Distribution Agreement

Signature:

________________________________ _______________

Bisan A. Salhi Date

Diagnosis Homeless:
Emergency department “super-utilizers” and urban poverty in Atlanta, Georgia

By Bisan A. Salhi
Doctor of Philosophy
Anthropology

Peter J. Brown, Ph.D.
Advisor

Chikako Ozawa-de Silva, Ph.D.
Committee Member

Melvin J. Konner, M.D., Ph.D.
Committee Member

Craig Hadley, Ph.D.
Committee Member

Accepted:

Lisa A. Tedesco, Ph.D.
Dean of the James T. Laney School of Graduate Studies

Date

Diagnosis Homeless:
Emergency department "super-utilizers" and urban poverty in Atlanta, Georgia

By

Bisan A. Salhi
MA, Emory University, 2014
MD, University of Michigan, 2003
BS, University of Michigan, 1999

Advisor: Peter J. Brown, PhD

An abstract of
a dissertation submitted to the Faculty of the
James T. Laney School of Graduate Studies of Emory University
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy
in Anthropology

2018

ABSTRACT

A 2014 analysis by the Agency for Health Research and Quality estimated that the 1% of American patients account for nearly a quarter of health care expenditures (https://meps.ahrq.gov/data_files/publications/st448/stat448.shtml). These patients, referred to as "frequent fliers" or, more politely, "super-utilizers," have been the focus of a growing number of health care interventions designed to meet their needs, reduce their healthcare utilization, and curb rising costs in the process. Using a variety of ethnographic data—participant observation, unstructured and semi-structured interviews, chart reviews—this dissertation examines patients who have visited the Grady Memorial Hospital Emergency Department in Atlanta, Georgia, 10 or more times in a 30-day period and the healthcare providers tasked with caring for them.

Nearly all patients who were labeled super-utilizers in this study were homeless. Therefore, a focus on super-utilizers and urban poverty constitutes the bulk of this dissertation. Specifically, I turn my attention to the ways in Atlanta is a city where vast wealth and abject poverty exist side by side, and worlds apart. For people left behind by Atlanta's uneven development, Grady remains one of the last remaining safety nets for the poor. As such, the hospital picks up where Atlanta leaves off, providing shelter, safety, and life-saving services when the city simply turned a blind eye and comforted itself with its images of urban revitalization. This dissertation therefore challenges the assumption that hospitals are places where hospitals are simply institutions for healthcare delivery. Instead, I argue, they are urban safety nets, forced to supplement the shortcomings of a receding social service infrastructure. Further, they are extensions of the social world and all of its stratifications and inequalities.

Finally, this dissertation focuses on the ways in which marginalized people are maligned and labeled "frequent fliers" and "super-utilizers," thereby detracting from their vulnerability and labeling them a drain on health care (and by extension societal) resources. An important contention in this dissertation is that it is inadequate—even misleading—to label individuals as "super-utilizers." My research demonstrates that the "super-utilizer" is not a type of person, but that this category represents a time of extreme vulnerability in a person's life. Moreover, this vulnerability is not an individual deviance or shortcoming, but a product of Atlanta's uneven development that has seen hospitals turn into an omnibus service center warehousing and hiding the city's marginalized populations from public view. Thus, the attribution of this label to individuals, and targeting them through well designed and well-intentioned interventions obscures the broader processes that are necessitate this behavior. More importantly, this attribution obscures the immense costs and injustices associated with a privatized healthcare system and enables the disenfranchisement of those most in need.

Diagnosis Homeless:
Emergency department “super-utilizers” and urban poverty in Atlanta, Georgia

By

Bisan A. Salhi
MA, Emory University, 2014
MD, University of Michigan, 2003
BS, University of Michigan, 1999

Advisor: Peter J. Brown, PhD

A dissertation submitted to the Faculty of the
James T. Laney School of Graduate Studies of Emory University
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy
in Anthropology

2018

ACKNOWLEDGEMENTS

It is impossible to thank all of the people who contributed to the completion of this project and supported my efforts along the way. I am grateful to everyone who helped me along the way, but some individuals deserve special mention.

This project was supported by a Dissertation Improvement Grant from the Wenner-Gren Foundation for Anthropological Research. Emory’s Laney Graduate School supported my fieldwork and write-up periods.

I would like to thank my advisor, Peter J. Brown, for his personal and academic guidance throughout the years. Special thanks is also due to my committee members: Chikako Ozawa-de Silva, Craig Hadley, and Melvin Konner for their support and guidance in formulating the research question, during fieldwork, and in writing this dissertation. Students in the Department of Anthropology also deserve special mention for their camaraderie and their support throughout my six years in this program. I have learned much from each of them along the way and am grateful for their friendships.

As I write in this dissertation, my fieldwork would not have been possible without the support and generosity of patients, physicians, nurses, and staff in the Emergency Department. I owe each of them a debt of gratitude for their time, their feedback, and their insights that formed the basis of this dissertation. I would also like to thank Dr. Katherine Heilpern for her support along my unusual career path.

Finally, and most importantly, I want to thank my family for their love, patience, and encouragement throughout the years. My mother has been my greatest cheerleader in my life, and for this I will be forever grateful. My siblings, Rama, Jaleel, and Carmel, have provided me with love and laughs along the way. My husband and best friend, Adeem, has been a source of immeasurable love and support throughout this process.

Without his careful reading and insightful feedback, this dissertation would not have come to fruition.

Many thanks to each of you. All shortcomings are my own.

TABLE OF CONTENTS

PART ONE: THE PROBLEM AND THE PROJECT

PART TWO: HISTORY AND CONTEXT

PART THREE: THE LIVES OF SUPER-UTILIZERS

PART ONE: THE PROBLEM AND THE PROJECT

All in all, the health care industry is replete with rackets that neither honest practitioners nor regulators find worrisome enough to effectively challenge.

–Ralph Nader

CHAPTER ONE: INTRODUCTION

Cornell was brought by ambulance on my Tuesday morning shift. His name popped up on my electronic tracking screen, which lists all of the patients in the Emergency Department (ED).[1] It was late in the morning and, until now, there had been a steady but manageable stream of patients. I knew that would soon change as I glanced at the surge of patients signing into the waiting room and heard the ambulance calls announcing the stroke patient ten minutes away.

I glanced at the tracking board and looked at Cornell's summary. He was a 42-year-old man who was there for chest pain. His vital signs were reassuring, so I opened his chart to review his medical history: bipolar disorder, stroke, high blood pressure. I glanced back at the clock to see that I had eight minutes before the ambulance arrived and walked to his room. His door was closed and the paramedics were standing outside. "You don't want to go in there. He's using the urinal," one of the paramedics announced.

"I see. What's his story?" I answered, trying to make the most out of this time.

---

[1] "Emergency Room" was more popular when emergency services were provided by under the auspices of internal medicine and general surgery in a single room of the hospital. The term "Emergency Department" became increasingly preferred as emergency medicine became recognized as an independent medical specialty, and emergency physicians began presiding over their own departments. I use "emergency department" here to remain consistent with current nomenclature.

“We picked him up across the street from a hospital across town. He was there last night, got discharged, walked outside and called 9-1-1. He said he wanted to come to Emory and while we were on the way here he said he had chest pain. Tried to give him an aspirin, but he kept falling asleep and saying he didn’t want anything.”

“Got it. Thanks.”

She shrugged and asked me to sign her transport form before I walked into Cornell’s room. He was wearing a tattered Georgia Tech t-shirt, sweat pants, and sneakers missing the laces. His face was weathered and he looked older than his 42 years. He limped to the bed, leaning towards his right side and steadying himself with his stiffened right arm, both permanent reminders of his old stroke. He looked at me with disinterest as I introduced myself as his doctor. “Where’s the phone?”

“It’s over there,” I pointed to a stand behind him. “I’ll give it to you when we’re done.” I proceeded to ask the standard chest pain questions: Where is it? What does it feel like? When did it start? He answered my first set of questions impatiently: In the middle of my chest. Like electrical shocks. An hour ago. Then gave up altogether, closing his eyes and ignoring my questions or responding with “I don’t know” when I prodded.

I glanced at the clock. The ambulance hadn’t arrived, but it would be here any minute. I decided to leave him alone for now and move on to examining him. As I listened to his heart and checked his pulse, I noticed three hospital wristbands on his right arm. I sat back down. “Cornell, where are you staying right now?”

“Jail.”

“You mean you just got out of jail?”

“Yeah. Been locked up for two weeks.”

“Where were you staying before you got locked up?”

“A personal care home.”

I was perplexed. “How’d you get locked up from a personal care home?”

“One of the residents fell, but he said I attacked him. So they called the cops and they locked me up. Let me out two days ago.”

The overhead speaker announced the arrival of the ambulance, interrupting our conversation and prompting me to hand him the phone in the room and rush out to the adjacent resuscitation room. I knew from our conversation that Cornell needed more time and attention than I had, so I asked Claire, the ED social worker to look into his situation. I spent the next two hours tending to patients vomiting blood, managing strokes, and treating heart attacks. Cornell slipped to the back of my mind, except when I would get periodic updates from staff about how he was only interested in sleeping, getting on the phone, and “gaming” the system.

“I don’t even know why this guy’s here. He’s just sitting there sleeping and taking up a bed when we have people who are *really* sick who need attention. This is *not* what the hospital is for!” exclaimed his nurse as she walked out of his room with vials full of his blood. The implication was clear: The ED is for emergencies, and Cornell clearly did not fit into that category.

Hours later, during a brief lull, Claire gave me an overview of Cornell’s situation. She had verified that he had been arrested after attacking another resident. He disputed this and no charges were brought against him. He was eventually released, but his personal care home was adamant that they would not take him back. Apparently, this was not the first time this had happened. Cornell had been labeled a “problem” and kicked out of multiple care homes. Those who knew him wouldn’t take him back and those who knew his history didn’t want to take a chance on him.

When he was released from jail, Cornell didn’t know his any of his family or friends’ addresses or phone numbers. The police dropped him off at one of the city’s homeless shelters, where his disability attracted attention, ridicule, and assault from the other residents. The shelter staff, worried for his safety, called the ambulance to send him to a hospital. Since then, he had been going from hospital to hospital trying to get admitted and to buy time to get in touch with someone who would take him in until he figured out his next step. It should be easy, he figured. He had a monthly disability check; he just had to wait until next month because his personal care home had collected his income for the month.

After hours of phone calls and coordination, Claire was able to find his family and his case worker, who’d been looking for him since he got out of jail. She called his mother who agreed to take him in for a few days.

I finally got a chance to review Cornell’s labs and go back in his room to give him an update. He was sitting up in his bed, watching television. I told him that his x-ray and blood work were normal, and that he would be able to go home with his mother.

“How’s your chest pain?” I asked in follow-up to his initial complaint.

He looked away from the television just long enough to give me a disinterested glance. “What chest pain?”

Safety Net or Specialty?

It would be easy to juxtapose Cornell with other patients on my shift that day, to reiterate a narrative in which he spent hours on my shift depleting scarce resources of money, time, and labor. Whatever emergency services are for, surely they are not for *this*. Perhaps that’s why popular portrayals of emergency medicine pay little attention to people like Cornell, focusing instead on the “doctor versus death” storyline—the fast-paced, dramatic resuscitations of “real” emergency medicine (Taylor 2003).

This thesis deliberately turns away from this dramatic narrative, focusing instead on the mundane, daily tasks that comprise the bulk of emergency medicine (EM). More specifically, I pay close attention to the ways in which the ED is the closest instantiation of universal healthcare in American medicine. I characterize the ED as an example of universal healthcare because there are no income or insurance limitations to accessing care. Thus, the ED’s availability to the most marginalized (e.g., undocumented or homeless persons) enable health care to be provided to many persons who would not otherwise have access to care. However, the ED should be considered a *limited* instantiation of universal health care, mainly because its infrastructure naturally lends itself to the provision of episodic, acute care. For example, patients may reasonably expect to receive an evaluation for chest pain or a cough, but not for ongoing management of high blood pressure or diabetes. The ED therefore comprises a problematic “state of exception” in

American healthcare—an entity available to all, but whose resources are finite and subject to close scrutiny.

This finite moment of universal healthcare engenders much consternation within an otherwise privatized healthcare system. Since the explosion of the number of American hospitals and EDs following the Hill-Burton Act of 1946, ED staff, administrators, and policymakers have been decrying excessive patient visits and inappropriate ED use, which they claimed were responsible for hospital crowding and a national healthcare crisis. Historian Beatrix Hoffman (2006) points out that panic over this crisis began in the 1950s and has since been an ongoing preoccupation that continues today. The crisis, she contends, is the status quo. Although EDs were initially intended as a place for treating the acutely injured, their capacities expanded as the care for acute medical illnesses (e.g., stroke and acute hemorrhage) became possible. Bolstered by the technologies and possibilities of acute care and resuscitation, EM eventually emerged as a bona fide American medical specialty (Zink 2006). But even as EM has gained recognition and legitimacy, the ED has been cemented as a “one stop shop” for all—the acute and the chronic, the dramatic and the mundane.

The dilemma, as one doctor asked me rhetorically, is: “Are we a safety net, or are we a specialty?” Within this dichotomy, a safety net is a radical, laudable moment in which basic lifesaving measures are available to people who are excluded from the ambit of privatized healthcare. On the other hand, a specialty is a narrow area of expertise, in which specialists attend to a predefined set of problems and ignore others. After all, one would hardly expect a dermatologist to attend to an obstetrical problem, so why should one expect an *emergency* physician to attend to a chronic, let alone *social*, complaint? The answer to this question is found in a series of piecemeal developments that shaped the ED as we recognize it today.

Shortly after their growth in the 1950s, demand for ED care increased tremendously. A study in *The New England Journal of Medicine* also found that emergency-room visits had increased fourfold from 200,000 in 1940 to nearly 800,000 in 1955 (Shortliffe, et al. 1958). This was exacerbated, in part, by reduced access to private doctors, the end of house calls, and insurance restrictions on non-hospital care—all of which amounted to healthcare rationing.

This was dubbed the ED overcrowding crisis (too many patients and little resources to meet their needs), but was largely tolerated given that government payments made this a viable revenue stream for hospitals. By the 1970s, however, white flight to the suburbs left urban EDs largely caring poor minority populations who faced dwindling number of urban physicians. In the 1980s, the “managed care revolution,” along with decreasing government reimbursements were led to major reductions in charity care (Stoline and Weiner 1988). The overcrowding crisis also became a financial crisis for hospitals, who responded by turning away ED patients unable to pay for services (so-called “wallet biopsies”). Thus, as the rest of the US was embroiled in a painful struggle to increase access to healthcare and health insurance, EDs were in the midst of the opposite problem—a crisis of access and over-accessibility. It is this crisis of healthcare access that shows how our current healthcare system has been maintained by the exclusion of the poorest, the sickest, and the neediest of healthcare.

The intractability of this crisis was cemented in 1986 with the passage the Emergency Medical Treatment and Active Labor Act (EMTALA). In response to an epidemic of emergency care refusal—patients being turned away from EDs or transferred to public hospitals when they were deemed to be poor or uninsured (Ansell and Schiff 1987; Kellermann and Hackman 1988), EMTALA required that any US hospital receiving Medicare funds (i.e., nearly all hospitals), "must provide for an appropriate medical screening examination within the capability of the hospital's emergency department … to determine whether or not an emergency medical condition exists." When an emergency condition is recognized, EDs are obligated to provide any necessary stabilizing treatment or appropriate transfer to a facility with appropriate capabilities. [2] EMTALA also stipulated that patients themselves could predetermine that their symptoms constitute a medical emergency prior to medical evaluation. The passage of EMTALA, which came with little debate or fanfare, represented a critical juncture that established emergency care as a legal right within American healthcare.

As access to EDs was being solidified as a right, EM was emerging as a specialty concerned with the stabilization of acute medical conditions and determining patient's need for hospital admission, observation, or discharge (Zink 2006). EM was therefore constituted as a "gatekeeping" specialty responsible for distributing acute care services as a highly valuable and scarce resource. Emergency staff are responsible for deciding who is "truly sick" and excluding the "inappropriate" users of the hospital—a task that runs in direct contradiction with

---

[2] For details, see: https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/

the ED's legislated mandate of providing care for all. More importantly, this task runs in direct contradiction with the reality of American healthcare, in EDs have quietly become the de fact providers of care for the impoverished and uninsured. In this dissertation, I focus on a small segment of this population: homeless patients who rely on the ED not just for health care services but also for a wide range of subsistence needs during their times of exceptional needs and vulnerabilities. I argue that their dependence on the ED is neither arbitrary nor "inappropriate," but rather a product of broader ongoing efforts that have made EDs part of an omnibus service system designed to keep the homeless out of sight and out of mind. Ironically, the developments that have expanded the bounds of the ED have existed alongside efforts to streamline, economize, and ration health care services in the name of value and efficiency (Porter and Teisberg 2006). The contradictions between these two streams of thought results in an intractable tension that defines the daily work of ED staff.

