputies verbally tell nurses that certain patients were refusing to come to clinic to sign the form, and on how often I saw patients refuse to come to the pill call line, it is likely that 83 is an underestimate.

The most frequently documented medical service refused was placement of a PPD (n=23), the skin test for tuberculosis.[10] It was protocol for every new arrival to CJ2 to receive a PPD, as a public health measure. Many of the women refused their PPD because they had recently had one, usually during another jail stay; these refusals highlighted certain inefficiencies and duplications of a protocol-based system. Medications were the second most documented refusal; these forms were often not signed by the refuser, because they, as nurses documented, "refused to get out of bed" for pill call or to sign the form.

Written reasons for refusals were variable. There were scattered refusals due to medication side effects, but the majority of reasons were mundane and nuisance expressions: “Don’t want to be seen.” “Tired.” “Tired of waiting.” “On my period, please reschedule.” “In class.” The bureaucratic ritual codified this blasé affect of rejection into a confrontational word, refusal, which belies its subtleties. It was as though the clinic staff and patient-prisoners did not take the bait of oppositionality that both a jail environment and a refusal would prescribe. We would expect providers, especially in the rigid, rule-based space of a jail to be angered or to express their authority over patient-prisoners who refuse. Their responses were, in fact, varied and contradictory, but not authoritative. The banal acceptance of refusals puts the concern dimension of care at the forefront. It pits concern for a patient’s right to autonomy against a concern for the medical consequences of a refusal—and packages it into a bureaucratic task for completion. Clinic staff took the coherence of the disciplinary regime—in which a refusal fits well—and made it ambiguous, even permitting moments of care.

Recognition in Refusals

To illustrate the complexities of care and affect harnessed in the refusal, consider the emotions around Angela Johnston’s refusal. Like so many of the women in Bridgetown’s jail, Angela had been in and out of incarceration for years, so deputies and medical staff knew her. It was a quiet morning in the clinic, and the nurses and I were making small talk.

All of a sudden, I heard yelling and swearing from down the hall in the holding area. Angela was standing in front of the deputies’ desk, crying and angry. She was seeking advice from them: “They gonna move me? She’s being mean. I don’t know what to do.” The deputy consoled her with words that she would likely be moved to another pod. A few minutes later, Angela stormed down the hall to clinic, unescorted, eyes still swollen with tears, and announced “Johnston is refusing!” Josie, an LVN, quickly handed her the refusal form and the pen that Angela was expecting. “You have to write down why,”

Josie reminded her. Angela explained to her it was "because I can't focus right now. I don't know why. I just can't."

The nurses knew why Angela was so upset—she and one of the deputies who fought during a prior incarceration got into it again that morning. Last time, when Angela was still pregnant, the deputy spit on her. Angela wanted to be in a different pod to avoid this deputy; she felt too emotionally distracted to wait on the clinic bench and be a patient right now. Angela signed the clinic refusal form and then huffed and puffed back down the hall to the holding area. While nurses' and LVNs' orientation towards refusals was more procedural—getting the form signed— doctors and nurse practitioners were generally more overtly invested in the circumstances of refusals. NP Vivian was a particularly good example of this. On a number of occasions, she burst into my exam room, pulled me aside in the hall, or directly chastised the nurses for disinterestedly managing refusals. "Whatever happened to assessment? Nursing 101? . . . They just don't care." "It is unprofessional," Vivian explained, for them to let people refuse without looking into why they are in clinic, without explaining to the patient, or without notifying the clinician who might be able to provide detailed information to the patient to help her make an informed refusal decision. So when Vivian opened her clinic room door and discovered that Angela had refused, she looked at Josie in disbelief and I knew what Vivian was thinking. Vivian really wanted to see Angela—she had an infection in her breast that might have been turning into an abscess.

Vivian herself marched down to the holding area, where Angela waited for her deputy escort back to the pod. The other women in the holding cell, seeing Vivian's determination, told Angela that she better go back to clinic. Vivian and Angela exchanged a few quiet words, Vivian explaining that the infection could become an abscess. Perhaps it was a dose of biomedical logic, perhaps it was merely that Vivian showed enough concern to leave clinic for the holding area and talk to Angela directly; Angela changed her mind about the refusal, and then the two of them walked back to clinic together.

Angela's tears had evaporated. She had a resigned grin on her face, and shuffled her feet a little on the way to have her infection checked. While examining Angela, Vivian later told me, she also counseled her on how to remain calm in stressful situations, like the one with the deputy. Vivian's caregiving was geared not only to Angela's breast infection, but also towards how to manage the relational dynamics of being in custody. Vivian hoped such lessons could help patients like Angela in the outside world too.

Had we looked at Angela's refusal in its documented representation, we would have simply found another paper trail of transparency in the penal system. Instead, the processes surrounding documenting a refusal reveal themselves to be imbued with Angela's fundamental desire for recognition, and with her and Vivian's affective responses to the consequences of her inmate status which made her susceptible to abuse from a deputy.

As Judith Butler (2004) has expanded on Hegel, recognition and a desire for recognition are centrally linked to our sense of personhood, and are apprehended through social norms. Recognizing Angela, as Vivian did, contrasted with the norms, such as recalcitrant, of what a prisoner was expected to be. This form of recognition was animated by making those categories of patient and prisoner ambiguous. Into the bureaucratic transparency of the blame-transferring refusal, Vivian interjected compassion, concern and recognition.

Refusals were much more than a matter of policy and procedure (although they were that too). While nurses, LVNs, and clinicians may have immediately responded to patients' refusals with casual acceptance or (more rarely) emboldened persuasion, they also, when patients were not around, made their own interpretations of what refusals signified. Refusal moments provided staff with an opening to broader social commentary about rights and entitlements to health care. When I asked medical staff and deputies why they thought people refused medical care, they first recited a list of reasons, grounded in the taxonomies I presented above; a few deputies added to the reasons, as one male deputy put it, "some of 'em just don't like the medical staff." Many deputies and clinic workers went on

to express the sentiment that “these inmates don’t know how good they have it.” They were critical of inmates who took their free, readily accessible medical care for granted so much that they could casually reject it.

All of the full time employees at the jail had health insurance, and some held onto this job because of the good benefits which came with it. But some jail workers also had friends and family who did not have health insurance; and they themselves would gripe about their own experiences of how long they had to wait to see their doctor or a specialist. So they viewed refusing patients as ungrateful, offering monologues of entitled prisoners. Reflected in the staff’s interpretations of refusals is a familiar tension between the responsibilities of a welfare state to care for the most marginalized and the presumption that those recipients are lazy and entitled. The presumed laziness and lack of gratitude associated with interpretations of medical refusals—people who did not want to get out of bed, for instance— in jail got coded as an expression of individual choice, inmates’ locus of control to reject medical care.

One female deputy, Deputy Harrison, became especially agitated when she vented to me her frustrations with medical refusals:

> Excuse me, but that pisses me off, because . . . now you don't want to go to medical? You're on the medical list, you need to get up and go. “No, I don't want to go.” I hear what you're saying. No. You need to go. Or they finally put them on the thing to go out to Bridgetown County Hospital. “I don't want to go because it's too early in the morning.” So, it's always something for them. . . . It's like you put in all of these requests and now you don't even want them to take a look at it? You want it to be convenient when it's convenient for you. You know that this is the time. Every day it's the same time that they go to medical. You go to medical first thing in the morning and first thing on swing watch. If you're hurting or whatever, you need to get up and go. So, it makes me mad.

This deputy saw refusals as an expression of inmates’ sense of entitlement—that they felt medical care should adapt to their wishes of convenience. And yet Deputy Harrison immediately followed this up with an empathetic reflection: “But then at the same time, I understand where you guys are coming from. Then it's like a conflict if they're saying they don't want to go. Now I've got to drag this person

down there kicking and screaming. It's like – I think that's a little bit too much." Deputy Harrison held this ambiguity between anger over inmates' medical refusals and discomfort with her coercive role in managing refusals. Jail workers approached refusals in the jail clinic not as static matters of procedure nor as predictable acts of resistance. Rather, providers dealt with refusals in many, often contradictory ways as unremarkable moments, as respect for individual autonomy, as loyalty to protocol, as interpersonal and intra-professional conflicts, as moments to sort through entitlements to care, and as moments to interject affect into a disciplinary regime.

Intimacy of Bureaucracy

These three documents—MCRs, chronos, and refusal forms—were integral to the functioning of the medical apparatus in the jail; and all were dutifully documented in CHART. There were some aspects of how these forms were managed which conformed to expected processes and sentiments of bureaucracy. Yet this exploration has shown how critical it is to look beyond notions of how bureaucracy produces governable subjects, and even beyond merely the "social life of things" (Appadurai 1986) which circulated with instrumental force through the jail's clinical economy. For despite the appearance of coherence which bureaucratic schemes project, it is precisely the reiterability of paper-pushing and rule-following which invites possibilities for particularized adaptations, for creative enactments (Sharma and Gupta, 2006: 12; see also Riles 2001: 21) in jail.

As part of the jail's audit culture, these documents indeed compelled creativity from all involved in the forms' processing. From inmates' narrative constructions of their bodily and psychic needs on MCRs to clinic providers' handwritten chronos, the bureaucratic objects provided a locus around which caregivers and patient-prisoners created the kind of ambiguous intimacy that we have now come to recognize in this medical-carceral milieu. This intimacy derived from the shared experience of clinic workers and patient-prisoners constantly interfacing, through the chronicity of recidivism and through the intensity of medical management of daily life in jail.

These actors invested considerable affect in the documents, for it was through them that they worked through the moral stakes of what mattered to them on a day to day basis—recognition, ameliorating the discomforts of incarceration, adherence to professional standards, sympathetic caregiving; the forms also furnished regular opportunities for providers to reflect on the boundaries of health-related deservingness for marginalized people confined in an institution. Bureaucratic practices were thus vital, not simply instrumental tasks, to the mutual coexistence of punitive deprivation and concerned caregiving in this carceral institution.

Part I of this dissertation has explored the contradictory forces which comprised the caregiving endeavor within the Bridgetown jail clinic apparatus. These tensions gave rise to forms of care which were not concerned with resolving the contradictions; instead, the care forged within this institutional setting was attuned to constant grappling with the intersecting realities of inequalities on the streets, restrictions of incarceration, and desires to care. In Part 2, I extend these complexities of care within an institution organized by its carceral limits to the rest of the jail beyond the defined clinical space. These ambiguous intimacies, as we shall see, also played into the relations conjured by women's reproduction in jail and ultimately to women's conflicting desires to be cared for by the institution.

[1] These numbers include MCRs from CJ2, which housed all of the women in the jail system, men and women in the infirmary unit "C-pod," and roughly 50-100 men in the intake pod, waiting to be distributed to the other jails for men. The 22,000 count also includes requests from CJ3, CJ4, and CJ5, which housed only men. While women made up 9% of the jail population, they disproportionately submitted the majority of MCRs.

[2] This function of MCRs as entry points into the everyday triage system of the jail medical apparatus gives them a testimonial quality. Vinh-Kim Nguyen has analyzed how resourced entities like medical humanitarian non-governmental organizations make decisions about anti-retroviral therapy in Côte d'Ivoire based on how HIV positive patients represent themselves as worthy therapeutic citizens in their personally crafted HIV narratives (see also Ticktin [2006]). MCRs at the Bridgetown jail encouraged a similar self-crafting as a subject deserving of medical intervention.

[3] Keramet Reiter (2012) has written about how litigation on prisoners' rights shapes the actions of people working on the ground in these settings. Her article focuses on supermax prisons, first built in the 1980s. Numerous court cases, especially from the 1970s and 1980s before the first supermax was built, made decisions about very detailed aspects of conditions in prisons, such as types of food that could not be served, appropriate size of cells, bedding,

access to showers and cleaning supplies, physical activity, and more. Architects who subsequently designed supermax prisons took the stipulations of these court cases into account when they designed sensory depriving isolation cells and supermax prisons. The codification of these earlier judicial standards into the design of these prisons, known to have negative effects on people's mental health and well-being, represents the ways that the courts shape the terrain of social action of institutions.

[4] "A prisoner's dictionary" with an extensive definition of prison slang includes the term "chrono," but provides no information about its etymology (http://aren.org/prison/documents/dictionary/words.htm).

[5] Vivian herself initiated this pregnancy privilege years ago. She urged her patients to stay hydrated, as this has many benefits in pregnancy. But the women complained about the warm water. So Vivian thought that if they could cool down their lukewarm water with ice, they would be more likely to stay hydrated. Ice is now an accepted part of the pregnancy privilege package.

[6] The right to refuse medical care in prison has played out in recent hunger strike dramas, especially at California's Super Max prison Pelican Bay and at the US Military's detention camp Guantanamo Bay. In the latter, the force feeding of detainees by medical professionals eliminates the right of refusal of medical care, and thereby strips inmates of their only opportunity to resist (see, among others, Anderson 2009 and al Hasan Moqbel 2013). The controversy surrounding this medically-enforced suppression, including violations of human rights and medical ethics, highlight the significance of the ability to refuse medical care in a controlling institutional setting.

[7] One example of a refusal leading to confrontation and fulfillment of anticipated roles involved a pregnant woman named Tami. She refused to come to clinic for an important prenatal visit. Tami was close to her due date and needed to decide if she wanted a cesarean section (which would require scheduling), like she had in her last pregnancy, or to attempt a vaginal delivery (which carries a small risk of rupture of the uterine scar). Despite her refusal, because she was pregnant and because the deputies overheard me talk about the importance of this visit, the deputies brought her down to the clinic against her will. The coercion, combined with her active psychosis, fueled her further resistance when she was in the exam room. With a deputy standing in the doorway for my protection—the only time in 6 years that I have had a chaperone—Tami would not engage in the discussion about her preferred mode of delivery. Her anger was palpable. And her continued "refusal" led to continued coercion: the psychiatrists, medical director and city's attorney decided it was reasonable to send her to the hospital for an involuntary psychiatric commitment, where she would also be close to the labor and delivery suite if she went into labor.

[8] Recall that there are some men housed in CJ2: those in F-pod, the inmate classification pod, and those in C-pod, the infirmary pod. Therefore, their refusal forms are included in this tabulation.

[9] There were 117 forms total, making the women's refusals 71% of them. This is roughly proportional to the number of women in CJ2 overall, since most men are housed at other jails in Bridgetown.

[10] Jails and prisons are known to be reservoirs for the transmission of tuberculosis. Based on guidelines from the Centers for Disease Control, most facilities have some protocol for screening for active tuberculosis with symptoms and with a skin test or a blood test (Centers for Disease Control, 2006).

Part II

CHAPTER 4
Gestating Care: Incarcerated Reproduction as Participatory Practice

"Attention is the rarest and purest form of generosity"

-Simone Weil

"Better off in jail" or "No place for a pregnant woman"?

Alisha was trying to make things work. At age 32, she was pregnant with her third child. The other two children were not in her custody, though reunification with them was always a dream of hers. She was determined to raise this child to whom she would soon give birth. Alisha had enrolled in a methadone maintenance program for pregnant women,[1] and only rarely used street drugs. She attended most of her prenatal appointments, which were frequent due to a pregnancy condition, shortened cervix, which increases the risk of preterm birth. Alisha had also recently assaulted her ex-girlfriend, who had stolen Alisha's money that she was using to pay for housing. A judge mandated that Alisha attend a 52-week long domestic violence class. But she missed a few classes, both because of frequent prenatal appointments, and because she was excessively fatigued from her cocktail of psychiatric medications and methadone. At a subsequent court appearance, she also admitted to occasional use of drugs. The judge and probation officer initially recommended an outpatient drug treatment program for Alisha.

But then, Alisha told me, they factored in that this was considered a "high risk pregnancy," due to her shortened cervix and drug use. "They was worried about the baby," Alisha told me, rubbing her pregnant belly under an orange jail uniform, a gesture of connection to her developing baby. "So they remanded me to custody, because of the baby." The judge considered pregnant Alisha to be "better off in jail," that the carceral environment would be better for the pregnancy than her current life. In jail, she

would be escorted to clinic appointments and be away from drugs; she would be disengaged from behaviors which were harmful to the fetus. Had she not been pregnant, Alisha believed, she would not have been sent to jail. There was no anger in her voice as she told me this; Alisha was resigned to this protectionist conviction, even as it came with a moral judgment about the inappropriateness of her maternity behavior. Perhaps she was accustomed to the state's intervention in her life, even in her reproduction: her long-standing involvement in the criminal justice system, her enrollment in publically-funded Medicaid during pregnancy, and her hyper-managed daily attendance at a methadone maintenance clinic (see Bourgois 2000; Knight, in press). So the state's involvement in Alisha's current pregnancy by way of incarceration was merely an extension of what she already knew. Alisha stayed in jail for three months, and was released to a residential drug treatment program when she was 36 weeks pregnant.

In contrast, Maria was 28 weeks pregnant when she was arrested for a non-drug related, non-violent offense. A quiet woman who spoke only Spanish, Maria kept to herself in the pod. She had received regular prenatal care in the community, lived in a house with family members, and had no history of drug addiction. I saw her for a prenatal visit in the jail clinic on her second day at the Bridgetown Jail. She had just had a court appearance, and the judge had decided to release her from jail the next day. "Jail is no place for a pregnant woman," he had told her. He was referring to the material depravities of incarceration which seemed unsuitable for a pregnant woman's needs: uncomfortable beds, food only at scheduled meal times, close living quarters, and in general (though not at the Bridgetown jail), access to inconsistent and substandard prenatal care (Rebecca Project 2010). Maria left jail the next morning and never came back.

One judge's ruling that Maria should not be in jail and another's that Alisha should be there might seem to indicate the arbitrary inconsistencies of the criminal justice system. More broadly, these decisions reflect the state's deep and persistent involvement in regulating women's reproduction. The

management of women's reproduction in a carceral setting represents a convergence of the racialized, gendered, and economic dimensions of mass incarceration at the level of the "politics of life itself" (Rose 2007), when a new life is gestating within the confines of a regulated state institution. Incarcerated reproduction is thus an exemplary site for what Lynn Morgan and Elizabeth Roberts (2012) have called "reproductive governance:"

> Reproductive governance refers to the mechanisms through which different historical configurations of actors—such as state institutions, churches, donor agencies, and non-governmental organisations (NGOs)—use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviors and practices (Morgan and Roberts 2012: 243).

Reproductive governance is about the kinds of subjects and effects that are produced when various "moral regimes" of valued reproductive behaviors intersect with political economic forces (Morgan and Roberts 2012: 242 and 244).

The management of reproduction in prisons and jails certainly fits into this analytic, from, for instance, the initial court-based designation of whether a pregnant woman should or should not be in jail to restricting incarcerated women's access to abortion (Roth 2004; Sufrin 2009). However, understanding the entanglements of incarceration and reproduction should not end with a story of producing governable subjects. For as we have already seen, relationships grounded in the unsettling contradictions between caregiving and custodial discipline in a jail saturate the carceral endeavor. Exploring the experiences and management of women like Alisha's incarcerated pregnancies reveals how these relational tensions of carcerality come to shape both the moral claims of the people charged with taking care of prisoners and their gestating fetuses and the maternal sentiment of poor, marginalized, reproducing women. Pregnancy in this setting, in turn, sheds light on the vulnerabilities of the institution itself. Furthermore, the intimate and contradictory interactions between jail workers and pregnant inmates amplify and are amplified by the uncertain status of the incarcerated woman's fetus.

Considering these two social and political processes—pregnancy and incarceration— together is, at one level, discordant. How can life-giving reproduction occur in a place classically thought of as devoid of humanity? Moreover, criminality and motherhood are often seen as incommensurable, for how could a female who allegedly broke the law, who transgresses gendered norms of femininity (Rafter 1990; Kann 2005; Talvi 2007: 12;), also be maternally nurturing? It is through this apparent contradiction that inmates and jail workers actively figure out what kind of care alleged criminals, marginalized by an ineffective public safety net, deserve. Incarcerated reproduction articulates what is at stake in an environment which lays bare the broader inequalities of society.

Governing Reproduction through Incarceration

There are many ways, as I have already suggested, in which the reproductive experiences of incarcerated women represent the classic strategies of biopower which Foucault delineated, controlling life at the level of the marginalized population of people who are disproportionately prone to be incarcerated and at the level of the individual pregnant prisoner whose behavior is regulated by the conditions of incarceration. It is worth acknowledging these legitimate political dimensions, for they are critical backdrops for the day-to-day interactions surrounding pregnant women at the Bridgetown jail; these predictable politics of control of reproduction also serve as a foil to some of the more surprising ways that care can be engendered in a carceral setting when the reproduction of future generations is involved.

Racialized mass incarceration and the criminalization of poverty are themselves techniques of differentially regulating reproduction (Roberts 1999; Silliman and Battacharjee 2002). With most incarcerated women in their 20s and 30s, they are removed from society during the prime of their reproductive years, precluding many (at least those with long prison sentences) from reproducing. This population level "reproductive disruption" (Inhorn 2007) is an example of "stratified reproduction" whereby some women's reproduction is devalued and suppressed while others' capacity to procreate is

valued and encouraged (Colen 1986; Ginsburg and Rapp, 1995). Furthermore, a recent exposé revealed that nearly 150 women in California prisons were coercively sterilized from 2006 to 2010 (Johnson, 2013). One prison doctor interviewed for the report justified the actions by saying the operation was cheaper than these women having more babies which the state would then have to support. This practice suggests that state projects aimed at suppressing the reproduction of the poor and predominantly women of color are not historical lessons in eugenics, but are evidence of active stratified reproduction.

Disturbingly, medical literature has documented that women who are incarcerated during their pregnancies have lower rates of preterm birth, still birth, and low birth weight than similarly matched controls in the community (Knight 2005). The logic of these epidemiologic findings is premised on the idea of removing a woman from an unhealthy environment, like the reasoning of the judge who sentenced Alisha to jail-time in her pregnancy. This fetal protectionist sentiment has also been widely translated in many states into criminal convictions of pregnant women who are perceived to be harming their fetuses in a variety of ways, most notoriously incarcerating pregnant women for using drugs (Paltrow and Flavin 2013). Such laws incarcerate women in order to multi-task at punishing women for what is simplified as bad behavior (see also Tsing 1995) and, ostensibly, at protecting the fetus from those "dangerous" mothers. Such policies elide the underlying structural forces which constrain these women's choices.

For the 6-10% of incarcerated women who are pregnant at any given time (ACOG 2011), their incarceration may be marked by abysmal access to prenatal care. A comprehensive review of pregnancy care in state prisons documented that 38 states had insufficient or no prenatal care, or inadequate arrangements for childbirth (Rebecca Project 2010). In a Department of Justice report, 54% of pregnant women in state prisons indicated they received no prenatal care (Maruschak 2008). Custody staff, who have no medical training, are usually the first point of triage for the subtle symptoms of pregnancy such

as bleeding and cramping which, even when mild, can be signs of labor, miscarriage, preterm labor or other conditions. Narrative accounts, lawsuits, and media reports also chronicle pregnant women's neglectful prenatal care at many facilities across the country (Levi and Waldman 2011; Roth 2012). I personally have reviewed, as an expert witness, cases from other county jails where pregnant women's bleeding was ignored and they miscarried or gave birth to still- and live-born babies in their jail cells. These harrowing instances are not exceptional on a national scale, and should not be forgotten as I further describe the conditions at the Bridgetown County Jail, where pregnancy care was thorough and attentive.

Twenty-nine states have no laws prohibiting the use of shackles during labor, so many incarcerated women end up giving birth in chains. Women who give birth while incarcerated, of whom there are approximately 1200-1500 per year (ACOG 2011), are separated from their children at birth; an exception to this are prison nursery programs. In thirteen states and New York City's Rikers Island jail there are special wings of the prison where babies live with their mothers for up to 18 months in some cases (Rebecca Project 2010).[2] Most incarcerated women, about two-thirds of them, are already mothers (Rebecca Project 2010); so when they go to prison or jail, they risk having their parental rights terminated if their children are in foster care for more than 15 months (Roth 2012: 5). Other pregnant women who want to terminate their pregnancies are frequently denied access to abortion (Sufrin 2009, Roth 2004 and 2012), despite clear legal precedent that they retain this right while incarcerated (Kasdan 2009)—although abortion was easily accessible for women at Bridgetown jail.[34]

What these examples show is that, whether being prevented from reproducing, disabled from maintaining their pre-existing motherhood, forced to continue an unwanted pregnancy, or actively giving birth, reproduction in prison is a critical phenomenon upon which problems of poverty, racism, gender roles, oppression, and societal responsibility converge. Pregnant women in jail or prison, by way of their abdominal girth, visually intimate the social reproduction of criminality and of structural

vulnerability. Much effort has been expended to explore the consequences for children of incarcerated mothers (Women's Prison Association 2009). Most of these studies demonstrate that children born to incarcerated women, especially if they are placed in foster care, are at high risk for being incarcerated as adults.

Surprisingly few scholars have explored the experiences of motherhood and the politics of reproduction from the level of the everyday experiences of both incarcerated women themselves and the people managing them. Existing narrative representations of women's pregnancy experiences convey neglect and callousness from the institution, including sparse medical care and humiliating shackling during childbirth, and the pain of being separated from their children (Watterson 1996; Warner 2010; Levi and Waldman 2011). These various reports of incarcerated women and reproduction rightly point out how women's reproductive capacity is always already enmeshed in patriarchal regimes of control (Roth 2012). Many of these representations try to humanize the plight of women prisoners through their status as mothers, a depiction which romanticizes the symbolic, affective dimensions of motherhood; such strategic romanticizations of motherhood may appeal to policy makers who could then improve conditions.

To be sure, the stories of Evelyn, Kima, Alisha, and other women in the Bridgetown jail whom I describe are rife with evidence of the state's deep regulatory involvement in every aspect of women's reproduction and the criminalized politicization of motherhood (see Roth 2012). But the existing accounts of the intersection of reproduction and incarceration are so focused on power dynamics and the oppression of women that they leave little room for understanding what is at stake for reproducing women suspended in the criminal justice system and for the guards and medical personnel who are charged with managing—and caring for—them.[5]

Ethnographic insight into reproductive experiences as they unfold in the jail context allows us to see the nuanced ways that institutions and the people who animate them can care and control in the

same gesture. Reproduction and incarceration come to shape each other, as reproducing women and the carceral apparatus give each other pause—in part because the politics of life at the core of both of these endeavors—to figure out what kind of care people marginalized by institutions and structural inequality deserve.

Favoritism

Anna approached the deputy watchtower and asked Deputy Brody if she could get some hot water. Anna held a shrink-wrapped bowl of Ramen noodles in her hand, the noodles thirsty for rehydration and Anna hungry for an evening snack she had purchased from the jail commissary. She was five weeks pregnant and her appetite had increased as soon as she learned she was pregnant—which was during her intake evaluation in CJ1, the booking jail, a few days ago. It was now 8pm in B-pod, outside the window of time when inmates are allowed to use the microwave in the pod's pantry. So Deputy Brody gently and sardonically reminded Anna that she could get warm water from the tap, but not the microwave. As Anna sighed in annoyed resignation, Deputy Walker, the other pod deputy for the evening, chimed in to override her colleague's enforcement of the rules. "It's OK. I authorized it. She's pregnant."

That last of Deputy Walker's pithy declarations hung in the air, as though it were an obvious justification for Anna being permitted to use the microwave off-hours. Deputy Brody also knew that Anna was pregnant, for her housing card had "pregnant" written on it in blue ballpoint pen, yet this did not move Deputy Brody to bend the rules. With the momentary displacement of her authority by her colleague, Deputy Brody quietly swiveled her chair back to some paperwork she had been doing. Anna steeped her Ramen in microwaved hot water and, back in her cell, slurped the noodles.

That same evening, Anna walked up the stairs, which involved passing by the watchtower. Deputy Walker stopped her, wanting to talk. "How far along are you?" she asked Anna. Even if she had been 5 months pregnant, it would be hard to tell underneath the baggy orange sweatshirt she wore. "5

weeks," Anna dutifully responded. Deputy Walker used this as an entrée to start a conversation with Anna about raising children. Anna realized it was going to be a long chat, so she got herself comfortable on one of the steps. Deputy Walker had a daughter in her late teens, and Anna was already the mother to a 14 year-old son, they quickly learned about each other.

For the next half hour, they shared their perspectives on spoiling children and teaching them discipline. Anna shared the story about her arrest, in her mind a misunderstanding that started with a dispute with her son. Deputy and inmate both reminisced about their own childhoods, eventually realizing that they went to the same high school, twenty years apart. They laughed, agreed with each other's parental insights, and talked about old high school teachers. Had my eyes been closed, I could have imagined that they were two friends getting to know each other over a cup of coffee. But then I would have opened them to see one woman wearing an orange jail uniform and the other wearing a black guard's uniform, adorned with handcuffs.

A few minutes after their conversation had ended, Anna called from the upstairs balcony and asked Deputy Walker if she could read the newspaper that was lying on watch tower desk. Deputy Walker looked furtively at a cell which housed a woman—not pregnant—whose multiple requests for the newspaper that night she had denied—"Because I'm not done reading it," Deputy Walker had told her. The other woman was not looking, so Deputy Walker quickly passed the paper to an inmate walking up the stairs, who then discretely passed the item to Anna on the upper level.

There were numerous examples like this of pregnant women getting tender, sometimes furtively delivered, care from the deputies. I noticed pregnancy kindness in the pods when a deputy would call a pregnant woman over to the watch tower, just to ask "how are you feeling?" It was not uncommon for deputies to transgress their own rules and give extra food to the inmates—if there was an extra meal tray, some deputies might offer it to a pregnant woman. I saw other deputies give a bag of chips from their work-issued meal to pregnant women. And some deputies even stealthily brought in

shrimp and steak burritos, or other outside food, for the pregnant women, delivering the food with a wink of the eye and a kind acknowledgment, “it’s for the baby.”

Deputy Walker’s favoritism for Anna, sparked by knowledge of her pregnant status, was not uniform. Not every pregnant woman in the Bridgetown Jail was treated with this tenderness at every moment by every deputy or medical staff member. To be sure, there was tremendous variability. Some deputies strived to adhere to the conventional wisdom that all prisoners should be treated the same, so they ignored pregnancies as much as possible. For instance, a few days later, I watched Anna in the holding area near the clinic flaunt her bag of ice to a deputy, telling him “you know why I got this? I’m pregnant!” He nodded his head without looking at her and without saying a word—until she left, when he said to me and the other deputies “now why should I care?” These stories of quotidian moments between deputies and a pregnant woman expose the ambivalence surrounding reproduction in jail: the mixture of exceptional concern and standard disregard for pregnancy.

Pregnant Inmate as Pangolin

Pregnancy is a socially complex state, and anthropologists have long been drawn to this complexity (Inhorn 2007). A classic interpretation views pregnancy as a liminal state, betwixt and between social status as a woman and as a mother (van Gennep 1966; Turner 1969), between the uncertain living fetus (Duden 1991; Weir 2006) and birthed, living child. Pregnant women are highly valued because of their biological capacity to enable social reproduction. Such reverence for Anna’s pregnant status in jail inspired Deputy Walker to bend the microwave rules and to deny a non-pregnant inmate the daily news. For the same powerful reason they are revered, pregnant women are also feared: they generate cultural anxieties about the social order they have the power to reproduce. This coexistence of reverence and fear contributes to pregnant women having an ambivalent, and, relatedly, ambiguous, symbolic status.