It is precisely this tension that forms the crux of this dissertation. The ED, I argue, is a space of negotiation and contestation that mirrors the broader social prejudices and moral valuations. I therefore deliberately turn away from the "hype" often associated with EM. Instead of focusing on the dramatic saves, near misses, and inevitable tragedies, this work focuses on (non)emergency medicine: the waiting, the boredom, the sad, the mundane, the depressed, and the destitute. These banalities comprise the bulk of work in the ED, even as they are deemed marginal, insignificant, or inappropriate by ED staff. A quick walk through an overcrowded waiting room quickly illustrates this fact. The ED waiting room is a tense place with a distinct absence of conversation, and a steady whisper of murmurs of resentment for mass of bodies crowding the waiting room and compounding the collective misery of the experience. Patients complain bitterly about the wait times, which often exceed an average workday, and some leave before their treatment was completed or received any diagnosis or treatment for their ailments. In one example of this, on a particularly busy summer evening, I was in the waiting room and saw a young woman who appeared to be in her early twenties approach a nurse to inquire about how long it would be before she would be seen. “Honestly, I can’t give you an exact time because we don’t see people on a first-come-first-served basis. But I can tell you that it’s been a really busy day and that you’ll probably be here at least a few hours longer.”

“But I’ve already been here *all day*!”

The nurse looked at her sympathetically. “I know, and I wish there was something I could do about it. But if there’s anything else you need, I can see what I can do to help.”

The woman turned to address the waiting room. “Y’all just need to understand that this is NOT the place to come for a checkup! There’s just too many damn people here and you know you’re not THAT sick!”

Her outcry was met by jeers from other patients: “You don’t look that sick to me!” and “Why don’t you just go on home then?!”

The woman shoulders stooped. She muttered something indistinctly in return and walked back to her seat.

These interactions illustrate not only the tension and animus that can arise from such circumstances, but also the ease with which blame can be deployed to make sense of the difficulties. As people who do not neatly conform to ideas of “good” or “worthy” patients (Higashi, et al. 2013), my informants easily became objects of blame for other patients and staff alike. “Look at that waiting room,” a frustrated nurse explained to me. “I can just scan the room and see ten people that are here *every* night. They’re here to sleep, watch TV, wait for a sandwich. Whatever. No matter what you do, they just keep coming back.”

Indeed, my informants weren’t there for ailments that could simply be cured with medical technology. Their access to food, shelter, employment—the building blocks of a “good life”—could not be cured by a medical system, be it in the ED or otherwise. But in surviving under the weight of crushing poverty, my informants had experienced firsthand the medicalization of poverty in the US, which made medical and psychiatric diagnoses the primary means by which people could obtain disability and social security benefits (Hansen, et al. 2014; Kleinman 1991; Mills 2015). As such, they had come to rely on the medical system as a bridge to food, housing, and other social services. Ironically, however, their presence in the medical system was treated as a matter of imprudent consumption—a primary contributor to ED wait times, overcrowding, and all manner of dysfunction.

Defining Deviance: What is a Super-Utilizer?

On my first evening of fieldwork, I sat next to a middle-aged man who introduced himself as Leo and told me that he was there to see about his high blood pressure. He was a middle-aged man who was happy to have landed a job as a truck driver after searching for over a year, but frustrated when a required health screening revealed his blood pressure to be unacceptably high. He wouldn't be allowed to work without a doctor's note clearing him to drive, and without health insurance that meant a visit to the ED. Leo was bored and annoyed to be in the ED. Eager to pass the time, he asked me if I was there with a friend or family member and seemed bemused when I told him that I was not. "You don't have an armband," he gestured to my wrists, which were not adorned with the usual patient wristband. "And you've been sitting here for over an hour. What are you doing here?" I stumbled through an unpracticed explanation of my research, telling him that I was there to get patients' perceptions of the ED and to get an idea of why some people are there more than others. "You mean like her?" he said matter-of-factly, pointing across the waiting room to Annie, a homeless woman in tattered clothing who carried her belongings in a large garbage bag and had been coming to the ED daily for days on end. Leo had never been to the ED before and had never had occasion to meet Annie.

Leo's comment caught me off guard. I hadn't expected him to be able to identify a specific person based on my description. "What made you pick her out?" I asked, flustered about how to handle such a situation.

"I was standing behind her in line to check in," he explained. "I see that the staff know her by name and she's here all the time. It's not hard to see that's why it's so crowded here. People using the ER like a homeless shelter or come here for food is why it's so crowded here. I've been waiting for *six hours* and I'll probably be here for six hours more at this rate! People just don't know what the ER is for, I guess."

Leo echoed the same frustrations I had heard staff express about Cornell, Annie, and the rest of my informants. These sentiments fit within a widely accepted narrative about the state of healthcare in general, and EDs in particular. That is to say: the ED is for emergencies and people who come to the ED for "inappropriate" complaints crowd the system and deplete hospital resources. Among these inappropriate visitors are some outliers whose illiberal demands and overconsumption of precious hospital resources drive up costs and threaten to collapse healthcare as we know it. These outliers are a longstanding fixture within the ED, having been dubbed "gomers" (an acronym for *G*et *O*ut of *M*y *ER*), "frequent fliers," "regulars," or—most recently—"super-utilizers."

Super-utilizers are the focus of this dissertation. For reasons that I detail in the following methods section, I define super-utilizers to be individuals who make ten or more ED visits per month. Based on this definition, my informants were, for all intents and purposes, living in the ED. Far from being abusers of the healthcare system, I argue that these individuals represent the most marginal segments of society—those who have literally nothing and have suffered from the long-term adverse health effects of extreme poverty, and marginalization. In particular, I am interested in the ways in which these individuals are discursively produced and pathologized as drains on an ailing healthcare system by ED staff, other patients, policymakers, and even the popular press. Significantly, this construction does not exist only at the discursive level. The pathologization of super-utilizers is effected through both subjective and structural interventions wielded by policymakers and administrators. These interventions are designed to reduce super-utilizers' use of the ED rather than address the medical and social maladies that bring them there. This is especially peculiar when we consider it in the context of the ED—that radical moment of universal healthcare within which a group in greatest need becomes particular, unusual, and maligned.

The term super-utilizer was popularized by Atul Gawande in an in-depth article in the *New Yorker* about medical "hot spotting," a data-driven process for the identification of outliers in the health care consumption and the delivery of targeted interventions (Gawande 2011). Hot spotting draws on longstanding techniques in epidemiological disease mapping (Friendly and Palsky 2007) and criminological surveillance techniques (Weisburd and Lum 2005), applying these methods to identify people with the highest medical costs. Gawande's article highlighted the work of Dr. Jeffrey Brenner and others doing similar work. Brenner and his team of social workers and nurse practitioners, the Camden Coalition,[3] had identified that one percent of patients account for nearly 30% of hospital costs in Camden, New Jersey (Gawande 2011). Using this data, the Camden Coalition zeroed in on the neediest (and most expensive) cluster of patients in Camden, building relationships and helping with patients' difficult circumstances whenever possible. For example, in the course of his reporting, Gawande met a man whose diabetes was poorly controlled, largely as a result of his unstable living situation. The Camden Coalition helped move him into a more stable housing situation where his medications were dispensed regularly and his diabetes could be better managed. Brenner explained

---

[3] https://hotspotting.camdenhealth.org

the philosophy driving his work: “’Emergency-room visits and hospital admissions should be considered failures of the health-care system until proven otherwise,’ [Dr. Jeffrey Brenner said]—failures of prevention and of timely, effective care” (Gawande 2011: 43).

Though Gawande is careful not to make any definitive statements about the impact of such interventions, he is clearly optimistic about hot spotting as a method and its potential for reductions in ED visits, hospitalizations, and overall healthcare costs.

Journalists, economists, and health researchers across the country were similarly impressed and optimistic, reasoning that this could—and should—be replicated anywhere (Lynch, et al. 2016). If, they argued, this work could catch on across the country, the results would be nothing short of seismic. Policymakers behind the Affordable Care Act (ACA) agreed, building in large subsidies for “medical homes” and “accountable care organizations” to increase healthcare value while decreasing healthcare costs (Fisher, et al. 2007). Researchers clamored to apply data systems and employ staff to address the social determinants of disease and *finally* provide an answer to the great American healthcare crisis.

Yet the seductive logic has yielded mixed results at best. Even the best designed and most funded interventions had no more than 50% enrollment rates of eligible super-utilizers, and even in the patients who participated the overall effects have been mixed (Thomas-Henkel, et al. 2015). Since I completed my fieldwork in December 2016, the fate of the ACA has come into question. Nevertheless, the discursive production of super-utilizers as the greatest threat to healthcare costs remains largely unchallenged.

In this thesis, I explore the reasons that, despite its failures and shortcomings, this logic remains steadfastly engrained in the popular discourse. I delve into the production of super-utilizers as a fixed, undisputed category of persons with excessive needs who consume a disproportionate amount of limited healthcare resources and drive costs. For example, it is often repeated that the one, five, or ten percent of patients account for over a fifth, quarter, or half of all health costs (Berk and Monheit 2001; Billings and Raven 2013). This statistic is dramatic and rarely questioned, largely because it maps onto a longstanding categorization of patients that frequent the ED and more visits per month than some people make in a lifetime. I show that this statistic has little, if anything, to do with costs but is rather the latest iteration of a longstanding discourse that paints patients as the principal problem of American healthcare. Indeed, this characterization of patients is as old as EDs themselves. Historian Beatrix Hoffman notes that the number of patients classified as “non-emergent” in the 1950s and 60s exceeded the numbers quoted today. In outcries that ring eerily similar to today’s crisis discourse, a 1960 “study in *The Modern Hospital* commented that the emergency room ‘has now become a sort of a community health center to which many patients come for care of non-emergent illnesses.’ ‘Is the “Accident Room” Evolving into the Community Medical Center?’ echoed the Bulletin of the American College of Surgeons in 1961” (Hoffman 2006: 254).

In the 1950s and 60s, the crisis was not framed in terms of cost, but in terms of ED overcrowding and poor conditions that left patients dissatisfied and compromised hospitals' reputations. Patients who were noted to be egregious examples of inappropriate ED use were not labeled super-utilizers, but gomers, crocks, and so on. The framing of the ED crisis has evolved since the 1950s—taking on explanations such as inappropriate use, overcrowding, the crisis of the uninsured, and so on. Yet the existence of healthcare crisis has remained largely unquestioned; only the urgency with which the crisis is treated has waxed and waned over the years. Likewise, the labels for the patients responsible for this crisis has changed, but the assumption that patients are responsible for at least some (if not the majority) of the crisis has had little challenge. Simply put, patients labeled gomers, crocks, frequent fliers, and (most recently) super-utilizers are mainstays of EM, their existence no more questioned than that of "the diabetic" or "the elderly."

Before continuing further, I should underscore that this dissertation is not about the healthcare costs incurred by informants nor the consequences of these costs for the hospital or the ED. As I show in a later chapter, the attention these patients garner has little to do with costs and more to do with widely held beliefs about what a well-functioning ED, hospital, city, and society should look like. Few (if any) of these visions of what should be include the poor. I was forced to grapple with this idea throughout my fieldwork. When I began my research, one of the ED nurses explained her ire with super-utilizers: "As a nurse, it doesn't bother me so much that they're here. That's my job, to take care of patients. But as a taxpayer, I don't want to be out $400 every time one of them gets bored and wants to come here to have their vital signs taken. That’s just a big waste of money.” Her sentiment was one I had heard echoed in healthcare and other domains: one way or another, everyone suffers from fiscal irresponsibility and waste.

I later found out that the costs incurred by my informants was an order of magnitude less than $400 figure she nonchalantly tossed out during our conversation. I was eager to recount this information, thinking that it would be a powerful way to invalidate the assertion that the presence of super-utilizers were threats to the hospital’s fiscal stability. But everyone I shared this fact with was nonplussed. One doctor told me summarily, “Cost isn’t just about money. It’s about what their presence does here. It requires time, space, overhead costs. And it sends the wrong message to other patients about what we do and what the ED is for.” His reaction clarified for me that a lengthy engagement with monetary costs would be futile. No dollar amount I would come up with, regardless how low, would dispel the stigma associated with my informants. Indeed, the economism with which they were framed was simply the latest iteration of a longstanding belief that this category of patients simply does not belong in the ED. Thus, instead of engaging with costs, I turn my attention to the processes by which the most vulnerable ED patients are categorized as “super-utilizers” or “abusers” of the healthcare system, and the ends that these processes achieve. Much work in anthropology has demonstrated that categories do not simply exist in the natural world but are instead constructed and reconstructed through relational processes. Durkheim and Mauss, for example, were among the first to suggest that categories be investigated outside the limits of nature, as their origins are in society itself (Durkheim and Mauss

1963). They argue that classification, as we understand it today, is the arrangement of things (e.g., animals, people, plants) into clearly demarcated groups and is a relatively recent historical development derived from a science of taxonomy. Likewise, in *The Order of Things*, Michel Foucault (2002) refers to a Chinese encyclopedia in which animals are grouped into categories such as “belonging to the Emperor,” “embalmed,” “tame,” and “fabulous” (p. xvi). It is easy to dismiss these categories as unscientific or laughable, but closer examination reveals that indistinct boundaries and fallacious classifications are not simply characteristics of “primitive” societies but are instead products of societal beliefs and values. These values shape our own beliefs and thoughts and simultaneously place limits on our own conceptions of what is logical and what is possible. Extending these their insights, Mary Douglas argued that these classifications stabilize societies by creating order, hierarchy, and boundaries to be policed and maintained (Douglas 2003). Similarly, the category of the super-utilizer, and the myth of the person whose deviance contributes to the healthcare crisis, is not a natural category. Rather, this category is a kind of medical folk wisdom and vernacular, passed on to medical students and residents, and reproduced and legitimated through “scientific” publications and health service interventions.

Even the available health services research hints at the fallacies that hold this category together. One cross-sectional study revealed that just over 70% of patients labeled “super-utilizers” no longer fit the definition within six months to a year (Johnson, et al. 2015). Another study noted that he conclusion man patients experience costly events that resolve without any kind of intervention (Horn, et al.

2017). These findings demonstrates that the super-utilizer category does not *type* of person. Rather, this category represents a difficult *time* in a person's life. The difficulties associated with this category are further illustrated in the different *types* of overutilization. For example, one could qualify as a super-utilizer for accumulating too many ED visits or hospitalizations (cf. Harris, et al. 2016; Horst, et al. 2011; Sledge, et al. 2006). Even children are subject to being labeled super-utilizers (cf. Kuo, et al. 2015; Neuman, et al. 2014).

Importantly, the available literature demonstrates that, despite the heterogeneity of definitions (Doupe, et al. 2012), many super-utilizer programs target Medicaid or uninsured populations and report that risk factors such as unemployment, substance abuse, and housing are key predictors of "avoidable use," although there is little evidence to support such claims (Bodenheimer 2013; Hasselman 2013; Joynt, et al. 2013). The implications of this are twofold. First, the health policy zeal surrounding surpasses any available evidence and is therefore more rooted in preconceptions and prejudices surrounding the poor. Second, and related to the first, it is impossible to understand super-utilizers without attention to the assumptions about social value, productivity, and investment that dominate our understandings of the poor (Morgen and Maskovsky 2003). As a result, homelessness and urban poverty are a primary focus of this dissertation.

In light of the heterogeneity of who counts as a super-utilizer, it is impossible for this research to address all facets of this discursive category. Instead, I turn my attention to the patients that the staff in my research site identified as "super-utilizers." These patients were, for all intents and purposes, living on hospital grounds, and were therefore known to ED staff by name. My research therefore examines an exceptional subset of “super-utilizers” as compared with the heterogeneous population referenced in the available literature. Nevertheless, my research is well-positioned to shed light on the conditions that produce extreme poverty on one hand, and denigrate victims of these conditions as gluttonous over-consumers on the other. Further, a primary focus is dissertation is to decenter the costs discourse and to highlight that my informants’ use of the ED is not a product of individual shortcomings or moral deviance. Rather, it is a consequence of Atlanta’s uneven development that has seen hospitals turn into an omnibus service center warehousing and hiding the city’s marginalized populations from public view. Thus, the attribution of the super-utilizer label to individuals and targeting them through well designed and well-intentioned interventions obscures the broader processes that are necessitate this behavior.

More importantly, this thesis explores the discursive production of the super-utilizer as the Achilles heel of an otherwise functional healthcare system. For instance, Laura Jackson, an executive at Wellmark Blue Cross Blue Shield in Iowa, recently claimed that a teenager with a rare form of hemophilia was singularly responsible for a 10% hike in the state’s insurance premiums (Demko 2017). A few weeks later, Wellmark pulled out of the Iowa health insurance market altogether. The message was clear: this patient will surely deplete everyone’s access to healthcare unless we *do something* to curb his egregious consumption. The shortcomings of the ACA and the exorbitant costs associated with the bureaucracy of private insurance become of secondary importance (Mulligan 2017).[4]

Importantly, I never met a person to him or herself as a "super-utilizer," "regular," or "frequent flier." Staff would sometimes point out to patients that they were in the ED more days than not, but I never witnessed an interaction or was told of a story in which a staff member labeled someone a super-utilizer to their face. Doctors and nurses did tell me, however, that they would review patients' records and try to ask why patients were frequenting the ED. One doctor, for example, told me that she would say to patients, "Sir, you've been here six out of the last seven days. What's going on?" The responses she received were varied, ranging from shrugs to citing difficulties getting prescriptions to detailing some of the hardships of being out on the street.