The fetus, too, is replete with ambiguity, cultivating a plethora of biomedical, religious, cultural, moral values whose polyvalent contradictions speak to existential questions about personhood (Casper 1998; Rapp 2001). In the US, the fetus is imagined as the ideal citizen (Berlant 1997), at once a tabula rasa for all of life's potential and also a figure already deeply entangled in social, economic, gendered, and political discourse. The multiple ways that broader social values converge on the fetus are crucial context for the pre-existing understandings that deputies and jail health care staff brought with them to the situation of pregnant inmates.

The ambivalence of pregnancy is tied both to this symbolic value ascribed to the fetus and to the mother's role in nurturing the fetus. We now take this interdependence of the maternal-fetal unit as a biological and social fact. However, Lorna Weir (2006) has carefully argued that the biomedicalized connection between pregnancy behaviors and fetal health is a relatively new understanding, emerging in the 1950s when the epidemiologic concept of "risk factor" developed. This shifted the threshold of when life began from the moment of birth to the nine month time of in utero gestation in pregnancy. The fetus too became an entity "at risk" of harm. Thus was created a need for prenatal care as a means for optimizing fetal life in the present, rather than deferring to the future after birth. The perinatal threshold of life, rather than the birth threshold, made pregnancy into an obvious site for risk governance, authorizing the management of the conduct of pregnant women—the do's and don'ts of consumption during pregnancy, the good pregnant patient who sees a doctor regularly, and who does not use drugs.

Because the fetus is viewed as highly dependent on its maternal host, it is a vulnerable figure who, in turn renders the pregnant woman vulnerable. She is implicitly seen as more susceptible to harm. The biomedicalization of our contemporary moment (Clarke et al 2010) has meant that pregnancy is seen as a physiologic state of increased needs which, if fulfilled (ideally through biomedical interventions), can mitigate the vulnerability. State and biomedical apparatuses, as Weir and others

have elaborated, intervene on pregnant bodies because of their precarious and needy status. After all, vulnerability opens us humans up to regulatory governance (Somers and Roberts 2008; Ticktin 2011). The vulnerability of pregnancy and of the fetus incites protectionist stances like the incarceration of dangerously behaving pregnant women, like the judge who sent Alisha to jail at 26 weeks.

Beyond its invitation to regulate, vulnerability is also what makes us entangled in social relationships, "the fact that one's life is always in some sense in the hands of others" (Butler 2009: 14). Apprehending another's potential for injury also reminds us of our own vulnerability (Butler 2009: xvi), which can therefore evoke empathy and be a basis for care (Garcia 2010). Accordingly, pregnancy, particularly when its vulnerability is revealed, can engender relationships of care. After all, Deputy Walker, a mother herself, was moved to provide special care for her pregnant charge, Anna.

Pregnancy is thus already enshrouded in ambiguity. Ambiguity, as I explored in Chapters 2 and 3, entails the coexistence of multiple, often contradictory, interpretations of figures or phenomena. That pregnancy is a valued force of social and economic reproduction, a potential threat to existing social orders, an act of gestating a being whose vital status is uncertain, a state of vulnerability opening up the pregnant body to regulation and care, these registers all contribute to its ambiguity. Jail amplifies that ambiguity. What to make of a fetus, that innocent, idealized citizen who is in the womb of someone who is being punished for committing a crime? Is the fetus incarcerated? What is the transference of freedom and confinement when the fetus is born from the womb of an incarcerated mother?

Mary Douglas' analysis of the pangolin is useful here (1957). The pangolin is a four-legged animal which lives on land but has the scaly body and tail of a fish; it also gives birth to one offspring at a time, like humans and unlike animals which birth a litter at a time. The Lélé of central Africa took the contradictions of the pangolin as ritually symbolic, and saw the pangolin as mediating between human, animal, and spirit worlds, with the ability to bring both fertility (because of its association with water) and herds of animals. The pangolin is an anomaly, a figure upon which apparently contradictory

categories—like land and sea— converge. As people manage the potential threat of an anomaly, it becomes something through which "people both pronounce cultural distinctions and imagine their alternatives. With the plural uses of these anomalies, cultural values are simultaneously experienced, made real, and questioned" (Whitmarsh 2008: 13-14).

With this understanding of anomaly as merging contradictory categories with symbolic force, the figure of the pregnant, incarcerated woman can be seen as hyper-anomalous. Not only does she contain the contradictory categories of certain living subject (woman) and uncertain living subject (fetus) which all pregnant women carry; but she also combines various characteristics of life-giving and life-depriving, gestating as she does in a carceral dwelling designed ostensibly to deprive and dehumanize. The pregnant prisoner also transgresses expected gender norms by allegedly committing a crime. It is through this anomalous figure, who conjures ambiguities, that jail workers and inmates in the Bridgetown jail sorted through the tension between what kind of care can emerge a punitive context.

Pregnant Inmate as Moral Slate

Because of this anomalous and ambiguous status, having a pregnant woman in their midst triggered deputies to discuss amongst themselves broader questions about who should and should not be reproducing. Even if the full belly was not visible through the baggy orange clothing, the "pregnant" label on the housing card marked a woman's status and brought with it a constant, low-level reminder of the fetus, with all of its political baggage and suggestion of future generations. The discordant situation of life-giving pregnancy in life-constraining jail was a prompt to map societal level values of motherhood and reproduction onto the figure of the pregnant inmate. This speaks to "moral regimes of reproduction," which Morgan and Roberts (2012) argue are the standards from which reproductive governance arises. Building on Fassin's application of the politics of life as the mechanics of how human lives are valued (2009), moral regimes of reproduction are about "the evaluation of actions and

ideologies related to generation, perpetuation, and human continuity" (Morgan and Roberts 2012: 242). Such moral ruminations on human continuity through the bodies of female prisoners were part of how the jail managed them.

One day when I sat with the deputies in the holding area, Nicole, a woman I knew had recently had an abortion while incarcerated, walked from the holding cell to the clinic to see NP Vivian for a post-procedure follow-up. After she left the holding area, Deputy Carter began to talk about her. He had noticed that her housing card used to say pregnant, but now it was crossed off. Deputy Carter assumed, correctly, that Nicole had terminated the pregnancy—although the change in pregnancy status could have also signaled a miscarriage. "I don't want to sound like I don't respect life and all, but maybe it's a good thing she's not bringing a baby into this world. I mean, some of these people shouldn't be having babies they can't take care of." Another deputy nodded his head in agreement, similarly adjudicating who should and should not be reproducing based on their ability to display maternal norms, to raise their own children, to not use drugs, and to be upstanding citizens.

The conversation led Deputy Carter to reminisce about Raquel, a woman who had been in and out of jail several times a year for the last twelve years. She had delivered six babies while in custody—I myself took care of her during one of these pregnancies—and all of them were funneled immediately into foster care. Deputy Carter recalled watching over her in the hospital nursery after one of her deliveries. Raquel cradled the baby in her arms, cooing and bonding with the infant. Deputy Carter folded his arms in front of him, as though he too were rocking a baby while he told the story. A social worker from Child Protective Services then arrived in the nursery, not to tell Raquel that she was taking the baby, just to inform Raquel that she was looking into the case.

"As soon as this lady walked away," Deputy Carter recalled, "Raquel practically dropped the baby back into the basket and says 'I wanna go back now.' And all that tenderness, all that mother love went away in an instant. I mean, not meanly, but, she was done with that baby." This is the kind of

woman that should not be bringing babies into the world, these deputies agreed. Here, moral regimes of reproduction about the ideal, loving mother were small talk, part of how the deputies filled their down time in their day. These judgments were then folded into the work custody staff did to manage pregnant inmates as both equal to other inmates and as having exceptional needs.

The tone among this group of deputies, all male, was one of resigned cynicism. Other deputies I spoke with expressed anger. One male deputy, Deputy Randolph, summarized for me what some of the female deputies have expressed to him about the pregnant women in jail:

> There are a number of female prisoners who come through here, repeatedly over the years, pregnant. It really causes a pretty deep negative emotional response with the female deputies. They just are angry about it. That's a very complex thing. They're angry about it, because in their perception the woman is irresponsible. She's not practicing any kind of birth control. She wants the county to pay for all this, to take care of this, somebody else to take care of the baby. They're angry because they feel bad for the babies.

Though he characterized the anger as being specific to the female deputies, it was clear from Deputy Lewis's exasperated sighs, his shaking head, and his gesticulating hands that he, too, felt some anger towards pregnant inmates.

As they freely expressed among themselves their judgments about the reproductive limits of women in their custody, these deputies also, as I observed, maintained professionalism in front of the pregnant women. Other deputies did not. Evelyn had reproductive insults hurled at her by some deputies, as she told me:

> One deputy told me I needed drug rehab, not a baby, that I shouldn't — Why am I bringing another child into the world? They said I should be — I should — She was being really rude. She basically was saying because I'm an addict, I shouldn't have kids. Like, I should go to a drug rehab and not — She told me I needed to get an abortion, basically. That's what she told me.

I observed other deputies who treated Evelyn tenderly and carefully, who snuck food in for her. Whether they kept their comments to themselves or shared them directly with the inmates, deputies encountered pregnant women as a canvas on which to consider a broader cultural narrative about

appropriate motherhood and the societal burden which these women's children, extracted from their custody by social services, created.

Institutional Vulnerability

Another element of a pregnant prisoner's status as an ambiguous figure was that while she may be vulnerable to the whims of the institution, she also could be a danger, a liability. A pregnant prisoner had the potential to reveal weaknesses in the institution. Although most pregnancies proceed uneventfully, complications can arise for any pregnant woman—bleeding, miscarriages, pre-term labor, still birth. If something happened while a pregnant woman was incarcerated, then the jail would be held accountable. Furthermore, fights occasionally broke out in jail, a hazard if a pregnant inmate was involved. The Bridgetown jail administration indirectly revealed its stance that jail and pregnancy were a potentially dangerous combination when Deputy Lewis was given a reassignment when she announced that she was pregnant. Starting in her first trimester and for the rest of her pregnancy, she was removed from the role of "pod deputy," where she interfaced and managed inmates constantly, and could risk having to deal with a violent inmate. During her pregnancy, then, she was assigned to work in the central command tower, watching security camera screens and pushing buttons to remotely permit other people's movements through metal doors throughout the jail. Security from a distance, without direct inmate interaction.

At a pragmatic level, the anomalous figure of the pregnant prisoner with her highly dependent fetus was a looming threat to the institution. Deputy Allston shared her fear with me: "It does feel like a liability, because one of them can trip and fall down these stairs and is maybe a lawsuit ready to happen." This is not a theoretical threat, for many jails and prisons across the country have had lawsuits brought against them for neglectful care of pregnant women and adverse fetal or neonatal outcomes (Roth 2012). The liability from the fetus in jail meant that deputies had to be hyper-vigilant of pregnant women—from watching how they walked up and down the stairs to retrieve their meal trays, to having

a low threshold to transport a pregnant inmate to the hospital. For behind a pregnant woman's symptoms of pain, bleeding, or even, as Deputy Randolph joked, "a hiccup," lurked the potential for fetal harm, for perceived neglect, and for subsequent legal consequences. In jail, the fetus' and pregnant woman's interdependent vulnerability thus reciprocally made the institution vulnerable. It also inverted the usual power vector between and inmate and a jail worker. The pregnant woman, by virtue of her fetus, was a threat to the institution, and therefore had power over jail staff who had to care for her accordingly.

This vulnerability and powerful threat of the pregnant inmate blurs the line between penal logic which tries to tame the threat of an inmate and caring concern for the mother-fetus unit. That is to say, it was sometimes difficult to discern whether the increased attentiveness to pregnant women represented jail staff's fear of liability, or their genuine concern for the well-being of the woman and the fetus. Alisha, who was in jail from when she was 26 weeks to 36 weeks pregnant, experienced the deputies' attentiveness to her pregnancy state both as nagging control and compassionate concern. "Sometimes they [the deputies] treat me okay. Some treat me special. And some of them just, is like, really cold and rude. . . . They'd be like: Well don't do this, and don't do that." One day, she ran up the stairs to get her meal tray, and a deputy scolded her to "slow down" and "hold onto the rail." Another day, she danced to the music playing on the pod's boom box during free time, and a deputy told her she should not be dancing, "because of the baby."

Alisha was annoyed at their micromanaging, policing comments: "Just because I'm pregnant, I mean, I can't dance? Sometimes it's bothersome." And yet she also recognized that within the discipline was a hint of concern and care. "But sometimes it's good to know that people care." Alisha recalled one deputy's worried response when Alisha told her she had not felt the baby kick that day: "I guess she [the deputy] had been pregnant before, so Deputy K. was like: 'As a woman, I'm going to take you now to medical. If you have to go down to medical 100 times a day so you can feel safe to know that your

baby's all right, then that's what you've got to do.'" Importantly, Alisha sensed the ambiguity around the object of care. "Is it that they care about me, or is it just the baby?" The answer to Alisha's astute question was never clear.

Deputies often routinized the need for hyper-vigilance with pregnant women as a job-related nuisance. Deputy Allston explained that the hospital transports for pregnant women were a burden:

> It taxes the staff because we have to go all the way to the hospital and come back. That takes away another deputy from our minimum. So, we rarely have enough staff to cover what we need to cover, and then on top of that, take on another added responsibility of a pregnant [woman].

One night, I was on call on the Labor and Delivery unit at Bridgetown County Hospital. At about 10pm, a woman in an orange jail uniform walked onto the labor and delivery unit, wrists cuffed in front with blue plastic handcuffs, and a male guard by her side. I recognized both of them. The patient was Evelyn, who was now 37 weeks pregnant, and the deputy was Deputy Faderman, whom I had gotten to know during his afternoon shifts at the jail.

I knew from the night nurse at the jail, who had called the hospital, that Evelyn was here because her water may have broken. But Deputy Faderman did not know such details. He presumed that the jail nurse ordered the transport because Evelyn might be in labor, even though Evelyn did not have any contractions in the van ride from the jail to the hospital. So while Evelyn was behind the curtain getting changed into a hospital gown, Deputy Faderman turned to me with a roll of his eyes and said with complete sarcasm, "Yeah, *she's* in labor." The end of his shift was nearing. He was annoyed that he had been dispatched to the hospital, that he was going to have to stay on duty well past when he had expected. Treating pregnant inmates as nuisances with an excess of needs attempts to place these uncertain, liminal figures back into the mundane category of inmate.

Normalizing Pregnancy, Normalizing Jail

There were ways in which pregnancy in jail, as anomalous as it might seem, invited normalizing gestures. In the introduction, I described how Kima, 34 weeks pregnant, performed a dance at the

talent show in D-pod. She also recited poetry and sang, quite beautifully, a rhythm and blues song "No Matter How Hard it Gets." Kima performed so comfortably, so joyously, and got even more energized as her podmates cheered her on. She was at ease, in jail, rubbing her pregnant belly with other incarcerated women providing encouraging words. There were no gifts for Kima, but the celebratory, supportive tone of the talent show gave the event the feel of a baby shower. Having learned from Kima about and seen some of the places where she spent her life on the streets—at the subway plaza teeming with commuters and drug dealers, in SRO hotel rooms, and in the small apartment of her frail mother (herself a recovering addict who had spent time in jail in her youth)—I surmised this was more of a celebration than Kima would have gotten outside of jail.

Coincidentally, just a few hours earlier, I had attended a baby shower in the deputies' break room for Deputy Lewis, who was now 36 weeks pregnant, and who had survived 5 months of the safe, uneventful work assignment in the control tower. Pizza, a frosted cake, and "It's a boy!" banners made it easy to forget that we were in a jail. Celebratory moments of pregnancy were possible in this ostensibly austere space of the jail. Deputy Lewis's black Sheriff's Department uniform clung to her pregnant belly tightly and awkwardly, her shirt untucked; clearly there was no maternity size. There was also no maternity jail uniform for Kima. Just an extra, extra-large thin orange t-shirt that made it hard to discern whether Kima was pregnant or just obese. Although some female deputies who had been pregnant might have found ways to identify with pregnant inmates, the imagined similarities could only go so far.

Deputies conjured sympathetic responses to inmates' reproduction when women displayed culturally appropriate maternal emotion. This was the case when Nellie had a miscarriage at the Bridgetown Jail. Nellie, like so many others, first found out she was pregnant when she got to jail. At 39 years old, she already had given birth to nine children, starting when she was 13. It had been 12 years since her last pregnancy, so Nellie was quite shaken to learn, in CJ1, that she was pregnant again.

It had also been many years since she had been in jail. Nellie lived 200 miles from Bridgetown, and only got into trouble when she came to Bridgetown. She had traveled here a few weeks ago in order to make some "fast money," by prostituting and selling drugs. It was Christmas-time, after all, and she needed money to buy presents for her nine children—none of whom she had raised but all of whom were still in her life— and 3 grandchildren. But her fast money activities led her to jail, where she also found out she was seven weeks pregnant. Initially, she had wanted an abortion. But as the days passed in jail, as her incarceration enabled contemplation, she had decided to continue the pregnancy. Maybe this would help her get her life back on track, she thought. I met her in clinic the day she excitedly affirmed her resolve to keep this baby. I did an ultrasound to measure how far along the pregnancy was. In a cruel twist of fate, the embryo had no heartbeat. Within minutes, Nellie's transformed pregnancy hopes had to be transformed yet again. She was visibly upset when she returned to D-pod.

An hour later, Deputy Anderson called me in the clinic from D-pod. A tall white woman with a hair slicked back into a tight, long braid, Deputy Anderson was someone whom I had never seen smile. She had a quiet demeanor, but like anyone in charge of jail inmates, she could get loud and authoritative at any moment. "Is Nellie pregnant?" Deputy Anderson asked me in a monotonous, business-like tone. I hesitated to answer, concerned about protecting Nellie's privacy. Deputy Anderson jumped in, "She told me that she had a miscarriage, so I just want to know if I need to take 'pregnancy' off of her housing card." It was a reasonable, pragmatic question for someone charged with overseeing people in their intimate living quarters.

Since Nellie had clearly shared the news with Deputy Anderson, I felt authorized to confirm the medical facts. "Well, there is no heartbeat, so the pregnancy isn't viable. But it's still inside her, and we're working on a plan to take care of that," I informed her. As it turned out, Nellie later told me, Deputy Anderson had intuitively noticed Nellie's sad affect upon her return to D-pod after clinic. "Are you OK?" she had gently asked Nellie. Nellie felt at ease with Deputy Anderson, and with all of the

women in D-pod. So she had no qualms sharing her sad news with everyone. In fact, Nellie wanted to, so that people could support her.

In the subsequent week, when deputies would ask Nellie about her pregnancy, she tearfully told them the news. She was warmed by their kindness. Nellie explained that they would tell her, "'Oh, I'm so sorry to hear that. I'm really sorry to hear that you had a miscarriage.' They were very concerned and very supportive." The kindness continued when Nellie went to the hospital for a procedure to end the miscarriage. The hospital deputies let her watch TV, and fed her some homemade barbeque chicken they had brought into work that day. "Oh my god, I tore it up, it was so great. They just treated me like I was a princess," Nellie recalled with amazement. Jail medical staff were also supportive, Nellie noted. But it was the deputies, with whom she interfaced more regularly, whose kindness surprised and even sustained her.

Nellie had responded, at least outwardly, with the appropriate and expected maternal response to a miscarriage: grief. Unlike the woman whom the deputies disparaged for not lovingly holding her newborn baby, Nellie deserved the deputies' sympathy. The moral regime of the carceral system of care imagined a pregnant figure who expressed conventional emotions of attachment to the gestating fetus. The system's maternal ideal recognized the reality of drugs and criminality on the streets, but held onto the idea that jail could be a space to cultivate "healthy" pregnancy behaviors or appropriate maternal sentiment. What first appeared as an inconsistency of categories, Nellie's pregnancy and incarceration, emerged as a normative yet ambiguous experience in which a woman grieving over a miscarriage could elicit compassionate concern from those with power to manage her daily life.

Hyper-medicalizing Pregnancy

The jail clinic staff were equally involved as the deputies in managing the ambiguity around the status of a pregnant inmate. Pregnancy magnified the medicalization of the comforts of daily living that already existed in the jail, discussed in Chapters 2 and 3. Being pregnant in jail activated a special

cascade of medically prescribed privileges. As soon as medical staff knew that a woman was pregnant, they ordered a series of pregnancy-justified amenities: a chrono for a lower bunk, to avoid the fall risk of climbing up to a top bunk; ice to encourage hydration; a daily prenatal vitamin; and a pregnancy diet. The pregnancy diet included an additional bologna sandwich at lunchtime, and an evening snack of a carton of milk and a piece of fruit.[6]

These few additives to jail life were highly coveted.[7,8] In the pods, these privileges also became routine reminders for the pregnant women, other inmates, and deputies of this woman's gestating state. Bologna, ice, and a bed became medicalized in this jail setting of relative deprivation. Pregnancy's status as worthy of exceptional treatment in the jail thus got codified into how pregnant women were managed, medically and mundanely in the jail.

Pregnancy in western societies, as already discussed, has become a highly biomedicalized event, with prenatal visits, lab tests, screening for genetic abnormalities, ultrasounds, weight checks, urine testing, and blood pressure monitoring ensuring thorough surveillance. The "technocratic model of pregnancy" (Bridges 2012: 83) has been well documented in the literature as a regime of care premised on a pathologized understanding of pregnancy (Davies-Floyd 2003). Khiara Bridges (2012) has explored how this model of pregnancy is woven into the social management of poor, black, pregnant women receiving state-sponsored prenatal care at an urban safety net clinic in the New York. In exchange for free prenatal care and other social services, the Medicaid infrastructure demands that women disclose extensive, private details about their home lives. Certain aspects of their lives—such as strained relationships, housing conditions— then are translated by the Medicaid system to be risks for the pregnancy, which then authorize the publically funded health system to further intervene on women's pregnancies with more testing or clinic visits. The pregnancies of poor, black women are excessively medicalized, Bridges argues, by the public system upon which they rely, which constructs these women's bodies as unruly and in need of further medical regulation.

Moreover, Bridges continues, the medicalized pregnancy model as applied to poor, black women excessively medicalizes them by consistently categorizing their pregnancies as "high risk" due to their myriad struggles with inadequate nutrition, poverty, marginal housing, unemployment, poor social support. These experiences of structural vulnerability have been taken up in epidemiologic discourse which associates these women's status with negative pregnancy outcomes like preterm birth and low birth weight. Translating these women's poverty into risk, Bridges writes, homogenizes individual women's experiences of marginality into one of a population which therefore authorizes increased state intervention—such as state-mandated investigation into living environment and behaviors as a condition to receive free prenatal care—in order to mitigate the "risk factors."

This perspective on excess medicalization is relevant for understanding, and for nuancing, the medical management of pregnancy in the Bridgetown jail—which, as we know, disproportionately housed poor and black women. For example, in our clinically-based discussions about pregnant patients, Vivian and I routinely talked about these pregnancies as "high risk," because of coexisting drug addiction, mental illness, poor nutritional status in the community, domestic violence, sexually transmitted infections, and other factors which could be traced to these women's poverty. This trope defining incarcerated women's pregnancies as high risk because of their pre-incarceration lives can also be found in the scant medical literature about pregnancy among incarcerated women (Knight 2005; Clarke and Adashi 2011) Simplifying a range of complex life experiences which all have a deep political economic context has its dangers, to be sure, as Bridges delineates. And yet simplifying the embodiment of incarcerated women's marginality into the category of a "high risk pregnancy" can also be a linguistic signifier for providing care and services for women who have otherwise been neglected. I myself have found the categorization, politically laden as it is, strategically useful when trying to convince practitioners at other jails and prisons about the need to improve services for pregnant women.

Additionally, the clinic at the Bridgetown jail explicitly aimed to provide equivalent, community standard of prenatal care in the jail; the clinic followed the prenatal care guidelines used at Bridgetown's publically funded DPH clinics, which were much like the one Bridges described.[9] What was different from the community clinics in jail was that the prenatal care surveillance occurred even more often: every one to two weeks, even in early pregnancy, as opposed to every four weeks.[10] One might say that this, along with the medical privilege system, *hyper-medicalized* incarcerated women, a strategy of reproductive governance. Or in the institutional vulnerability approach, the hyper-medicalization might be seen as protecting the jail from liability. These interpretations are certainly valid readings of disciplinary practices; but they overlook the intimate, relational aspects of care.

The frequent prenatal visit protocol at the jail was formalized in part by Vivian and myself. Part of our explicit reasoning indeed included a predictable risk discourse that these women's pregnancies, by virtue of coexisting malnutrition, mental illness, and addiction, were at higher risk for complications. Moreover, we knew that many of these women were not accessing prenatal care in the community. Jail prenatal care was a way to mend the absences in their non-jail lives.

But Vivian and I also discussed the high frequency of visits as an intentional desire to provide these women with recognition. Many of our patients had disclosed to us their fears about being pregnant in jail—fears of being neglected, that something might happen to their baby, feeling alone, and having to be separated from their newborns after birth. Vivian and I were deliberate in our hope that interfacing with medical staff in clinic would allay some of their fears, would provide them with recognition of their pregnant state, and of the women themselves. We wanted them to feel cared for. This was, perhaps, the antipathy to deliberate indifference.

The frequent prenatal visits enhanced the familiarity between clinicians and pregnant patients. Combined with the intermittent ability to spend longer with the patient in the jail clinic than at a community clinic, a particular kind of temporality helped to enable intimate relationships with pregnant

patients. So did recidivism, for women like Kima and Evelyn were incarcerated several times during their pregnancies. In the clinic's exam rooms, Vivian and I would both rush through the standard questions about contractions, bleeding, fetal movement, for we had come to expect that our pregnant patients wanted to talk: about their excitement and fears of the pregnancy, their boyfriends, their other children, their childhood sexual abuse, their drug addiction as salve for the abuse, their intentions to or disinterest in attending drug treatment programs. As Vivian had said on a number of occasions, "sometimes they just want someone to listen to them."

I had started seeing Evelyn for prenatal care in the jail when she was about five months pregnant. The first visit was quick. She was still coming down from drugs and was not up for talking much. The second week was also quick, as the deputies needed to move Evelyn back to the pod as soon as possible, so that one of the deputies could go on his lunch break. By the third week, Evelyn was sober and the deputies did not bother me about timing. So I decided again to try to get Evelyn to talk about her addiction. Instead of a quantitative question about how much, I started boldly with "Evelyn, what do you like about crack?"[11] Her single-word answers and the lack of eye contact from previous weeks were insufficient for that kind of a question. We sat in an extended silence, the way one minute of quiet can feel like an hour. She slowly nodded her head to introduce her speech. "It feels good. It feels real good." Then the good turned into bad. "Mostly it just helps me forget." It helped her forget, she explained, about how her father and uncle had abused her as a child, something, she told me, she had barely talked about in the last 15 years. According to Bridges' interpretation of prenatal care for poor, black pregnant woman, this conversation might have been viewed as an instance of a state-sponsored medical establishment extracting detailed, private information from patients in order to refer them for other services, further inscribing them into relationships of state dependence (Bridges 2012: 72). But Evelyn continued.

She narrated her current struggles, and continued to open up to me the following week.

> I want to get off drugs, I want to stop using, but it's hard. I'm getting out soon, and I have no place to go. I'd go to Whitman House [a residential drug treatment program for mothers and children], but they told me I can't go back, since I left once before.

Evelyn was figuring out her options, anticipating release soon. I felt inept at helping her—every idea I had she had already looked into. Her knowledge of what safety net services did exist in the community far eclipsed mine. In the long, intense clinic visits, I learned a lot about Evelyn, more than I did of my patients in the community. She had a witty personality and a sly, charming smile. I was growing quite fond of her. I felt sad one day when I learned that, in the middle of the night she had been released from jail. Back to the streets. I knew, because Evelyn had told me, what that meant for her. It was an unsettling feeling to have, to be disappointed that someone was released from jail, to imagine the dangers encountered on the streets that were absent in jail. Indeed, a month later, I ran into her at 60th and Atlantic streets, high on crack, in the scene I described at the start of the introduction. When Evelyn then inevitably returned to jail six weeks later, our weekly prenatal visits continued.

The frequency of prenatal visits in the jail clinic enabled a kind of intimacy that is more difficult to achieve in the community, where overbooked schedules and the exigencies of insurance companies and Medicaid constrain time. This is not to say jails do not need to care for a large number of patients, nor is it to say they work without time constraints. It is to say that if some visits take longer, a waiting patient can easily be seen the next day. Moreover, recidivism was, tragically, built into Evelyn's life. Frequent medical pregnancy visits in the Bridgetown jail capitalized on that recidivism, an ambivalent position of exploiting her apparent misfortune, and cultivating intimacy of care which Evelyn did not experience on the streets. This is the essence of "jailcare," the kind of care born out of ambiguity—ambiguity from recognizing how the jail can in some ways be more nurturing and healthy than life on the streets.

"Instead, the police is doing it!"

The jail clinic's hyper-medicalization of pregnancy, at one level, appeared as a technique to sort this pangolin-like figure of a pregnant inmate into a recognizable category of pregnant patient. In dealing with the anomalous pregnant women, jail medical staff, like deputies, were articulating what kind of care these women deserved while they were in jail: regular prenatal care, like they would have available for free in the community; ultrasounds (done at Bridgetown County Hospital), blood pressure checks, auscultating the fetal heart rate with a handheld Doppler machine.

There were aspects which made it impossible to fully create the semblance of a community prenatal clinic, like the fact that we providers had to talk to pregnant women in their third trimester about signing the official form with a jail case manager to designate where the newborn would go, should she give birth while in custody—to a responsible and willing family member or friend, or, for those who did not have such a figure, foster care (nursery programs to keep mother and child together did not exist at the Bridgetown jail, and generally jails have too much flux to make such a program feasible). But in general, the fidelity to routine, standard-of-care prenatal care aspired to create equivalence with prenatal care outside of jail, to minimize the strange reality of providing care within a carceral institution. Yet as much as the clinic's pregnancy care tried to forget the jail environment, to clarify the space as a clinic, ambiguity nonetheless flourished in these attempts at clinical normalization. Shante's experience of a miscarriage, which differed from Nellie's, is a key example of this.

It was late afternoon in E-pod, after dinner time, when Shante's bleeding and cramping started. She was eleven weeks pregnant, and had been unsure whether this was the right time in her life to have a baby: she worried about her financial ability to support a child, her unstable housing, and whether she would get support from her boyfriend who was also in jail. But when the bleeding started, her ambivalence faded as fear and devastation set in. The pod deputy called the clinic and a nurse came to E-pod. He took Shante's blood pressure and pulse, told her she was fine and that she could wait for her

scheduled appointment in clinic in two days. Shante said she felt neglected, but had little ability to do anything. The next day when her bleeding increased, Deputy Sinclair called a nurse back to the pod. This time, nurse Patrick saw how much blood was in the toilet, and had Deputy Sinclair escort Shante to C-pod, the medical unit, where he could keep a close eye on her. Patrick discretely arranged for a hospital transport, and called the emergency room to prepare them for her arrival. From a purely clinical standpoint, he gave appropriate medical care.