I also tried to broach this subject in various ways with super-utilizers throughout my fieldwork. Each time, I was met with blank stares. Coming to the hospital "inappropriately" or "too much" was, to put it bluntly, a stupid idea. For them, it seemed far from self-evident that the hospital's only function is to host the "purely clinical" or administer technological cures. For them, the hospital was many things—public space, social welfare institution, safe haven, and so on. A claim to be using the hospital "too much" was therefore as absurd as claiming one borrowed too many books from the library or drank too much out of the water fountain.

---

[4] Administrative costs under Medicare range from 3 to 5% of total health care costs. In contrast, private insurance companies spend 20–30% of every dollar devoted to health care on administrative costs (The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 2017; Woolhandler and Himmelstein 2017).

Their conceptions of the hospital as a myriad institution are not especially far-fetched. Medical anthropology is replete with ethnographic evidence disputing the assumption that medical practice is a “purely clinical” endeavor (Berg 1992; Bosk 2003; Cassell 2002; Farmer 2001; Fox 1980; Good 1994; Good 1995; Good, et al. 2005; Holmes and Ponte 2011; Kleinman 1995; Lock and Nguyen 2010; Mattingly 2010; Moerman 2002; Mol 2008). In doing so, anthropologists have shown that medical knowledge and practice are products of the same political and economic pressures that shape human systems and behaviors (cf. Lock 2002; Luhrmann 2000; Mulligan 2014; Rhodes 1991). Moreover, anthropologists have demonstrated that the clinical encounter is a fundamentally human endeavor—inextricable from the emotional suffering and hardships that shape all human relations (cf. Cassell 1991; Cassell 2005; Kleinman 1988; Mattingly 2010; Moerman 2002). Finally, anthropologists have challenged the idea that medicine is a standalone institution, arguing that it is subject to the same historical, political, and economic pressures that shape all facets of human life (Lock and Nguyen 2010).

Therefore, to better understand super-utilizers, I argue that we have to look beyond the hospital’s role as a technocratic and administrative institution. To do this, I turn my attention to the hospital’s ostensible predecessor: the almshouse. I argue that hospitals continue to serve as a safety net for the poor and dependent, and that this role is particularly pronounced within the ED. I show that, for my informants, the ED is more than the provider of a narrow range of life saving technologies. It is a source of food, shelter, and respite from the perils and consequences of living on the streets and within shelters. For the most frequent utilizers, the hospital staff becomes their social network, providing the contact, caregiving, and protections that would otherwise be shouldered by friends and family members. In other words, the modern hospital has not replaced the almshouse, but has instead subsumed its functions—even as it has attempted to distance itself from this role. In thinking about the hospital as a place beyond the medical, I hope to shed light not just on super-utilizers, but the hospital itself.

A Note on Terminology

An ethnography of super-utilizers and urban poverty constitutes the bulk of this dissertation. However, another important theme is my contention that it is inadequate—even misleading—to label individuals as “super-utilizers.” Nevertheless, despite the difficulties and drawbacks of labeling a person a “super-utilizer,” I have chosen to use this term throughout this dissertation. I do so because the term is an unavoidable shorthand to indicate the manufacture of groups by the inscription of cost onto individual bodies. This, in turn, creates “new categories of people” and facilitates new modes of social inequality, stigma, and subjugation (Hacking 1982).

Another reason I have chosen to use the term “super-utilizer” is that its roots are largely philanthropic and that it stands in contradistinction to more pejorative labels: frequent fliers, ED recidivists, gomers, and so on. I detail these labels and their relationship to the super-utilizer category in Chapter One. But while “super-utilizer” is the most palatable term available, it should nevertheless be understood as deeply problematic, for reasons I have already highlighted and for others I detail in Chapter Three.

Throughout my fieldwork, doctors, nurses, physician assistants and nurse practitioners reiterated that the ED is for “emergencies.” The distinction between “emergent” and “non-emergent” conditions generally refers to conditions that require expeditious evaluation or immediate action (i.e., “emergent” conditions such as a stroke) from those that can safely wait or are better treated in an outpatient setting (i.e., “non-emergent” conditions such as a cold). However, patients do not seek care in the ED for symptoms (e.g., chest pain) rather than concrete diagnoses (e.g., a heart attack). Therefore, the distinction between emergent and non-emergent conditions is often nebulous (see, for example, Raven 2013).

Medical anthropologists have demonstrated that diseases do not simply exist in the individual body, but are complex byproducts of interpersonal experiences (Cassell 2004; Kleinman 1988; Mattingly 2014), political factors (Baer, et al. 2003; Bourgois and Schonberg 2009; Hansen, et al. 2014; Page and Singer 2010; Singer 2009; Singer and Castro 2004), and social beliefs (Biehl, et al. 2007; Good 1986; Good 1994; Sweet 2010). Although the concept of the “medical emergency” has received considerably less scrutiny in medical anthropology, it is nevertheless subject to the same complexities that shape other diseases.

Despite the imprecise nature of the term “emergency” and the difficulty with the binary division of disease and patients into “emergent” and “non-emergent” categories, I have chosen to use these terms in this dissertation. These terms are useful insofar as they convey what ED staff consider “appropriate” usage of the ED and who “belongs” in the hospital. They should not be considered markers of disease severity or descriptors of suffering of the patients included in this dissertation.

The Field Site: Grady Memorial Hospital and Atlanta

My research takes place in the Grady Memorial Hospital (henceforth Grady) ED, one of the last standing public hospitals in the US dedicated to indigent care. Grady is not only an indispensable health care provider for Atlanta’s poor, but it is also a significant node in Atlanta’s racial and class politics.

Grady first opened its doors in 1892, with a mission to “benefit suffering humanity and an impulse of gratitude to do honor to Henry Grady’s memory,” a journalist and philanthropist who envisioned the hospital as a cornerstone of Atlanta’s development in the wake of the Civil War (Moran 2012). Its 110 room facilities were segregated by race, gender and class, with patients who were able to pay being given access to superior services (e.g., private rooms). As Grady grew into Georgia’s largest hospital, segregation remained an integral part of its geography. Grady was one of the few medical facilities available to black patients in the Jim Crow era, housing up to three quarters of Atlanta’s black patients at a time, and providing separate quarters for black and white patients. This practice led to the hospital being known as “The Gradys,” one black and one white—a nomenclature that persists among patients today.

Since 1892, Grady has grown into Atlanta (and Georgia’s) safety-net hospital, a term that describes the provision of services to the poor and uninsured, but also the practice of other hospitals of sending their indigent and uninsured patients to the “Grady Curve” along the I-85/75 highway to get medical care. This practice maintains the solvency of other hospitals and buffers the segregation by race and class so prevalent in Atlanta. As one super-utilizer told me plainly, “Grady’s just the place where black folks go.” Her statement offered a pithy slice of life at Grady, a place where elite medical staff struggle to provide “top of the line” care to society’s most marginalized—patients, predominately poor and black, but increasingly other people of color, who are both the victims and beneficiaries of Grady’s existence.

Atlanta is a city whose racial order is inscribed into the name of streets and roads,[5] the design of its wanting public transit system, and the planning of its sprawling highways. But Atlanta has also been a hub of black capital in the US, attracting and hosting thriving black upper class (Rutheiser 1996). Thus, the city is emblematic of our current historical moment, marked by concurrent racial domination and racial progress, and besieged by racial contradictions and paradoxes. Grady keeps the poorest of Atlanta out of sight and out of mind, thereby subsidizing the city’s image as a thriving metropolis of wealthy urban professionals. Thus, Grady is not only Atlanta’s indigent care hospital, it is an emblem of the city’s race and class relations. I discuss this further in Chapter Two.

Yet Grady has been the object of much negative attention, plagued by accusations of corruption and mismanagement. Grady’s troubles came to a head in 2007, when its budget deficit topped $60 million and inspections revealed

---

[5] Newcomers to Atlanta frequently note that the same street will change names at particular intersections. This is a byproduct of deliberate planning to contain the movement of the city’s black population and to monitor their spatial migration. (For more details on this phenomenon, Bayor 1988.)

nonfunctional medical equipment, sanitation troubles, and record keeping problems that threatened to revoke the accreditation the hospital needed to receive Medicare and Medicaid funding it desperately needed (Moran 2012). While Grady's fiscal turnaround was quick and unprecedented, it was also not without consequences. Faced with having to make changes to remain financially solvent, Grady had to cut longstanding services. Many of these decisions, such as closing the outpatient dialysis center and relocating its patients, were highly publicized and widely contested (cf. Sack 2009b). This financial restructuring was accompanied by a rebranding strategy to distance Grady from its image as a place that only excelled at treating trauma victims (a message reinforced by bumper stickers that read "If I'm in a car crash, TAKE ME TO GRADY"). The rebranding came with billboards all over the city declaring, "Atlanta can't live without Grady," along with short blurbs of patients and how was critical in their path to recovery. The ads were part of an ongoing campaign to attract patients with private insurance, and to bolster Grady's reputation as a first-rate hospital.

Although this structuring and rebranding has worked to attract more affluent patients, the care of Atlanta's indigent and marginalized, whose numbers and needs are rapidly expanding, remains central to the Grady mission and operations. Within this, the Grady ED occupies a central role in the care of the indigent, and especially the homeless. While not free of bureaucratic constraints, the ED functions as a hospital's front door, which federal law (i.e., EMTALA) mandated remain open to all. And although care is stratified and rationed, the ED represents the most democratic form of American healthcare. ED care is widely talked about as a right or a public service, especially by my informants. It is therefore an important index of index of broader political and economic currents.

In this dissertation, I use Grady to tell a story of Atlanta, and Atlanta to tell a story of America.

Outline of the Dissertation

This dissertation is organized into parts and chapters as follows. **Part One** attends to the ways in which super-utilizers have come to constitute a "problem," and the ways framework used to address this problem. **Chapter Two** is an overview of my methods and data collection that forms the basis of this dissertation. **Chapter Three** explores the invention of the "super-utilizer" category. By "invention," of course, I do not mean to deny the reality that my subjects were, for all intents and purposes, living in the ED. Nor do I seek to downplay the challenges this posed for them and for ED staff. I do, however, trace a genealogy of the super-utilizer category and seek to challenge the assumptions contained within it. I begin with an examination of the gomer and its various synonyms: dirtball, crock, and so on. I argue that such terms are the predecessors to the "super-utilizer," a term putatively devoid of pejorative connotations. I show that the term super-utilizer retains vestiges of stigma but differs from its predecessors in one important aspect—namely the economistic way with which patients are framed. Further, I argue that the popularity of the term, and the economism with which it is associated are closely related with the reforms enacted by the ACA. I conclude this chapter by arguing that the discourse around super-utilizers performs two important, related functions. First, it further entrenches market-based medicine, and the idea of medicine as a scarce, finite commodity within American healthcare. Second, it frames the poorest and most vulnerable segments of the population as an imminent threat to the availability of healthcare for all, thus detracting from the ways that health care costs in the US are opaque and highly variable (Baker and Simon 2010; Stone 2011). For example, there is great variability in what a single provider might charge for a service depending on geographical location, one's insurance coverage, or lack thereof.[6] Additionally, attention to super-utilizers (and patients in general) as sources of "waste" renders invisible the very threat to healthcare engendered by insurance providers and corporate actors in medicine (cf. Mulligan 2016).

Part Two turns to the context in which this research takes place, setting the historical and contemporary significance of the ethnographic field site. In **Chapter Four**, I sketch the history of Grady as a history of Atlanta, paying attention to the racial and class stratifications that have shaped the hospital. I then turn my attention to present-day Grady and show that it continues to be a significant node in Atlanta's social fabric. I demonstrate this by paying close attention to the ways in which patients born at Grady proudly declare themselves "Grady Babies," and use bell hooks' formulation of "homeplace" to show the ways in which this institution is constantly being made and remade. I extend this argument to argue that hospitals are far from lifeless bureaucratic entities whose significance can be captured with narrowly conceived performance metrics. More accurately, they are extensions of the social world. Within them, every interaction is negotiated, contested, and reinterpreted with consequences that extend from the lives of individuals to broader debates about identity and belonging.

---

[6] For further information and details about this variability, see: https://www.hcup-us.ahrq.gov/

Building upon this argument, **Chapter Five** examines the ostensible predecessor of the “modern hospital”—the American almshouse. I begin by tracing a brief history of the hospital, showing how this “scientific” institution was carved out of the “social” and continues to serve functions far beyond clinical care delivery. Specifically, I pay attention to the idea of the “social admission,” a term used to refer to patients with no acute medical needs who are admitted or remain in the hospital because, to show that the modern hospital functions in part as a contemporary almshouse, in which poverty and dependence are contribute to hospital admission. I present two ethnographic cases to demonstrate that the lines between “the medical” and “the social” are artificial and constantly in flux. Finally, I draw upon Atlanta’s tenuous relationship with poverty, public housing, and homelessness to argue that its urban development and gentrification has been sustained, in part, by Grady’s underappreciated almshouse role. This keeps the poor and the undesirable out of sight and buffers the city’s shrinking welfare infrastructure.

Part Three details the lives of super-utilizers. **Chapter Six** attends to two interrelated questions. First, what does it mean to be “homeless”? To answer this question, I interrogate homelessness as a cultural signifier and a manifestation of extreme and racialized material deprivation. I challenge the prevailing view that homelessness is a relatively new phenomenon that rose out of the neoliberal restructuring of the 1970s and 80s (Lee, et al. 2010; Rossi 1990). I argue instead that marginalization from housing has been a longstanding feature of American history, which, like most aspects of American history, takes on an acutely racialized dimension. To demonstrate this, I consider a brief history of housing deprivation and its accompanying discourses in the US and in Atlanta. I contend that "the homeless" is a category that is systematically produced by the conditions of housing in which we all live. Yet the prevailing discourses of the homeless as inherently deviant persons (i.e., addicted or mentally ill) turn attention away from the conditions of housing and onto purported individual vulnerabilities (Fischer, et al. 2008; Rowe, et al. 2001; Snow, et al. 1986). These discourses therefore medicalize homelessness and reinforce longstanding distinctions between the "deserving" and "undeserving" poor (cf. Chavez 2012; Horton 2004; Mulligan 2014; Oorschot 2000; Willen 2012).

Having established this, I move on to the next question in this chapter: what does homelessness have to do with emergency medicine? The easiest and most obvious way to answer this question is to list the myriad ways in which homelessness is a hazard to one's health. For example, homeless persons have mortality rates three to six times those of the general population, with homelessness found to be an independent risk factor for mortality (Baggett, et al. 2013; Barrow, et al. 1999; Buck, et al. 2012; Hibbs, et al. 1994). They also experience higher rates of chronic illness, acute injury, violent victimization, and infectious disease (e.g., TB, HIV, and hepatitis C) than their low-income, housed counterparts (Salhi 2018).

I contend, however, that the role of the ED in caring for the homeless extends beyond their medical needs. Specifically, I argue that the medicalization of homelessness made it incumbent upon EDs to expand their homeless services in order to keep the homeless out of public view and to buffer the effects of an increasingly unequal society and a vanishing welfare safety net. Further, I show that homeless persons, with their multiple health care needs and compounded by their extreme material deprivations, challenge the dominant biomedical paradigms of emergency medical care delivery and its need to frame patient complaints in terms of solvable problems.

Chapter Seven turns to the super-utilizers themselves, who are often described as “socially isolated” and often refer to themselves as “loners.” I ask: how do self-professed loners survive? To answer this question, I draw on the ethnographies of kinship ties within the urban poor (cf. Stack 1974), and the mounting critiques against the saliency of such ties among them (Desmond 2012a; Granovetter 1973). I then explore the difficulties of identifying and locating *true* social isolation as an analytical category and show that the production of this category is dependent on preexisting biases of what constitutes worthwhile, productive relationships. I conclude by turning my attention to the social relations within medicine, the tenuous social ties of the urban poor, demonstrating that this behavior of “excessive” ED utilization constitutes another type of temporary and utilitarian relationship within the lives of these individuals. I argue that super-utilizers in this study are, in fact, far from isolated and that the ED is a necessary place for social contact and relationships that enable their survival and inclusion in social life.

Having established that the cases presented represent an extreme and time-limited period in my informants’ lives, **Chapter Eight** answers the question: What happens to super-utilizers? I revisit the individuals presented in detail in this dissertation and give updates on their lives as of March 2018. **Chapter Nine** concludes by addressing the contributions of this dissertation and discussing opportunities for change and advocacy in the lives of super-utilizers and other vulnerable populations.

CHAPTER TWO: METHODS

Introduction

In conducting this research, I was interested in the daily routines and survival strategies fashioned or appropriated by patients dubbed “super-utilizers,” as well as the factors that influenced and shaped these strategies and routines. Of course, these survival strategies do not emerge randomly. They are the product of a complex interplay between the life histories of the super-utilizers, the organizational, political, and ecological constraints of Atlanta’s urban environment, and the bureaucratic procedures of the hospital. To navigate these constraints, super-utilizers relied on ingenuity and resourcefulness. An understanding of the experience of super-utilizers and how they are managed also requires consideration of the ED, and its internal features that simultaneously serve and marginalize these super-utilizers.

These considerations shaped the 18 months of research and data collection that produced this dissertation, which are described in the subsequent pages.

Location

This primary site of this research is Grady Memorial Hospital (Grady), the largest hospital in the state of Georgia, and the fifth largest public hospital in the United States. Its ED currently sits on 2.8 acres of land, cares for over 120,000 visits per year, and provides the bulk of medical care to the indigent populations of the Atlanta metropolitan area.