For Shante, this medical experience was a nightmare. She waited for over two hours in the wheelchair, bleeding through her clothes. Shante felt scared. She had no idea that Patrick was planning to send her to the hospital, because Sheriff's Department rules prohibited medical staff from telling a patient such things (the inmate could, in theory, make a phone call to a friend to help stage an escape). While they waited for the transport vehicle, Patrick continued with his many other nursing tasks in C-pod and barely said a word to Shante.

Despite what she perceived to be neglect from the nurse, Shante did not feel alone. Notably, Deputy Sinclair waited with her in C-pod. The gesture was procedurally unnecessary: there were plenty of deputies in C-pod to watch over Shante. But Deputy Sinclair had experienced the scare of bleeding in pregnancy herself. She tried to reassure Shante by sharing her own story, and how she went on to deliver a healthy baby boy. Deputy Sinclair comforted Shante with words like "Everything's going to be OK." She massaged Shante's shoulders. She helped Shante back and forth to the bathroom to change her blood soaked pads. And she stayed with her. In sharing her own experience as part of her tender care of Shante, this deputy offered an empathetic response, even infused with an isomorphism between Shante's pregnancy stress and her own. What made the Deputy Sinclair's care even more nurturing for Shante was that they had an 18-year connection. In a disturbing intergenerational coincidence, Shante's mother had given birth to her while she herself was incarcerated, at a jail in a different part of the state. Deputy Sinclair had worked at that other jail at the time, and so had met Shante as a newborn. This

connection since birth put Shante especially at ease with Deputy Sinclair's solace at this reproductive event. Perhaps it was this connection which made Deputy Sinclair particularly attentive to Shante's situation.

Reproduction in jail enabled a shift in expected sentiments. Shante expected compassion from the nurse, and callous disregard from her jail guards. Instead, she experienced nurse Patrick's procedural concealment of the plan and going about his other tasks as lack of care. As she declared a few days later:

> Medical staff, and the whole medical system, is full of shit. Like they don't care about you here. Like they do anything, they give you anything. They tell you to do this, they tell you to do that, they don't tell you to do this when you really need to do that. So it's like they don't care.

Instead, Shante felt compassionate concern from a uniformed agent of the jail's disciplinary apparatus. Deputy Sinclair did "everything that the medical staff should have been doing. But instead, the police is doing it," Shante noted.

Shante was transported to the hospital and then back to jail. She finished passing the pregnancy in the bathroom of the jail clinic the next day. Shante's pregnancy loss brought into relief different relationships of care and punitive confinement. The pangolin characteristics of a pregnant incarcerated woman experiencing a loss draw our attention to how jail staff negotiate what kind of intersubjective care inmates deserve. Deputy Sinclair was guarding her charge, but had also deemed that the reproductive event made Shante deserving of her solace. Nurse Patrick's approach involved a clinical calculus of triaging a patient for acuity; this pragmatic form of care was refracted through the jail rules which necessitated his concealing the hospital plan from Shante. And this non-disclosure made Shante feel uncared for. The ambiguity inherent to the pregnant prisoner's status enables further ambiguity in the forms of care which emerge within a confining institution.

Spectral Ambiguity: Shackling Pregnant Women

Pregnant women in jail can also be seen as anomalies because they are prisoners whose bodily processes mark them as distinctly female in an environment designed for males. Feminist criminal justice scholars have enumerated the ways in which the US prison system is distinctly gendered (see among others Bosworth 2000; Britton 2003; McCorkle 2013). From linear, non-communal architecture to the toilets, from jumpsuit uniforms to male-centered programming, from an inability to deal with women's health issues to misrecognition of women's different pathways to crime, these scholars have consistently exposed the highly gendered nature of the US carceral system.[12]

The visible, physiologic changes of pregnancy, a state that has classically essentialized women to their reproductive capacity, present a stark challenge to a system which homogenizes all subjects into a particular hierarchical and masculine environment. While pregnant women make up less than 1% of the incarcerated population, the impact of the imprisoned pregnant female body is significant, as noted by the deputies who were worried about pregnant women and their vulnerable fetuses being a liability for the institution.

It is hard to think of a practice which more graphically illustrates this categorical clash between pregnancy and a male carceral system than the shackling of pregnant, incarcerated women. When any inmate, male or female, is transported outside of a correctional facility to a court appearance or to the hospital, it is standard procedure to restrain that person—even while a patient prisoner is in a hospital room, with a guard outside the room—to prevent him or her from absconding. The restraints may be applied in a variety of ways, usually combined: iron chains around the ankles and the abdomen; handcuffs around the wrists, behind the back; chains connecting one prisoner to another, reminiscent of chain gangs from slavery days.

These techniques of control—ostensibly to ensure "public safety" when presumed dangerous criminals are in public spaces—make little sense and pose medical risks for pregnant women. A woman

who is labor would have a difficult time escaping in between painful contractions, not to mention the fact that most incarcerated women are not "dangerous criminals," but are arrested for non-violent crimes. Moreover, the medical risks of shackling pregnant women are clear, with potential for maternal or fetal harm if a woman trips because shackles impair her already compromised gait, or if an obstetrical emergency arises and iron chains obstruct medical interventions (ACOG 2011). Numerous medical professional organizations have outwardly condemned this practice on medical and human rights grounds.

Nonetheless, pregnant women are still shackled in this country. Only 21 states have laws prohibiting this practice.[13] Mothers who have experienced this and advocacy groups leverage concepts evocative of human rights—lack of dignity, humiliation, exacerbating the pain of the isolated, incarcerated birth with chains. Women writhing in pain, laboring in childbirth, while locked in chains. Such an image invokes what Veena Das (2004), Taussig (1997) and Aretxaga (2003) have identified as the spectral performance of the state in the everyday. State power, these authors have explored, is too often examined in its obvious, central locations like governments and militaries. Instead, they describe instances where the power of the state is visible in theatrical performances in everyday life, such as elaborate handling of divorce papers of an Indian widow, or the rituals of a border checkpoint (Das 2004). Taussig writes metaphorically of the circulation of the state through people's daily existence by describing elaborate performances of spirit possession, which are then fetishized by people in highly valued wax figurines. Aretxaga (2003) extends these ideas to explain how the rational technologies of control—such as incarceration—that we so often associate with state power are animated less by rationality and more by fantasy, intimacy, and bodily experiences. These fantastical qualities which are part of the routine, daily functioning of the state are what make it spectral.

Shackling of pregnant women can similarly be thought of through this analytic of state power circulating through people's bodies in performative ways. The spectral force of the state comes not from

the mere technology of restraints, but from the graphic, bodily experience of iron chains constraining a woman at a moment culturally scripted to be one of the most intimate moments imaginable, birthing a child from womb to world.

It is a visceral image, a woman giving birth in chains. But the spectrality of this practice becomes normalized in its everyday unfolding. In states where there are no laws prohibiting the practice, shackling pregnant prisoners is a matter of routine; it is done because that is what is done with all prisoners who are transported off site.

As an obstetrician in Pennsylvania in 2004 before the state passed an anti-shackling law, I delivered the baby of a woman who was shackled. I have colleagues in other states who must deal with this in their hospitals, and have told me with great emotion the challenges of trying to care for the patient and of negotiating with the guard to remove chains. On labor and delivery units in such circumstances, shackling is usually confronted as conflicting discourses of risk and threat: from the guards, threats to public safety if she is not restrained; and from medical staff, threats to maternal and fetal well-being. The safety friction positions the fetus, soon to be born, in uncertain terrain, between an incarcerated womb and the outside world. Who exactly is being shackled and who exactly is at risk? The fetal subject interposed between the incarcerated subject and the oppressive carceral apparatus problematizes the goals of discipline and punishment, and calls into question the kinds of life that can be subjected to such repression.

Banality of Shackling

In Bridgetown, shackling was rarely an issue when pregnant women were brought from the jail to the hospital for childbirth, due to a 2005 California law prohibiting the shackling of pregnant women during transport for labor, labor, and post-partum recovery, and due to the Sheriff's Department's appropriate response to change their policies and practices. However, not all California counties complied with the law, and the law still implicitly permitted shackling at other points in pregnancy, even

though the same medical risk and irrationality apply outside of labor. The day that Alisha was released from jail, 36 weeks pregnant, I watched as the deputies put handcuffs around her wrists as they escorted her from E-pod to the jail exit. Deputy Gibson saw my jaw drop, and intersected the words that would have come out of my mouth. "Don't worry, doc. It's just procedure," he told me as he shrugged his shoulders.

Policy discussions of the practice can also reinforce the banality which something as graphically intimate as chaining a pregnant woman can assume.[14] I worked with activists from the American Civil Liberties Union and community organizations to help expand California's 2005 law to outlaw shackling at any point in pregnancy, and to ensure more compliance with the original. At a lobbying meeting with the state organization which oversees county jails, the discussion focused almost entirely on a procedural specificity. A man named Alex was the head of this jail regulatory board. A middle-aged white man with an ill-positioned comb-over covering his bald spot and pungent cologne, he had the air of an archetypal bureaucrat. Alex insisted that the crux why this law had been rejected in the two prior years[15] was that once shackling restrictions become law, the jail oversight board could not include the law into its official Policies and Procedures code. The jail board would then have no authority to enforce something that was not in their Policy and Procedures.

Alex spent nearly forty-five minutes explaining this supposed conundrum, with a condescending tone. The lobbyists in his presence were all women, and he peppered his exasperated explanations with diminutive comments, like "there's been incremental change; each year, you gals are making progress on this." Without any subtlety about the fact that the incarcerated women themselves were being omitted from the discussion, Alex declared that this law was not about shackling pregnant women. "It's not like they [people who work at jails] think we should shackle pregnant women!" He smacked his hand on the table, to parody someone who would think adamantly that women should be shackled. "No, that's not what this is about!" It was a sarcastic gesture, to contrast Alex's point that this

law, and the discussion in the conference room, were merely a matter of the difference between statute and procedure.[16]

Alex's redirection away from the affected subjects, pregnant incarcerated women, was perhaps a symptom of his unwillingness to confront the uncomfortable inconsistency between pregnancy—biologically female—and incarceration—systematically oriented to males. Instead, what such a focus on bureaucratic matters does is to sustain the myth that "prison is the great equalizer," treating everyone with the same harshness.

Shackling a pregnant prisoner brings a guard and her charge into close contact in a banal intimacy. It is again another instance through which the exceptionality of pregnancy in a jail cultivates ambiguity in the relationships of discipline and care. The pregnant inmate can go from a figure who deserves special care, to a liability threat who deserves hyper-vigilance, to a security threat who deserves iron chains. Nicole, a woman who was pregnant in jail until she later decided to have an abortion, went from jail to the hospital one day because of a severe case of pancreatitis. In preparation for the hospital transport, a deputy handcuffed her, cuffed her feet, and put a chain around her belly. Nicole told him that she was pregnant. But, disregarding Nicole's protestations and the jail's written policy, he left her, she said "all shackled up. He didn't really care about me saying what I had to say; he just did what he had to do and walked out." Then Deputy Lucas walked by and noticed that Nicole was fully shackled. He also knew that she was pregnant. So when he saw Nicole shackled, Deputy Lucas removed everything except the handcuffs, loosening those to make sure they were as comfortable as handcuffs could be. And then Deputy Lucas offered Nicole an apology, with a commentary: "You know, we shouldn't be cuffing a pregnant woman like that." That act and the apology were tremendously meaningful to Nicole. She spoke about Deputy Lucas with fondness and appreciation. His kindness was exceptional to her in this moment created by shackling.

Shante, when transported to the emergency room during her miscarriage, experienced ambiguous emotions when she was shackled. The second deputy guarding her (not the one who knew her since birth) also helped Shante as she changed her pads. When it was time to go to the transport vehicle, the deputy shackled her, as a matter of routine. Shante felt angry and disempowered as she recalled that moment:

> She shackled my ankles and she shackled my stomach, my hands to my stomach, and I'm thinking in my head like I don't know too much about the legal system and these shackles, but I know I have rights as a pregnant woman. My stomach is not supposed to be shackled. But I ain't saying nothing. I'm like okay, whatever, 'cause obviously I'm not going to get nowhere. So she shackles me up and she makes me walk.

Despite her indignation, Shante also felt comforted by this deputy. While they were in the hospital, the deputy stayed with Shante while doctors and nurses came in and out, and eventually confirmed the diagnosis of miscarriage. Shante recalled ambivalently that the deputy "did some things that, to me, wasn't okay, like the shackling and stuff like that, but she was very soothing and she was very helpful." Shante did not forget the shackling, but she was still able to feel cared for by this deputy.

The discretionary use of restraints on pregnant women is not only a matter of statutes and procedures—as bureaucrat Alex reduced the issue to—or threat—as the disputes over security logic and medical logic emphasize. Nor is it only a degrading, emotionally scarring display of state power. Shackling of pregnant, incarcerated women certainly is all of these things, and that it is experienced as cruel and unusual punishment by women cannot be minimized. But, as the mollified restraint practices in Bridgetown suggest, shackling and pregnancy can also be a focal point for experiencing or not experiencing care.

Incarcerated Reproduction as Participatory Practice

It would be easy to read the jail's approach to pregnant women as "reproductive governance," coercing them further into state regulatory apparatuses: the hyper-medicalized prenatal care they receive in jail; the special privileges they receive to mitigate the discomforts of living in jail; how they

may be shackled in childbirth; and their newborns' immediate entry into state institutions either of foster care, Child Protective Services (CPS), or Sheriff's Department coordination for visits with their babies. These would then be easy to connect to a narrative of poor, black, reproducing women's entrenchment in regulatory mechanisms which further perpetuate their marginality (Bridges 2012). But such an interpretation would overlook the everyday experiences in jail through which their reproduction unfolds.

Pregnant incarcerated women, deputies, and medical staff came together in a variety of ways to nurture and discredit these women's reproduction. Jail staff interchangeably treated some pregnant women as exceptional and worthy of special treatment; others disparaged them as unworthy reproducers. Sometimes pregnant inmates were understood as threats, who must be regulated and shackled, and other times they were loci of sympathy from those who were unsettled by the coexistence of the nurturing state of pregnancy with the depriving state of incarceration.

Pregnancy, with that thorny reminder of a new potential life, brings into stark relief the dynamics of incarceration: the desire to punish women judged to be bad mothers and the desire to care for them as they nourish the next generation. The fetus is not, of course, a *tabula rasa*, for the care of pregnant women in jail presupposes a range of assumptions about her future child. A fetus in an incarcerated womb is already enmeshed in the forces of structural inequalities which shape its maternal host. The relationships and practices around reproduction in jail work through these inequalities in a variety of managerial and intimate registers. They reveal not only that individual vulnerability renders people susceptible to governance and care, but that the institutions entangled in those practices are themselves vulnerable. Reproduction is revealed as a participatory practice for the inmates and the jail workers, something that will become even more apparent in Chapter 5 where I delve more deeply into pregnant women's gestational trajectories. These people engage in a complex and often contradictory mix of intimate concern, struggles to promote and perform normative motherhood, and imposition of

controlling—even punitive—strategies. Throughout, they cultivate ambiguity in the way that carcerality constrains and cares.

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[1] The standard of care for pregnant women who are addicted to opiates, including heroin, is to substitute the street drugs with legal, prescribed opiate analogs, either methadone or buprenorphine (ACOG 2011). Opiate withdrawal in pregnancy is not recommended, because of a theoretically increased risk of miscarriage or stillbirth in the high catecholamine state of withdrawal. Prescribed opiate substitution therapy eliminates opiate cravings, avoids the harms of street drug use (such as infectious risks from needle sharing or mixtures with other drugs), and also comes with non-pharmacologic addiction treatment from therapists.

[2] Those states are California, Idaho, Illinois, Indiana, Massachusetts, Nebraska, New York, Ohio, South Dakota, Tennessee, Texas, Washington, West Virginia.

[3] In fact, California is the only state which has a statute actively affirming that women in jail and prison have a right to abortion. The statute also mandates that pregnant women in jail or prison be made aware of that right.

[4] The NCCHC standards include one called "Pregnancy Options Counseling," a euphemistic title for abortion. This standard states: "Pregnant inmates are given comprehensive counseling and assistance in accordance with their expressed desires regarding their pregnancy, whether they elect to keep the child, use adoption services, or have an abortion." Meeting this standard, however, is not required for a facility to be accredited. It is one of the few "optional" standards which an accredited jail or prison can choose to follow. This, along with the tremendous localized power that prisons and jails have, forces women to continue pregnancies they might not want to carry. It makes pregnancy part of their punishment, "a uniquely gendered form of punishment" (Roth 2004: 376). In 2014, the NCCHC will publish revised standards and preliminary reports indicate that this mention of abortion will be integrated into the general "pregnancy care" standard, which includes prenatal care and which is mandatory.

[5] When I first imagined this dissertation at the start of graduate school, I envisioned studying abortions in prison. What happened when incarcerated women requested abortions? Although in theory the right to access an abortion must be upheld while in prison (Kasdan 2009), I wondered what these women experienced and how the institutions responded to their pregnancy termination requests, when abortion is so fundamentally controversial and politically charged in US culture. But my reading of this abortion-prison scenario was already so heavily imbued with arguments about gender oppression and regulation of reproduction that it seemed an uninteresting analysis to undertake.

[6] These additives were technically adequate caloric increases for pregnancy, but left many pregnant women still hungry. If women were lucky enough to have money put on their books by a friend, relative, or boyfriend outside of jail, then they could buy food off the commissary once a week. Wednesday was commissary delivery day. One Wednesday I was in D-pod and watched as Anna, 6 weeks pregnant, had a clear plastic garbage bag full of Cheetos, Ramen noodles, potato chips, cookies, and candy handed to her. This sustained her.

[7] A bottom bunk not only avoids the inconvenience of climbing to the top, but it also allowed the bed's resident to entertain and "hold court" more easily for other inmates.

[8] During my fieldwork, I visited one of the largest county jails in the country. One of the doctors gave me a tour of the facility. As we walked through the booking jail, she told me that scores of women falsely report during their jail intake that they are pregnant, because they know the privileges they will be granted for such status. As a result, this booking jail now runs urine pregnancy tests on all women, in order to avoid the exploitation.

[9] A debate over what constituted "community standard" ensued during my time as an obstetrician at the Bridgetown jail. National screening recommendations for genetic abnormalities like Down's Syndrome had changed. The test was optional for all pregnant women, but for those who chose it, it consisted of a blood test and a specialized ultrasound. In Bridgetown, the ultrasound test could only be done at the University Hospital, not the County Hospital where jail patients usually went for care. Going to the University Hospital meant both extra travel logistics for the deputies and extra costs for the health department. So it became a debate whether or not to make this test available to women in jail. Ultimately, I argued with enough scientific evidence and conviction that the test was approved. The crux of the argument was that this constituted a "serious medical need" and that care had to match the community standard.

[10] Several years into my stint as an Ob/Gyn at the jail, I learned that in addition to prenatal visits in clinic, pregnant women also were scheduled to have a weekly nursing visit every Saturday morning, which was called "high risk check." At this visit, the nurse would check the woman's blood pressure and measure the amount of protein and glucose in the woman's urine with a dipstick, to screen for pre-eclampsia and for gestational diabetes. These visits were unnecessary, for at the regular prenatal visits in clinic every 1-2 weeks, these same evaluations were done. That increased frequency was not rational, but it had become routine. Eventually, the policy was changed and this redundancy was removed.

[11] One week earlier, I had attended a workshop for physicians where I learned about "Motivational Interviewing" as a technical approach for talking about drug and alcohol use with patients. We were guided to ask questions about what patients enjoyed about drugs as a means to get them talking about their addiction. Carr (2011) has explored the potential benefits of motivational interviewing as a collaborative, less disciplinary therapeutic strategy.

[12] Many feminist criminology scholars have emphasized that incarcerated women have high rates of prior sexual, physical, and emotional abuse, and that their entry into crime is often facilitated by emotional dependence on and coercion by boyfriends and husbands. Prisons have contributed to re-traumatizing these women, and so, the rallying call has been, that they need to be re-thought and reorganized in order to attend to women's specific circumstances: pathways to crime, family violence, parenting responsibilities, the disproportionate impact on women of the war on drugs (Bloom et al 2003). This has been called a "gender responsive approach" to incarceration, and has gained traction—with California prisons leading the way—since a comprehensive report on this strategy was published in 2003 (*ibid*). The ironies of gender-responsive strategies are two-fold: first, prisons have always been "gender-responsive," responding to male's contextualized needs; second, this movement has entailed building new prisons, at a time when the prison system is already hypertrophied (see Braz 2006). Nonetheless, the calls for gender responsive strategies for women in the criminal justice system have brought to light the implicit and extreme male bias in the correctional system.

[13] As of June, 2014, those states are: Arizona, California, Colorado, Delaware, Florida , Hawaii, Idaho, Illinois, Louisiana, Maryland, Massachusetts, Minnesota, New Mexico, Nevada, New York, Pennsylvania, Rhode Island, Texas, Vermont, Washington, and West Virginia. The first state to pass an anti-shackling law for pregnant women was Illinois in 2000. The Federal Bureau of Prisons has banned shackling of pregnant women since 2008, and in 2012 Immigration Detention also instituted a similar policy. In February, 2014, Governor Patrick Deval of Massachusetts issued an emergency statute to ban the practice for 90 days while the legislature worked to pass a law. And as of March, 2014, Maryland was also considering a bill.

[14] Published narratives, media reports, and testimonies from lawsuits attest to the fact that the pregnant women who have been shackled during childbirth feel humiliated, devalued, ashamed, traumatized, and less than human. The image of a woman giving birth in chains is graphic and disturbing to the senses. It is an easy reminder of the violence of the carceral apparatus, restraining a woman in the throes of labor pains, ushering a new and idealized life into the world. The issue has been repeatedly framed through human rights discourse, explicitly denouncing the practice as a human rights violation, and a violation of the eighth amendment's prohibition of cruel and unusual punishment. Such framings of the issue implicitly attempt to answer the question of what it means to be human, to be a human with rights, and to be humane.

[15] In 2010 and 2011 the bill was proposed and passed unanimously in the state legislature. However, each year it was vetoed by the governor, under pressure from correctional organizations

[16] Incidentally, investigation after this meeting revealed that Alex's claim that the jail oversight board cannot enforce something that is a statute was incorrect.

CHAPTER 5
Reproduction and Carceral Desire

"Jail brings me back to what being a mother is."

-Karen, frequent Bridgetown jail inmate

Reckoning

It was a mild winter day in Bridgetown when Kima was arrested on charges of drug possession. It was not a disruptive event for her—she and her lawyer had started counting a few years ago, and Kima kept track that this was her 71st time in jail in fourteen years, since she turned 18 years old. She knew not only the routine, but also the people who worked there. So she felt familiarity when triage nurse Charlie, who had worked at the Bridgetown jail for over 20 years, asked her the litany of standard questions during the intake medical evaluation in CJ1. The routine intake questionnaire I described in Chapter 1 included, for women, questions assessing the possibility of pregnancy: "Are you pregnant right now? Was your last period more than 30 days ago?" "I don't think I've missed any periods," Kima told Charlie. Although she did not recall missing a period, on the streets, Kima had sensed she was pregnant. As she later related to me, "I had morning sickness, change in moods, craving a lot of stuff. So those are three signs that I'm pregnant, and those are the signs, especially the mood part, 'cause I get really mean to certain people." Kima had been pregnant three other times, after all. She knew her body.

Although Kima laughed as she recounted for me this moment with Charlie in CJ1, she told me that she cried to Charlie as she confessed to him that she might be pregnant, a scene I briefly described in Chapter 1. She was afraid of having her pregnancy suspicions confirmed, she admitted. Kima

composed herself as Charlie escorted to a private exam room, where there was a steel toilet shielded by a half wall of concrete. Kima urinated into a small paper cup. With Kima watching, Charlie squeezed four drops of her urine onto a pregnancy test cartridge. Two pink lines appeared. Kima was pregnant. "Congratulations!" Charlie bellowed, oblivious to the ambivalence which a positive pregnancy test might stir in a woman. Kima burst into tears. She later explained to me why she cried:

> I had came in for a drug possession and I was using. I was in my active addiction, so like I said, it's something about knowing but not knowing that makes me not accountable or makes me think I'm not accountable, but then if I go to the doctor, then I know that I have to be accountable. So when I was out, I didn't go to the doctor even though I kind of knew I was [pregnant]. I kind of knew I was, but I wouldn't go to the doctor. Now here I am knowing for sure that I am, so it's just — it was really — I was really scared.

On the streets, Kima's bodily changes convinced her that she was pregnant. Yet it was with medical recognition of her pregnancy, in the context of jail, that she could no longer feign ignorance of it. Now, she confronted the cultural weight of moral responsibility which a pregnant woman was supposed to have for her fetus.

Barbara Duden (1993) has chronicled how the confirmation of pregnancy has been co-opted from the woman's embodied perception of it to the clinical discovery of pregnancy hormone in a woman's urine or serum. A positive pregnancy test then conjures the fetus as the central figure of pregnancy, rather than the pregnant woman's perceptions. Kima had internalized this model of pregnancy affirmation, for she, somewhat consciously, suppressed her own embodied sensations of nausea and food cravings to deny that she was pregnant. Relatedly, and as her stated reason for ignoring the signs of pregnancy, Kima had also internalized society's judgments which equated her behaviors, upon which the fetus relies, with moral choices. She knew smoking crack was something she should not do during pregnancy. So on the streets, Kima deliberately avoided the medical system. It was as if without medical affirmation of her pregnancy, she was not being a bad pregnant woman, putting the fetus in harm's way; she could deny the pregnancy, despite her embodied perceptions, because there was no medical proof. In jail, Kima was funneled into the churn of the intake medical

evaluation, the routine medicalization of her jail processing. The objective confirmation of pregnancy by a medical professional then made Kima feel that she now had to contemplate the ramifications of her drug use during pregnancy.

Kima was ambivalent about the pregnancy. Ambivalence is defined as having mixed or contradictory feelings about something, which Kima certainly did. One the one hand, she said "I was happy because I knew I was going to have my baby. I was going to have this baby. That was for sure." But she was also terrified. "The scary part was knowing that it didn't stop me before. I didn't stop myself before. I used with my other child. . . . So that was all I was worried about, was scared that — I didn't want to mess up this baby." The tears she produced when Charlie congratulated her on the pregnancy were the materialization of her ambivalent sentiments about this pregnancy, about her addiction, and about motherhood in general. Kima's own ambivalence about the pregnancy mirrors, as discussed in Chapter 4, the ambivalence with which the institution treated her and other pangolin-like pregnant inmates.

Pregnancy ambivalence is certainly not unique to the carceral setting. In fact, pregnancy ambivalence is a categorical entity used in family planning research and in clinical approaches to women with unexpected pregnancies. Without jail, Kima might have eventually gone to a doctor's office. She might have had a similar mixed emotional response of joy and fear. She might have felt guilt over her drug use, having already internalized the medicalized moral expectations of what comprises healthy pregnancy behavior. But jail magnified and reframed these tensions. In jail, behavioral regulation was incessant. So were punitive sentiments, with their moral overtones, as was, at least nominally, a discourse of prisoner rehabilitation. As Kima and other women's pregnancies progressed in jail, these carceral features permeated women's preparations for motherhood. So did the intimacy of care which we have already seen emergent in the routines of discipline. This care was linked to the ethical

demands on pregnant women cultivated in the jail, demands infused with punitive dimensions that pregnant women should act in certain normative ways.

Although Kima could have easily refused the urine pregnancy test, she did not. Her willingness to confront the reality of the pregnancy here in jail was enabled, in part, by her familiarity with and trust in Charlie built over years of intimate recidivism. Kima felt comfortable being vulnerable in front of Charlie. And she also knew what to expect from being pregnant in jail: eight years ago, she gave birth to a daughter while she was incarcerated at the Bridgetown jail. Kima had used drugs throughout that pregnancy and, as a result of this and her ongoing use, she did not have custody of this daughter. "I still feel a teeny bit of guilt behind the fact that my addiction was so strong that I couldn't stop using for the sake of my baby. . . . I didn't want to travel down that same road with this baby."

Kima took that moment of pregnancy discovery, in that small exam room with Charlie in CJ1, as a chance for reckoning: "I had a chance to get this one right." This hope was a commonly expressed narrative for pregnant women who passed through the Bridgetown jail. Jail played a unique role in constructing such aspirations of transformation, as this chapter will explore. Understanding how being in jail framed women's own narrative commitments to pregnancy builds on the notion, developed in Chapter 4, that incarcerated reproduction is a participatory practice; the institution itself, not only the people working and living within it, is a critical participant as well.

Rescue

The notion that incarceration can be a transformative experience has been widely explored. Foucault (1977) elaborated the techniques of the penitentiary—whose ideological and etymological roots are in "repentance"—as seeking to transform the soul of the prisoner. The disciplinary mechanisms of the prison seek to correct the prisoner by power operations on his body which then expose the truth. The soul, Foucault argued, is the effect of these strategies of punishment and constraint.

Historically, these principles have manifested in policies aimed at rehabilitating the prisoner, or "correcting" his character (hence the categorical term "correctional institution" to stand in for prisons and jails).[1] Numerous accounts have documented a decline in the rehabilitative commitments of correctional institutions in the age of mass incarceration, though these impulses have not been universally displaced (Irwin 2005). As we have already seen with the busy daily programming schedule and with policy makers' commitments at the Bridgetown Jail, the hope that incarceration can transform an individual still existed despite the preponderance of "warehouse prisons" (Irwin 2005). When combined with the transformative potential in pregnancy's gestating a new life, jail and pregnancy can become fulcrums for each other. Evelyn's desire for jail during pregnancy reflected that interaction.

Evelyn was released from jail to the streets when she was 26 weeks pregnant. She had no place to sleep, and quickly spiraled into her familiar life of smoking crack, shooting heroin, not sleeping, and selling drugs. Her Aunt Vera, who had partially raised Evelyn until she was swept into the institutional life of foster care and juvenile detention, had tried to rescue Evelyn. Late one night, Aunt Vera drove 45 minutes from her quiet suburban home, where she was raising Evelyn's 4 year old son Adam, into Bridgetown. She combed the dangerous streets by herself, and when she found Evelyn, pregnant and high, Evelyn rejected Aunt Vera's offer to take her in. Later, Evelyn told me that she did not want her son Adam to see her in this state, coming down from drugs, disheveled, and sleeping for days at a time in Vera's home while her body recovered. Though Adam knew Evelyn as his Aunt, and believed Vera to be his mother, Evelyn hoped some day she could tell him the truth. It was important to her that she shield her son from her current desperation.

So Evelyn stayed on the streets. When I ran into her there at the 60th and Atlantic subway plaza, a few people around her, when they learned I was her doctor in jail, chided her "Evelyn, you shouldn't be doing this stuff, you've got the baby!" Yet their well-rehearsed comments of concern did not stop them from selling drugs to Evelyn. Eventually, Evelyn did ask for help. She did not ask Aunt Vera, for

fear of alienating her son. She did not come to Bridgetown County Hospital, or to the Homeless Prenatal Program, or to any number of drug treatment programs she had attended— albeit for no more than a week— in the past. Instead, Evelyn chose to come to jail; she desired jail. She turned herself in to the police on her corner, citing that she had violated her parole and had outstanding warrants. "I just wanted to be in jail where I knew that I could eat, I could sleep, and that even if it's not the best of medical care, I was going to get some type of care."

Evelyn knew what to expect from jail: institutionalized living she had been accustomed to since age 9, a bed, water, food, familiar faces, prenatal clinic visits which she was escorted to, and the complex mix of tenderness and discipline I have documented in the Bridgetown Jail. Where life on the streets had failed her, jail was a place of comfort. As Evelyn so aptly put it, "I didn't get arrested, I got rescued." This unsettling desire for the constrained reality of a carceral institution should lead us to question the role of state institutions in governing people's emotional states. Lynn Haney (2010), in her study of a group home for incarcerated, addicted mothers in California, describes a therapeutic model geared towards regulating women's desires. In this community-based carceral setting, official mantras of empowerment and staff involvement in women's minute decisions attempt to transform what women want in life: a healthy lifestyle instead of drugs and "bad boyfriends." Haney gives the example of a dispute between a mother serving Ramen noodles to her child, a cheap and tasty food the mother herself had grown accustomed to. A program staff member chastised her for Ramen's lack of nutritional value and told the woman she should instead give her child healthier Luna Bars, which she would not be able to afford outside the program's free provision of the nutrition bars.

Evelyn's desire for jail may be seen in part as a mutated consequence of these kinds of treatment discourses, perhaps yet another strategy of "reproductive governance" (Morgan and Roberts 2012). Evelyn wanted to be in an environment that was, by contrast to the street corner at 60th and Atlantic, not teeming with drugs, an environment that was more "healthy." The sense of desire Haney

claims is cultivated by current therapeutic models for incarcerated women coalesced for Evelyn into a desire for the institution itself. But we cannot stop there, at an analytic of governance where we see Evelyn's emotional state as regulated. For her desire was produced by the comparative material realities of her life inside and outside jail. Accompanying her recognition of jail's benefits was a memory, instilled by the chronicity of recidivism, of feeling cared for by the institution. Rescue was part and parcel of this form of institutional care which made recidivism into an intimate, intersubjective process and not simply a statistical failure.

This sentiment of appreciation for jail was not infrequently expressed by women in general. But it was more pronounced among the pregnant women or mothers who reflected on their prior pregnant incarcerations. Women focused on their developing fetuses in the sense of relief jail gave them, citing the harm that they believed they were doing. Kima expressed her gratitude for jail in two of her pregnancies:

> Well, part of me was really grateful. In 2004, when I had my daughter, I was really grateful. I was grateful that the police came up with some bogus charges and sent me to jail, because here I am. If I would've not gone to jail, I would've not stopped. She would've been born with drugs in her system. And I did give her — I mean, well, my higher power did send me to jail, gave her a break. So for the last two and a half months she was clean, and she clean now, so that's the most important thing.

Jail provided a built-in mechanism for sobriety, which Kima recognized to be beneficial for daughters. In her desire for rescue, Evelyn also believed jail would be good for her pregnancy. In jail, the institution recognized their pregnancies with medical care and special privileges. They, in turn, recognized their gestating fetuses in different ways than they did on the streets. In jail, their drug lives were disrupted. The confessional coercion of the disciplinary apparatus which Foucault described allowed Kima to displace her initial denial of pregnancy on the streets with overt awareness in nurse Charlie's CJ1 exam room. For Kima and Evelyn, it was jail, not pregnancy alone, that oriented them more towards their fetuses, a harm reduction strategy they both explicitly and gratefully identified. Because these women

were already entrenched in institutional regulation, they also knew the value of having a baby born clean, for that increased their chances of child custody.

Redemption

These women were conditioned to see their actions on the street as bad behavior, bad choices. (Haney 2010; Knight *in press*) This was why Kima, on the streets, avoided going to a clinic to confirm her pregnancy because it would make her "accountable" to the fetus for her drug using behaviors. Sheigla Murphy and Marsha Rosenbaum (1999) have studied pregnant women who use drugs. In analyzing women's narratives of their experiences of addiction while incubating life, the authors argue that, for these women, "impending birth represented choosing life, an opportunity for redemption for past failures, hopes for the future, and a chance to claim a socially acceptable and respectable identity" (3). Given the symbolic currency of the fetus, this interpretation makes sense. In popular culture and abortion debates in the U.S., the fetus is widely imagined to be the idealized, innocent citizen (Berlant, 1997). It is venerated as a hopeful symbol of the future, a tabula rasa for potentiality and social reproduction.

Both pregnancy and incarceration independently offer themselves as possibilities for transformation and redemption, although those possibilities are geared toward a particular, normative way of being. Accordingly, being pregnant and incarcerated are synergistic domains of experience which entice women like Kima and Evelyn into normative maternal ways of being.

It is important to recognize that incarceration can shape maternal desire in other directions besides, as it did for Kima and Evelyn, the wish to be a mother. For some women, being incarcerated and enmeshed in the criminal justice system made them want to avoid pregnancy. I took care of plenty of patients in jail who wanted to terminate their pregnancies, often with reasons similar to what non-incarcerated women give for wanting an abortion—not the right time, unable to afford a child right now. But sometimes their reasons were distinctly produced by the carceral environment. For instance,

one patient told me she wanted an abortion because she would soon be serving her sentence in prison. "When I go to prison, I fight. That's how I do my time." Pregnancy would cramp her fighting prison style, so she wanted to terminate the pregnancy. Other patients have thought through their decision in terms of what has happened to their other children. "I don't want to burden my auntie with another one of my kids," a patient told me. She knew that both being in jail and her life as a drug addict would make it unlikely that she would be able to take care of a baby; she felt guilt over further burdening her family members with her reproduction. For such women, their desire for abortion was entangled with their incarceration.

Pregnancy could also uniquely shape someone's desire for jail. When Evelyn was arrested the third time this pregnancy, she had desired jail this time, had turned herself in. Deputies and medical staff knew, and some even liked, Evelyn. Deputy Lucas endearingly called Evelyn "Toothy" because, he told me, of the sly, toothy grin that he often saw on her face in jail. I later learned that this was Evelyn's street name, and that its etymologic roots had nothing to do with Deputy Lucas. Nonetheless, Evelyn could feel comfort and familiarity in jail. In jail, Evelyn and other mothers also attended Sheriff's Department-sponsored parenting classes, which conveyed models of appropriate mothering. All of these factors conspired to enable deep reflection for Evelyn to change and to be a mother for this child, a contemplative process I witnessed during this incarceration.

I spent a lot of time with Evelyn during the final weeks of her pregnancy, in the pods in jail and when she was hospitalized for a few days at Bridgetown County Hospital for having more frequent seizures, something she had suffered from since childhood. We talked many times about the future she imagined. Here is an excerpt from one of our conversations in which she begins with her last pregnancy. At that point five years ago, she had been released in her second trimester from jail to "Revelation House," a residential drug treatment program for mothers and children:

> I stayed about maybe a month-and-a-half, which is one of the longest times I've ever stayed at a program up 'till then. Like, I have been to programs before, and I just go, stay a day, eat, gain

> some weight and then leave. . . . But like the house is right across the street from Westside projects. So people would buy their dope, and then there was an abandoned — like a house where nobody lived next door. And I think what triggered me is I was outside sweeping the porch, and a guy was smoking crack. And he blew it, and the wind blew his smoke, like, right in my face. So then I was like: Oh, I want to go use. So I left that day. . . . I really wanted to change. Like, but then I think I got scared. I have a tendency to be self-sabotaging. Like, I let myself only get to a certain point, where I do good for a certain amount of time. Then for some reason, I start thinking like I'm not good enough or I'm not worthy enough to be clean or have a normal life. So I start — I purposely mess up.

Her self-critique is rich with therapeutic language that attributes misfortune and the power to overcome it to individual will. This kind of therapeutic script is deeply entrenched in community drug treatment programs for women (Haney 2010; Carr 2011). In directing women to focus on their emotional and psychological flaws, rather than the concrete social and economic factors structuring their lives, many contemporary treatment programs' "therapeutic agenda turned injustice into an emotional issue" (Haney 2010: 155). Both Evelyn and Kima had been in and out of programs similar to the one Haney describes (and were often court mandated to such places as conditions of their release from jail). Evelyn's ruminations about self-sabotage reflect this therapeutic approach to transform structural vulnerability into personal failure in order to recalibrate one's desires. Pregnancy, with Evelyn's desire to care for her gestating fetus, made jail entangled in her desires.

Yet even while Evelyn knew to ascribe her failures to her own choices, she also blamed the ineffective safety net that she felt abandoned by. Referring to her last release from jail, only 3 months prior:

> But it's not that I started using again 'cause I wanted to. I started using because it was so hard to get anywhere. I got released with nowhere to go. I had been being told I was going to a drug treatment program my whole time in jail so that I didn't have a backup plan. So then when I went to parole to try to get into a program, my parole agent was like, there was no beds. Everywhere he called there was no beds. There's no beds. There's no beds. There's no beds. So I started selling dope, and then of course, to stay up longer, I started using. And it kind of — it really hurt because I didn't want to use. But it's like, I felt like that's the only option I had, like use to make money, use to eat, use to use.

From desperation and abandonment on the streets to contemplation in jail, Evelyn interpreted this incarcerated pregnancy as an opportunity for change.

> But, like, I'm nine months pregnant now, about to go back to Revelation House, and it's very important for me to change my life. . . . Not just for my child, but it just gets to a point where enough is enough. And plus, I'm just tired of being a dope fiend. Like, I know I'm worth more. . . . Yeah, in jail, I'm thinking about my baby and then just looking at my life. Like, at least in jail, you're able to get a little bit of get-back. Get-back is where you're back to your normal self. A lot of people are happy when they go to jail because they gain some weight. They get to rest, and then their run starts all over again.

Evelyn identified the version of her self in jail as her normal self. In this "get back" phase, she was actively planning for change. Her plan was to stay sober, go to a treatment program, learn how to parent, and get a job as an office assistant or a chef's assistant. She was, any day now, to be leaving jail for the same Revelation House she had absconded from her last pregnancy. I asked Evelyn what made this commitment to change in pregnancy different than other get-backs.

> Somebody once told me that I might have a lot of runs left in me but how many get-backs do I have? Not only do I have a chance to raise one of my kids for the first time by myself, like I said, you can only go so far. I don't want to get high no more. I don't ever want to have to sleep in the subway station with the mice running over my feet or wonder where my next meal's going to come from or — and I couldn't imagine bringing a kid into an environment like that. And not only that, my auntie — she's not taking this kid. But she has no intention of raising another one of my kids. She — and she's right. It's a time where I have to stand up and be a woman and raise my own kid. I'm the one who keeps having them. So I can't keep having kids and put it on this person, this person, this person. It's a time where I have to be responsible for me. So it's a choice that I made to have another kid, so I have to raise this kid myself.

I have heard similar affirmations from other pregnant women in jail, conditioned to believe that if only they made the right choices, their status as responsible mothers would come to be. Evelyn was clear in identifying this jail "get back"—a contrast to her rock bottom on the streets—as an enabling factor in this time being different. Whereas her other times in jail were just part of what she (and many others, including policy makers) had called "a revolving door," pregnant incarceration made both into deeply moral experiences. In this extended monologue, Evelyn articulated just what was at stake for her at this moment of convergence: a sense of self-worth, struggling with addiction, caring for another human, the desire for maternal transformation, and webs of connection to other humans and institutions.

Evelyn's commitments to change were not about rehabilitation, that dwindling maxim of prison therapeutic approaches. Rehabilitation, as James Waldram (2012) has deconstructed, implies

restoration to a previous state. In his ethnography of treatment of incarcerated sex offenders, Waldram argues that the purported aspiration for prisoner treatment is more akin to "habilitation," a transformative rather than restorative process: "the idea is to create moral individuals who emerge from prison as 'fit' for society" (11). Likewise, the combined experiences of incarceration and pregnancy invited Evelyn to transform herself into a morally fit mother, an identity she had yet to develop. In this pregnancy, Evelyn was not striving to return to some prior maternal state, to rehabilitate; she did, however, recidivate to a prior state experienced in her last pregnancy in which she hoped being pregnant while in jail could inspire change. Now, Evelyn wanted a new life. She wanted to habilitate to motherhood.

Both pregnancy and jail bring the future into the present. Pregnancy, with its 9 month circumscribed duration, signals the inevitability of childbirth. Being in jail, a short term place of confinement, implies that release from jail will inevitably happen (at least for most).[2] Indeed, even as they lived out the interchangeable monotony of the daily routine in jail, inmates in Bridgetown constantly talked about their plans for and estimations of when they would be released; programming in the pods both tried to occupy their time while they are there, and, at least in theory, to prepare them with life skills (including parenting) for release.

Thus, these imagined dual future moments of life with a new child and life out of jail are part of the present realities of a pregnant woman in jail. These intersecting, matching temporalities are perhaps best thought of as what Jane Guyer (2007) describes as the "near future:" "The reach of thought and imagination, of planning and hoping, of tracing out mutual influences, of engaging in struggles for specific goals, in short, of the process of implicating oneself in the ongoing life of the social and material world" (410). Evelyn meditated on the synergistic near futures of childbirth and release from jail. She confronted her time in jail with a meditation on her outside, "para" (see Mahuya 2010) jail life, imagining both the memory of her pre-jail life and the hopes for her maternal post-jail life.

Some policy makers have similarly recognized the transformational opportunity that pregnancy in prison presents. An example is the prison nursery programs I described in Chapter 4. Although the idea of an infant starting its life in prison is disquieting, there is some evidence to suggest that promoting bonding with their infants helps prevent recidivism in these women and has benefits for their children (Goshin et al 2013).[3] Proponents of these programs also cite the statistics showing that children of incarcerated parents are more likely to become incarcerated as adults, hoping that early maternal bonding will mitigate this risk. Incarcerated reproduction thus generates a temporal imagination of a future for change.

In Bridgetown, Sheriff's Department administrators approached me and a few others from the jail's clinical services to help brainstorm ways that the jail could improve conditions for pregnant women. During our first meeting and later at a public press conference held on Mother's Day, the Sheriff's Department expressed an its interest in this small population because of the high impact potential for reducing recidivism if we could better promote mother-infant bonding when the babies were born. One result of these meetings was to work towards increasing contact visit frequency for mothers and newborns from two times per week to five times a week. Previous research has advocated increased visitation between mothers and non-newborn children as a recidivism-reducing strategy (Showers 1993), but has been critiqued for assuming all mothers have similar pre-incarceration connections with their children (Enos 2001: 14). The enthusiasm for newborn bonding and pregnancy preparation at the Bridgetown jail and in prison nursery programs tries to circumvent this variability by optimistically investing an incarcerated pregnancy with the power to establish anew or re-establish motherhood.

Despite the hopefulness of the Sheriff's Department's leadership, many of the deputies and medical staff who interfaced constantly with these women took a cynical approach to pregnant women's transformational proclamations. I noticed some jail staff who would nod their heads as they

listened to the women, and then furtively roll their eyes, or told stories of disbelief to each other about a woman's other children they knew she was not raising. Recidivism manufactured this cynicism, for jail staff saw these women over and over again, pregnant, not pregnant, and pregnant again.

"Jail talk"

One mother of an incarcerated pregnant woman was similarly pessimistic. Her daughter, Daisy, was 6 weeks pregnant in jail. Daisy was addicted to heroin and, despite periods of sobriety, was not raising her four other children. She too talked about this pregnancy as a chance to turn things around. She had only relapsed 4 months ago, after all, to cope with her grandmother's death. She could get clean for this pregnancy, she declared. As I helped Daisy prepare for her release, trying to connect her with community resources and to help her devise plans, she broke down with her desire for motherhood. "I want Saturday mornings," she pleaded, amid wet, full sobs. "I want Saturday mornings with my kids. Cuddling in bed, watching cartoons." This pregnant incarceration helped her imagine a fantasy of normal motherhood. Daisy wanted to "get things right" not only for this pregnancy, but for all of her children.

I called Daisy's home 2 weeks after her release from jail, after she had missed doctors' appointments and an intake at a methadone clinic. Her elderly mother who picked up the phone knew Daisy had relapsed. When I shared with her Daisy's impassioned declarations to change, her mother cynically lamented Daisy's fate and empty promises; she had heard such things before from her daughter. "All that cryin', that wasn't nothin' but jail talk."

Jail talk. Daisy's mother's disparaging phrase suggests that being in jail provoked her daughter to speak about a particular trajectory of transformation, one that Daisy had yet to follow through with outside of jail. All of the pregnant women I encountered at the Bridgetown Jail, whether through interviews, informal conversations in the pods, or in the exam room in the clinic, at some point narrated a version of this maternal jail talk. Whether their narratives had realistic understandings of the

demands of childcare or not, pregnancy became a focal point, an incitement to talk about change for the changing life form they were gestating.

This notion of "jail talk" recalls E. Summerson Carr's (2011) analysis of therapeutic talk in a drug treatment program for homeless women. These patients were well aware of the importance of scripted linguistic performances of taking responsibility and committing to change. The recovery language they were supposed to adopt referenced their inner states, such as denial, desire, shame. Women in this treatment program learned to speak "the language of inner reference without abiding by its principles" (191). Carr calls this "script flipping," the conscious performance of recovery linguistics with the intention not to act according to that script.

Like the women in the program Carr describes, pregnant women at the Bridgetown jail spoke with similar reference to their inner states as pivot points for the locus of responsibility and change. This is not surprising, since most of these women had spent time in similar drug treatment programs; there was also a drug treatment program within the Bridgetown jail. Other non-pregnant women in the jail had told me, with smirks, how they frequently convinced judges of their commitments to recovery, so that they would be released from jail to a drug treatment program—only to abscond from the program after one day. Pregnant, incarcerated women in Bridgetown so frequently talked about their maternal wishes to transform, that it might similarly be read as cleverly performative. Most of them, like Evelyn, Kima, Daisy, and Alisha already had given birth to children whom they were not raising, so these children were the historical referent to their mothers' scripts of "getting it right *this time*." They knew these to be appropriate scripts for CPS workers, who would make determinations about the baby's custody after birth. So pregnant inmates had strategic reasons to rehearse and perform these maternal transformational scripts while in jail.

In the case of maternal jail talk, the intentionality of the performance was less relevant than it was for Carr's script flippers. What mattered was that jail gave them an opportunity to craft a narrative

of change and to assert their desire for motherhood. As well-versed as these women were in the therapeutic talk of individual responsibility, they were also privy to the ways their cycling through jail was related to how the public safety net had failed them in a variety of ways. As I quoted from Evelyn earlier, "it's not that I started using again 'cause I wanted to. I started using because it was so hard to get anywhere. I got released with nowhere to go." Evelyn's "jail talk" was paired with an experiential understanding of the kind of care and comfort she could get in jail, a remedy for having nowhere to go.

I became quite captivated with Evelyn's jail talk. It seemed consistent, insightful, and impassioned. And she was making concrete plans, a sign of normative, futuristic action so venerated in our capitalist reality (Guyer 2007). Over the course of the time we spent together, Evelyn told me that she planned to name this baby, her first girl, Carolyn. This was her deceased mother's name, but Evelyn insisted she had also chosen it because of me. When I would leave the jail at nighttime, she would tell me not to get out of the subway at her corner because it was unsafe; she was looking out for me. This made it hard not to have faith in Evelyn's jail talk.

As she approached her due date in jail, she told me furtively about the occasional contractions she was having. She did not want to tell the nurses, because then they would transport her to the hospital. Evelyn was awaiting release to Revelation House any day now, and did not want anything— hospital transport or spontaneous labor— to preclude that transfer. She wanted to be out of jail when she gave birth, so that she could leave the hospital with her newborn in her arms. I wanted this for her too, and drew from my clinical judgment to reassure her that with only a few contractions an hour, she was probably not in labor.

Evelyn was released from jail while still pregnant. A few days later, a case manager from Revelation House escorted her to a prenatal visit at Bridgetown County Hospital, and I met them in the clinic. This was her first prenatal visit outside of jail. Evelyn wore a gray and pink striped track suit that another woman from the program had loaned her. Her hair was still in the braids her cellmate in jail

had tightly woven. She smiled her charming grin, and chatted up everyone in the clinic from the other patients to the ancillary staff. At Revelation House, Evelyn was attending group therapy, and getting her dorm-style room ready for her baby. She was habilitating. A few days later, non-incarcerated and sober, Evelyn gave birth to baby Carolyn. The change she had imagined in jail seemed to be here.

A Baby Girl is Born

Kima was also working on plans to go from jail to a residential drug treatment program for mothers and children. She was still incarcerated when she went into labor early one morning in C-pod. She told the night nurse about her contractions, who quickly arranged for her transport to Bridgetown County Hospital. Once admitted to the labor and delivery unit, Kima was almost like any other non-incarcerated patient. She wore a patient gown; she was hooked up to an electronic monitor to track her baby's heart rate; she had an IV infusing fluids; an epidural numbed her pain. Unlike other patients in labor, however, Kima had a uniformed guard outside her room, ensuring that she, with her numbed legs and regular contractions, would not escape. At 1:30pm, Sheriff's Department rules allowed Kima to have visitors. For 20 minutes, Kima's elderly, hunched-over mother and step-father shared in the excitement of the imminent birth. Deputy Oberton was not supposed to allow more than one visitor at a time, but he was trying to be reasonable. "Especially when, you know, there's a kid. It's up to our discretion. There's a gray zone." To offset his bending of the rules, Deputy Oberton stood in the corner of the room, instead of outside. When it was time for them to leave, Deputy Oberton gently interrupted the family conversation. Kima's mother and Deputy Oberton then had a friendly exchange, with well wishes and smiles. They had known each other for a long time—Kima's mother herself had spent years cycling in and out of jail when Kima was growing up.

An hour later, Kima was fully dilated and ready to push her third baby into this world. She took a deep breath in, looked up to the ceiling, covered her face and cried with anxiety and anticipation. "I'm scared! I'm scared!" Then she announced she was praying to God to help her push the baby out. Within

seconds, she returned to the outgoing, unhesitating Kima whom I had seen dance to Beyoncé a few weeks earlier. With only a few pushes, Kima birthed baby Koia. I placed the baby onto her mom's belly. A few moments of staring into her newborn's eyes, and then Kima picked up the phone she was privileged to use while outside of jail. Her 8 year-old daughter, cousins, aunts— Kima was thrilled to share the news with everyone, and to make sure they were ready to help her. The phone was her surrogate family support, given the jail's visitation restrictions. Deputy Jenks entered the room unobtrusively. With a gentle tone, he wished Kima congratulations; Kima welcomed his warm wishes, smiling a "thank you" at him.

Kima would be going back to jail after the routine post-partum hospitalization, and her older sister had agreed to take care of baby Koia until Kima got released from jail. Kima was making the most of her two post-partum recovery days in the hospital, keeping her baby in her hospital room instead of the nursery, singing made-up lullabies to her, and breastfeeding. Kima was not surprised when, the day after giving birth, a CPS worker came to interview her. She had previous involvement with CPS, and expected that they would visit her as a matter of routine. But Kima's joy changed to disappointment and anger when the CPS worker told her that her sister had an active CPS case and could not take baby Koia into her custody. She left the room and Kima immediately called everyone she knew, desperate to find a temporary home for her baby. Kima was frantic. She cradled her baby in one arm and cradled the phone with her other shoulder. Forty-five minutes later, a nurse entered the room and abruptly announced "Kima, I'm going to have to take your baby to the nursery right now."

We were both confused by the urgency of the edict and the coldness of the nurse. As it turned out, the CPS worker had decided to put a "police hold" on Kima's baby. This meant that the baby could not leave the nursery, and Kima would have to be escorted there with a guard to see her baby; Koia could no longer room with her mother. Kima was devastated. She began wailing, sobbing while she pulled her baby closer to her chest. "Why is God doing this to me? Why? All these other women get to

go home with their babies. I want to spend every minute I can with my baby, because soon, I'm going back to jail." She bargained with the nurse for 45 more minutes with her baby. Kima intently breastfed baby Koia, even though she did not seem hungry; she explained to her infant in a high-pitched baby voice what was happening. All the while, she continued aloud her angry tirade against the CPS worker. Kima got no sleep that night, not because of a crying newborn, but because of her anguish.

The next day, Kima's anger had softened. I found Kima sitting in a wheelchair in the nursery, a deputy 10 feet away. One hand was handcuffed to the wheelchair she sat in, and the other arm held her baby against her breast. Kima told me she felt embarrassed, that the other parents in the nursery were staring at her. She was also excited: her cousin had agreed to take in her baby and Kima found out she would be going to a drug treatment program in two weeks. Two weeks, she counted, and then a one month trial period at the program and then she could be fully reunited with Koia. As Koia settled into her latch on Kima's breast, Kima drifted off into a light, contented sleep.

Kima's childbirth and postpartum recovery represent a confluence of institutional forces: the biomedical birth, the jail, and the state-sponsored child welfare system. In their analysis of pregnant women on drugs, Murphy and Rosenbaum (1999) discuss childbirth as putting a "spotlight" on the moral and behavioral tensions drug-involved pregnant women struggled in relative privacy to confront or ignore antenatally. By delivering in a hospital, they argue, women opened themselves up to institutional scrutiny, and the legal apparatus that adjudicates custody. However, for women like Kima whose hospital birth occurs during their incarceration, childbirth is not the same dramatic moment of scrutiny on the mother. Kima, like Evelyn and others, had already had such exposure on their maternal struggles in jail.

What baby Koia's birth did was to put the spotlight on the jail and its related carcerally-inflected institutions—the hospital, child welfare system, drug treatment programs. Kima's birth experience diagnosed institutional inconsistencies in their most intimate manifestations (see Rhodes 1998).

Childbirth is often a moment where women are surrounded by family; but because Kima's incarcerated status persisted at the hospital, and because the final stage of labor did not occur between 1:30pm and 2:30pm, Kima was restricted from family support during this intense moment. "It's a hard time," Kima reflected. "It's not the most comfortable position to be put in, to actually be in custody and giving birth, 'cause your family can't come to see, to push you forward to have the baby." The justification for this restriction was thin—following procedure. The unpredictability of childbirth timing made the hospital visitation rule seem arbitrary, without regard for the exceptional interruption in carceral routine that delivering a baby presents. And yet while maintaining some rigidity in visiting hours, Deputy Jenks was inspired by the moment to bend the rules and let more visitors in. "Especially when, you know, there's a kid. It's up to our discretion. There's a gray zone," he had said. He was cultivating ambiguity between institutional requirements and a cultural reverence for childbirth.

Kima tried to maximize her opportunities for bonding with her infant, creating a semblance of normal mothering in her hospital room. When the CPS police hold re-directed her efforts to occur only in the nursery, the absurdity of the system was made visible. On the one hand, Kima was not discouraged from breastfeeding even though she would soon be going back to jail, without her baby. In fact, the Bridgetown Jail was notably supportive of breastfeeding: official policy allowed a woman to pump breast milk in the pods, have the milk stored in clinic, and then picked up by the infant's caregiver.[4] On the other hand, in the hospital nursery, Kima had to manage this intimate encounter with her baby while one arm was chained to a wheelchair. The necessity of physically restraining a breastfeeding woman while a guard towered over her is questionable. With a custody approach, care (as the enabling of breastfeeding) and violence (as constraining its possibility with chains) graphically coexisted in this moment.

The police hold which the CPS worker placed on baby Koia was not, as Murphy and Rosenbaum (1999) would argue, a coalescence of institutional scrutiny on a badly behaving mother. Rather, it was a

reflection back on the institutions professing to be simultaneously protecting (Child *Protective* Services), punishing (jail), and healing (hospital). When Kima reached a CPS supervisor on the phone, she was told that the police hold was unnecessary. A standard CPS hold, keeping the baby in the hospital until CPS confirmed the safety of her designated guardians, would have sufficed; it also would have allowed Kima to be with her baby in the room. Moreover, an incarcerated mother holding her newborn already *de facto* has a kind of "police hold:" an armed law enforcement agent is always posted outside her room.

The CPS worker's decision was thus procedurally unnecessary in order to protect the child; it might even be viewed as punitive, depriving Kima of a maternal comfort simply because she was incarcerated. In this scenario, the jail system was, in one sense, a bystander to CPS' extreme actions. The deputy outside Kima's room when the police hold went into effect told her he would take her to the nursery as often as she wanted. "The last thing I want to do is come between a mother and her newborn baby," he told her, trying to mollify how CPS had come between this mother and her newborn. But the jail has also set the conditions of possibility, for inmate Kima had to make some arrangements for the baby she could not take back to jail with her. Moreover, Bridgetown County Hospital, and the nurse who abruptly moved baby Koia from her mother's arms to the nursery, was also complicit in the institutional care and violence Kima experienced.

Kima's experience shares many qualities with other incarcerated women's births that I have attended. There was also variability. Mimi, for instance, happened to give birth at the hospital between 1:30pm and 2:30pm, so her mother was there by her side. Her mother, who had no criminal record like Kima's mother and sister had, was able to care for the baby. After Kaylee delivered her baby, she was relieved that her newborn was placed into temporary foster care instead of going to her inebriated boyfriend, the baby's father. Another variable quality to incarcerated childbirth is that hundreds of women in other counties and states, as discussed earlier, give birth in chains. These women's varying experiences of childbirth shed light on the institutional webs in which they were enmeshed. The

outcomes of their reproduction cannot be understood solely through a lens of individual choices like becoming pregnant or using drugs or committing a crime, or through a lens of "reproductive governance" where they are subjects produced by technologies of control. Rather, their "choices" and their "control" were animated by individuals in a complex system of carceral and caring relationships where motherhood was made.

"Jail brings me back to what being a mother is"

Kima had two more weeks in jail before she was released to Whitman House. She continued to pump breast milk for her baby, which the clinic stored. A Sheriff's Department "family programs" worker, Claire, coordinated the transfer of the milk to the baby's guardians. When a piece of the breast pump broke, Kima repaired it with string from the end of an unused tampon. She was committed to providing for her baby, to making sure baby Koia consumed her breast milk.

In that two week period, Kima had several contact visits with her baby. I waited with her before one of the visits. She fantasized about all the things she would do with baby Koia in the years to come:

> But being that I do believe that I can do it, I know that this has got to—this is my last time. It's so much that I've got to look forward to. Crawling on the floor with my baby. I mean, who wants to not crawl on the floor with their baby? Like it's just going to be so fun 'cause I've been chasing her around. I could just see it now, just certain things, singing with my baby. It's like I want to be able to teach my daughter how to say excuse me when you're talking behind somebody or bumping into somebody or asking for something to say please and thank you. That's exactly what my plan is, to teach my daughter how to be a young lady, a little princess and act accordingly, and know that she's tough, she's a fighter.