Because of its size and the volume of patients, the Grady ED is divided into seven contiguous areas where attending physicians, residents, nurse practitioners

(NP) or physician assistants (PA), and nurses evaluate and treat patients. Patients are divided between these spaces according to the severity of their injury or condition and the availability of space, staff, and resources to care for them. All patients who walk in to the hospital are first evaluated in the Ambulatory Triage area, where the severity of their condition is assessed and recorded by a nurse, attending physician or PA or NP. This assessment determines the necessary laboratory and/or other diagnostic studies to be initiated, and—more importantly for patients themselves—where and how long they will have to wait.

A small segment of patients is seen and discharged directly from triage or sent to the walk-in center to receive more expedited care. The majority of patients, however, are asked to wait in the crowded waiting room until space is available for their visit. It is notable that the number of ED visits at Grady and across the nation have outpaced growth of the general population (Weiss, et al. 2014). This has occurred in the despite closures of ED facilities in Georgia and across the US (Hsia, et al. 2011). This increasing numbers of ED visits are complex and multifaceted. An aging population, high numbers of uninsured and underinsured patients, and increasing prevalence of chronic disease in the American population make ED crowding a problem that cannot be simply solved with larger facilities, increased health care personnel, or improved access to primary care clinics (Byrne, et al. 2003; Derlet and Richards 2000; Trzeciak and Rivers 2003).

Wait times can reach 12 hours, the number of patients in the waiting room can exceed 100 at a time, and the mood often vacillates between resignation and anger, stagnation and chaos for both patients and staff. The seemingly indefinite wait times in the waiting room and the Ambulatory Triage Area facilitated the ethnographic component of this research, as patients were often bored, frustrated, and eager to voice their opinions to a researcher who would take note of their complaints and suggestions.

It is notable that the ED was undergoing construction throughout this research (see Appendix A for a map of the ED during construction). While this posed challenges and discomfort for patients and healthcare providers, the disruption of normal ED processes helped highlight the flexibility, contingency, and arbitrariness of ED processes that frame this research. In particular, the ongoing construction highlighted how super-utilizers were subject to the institutional time and its rigid structures. At the same time, they are also vulnerable to its arbitrariness (e.g., due to constant changes of the physical space or staff turnover) that would often challenge their abilities to navigate the ED or receive the resources they need.

Notably, I found in the first month of my research that it would be most fruitful to conduct my research in the evening and at night, as these were the times of greatest patient volume, and were the times during which super-utilizers spent the most time in the ED. The hospital, and by extension the ED, is comprised of

> two distinct places, though they share the same address. One is a hospital that operates from approximately 7 a.m. until 7 p.m., Monday through Friday. The other is a hospital that operates in the evening, through the night, and on weekends. Although these facilities appear to be one and the same, they in fact represent two very different medical environments. (Shulkin 2008: 2091)

Like the rest of the hospital, the ED is a different place at night, with fewer resources and staff available and usually a backlog of patients who had been waiting since the morning or afternoon. Within this backlog, super-utilizers could often go unnoticed or undisturbed by staff members who usually had more pressing priorities on their minds. Conducting my research primarily at night therefore allowed me the opportunity to both meet and spend sustained time with my informants.

The Grady ED is an important setting for this research for three important reasons. First, the ED is arguably the most accessible service in American healthcare, existing at a threshold between a public in need and the hospital services available. Demand for ED services reflects broad social and political processes in Atlanta. Second, the ED serves simultaneously as a medical and urban safety net and the gatekeeper of controlling access to the hospital and its much-valued services. It is therefore a potential site of conflict between the intended (or appropriate) work of emergency medicine, and the needs of an ever-growing population demanding entry. Third, and because of its status as a safety net hospital, Grady serves as an extraordinarily large number of patients that would be classified as super-utilizers. While most of the existing literature defines super-utilizers as patients with six or more ED visits per year, a data pull by Grady administrative staff in October 2016 identified nearly 13,000 patients with twelve or more ED visits per year. Grady is therefore an exceptional ethnographic site that illuminates general trends in healthcare delivery.

Institutional Review and Approval

This research was independently reviewed and approved by Emory University's Institutional Review Board and Grady Memorial Hospital's Research Oversight Committee.

Procedure

Because social reality is too multifaceted to be grasped adequately by a single method, it is better to combine multiple strategies rather over a longitudinal period of time rather than wrestling with the merits of some research methods over others. With that in mind, I pursued two basic research strategies in order to address the complexity of social reality and the inherent limitations of a single research methodology. First, I relied on a combination of directed observation, unstructured and semi-structured interviews with patients and staff over the course of 18 months. Second, I relied on ED level data and chart reviews to both identify super-utilizers and to glean information regarding staff members' observations and experiences that may not have been captured through observation or interviewing. This data is also tracked by hospital administrators in order to track patient metrics (e.g., number of visits, chief complaints, length of stay), paint a picture of hospital operations, and make garner evidence upon which future decisions and changes are made. This data therefore provided an important supplement to the ethnographic data.

In part, this multimethod approach is meant to challenge the unquestioned affirmation that clinical, quantitative, or hypothesis-driven research is the best means or most appropriate of obtaining useful information. Moreover, this approach brings into question the idea that medical science is purely objective evidence-based data is the best driver of medical work or patient-care. Instead, my work shows that the “super-utilizer” category is, at best, an example of emergency medicine folk mythology, with definitions and data sets configured and manipulated to support it. Further, this approach allowed me to the processes by which these categories are accomplished and negotiated, and how they are reported and circulated as “hard evidence” upon which important decisions are made.

Studying Staff. This research began with directed observation and unstructured interviewing with ED staff, composed primarily of nurses, attending physicians, nurse practitioners, and physician assistants responsible for the various aspects of caring for ED patients. While their work can vary widely, I found little variation between different types of staff with regard to their perceptions and relationships with super-utilizers. Therefore, when I refer to “ED staff” in this dissertation, I am referring broadly those who work in the ED. When applicable, I specify individuals’ roles and responsibilities to provide clarity.

Directed observation is distinguished from participant observation in in that participant observation requires that the researcher become a participant in the culture or context being observed, becoming accepted to some degree in order to gain greater insight into social groups in their environment. In contrast, a direct observer does not usually try to become immersed as a participant in the context, focusing more on observing certain situations or people. Specifically, my observations centered on the processes of patient triage, where they adhered to medical and organizational criteria, and where they were based in moral criteria and interpersonal negotiation. While I was not a Grady staff member myself at the time of my fieldwork, I would later come to work some of these same shifts and deal with many of the conditions and barriers I had observed as a researcher. I convert these experiences into a form of autoethnography that has been used to shed light on difficult to access domains (cf. Mulligan 2016; Oldani 2004).

The observations also paid attention to the meanings of these interactions for staff, as well as the organizational culture of the Grady ED in order to situate these interactions within their broader context. This provided insight into appropriate and inappropriate service demands, standard and non-standard (or informal) ED operations, and the blurred line that distinguishes them. Additionally, this provided insight into how "super-utilizers" were identified and categorized among ED staff.

Throughout my research, I openly identified myself as a researcher and told my informants that I would write field notes of our unstructured interviews, but that their identities would always remain confidential. Because of the volume of research conducted within the ED, the staff members were familiar with and open to the roles of researchers. However, because most of the research conducted in the ED is clinical in nature, there were many questions regarding the objectives of my research, and its potential applications. Upon learning that super-utilizers were the focus of my research, staff were usually eager to participate, and offer their experiences and opinions. Similarly, they were active participants in pointing out patients they considered super-utilizers that should be included in my data set. It is important to note that ethnographic fieldwork is heavily dependent on identity performance, in the roles the researcher take on, the expectations taken into the field, how these are dashed and fulfilled, and (most importantly) in the relationships established. All of these rest on the foundation of self-presentation and identity construction. Therefore, my own training as an emergency physician, most of which was developed at Grady, is a cornerstone of this research. This helped garner the trust and cooperation of staff members on some incredibly busy shifts. It helped me know instinctively where to stand, when to speak and when to observe quietly, and it allowed me to be able to be helpful and participate in ways that perhaps a non-medically trained researcher would not have been able. It is not lost on me that this research was relatively low on their list of priorities, and I question whether I would have been as generous with my time if I had been in their position.

In contrast to my research with ED patients, I could participate in most activities with staff and I had many experiences that approximate their perspectives. Nevertheless, my position as a researcher took my outside of the time constraints that define the work of emergency medicine and allowed me to interact with staff and patients in ways (and for lengths) I had never been able to as a physician. The pressing need for efficiency that colors all aspects of emergency medicine stood in sharp contrast to the “hanging out” that defines ethnographic research.

I was therefore positioned at a shifting nebulous boundary, sometimes an insider and sometimes an outsider. This data set therefore relies on a combination of data collected from staff members, as well as my own experiences and observations gleaned from fifteen years of clinical practice in emergency medicine. I have tried to clarify the distinction between these two categories whenever possible throughout this dissertation.

Identifying super-utilizers. As mentioned previously, most of the existing literature defines super-utilizers as patients with six or more ED visits per year (Jiang, et al. 2017). Staff in this study expressed frustration or disagreement with the six visits per year cut off cited in the research. Anyone, they pointed out, could qualify as a super-utilizer if they had a serious injury, complications from surgery, or a complicated medical diagnosis. When I asked staff what their definition of a super-utilizer entailed or how many visits were too many, they did not respond with concrete numbers. Instead, they offered descriptors such "patients who are here *all the time*" or "people who use the ER like a homeless shelter." More often than not, however, they cited names of specific individuals: "Miss Gomez is always here with high blood sugar because she refuses to take her insulin and wants a warm place to sleep"; "Willie Harper is always here complaining of knee pain, but what he really wants is a sandwich." Their insights helped form the definition of a super-utilizer used in this dissertation. In cross-referencing the names they listed with the medical records, it became apparent that the patients they referenced were being seen in the ED at least once every two or three days. Based on this information, a super-utilizer is defined in this study as a patient with more than 10 Grady ED visits within a 30-day period.

This definition corresponds to my ED staff informants' conceptions of a super-utilizer, however it departs from other definitions super-utilizers employed in the literature that use fewer ED visits accrued over longer time frames (typically one year). This definition limits the comparability of findings, but creates a homogeneous population that is more appropriate within this qualitative study.

Further, this definition assured that the patients included in this study were: 1) recognizable to ED staff, 2) did not suffer from medical conditions that required urgent intervention (e.g., need for emergent dialysis), 3) could feasibly be included in this research project, and 4) would shed light on both informal ED operations and the broader context of urban poverty within which the ED and these individuals exist.

One hundred and thirty eight patients (out of approximately one hundred thousand) met these inclusion criteria and were included in this research (Table 2). While the "super-utilizer" category is generally a heterogeneous one, all of these super-utilizers identified in this study were homeless and living on the street.[7] Homelessness was not an explicit inclusion criteria in this study, but became an important focus given ED staff's perceptions of what constitutes a super-utilizer and the high cut-off for ED visits that came from their definitions. This is consistent with other studies noting a high reliance on ED services among the homeless (Szymkowiak, et al. 2017). Super-utilizers' time of living on the street varied from one month to twenty-two years. Most are men with some diagnosis of mental illness, though none were in a state of mental health crisis during their visits. Though some of my informants did volunteer that they had struggled with drugs and/or alcohol in the past, none of them reported an active problem with drug use and I did not witness anything in my fieldwork that indicated otherwise.

Studying Super-Utilizers. Patients with ten or more ED visits in a 30-day period were identified by chart review and healthcare providers were also approached for

---

[7] While this may seem like an insignificant distinction, I clarify what it means to be homeless and the ways in which this is not synonymous with shelters or street people in Chapter Four.

participation in this study. Patients’ charts were reviewed and monitored throughout the 18 months of this research. Super-utilizers who consented to take part in this research participated in a combination of directed observation, unstructured, and semi-structured interviewing.

As with the staff members, I openly identified myself as a researcher and noted my university affiliation to all informants. I told my informants that I would write field notes of our unstructured interviews, but that their identities would always remain confidential. Informants responded to me in different ways, ranging from treating me like a friend to a staff member. Nearly all of them were familiar with the roles of researcher and informant (or research subject), though the object of my research had to be explained and reframed in various ways in order to elicit understanding of the research.

Perhaps the biggest obstacle in explaining this research (as well as an important observation underlying this entire dissertation) is that the category or concept of “super-utilization” was simply nonexistent for patients in this study. For them, healthcare was not a product that could be “overconsumed.” And while a small subset did acknowledge that emergency services could be “inappropriately” utilized, no one I came in contact with identified themselves as an over or inappropriate consumer of services. It was therefore more fruitful for me to frame my research in terms of “understanding patients’ experiences” or “describing what it’s like to be at Grady” rather than to focus on over- or super-utilization of services.

This helped frame my research in a way that was legible, though not complete. I noted, for example that this wording led to an interpretation of my research that led my informants to think of themselves narrowly as “patients” or “customers.” This, in turn, elicited data about staff members (“The clerks are *so rude*!”), processes (“I don’t understand why I have to answer the same questions over and over again.”), wait times (“I’ve been waiting here for hours!”) that mirrored some of the bureaucratic concerns of ED staff. This was important information that helped frame some of the research. Nonetheless, this framing did not help me understand the conditions under which patients’ life histories were formed nor the constraints of Atlanta’s urban environment that eventually led them through the doors of the ED.

Some of my informants recognized that their life histories and own stories of ingenuity and resourcefulness were inseparable from their temporary identities as patients. For others, I had to further reframe my research as “understanding people’s lives,” or as one informant summarized for me, “you’re trying to see where we’re coming from.” This wording helped open many conversations about life circumstances, stressors, hopes and expectations that were inextricably linked to both Atlanta’s urban ecology and individuals’ life circumstances. Importantly, for many of my informants this helped build rapport and trust by distinguishing me from “other doctors,” since my research required me to ask questions of homeless people that other healthcare providers were less likely to ask (e.g., personal questions about an individual's past). In sum, my physician and researcher roles gave me credible reasons for inquiring into such personal matters, and simultaneously generated trust and goodwill that my informants responded.

Initially, the research plan called for semi-structured interviews, but because informants tended to give non-descriptive answers and avoided informative conversations, I changed tactics and I moved to unstructured interviews and observations. With a less constrained interviewing style, the informants tended to discuss their lives and experiences freely and, most of the time, without any probing or questioning. After rapport was achieved, I was able to ask more direct questions, and a clearer picture emerged as I was gradually able to triangulate accounts from ED staff, super-utilizers (and sometimes their friends and family members), and medical records. After rapport was established, informants participated in more informative semi-structured interviews, which were recorded and with the informants' consent. My role as a researcher granted me access to a variety of patients' situations and experiences, all of which were valuable but nevertheless diluted of the direct experience typical of participant observation. Therefore, rather than using my personal experiences as the primary data base, my goal was to collect data from the informants themselves. In contrast to my experiences with staff, I had no experiences that could approximate those of the patients or super-utilizers at Grady. I could, of course, participate in some activities with them, most notably waiting. However, any discomfort I experienced was always tempered by being inherently voluntary; the option to leave the ED was always available to me. Moreover, I was never sick or frightened or vulnerable in my research and, even if I had been, I had access to resources and information that would never enable me to experience illness in quite the same way.

Thus far, I have primarily focused on my research procedures and actions. Yet it should be stressed that a significant portion of this fieldwork was spent in idle time, *waiting* for things to happen. While I explore the implications of this in a later chapter, I would like to emphasize here that the prevalence of this idle time and waiting required a significant deviation from my original research plan. Based on my preliminary research, literature searches, and (most importantly) preconceptions of super-utilizers and homelessness in Atlanta, I envisioned that my relationships with my informants would take me all over Atlanta to various purveyors of services to the homeless (shelters, streets, soup kitchens, etc.). While these are undoubtedly important core institutions in the lives of many of the homeless in Atlanta, this was not the case for the super-utilizers I had studied.

Instead of living as “urban nomads” (Amster 2008; Spradley 1999), I quickly found that my informants lived their lives confined within a three to four-block radius around the hospital. Some had been urban nomads previously, interacting with a wider subset of Atlanta’s public service institutions, and some would go on to become urban nomads during my research. While they were super-utilizers, however, my informants remained primarily at or near hospital grounds, relying on it as more than a provider of health services, but as an all-in-one service provider for the poor (e.g., as a source of food and shelter). This was dictated, in part, by limitations within their own bodies (illness and disability), but also by a shrinking availability of public spaces and an increasingly unwelcoming urban landscape. Simply put, much of Atlanta’s space was unwelcoming and its welcoming spaces were often inaccessible. Thus, rather than traversing the city in search of services, my informants spend most of their time waiting in and around hospital grounds, which shaped both my data collection plan and findings.

Other Patients. Although the focus of this study is on super-utilizers, the experiences of other patients quickly became a central part of understanding the culture of the ED and super-utilizers' place within it. I therefore conducted directed observation and unstructured interviewing with over fifty ED patients in the waiting room, paying attention to their perceptions of the Grady organizational process and culture and its meaning for them and their family members. Observation also focused on how patients often participated in the categorization process, interpreting their own symptoms and identifying and labeling other patients as either "truly sick," "in need," or "inappropriate" users of ED services. Frequently, patients would tell me what staff members said to them (or what they had overheard) regarding ED operations and other patients—especially super-utilizers. This provided an important check to my own observations, helping to ensure the validity of findings.