The imagined future was very much a part of what sustained Kima in the present reality of jail.

At 4:30pm, it was time for her visit. Time to crawl on the floor with her baby in a windowless jail classroom with stained, gray institutional carpet. Koia's guardian had driven the baby to jail, where Claire the family program worker then brought her, in her car seat carrier, up to the fifth floor visiting room. The spatial designation of where these newborn visits occurred, in a room in the administrative wing of the jail, symbolically implied that the housing units of the jail were no place for a mother and infant to be together. A deputy escorted Kima to the room, where she rushed over to her baby and

picked her up from the carrier. Koia wore a onesie embroidered with "Sugar and Spice." Kima wore her standard issue orange uniform. They had about two hours together in this room, laid out like a pre-school classroom with bright posters on the walls, with family worker Claire watching closely.

Into those two hours, Kima condensed as much maternal practice as possible. She sang made-up songs to her baby about love and, when the time came, poopy diapers. Kima spread out on the floor a changing pad Claire provided and changed baby Koia's diaper with gusto. When the baby cried, Kima held her close and rocked her back and forth. Then she guessed her baby was hungry. Kima arranged herself in a blue plastic chair, lifted up her shirt, and pushed her right nipple into Koia's screaming mouth. She used her rolled-up orange, jail issued sweatshirt as a lap pillow, to stabilize the baby. Claire and I watched closely as the baby tried to latch. Fifteen seconds was the longest she suckled, before she started crying again. Kima was patient, knowing her daughter had only seen her nipple a few times during her ten day life. After a few position changes, Kima calmly covered up her breasts and asked Claire to mix a bottle of formula (with supplies purchased by the Sheriff's Department) for her hungry baby. Kima offered the bottle to her baby, who happily imbibed. When the visit ended, Kima was sad to say goodbye, but she was energized about getting out in a few days, when she could see her baby more regularly.

Jail enabled these nested moments of motherhood. The Sheriff's Department coordinated mother-child visits when possible. Claire had worked in family programming for the Sheriff's Department for several years, and knew many of these women, including Kima, well. Claire and her colleagues taught parenting classes, which Kima had taken several times, even long before she was pregnant with Koia. One woman, Karen, in her early 40s, attended these classes even though her three children, whom she did not raise, were grown. Karen spent most of her addicted adulthood cycling between the streets and jail. She had left the childrearing to the children's father and her own mother, but Karen still visited them when she could.

Karen loved the parenting classes in jail, and hoped they would now help her be a good grandmother. The camaraderie she felt with other women in the pods who were mothers also energized her maternal sentiments. Volunteers from a church would come to the jail periodically and record women sending audio messages to their children. At the end of the session, there was a stack of cassette tapes the volunteers would take with them and send in the mail. But some women could provide no address. I also could not help but think that very few people still had the ability to play cassette tapes. Nonetheless, the opportunities to be a mother in jail were numerous. Karen wistfully summarized what jail facilitated, implicitly referencing what her life on the streets lacked: "Jail brings me back to what being a mother is." Megan Comfort (2009) has similarly explored how a carceral institution can cultivate love in romantic relationships. Her ethnographic study of visits between male prisoners and their non-incarcerated female partners shows how, for some women, prison enhanced their romance, because they did not have to negotiate things like financial logistics or even abusive elements of their relationships. The limited times to visit enabled couples to have picnics and other interactions which replicated an idealized version of romance.

Sandra Enos (2001) interviewed mothers in prison to explore how they construct and manage motherhood while incarcerated. She found that women employed a variety of strategies, from micromanaging their children's caretakers, to denigrating other inmate mothers who used drugs in front of their children instead of concealing it, or demonstrating their maternal fitness to official agencies. Regardless of their strategies, women's identities as mothers were something to be tended to in prison. Barbara Owen's (1998) study of women in prison found a similar attentiveness to motherhood in prison, with many women expressing a desire to stop their criminal behaviors so that they could care for their children (58-59).

What Enos' analysis did not fully capture was how, for some women, this intense focus on motherhood while incarcerated was a stark contrast to their lack of involvement on the outside (Owen

1998: 121). Claire, the Sheriff's Department family program employee, knew this to be true for many of the women she tried to help. Claire worked hard to coordinate parent-child visits for inmates, even though she knew that for some of these women, jail was the only time they ever saw their children. "I'll call up some families to arrange dropping off the kid and they'll say 'well, she never sees them when she's outside of jail, but I guess we'll bring the baby in.'"

Jail provided these women direct access to these coordinating services, with fewer logistical barriers than city agencies imposed outside of jail on these women without custody of their children. Moreover, jail provided a sober pause where some women, surrounded by other inmates who would hang pictures of their children in their cells, idealized their roles as mothers. As with the women in prison whom Owen (1998) and Enos (2001) interviewed, incarceration could foster reproductive contemplation. Patients I took care of in the jail clinic asked me to start them on a method of birth control, because they wanted to get their lives together without an unintended pregnancy, to focus on housing and employment and the children they already had. There were other women who came to me to remove their intrauterine contraceptive devices (IUD), so that they could plan to have another baby. Alexis, a woman whose twins I had delivered 2 years prior and whose mother was raising her five children, told me as I removed her IUD, "I think having another baby is going to slow me down and I think I'm ready. . . .It's time for me to grow up."

So when Kima was released from jail on Labor Day, she was full of enthusiasm to be a mother to baby Koia. When she got to the jail lobby, she, later explained, "nobody was downstairs far as like my case manager to drive me to the program, even though that's a very lame excuse for me not making it that day. I didn't go." Instead, she hit the streets. The drug-filled Salisbury District she spent much of her time in was only 5 blocks away. "I smoked some weed, and then I went and smoked some crack, and then I went to the program the next day. Everybody was really happy that I called and showed up. So I ended up having some having some clean pee, so I gave them some clean pee." Kima giggled at this

detail, which she told me from jail, two and a half months after her Labor Day release. She was at Whitman House for only two weeks. While there, she attended group therapy, parenting classes, supervised visits with her baby, and rested comfortably on their beds. She also, on a pass to leave for a few hours one Saturday, went to a friend's house and got high before returning to the comforts of Whitman House. A few days later, she quietly walked out the front door.

And here she was again, in jail. Now I knew why the staff at Whitman House would not allow me to visit Kima when I called them—Kima was no longer there, but they could not tell me that. Now I knew why Kima had not come to her post-partum clinic visit at Bridgetown Hospital, where we would discuss birth spacing and contraception: she was high on the streets. With multiple stints in therapy, Kima was versed in taking individual responsibility for her failed attempt at reunifying with her baby. In jail, several weeks after leaving Whitman House, she confessed to me,

> I kind of like set myself up by doing that in the first place. I got to give myself a chance. It's not the fact that I got away with using [before going to Whitman House]. It was the fact that I didn't give myself a chance by staying clean. I let them not showing up be a reason that I went and got high. And so I kind of set myself up again.

Koia was still only 3 months old. Legally, Kima still had time to gain custody of her daughter, whom her cousin was currently caring for, and whom Kima hadn't seen in two months.

Kima, armed with this proclamation of taking responsibility, then proceeded to tell me that she wanted to try again to be a mother. But trying again did not mean trying to reunite with Koia. She believed that was now only a legal matter, and a lost cause: "If they say in court 'no,' then it's no. It's nothing I can do about it. And they may well just say no, Dr. Sufrin, 'cause I didn't — I never unified — I failed the unification services with my daughter, my older daughter." But Kima had already hatched another plan for motherhood. On the streets, after leaving the drug treatment program she hoped would reunify her with her newborn daughter, Kima tried to get pregnant again:

> **Kima:** I tried to get pregnant by this Mexican and white boy. Oh, yes, I did. I tried that. I tried to get pregnant because I — 'cause I'm going to have a baby and they're not going to take it. I

> will end up having a baby that they can't take, so — I know that sounds kind of fucked up, 'cause it's like, well, damn, you don't have none of your kids, but still.
> **CBS:** And what do you think would be different this time?
> **Kima:** I don't know, but I'm going to end up having a baby that they can't take, 'cause the social worker told me that if I don't — if I'm not in jail and I'm not using, they can't take a baby from me. If I have everything — If I get pregnant and I don't test dirty, and I give birth and I'm not in jail, how can they take it if I'm there, if I'm doing right? So that's my — If I was pregnant right now, I would be happy because — not saying that I can forget about my other children. I mean, that's not what it is, but just to try to have one that I can keep, so that I can keep it.

She alternated between childish laughter and a serious tone as she told me about her attempts at pregnancy. To her, this was an organized, sequential plan.

Perhaps for someone who had been so deeply enmeshed in having institutions managing her reproduction, in her drug addiction shaping the contours of the state managing her reproduction, Kima's plan was logical. Similarly, Nancy Scheper-Hughes (1992) has eloquently described how political-economic circumstances characterized by limited resources in a Brazilian shantytown shaped maternal sentiments. Malnutrition, diarrheal illness from poor sanitation, and the government's indifference contributed to high rates of infant mortality. Mothers expected that only some of their children would survive. They pragmatically calibrated their maternal sentiments and actions to optimize the lives of those whom they learned to sense would live.

Similarly, Kima had come to expect that her reproduction overtly required the involvement of state institutions, namely jail, the courts, and CPS. Each child involved a trial period of varying length in which Kima had to prove herself a fit mother. She had yet to succeed. It is not hard to imagine how the trial mentality could produce her apparent nonchalance, that she could just try again. Kima believed a clean pregnancy—not an easy task for someone with longstanding addiction—would overcome the regulatory obstacles that had impeded her success. Kima's past experiences produced in her an experimental approach to pregnancy. Moreover, Kima had spent much of her reproductive years in and out of jail, with only an occasional stint in prison. Each jail release equipped her, at least in theory, with a re-entry script to re-orient herself to a different way of being. The repetitive nature of these re-entries

differed from the context of the mothers in state prisons whom Owen (1998) and Enos (2001) interviewed; while these women may have been in prison before, their prison-induced aspirations to be better mothers had a singular chronicity to them. Instead, the intimate recidivism of the jail reality enabled Kima to have a mentality of hope, of trying for motherhood and for custody of her child, *again*.

This is not to say, as Kima declared, that "I can forget about my other children." Kima was capable of imagining the next pregnancy as better, even while still loving baby Koia. Jail facilitated this mixed aspiration; it nurtured Kima's maternal emotions. When Kima returned to jail when Koia was five and a half months old, she asked me for copies of the pictures I had taken at Koia's birth. Kima then taped these to her cell walls. With barely a visit in her six weeks out of jail, and with the termination of parental rights at 6 months imminent, Kima still wanted visits with her baby. So Claire, the Sheriff's Department family worker, arranged for them again. The visits, Kima said, made her both "happy and sad." She was happy to see her baby, but sad that Koia cried so much, because the baby identified Kima, her own mother, as a stranger.

On one particular visit day, Kima was irritable and upset over an argument with other women in E-pod. So when it came time for her visit with baby Koia, Kima was distracted. She played with Koia while she complained to me and Claire about the drama in the pod. I was sad that Kima was wasting her limited time on such trivial he-said-she-said matters. Then Deputy Murphy stopped by to admire Kima's adorable baby. Kima put her baby in the carrier, and took the opportunity to tell Deputy Murphy about the argument and to request that she move Kima from E-pod to B-pod, to avoid the women she was fighting with. Deputy Murphy was familiar with Kima's impulsivity. She took a deep breath in, put a hand on Kima's shoulder and calmed her down with soothing but instructive words. Her voice was sympathetic, with a hint of reprimand. "Kima, you can work this out. You need to think about the big picture. You need the programming in E-pod." Attending programming, after all, might help her gain custody over Koia, although we all knew the cousin's adoption of baby Koia was likely to be approved in

a few days. Deputy Murphy's tender gestures were enough to mollify Kima for now. They hugged. Kima went back to holding her baby and singing to her, as Deputy Murphy, Claire, and I watched. We also watched as Kima slipped Koia's partially soiled diaper into her bra, a multi-sensory reminder of her baby she would discretely keep in her cell until a deputy would find and confiscate it.

This visit exemplified the intimate ways that jail and reproduction are deeply entangled with each other. It was the ostensibly punitive but tragically normative space of the jail which enabled Kima to connect with her baby in ways she did not outside of jail. She could be more of a mother inside than outside. What's more, solace and instruction from a deputy directed her back into the maternal moment. These moments were glimpses of maternal possibility for Kima, enough to sustain her institutionally-produced experimental desire to try again with another pregnancy.

Carceral Desire

The jail pregnancy experiences of women like Evelyn, Kima, and others illustrate how carcerality and motherhood are co-produced. Despite the hyper-medicalized, morally judging management of pregnancy in jail discussed in Chapter 4, women could still yearn for jail and the various kinds of maternal sentiments it enabled. Even as safety net services like free prenatal care or residential drug treatment programs existed in the community for them, these women were deeply inscribed in a reality where jail paradoxically enabled certain elements of reproduction that other regulated services like CPS and drug treatment programs could not fulfill for them. We have seen how some women came to desire the reproductive comforts of jail, such as prenatal care, parenting classes, coordinated visits with their children, even a wall on which to hang photographs.

Such desires, and the jail's efforts to manage reproduction, implicitly diagnose the failings of a broader system that has perpetuated these women's marginality, a system in which they expected their reproduction to be adjudicated by institutions. Incarcerated reproduction reveals the fundamental equivalence of the carceral and medical-social safety net in our unequally structured society, particularly

for poor, young women of color.[5] The carceral desire that was disturbingly woven into their reproduction sets the stage for thinking about how some of these women came to see jail as home, a process I now turn to in the final chapter.

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[1] "House of corrections" was a term that came into usage in the 17th Century. After the passing of the Elizabethan Poor Law, these houses of corrections were built for vagrants and people who did not want to work. It is not entirely clear when, in the modern age of punishment, prisons and jails started to become known as "correctional institutions," but it was likely tied to prison reform movements which sought to correct the moral failings of people who had committed crimes. Nowadays, "correctional institution" is used facilely and unironically throughout criminal justice circles simply to refer to the a prison or jail, not to connect the institutions to any aspirations of correction.

[2] There are a few exceptions to this short-term, inevitability of release in jail. People who are tried while in jail and then sentenced to life in prison have little promise of release. Moreover, some trials and sentencing can take years, depending on the process of appeals, and this may make release from jail seem like an unreality.

[3] Avoiding a carcerally-enforced separation between a mother and newborn has its benefits. However, many advocates of mothers in prison argue that the best option is to have community-based alternative sentencing programs for these women, where they serve their time under close supervision—either probation or in a residential, supervised program, not unlike a half-way house.

[4] Towards the end of my fieldwork, the Sheriff's Department's initiative to improve care for pregnant women also involved strengthening this already unique allowance of breastfeeding in jail. Some of the changes related to breastfeeding. I helped to procure an electric pump, which is much easier to use than the manual pumps women currently had available; we educated nursing staff better about breastfeeding; we enlisted a lactation specialist who could visit these women in jail; we created more private spaces for women to pump milk; and increased the number of contact visits between mothers and newborns.

[5] Although there are also pregnant, white women who are incarcerated, including at the Bridgetown jail, black women are disproportionately represented as the pregnant ones in this jail. Of the eight pregnant women whom I followed in my research, all were women of color: seven were black and one was Latina. During the same year as my fieldwork, I also provided obstetrical care to approximately ten other women who were pregnant at some point during their time in jail. Two of them were white. These racial pregnancy proportions may be different in other locales, including in prisons. While there are rough estimates of how many births occur annually to women who are incarcerated, there are no systematic attempts to track characteristics of these births, including the racial identification of the mother. Nonetheless, because women of color are disproportionately incarcerated, we can also imagine that at least a parallel demographic trend exists for pregnant, incarcerated women.

CHAPTER 6
At Home in Jail

Sitting in the cold royal blue chair
Reminiscing ten years that loneliness bears.
Inclined to recite an unnatural form.
Stuck in a cell, a fishbowl for a dorm.. . .
Lying flat on a mattress, which felt hard as cement.
Resuscitation of joy, which was bound to ferment.

-Excerpt from "Poetry Blues," by Kima

"My worst day in jail. . ."

Kima and I sat in one of the classrooms in E-pod, where we could have at least some audio privacy, if not visual. The clear glass walls of the room, which allowed everyone from the other inmates to the deputies to watch us if they wanted to, were not a privacy concern for Kima. She was accustomed to the constant surveillance of life in jail. Kima watched too, looking through the glass at the action unfolding in the pod: who was talking to whom, who was sitting where, where the deputies were looking, the time displayed on the clock. Kima had just come back to jail, having been out on the streets for only a few days since her last incarceration. With a rhythm of distraction that I had come to expect in our conversations, Kima looked out the glass wall, then picked at her nails, then looked down at her feet. She wore standard issue flip flops, and on each was etched in blue ballpoint pen a name: "Dante" on the left, to commemorate a pregnancy she lost through a miscarriage; and "Koia" on the right, her five-month-old baby who was now being cared for by one of Kima's cousins.

I asked Kima whether she thought she would try to go to a drug treatment program again after this time jail. Her ruminations on life in a program quickly led her back to her present situation in jail, and where she had come from off the streets. "I mean, my worst day in jail is way better than my best day on the streets." I had heard Kima tell me this before, but each time this pithy comparison came out of her mouth, I had to pause to digest. It was a profound statement. Kima continued. "My worst day in

jail is better than my best day on the streets. It is hard out there. It's dangerous. You never know when stealing something from someone's car is going to get you killed."[1]

Kima lived in a constant state of uncertain danger, her survivalist mode of living intertwined with the daily potential for physical violence from fists, knives, guns, rape, and drugs. "I always get hurt when I'm out of jail." As Kima spoke, I looked at her right index finger. It was hurt. It was swollen, red, and the nail had fallen off. On the streets, she had burned her index finger with a hot crack pipe, and the wounded skin became infected. Within 24 hours of her arrival in jail, she had seen NP David in the clinic. He lanced open her swollen digit so that the pus could drain out, and prescribed her antibiotics. Kima continued her statement about her life outside of jail, and offered insight into her own recidivism: "I always get hurt when I'm out of jail. I think that's why I keep coming back here; even though I don't like it, at least it's safe."

With that poignant reflection, Kima summarized the tragic state of affairs in which economic insecurity and the disarray of the public safety net (Bourgois and Schoenberg 2010; Wacquant 2001, 2009a, 2009b, 2010) coupled with the expansion of carceral institutions have made jail a safe and even desirable place for women like Kima. With this sense of safety and stability, jail thus becomes a version of home. But it is a home overlaid with the women's knowledge that their only safe place is one in which they must remain criminal: punishment is the institutional form that safety and security must take for these women. In this chapter, I continue to explore the entanglements of care and carcerality as they play out in the pods, the jail housing units, from the perspectives of the deputies and the enjailed women as they interface constantly in this intimate living space. Kima's index finger, injured on the streets and healed in jail, is symbolic of the relationship between the violence of the streets and the care of carcerality.

Ubiquity of Punishment

Jail is unequivocally an institutional part of an archipelago of punishment, yet, simultaneously, jail ambivalently poses as a refuge for those whose lives are precarious. As I have described, the rhythms of regimentation, the constant surveillance, and the power configurations have all the hallmarks of punitive discipline which have come to characterize modern carceral institutions. To be sure, it is a space of punishment, where those who have been arrested for alleged crimes or have been convicted of minor crimes are punished through confinement.

The punitive dimensions to everyday life for women incarcerated at the Bridgetown jail came in many predictable forms. It is crucial to describe some of these routinized moments in the midst of my discussion about care. For affect and intimacy in the jail should not be understood merely as disruptive to the punitive interactions we would expect; rather, the intersubjective tendencies of care are woven into degrading forms of punishment. Thus, even when caregiving within the jail clinic or the housing units appears to be a "successful" salve for experiences of abandonment on the streets, the intimacies still serve to sustain problematic regimes of incarceration.

For women in the Bridgetown jail, there was the punishment of being separated from the world outside of jail, including the psychological pain of being apart from their children and other extended family members. There was the constant surveillance from deputies on their elevated, tower-like platform in the center of the pod, watching panoptically every move an inmate made. Inmates experienced the routinized diminishment of autonomy, such as the inability to freely choose when they could shower, when and what they ate for meals, and when they were permitted to read a book. Women at the Bridgetown jail were dependent on deputies for access to all of their basic needs of living. Punishment was also experienced as the deprivation of small comforts, such as a pillow, its absence making the thin blue foam mattresses feel "hard as cement," as Kima described in her poem.

Women also felt punished by what they perceived to be unhygienic conditions. When I asked women the open-ended question of what they thought about medical care in jail, many of them would respond with complaints about the unsanitary conditions of the jail, of being forced to live in close quarters with disheveled people coming straight off the streets. One woman's comments were representative:

> This jail is like by far the worst I've been in. I'm not going to lie to you, as far as disease control and just Ugh! It just really scares me. This lady came in here. She had lice and scabies. They didn't get rid of the mattress. They just threw me in that room. . . . Some lady literally defecated on the carpet, left it there, someone stepped in it, tracked it on the carpet. Why is the carpet here in a jail anyway? Women leave their [menstrual] pads around. Bridgetown needs to get it together. I swear to God, I've never in my life seen anything this nasty. I am terrified about what I'm exposed to.

This woman lived in jail in fear. She and others protested that just because they were in jail, they did not deserve these conditions. The perceived filth of the institution was thus also part of the punitive reality these women identified.

Humiliation and mockery were also part of the punishment. Deputies knew every time a woman had to relieve herself, for inmates had to ask for permission in order to use the bathroom. When one inmate turned in a grievance form to her pod deputy, whose job it was simply to send it to the supervisor, I watched as the deputy read the complaint and then burst out laughing. The inmate was requesting to get moved to another pod because one of the deputies was mean to her. "You can't choose your deputy! This isn't something you can grieve," the deputy said to her while laughing. Deputies constantly yelled orders, laced with insults, to the inmates. At dinner time one afternoon, for instance, Deputy Mullins chastised inmates for not following her particular meal time instructions of lining up on the right side of the stairwell to await their meal tray. Deputy Mullins wore flaming red lipstick which matched the anger she projected onto the inmates: "Can you not follow simple instructions? Are you all that stupid?" She then turned to me and cackled with what seemed like amusement; she explained to me that since she had worked here for decades, she had her system for

making sure the women behaved. I thought about how each deputy had her own set of instructions for meal time, and how hard it must have been for the women to remember how "to behave" properly for each deputy.

The consistent arbitrariness in the deputies' rules created incessant opportunities for punishment and verbal abuse. If an inmate talked back, as Evelyn and Kima sometimes did, they might be placed on "ad seg," higher security housing in which the inmate was confined to a locked cell 23 hours a day, with no ability to participate in programming or social activities in the pod. Evelyn's self-proclaimed anger issues from her first 10 years in and out of jail had a permanent place on her jail record, such that, even though she was calmer now, she was automatically housed in ad seg every time she arrived in jail—punished pre-emptively with jail housing isolation before doing anything.

In addition to these more subtle, controlling forms of punishment and verbal abuse, there was also physical force. I watched as a psychotic inmate, presumed to have the potential for violence, was aggressively pinned down by four deputies, placed in handcuffs, and dragged with an entourage of guards to a concrete block "safety cell" in the medical housing unit. Although I did not personally witness fist fights (perhaps my presence in the pods influenced people's behaviors) I heard first-hand from deputies and inmates who had engaged in fights. Evelyn recounted the days when she assaulted and was assaulted by deputies:

> Like, okay, you might get in a couple good licks when it's just you and you're fighting a deputy one-on-one, but once all the other deputies rush in—and it's never female deputies. It's like you fight a deputy and all these men come in. And then the elevator ride from say B-pod to Lower C-pod or Upper C-pod safety cell is really, really hard because, like, there's no cameras, so we're prone to getting our ass whipped in the elevators. Like I got my finger broke one time. I had a 300-pound deputy step on my back, like twist—They're not—the male deputies don't take in consideration that we're females. So okay, I understand I assaulted one of your co-workers, but I'm a girl. I'm not a guy. And they slam us; they twist our arms.

Surveillance cameras were predictably located throughout the jail, for panoptic surveillance of inmates and staff; but the elevators were, for unclear reasons, surveillance-free. In her recounting, Evelyn admitted to some degree of complicity in the violence. She also described excessive force in the

unmonitored elevators, where inmates were usually handcuffed to begin with. There were other instances as well, described by her and other women, of inexplicable, unprovoked physical assaults, in full view of cameras and other people.[2]

The Bridgetown Jail was thus seeped with the elements of carcerality Foucault delineated, of mortification processes described by Goffman, and of the arbitrary, punitive deprivation seen in today's "warehouse prisons" (Irwin 2005). These examples should serve to emphasize that carceral life and power relations within it continue to be sustained, in part, by a radically dehumanizing logic. Expanding on the mortification process of total institutions which Goffman described, Irwin has written about the entry to jail: "[Prisoners] are impersonally and systematically degraded at every step in the criminal justice process" (1985: 67). He continues, "most deputies embrace and help sustain the theory that prisoners are worthless and deserve their deprivation. . . . [They] must consciously reject more humane and tolerant conceptions of prisoners" (1985: 76).

Scores of books and daily journalistic accounts depict jails and prisons that lack some of the most basic amenities, where physical abuse of inmates is standard, and where they are left to wither without adequate medical care. The Bridgetown Jail is part of a historical trajectory in which our country's penal institutions have transformed their commitments to rehabilitate into more punitive goals of deprivation, and then to an ideology of risk management which routinizes the carceral treatment of a population constructed as dangerous criminals— what Malcolm Freely and Jonathan Simon called "the New Penology" (1992). Of course, no episteme completely replaces another (Dreyfus and Rabinow 1983: 99), and all of these penal impulses are present in contemporary carceral institutions.

Pastoral Custody

What has remained constant through the ideologically defined shifts, though less often acknowledged, is the function of carceral institutions to keep people, to guard them in one place. As

such, jail—perhaps even more so than prison because of jail's pre-trial detaining role— is involved not only in punishment, but in what is called "custody." This is the word used in official and common parlance by people who work in jails and prisons to describe the basic workings of keeping a carceral institution and those within its walls safe. People who work in jails less frequently describe the inmates as being "incarcerated" and more often as being "in custody." In fact, the division within Bridgetown's Sheriff's Department whose responsibility it was to manage the county's jails was called the "Custody Division." Rhodes (2004) offers a nuanced window into custody in the management of maximum security prisoners. She shows how civilian and uniformed prison workers tack back and forth between custody-security and psychiatric-treatment perspectives. They engage in an ongoing negotiation where "the boundary between custody and treatment is contested" (Rhodes 2004: 157). We can push this further by seeing custody itself as contradictory.

To start, the Bridgetown Sheriff's Department's website intimates the possibility for custody as more complex than just the elements of enforcing law and order. The department's mission statement provides a practical description of what its Custody Division does:

> The Custody Division is the [Sheriff] Department's largest division. This division is charged with the operations of all six of our County Jails, the Hospital Ward, the Classification Unit, and the various Jail Programs. The division strives to maintain a safe and secure jail system and to facilitate an environment in which the various educational and rehabilitation programs can accomplish their missions. These in-custody programs offer a variety of educational, vocational, substance abuse treatment and violence intervention classes.

Custody includes maintaining safety. It also entails, at least according to the Bridgetown Sheriff's Department's official statement, enabling individual transformation to escape cycles of incarceration through the ideals of rehabilitation. Incarcerated individuals are absent from the grammar of the Custody Division's mission statement—the activities are all directed toward the jail and its programs, not to people. Nonetheless, the sentiment of this description of custody is nonetheless one of concern and investment. We would do well here also to consider the Oxford English Dictionary definition of "custody:" "the protective care or guardianship of someone or something." Custody, then, is also a

form of care. In a jail, custody may take shape through practices oriented toward safety and security, however defined; but custody still has practical and rhetorical roots in a kind of care. These two dimensions of custody, care and control, coexist at each moment, making each practice complicit in the other.

To consider further this linkage between custody and care, and thus the implications for the Bridgetown jail, it is useful to return to Foucault's description of pastoral power. Foucault explores the shepherd tending to his sheep as exemplary of pastoral power. The shepherd's pastoral work ensured the flock's welfare by providing food and security for each individual sheep. As the shepherd looked after his sheep, he had power to determine the conditions of their daily lives. And here we have the entanglements of power and care, for "pastoral power is a power of care" (Foucault 2007: 127). The shepherd's power over his flock was exercised through a benevolent provision of subsistence for his sheep, looking after them, and "treat[ing] those that are injured" (*ibid*). Foucault does not linger long in these aspects of care, instead focusing on pastoral precursors for governmentality and regulating the conduct and knowledge of the population.

Angela Garcia (2010), in her account of intergenerational heroin addiction and treatment programs in bucolic New Mexico, pushes the notion of pastoral care beyond the control of the subject: "far from excluding the possibility of pursuing ethical ideals of caring, pastoral power might actually instantiate such an ideal" (31). Pastoral care, with its roots in guardianship for the flock, is thus a complex enactment of benevolence and power, where the kindness of care and the control of subjects are inseparable. So too are these nodes inextricable in the carceral enactments of custody. The daily work of Bridgetown pod deputies consisted of micropractices which could always be justified as ensuring safety, from breaking up fights with pepper spray to then flushing the caustic chemical out of an inmate's eye. The safety that deputies worked to achieve, as we shall see, was a knotty entanglement of these tensions between control and benevolence, what I call pastoral custody. Despite the perceived

perils of the living environment of jail and the demeaning acts of punishment, women also experienced jail, as Kima's index finger so poignantly demonstrated, as a safe place— the ultimate safety net.

Custody as Safety

To explore the pastoral care of custody as it played out in the Bridgetown jail, let us begin with the start of a deputy's work shift in the jail, "muster." The name of this ritual is an un-ironic reference to the military practice of assembling and inspecting troops. Fifteen minutes before the changing of the guard in the jail (6:45am, 2:45pm, and 10:45pm each day), the oncoming group of deputies routinely meet in a cramped, windowless conference room on the fifth floor of the jail. Deputies must enter the room ready to work, dressed in their black Sheriff's Department uniforms and adorned with their belt of enforcement gear: handcuffs, stick, pepper spray, flashlight, walkie-talkie.[3] Their uniform and accessories represented the so-called safety and security mission of custody, ready to injure an inmate who crossed the line of safe behavior.

The structure of muster was the same everyday: deputies trickled into the room, collected their food vouchers for the shift, they greeted each other and made jokes, and they leisurely sat in chairs while they awaited their senior officers' arrival. The charge nurse for the shift was supposed to stay for muster, but usually he just dropped off the medical lists of which inmates needed to come to clinic, and who was entitled to line up for pill call. The shift supervisors—more highly ranked senior deputies, lieutenants, or captains—would then file into the room and sit at the front. The "watch commander" of the day would take attendance by announcing each deputy's assignment for the shift (which usually remained the same for one month's time).

New announcements were read from the "muster board," a clipboard with a cumulative stack of official departmental memos from the year. The range of muster board announcements was varied:[4] beware of the recent resurgence of "tomahawks" (creative repurposing of the safety razors inmates could use to shave); Alisha, a pregnant woman, was court-ordered to have a free phone call one day; a

nurse had just been fired because romantic relations with an inmate and had her jail clearance revoked; in-service training dates for a suicide prevention module; overtime shifts to sign up for. The messages were efficiently and unidirectionally announced, from supervisor to lowest-ranking deputy. As they listened to the routine, deputies joked with each other, and a few distractedly completed crossword puzzles. After the swift communication of information, deputies then dispersed to their posts, to carry out the duties their supervisors had just told them to do.

I spend this time describing muster to frame custody as a set of managerial, routine practices geared toward safety (beware of tomahawks) and security (the evicted nurse who was not allowed back in). Deputy Faderman summarized for me his interpretation of his job, one which was well represented in muster discourse:

> Our role is to make sure that they do their time in accordance with the law. That's it. Our job is to make sure that we maintain the safety of ourselves, the people that are coming in and out of the facility, and the safety of the facility itself. That's it. That's our job.

Muster reflected this procedural orientation. The thrice-daily ritual ensured that everything in the jail, even potentially shocking things like inmates' weaponry or staff-inmate trysts, was routine. One could get a clear, albeit sterile, sense of what custody officially meant from attending muster.

It was when the deputies left the predictable organization of muster and entered the pods, inhabited by inmates, that the meaning of custody was made real; this was when its pastoral contradictions emerged. Custody was enacted in various ways, from the bureaucratic administration of the living space to the management of interpersonal relations. The carceral space of the jail, in both physical architecture and discursive formations, enabled custody to be a form of caregiving. At one level, custody certainly entailed a sense of routine and duty which the deputies orchestrated.

For instance, here is a sample of activities from a daytime deputy's shift: arrive in the pod at 7am to relieve night deputies; do a quick walk around of the women in their cells, most of whom went back to sleep after 4:30am breakfast;[5] at 7:15, answer a phone call from the "movement deputies"

stationed in the holding area near the clinic to talk about who was on the clinic list for the day; then call out the names of women scheduled to go to clinic that day and line them up to leave; at 7:55 am, call out to the women going to the in-jail school for a General Educational Development (GED) diploma, who gather on the upper level waiting for their escort; put on a pair of medical gloves and pat down every inmate before leaving the pod for clinic or class; inspect every dorm area and ensure there is no contraband in an inmate's property; when the kitchen duty inmate workers arrive at 9:30am with 2 carts of stacked lunch trays, supervise the pod workers who distribute lunch; at 10am, the call out to the inmates that lunch is being served, and then stand guard as inmates receive then eat a tray of food; supervise lunch tray collection; communicate with the clinic to come for 10:30am pill call; stand by pill cart and inspect inmates' open mouths after consuming a medication; supervise 1 hour of "quiet time" in which inmates must stay on their beds; at 12, direct a civilian worker to a classroom to conduct classes like violence prevention or group therapy; 2pm count time, when all inmates stand by their beds and deputy counts their presence; 3pm, relief from swing shift deputies. This pattern of activities was, roughly, repeated every day, with minor variations such as the content of inmate programming, or the Wednesday distribution of items inmates purchased from commissary.

As part of managing the routine, deputies enacted the custody mission "to maintain a safe and secure jail system and to facilitate an environment in which the various educational and rehabilitation programs can accomplish their missions" When "civilians" (non-inmates, and non-uniformed personnel) entered the pods, such as attorneys, community volunteers, or even medical staff, deputies took their job of maintaining the safety of these people seriously—with an implied sense that the inmates were dangerous.

On one particular evening, the conflict between safety and care within custody was especially problematic. Eliza, a doula (trained birth support person) with whom I had worked to start a program for the women in jail, was teaching a participatory class to help the women understand basic processes

about their sexual and reproductive health. These weekly sessions had become popular and the women had come to trust Eliza and the other doulas who came with her. Towards the end of the class, a woman collapsed onto the floor and started convulsing. She was having a seizure. Eliza was also a registered nurse, and immediately tended to the seizing woman to make her safe—helped her to her side, moved chairs and people away from her, and asked the deputy to call the jail nurses. "You back off and get away from her immediately!" the deputy yelled harshly. Eliza was confused, taken aback.

The deputy continued to yell at and threaten her. "I can have your security clearance revoked!" The woman's seizure stopped and she came to by the time the jail nurses arrived. But Eliza and the inmates who had witnessed the event were still in shock. Many of them, including Eliza, came to me for advice and expressed how traumatic this moment was—not only witnessing the seizure, but watching the deputy thwart Eliza's qualified help. Other deputies later shared with me their perspectives on such instances. "We need to make sure that civilians who come in here are safe. She could have been faking that seizure, then done something to anyone trying to help." Here, the custody charge for maintaining safety was geared toward a potential for danger for a non-inmate, rather than the safety and health of an inmate in the potentially dangerous throes of a seizure.

Custody as Sociality

Amid the highly-scheduled structure of the jail and the regimented safety focus, there was also constant face-to-face proximity between deputies and inmates. This was a consequence of the "pod" design of Bridgetown Jail's housing units, what is part of a custodial strategy called "direct supervision." Pods are in contrast to the "linear" design with rows of iron bar cells so often depicted in the media—and still present in many jails and prisons. With the pod system, cells (except for those on higher level security) had no doors to them. Pods were lined peripherally around a circular layout, and opened to the common area where inmates ate and socialized. Bridgetown built these pod-style dorms in the early 2000s, as part of a deliberate attempt to create community, make more space for programming,

and potentially foster therapeutic transformation, as one administrator relayed to me. The deputies were stationed on a platform, unabashedly located like a panopticon in the middle of the circular, open pod. The platform was armed with control buttons for the locked cells, computers for documenting, and various supplies. The platform itself was open, and thus it was easy for inmates to approach, either by looking up from the lower level or by stopping directly at the guard platform in the middle of the staircase connecting the lower and upper levels of the pod. The constant deputy-inmate interaction which the pod design forced created tremendous opportunities for custody to be a social relationship.

Women constantly approached, with permission, the deputies to ask for all kinds of things: toilet paper when the stalls were low on supply; permission to use the bathroom; medical care request forms to fill out; books to borrow from the shelf of old, donated books, to name a few. Menstrual products were in a plastic bag tied to the handrail at the bottom of the staircase. They were freely available, except to the women in locked "ad seg" cells, which were in turn behind another locked gate. One night I watched as a woman in ad seg pantomimed to Deputy Brody that she needed a tampon. The deputy was comfortable at her perch. Instead of getting up, opening the gate and giving the woman a tampon directly, she asked another non-ad seg inmate to retrieve one from the bag. The woman casually obliged, like she was doing a friend a simple favor, and then tossed the tampon around the gate and into the ad seg area, through a balcony open to the rest of the pod. Deputy Brody then, with the touch of a button at her command tower, "popped" open the menstruating inmate's cell door, and she retrieved the tampon from the table on which it had landed.

While this might seem like an instance of laziness, Deputy Brody and the inmates were laughing together the entire time, cracking jokes about flying tampons. At one level, the inmates' dependence on deputies for hygiene supplies may "bring the [prisoner's] body into focus as a natural object rather than an aspect of a social self" (Rhodes, 2009: 205). But at another level, the dependent relationship enabled spontaneity and sociality through shared humor. This was not the rote work of custody which was

represented at muster. The intimacy garnered through this constant interface between inmates and their custodians, even over what appeared to be the most biologically basic needs, meant that custody was punctuated with softness and humor.

Custody was an ongoing practice at the Bridgetown Jail. It demanded a skilled negotiation of the bureaucratic distance of a carceral regime with the proximity furnished by both the pod architecture and the need to tend to inmates' intimate needs. There were many ways in which the jail itself reaffirmed distance between the deputies and inmates. The most obvious was the power differential which maintained them in a hierarchical configuration. The deputy was there as a matter of chosen employment,[6] a citizen with rights and opportunities in mainstream society; the inmate was there for allegedly committing a crime, deemed a non-citizen by the stripping processes of incarceration. The contrast between the deputies' black, armed uniforms and the inmates' baggy orange uniforms reinforced the difference between them.

Moreover, the guarding nature of custody also had elements of distance. They were not the ones who had decided a person should be in jail (that came from police officers and judges). This seemingly incidental role in the criminal justice system gave the guardianship task of custody a sense of being a neutral bystander to the process. Deputies could feel that they were there simply to do a job, "to make sure that they do their time in accordance with the law," as one deputy dispassionately stated. Deputies were there to carry out a set of tasks of watching over people; counting, documenting, and other paper duties could make inmates into generic, distanced objects of governance (Arendt; Rhodes 2009:205). Another deputy explained his detachment from the inmates: "I don't get mad at them. Because to get mad, you have to care. And I don't care." This is the ultimate expression of indifference, that hallmark unsentimental sentiment of bureaucracy. The potential for moral and social indifference is endemic in modern prisons and jails (Rhodes 2009), so much so that it was the basis for the Supreme

Court's 1976 mandate that prisons provide medical care; "deliberate indifference" was equated with cruel and unusual punishment, the medical ramifications of which I have explored in other chapters.

Proximity and Distance in Custody

To consider how care can arise specifically from this specter of indifference which custody allows, Lorna Rhodes' (2009) analysis of physical proximity and distance in a maximum security prison is a useful starting point. She describes how prison guards and prisoners are in constant negotiation of the distance imposed by the thick concrete walls and psychological isolation of incarceration, and of physical closeness experienced in guards' forceful regulation of inmates' behavior. Distance in the presence of bodily proximity is not, she argues, a static geography to be maintained and from which indifference arises. Rather, the management of distance and proximity afforded by the prison setting is a dynamic, an ongoing process which is the very "social fabric" of the place (Rhodes 2009: 207). Indeed, the open deputy platform at the Bridgetown jail was representative of this distance-proximity based sociality. Deputies listened to women when they approached their custodians for platform chats; but they were simultaneously wary of caring too much, as one deputy told me: "They've all got a story they try to tell you, and you just can't get sucked in." This negotiation illustrates Rhodes' point that indifference is about humans in social articulation. Indifference is not the absence of human connection, as Hannah Arendt (1976) or Michael Herzfeld (1992) might argue; instead, it is an "accomplishment" of ongoing, precarious social relations.

The bodily proximity of inmates and deputies in the Bridgetown jail pods was, as I have already described, significant; likewise, all the bureaucratic features of carceral distance were also present. Dealing with this carcerally given reality was indeed a constant and social negotiation, as in Rhodes' supermax. What pastoral custody in the Bridgetown jail sheds light on is how these negotiations wrestle with the terms of caregiving—not care that is the flip side of indifference, but care that emerges from the same work of distance and proximity. The same deputies who would bark out orders, who would

arbitrarily revoke “free time,” or who would sit at the guard platform and distractedly play with their iPhones[7]—all techniques which engendered distance by affirming hierarchy—would also seek out opportunities for proximity. Deputy Brody, from the flying tampon episode, made one of her periodic inspection walk-arounds one evening. It was close to 9pm, but lights were not out yet. Deputy Brody stopped at an ad seg cell. She opened the small latched door embedded in the larger, locked glass door and invited conversation with the inmate. “What book are you reading?” she asked. For the next few minutes, the two talked about literature.

Another afternoon in B-pod, Deputy Bellinson had just carried out her custodial task of inspecting the cleanliness of and absence of contraband in each person’s cell. While the inspection practices involved close rustling through inmates’ few belongings and temporary personal space, the roteness of the task was also part of the distancing, rule-based bureaucracy of the institution. The women of B-pod had passed the inspection, and were granted free time. She turned the three pod TVs on, and set them to a local channel. On the streets 5 blocks from jail, there was a parade to welcome home the Bridgetown Bears, the hometown baseball team that had just won the World Series. I sat with several women on the lower level as we cheered the players on. Out of the corner of my eye, I could see upstairs that Deputy Bellinson had paused in her busy work to watch the televised parade. She casually sat next to an inmate, although she could have chosen other empty places to sit. The two sat together at a table, on the same level, laughing together at the players’ celebratory antics.

Custody as Choice

These were sought-out opportunities within the mundane rhythms of the jail. But even in the closeness of shared entertainment, proximity was not an either/or scenario. Anna, the woman from Chapter 4 who was 6 weeks pregnant in jail, experienced the deputies’ working through the carceral distance and closeness with anger:

> Like, that’s how they really — especially as far as deputized staff, that’s how they talk to you. You know, that’s how they treat you. Like, you’re gutter alligator or something that you can’t

> even see in the gutter. And, they just look at you like "Uh". Like, if they touch you, they could just die. . . . But, you want to still have some type of dealings with me because you're bored. You know, some deputies, they want to play cards with you and they'll put on gloves. But, you asked me to play cards with you. Seriously?

What Anna described was not the familiar trope of deputies' indifference to her. It was frustration with the ambivalent ways deputies socially engaged her. A deputy wearing gloves while choosing to play cards with an inmate perfectly encapsulates how the work of custody is built on tension. Anna did not experience this as care, but as a demeaning gesture; a game of cards made her feel that the deputies exploited her close presence to entertain them in their boredom.

Evelyn, on the other hand, found a deputy card game therapeutic. During one of her postpartum incarcerations, Evelyn had learned that five month old Baby Carolyn was in the hospital with recurrent seizures. Evelyn felt "frustrated" and "antsy," in part because she could not contact her aunt who was caring for her infant to get updates on the baby's health. Evelyn was struggling. One night on her rounds, a deputy could see that Evelyn had not yet fallen asleep. Although the lights were out in the pod, the deputy gave permission for Evelyn to get out of bed. At the deputy's suggestion, the two played cards, in the dim light of the pod, as Evelyn shared her woes with the deputy— like friends, perhaps like family members, but not like powerful guard and submissive charge.

Evelyn told me about this late night game in passing, as part of the larger story of how she was managing her maternal angst. That the deputy would be a comforting part of that process was not exceptional to Evelyn. It was a kindness that did not surprise her after her years in jail. Evelyn had come to care about the deputies too.

> Certain deputies and I, we are hella close. I ask how their children are doing. . . . I know Deputy Walker is sick [with multiple sclerosis]. So that's my friend. So, when she came back [to work] I was like "Where you been?" She was like, "I'm sick." I almost cried.

Evelyn's emotional response to a deputy's suffering is extraordinary. But it is also not surprising given the care that has come with the ways deputies have enacted pastoral custody.

These examples demonstrate choices the deputies made in cultivating what they deemed to be an appropriate distance from and proximity to the inmates. This is a topic of perennial discussion in corrections magazines and at professional conferences, but it is usually discussed in terms of the dangers of crossing a line—presumed to be static—between inmate and staff. Playing cards to comfort an aching mother, reveling in local sports pride, discussing books, these are not acts of crossing a line or staying behind it. They are about the constant play with the line that the carceral environment prescribes. That they were choices the deputies made in how to comport themselves with inmates was clear from Deputy Faderman, who unequivocally believed his custody role was "to make sure that they do their time in accordance with the law, that's it." For after this, he added, "Now anything that we do outside of those parameters can be determined by whoever is making the decisions."

Those choices of engagement were precisely part of the parameters of custody. In addition to custodial choices inside, jail deputies had to choose their own approach of how to interact with these people outside of jail. Run-in's inevitably occurred, since the corners, alleyways and SRO hotels where many enjailed women spent their non-jail time were located just a few blocks from the jail. Some deputies told me they would say no more than hello if they ran into a former inmate on the street. And other deputies told me that they had gone to a bar and had a drink with them.

This kneading of distance between staff and inmates, folding in and stretching out, is the substrate of intimacy. The carceral institution must grapple with the essential intimacy that arises from its regimes, and from its totalizing nature. Interactions are fraught with ambivalence, something which Berlant identifies as characteristic of everyday intimacy:

> Contradictory desires mark the intimacy of daily life: people want both to be overwhelmed and omnipotent, caring and aggressive, known and incognito. These polar energies get played out in the intimate zones of everyday life (Berlant 2000: 5).

Such contradictory desires were at the heart of how deputies and inmates engaged each other. Of course, incarcerated women had less agency than the deputies in directing the kneading. Some women

yearned for closeness in approaching the platform with quandaries; other women rejected the deputies' unpredictable invitations to chat with monosyllabic responses. The seemingly rigid structures of carcerality, the rote bureaucracy, the givenness of punishment, the presence of these predictable elements were, paradoxically, what enabled people in this space to be more free to explore the nuances of intimacy and care.

Moreover, while the carceral institution imposed a suprastructure of distance between inmates and staff, the broader realities of mass incarceration folded them closer together. The majority of the incarcerated women were not employed in the legal economy; their poverty was inextricably linked to their petty crime, acts which were tied in some way to ensuring their survival on the streets. These women's economic and social marginalization was the underlying reason for their incarceration. Critically, without their incarceration, deputies themselves would not have a job, economic security, or health care benefits. The deputies depended on these women for their survival as profoundly—though in very different ways—as the women in jail depended on the deputies.

This interdependence was rarely discussed openly, although a few women shared with me their recognition of the economic role they played in the deputies' lives. What this connectivity points to is another way that distance, intimacy, and care were interconnected in the jail. Intimacy, Berlant also writes, "links the instability of individual lives to the trajectories of the collective" (2000: 3). This collective impulse emerged in the Bridgetown Jail, albeit intermittently, from the distance that deputies had from "the system" that deemed these women worthy of incarceration in the first place. This bureaucratically-imposed distance creates the potential for indifference to the inmates, as discussed earlier. But the deputies' exclusion from the incarceration decision also enabled them to generate narratives about why the women were in jail.

“We’re the catchall, but we’re not”

Most of the deputies I spent time with disclosed to me some opinionated interpretation of the state of affairs. Many of them offered predictably disparaging comments on the bad choices these women continued to make which landed them repeatedly in jail. Yet, simultaneously, there was also surprising consistency in the sympathetic and structurally-oriented narratives deputies had cultivated over their years working in this environment. When I would briefly describe my research project to deputies or to senior administrative staff, they would often spontaneously offer an analysis of the criminal justice system which included a deep awareness of the interplay between addiction, poverty, education, mental illness, abandonment, and abuse.

I was perhaps most surprised by Deputy Allston. I had observed her at muster and when she escorted patients to the jail clinic. She moved slowly and awkwardly, easily winded when she had to walk up stairs. Her plump face had a resting, curmudgeonly expression that conveyed annoyance and disgrunteldness. So I was taken aback to hear, when we had a chance to sit alone at one of the tables in E-pod, her narrative of “the system.” I asked her what had kept her working at this job for 30 years. As explication of why she loved her job, this was her 10 minute response:

> If people get complacent and people just clock in and clock out without seeing the other human aspect of this, I question if they really should be in this profession, jail or custody.
>
> I am very proud to be born and raised in this area. So, I feel that I'm a part of the population, and I don't concern myself necessarily apart. I think I'm lucky I've lived by this, if you're not part of the solution, then you're part of the problem. If you don't partake in this society and be part of it, then you really have no cause to complain. I mean, a lot of people do a lot of complaining, but then they don't actually participate in the communities that they are responsible for. . . . I think that when I'm dealing with this population, I bring a different – even the inmates will tell me, because they go, "Deputy Allston, you're cool. You're a regular person." I told them, "Yeah, I am a regular person, but I'm still professional. I'm still going to do my job. Don't expect me to bend over just because I show you my humanity."
>
> These are the people that are riding the bus next to you. These are the people in the mall. These are the people in the movie theaters with you. These are the people that may go to your place of worship. These are the people that may go to your kids— if you have a family, they're there too. I mean, they're not absent from the society that you're in. They just don't see them as

> inmates. When you're in here it's so easy. You think they're locked away, but they're only here in transition. So, they're going to transition right back out.
>
> The criminal is really drugs and alcohol, and domestic abuse. There is so much of it, all of these things. We know what they are, but we're not addressing them. So, consequently, we're just round and round. We're just like hamsters on a wheel with each and every person that comes through the system. I'm like, "But this is the same population. Do you guys not get it?" You can get a whole list of names, and once you start cross-referencing all of these names, then you get it. Oh, okay.
>
> The catchall right now is the criminal system. That's the thing. We're the catchall, but we're not. This is what I've seen happen. We're not truly equipped or the most appropriate way to handle this segment of the population. We're not meant to be a mental ward. We're not meant to be a medical catchall. What happens with these people when they're not getting their needs met? Guess what? Why not commit a crime and at least get something. You get a bed. You get linen. You get food on the regular. You're safer than you would be living on the corner in an alleyway, or being beaten by your lover, pimp, whatever, or pusher, or being stuck in a mental institution or a psychiatric ward. This is where they come. This is where they go. Women that don't have access to just regular prenatal healthcare, dental, all of that stuff, why not commit a crime? They're going to get some of their needs met.
>
> Are they criminals? I don't think so. They do things, and they live a high-risk life, but I don't think that they are. I would say about a good third of the population are just here for psychiatric problems. They do things and they break the law, but they're not really criminals. To me, they don't have the competency. They do what they have to do to survive, but they're not actual criminals.
>
> They get programs here. They don't get this on the outside. At least here they get treated a little bit more human by my perspective.

Deputy Allston's monologue perfectly summarizes one of the main analyses offered in this text. Deputy Allston identified that society had abandoned people, and as a result jail had become their safe place. In her reflection, Deputy Allston was aware of how we are all, including her, complicit in this phenomenon of locking people up as a substitute for providing adequate public services. As she elucidated her critical commentary, she also maintained a sense of distance from the laws and the decisions to incarcerate certain people. Because she was external to those non-jail decisions, because her job was to be a custodian of the people whom someone else sent to jail, Deputy Allston could maintain a critical distance from the way things were. And this allowed her sympathetic proximity to the women she guarded.

I then saw her comforting an inmate after bad news from court, a gesture of care. Her comprehensive assessment, culled over thirty years at this job, linked her to the women through a shared sense of injustice. Of course, Deputy Allston participated in the injustice without the suffering that the enjailed women endured; she was a caregiver in this unjust arrangement. But nonetheless she could script herself—quietly, as she told me she had never shared these views with anyone— into a collective narrative, one that connected her and the women, about the injustices and twisted humanity of the criminal justice system. Deputy Allston's consciousness was part of the intimacy and care which characterized her enactment of custody.

Custody versus Medical

This distance from systemic and legal operations which then facilitated caregiving also came from the deputies' separateness from the medical services at the jail. Deputies were necessary mediators between the inmates and medical staff. If a woman had an acute health need in the pod, she relied on the deputy to transmit this information to the nurses. Based on the nurses' responses to phone calls from the pod, deputies knew there was variability in the competence of the nurses and in their patterns of coming to the pod after a phone call. At 1am one morning, when all the other women were asleep, Chandra told Deputy Peterson that she was having severe abdominal pain. Deputy Peterson called the head night nurse, who told her someone would try to come, but there were only two nurses covering the entire jail right now. And then they waited.

> Chandra: You called medical?
> Deputy Peterson: Yeah, I called medical. They said you've got to wait.
> Chandra: But I'm in pain!

Chandra was getting louder and groaning with her pain. Deputy Peterson worried about the other people trying to sleep, and about how uncomfortable Chandra seemed. But there was nothing more she could do. Deputy Peterson shrugged her shoulders and furrowed her brow with sympathy; "I'm

sorry, I'm sorry I already called medical." What more could she do? She was not a nurse, and had already called. Inmate and deputy were aligned, both waiting for the nurse.

Eventually the nurse came, did a cursory exam and diagnosed the patient with indigestion. The nurse gave Chandra some Tums, which eased her pain. As the nurse gathered his things, Deputy Peterson chimed in: "Could you give her a few more for the rest of the night?" He did. Deputy Peterson was advocating on behalf of Chandra. I observed similar moments when some deputies sat with the waiting patients, trying their best to comfort them with words or even stroking their shoulders.

Some deputies commiserated with inmates when they felt that the woman's symptoms were disregarded or mismanaged. Deputy Allston got very worked up as she shared her observations about how medical services were provided in the jail:

> There's some inattentiveness [from the nurses]. There's no real listening sometimes. . . . There are some nurses that I'm looking at what they're doing and I know that it's not right, but I'm not going to step in. I'm not a medical person, but common sense dictates some things. I can't, for liability purposes, circumvent what the medical staff is doing when I know, I know, that it's not right. It puts us within a rock and hard place, because we're not going to tell the medical their job. *It's really gut wrenching sometimes. It's extremely difficult.*

Deputy Allston would patiently listen to women's complaints about the medical services. Some deputies even offered tactical suggestions to the women, to help direct them to the nurses they had come to trust as competent, and away from others. The deputies' distance from the medical system in the jail, like their distance from the system that sent these women to jail, allowed them to tend to the women's medical issues in a non-clinical way. For Deputy Allston, dealing with the shortcomings of the jail medical system was part of her custody mission. She added to her critique of some of the nurses, "It's us that are actually watching the inmates, making sure they're safe and secure while they're in custody during the time they're incarcerated." Deputy Allston used the custody language of "safety and security," but applied it to what she thought the nurses should be doing. This implied both a health and caregiving dimension to her understanding of safety and security. Yet because of the nurses'

deficiencies, it was "actually" she who had to tend to this. This conflation of expected roles of caregiving and control is representative of the contradictory nature of pastoral custody.

Parental Custody

In addition to the custody of law enforcement, another common usage of "custody" is parental guardianship. Custody in this case is an official certification of who is legally bound to care for a child. Parental custody is brought up in situations which call it into question—divorce, or institutionally defined (usually by CPS) inability to parent. Kima, Evelyn, and other women like them frequently spoke and thought about gaining custody of their own children, for raising them themselves was not a given. It was perhaps a cruel irony that these women themselves were referred to collectively as being "in custody," while they fixated on the custody of their own children. The parent-child relationship too has elements of pastoral care, in its mix of watching over and regulating behavior which characterizes the shepherd's benevolence. Relationships between parent and child are, of course, variable and contradictory, capable of love, violence, care, indifference. The lens of parental ties is thus apt when considering the custodial role that jail and its staff play in the lives of women cycling through this space. As Deputy Lewis —herself pregnant with her first child—remarked about the multiplicity of her role, "Sometimes you're required to act as medical [staff], psychiatrist, *mother, father*, confidante" (emphasis added).

The authoritarian cadence to how prison and jail workers speak to inmates is well known. But it should not be taken for granted simply as part of the prisoner subjectivation process, or as a paramilitary form of punishment. Seeing the parental dimensions to deputies' pastoral custody is an important step in understand how jail can be experienced as home for women like Kima and Evelyn. At meal times, at pill call, when calling out women for court or clinic, I heard deputies bellow instructions with loud, domineering, and even demeaning tones. At pill call one evening, Deputy Walker barked at the women:

> Line up! Like ducks in a row. Remember kindergarten, first grade? Line up! No talking. You don't need to talk to get your pills. One line! You think I'm joking?

Threats to "write you up" for not following instructions were common, as were instructions to "get your lazy ass out of bed." These moments, as revealed by the elementary school reference, were infantilizing. Chandra compared this infantilizing treatment from the deputies to her own childhood experiences. "I was abused as a child. The petty psychological interactions with the deputies, they feel emotionally abusive. I'm being treated like a child."

In her account of women in prison from the 1970s, sociologist Kathryn Watterson (1996) elaborates on Chandra's analogy. Watterson likens the entire prison system to an abusive parent, infantilizing women and creating a situation of forced dependency whereby inmates rely on the total institution for their every need (73-83). Rhodes sees the less abusive possibilities of parenting in a prison setting. For those professionals working with mentally ill and behaviorally challenging inmates, assuming a "parental orientation" with inmates allows mental health workers to distance themselves from "custodial imperatives; they can then be more attuned to emotional reactions they and prisoners have" (2004: 123-124). The Bridgetown jail deputies' periodic parental tendencies help us see that custody is a form of care which sutures kindness and cruelty together.

Some deputies were conscious of this move to treat adult inmate women like children, but they believed that this was what these women needed. "Most of them never had a mother to teach them how to behave," I had several deputies reflect to me after yelling orders like a drill sergeant. Informal decorum lessons were common, with deputies correcting inmates on how to say "please" and "thank you," on how to talk without being noisy. There was a parental impulse at these moments; although it was disciplinary in nature, it also came from the parental place of care, of trying to impart wisdom to a developing child.

As Garcia (2010) has elaborated, care emerges in the commensurability of experience that comes from humans being present with each other (68). Likewise, by virtue of their jobs, deputies were

present when women had interpersonal conflicts with other inmates over watching TV in the pod, when they had an upsetting phone call with a boyfriend, or when, like the women described in chapter 3, they had miscarriages. Deputy Harrison had a sense of inevitability about the advising role that this co-presence cultivated.

> I mean, at first they have no other choice but to talk to us. When it comes to certain issues, they don't know where to go. They come up—it could be a legal issue, it could be medical, it could be they're having issues with their bunkies, or they're having issues with other deputies.

Deputy Harrison was blunt in how she translated this element of necessity, the insistence of presence, into parental guidance.

> I almost feel like they're my kids, and I actually say that to them when they're just being pestering. I'll be like, you guys are worse than my kids. I have to clothe you, feed you, I have to take you to the doctor, I have to answer your questions, and you know. . . . I mean, back then a couple of years ago before I got into the church and stuff like that, my attitude was like, you know, I don't even want to hear it because you're saying the same old thing. Now, I don't say that to them. I do give them the lectures, and I tell them you can go ahead and cry if you want. I don't care. You're going to hear it because you know you did wrong. You know you messed up, this and that. So, I still listen to them, because that's what they want. That's what they need. Maybe this will be the time, or maybe something I say will be enough of make them say, "You know what? She said this, and I'm going to try." You know? So, I still give it a try.

Her attitude was representative of what many other deputies also expressed. It suggests a “tough love” approach which is a classic, though not always effective, parenting style. Another deputy similarly echoed the parental guidance aspect of her job; in her case, she noted its impact on her own desire to have children, for “it’s like birth control to work here. . . . I don’t need kids with this job!” It is clear then that many of the deputies at the Bridgetown women’s jail experienced their custodial role as parental. Deputy Harrison consciously translated her parenting experiences from her own life to her relationship with inmates.

The familial metaphor of life in the Bridgetown jail pods went beyond the possibility of parent-child relationships. Indeed, several scholars have conducted studies of the familial dynamics of daily life in women’s prisons. Their analyses reveal that it is common for women in prison, who are incarcerated for multiple years, to form family groupings. Studies from the 1960s of the social worlds female

prisoners created emphasized the importance of kinship structures (Ward and Kassebaum 1965; Giallombardo 1966); they described how women imported traditional male/female gender roles into same-sex, yet heteronormative sexual and familial dyads. Later studies explored how crafting a pseudo-family structure, including sexual relationships, which replicated women's familial relationships in the community, was central to how women experienced prison (Propper 1982; Larsen 1984; Leger 1987).