Ethnographic Data Collection. My observations of their behavior and conversations were recorded in a stepwise fashion, beginning with mental and jotted notes in the field and culminating in a detailed field narrative based on elaboration of these notes. Field notes were written the day of, or the day after, fieldwork. I would try to recreate detailed observations and conversations with the participants that occurred in the ED or around the hospital. I also added my reactions and assessments of events I observed, while simultaneously noting and honoring participants' requests not to include specific comments or observations in my notes. In recording my notes, I attempted to mentally walk through the day, noting as many details and conversations as possible. These narrative elaborations constitute the ethnographic data log on which much of this dissertation is based. During the 18 months of data collection, I had ethnographic encounters and informal interviews with fifteen men and seven women categorized as "super-utilizers." I conducted life history interviews with six individuals who had been dubbed super-utilizers for lengths of time ranging from one months to one year. Each of these individuals was a key informant, with whom I had numerous ongoing contacts. Table 1 provides a summary of this data.

Of course, researchers must be aware of their own positioning in the social world being studied and in the contingencies that shape the processes of fieldwork. In other words, we must acknowledge that "ethnographies are constructed by human beings who make choices about what to research, how to interpret what they find, and that they do this all in the context of their own personal biographies" (O'reilly 2012: 213). An awareness of these processes does not undermine the data. Rather, it acknowledges that the researcher and the researched are inextricably linked both within the social world and in the resultant ethnography (Brewer 1994; Clifford 1983).

In the context of this research, there are two aspects of my positionality that should be acknowledged. First is my positionality as an emergency physician, having been trained at Grady and working there for years after completing my residency. As I noted previously, this granted me access to the ED and staff that otherwise would not have been possible. However, my proximity and familiarity with the ED and its staff necessarily placed me at a distance from patients. While it is impossible to erase this distance, working to overcome it was an important endeavor that forms this research. This involved decentering my own experiences and biases about what the functions of the ED and the motivations of the people seeking its services. Over my years of clinical practice, I formed a particular view of what constitutes "an emergency" and what "counts" as worrisome. Recognizing that determining the medical emergency is both subjective and socially constructed was a critical component to my research process (Salhi 2015). More importantly, gaining access to my informants required a recognition of my class position and building relationships in ways otherwise unfamiliar and uncomfortable. Describing their ethnographic fieldwork with homeless heroin addicts, Bourgois and Schonberg (2009) write,

> At first, we felt overwhelmed, irritated, and even betrayed by the frequent and often manipulative requests for favors, spare change, and loans of money. We worried about distorting our relationships by becoming patrons and buying friendship to obtain our research data… We had to learn… not to take their petty financial manipulations personally, and to refrain from judging them morally. Otherwise, we could not have entered their lives respectfully and empathetically. (p. 6)

While my informants were not part of the street drug culture described by Bourgois and Schonberg, building relationships with them meant learning and participating in a new moral economy. This required not only spending time with my informants, but also participating in a gift economy that included providing favors such as food and small monetary loans. For example, my informants regularly asked me to purchase food for them from establishments where they were not welcome (e.g., local convenience stores). For instance, I first met Tony in the Grady ED and ran into him a few weeks later outside a convenience store near the hospital. I was wearing hospital scrubs, a fact that he used to get my attention. “Hey Doc! Doc!” He called as he walked up behind me. I turned around to see his dark, wrinkled face. “Doc, you got a dollar to spare? I’m hungry, I’m diabetic, and I got nothing to eat.”

I told Tony that I had no cash to give him, but that I could buy him something to eat with my credit card. His face perked up at the suggestion. “Yeah! Okay, can you go in there and get me some canned sausages and saltine crackers? They’re in the back toward the side of the store,” he said, gesturing to the convenience store.

I had little time to spare and I was not sure what he was talking about. “Why don’t you just come in with me and pick out what you need?”

Tony looked down at the ground, embarrassed, “Oh, I can’t go in there. I went down the wrong aisle and now the owner won’t let me…” His voice trailed off as I replayed his words and figured out that he had been caught shoplifting in the store. I went into the store and bought his sausages and saltines, which prompted the store owner to tell me that I was “being hustled” by Tony. A patron standing behind me in line chimed in that I was just “too nice.”

At first, I was uncomfortable with obliging Tony’s request for food and unsettled at the accusation of being gullible or exploited. My discomfort waned, however, with the realization that my informants’ very survival depended upon these petty exploitations and that they never took serious advantage of my presence. I never felt personally threatened, nor did they ever ask me for more than small favors.

The second aspect of my positionality that forms this research is my gender. As a woman researcher, there were some relationships that came more easily than others, and situations in which I belonged more than others. This did not mean that I resigned myself to collecting data solely from or about women (Gregory 1984). However, it would be misleading to not acknowledge the role this played in this research. For example, although it was just as easy to initiate contact with men as it was with women, it was easier for me to sustain meaningful, longer term relationships with women. As detailed in Table 2, men made up over three quarters of the super-utilizers at Grady. This likely reflects gendered aspects of poverty and network-based survival strategies that may keep many poor women from employing the survival strategies of interest here (Lindsey 2015; Roschelle 1997). Nevertheless, I noted that men and women alike depended heavily on the ED during their times of greatest difficulties. With respect to the survival strategies described here, the similarities between men and women far outweighed the differences. Cases presented in the following chapters were selected to maximize ethnographic depth and present the full complexity of individuals and their experiences. In light of my positionality as a woman ethnographer, women comprise the majority of the cases presented here even if they did not comprise the majority of my ethnographic encounters nor the majority of patients labeled super-utilizers.

The relationships I established with super-utilizers decentered my assumptions of the ED and its functions and challenged my perceptions of the relationship between poverty, housing, and healthcare in the US. This is, in large part, why this work required 18 months of fieldwork to produce.

Table 1. Summary of ethnographic data

Type of Data	ED Staff	Super-Utilizers	ED Patients
Primary Informants	69	22	50
Key Informants	8	6	NA
Semi-Structured Interviews	34	6	NA
Chart Reviews	NA	123	NA

Chart Reviews. Patient charts were reviewed and analyzed to determine how healthcare providers described these patients and the process of healthcare delivery. Patients with ten or more ED visits in a 30-day period were identified by chart review. Patient demographic details are included in Table 2.

Table 2. Demographic and utilization characteristics of 138 emergency department patients identified in this study.

Characteristics	**All patients (n=138)**	**Average Age (range)**	**Average months of super-utilizer duration (range)**	**Average Number of visits/patient**
All Patients	138	46.2 (28-73)	1.97 (1-11)	28.4
Gender – n (%)				
Male	107 (77.5)	45.8 (22-70)	1.97 (1-11)	27.7
Female	31 (22.5)	46.4 (18-73)	1.96 (1-11)	30.6
Race – n (%)				
Black	120 (89)	46.0 (20-70)	1.92 (1-11)	26.8
White	15 (10.8)	46.1 (18-73)	2.33 (1-9)	38.1
Other	3 (0.2)	54.3 (51-61)	2.33 (1-4)	43.3

This research oversamples individuals in some categories (Black) and under-sample in others (Whites, Hispanic or Latino, Native American). The study design reflected the pre-existing patient and staff demographics of Grady, and its historical and contemporary racial dynamics of Atlanta, as well as the study setting's role in the Atlanta community. I discuss these in greater detail in the following chapters.

In addition to the descriptive data provided above, charts were reviewed qualitatively, noting the words, phrases, and intentions attributed to patients by staff members. These were used to supplement the words and experiences of both patients and ED providers derived from the observations and the unstructured and semi-structured interviews conducted.

Anonymity & Data Protection

This research poses some difficulty with anonymity and data protection. The research proposal and methods attempted to anonymize all participants. Nevertheless, this is more difficult to achieve than in clinical trials or statistical analyses where individuals could be reduced to numbers and participants' stories and voices are absent. In contrast, individuals' stories, experiences, and voices are the central focus of this research.

To ensure the confidentiality of all informants, all research for this project was carried out in accordance with Emory University's Institutional Review Board and Grady Memorial Hospital's Research Oversight Committee. Hand-written field notes were kept on my person or in a locked cabinet in a locked office at all times. All subject identities will be coded to protect informants' identities. A codebook with the subjects' identities were kept separate from the field notes as a password protected file on the researcher's computer, which were password protected. All interview (audio and written) and participant observation data was entered electronically to ensure safe storage. All files were password protected and backed up on a hard-drive to which only the researcher had access. All names of informants presented in this dissertation are pseudonyms.

Throughout this research, I attempted to maintain foundations of respect for the well-being of others, recognizing that this is something that is could not be prescribed by research protocols and that varied widely between individuals.

Conclusion

In sum, data for this research were derived from three sources over an 18-month research period: (1) ethnographic encounters with 22 super-utilizers in the

Grady ED; (2) ethnographic encounters with 69 staff members of the ED; and (3) hospital records of 138 patients. These data sources were tapped by a mixture of procedures: directed observation, unstructured, and semi-structured interviews in the case of the super-utilizers; participant and directed observation, coupled with formal and informal interviewing in the case of ED staff; and a systematic review of institutional records.

Throughout my research, I moved between two positions. The first was defined by my status as an observer and (sometimes partial) member of the staff. The second position was defined by my relationships with patients, which was usually that of a sympathetic outsider, limited in the proximity I could obtain. In the moments when my proximity was closest, I was particularly interested, not only in what they would show me in their worlds and how they negotiated their constraints and limitations, but also in how I had accomplished that proximity.

My positioning as matter "out of place" (Douglas 2003) directed my attention to the broader issues of urban life that were often cordoned off as insignificant or outside the bounds of the hospital by staff and patients. The focus upon super-utilizers, here defined as patients with ten or more ED visits per month, therefore shifted to a broader interest in the conditions of urban poverty and its medicalization within an emergency medicine context. Furthermore, this liminal space (Turner 2008) in which I conducted my research, neither patient nor staff member, illuminated the arbitrariness, artificiality, and the continuous movement of the boundaries between the hospital and its urban conditions and surroundings. Further, this clarified what it means to construct homeless patients as "super-utilizers," and was instructive in broadening the understanding what a contemporary hospital is and what roles it fulfills.

CHAPTER THREE: SUPER-UTILIZERS: A GENEALOGY

Introduction

> "What's a gomer?"
>
> From outside the rom there came a high-pitched, insistent cry: GO AVAY GO AVAY GO AVAY…
>
> "Who's on call today? You three interns rotate days on call, and you only admit patients on your on-call day. Who's admitting today?"
>
> "I am," said Potts.
>
> "Good, 'cause that awful sound comes from a gomer. If I'm not mistaken, it's from one Ina Goober, whom I admitted six times last year. A gomer, or rather, the feminine, gomere. Gomer is an acronym: Get Out of My Emergency Room—it's what you want to say when one's sent in from the nursing home at three a.m."
>
> "I think that's kind of crass," said Potts. "Some of us don't feel that way about old people."
>
> … "But gomers are not just dear old people," said Fats. "Gomers are human beings who have lost what goes into being human beings. They want to die, and we will not let them die. We're cruel to the gomers, by saving them, and they're cruel to us, by fighting tooth and nail against our trying to save them. They hurt us, we hurt them." (Shem 1978: 29)

The unsettling excerpt above, taken from Samuel Shem's now-iconic *The House of God* conveys that the stress, fatigue, and the constant assault of human suffering encountered during residency can make trainees lose their compassion, their moral compass, and their humanity. Stretched to physical exhaustion, feeling abandoned, and overwhelmed with responsibility for their patients' well-being, residents develop a hatred toward them, the seeds of which are sown during first days of residency. Endless examples of this us-versus-them attitude abound in the book, each more cringeworthy than the next. Shem depicts the gomer as the quintessential enemy of the medical resident—pushing young doctors to the brink of insanity, draining medical resources, all the while obstinately refusing to get better.

To be sure, Samuel Shem did not invent the term gomer, nor the cruelty with which these patients were treated. Victoria George and Allen Dundes (1978) trace the origins of the term to the late 1950s, noting that it was predominately used in Veterans Administration Hospitals, county hospitals, and academic teaching centers—all places with a disproportionate share of poor and uninsured patients. Like Shem, George and Dundes emphasize the stress associated with caring for these patients and medical staff's need to vent their frustration through callous humor. They write, for example,

> Why should doctors and nurses have to care for someone who evidently cares little or nothing about himself? No matter what is done for such patients, they will only return again and again to the hospital admitting room in the same miserable, unfortunate condition. In fact, the logic could easily be: the better the care in the hospital, the sooner the gomer will return to plague the staff once more… There seems to be no way of escaping permanently from

> such patients. Creation of the gomer figure… is one of the few available defenses against this deplorable situation. (George and Dundes 1978: 579-580)

Interestingly, the medical community was not nearly as forgiving as George and Dundes in their assessment of the term or the inhumanity associated with it. They note, for example, being chastised by the Chief Nurse in the hospital where they conducted their survey of slang terms used to describe patients at the Veterans Administration Hospitals. Having found their study in poor taste, this Chief Nurse pulled their questionnaire from circulation. Administrators and medical educators had similarly negative responses to Shem's controversial work, even as the book has sold more than two million copies in nearly fifty countries (Wear 2002).

One of the reasons that *The House of Gods* remains relevant is that it is one of the few works in which the anger and antipathy towards patients engendered by clinical work are laid bare. Yet this is also a primary reason that the work has been publically disavowed by medical professionals (Floyd 1981; Gillette 1981; Hood 1996). For doctors and nurses alike, the pejorative labeling of patients, especially the term gomer, presents a very real tension between the "ideal" professional role prescriptions and the indignities associated with medical training and practice (cf. Chisholm, et al. 2009; Klass 2008; Kusin 2009; Updike 2008). Where the ideal health care provider is caring and nonjudgmental, Shem's characters are cruel and disparaging. While this tension remains largely unresolved, Shem's work points to an uncomfortable and largely undisputed fact: doctors do denigrate patients (cf. Singh and Posner 2015; Wear, et al. 2006).

Taking this fact as a starting point, this chapter addresses two related questions: Who are gomers and how do they differ from “normal patients”? More importantly for this dissertation, how does the gomer relate to the super-utilizer, and what are the respective functions of these ascriptions? To answer these questions, I begin with an examination of the gomer and its various synonyms: dirtball, crock, and so on.[8] By examining the available literature on medical slang and its functions, I show that these terms do not apply to an easily identifiable type of person. Rather, these terms represent a moral evaluation of people who do not easily conform to the role of the “good patient”: one who is compliant with societal norms, family wishes, or health care providers’ recommendations in order to get better (Holmes 2012; Horton and Barker 2009; Rivkin-Fish 2011; Willen 2012).

Building upon this, I show that terms like gomer and crock are the predecessors to the “super-utilizer,” a term framed as a statistical variable rather than a moral valuation of individuals. I show that the term super-utilizer differs from its predecessors in one important aspect—namely the economistic way with which patients are framed. While this economism appears as “scientific” or “value neutral,” it nevertheless retains vestiges of stigma associated with terms like gomer and crock. Further, I argue that the popularity of the term super-utilizer, and the economism with which it is associated, are closely related with the reforms enacted by the Affordable Care Act (ACA).

I conclude this chapter by arguing that the discourse around super-utilizers performs two important, related functions. First, it further entrenches market-based

---

[8] The list of medical slang and acronyms used to describe patients, other medical staff, and/or medical conditions is variable by region and too extensive to describe here. For a more detailed list of medical slang, see: http://messybeast.com/dragonqueen/medical-acronyms.htm

medicine, and the idea of medicine as a scarce, finite commodity within American healthcare. Second, it frames the poorest and most vulnerable segments of the population as an imminent threat to the availability of healthcare for all, thus rendering invisible the very real threat to healthcare engendered by insurance providers and other corporate actors in medicine.

The Gomer Phenomenon

Although the word gomer is an iconic expression of doctors' hostility to certain patients, it is not anomalous. Terms such as "dirtbag," "shit," "scum," and "crock" (short for "crock of shit") are similarly hostile epithets for patients (Burson-Tolpin 1989; Coombs, et al. 1993; Konner 1987; Winick 2004). Yet, even within the cynicism that pervades medical speech and *House of God,* not all patients are deserving of hostility. Shem, for example, contrasts gomers with other patients, writing, "That's the challenge of medicine: gomers gomers gomers where you can't do anything for them, and then, suddenly—WHAM!—in comes Leo, a lovely guy who can die, and you gotta move fast to save him" (Shem 1978: 40). Gomers, therefore, are specific patients who stand in direct contrast to "perfectly nice" or "normal" people who, in a cruel twist of fate, suffer terrible outcomes while gomers seemingly live forever. Shem therefore implicitly likens gomers to cockroaches—revolting creatures that are so resilient that they are said to be the only ones able to survive a nuclear war.