Barbara Owen's study of a California Prison in the 1990s also affirmed the centrality of family and inmate relationships to women's ways of existing in prison. Relationships with staff were less important for the women she interviewed, she argued; Owen characterized inmate-staff relations either as cooperative or conflict relationships (1998: 160). These and other studies (see also Kruttschnitt and Gardner 2005) present a limited view of prison kinship. They delve into some of the emotional and physical intimacies among inmates, but do not incorporate the staff. As I have explored the contradictory content of pastoral and parental custody in Bridgetown, deputies must also be considered as part of these familial dimensions of incarceration.

"Hi, family"

While jail time is more variable and transient than prison, it is still characterized by the intimacy of a group of women spending every moment of every day and night in the same space. Thus, the potential for family ties identified in earlier accounts was also present at the Bridgetown jail. This was most evident in D-pod, which was a designated, in-jail drug treatment program run by the community organization Whitman House. Whitman House also ran community facilities which many of the incarcerated women had spent time in, either voluntarily or by court mandate. Without subtlety for its familial aspirations, it was called SISTER: "Sisters in Sober Treatment Empowered in Recovery."[8] In fact, the counselors who came to the jail to facilitate the program taught the women to call each other family. The evening ritual of "sunset circle" in D-pod consisted of all the women gathering in the circle

and sharing their current feelings, something about their day. The individual testimonials all began with "Hi Family."

This mantra seeped into the way people talked to each other and to me about the program. Most of the women from D-pod with whom I interacted commented, without my prompting, on how special the place was, on how it felt like family. This is not to say that there was a clear family structure in D-pod, or that even in their parental custody role the deputies were the heads of a D-pod family unit.[9] But it speaks to the possibility of overlap in the institutions of jail and kinship. Nellie, the woman I discussed in chapter 3 who had a miscarriage, reflected with gratitude on the warmth of D-pod, something she missed when she had to move to E-pod:

> D-pod was so much better. Over there we all acted different over there. It was just such a loving family over there. It was so great over there, you know? It really was. In D-pod it was my sisters over there. We was all cool, and it was like a family.

After this comment, Nellie talked of her miscarriage experience, and how kind and supportive the other inmates and deputies had been. It had been one month, but she still warmed to the thought of the deputies who helped her. "They have a heart too. You know they do. So that made me feel good to know that they do care."

What was notable about the family tenor of D-pod which women like Nellie seemed to internalize was the referents for family that they had in their non-jail lives. Other studies of family networks in women's prisons also consider inmates' outside families, showing how women try to replicate their outside family life in prison (Heffernan 1972; Propper 1982; Larsen 1984; Leger 1987). But Nellie's and Kima's non-jail families were hardly as predictable as the ones alluded to in the prison studies. Nellie spent her early childhood with her mother and step-father. Both were drug addicts, and her step-father, whom she called dad, beat her mother constantly. Nellie helped her mother steal things, beginning at a young age, in order to finance her dad's heroin addiction, because when we was high he would not abuse her mother. Still, Nellie thought of him as "a good dad. As far as like he took

care of me and made sure I had what I needed and everything," even if they were things they stole together. He only beat her once, and though she remembered the incident vividly, she still thought of him as a good father. Nellie's mom was in and out of prison much of Nellie's childhood.

Eventually, Nellie was placed in foster care. Starting at age 13, she had children of her own. But Nellie remained close with her mom, and wanted to be with her. One way was to learn from her mother:

> Selling sex was something that my mom did. My mom did it, and I'd do what she was doing. I was never encouraged to do it. It was never forced on me. I asked her to teach me. That's what she did, because I asked her to. Me and my mom was like this [crosses fingers]. My mom, that's my best friend. So, she taught me. I knew it wasn't right for her to show me, or to tell me, but what was she going to do? That's why I love my mom. I miss her so much. . . . We did drugs together and everything. We had a great relationship though. A lot of people didn't understand it, but I had the best mom there was.

Nellie loved her mother deeply. She even stopped using crack for four years to care for her mother, slowly dying from hepatitis C. Nine years after her mother's death, Nellie's eyes still welled up with tears as she told me about her mother.

Nellie's adult family life was similarly disjointed. She had nine children. Though she knew where all of them were and was in touch with them, she had only intermittently raised them in her custody, due to her struggles with addiction and CPS involvement. It was love for her children, in part, that had led to her current incarceration, for she had wanted to make some fast money selling drugs and turning tricks in Bridgetown to buy Christmas presents. Nellie's non-jail family experience was based on a combination of sanguinity, co-habitation, separation, shared drug addiction, provision, and care. Nellie's D-pod family, with the exception of biological relatedness, had elements of these too.

Similarly, Kima spent her childhood moving between her drug addicted mother's home, aunts' homes, her grandmother's and the streets. She had yet to have any consistent relationship with any of her three children. Kima was angry that a distant, biologically-related cousin was currently caring for

baby Koia, but not because she had not seen the cousin in 15 years. Instead, she resented the guardian, and denied her familial ties, because she was not black, like Kima and her baby:

> Everybody's basically saying, "Well, she's with family, Kima." Be okay with it. She's not fuckin' family. If she was family, she wouldn't be white.

Kima then vacillated about whether it was love, rather than race, that made a family:

> Well, as long as she's being loved. Yeah, okay, as long as she being loved. I don't know that either. She could be with my mama and not be loved, 'cause we were with my grandmother and we had a hard time being loved by my grandmother. So that's just another loophole to me.

Whether tethered to race, biological relatedness, or being loved, family was not a straightforward relation for Kima.

Indeed, that classic anthropological object of study kinship has always been able to incorporate a range of fictive kin relations (see, among others, Stack 1975; Weston 1991). Was D-pod sincerely a family environment for Kima and Nellie? Perhaps we can take a cue from Kima's relationship with Deputy Lewis, whom she had come to like over the six years that Deputy Lewis had worked at the jail. Kima was relieved when Deputy Lewis came back to work from her own maternity leave, which had caused her to miss the time when Kima gave birth. Still, Kima proudly showed Deputy Lewis pictures of baby Koia, and talked with her after the supervised visits Kima had with her infant. Kima's familial feelings towards Deputy Lewis were encapsulated by what I heard her call the deputy: "Titi," an affectionate nickname derivative of "auntie." Kima proudly pointed Deputy Lewis out to me in the pod one day—"see, there's my titi. She'll help me." Kima was having a tiff with another inmate and wanted to be moved to a different pod. She trusted that her "titi" Deputy Lewis would try to make it happen. This was part of Deputy Lewis providing custody. Both Deputy Lewis—whom I quoted earlier for her comment that her role included being "mother and father"—and Kima likened their co-presence to fictive kin.

On the one hand, we might think of the familial dimensions of jail as tapping into an ideal of stability and need fulfillment which many of these women had not experienced growing up. On the

other hand, there is a common thread between the disjointed family relations outside of jail and the institutionalized relations inside of jail: care. John Borneman (1997) has explored the ways that apparently contradictory kin affiliations—in his case marriage and parentage—can coexist. Borneman's re-thinking of kinship, out of its static diagrams of cross-cousin marriage, is based on the diversity of relations through which people experience at a fundamental level "processes of caring and being cared for" (574). Deputies at Bridgetown, for the most part, recognized jail as a space where people experience the need to be cared for. It may have been in the simplest sense tending to functional aspects of living—food, sleep, hygiene. But even some of the gruffest deputies, when I talked with them individually, offered deeply sympathetic analyses of their charges, and expressed their desires to help some of these women break out of their cycles. With Borneman's urging that we think about how processes of affiliation involve the impulse to care, it is easy to understand the kinship dimensions of jail custody.

Homecoming

These familial and caregiving intimacies, ambivalent though they might be, help to furnish the jail with the trappings of home. Indeed, as one incarcerated woman told me, "Some people, it's just like, when they're in jail, they're home." Kima even took a bit of home ownership in the space of the jail when I asked her once what she thought about the fact that many deputies treated medical staff like they were guests at the jail:

> Guests? *They're* [the deputies] the guests. We're here all the time and I don't care how many doubles they work they're not here all the time. We shit here. We go to church here.

Kima identified the deputies as outsiders to the inmates' continuous and living (not working) presence in the jail—like guests in inmates' home.

Deputies, too, commented that coming to jail seemed like a homecoming for people. I watched as recently arrested women entered into B-pod. Though ragged from the streets, still high or coming down from a high, many of these women brightened briefly when they saw familiar faces in the jail. I

saw them smile and wave to their friends, with what one deputy joked was a "Miss America wave." "Hey girl!! Good to see you! How you been?" Women knew each other from the streets, from previous times in jail, or both. They also knew the deputies. Kima actually kept a few items, such as poems she had handwritten, stored in jail. When she would get released, she entrusted another inmate who had a longer sentence, with these belongings, which Kima would then retrieve a few weeks later when she returned to jail from a chaotic run on the streets. Administrative reports would simplify this reality into a statistic of recidivism, rather than representing an intimate relationship with the institution.

Upon arriving into B-pod, most of the women knew the routine. The pod deputies hardly had to direct women to the location of the bedrolls containing a sheet, a blanket, and a towel. Women would grab a bedroll from the stockpile, and make their beds on a thin, dark blue, foam mattress in the cell the deputy assigned to them. And then, exhausted from whatever preceded their arrest and from the processing of CJ1, they would plop down on their assigned bed and sleep. Evelyn, as with many others, would sleep for days, catching up from a month of street life insomnia where she had no safe place to sleep, her body crashing from the adrenaline surge of crack.

Familiarity, routine, rest, safety. These elements are, at a visceral level, evocative of home. If a place defined by carcerality can be on par with home, what then is home? Scholars have long been concerned with the concept of home. Government agencies attempt to define the absence of home in census data about homelessness. Hallmark cards and pop songs try to capture the meaning of home with platitudes—"home is where the heart is." Home is an imagined ideal and a material structure. Theories of home have explored its relatively recent emergence as a physical place within which the property and people of the family are safe (John Berger in Jackson 1995: 86). For Foucault (2007), home became the space where the governmentalizing norms of society were maintained. Marx (1978) and Engels (1978) recognized the home as a consumptive unit, providing capitalism with an ever-present source of its perpetuity. Feminist theorists saw the domesticity of the home as a gendered sphere which

served to naturalize repressive cultural associations of the roles men and women should be in the world (Ortner 1974; Erenreich and English 2005). With all of these varied social, economic, political, and cultural dimensions to it, home defies a singular definition. Instead, it is better thought of as a field of experience (Jackson 1995: 122); then, the inquiry rests with exploring what it means in people's everyday experiences to be "at home in the world" (Jackson 1995).

The absence of home, homelessness, is perhaps one way to think about what jail as home might be for Evelyn and Kima. By official and common sense understandings, they were homeless: they lacked permanent addresses; they moved from corner to SRO room to program to extended kin's house to jail. Their reality out of jail was not unlike Philippe Bourgois' and Jeff Schoenberg's (2010) vivid description of the everyday lives and broader political economy of homeless drug addicts, or Kelly Knight's (*in press*) account of pregnant women struggling with addiction and marginal housing. The people they describe live precariously, with a mix of forced dependency on the state and abandonment by it; they are excluded from the mainstream economy. Despite being categorized as homeless, the people Bourgois and Schoenberg depict also build shelter, have intimate relationships, affinal kin relationships, informal economies, internal racial hierarchies, and systems of care. The category "homeless" here has meaning only as a political and demographic label, for these people are finding ways of being at home in the world.

Dwelling

The experience of home involves people, sentiments, relationships, ongoing negotiations of existence, and inhabiting a space that encompasses all of these things. To inhabit a home is to dwell in it, but dwelling in a home is not necessarily confined to a particular place. According to Heidegger, dwelling is an essential feature of being in the world (1971); it is what we humans do. We dwell in buildings we build and inhabit. "To dwell," he writes, "means to remain at peace within the free sphere that safeguards each thing in its nature. *The fundamental character of dwelling is this sparing and*

preserving" (147, italics in original). Dwelling, therefore, is a process of being safe to be how one is in the world. Relatedly, home is a way of dwelling, and dwelling is a way of being at home (Ingold 2005: 503). Careful not to romanticize Heidegger's conception of dwelling, Timothy Ingold reminds us that home may not be a pleasant or peaceful place, and that its dwelling practices take place within fields of power (*ibid*).

Infusing Heidegger's existential take on dwelling and safety with Ingold's recognition of the relational power aspects of experiences of dwelling is a useful framework for thinking about how jail is home. "Safeguarding each thing in its nature" implies a sense of being safe to be oneself. Heidegger insists this occurs "within the free sphere," while Ingold presses for considering inequalities of power relations. These are not mutually exclusive, as the dwelling perspective in a place laden with hierarchical regimes like a jail suggests.

To some degree, the notion that people dwell in carceral institutions is not surprising. Ethnographies and personal accounts of life in prison depict how women, confined to the same place for an extended period of time—some even for the rest of their lives—create a semblance of home life (Owen 1998). The prison is where they exist while incarcerated. It is where they eat, sleep, bathe, socialize; it is the only place where their lives unfold for the duration of their incarceration. It is entirely predictable that when humans are forced to live in a confined space for an extended period of time, they will do what they can to build a comforting, familiar space. This building is what Heidegger equates with dwelling.

Michael Jackson (1995) further explores the existential qualities of home, untethered from spatiality. Through his wanderings with the Walpiri, a nomadic Aboriginal tribe in Australia, Jackson is interested in how people "transform givenness into choice so that the world into which they are thrown becomes a world they can call their own" (123). What emerges in this process is a lived relationship, sometimes contradictory, among elements, people, sentiments, imagination, materiality, fixity,

movement. The ongoing transformational processes are what constitutes "being at home in the world," Jackson argues.

While this open conception of home as making a world that feels one's own is useful, the notion of transforming givenness into choice is problematic. Even for the Walpiri tribe, their experiences of being at home in the world are involuntarily shaped by the effects of colonial violence, of being dispossessed of their land. So too with women in prison who forge ways of being at home in their carcerally confined world. The conditions of their criminal activity—or the categories of behavior that are constituted by a political economy that must punish its poor for things like minor drug crimes and petty theft—are attributable more to the structural violence of their lives than to free choice. Nonetheless, the notion of dwelling in the environment one finds herself in is relevant in the literature describing life in prison. These writings frame the everyday of prison as a spatial-temporal process of how people "do their time" (Owen 1998; Kruttschnitt 2005), of "carving out a life" (Owen 1998: 81) for themselves, something which ethnographers of prisons have long explored for both women and men. Prisoners are thrust into a prison environment in which they must live for an extended period of time. Even if they have been to prison before, they must settle in anew for a known time period. So they create home, a process of building and dwelling.

Jail is different. People come to jail for uncertain durations of time, which last anywhere from a few days to a year. The constant flux of people in and out of jail makes it a more dynamic configuration than the static nature of prison. The short intervals of recidivism—in the time I knew Kima, she was back in jail between 3 days and 2 months of a previous jail release— give jail a paradoxical sense of stability and predictability. That is, because jail is folded into the rhythms of people's lives, it can exist as a source of constancy. Instead of working to be at home in the world of jail, these women are already at home. Jail exists as a place of refuge, not a place they have to create as a refuge.

Refueling at Home

For the majority of the women in the Bridgetown jail—73% if you go by the Sheriff's Department's recidivism statistic—coming to jail periodically was an expectation. Their lives on the street were heavily policed. Many of them were on probation or parole, which came with a plethora of reporting and behavioral requirements; these furnished numerous opportunities for "violations," which could also land them back in jail. Furthermore, by repeated exposure to the jail, cycling through its wall became an unexceptional, normative part of their lives. The metaphor of the "revolving door" was so frequently expressed by inmates and deputies alike (and in criminal justice policy circles) that it would be hard to understate its' taken for grantedness. As one inmate succinctly summarized, "they're like revolving doors here in jail. When I walk out, I'm walking right back in."

When I talked with women in jail about their lives, I usually asked whether they thought they would be back. With rare exceptions, most of the responses predicted a probable return. I once asked Evelyn while she was still in jail and preparing for release if she thought it would be her last time in jail:

> I'm not going to say that. I'm not going to say that. I hate when people say, "I'm never coming back to jail," and then you see them in jail again because that makes you a hypocrite. I don't want to be a hypocrite, so I'm not going to say that. I'm going to say I'm going to try to make this my last time. I'm not going to say this is going to be my last time, because I don't know. Everything I'm planning on doing right now might backfire. I might smell fresh air and everything that I have intentions on doing might go out the door. I think that I won't know until I'm tested with that free air. People say a lot of stuff when they're in here, and then they get out those 7th St. doors, and they smell that free air, and they don't have people in black and yellow telling them what to do, and they have to opportunity to walk up the street to 6th St. and get whatever it is under the sun they possibly might want. So, I'm not going to say it [that I won't be back].

Evelyn had grown accustomed to the presence of jail in her life, either as the place she was or the place she might soon be sent to. In articulating jail's expected presence, Evelyn raised a contradiction in the experience of being free. The "free air" outside of jail gave what she saw as choices to use drugs—6th street teemed with people buying, selling, and using drugs, all just a few blocks from the jail. There was a hint in Evelyn's comment of the paradoxical safety of deputies, "people in black and yellow," telling inmates what to do; that while inside jail, the regimented structure of carcerality kept her safe from the

free air on 6th street that was heavy with drugs. That supposed freedom was the realm of uncertainty for Evelyn, which kept the possibility that she would be back in jail certain. Home is a place you know you can always return to. And so was jail for Evelyn.

Recidivism is thus more than a statistic of failure. It is an account, a public account, of how we are taking care of society's most vulnerable and "disposable" people. As this and previous chapters have described, the cycles of recidivism cultivated ambivalent intimacy among the inmates and the people who worked in the jail. The flux between jail and not-jail complicates Heidegger's perspective on dwelling, which he introduces by signifying dwelling as "to remain, to stay in a place" [REF]. Dwelling in jail adds a temporal conditionality to this sense of permanence.

The lived experience of the revolving door also meant that people had a relationship with the institution itself, with what its space enabled. Women knew to expect regimentation, being told what to do by the deputies, being infantilized by asking permission for going to the bathroom, consistently bland food. They had also come to expect the institution as a place of nurturance[10] or, as referred to by the women and deputies, a place for "refueling." This metaphor suggests a cycle of being drained and then filled. Home, in its multiple meanings, can be similarly understood for its replenishing qualities.

The cyclic aspect of women like Kima's and Evelyn's lives involved being physically depleted on the streets. Both of them experienced thirty day stretches during which they did not sleep more than a few hours, riding the catecholamine rhythms of crack, living hour to hour to survive. Kima burned her finger using drugs. Their bodies and psyches were shaped by this constant precarity which made them weary. They knew jail would replenish them through shelter, food, and medical care. In her pregnancy, Evelyn had turned herself in specifically to get prenatal care, and to remove herself from the draining street environment. Jail was the place Evelyn and Kima knew they could rest.

The common sense expectation of jail as a refueling site for bodies manifested in many ways—slumber, nutrition, hygiene supplies, pharmaceuticals. In Chapter 3, I described the document triage

practices for a woman who continuously requested nutritional supplement shakes to be prescribed by medical staff. Her insistence on these cans of liquid calories was premised on her expectation that jail was where "I gain my weight back."[11] The brand name of these supplements is symbolic: "Boost." Nina saw jail as the place to boost her nutritional status before going back to the streets.

Deputy Mullins did her part to help the women clean up and refuel when they came to jail. When women entered the pod, fresh off the streets, she would strongly encourage them to shower. "If they won't shower, this is how I get 'em to clean up," she told me on the platform one evening. She then opened her bag for me and showed me bottles of lotions and shower gels from Victoria's Secret. "This is my trick to get the stinky ones to shower!" She enticed them with upgrades from the standard issue bar soap, with pleasant smelling elixirs from an upmarket store. Her gesture struck me as parental, like a parent cajoling her child to clean off the mud on her body after playing outside. The Victoria's Secret trick combined regulatory governance with tender care in a way that was consistent with the ambiguous kindness that women had come to expect from the jail.

Many women experienced jail like home through opportunities for rest and relaxation. Time in jail and prison is highly planned, but within the regimentation, some of the scheduled time is devoid of activity. Taken to an extreme, the absence of any planned activities like school or counseling undermines attempts for incarceration to be rehabilitative. This is a widespread and valid critique of how so many prisons and jails function in the age of mass incarceration. But there are some women at the Bridgetown jail who appreciated the idle time as a respite from the chaos of life outside of jail. Jayla, for instance, had just finished telling me the story of the scar on her hand, from a copper pipe heist gone awry. She laughed as she recounted the caper to me, and then told me that was why she appreciated coming to jail, for a break from that. Jayla even bemoaned the presence of too many activities at the Bridgetown jail, reminiscing about the good old pre-pod days when the jail was linear and had fewer daily activities.

> Back then, there was time for respite, to relax. But now there's so much going on—class, programming— and they make you go to programming. If you refuse one day, because you are tired, then you can't get the other services they offer, they just take it as a refusal for everything else. You get punished for not going.

For Jayla, the standard activity-filled agenda of rehabilitation interfered with her desire for the role jail filled in her life: a periodic refuge, a place to rest.

One of the most notable ways that this home-like experience of jail as a site of replenishment manifested was in the use of medical care. Kima's injured index finger is a case in point, for she did not seek medical expertise until she came in jail. Women I spent time with in the pods and women who were my patients in the jail had a range of interfaces with the health care system outside of the jail. A few had primary care doctors at one of Bridgetown's safety net clinics. Some of them knew they were eligible for Medicaid or Bridgetown's innovative universal health care coverage plan. Most of them knew of a few clinics where they could walk in and get free health care services. And yet a substantial majority of them admitted that they only accessed medical care while they were in jail. They knew from experience that they could rely on jail for medical care. "It's just not a priority for me out there," a number of women guiltily admitted to me; they were ashamed to admit to a doctor that tending to their addiction was a more immediate concern than seeking medical attention.

Karen was one such woman. I came to know her through her cycles through E-pod, and her visits to the jail clinic. After she had had a few days to rest in jail, her demeanor was friendly and spirited. Karen recounted for me the restorative role that jail played in her life by first referencing the familiar relationship she had with the medical staff:

> When I first get here they had me go down three days in a row when you're kicking to do vital signs and stuff. I go down there with attitudes and stuff. I give the nurses a hard time. But they're actually used to me. . . . The nurse, she just gave me my medication, right? She said, "Oh, my God, you look so much better. You look alive." I said, "What do you mean?" She goes, "You don't know how bad you look when you come in here." I be like, "Are you serious? Am I that bad?" She goes, "Oh, my God, you're like the dead walking, Karen, I'm not even going to lie."

Karen was not in disbelief over the nurse's assessment; she presented this exchange to me as an example of her awareness of jail's role in her well-being. The grammatical structure of Karen's quote is also telling: "*when* I first *get* here," "*when* you *come* in here" these phrasings imply recurrent events, not a singular past occurrence. This verb tense was taken for granted by Karen.

Karen extolled her gratitude for jail. Her sense of restoration was rooted in health, and tending to her medical needs.

> This is going to sound dumb for me to say it, but I appreciate when I do get arrested because I get to get my health back together, you know what I'm saying? Most of my medical care is taken care of in the jail because for the last, I'm going to say, 10 or 13 years I've been incarcerated more than I've been outside. So yes, I do get my most care in jail. I be out there and not even caring about myself, which is not good. . . . You know, I kind of like – this is like – I needed a rest, I mean, get some proper food, eat right. I'm able to get my – and my thyroid medication, I take them every day, you know. *I'm able to get my health back in order and be like myself again.*

Jail gave Karen the opportunity to reorganize herself through her sense of physical well-being. Taking her thyroid medication was an important act for her to feel like she was getting herself together. Health care in jail was more than just the provision of services for the duration of Karen's incarceration. It exceeded the temporality and spatiality of jail to a broader sense of Karen's embodied being in the world, to what being like herself was. And here we come back to dwelling. Recall that "the fundamental character of dwelling is this sparing and preserving" (Heidegger 1971: 147). "Sparing," Heidegger explains, "takes place when we leave something beforehand in its own nature, when we return it specifically to its being" (*ibid*). Karen proclaimed that, through thyroid pills and other medical services, jail was likewise sparing for her. This is not to say that Karen and others who refuel in jail do not dwell outside of jail. Rather, it is to say that dwelling in jail is perversely sustaining for the existence of someone like Karen, regardless of where she is located.

The pervasive sense of jail as a space of refueling implies that the women were fortifying themselves for life outside of jail. This was, to some degree, true, as descriptions of Karen's, Kima's, and Evelyn's everyday insomnia suggest. But the reality of recidivism meant that jail's "fuel" also existed for

its own sake. That is, jail was the site of normative living for many people. Kima, ever an astute observer of her own situation, summed up the tensions between life inside and outside jail encompassed by the notion of "refueling:" "We actually live here and survive out there."

Dancing to Beyoncé

One of the first times I stepped out of the exam room in the jail clinic and into the pods was the day of the "D-pod Talent and Fun Show," which I had learned about from Kima at a prenatal check-up. When I arrived in D-pod, after much ado from the deputies, there were about 30 light blue chairs set up in rows on the lower level of the pod, all facing a makeshift stage area. The women of D-pod sat expectantly in the chairs, while a few raced around getting props set up in the corner. Grace, a counselor from Whitman House who ran the drug treatment program in D-pod, was standing in front of the crowd going over ground rules for proper behavior at a performance— at least at a performance in a jail with deputies standing guard: no yelling; keep applause quiet. "Are we allowed to laugh?" an older inmate asked. "Of course you can!" Grace affirmed, as though it were a silly question; I looked up at the deputies on the platform and knew it was a logical question. That was the ambiguity of custody, the unpredictable mix of repressive guardianship and permissive care.

Then the show began—singing, card tricks, humorous skits. One woman named Suzanne read jokes from a letter her grandmother had sent her. Her letter reading began with "Suzie, read these to the girls I think they'll like them!" Suzanne light-heartedly editorialized for her podmates before continuing with the letter: "I think she thinks I'm at summer camp, not in jail." The other women laughed, and Suzanne had not even started the joke-telling. Kima took center stage often during the talent show— reciting Maya Angelou's and her own poetry, singing a blues song, and dancing seductively to Beyoncé's "Get me Bodied." During the performances, a few women sat in the back looking bored or doing a Sudoku puzzle. But most of the women were engaged, swaying to the music,

applauding quietly, and, since permission was granted, laughing. They were having fun. They were relaxed and at ease.

I did not think much of Suzanne's summer camp comment at the time, but it stuck with me. Perhaps it was because I spent so much of my own childhood having fun and formative experiences at summer camp, and I was unsettled by Suzanne's sarcastic analogy. But the more time I spent in the pods, the more I saw how women engaged in a range of activities and displayed a range of emotions. The daily schedule, the hanging out on bunk beds, the communal living, the friend alliances and fights among the inmates, arts and crafts activities, these elements disconcertingly reminded me of summer camp. Women had a safe place to have fun.

Of course the relaxed, upbeat mood of the talent show was not present for every woman every day. To be sure, I observed the same performing women get angry with other inmates and the deputies. Women complained to me about being told what to do all the time. I saw Kima lose her temper one day over a skirmish with her bunkie; she loudly dumped the contents of her dinner tray into the garbage as soon as it was handed to her, mumbling "this is bullshit." There were lock-downs and searches when drug possession in jail was suspected. These moments occurred in the same days as movie showings and talent shows. They all folded into the rhythms of what seemed like a normal life.

Holiday times accentuated the unsettling opportunities to feel at home in jail. On Halloween, Deputy Chang brought bags of candy for the women in the pod she was watching over. Women joked about already wearing festive orange for the occasion. Birthdays were also cause for the women to celebrate. One evening during free time, I saw Kima limping to a narrow room known as the pantry, where there was a microwave for inmate use. "What happened?" I inquired about her limp. "Oh, I was doing some splits yesterday. I'm just sore!" Kima chuckled. I reflected on her ability to do splits in jail, and the relative difficulty of doing so on the concrete sidewalk or the cramped quarters of SRO hotel rooms where she sometimes slept. Kima continued hobbling to the pantry where she was in the middle

of making a batch of confections: Jolly Rancher suckers. She melted the candies in the microwave, then stuck plastic spoons in the molten sugar, and waited for them to solidify into lollipops. A group of women were in a classroom celebrating the birthday of another inmate. They had Kima's suckers, some art projects, and a makeshift cake concocted from commissary sweets. It was a traditional birthday party, made possible by the space of the jail bringing them together, scheduled free time, and the women's ingenuity.

Holidays like Thanksgiving and Christmas were acute reminders to people that they were separated from their families. Even if women did not celebrate with their families when they were outside of jail, the punitive isolation from their world outside of jail could exacerbate their feelings of disconnection. Perhaps recognizing this potential for holiday-induced despair, the jail hosted several holiday events. There were traditional turkey and stuffing meals, performances by a local gospel choir, more talent shows. Members of a volunteer church group called, "Women Aglow" brought guitars with them one evening. With twenty inmates crammed into a room, we all held hands and belted out a loud and spirited rendition of "Jingle Bells."

Kima appreciated this sense of normalcy enabled by the structure of the jail. We sat in a classroom, catching up since her last incarceration, which had been only nine days ago. She noticed that I was wearing new boots, and I noticed that her hair was shorter—she always shaved her head when she got to jail, because it was easier to manage. Kima again compared her worst days in jail and on the streets:

> My worst days out there — I would want it to outweigh any good days in here, but the truth is it doesn't. . .. I was tricking. I was selling dope. I was doing this. I was doing that. Right now what I want to do is — I don't want to have to go out there and live in that, and be in that chaos and deal with that struggle, 'cause it's hard. We just don't want to be in jail 'cause we don't want people to tell us what to do. But see, when we have people telling us what to do, that's how we end up living better. That's how we end up living, is 'cause somebody else is controlling it. We have a sense of some kind of normalcy.

Kima acknowledged that the same carceral regimes which were intended to punish her simultaneously enabled her to live what felt to her to be a normal life in jail. Jail was home; jail permitted Kima, as Heidegger (1971) wrote, "to dwell, to be set at peace. . . within the free sphere that safeguards each thing in its nature" (147). Here in jail, Kima could be the performer that her extroverted personality craved. Kima had a certain sense of normalcy that enabled her to dance to Beyoncé.

At Home in Jail

These thoughts of home, homelessness, refuge, and jail were running through my mind one cool November evening. Evelyn had given birth to baby Carolyn six weeks earlier, and was living at Revelation House, the residential drug treatment program for mothers and babies. Despite Evelyn doing all the "right" things at the time of Carolyn's birth, CPS decided that she had not been at Revelation House long enough to prove herself worthy of having her baby with her in the program. What ensued over the subsequent weeks were a series of CPS organized "TDMs"—team decision-making meetings—court appearances, document gathering from Evelyn's own time in foster care, twice-weekly supervised visits with baby Carolyn, attending group therapy, and living with other women who were struggling to make things work. All this during the immediate post-partum period, a time of hormonal fluctuations and physical and psychic recovery from pregnancy.