Medical anthropologists have taken much interest in gomers and the various hostile epithets bestowed upon patients by health care providers. In doing so, anthropologists sought to categorize the insults and identify the "types" of patients with whom they were associated. George and Dundes (1978), for example, define gomers as “unkempt, unsavory, chronic problem patients” and note the use of other synonyms: “turkey,” “crock,” “trainwreck,” “lizard,” and “reeker” (p. 572). They present a widely circulated “gomer assessment scale,” in which points are given to various loathsome characteristics or behaviors typical of gomers (e.g., “urinates on physician” or “found in the hallway without pajama bottoms”). They conclude that the term “gomer” is a category of hospital folklore used to dispel the tension between the ideals and realities of medical practice. They further argue that healthcare providers are respected individuals who, despite their high social standing, must reckon with society’s lowest elements: the homeless, the drug addicted, and the mentally ill. In positing this explanation, George and Dundes implicitly accept that the gomer is, indeed, a type of patient with “disastrous and disgusting behavior” that necessitates such cynical outlets (p. 581).

Building on George and Dundes’ work, David Paul Gordon (1983), compiled a glossary of hospital slang for patients, offering definitions such as: “gomer: Most commonly, an alcoholic or derelict with extremely poor personal hygiene and a record of multiple admissions to the hospital. Symptoms are predictable and illness is often feigned. When sick, shows lack of interest in recovery; is often disoriented and hostile,” and “SHPOS: *S*ub*h*uman *p*iece *o*f *s*hit; a *gomer*” (Gordon 1983: 175-76). Further, Gordon categorizes hospital slang into four categories: Category I consists of patients who demand resources out of proportion to their illness (e.g., “crock”); Category II is comprised of socially stigmatized patients (e.g., “gomer” or “shpos”); Category III refers to comatose or unresponsive patients (e.g., “gorks”); and Category IV consists of value-neutral or positive descriptions of disease category (e.g., “little old lady” or “good patient”). Gordon concludes that these monikers are simply shorthand for the mad, the bad, and the sad in society. Their function, he argues, is to form group solidarity among physicians, maintain the appearance of professional control in difficult situation, and, paradoxically, to facilitate the delivery of better health care. Gordon offers no evidence in support of his final contention, but it is difficult to believe that being dehumanized and derided would promote improved patient outcomes.

Like George and Dundes, Gordon accepts the existence of gomers, gorks, and good patients as preexisting categories in the natural world. In other words, they are simply “types of people” encountered in the hospital setting and present in the world. Taking a more nuanced approach to the gomers, Deborah Leiderman and Jean-Anne Grisso (1985) explore not the gomer, but the gomer *phenomenon.* They note that a variety of patients were labeled gomers, not simply those who were unsavory or self-destructive. While Leiderman and Grisso agree that the term was an outlet for health care providers’ frustration, they add that the problem lies not in the gomers themselves, but in the unacknowledged limitations of contemporary medicine. They write,

> Gomers may be seen as an index of medicine’s insoluble problems—the diagnostic dilemmas, the gradual deterioration of mental function, the chronic disabling problems that lead neither to death nor cure but to the new twentieth century institution, the nursing home. [Gomers represent] the inconsistencies in the system—the gap

> between the myth of omnipotence of technologic medicine and the realities of gomer patients on the wards. (Leiderman and Grisso 1985: 230)

Further, Leiderman and Grisso observe that medicine is associated with an overconfidence that medical technology can cure all manner of personal and social ailments (see also: Kleinman 1995). They conclude that gomers represent a broader existential angst that comes with realizing that high-technology, interventionist medicine not only comes up short in the face of social problems, but often exacerbates them. Rather than confronting the shortcomings and limitations of "modern medicine," healthcare providers project their anger onto patients whom they perceive to be self-destructive or refractory to help. Gomers, therefore, are reframed by healthcare providers as a kind of "pollution," "matter out of place," or contravention of medicine's system of ordering and therapy (Douglas 2003).

To further understand the idea of gomers as "matter out of place," it is helpful to examine the term's other synonyms, most of which compare patients to dirt or filth. Indeed, as Stephen Winick (2004) observes that, Like the taxonomies of Douglas' primitive societies, medical diagnoses are socially constructed ways of categorizing the chaos of experience. Patients who do who do not fit neatly within this schema—based on their diagnoses or personal behaviors that are unbecoming of patients—come to occupy a residual category that breaks the other rules of classification and must be contained, lest it disrupt the structures of medicine. Further, Winick notes that, although gomer has been the most studied of medicine's pejorative terms, it is also anomalous in being one of few terms that does not employ pollution metaphors. To illustrate this point, Winick turns his attention to the “crock,” or “the patient who has symptoms, or claims to have symptoms, but who cannot be diagnosed by his physician” (p. 92). Winick therefore concludes that filth metaphors are ascribed to patients who behavior violates the rules of the sick role (Parsons 1958) or whose diagnosis falls outside accepted biomedical disease categorizations.

The observation that filth metaphors apply to patients who violate the system of order in the hospital is helpful. Returning to Shem’s introduction of the gomer, two important characteristics of the interaction stand out. First, having admitted Ina Goober three times over the past year, the Fat Man was able to identify her by her high-pitched cry alone. Given that residents usually spend only part of their time on call admitting patients, we are left to assume that these three admissions represent a fraction of her time in the hospital. Second, in explaining what a gomer is, the Fat Man notes that doctors are “cruel to the gomers, by saving them.” In other words, gomers are specifically people who consume disproportionate medical resources—resources that are expended in vain, as no amount of medical technology can restore a gomer’s humanity (see also: Crane 1977). Not only does the expenditure of medical interventions on these futile cases waste precious resources, but it exacerbates the misery of the gomers as well as the doctors attempting to care from them.

More than any other demographic variable of medical diagnosis, it is these excessive needs and demands—for healthcare providers’ time, empathy, medical resources, admissions—that define the gomer and its myriad synonyms. The following quotes give a sense of the frustration associated with gomers' immoderate demands:

> It is not hard to understand why medical practitioners might feel anger and hostility toward individuals who demand and often receive a disproportionate amount of the precious time and energy of the hospital staff. (George and Dundes 1978: 579)
>
> The throwaway patients [are the ones who are] unexciting, noncompliant, and manipulative; the "crocks"—the bread and butter of ambulatory care—who fill the waiting room and keep coming back, and keep coming back… Crock is a good name for throwaway patients who seemingly cannot be helped, who seem not to want to get more functional. (Whitney 1981: 87)
>
> Staff may feel that any time spent on "gorks" is wasted, and experience a good deal of irritation at the medical requirements that prolong life beyond the possibility of recovery. (Gordon 1983: 179)
>
> [Gomers] include extremely ill patients who require a great deal of time and care: unresponsive 'no hope' patients, and seriously ill patients with numerous problems. (Coombs, et al. 1993: 989)
>
> Based on my own experience with doctors… in the case of the crocks, the time and resources spent testing the patient are not justified by any results, and although the patient cannot be considered culpable, the doctor's frustration is understandable. (Winick 2004: 102)

As Talcott Parsons (1958) points out, the sick role is legitimate only for a finite period of time. Gomers' chronic presence in the medical system—that they are always there—means that they are accorded less legitimacy than acute conditions. Indeed, gomers are seen to resist getting better because they are unconsciously motivated by benefits obtained by being ill—also referred to as "secondary gain." Thus, they are deserving of no legitimacy as patients, even as they are a sustained presence in the healthcare system.

In these portrayals, the gomer is untethered from the social and the familial and, more importantly, untethered from humanity and the morality and rationality associated therewith. Gomers are not only less than human, but their bodies are figured as an excess of personhood. Their bodies occupy too much inconvenient hospital space and demand attention in excess of their physical complaints and social worth. Just as gomers are conceptualized as people with no hope of cure, they are people with excess demands who are simultaneously undeserving of their demands. Gomers' excesses and shortcomings of personhood reinforce healthcare providers' feelings of disgust and sanction social abandonment (Biehl 2005).

Just beneath the derogatory language used to describe patients is an important implicit assumption: each person occupies a rank on a hierarchy of social value, and this rank determines the resources and effort that the person deserves (Shatin 1966). And while medical ethics would not differentiate between individual bodies, pejorative medical slang reminds that there continuous decisions and judgments being made about which bodies deserve resources and attention and which do not (Willen 2012). More important for the present study, however, is that the construction of the gomer as subhuman also ushered in the super-utilizer as the successor to the gomer.

To see the discursive shift from the gomer to the super-utilizer, it is useful to reexamine Atul Gawande's influential piece, *The Hot Spotters.*[9] As I noted in the introduction, Gawande's focus in this piece is on outliers—people with the highest number of hospital visits and admissions and, consequently, the greatest healthcare costs. Though health services researchers and statisticians have gone to great lengths to define what constitutes a "super-utilizer" (cf. Newton and Lefebvre 2015), Brenner explains this more bluntly: "For all the stupid, expensive, predictive-modelling software that the big vendors sell, you just ask the doctors, 'Who are your most difficult patients?,' and they can identify them" (Gawande 2011: 42). Health care providers in my study also defined super-utilizers in terms untethered from statistics or cost calculations. In response to my interrogation of what constitutes a super-utilizer, one doctor simply replied, "They're people who are here [in the ED] for a sandwich." Another explained it in more detail,

> What we tend to think about are people who make four or more visits per year, but I tend to think about the four or more visits per year which is kind of the frequent group. I hate fliers. The frequent visitor group, then there's kind of the super group where you're talking four visits a month, or more, but I tend to also think about them as people who have some social challenge. Maybe a disease

---

[9] Levine and Mulligan (2015) point out that there are two major strands that characterize over-utilization. The first, which I focus on here, concerns poor, uninsured patients cast as super-utilizers. The second focus is aimed at insured patients, the perils of overtreatment, and the so-called "moral hazard" associated with health insurance.

> burden which could be congestive heart failure, heart disease, mental health, but they also tend to have some social issue that's making them a super-utilizer, whether that's stable housing, stable transportation, economics, access to the money for their care.

As this quote illustrates, health care providers in this study departed from statistical notions of what constitutes a super-utilizer and instead included references to patients' social needs and the ways in which they challenged the ED's model of episodic health care delivery.

Though the word gomer does not appear in *The Hot Spotters*, it is not difficult to make the link between the gomer (or its many synonyms), "the most difficult patients," and "super-utilizers." To illustrate this, Gawande profiles a man named Frank Hendricks:

> Hendricks had severe congestive heart failure, chronic asthma, uncontrolled diabetes, hypothyroidism, gout, and a history of smoking and alcohol abuse. He weighed five hundred and sixty pounds. In the previous three years, he had spent as much time in hospitals as out… A toxic combination of poor health, Johnnie Walker Red, and, it emerged, cocaine addiction had left him unreliably employed, uninsured, and living in a welfare motel. He had no consistent set of doctors, and almost no prospects for turning his situation around. After several months, he had recovered enough to be discharged. But, out in the world, his life was simply another hospitalization waiting to happen. (Gawande 2011: 42)

As one of the “worst-of-the-worst” patients, Hendricks had many characteristics of the classic gomer. His obesity, alcohol and drug use could easily be construed as self-destructive behaviors that defy the very category of the patient, which to many doctors means a sick person who wants (or can) get better. Instead of referring to Hendricks as a gomer, a crock, or a SHPOS, however, Gawande introduces the term “super-utilizer,” billing these patients not as obnoxious derelicts, but as costly expenditures within the healthcare system.

At first glance, this may seem like an insignificant shift or just a matter of semantics. After all, central to the construction of the gomer is a patient with unwarranted demands on doctors’ and nurses’ time and the disproportionate utilization of health care resources. The discursive shift from the gomer to the super-utilizer, however, marks an important turn in the possibilities for management of this population. In contrast to gomers, who are to be abandoned and avoided, super-utilizers are persons incapable of self-management and in need of social rescue and directed intervention. Gawande, for example, describes how Brenner spent inordinate amounts of time getting to know Hendricks and to make a difference in his life. Indeed, Brenner’s time and energy investment were, according to Gawande, nothing short of life-changing:

> [Brenner] made sure he followed Hendricks closely enough to recognize when serious problems were emerging... He teamed up with a nurse practitioner who could make home visits to check blood-sugar levels and blood pressure, teach Hendricks about what he could do to stay healthy, and make sure he was getting his

> medications… The team also pushed him to find sources of stability and value in his life. They got him to return to Alcoholics Anonymous, and, when Brenner found out that he was a devout Christian, he urged him to return to church… He has gone without alcohol for a year, cocaine for two years, and smoking for three years. He lives with his girlfriend in a safer neighborhood, goes to church, and weathers family crises. He cooks his own meals now... He’s lost two hundred and twenty pounds, which means, among other things, that if he falls he can pick himself up, rather than having to call for an ambulance.

Gawande was enthusiastic about the results, pointing out that Brenner’s work was not only an effective means to reach a socially desirable end, but an important mechanism by which to reduce healthcare costs. Thus, the details of Hendricks’ life tells a story bigger and more compelling than just his own. How this man could drastically improve his health and his life speaks not just to the limits of medical technology, but also to the optimism, hope and progress that could be harnessed by expanding what falls under the scope of “the medical.” It is important to note, however, that this type of management was implemented in the name of efficiency, quality care, and expansion of access to healthcare.

To be sure, Gawande did not pioneer this argument. Market solutions to social problems have long been trumpeted as a commonsense way to achieve desirable ends (cf. Sandel 2012). For example, like Gawande, Malcolm Gladwell (2006) wrote a widely circulated article entitled *Million Dollar Murray,* in which he followed a homeless man and detailed the exorbitant costs of homelessness. Gladwell writes,

> Boston Health Care for the Homeless program… recently tracked the medical expensive of a hundred and nineteen chronically homeless people. In the course of five years, thirty-three people died and seven more were sent to nursing homes, and the group still accounted for 18,834 emergency-room visits—at a minimum cost of a thousand dollars a visit. The University of California, San Diego Medical Center followed fifteen chronically homeless inebriates and found that over eighteen months those fifteen people were treated at the hospital's emergency room four hundred and seventeen times, and ran up bills that averaged a hundred thousand dollars each. (Gladwell 2006: 101)

The implication of Gladwell and Gawande's work was clear: social abandonment was not simply cruel, it was costly. Furthermore, it was imperative that everyone be invested in the wellbeing of super-utilizers. Failure to do so would not only result in tragic outcomes for them, but would mean exorbitant fiscal costs for all.

The genius of this line of thinking, and the subsequent super-utilizer interventions attempting to replicate Brenner's work, is that it could mobilize neoliberal discourse of cost and efficiency to successfully advocate for what ethical and human rights discourses have failed to do—namely that medical care should be more broadly conceptualized and more readily available to all segments of the population. In recasting gomers in terms of financial cost, Gladwell and Gawande provided economic justification for improving and expanding access to healthcare and other basic necessities.

Interest in super-utilizers and programs profiled in *The Hot Spotters* coincided with the passage of the ACA in 2010, which promoted a groundswell of interest in super-utilizers. Section 2703 of the ACA authorized new forms of Medicare and Medicaid payments to develop “medical homes” and “accountable care organizations” to provide services for populations with multiple chronic conditions and complex social needs previously thought to be outside the purview of medical care delivery. Within this new model, accountable care organizations were entities formed by health care providers—from primary care physicians and specialists to hospitals—that agree to collectively take responsibility for the quality and total costs of care for a population of patients. In contrast with the traditional fee-for-service model, which incentivized healthcare providers to dole out more treatments because payment was dependent on the *volume* of services provided, health homes and accountable care organizations were funded model based on the *value* of care they provided.[10] Healthcare providers received direct financial incentives to think outside the bounds of office-based medical care delivery, coordinate care, and demonstrate reduced costs of patient care and improved patient outcomes.

This was nothing short of a sea change in American healthcare. Not only could the rational application of economic principles improve efficiency, it also promised better health outcomes, and the equitable distribution of scarce healthcare

---

[10] Value here is characterized as the greatest good achieved with the lowest possible costs accrued.

resources.[11] The response to this approach was overwhelmingly positive. The Center for Health Care Strategies (2016) recently catalogued super-utilizer programs in 26 states and expects this number to steadily increase. Increasingly, policymakers are making it a priority to launch and scale such programs. In 2016, the Centers for Medicare and Medicaid Services announced it would be provisioning nearly $160 million to pilot the most effective ways to address high-utilizers' social needs. Private foundations followed suit, aligning their strategies to fund and promote innovative interventions. Even the mainstream media has profiled these patients and the efforts required to rein in their exorbitant costs (Allen 2017).

Thus, gomers became super-utilizers, people who should be helped rather than people who should be abandoned or maligned. The fundamental contradiction between health care as a *right* and health care as a *commodity,* it seemed, was finally solved. No longer was there thought to be a conflict between what is *just* and what is *profitable*. Advocates of vulnerable and disenfranchised populations welcomed the attention and funding for their cause. Indeed, many of them had long made similar economic arguments (i.e., "it is more expensive to deny people healthcare, housing, nutritious food"), arguing that the right thing to do was fundamentally aligned with the cost-effective thing to do. Though many of them

---

[11] This logic originated decades before the ACA. The emphasis on introducing market-based mechanisms and incentives in American healthcare originates in the 1970s with the introduction of Health Management Organizations (HMOs) and managed care (see for example: Mulligan 2014; Starr 1982). Under managed, care, both patients and physicians were managed through cost-containment techniques strictly controlled use of medical services and offered financial incentives to doctors and hospitals to cut costs and services. Despite the backlash against HMOs and managed care, managed care principles have become the norm in nearly all forms of healthcare coverage in the US (Mulligan 2014).

were unconcerned with economics per se, they noted that appealing to economic sensibilities would be a politically effective mechanism to reach an altruistic end.

While it is difficult to argue against the immediate provision of housing, medication, and social support for vulnerable populations—or, for that matter, the provision of these basic necessities for all people at all times—I show in the following section that the economic is more than simply an argument or a means to an end. This discursive shift justifies the targeting individual behaviors and circumstances as the point of intervention while enabling the structures that reproduce profound inequality and social deprivation.

What's in a Name? Super-Utilizers Reconsidered

When I first heard the word super-utilizer, it was explained to me as the latest, albeit most politically correct, synonym for gomers and frequent fliers. Upon researching this further, I came across the widely quoted statistic that five to ten percent of Medicaid and Medicare patients account for 50 percent or more of total spending (Allen and Croke 2000; Hasselman 2013; Kronick, et al. 2009). A more detailed examination of the literature available on these patients shows that interest in this population is not simply about costs. For example, a report from a 2013 meeting of leading experts on super-utilizers stated that "the term 'super-utilizer' describes individuals whose complex physical, behavioral, and social needs are not well met through the current fragmented health care system" (Hasselman 2013: 1). Here, "behavioral" and "social" needs are thinly veiled to the poor and their excessive reliance on health care services. Discussing the most successful ways to intervene with super-utilizer populations, attendees advocated a careful consideration of who should be targeted for interventions:

> Programs participating at the [Super-Utilizer] Summit stressed the importance of carefully choosing "who's in and who's out." Examples of exclusion or "rule out" criteria include:
>
> - Inpatient admissions related to pregnancy, oncology, trauma, or a surgical procedure for an acute condition;
> - Advanced age (e.g., greater than 80 years of age) and a dementia diagnosis; or
> - Someone declining to participate in the super-utilizer program.
>
> (Hasselman 2013: 4)

While the report is sympathetic in tone, it nevertheless relies on a conflation of the poor with the mentally ill and the addicted. Moreover, addiction, mental illness, and poverty are used as justifications for successful interventions and opportunities for cost reduction. It is telling that attendees explicitly excluded other categories of high-cost patients. Surely there are opportunities for cost-reduction in other high-cost categories such as end-of-life care and surgical procedures. Yet the report, and others like it, reflect more of an interest in managing the poor than in true cost reduction.

Similarly, my informants were not simply referring to costs when talking about super-utilizers, but were also interested in a particular type of patient—those "worst-of-the-worst" people with "bad behavior," repeat ED visits, and ostensibly no motivation to get better or move on from the ED. Thus, super-utilizers evoke similar images as gomers and crocks: the most difficult patients, with disproportionate demands on healthcare resources, and the poorest prognoses. It is worth asking, then, if the super-utilizer is simply the latest iteration of the gomer phenomenon or if the term does denote a more substantive shift. In this section, I demonstrate that the super-utilizer is not simply another synonym for the gomer, or a label applied to a static social field. Rather, I argue that the term denotes broader transformative forces shaping healthcare with important implications.

The first and most obvious shift between the gomer and the super-utilizer is that the latter is a statistical model ostensibly devoid of stigma or moral judgment. Where the gomer was a pejorative label applied to those with uncivilized behavior or tainted moral character who also required disproportionate healthcare resources, the super-utilizer focuses explicitly on patients' overconsumption of healthcare resources, quantifying the waste in dollars and saying nothing of "bad" behavior or "uncivilized" character. To determine who is a super-utilizer, the gomer category is simply reconfigured as a statistical model for assessing the economic costs of a subpopulation. Thus, in contrast to the gomer, a category borne of a moral economy that stigmatized the undeserving poor, the super-utilizer is fundamentally an economic category in which the waste incurred by super-utilizers is measured against the behavior rational actor constantly seeking to maximize utility (i.e., homo economicus).

Moreover, in contrast to the gomers, which represented a category of people that "just is," the super-utilizer category is invoked with the explicit intention of intervention to correct the maladies of this population. One of my physician informants summarized it in the following way:

> In the old days we were good to provide [super-utilizers'] medical care, maybe have social work available for them, but now increasingly we have social workers, and case managers. We've tried to add pharmacists who help when people manage their disease. We've put in financial counseling that's more available both real-time in the emergency department as well as follow-up. I think Grady has recognized increasingly that social determinants of health really contribute to people's disease. So I think there definitely have been a lot more resources put in place to try and support that.

If we return to the gomer and its synonyms, for instance, we notice that there is no pretention of a cure for their maladies. These people were, in fact, defined by their incurability and the misery this brought upon their health care providers in expending energy on their futile cases. According to Shem's cynical account, which is corroborated by later ethnographers, the only cure for gomerism is death. Super-utilizers, in contrast, represent not people or cases, but statistical profiles with specific dollar amounts attached to their behaviors. This economistic configuration represents an opportunity for management that was simply not present in the gomer population. These management strategies that apply business logics to simultaneously maximize health and profits normalize the application of market solutions to social problems were part and parcel of the ACA.

Hendricks represents a prime example of such this logic. Here is a person who would have been left to die but instead became a shining example of what a newly envisioned healthcare system could be. Not only did his life drastically improve, but his healthcare expenditures were slashed as a result of Brenner's intervention. Hendricks' story therefore proves that super-utilizers are not simply inevitable, costly line items on a hospital or insurance company's accounting ledger. Instead, they are an untapped opportunity to improve healthcare operations: by limiting unnecessary use of services (determined by comparisons with "normal" utilization patterns), health care is streamlined, patients enjoy better outcomes, and efficiency is maximized. This logic was advanced heavily by the ACA, which, not coincidentally, dovetailed nicely with the interests of expanding insurance markets, eager to take advantage of new payment models and keep patient costs down and their profit margins up. In sum, the shift from gomers to super-utilizers represents a transformation of this population from extreme social marginalization to a governance problem best solved through rational, technocratic interventions.

Importantly, these interventions are touted as social welfare programs, picking up where the receding welfare state stops. For example, attendees of the aforementioned Super-Utilizer Summit noted the importance of interventions "that impact the person's basic needs—housing, jobs, child care, and food insecurity… before physical health can be impacted… Programs 'front-load social services'… to address gaps in and needs for social services" (Hasselman 2013: 6). These are undoubtedly laudable goals that can make important changes in the lives of individuals. Despite their widely touted altruism, however, the first and primary goal of these programs is to streamline spending and, when private insurance is involved, to produce a profit. Indeed, this is the very metric by which “success” in these programs is measured.

This is significant in that it challenges the characterization of super-utilizers as drains on the healthcare economy. Within these interventions, abandoned populations, previously seen as sites of economic waste, become sites of economic productivity. Craig Willse explains,

> The ways that political and social exclusions are forms of economic inclusion, occasions for moral claims set to business rationalities. Another way to say this is that the processes of extreme marginalization and dehumanization… take place *inside* an economy and to the benefit of that economy. Rather than bare life, these surplus populations constitute a form of surplus life—life that is considered unnecessary, and that is nonetheless productive of surplus value in neoliberal capitalism. (Willse 2015: 49)

Thus, Willse argues that the rollback of the Fordist-Keynesian welfare state did not simply leave behind a population abandoned, excluded from the political realm and incapable of assuming representation (Agamben 1998). Rather, this rollback made possible the corporatized social welfare programs that take disenfranchised populations to be objects of intervention—and profit making.

One might ask, then, what is the problem with this confluence of public good and capitalism? Shouldn’t we embrace the production of healthier populations and the creation of profits, especially as this logic allows the distribution of a limited good more justly (and widely)? First, it is important to note that the great promise afforded to this logic has yielded disappointing results. Even the best designed and most funded super-utilizer interventions could boast no more than 50% enrollment rates, and even in the patients who participated the overall effects have been mixed (Thomas-Henkel, et al. 2015). This is, in large part, due to the fact that, for the overwhelming majority of super-utilizers, their time spent “over-consuming” healthcare is finite. In the absence of interventions, for example, one study found that more than two-thirds of super-utilizers drop out of the category within one year (Johnson, et al. 2015). In other words, the super-utilizer category does not denote a *type* of person, but a particularly difficult *time* in a person’s life. The temporal aspect therefore makes it difficult to intervene on a subpopulation and to meaningfully measure the impact of an intervention. Measurements of success are done on the level of persons enrolled in interventions, or in “closed systems”—that is, where the payer also provides the care, so the organization spending money will be the same one reaping the benefits. Of course, the broader system of healthcare does not operate this way. Insurance companies and providers operate in separate and contradictory realms. Patients fall in and out of insurance programs frequently, they visit different hospitals, and move to different cities and states, thus making these programs unsustainable or ineffective in the long-term.

Despite the failure of these interventions to yield true cost savings or long-term changes in healthcare, policymakers, health insurance companies, and hospitals remain undeterred in their advocacy of these programs. This is, in large part because the ACA ushered in changes that incentivized insurance companies to define care in broader, more inclusive terms. To illustrate one of the ways in which Medicare, insurance companies, and hospitals devise creative workarounds to maximize their profits, I quote Jessica Mulligan at length:

> [The] distinction between medical and administrative costs is also known as the medical loss ratio, which is the percentage of total costs used to pay medical bills. The language is interesting here—the primary function of health insurance companies that is to pay for medical care is presented as a loss. Investors used to be attracted to low medical loss ratios (in the neighborhood of 80% or 75%) because it signaled that the insurance company was not saddled with high medical spending and was therefore more likely to be profitable. The ACA directly addresses this issue by requiring large health plans to maintain a medical loss ratio of 85% or higher. Plans with medical loss ratios below this threshold will be required to pay a rebate to the employers or individuals who purchased the plan. The purpose of the law is to ensure that health insurance premiums go to paying for medical services and to limit the proportion spent on profits and other administrative expenses. Attempts to circumvent the medical loss ratio rule popped up almost immediately. Insurance companies began attempting to reclassify administrative services (like disease and care management programs) as medical services… What constituted "medical care" became newly fuzzy and negotiable. (Mulligan 2016: 9)

As Mulligan explains, the ACA incentivized insurance companies to reclassify care management programs—of which super-utilizer interventions is one—as "medical care." In addition to the reimbursement changes described by Mulligan, the ACA also tied payments to addressing individuals' "social determinants of health" with the expectation that this would reduce spending and improve health outcomes. For example, Massachusetts Medicaid now includes two social determinants of health factors in its risk adjustment models, one of which is unstable housing (Ash, et al. 2017). Medicare is currently considering ways to account for social risk factors in its payment and incentive models (National Academies of Sciences 2017). While these changes are largely praised as a seismic shift in healthcare, they also constitute a creative mechanism by which an increasingly financialized healthcare system shifts costs and "games" the ACA reimbursement system to maximize profits.

Anthropologists have repeatedly documented the ways in which these changes in healthcare financing have adverse consequences for the poor, who are particularly vulnerable to the arbitrariness of these changes (Abadía-Barrero 2016; Maskovsky 2000; Mulligan 2017; Willging 2005). Furthermore, the poor do not conform to the apolitical, ahistorical, market-based ideals upon which these programs strive to mold patients into ideal cost-benefit aware health care consumers. Importantly, there is a highly classed component to the type of behavior that is idealized in market-based interventions advanced by the ACA. Specifically, the able-bodied middle-class subject with adequate health insurance coverage, high health literacy, and an active investment in personal health promotion. My super-utilizer informants did not fit neatly within this classed template, nor was it accessible to them on an abstract or material level—even if they did want to stop struggling with basic necessities. Thus, the while market-based social programs have a certain appeal, they necessarily de-historicizes and depoliticizes people's existence, choices, and behaviors.

For example, in her ethnography of a health maintenance organization (HMO) in Puerto Rico, Mulligan (2014) notes that managed care is based on the false premise that managing health is the same endeavor as managing money. In fact, there exist many conflicts between maximizing health and maximizing profit. For example, she notes that Puerto Rico's health reforms relied heavily on capitating primary care physicians (PCP), in other words providing a fixed stipend (capitation) per patient they managed.

> The idea is that physicians will spend more time managing their patient population and promoting preventive care if they have a financial stake in the outcome. Under this system, physicians have money deducted from their capitation for referring patients to specialists or prescribing medications. The predictable result is that the system incentivizes rationing care: the fewer referrals and prescriptions that a PCP provides, the higher his or her monthly payout from the Reforma program. (Mulligan 2014: 49-50)

Mulligan's insights are applicable to super-utilizer interventions. While these programs expand access to some services and promise for social betterment, it is notable that their most widely-extolled successes are reductions in overall costs, measured by reduced ED visits. In other words, these programs are implemented with the explicit intention of rationing health care resources. This is, after all, the foundation of any cost-containment strategy and is a longstanding component of American healthcare (with high copays for ED visits, denial of payment for lifesaving procedures, or the uneven geographic distribution of healthcare providers across the country). Super-utilizer interventions are therefore better understood as economic programs that aim to remove obstructions to the smooth functioning of a neoliberal healthcare system, benefiting in the short term a handful of patients who fit the profile of the socially disadvantaged.

These interventions are also economic in that the ACA has made the management of super-utilizers itself part of a broader healthcare industrial complex: the proliferation of programs and business addressing "the social determinants of health," the circulation of healthcare payments, the commissioning of endless reports on the status of the problem. Looming over this conversation about the United States' inordinate spending on healthcare is that our country's poor health outcomes have little to do with healthcare at all. While we pay more for health care than any other country in the world, we have forsaken other social services—education, subsidized housing, food assistance and more—that can deliver better health outcomes than any single health care intervention (Bradley, et al. 2011; Navarro and Shi 2001). Yet this simple fact, that it is our society that is making us sick, is simply ignored when the social determinants of health are swallowed up in the biomedical model of care delivery. Within the ACA and its myriad programs, the social determinants of health are not figured as a complex set of historical, political, and societal factors that becomes embodied as poor health (Adler, et al. 2008; Lynch, et al. 2000; Marmot, et al. 1997). Rather, the social determinants of health are reimagined as individual, behavioral risk factors (such as smoking and exercise) to be addressed and corrected.

And while these interventions do acknowledge that patients' behaviors should be understood as byproducts of inadequate safety-net programs or general investment in other aspects of social betterment, they do not (and cannot) go so far as advocating structural changes that might slow or end the reproduction of poverty and its myriad difficulties. Interventions remain narrowly focused on a "health is determined by healthcare" approach. The ACA's policies have therefore redistributed resources at the organizational level, deemphasizing social betterment in favor of economic containment of population costs. And while this move unexpectedly benefits otherwise abandoned and previously degraded and marginalized populations, its greatest danger is that it enables and extends the very violent economic conditions that produced their profound deprivation in the first place.

The focus on costs associated with super-utilizers further naturalizes an important assumption underlying this discourse: that patients are the costliest drains on healthcare. The ACA's emphasis on cost containment and rationing strategies further normalizes the idea that patients are responsible for the crisis in healthcare and obscures the damages done by the dominance of market-based medicine itself. This assumption is fallacious but serves an important function in obscuring the enormous economic costs brought on by the bureaucratic and corporate institutions in healthcare (e.g., pharmaceutical and health insurance industries). For example, a recent analysis using data from the Bureau of Labor Statistics and the American Medical Association found that the number of workers in the U.S. health system grew by nearly 75% between 1990 and 2012 (Kocher 2013). Further, this growth did not match the need for healthcare: from 2002 to 2012, inpatient days per capita decreased by 12% while the workforce in hospitals grew by 11%. More recently, healthcare surpassed retail as the largest American industry (Freedman 2018). Importantly, these exorbitant bureaucratic costs are more pronounced in the private insurance sector, whose administrative costs—money spent on advertising, billing, claims review, customer service, and profits—average just over 12% and can be as high as 20% (Woolhandler and Himmelstein 2017). In contrast, Medicare's most recent summary of operating costs reported just 1.4% of its operating expenses going to administrative costs (The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 2017).

In a measure intended to address this discrepancy and maximize the proportion of premiums insurance companies devote to health care services, the ACA places a ceiling on administrative costs at a maximum of 15–20% of premium income. Nevertheless, ethnographic analyses of the inner workings of health insurance companies give cause for reservation. Mulligan's ethnography, for example, demonstrates that companies are astute in their understanding of government reimbursement systems and employ creative tactics in the effort to maximize their profits. Mulligan's ethnography further details that insurance companies, despite all of their efficiency-promoting rhetoric, create duplicate bureaucratic systems, authorization procedures, and guidelines—all of which add to the healthcare costs in the US. Interventions that identify super-utilizers, create interventions, and measure the impact of these interventions adds further administrative layers to an already overly-bureaucratized industry. All of this is money and resources diverted away from spending on patients and healthcare delivery—money greatly in excess of what a small group of destitute patients can demand of the healthcare system at large (Anderson, et al. 2013). Contrary to rhetoric that portrays super-utilizers as health care gluttons, this population contributes little to the overall fiscal waste that consumes researchers and policymakers alike (Levine and Mulligan 2015).