Social workers assigned to Evelyn's case switched several times, and every week seemed to bring up a new, bureaucratically crafted argument for why she could not yet have baby Carolyn with her at Revelation House. Finally one day in early November, just after Evelyn and I celebrated President Barack Obama's election to his second term, there was hope in the air. This was the day when the judge planned to finalize that in two days baby Carolyn would be reunited with her mother. I picked Evelyn up and we met her sister Jada and Aunt Vera in the hallway outside the courtroom. We were all a bit giddy with excitement. And then Evelyn's lawyer showed up, late and looking worried. It seemed the attorney assigned to represent baby Carolyn—coincidentally the one who had fast tracked Evelyn's first son into

adoption ten years earlier—introduced a procedural delay to the reunification. Inside the courtroom, the judge was in disbelief. She rolled her eyes and questioned the attorney, indicating that she believed it was time for mother and child to be reunited. But the judge was obligated to grant the child attorney's procedural request, and delay reunification for another week. We were all angry and upset about this, but Evelyn took it in stride—she had become accustomed to this roller coaster.

Four days later, it was that cool November evening. My phone rang as I settled onto my couch in front of a roaring fire at home. It was Evelyn. "Hi Doctor Sufrin. I left the program." Her voice was so matter of fact that I did not fully register. "Yes, I left the program. I left three hours ago. I'm here on 60th and Atlantic. I called because I wanted you hear it from me." The phone then cut out. I was in shock. I felt compelled to find her. So I left the warmth of my home. As I took my heavy coat from the closet, I grabbed an orange wool blanket in the corner, in case Evelyn needed warmth that night. I then briskly walked the 7 blocks from my home to Evelyn's corner, through my gentrified neighborhood of artisanal coffee shops. I stopped in my purposeful tracks when I heard a street performer at a corner, only two blocks from where Evelyn was. He was singing a beautiful acoustic guitar rendition of the song my husband and I had danced to at our wedding: "Home," by the group Edward Sharpe and the Magnetic Zeroes.

> Oh, home.
> Let me come home.
> Home is wherever I'm with you.

What was home for Evelyn, I wondered. Was it Revelation House? Was it the streets? Was it the hope of being with baby Carolyn?

Then I found her. Evelyn was sitting on a concrete bench at the 60th and Atlantic plaza, a place I used to know just as the entrance to a subway stop that I now knew as a hub of the drug economy. Evelyn wore a purple and gray striped hoodie and wire-rimmed glasses she had borrowed from another woman at Revelation House while she waited for a pair of her own. Her hair, decorated with golden and

black braided extensions, was pulled neatly into a ponytail. Evelyn clutched her Louis Vuitton knock-off purse that she got from a church charity give away for Revelation House residents a few weeks ago. Inside the purse were a few belongings, including photographs of baby Carolyn. She looked ladylike, out of place in this nighttime drug market. And she also looked terrified. Her eyes did not blink much, and she seemed to be in a daze, like I was. She breathed purposefully, though with shallow breaths, and I could see she felt the weight of this moment. I did too.

Evelyn explained that the women at Revelation House "were irritating me," and that was why she left. But we both knew it was the profound disappointment of the court's repeated delay of reunification. I tried to persuade her to return to the program, or to let me take her to her Aunt's house, but she had a reason why each of my suggestions would not work. Eventually, Quiana, a woman she knew from the streets and whom we both knew in jail offered Evelyn to stay the night in her room at the Travelodge Motel, a few blocks away. Quiana gave us the keycard and told us "room 321." I escorted Evelyn to the motel, and gave her $20. We hugged and she agreed to return to Revelation House the next day and to call me. She did neither. Weeks later, I found Evelyn high on crack in another part of town. She wore the same purple hoodie; her glasses rested precariously on her face, for they were missing one of the end pieces that should rest on her ear. I learned that the Travelodge only had 2 floors, a detail I had not noticed that night. There was no room 321.

Evelyn was back in jail two months after that cold November night she absconded from Revelation House. I sat with her at a table in B-pod. She spoke for nearly 45 minutes about her relapse, her sense of failure, the constant pain of missing baby Carolyn. She paused her monologue only to shout out a warm hello to a woman below, a friend. Evelyn also made jokes and laughed as she told me stories. She looked rested and relaxed, unlike when I found her high on crack, hypervigilant, her clothes dirty, her glasses broken. Evelyn was now at ease. And then I thought of hearing the song "Home" when I had been en route to finding her that November night. Here in jail, it seemed, Evelyn was home.

[1] When Kima made this reference to breaking into a car, an image from a few months earlier flashed into my head of my own car with a smashed passenger side window and an absent radio. My car had been broken into, and though I knew it was not Kima (she was in jail at the time of the break in), the image reminded me of other ways that Kima and I were connected. The relationship we had was cultivated through our shared experiences of her pregnancy as patient and doctor, of spending time together in the jail as informant and anthropologist. Kima's criminal activities had always seemed petty and peripheral in my mind. To be reminded that this was an activity of hers and something I had been on the recipient end of reminded me that despite the intimacy we might have cultivated, we remained in very different places in society.

[2] Boredom and the tedium of unscheduled time are other classic techniques of punishment in contemporary U.S. "warehouse prisons" (Irwin 2005). Having nothing to do, day and night, repetitively, can be a form of punishment, and especially in solitary confinement units, can worsen mental illness (see among others Rhodes 2004). However, the Bridgetown jail was notable for having a very busy schedule of activities. So busy that the programming coordinator sometimes had trouble accommodating enthusiastic community volunteer groups who wanted to offer their services to the women.

[3] Contrary to popular representations, the deputies inside the jail did not carry guns.

[4] Even my research made it onto the muster board. Once my ethnographic presence was approved by the Sheriff and all of the watch commanders at CJ2, it was ensconced in a memo for the muster board, which was read aloud one day at each shift's muster.

[5] There are many reasons we could speculate that the routine wake-up was so early in the morning—perhaps so that each of the three work shifts had one meal to coordinate. Perhaps to instill a protestant ethic of 'early to bed, early to rise.' Perhaps it was punishment. When I asked the pod deputies, they gave me a logistical explanation. In the morning, they had to distribute women to a variety of places— such as court or the hospital for specialist appointments. These happened early, with the hospital van leaving at about 6am; so breakfast had to happen before then, deputies told me.

[6] The professional choice to be a deputy inside a jail is not so simple. For some, it might be a dead-end job. Others see it as opportunities for advancement through the ranks. Indeed, I met many employees of the Sheriff's Department who had started as pod deputies and were now in senior administrative positions at City Hall, working on policies. In Bridgetown, Sheriff was an elected position, and one of the candidates in the most recent election had started as a lower rank deputy. Another perspective on the "choice" of this profession is that offered by Ruth Wilson Gilmore (2007). Her meticulous political-economic account of the expansion of California's prison system discusses how the building of prisons in rural outposts creates jobs for the previously unemployed locals.

[7] Cell phones of any kind were prohibited in the pods. This rule was posted on flyers at the entrance to the jail and in the elevators. Deputies were expected to keep their phones in their lockers. Civilians entering the jail, like volunteers, had to store their personal belongings in a locker as well. Civilians who regularly worked at the jail, like clinic staff, were usually allowed to bring their bags in, with the understanding that they had spaces away from inmates to store their things. When my bag was cursorily searched, my phone was rarely discovered. If it was, I explained that it had medical software on it. No one could bring cell phones into the pods both because of the possibility an inmate could steal it and use it for nefarious purposes, and because the deputies could be distracted from their custody work by their phones. Nonetheless, it was still quite common for deputies to have their phones with them.

[8] This program was started by innovative, dedicated Sheriff's Department leaders in 1992. The model was to have a therapeutic community designed for women and by women inside a jail, with a focus on sisterhood and not hierarchy. A full daily schedule included various activities like recovery groups, individual therapy, acupuncture, journal writing, group reflection.

[9] Unfortunately for many inmates, D-pod closed in early 2013. It was a consequence of a positive change in Bridgetown's criminal justice system, whereby fewer people were being sent to jail in the first place, diverted to community-based alternatives to incarceration including drug treatment programs. With many empty cells throughout the jail, it was not cost-effective to keep D-pod open. So these women were moved to E-pod, integrated with other enjailed women who were not enrolled in the drug treatment program SISTERS. Most of the SISTERS women bemoaned the move after it happened. They could no longer cultivate the exclusive, intimate family feel to the pod, for they were diluted with the general population.

[10] Megan Comfort (2009) describes the ways that prison paradoxically cultivates enhanced opportunities for emotional intimacy, domesticity, and stability between male prisoners and their non-incarcerated female partners. The institution itself is an important figure in their relationships, more than just a physical structure or regime. Likewise, for the people who worked and were incarcerated at the Bridgetown jail, the institution itself was part of the women's intimate familiarity with the relationality of incarceration.

[11] Weight gain in jail is a complicated issue. The availability of any food nourishes those who are underweight when they enter jail. But there are also people for whom their poverty manifests in obesity, and they come to jail overweight. While incarcerated, many people gain an excessive amount of weight (Clarke and Waring 2012), due in part to the combination of being sedentary and eating tasteless meals which inmates supplement with junk food from the commissary. At the Bridgetown women's jail, there was a treadmill in each pod, though I rarely saw it used. Some women danced to exercise videos during free time. But most women were sedentary. Excessive weight gain while incarcerated remains an under-explored area of the harmful effects of incarceration.

CONCLUSION

Forever never ending, finding ways to belong
-Kima, from "Poetry Blues"

Mothers and Babies

Baby Koia and Baby Carolyn are each now almost two years old. Both are being raised in suburban homes by extended family members. Their mothers continue to live in the thoroughfare of drug-infested streets and the Bridgetown jail. Since Koia's birth, Kima has been in and out of jail twelve times. I last saw Kima, in jail, when baby Koia was 20 months old. It had been a year since she had seen her baby, during a visit in jail. With the names of all of her children etched into her flip flops, Kima still spoke with anger about who was raising her children, deriding what she knew of their parenting styles and upset that her 3 children were in different homes. Simultaneously, she also conceded her unwillingness to live differently, even with a range of free housing and other services that she knew her family and the city had offered her. She had not reached out for these services because, as she said, she was "still complacent. Still complacent with shit. Like, oh, it'll get better when it get better."

Baby Carolyn is a beautiful little girl with big brown eyes and a smile to match her mother's. I recently visited Aunt Vera's home, on a quiet cul-de-sac of a suburb 45 minutes from the same drug corners, SRO hotel rooms, and jail where Evelyn was still spending her time. I remain in awe of Vera's patience, love, and sacrifice in raising Evelyn's children, even though she and Evelyn have not been in touch in over a year; Vera declined a collect call from Evelyn at the jail once, and Evelyn has not called since. Baby Carolyn and her older brother Adam, also Evelyn's son, danced around the living room and played with their piles of toys. It was hard not to notice the family portrait hanging on the wall, taken

when Evelyn was about ten years old. In this posed photograph with her siblings and extended kin, Evelyn looked like a happy child—though I knew by that point in her life she had already been molested by her father and uncle. The normative scene of young Evelyn smiling in a family photograph, looking down on her own children playing, was a jarring contrast to the precarious street life Evelyn was living in Bridgetown.

I still wonder what would have happened to her and to baby Carolyn if CPS had allowed her to have her baby with her at Revelation House from the start. Would the immediate, constant (and supervised) presence of baby Carolyn in Evelyn's life—an actual opportunity to develop as a mother—have prevented her departure from the program, prevented her relapse? Kima's and Evelyn's reproductive trajectories remain enmeshed in the ways that the state orchestrates their lives, their identities as mothers—even as the state has seemed to abandon them at other moments of their lives.

Alisha, another woman whose pregnancy in jail I discussed in Chapter 4, is living at Revelation House, the residential drug treatment program that Evelyn walked out of. This is the third program she has been in since getting released from jail 18 months ago, just before she gave birth to her third child. She was kicked out of one program for smoking, against the rules. The second program let her stay even after she got high on her way back from a court appearance. Alisha left because this program was not set up for infants, and she was then happy to get a spot at Revelation House. Along the way, she had graduated levels of contact with her baby Johnnie, from 2 hours twice a week to occasional overnight stays with her at Revelation House. Her baby has now been living with her at Revelation House for the last 2 months, and, as she described the last time we spoke, she is delighting in being able to care for and raise him. Alisha hinted that she may be getting kicked out of the program, "because I'm not following the rules," and was looking for another program for her and Johnnie, so she could complete 12 continuous months in a drug treatment program. Though out of jail, Alisha is certainly not free from

other forms of carcerality; her time with her son is governed by the courts, the child welfare system, and behavioral models of drug treatment.

Alisha is in the initial stage of living with her son for the first time. Kima and Evelyn have not seen their babies in over a year. Motherhood is not a given fact of giving birth for these women. Motherhood is made through the involvement of state institutions in their lives. For Kima and Evelyn, motherhood is not imaginary, but it remains most vibrant in its imagined states. This is a disjointed reality of maternity which their intermittent stints in jail cultivate. It is hard to pinpoint what enabled Alisha's relative "success" and Kima and Evelyn's relative "failure" to unify with their babies.

Being strung along an institutionally-defined path of court appearances, supervised visits with your child, following the rules and stresses of communal living of a residential drug treatment program, these take an incredible amount of personal perseverance and patience which most people would have difficulty with. But Alisha and baby Johnnie being together is not reducible to her character. Moreover, though she has not been back in jail since a month before he was born, Alisha's motherhood is still intensely regulated by state institutions, conditions of her benefiting from safety net services that she will use when she completes her one-year term at a drug treatment program.

If ambivalence is a key sentiment of this project, then I would be remiss not to mention my own ambivalence in my relationships with these women. I first met Kima, Evelyn, and Alisha as patients when they were pregnant in jail. They told me about their drug use, and in Evelyn's case I saw her high on crack while pregnant. As doctors, we are trained to do our best to suppress our judgments of patients' behaviors, to focus instead on helping them change. I, like many of my colleagues, contextualize behaviors understood to be unhealthy in the larger structural forces of inequality which have created conditions for pregnant women's addictions. I hold this sympathy for systemic factors along with my concern for harm that drug use may cause these women's fetuses. As I got to know these women outside of the clinical context, I grew even more invested in their overall trajectories. I was,

admittedly, frustrated and angry with Evelyn when she left Revelation House. I was disappointed when I saw her a few weeks later on the streets, high and selling crack—and I let her know. And while I was still disappointed with her when I talked with her in jail a few months later, I was also happy to see her, especially to see her rested and sober. This ambivalence between anger and concern is not something to be resolved. It is, rather, central to the form of care I have described throughout this dissertation.

Jailcare

This dissertation has argued that these regimes of carcerality, whether in jail or in a drug treatment program, cannot solely be understood in terms of the power dynamics of subject production. Relationships unfold within these regimes which exceed the hierarchical arrangements that we might expect from a clinic or from a jail. These relationships are not based on some innate form of social human connection which a carceral institution threatens to dismantle, or whose presence serves as a foil to the dehumanizing forces of imprisonment. Rather, relations of care take form precisely within carceral structures.

Jailcare is thus a form of care that is fundamentally ambivalent. It arises amid circumstances in which a person's deservingness to be cared for is actively called into question, affirmed, and conditionally defined. Jailcare indexes the mutual coexistence of the violence of punitive discipline with the concern and attention of caregiving. The room 321 Travelodge keycard incident I described in Chapter 6 is a metaphor for this mutuality. In giving Evelyn a key to her motel room for the night, Quiana was performing a gesture that initially appeared as caring, as helping Evelyn. But then later, when I learned that there was no room 321, I felt conned, that Quiana duped us. A few months later when I saw Quiana in jail, she apologized to me for her error, offering a thin explanation that she had merely given us the wrong keycard. This conning of care is a heuristic through which to think about jailcare.

Duplicity, Diane Nelson (2010) has argued, is the space in between the two faces of victim and perpetrator, where the state can dupe: where it "claims to represent all the people, that is simply a

cover for its docile service to a small class segment" (Nelson 2010: 23), and is "the carrier of both suffering and benefits. . . perpetrator and succor, it dispenses death *and* life" (*ibid*). Anyone can dupe or be duped. The space in between which duplicity inhabits is where the care and violence of jailcare can be not simply opposite poles on a continuum, but where they are mutually constituted by this duplicity.

The constitutional mandate that prisoners have a right to receive health care is emblematic of tensions and duplicity involved in the "state's carceral burden:" if the state is to put people in the potentially dangerous environment of a prison or jail, then the state also has an obligation to protect them from harm (Dolovich 2009: 891). While these tensions may be debated in courtrooms or codified in policy manuals, their experiential meaning emerges in relationships between jail workers and inmates who work through these tensions in their routine, daily actions in the jail. The delivery of medical care within the jail is a crucial window into how carceral structures give rise to care. I have also shown how the ambiguity which is cultivated in the jail clinic seeps into the entire institution.

This dissertation is not a story about institutional violence. Evelyn's and Kima's lives are saturated with trauma, at individual and structural levels, but this is not a story about those traumas. This is a story about how people work through the inherent violence of the current state of affairs every day; about how they make meaning out of the unequal conditions which created an unjust reality of mass incarceration; and about the mechanics of care. Any account of jail or prison that does not depict the paradoxes in which people live and work is incomplete. The jail clinic is a crucible of biomedical caregiving, bureaucracy, socially-mediated medical triage, intersecting professionalisms, punishment, health inequalities, citizenship, race, gender, and rights. These multiple registers do not melt into each other in a crucible: they remain in constant engagement, articulated in the social interactions among clinic staff, patients, and deputies. This dynamic environment exposes the tensions between the state's responsibilities to care for its people and individual responsibility notions of excessive entitlement. This reality does not take for granted the answer to the questions "whose responsibility is it to care for

people behind bars?" and "what care do they deserve?" Deputies address those questions every time they sneak a burrito in for a pregnant woman or yell at someone to stop talking in the pill call line. Clinic staff enact their answers when they triage someone with a bulging abscess in the intake jail, or deny an inmate's request for a lower bunk chrono.

Privatized Prison Health Care

These questions of institutional care also play out in the rarely discussed terrain of privatized prison health care. In Bridgetown, JHS was a government agency, a branch of the local health department. In many other jails and prisons across the country, the facility contracts out the provision of medical services to a private prison corporation. Privatized prison health care emerged in the years immediately following *Estelle v. Gamble*. The first company, Prison Health Services (now a merged company called Corizon), was founded in 1978, and more than half a dozen for-profit companies have formed since (von Zielbauer 2005). Correctly predicting that health care in prisons would become a costly expenditure, private prison health companies established themselves with classic neoliberal rationality: the private sector could more efficiently and cheaply organize, distribute, and manage medical services in prisons than the government. Private prison health contracts now account for 40% of all inmate care in the US (von Zielbauer 2005). The companies compete with each other to win the contract by underbidding, and then have to provide all the services in the contract within that fixed budget amount.

Most of these companies are based in Nashville, Tennessee, far from the facilities they serve (the first private prison health company started in Nashville where a for-profit operator of U.S. hospitals was headquartered, and other prison health corporations followed suit). I visited a few of these corporate headquarters, all located in pleasant, generic suburban office parks, adjacent to real estate companies and restaurant chains serving the business lunch crowd. Upon exiting the elevator of one of the private prison health companies I visited, tagline words were inscribed on the wall: "Hard-working,

Honesty, Hunger, Humor, Humilty. Good people doing the right things." Halloween decorations festooned the lobby, including cut-out paper pumpkins, each with the name of a facility that contracted with this company. With this generic sense office culture, I felt like I could have been at company headquarters for any industry. These trappings depicted privatized prison services as unobtrusive, and as normal a part of the economy as a real estate agency. The sleek office architecture was a stark contrast to the prisons and jails these corporations manage across the country.

The flip side of the corporate sleekness and cost-effectiveness lingo at headquarters can be found in the media and the courtrooms. There are frequent and often disturbing accounts of egregiously neglectful medical care and avoidable deaths in privately contracted prison health settings (von Zielbauer 2005; Leonard and May 2013). Understaffing, unqualified doctors, missed diagnoses, withholding prescription drugs are some of the ways journalists and attorneys have argued that the "cost-effectiveness" strategies of private companies render harmful, unconstitutional care. Corizon has been sued 660 times for allegedly unconstitutional care in the last five years (Christensen 2013). A recent report found that, in the year and a half since the Arizona Department of Corrections privatized health care services, medical spending in prisons dropped by $30 million, while the number of inmate deaths surged to 50 in only eight months (there had been 37 in the prior two years combined) (Isaacs 2013).

This is not to say that correctional medical care delivered by public entities is immune to cost concerns or to incompetent care. Nor is it to disregard the possibility of nuance and compassion in the everyday experiences of nurses, doctors, and patients at private sites. Nonetheless, the pressure to keep health care costs below what the company bid trickles down into the resources providers use to deliver care, and the decisions they make about what counts a serious need, answering the questions of what care inmates deserve. As Frank, a private prison health care administrator at company headquarters in Nashville told me when I asked how the profit needs of the company influence medical

decisions, “We’re interested in cost-effectiveness everywhere.” He went onto explain that this commitment factored into decisions about the drugs they have on their facilities’ formularies, the degree of preventive health care screening tests they made available, and limits on costly treatments like hepatitis C treatment.

The calculus of care in its quantitative sense for Frank, himself a physician with a public health background, had a particular moral quality to it. Like the triage nurses on the front lines at the publically-administered Bridgetown jail, the moral dimensions of Frank’s version of private prison health sorted through the balance between providing too much care and the minimum necessary to fulfill the “carceral burden” (Dolovich 2009) to care. But unlike the moral struggles of the Bridgetown nurses, who thought about ameliorating the deficiencies in the community, Frank had a different take. He used hepatitis C, prevalent in incarcerated populations, as the example: “I mean, we're not going to screen them [for hepatitis C] at short-stay facilities. That's the community's responsibility. If the community doesn't do it, then . . . why should you expect the county jail to?” Frank then added with conviction, “The correctional system should not be held to account for the weaknesses of the community system. That's my belief.”

With that, Frank highlighted the essential tension which gives rise to “jailcare” in its myriad forms: there are weaknesses in the community system which leaves millions of impoverished people without housing, food, health care. Prisons and jails provide housing, food, and health care. The quantitative and qualitative characteristics of these services are instantiated locally at each jail and prison, based on a combination of judicial directives, professional standards, budgets and profit margins, facility polices, and the individualized moral claims of custody staff and medical staff who are constantly face to face with incarcerated people. These myriad forces, structured by the outside reality of inequality, are what give rise to the ambiguities of care.

Expanding Health Care Access

The connections between the deficiencies of the U.S. health care system and the health of incarcerated people have long been recognized by public health advocates. Currently, policy makers are paying attention to the links between systems as the Affordable Care Act, the landmark legislation to provide health care coverage for most Americans, is being implemented. Prison officials are recognizing that if their inmates are hospitalized for more than 24 hours, Medicaid will cover the cost of the hospitalization rather than the prison, if that patient is Medicaid eligible. States which have expanded Medicaid eligibility recognize that many more of the people cycling through prisons and jails will now, upon release, be covered by Medicaid whereas previously they lacked health insurance. Some leaders have even gone so far as to say that this expansion could, by providing much needed medical and mental health care and drug treatment, keep people out of prison in the long run (Beiser 2014). The Sheriff's Department in Bridgetown is currently devising a system to enroll inmates in health care plans before release. The department estimates that the city will save about $2500 annually per inmate enrolled, and that there will be a 20% reduction in future arrests for these enrollees.

Bridgetown's jailcare thus can be found not only in the ambivalent relationships of care inside the jail, but also at the policy level. At the same time that Sheriff's Department leadership approached me and other JHS leaders to make improvements in the conditions for pregnant women inside the jail, a Bridgetown multi-agency taskforce published a report promoting community-based alternatives to jail for women in Bridgetown. The report was designed as a blueprint for how the city should use funds it received from the 2011 Realignment law—the Supreme Court mandate to depopulate California prisons— to benefit women. The taskforce was implementing a plan to prioritize sending pregnant women to halfway houses instead of to jail. These commitments, both to making jail more comfortable for pregnant women and diverting them away from jail when possible are notable signs of Bridgetown's progressive spirit. Indeed, the jail population decreased by 29% in the five and a half years I spent there,

with continued investment in public services. The city's probation department recently opened a large, one-stop shopping center to connect people on probation with a dizzying array of programs, benefits, classes, health care, family services. Bridgetown is certainly trying to support people in the community and to keep them out of jail. But these efforts do not replace jailcare. Nor do they mean that jailcare is unique to the Bridgetown environment, as opposed to a jail whose health care is delivered by a private company. Jailcare persists in relationships and institutions which are the source of both suffering and benefits (see Nelson 2010: 23).

Forever Never Ending

It is disquieting to think about a liberty-depriving, punitive institution like a jail as home. It is disturbing to see how Evelyn turned herself in so that she could be cared for in jail, to hear that Kima "prayed I went to jail." Yet ethnographic exploration of the tensions of everyday living in jail and the contrast to survival outside of jail has shown the logic in these apparent contradictions. The very structures of carcerality—such as custodial guardianship, the constant proximity of deputies and inmates, the constitutional mandate for medical care, communal living, and scheduled time for reprieve—gave rise to an environment where women experienced the certainty of care and a safe place to be a version of themselves that felt normal; in short, they experienced jail as being at home in an uncertain world.

To some degree, this normalization of the intimate familiarity of jail in these women's lives is exemplary of symbolic violence (Bourdieu and Wacquant 2007). This insidious form entails the "misrecognition" of violence as something natural, taken for granted, so much so that even the sufferers do not perceive their own experiences to be based in violence (see also Žižek 2008). With symbolic violence, women who desire to be in a carceral institution so characteristically defined by its own institutionalized violence are made to be complicit in their own oppression. Kima and Evelyn had both internalized a narrative of individual responsibility where they believed they deserved to be in jail.

While I have shed light on the joy, comfort, and care that women can feel in jail, these experiences should not displace the broader unequal and racialized conditions which keep them cycling through jail. To do so indeed would be symbolic violence.

However, naming marginalized women's desire for jail as symbolic violence flattens the human experience of their relations with jail staff and the institution itself into predictable replications of power dynamics. The women's actions within such an understanding remain limited to the dichotomy of oppression or resistance. Instead, the everyday texture of jail must be understood for the myriad ways that human relations unfold—most surprisingly, the intimacy of caregiving. These are real experiences for women in jail, full of comforted tears from miscarriages and mutual ogling at a photo of an inmate's baby. Women can inhabit and desire seemingly repressive norms as a way of experiencing freedom (Mahmood 2005).

Furthermore, the women themselves were acutely aware of the irony of wanting to be in jail. They desired it and they hated it. In the same conversation that Kima told me that she lives better in jail, that "I prayed I went to jail," I asked how she felt about coming back to jail.

> CBS: Were you upset that you had to come to jail?
>
> Kima: Yeah, Everybody be upset about coming to jail. I mean, look at these people [motions to deputies]. They're horrible.

Yet she also had affection for some of the deputies, like her "titi," Deputy Lewis. Other women unproblematically expressed similar ambivalence. They told me they appreciated being able and wanted to refuel in jail, and then told me how much they hated being in jail. The coexistence of these sentiments connects us again to a sense of home, for as Jackson notes, home by its very nature encompasses contradictions: "Home is always lived as a relationship, a tension. Sometimes it is between the place one starts out from and the places one puts down roots. . . . Home may evoke security in one context and seem confining in another" (1995: 122).

The notions that jail can be a site of caregiving, home, and a place women sometimes desire make it seem like some part of a larger system "is working," for these marginalized women do experience caregiving. But to read this depiction of the safety net of jailcare in such a pragmatic and fatalistic way ignores the punitive structures from which caregiving arises; it claims to see a glimmer of hope in a fundamentally flawed system, where intimacy can be appreciated as disruptive of carcerality rather than serving to sustain it. The terms of being cared for should not have to include living in an institution of incarceration. Let me be clear: jail may be integral to the safety net, but it should not be. It is, as Wacquant has noted, perverse that the carceral system has become an agency for delivering human services (Wacquant, 2002: 388). As a doctor treating patients inside a jail, I continually felt this struggle between feeling relieved that I could provide much-needed care to these women, and feeling shame with my complicity in the inequalities of mass incarceration.

With this understanding of the fundamental ambivalence of jailcare, I return to one of the last times I saw Kima. She was in jail again, living the intimacy of recidivism that is simplistically represented as a statistic. Although she offered the possibility that she might try a drug treatment program again, to get baby Koia into her custody, she did not speculate about whether she would be back in jail again. That was a given for her. We sat again in a classroom in E-pod, on the ubiquitous blue plastic chairs. It was just after Martin Luther King, Jr. day and she recited for me a poem she wrote about him. I was so moved by her talented composition and performance that I begged for another of her poems. She gladly obliged. She took in a deep breath, closed her eyes for a moment, and announced the title of her poem, "Poetry Blues." She followed with a rhythmic performance of the following poem:

Sitting in the cold royal blue chair
Reminiscing ten years that loneliness bears.
Inclined to recite an unnatural form.
Stuck in a cell, a fishbowl for a dorm.
Conversed upon ways to mend spiritless tasks.
Uncovering the filth buried deep in my past.
A reckless minstrel struck out through a song.
Forever never ending, finding ways to belong.
Lying flat on a mattress, which felt hard as cement.
Resuscitation of joy, which was bound to ferment.
Soaked dried, a thousand and one tears of a wasted ten years.
Renouncing all claims through my unborn fears.
Locked inside a freezing hot shower,
Grasping anger within a slow paced hour.
A faithful mindless groupie in a maze of addicted lust,
Never always ending disregards reproachful trust.
Transportations of habits inflicting stilled waters.
Washed out, drowned out, and washed up as the street starts to falter.
A regretful exchange for parts of my soul.
Encourage redemption that resurrection may hold –
I can't even breathe—wrote anthems of loss, grief, and of pain.
Exploitation of guilt without a last name.
A rectifiable beat that ticks to no end.
Ending taking on a newfound beginning
In hopes of becoming a reborn friend.

Kima's performance took my breath away. I felt so privileged to be the audience for Kima's talents, and sad that the forces structuring her life made jail her stage. As I re-read the transcription of "Poetry Blues," I realized how perfectly Kima represented the reality of her intimate, ambivalent life of recidivism. I hesitate to provide a line by line analysis, for the poem's tragic, insightful beauty speaks for itself. Kima's disdain for jail was clear in the "cement mattress," "locked in the freezing hot shower," "anger within a slow paced hour." She despaired over the ramifications of her "addicted lust."

And yet she also felt a temporary "resuscitation of joy" in jail. This was the chronic everyday of her life, to move between the cement mattress and being washed up on the streets. This is the experience of recidivism, where the place of return can be home. She, Evelyn, and other women like them existed in these carceral, caregiving processes that seem "forever never ending."

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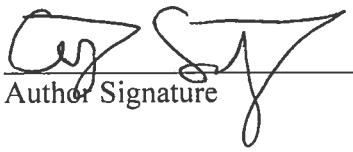

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