Taking this into account, it is evident that the super-utilizer category is no more objective or value-neutral than its pejorative predecessors. While the subjective moral valuations that come with terms like gomer and crock are easy to recognize and critique, the moral discourse of high costs and over-utilization is cloaked in statistics and science. As such, the latter is both compelling and insidious—especially its unfulfilled promise to deliver a more efficient and equitable healthcare system. Despite the mask of empiricism, the production of the super-utilizer is a moral project—one that has taken shape within a broader social context already saturated with valuations of what constitutes a good patient, who “belongs” in the ED, and on whom health care resources are “wasted.” To put this another way, if the term “super-utilizer” was simply a statistical descriptor of healthcare costs, it would seem appropriate to apply the label to insurance companies or their executives and administrators. Yet these people are simply referred to by their job titles: “analysts,” “directors,” “managers,” and so on. Indeed, to call such people “super-utilizers” seems absurd and unimaginable given the distinctly pejorative, lower-class connotations carried by the label. However, we must interrogate this categorization, as well as the use of the concepts of cost, waste, and inefficiency and who gets to decide what occupies these categories. In the current moment, the term “super-utilizer” is used with the assumption that there is widespread agreement about what it means and to whom it applies, when in fact the issue varies widely when it is considered from the perspective of the patient, the health care provider, or the insurance provider. Thus, we must ask ourselves when considering what constitutes “overutilization”: costs to whom? And intervention to what end?

Likewise, we must consider what economic functions the production of a super-utilizer population performs, for it is possible to see super-utilizers not as economic drains on the healthcare system, but rather as important contributors to the industry. Today, super-utilizers—and overutilization in general—form the basis of an ever-growing body of literature demonstrating that overutilization occurs, that super-utilizers exist, and that further measures should be taken to both understand this population and curb its impacts on the healthcare system. This literature has served as the rallying cry for policymakers, who have devoted money and resources in their eagerness to do something about this out-of-control problem. Ironically, then, the production of super-utilizers serves insurance companies doubly: first by fueling investment in resources in a growing healthcare industry of population management, and (when successful) by removing an obstacle to maximizing health insurance profits. Super-utilizer programs are therefore not simply subject to economic logics, but they become industries in and of themselves, sustaining rather than challenging the neoliberal economies that produce abject poverty and deprivation.

Conclusion

For at least forty years, gomers and super-utilizers have been important figures in the healthcare discourse. The term gomer emerged in literature about the hubris of healthcare—the overconfidence in the limitless potential of medicine and its attendant technologies. The audience for this narrative began as a group of frustrated physicians and the social scientists studying them. As gomers morphed into super-utilizers, the audience for this narrative has expanded: from physicians to economists, public health researchers, policymakers, and the media. Some members of this audience are sympathetic to the plight of the poor and uninsured and try to explain the logic of their ostensibly irrational behavior and advocate for the expansion of their access to social services (cf. Malone 1998). Having situated their arguments within a cost-savings discourse and aligned it with the priorities of the ACA, these advocates have gained important investments in otherwise disenfranchised populations.

Yet we must ask if the interests of a neoliberal economy and those most alienated from its wealth can ever be the same. Interventions that provide services to the neediest people based simply on their economic costs do nothing to alter the structural conditions that reproduce and disproportionately distribute adverse health outcomes among them. In this sense, super-utilizer interventions preserve a longstanding assumption of healthcare, as if removing “problem individuals” from the system is an adequate solution. The fact remains that our society—with its concomitant racisms, inadequate public assistance programs, and various other injustices—will continue to produce unhealthy populations.

PART TWO: HISTORY AND CONTEXT

And so we dreamed and loved and planned by fall and winter, and the full flush of the long Southern spring, till the hot winds rolled from the fetid Gulf, till the roses shivered and the still stern sun quivered its awful light over the hills of Atlanta.
-W.E.B. DuBois, The Souls of Black Folk

CHAPTER FOUR: GRADY BABY

Introduction

This time, Billy was sitting across from me, a middle-aged man wearing a loose t-shirt and faded blue jeans. His graying hair peeked out from under the baseball cap that cast a shadow over half his face but didn't hide his bright smile. "I been short of breath," he summarized, quickly telling me how he had been trying to ignore his symptom but it eventually became noticeable to his coworkers at the construction site. Finally, his boss told him he couldn't go back to work without a doctor's note or some treatment. And so he found himself at the Grady ED.

It was a hot and muggy Monday afternoon, typical of early fall in Atlanta. The ED was unusually busy. Patients crowded the waiting room watching TV, engrossed in their crossword puzzles, phones, tablets, books, and generally settling in for long wait times ahead. I was screening patients as they waited: make a quick assessment, order necessary tests or treatments, and make sure that the sickest patients didn't linger in the waiting room unevaluated. I was doing my best to maximize my speed but minimize the feel of an assembly line for the patients parading past me. Billy was next on this not-an-assembly line that day.

I took his history, nodded as he spoke, interjecting with a few questions, and gave him an overview of the steps to come, "I know we just talked about this, but you'll be talking more to another provider in the back. I've ordered some blood work, a chest x-ray, and a breathing treatment for you. Let me just tell you, we're going to be with you as soon as we possibly can, but I’m not going to lie. It’s extra busy and you have a *long* wait ahead of you today.”

He gave me a knowing chuckle. “Oh, I know. You don’t gotta tell me. I been here before plenty of times. I always tell people that no matter what you got, Grady’ll get you figured out. Might take a whole day, but they’ll get you figured out. That’s what I always say. Matter fact, I was born at Grady.”

“Oh, you’re a Grady Baby!” I smiled back. “It’s always nice to meet one of you!”

“Yes ma’am. I’m a Grady Baby,” he reiterated his distinction of being born here with button-busting pride as he gathered his few belongings and followed me outside the room to get his blood drawn.

My primary concern was, in fact, in the technical aspects of Billy’s symptoms—in interpreting them, devising a treatment plan, and wading through the bureaucratic inefficiencies ahead. I was, after all, a *doctor* working in a *medical* institution; my concern was his bodily health. I was not there to socialize, but to navigate a busy and overcrowded ED. As I reflect on this brief and mundane interaction, I realize the disconnect between the significance we attach to the idea of the Grady Baby. For me, Grady Baby was an element of phatic communication—a way to personalize an otherwise impersonal interaction. For Billy, however, being Grady Baby was more than small talk. It was clearly a source of pride, of belonging to Atlanta, of a matter of identity.

In many ways, the idea of the Grady Baby signaled the importance of Grady to Atlanta’s poor and black citizens. It is important to note here, that I do not mean use “black” as a synonym for “poor.” As I show later in this chapter and throughout this dissertation, Atlanta has a long history of being home to a prominent and influential black bourgeoisie class, earning the city the reputation of being the country’s “Black Mecca.” Nevertheless, Atlanta’s wealth has never been equitably distributed and the effects of poverty have been racialized as they have been throughout the US. As a place designated to care for the indigent, Grady therefore represents an important intersection of race and class in Atlanta. For the hundreds of thousands who walk through its doors, Grady is the invariable backdrop to the joys and tragedies—births, illnesses, moments frightening and memorable—in their lives. For Billy and countless other Atlantans, Grady is enmeshed in their personal history. In many ways, the hospital is a microcosm for Atlanta itself.

As such, it also takes on board the peculiarities of race and class relations that define the city. So the term Grady Baby was used for a while to euphemistically denote “poor and black,” for people like Billy the term is claimed with pride, worn as a marker of strength and belonging in a city that is increasingly hostile to the poor and a country still negotiating its race relations (Gentry 1999). This is the operative tension that the term Grady Baby symbolizes. Having been built as *the* place to provide healthcare for the city’s most marginalized populations, Grady has itself taken on the stigma associated with its patients. Even during the inception stages of the hospital, its ideological mission of caring for the poor made it a place where deviance and disorder would be bracketed from the rest of the city. Yet, for many like Billy, the working poor for whom healthcare does not come with the luxury of choice, Grady is reclaimed as a source of pride in their lives.

Indeed, when Grady faced its infamous fiscal crisis in 2007, it called upon Grady Babies to uplift its image. A local Atlanta blogger summed it as follows:

> You know you're from ATL when…you don't have to ask what a "Grady Baby" is. Grady Memorial Hospital (that big prison looking building you see when traveling the interstate through Downtown Atlanta) is seeking all true native Atlantans who were born at the hospital for a "Grady Baby Family Reunion." The hospital, which has been plagued recently with financial difficulties and sticky fingered orderlies, is seeking to add some positive news coverage to it's [sic] newly funded organization. (Grady received a new board in May and the Woodruff Foundation just delivered the first $50 million of a $200 million donation intended to save the hospital from financial ruin.) (Atlien 2008)

Since this posting, local hip hop artists have released songs declaring themselves Grady Babies, using the hospital as a gateway to declare their indigeneity to Atlanta and to proudly highlight aspects of Atlanta that are usually marked with disorder and depravity. In one example of this, Shawdy Raw raps "I'm the original southern boy/Grady Memorial Hospital is branded on my certificate," before showcasing low-income, black neighborhoods throughout the city and harkening back to urban life before the massive waves of gentrification and urban renewal.[12] For these Grady Babies, the hospital is personalized as a way to make sense of discursive dysfunction and lack with which the hospital—and its patients—are identified.

---

[12] https://www.youtube.com/watch?v=dFzs-FXwccI

In this chapter, I first present a brief history of Grady as a history of Atlanta, both of which are shot through with classed and racialized tensions (Rutheiser 1997). I argue that Grady is a significant node in Atlanta's social fabric—a place where racialized and spatialized relations intersect (hooks 1990; Kruse 2013; Lefebvre 1991; Low 2003; Low and Smith 2006; Massey 2001; McKittrick 2011). I trace how Grady, initially intended for Atlanta's poor of all races, came to be marked as a black space fraught with corruption and bureaucratic failures that threatened to shut down the hospital in 2007 if it did not restructure its operations. This restructuring was met with widespread protest and condemnation, which was largely portrayed as an irrational attachment to a crumbling institution (Springston 2007).

I argue that this attachment to Grady and the resistance to its restructuring are far from irrational. Instead, I argue that they are a logical reaction to a longstanding history that produces Grady as an emblem of the indignities visited upon black bodies and Atlanta's ongoing inattention to its most vulnerable populations (Hunter and Robinson 2016). Although Grady is touted by many as its patients' best shot at accessing quality healthcare, it is consistently underfunded and understaffed (Dewan and Sack 2008). Because Grady serves those people whom private institutions can refuse, and elites can choose to ignore, it has in turn become marginalized itself. Like its public counterparts throughout the nation, there was little Grady could do to avoid this stigma (Ko, et al. 2014; Reich 2014). As Atlanta's place of last resort, it continues to care for its patients to the best of its abilities. It is this very function that explains Grady's continued existence. Put simply, Grady survives because it meets the needs of people that other hospitals—and the rest of the city—is unwilling to address.

Finally, I argue in this chapter that Grady is unique in its embeddedness in Atlanta's struggles with race and class, but that it is not singular as an equivocal and significant node of social relations. Grady, like hospitals everywhere, is a place where the world, and its social orders, are constantly being made and remade. Therefore, to think about hospitals as nothing more than medical institutions is "to present a lifeless universe" (Risse 1999: 4). Indeed, hospitals are far from lifeless; their significance is negotiated, contested, and reinterpreted in every interaction, from small ones like mine and Billy's to debates that play out in sensationalized headlines and national politics. I conclude this chapter with this point, arguing that hospitals cannot be fully understood via statistical methods and bureaucratic spreadsheets, but must be considered as social worlds in themselves.

Grady: A Brief History

To understand Grady's significance and place as a uniquely Atlanta institution, it is useful to briefly review the hospital's history, paying attention to times and places where race and class converge and diverge (see also: Kruse 2013; Kuhn, et al. 2005; Moran 2012; Rutheiser 1996; Stone 1989).

Even before its doors opened, Grady was inextricably linked to the race and class formations in Atlanta. The hospital was named after Henry W. Grady, a prominent Atlanta journalist who was committed to building the "New South" following the Civil War, which left the region decimated and impoverished. During the Reconstruction Era (and through the first half of the twentieth century), the politics of Georgia were dominated by white segregationists who took painstaking efforts to exclude Blacks from local and state politics. These measures included a poll tax, a whites-only primary system, and deeply entrenched Jim Crow measures throughout the state.

Yet alongside this brutal and deeply entrenched racism grew a powerful community of Black educators, entrepreneurs, and civil rights leaders famous the world over. Thus, dating back over a century, Atlanta's history is a "tale of two cities": one host to the headquarters of the revived Ku Klux Klan, the other a Black Mecca.

Though Henry Grady was widely considered a progressive by the standards of his time, he was nevertheless a byproduct of segregationist, white supremacist politics in Georgia. His ambition was to fashion the "New South" from the ashes of the Civil War. Atlanta was a lynchpin in his vision. Grady sought to take advantage of cheap Southern labor (both white and black), which he imagined, with the help of Northern capital, would transform Atlanta into a city of affluence and prosperity. This, he believed would restore the South as a hub of national political influence—a platform dubbed the "Grady Doctrine" (Brattain 2001). Grady recognized that health was a prerequisite for productivity and advocated for the construction of a public hospital in the heart of Atlanta. This, he argued, would contribute to the infrastructure and health of the city, thereby boosting the available labor force and attracting investment. However, the realization of this dream was initially met with resistance and controversy.

The idea of a public hospital in Atlanta drew protracted and heated political debate. Detractors feared that the opening of a public hospital facility in Atlanta would “attract paupers [who] failed to understand the difference between a hospital and a poorhouse” and whose presence would detract from Atlanta’s positive image (Moran 2012: 9). In fact, and as I elaborate in Chapter Seven, there was little distinction between a hospital and poorhouse during this time. Still recovering from General Sherman’s “March to the Sea,” Atlanta had been reinvented as a city that was naturally healthy and prosperous—and conducive to investment and entrepreneurship. This argument was furthered when the Great Mississippi River Basin Yellow Fever Epidemic of 1878 bypassed Atlanta. The epidemic, which killed nearly 20,000 across the South, miraculously infected only six people in Atlanta, with one resultant death (Ellis 2015). Atlanta’s residents took the absence of the epidemic in their midst as proof of the city’s immunity to disease and pestilence and its natural predisposition to become a hub of capital investment. An influx of diseased and dependent paupers could only threaten city’s image and business interests, they argued.

The need for a public hospital eventually became evident with the advent of two important events. First, technological innovations (e.g., x-ray machines) transformed the hospital from an almshouse into a respectable institution, landing injured well-to-do persons onto hospital wards. Noting that hospitals were springing up throughout the urban US, and recognizing the economic opportunity they presented, Atlanta leaders eventually agreed to publically finance a hospital for the city’s impoverished citizens of all races. The inclusion of black Atlantans in this plan was predicated on their value as laborers, and a recognition that an investment in health would maximize this value. This entailed a shift in discourse from disinvestment in the poor and disregard for public health to a generalized agreement that civic betterment was essential to economic development. Thus, the stage was set to build Atlanta's first major hospital. The second event that propelled the plans for establishing the hospital was, ironically, the untimely death of Henry Grady. Drawing on the shock of his death and honoring his dogged advocacy for a public hospital, Atlanta's leaders set out to build the charitable institution in his honor. The hospital opened its doors to the public in 1892.

Reflecting the social order of its time, the hospital's facilities were segregated along the lines of race, gender and class. Black patients were relegated to overcrowded and understaffed quarters, and growing waiting lists for admission to the precious few beds available to black patients. Grady was one of the few medical facilities available to black Atlantans in the Jim Crow era, housing up to three quarters of the city's black patients at a time (Kuhn, et al. 2005). It was not until the passage of the Civil Rights Act of 1964, which linked Medicare payments to hospital desegregation, that hospitals were desegregated across the US. Yet the legacy of racial segregation persists today in the physical structure of the hospital itself, which is shaped like an "H" with the previously black and white quarters joined by a single hallway. Just as there had been two "Atlantas," one white and one black, there were also "Gradys," a moniker that persists among older patients today and signals the racial divisions that continue to define Atlanta.

The indignities of segregation were not simply limited to poor black Atlantans; they also extended to its bourgeoning black bourgeoisie. For example, until the 1940s, there were no black physicians on staff at Grady or in any official public health positions in Georgia. Black doctors were shut out from the state and county medical societies and, by extension, from the American Medical Association (AMA). Consequently, white doctors had exclusive rights to admit patients to the hospital's segregated facilities, as described by one black physician:

> You'd contact him [a white doctor]… He'd come over, look him over and agree with your diagnosis. Then *he'd* put him into Grady Hospital and operate on him. That's the way it worked. You couldn't do it, your face was black. I couldn't put anybody in there—because of segregation. I couldn't even visit there as a doctor, I went in as a visitor that visited somebody. If I went in Grady Hospital, I didn't go in as Dr. Nash, I went in as a visitor. You lost your patient at the front door. When the patient got there he belonged to somebody else. The thing has just been that tight. (Kuhn, et al. 2005: 243)

While this doctor describes being shut out of Grady on professional grounds, it is likely that he was also shut out on socioeconomic grounds. Grady was designated an indigent care hospital, dedicated to caring for Atlanta's poor. Atlanta had the peculiar problem of having "too many" middle and upper-class black residents: an Urban League report published at the end of World War II reported that "over half of Atlanta's black population had incomes high enough to disqualify them from treatment at Grady" (Kuhn, et al. 2005: 244). With black hospital beds in short supply, Atlanta’s well-to-do black residents had to travel large distances to obtain care at Johns Hopkins in Baltimore or even as far as the Mayo Clinic in Rochester, Minnesota (Kuhn, et al. 2005).

It was this population of black elites that earned Atlanta the title of America’s Black Mecca. In the 1950s, Atlanta’s Auburn Avenue was hailed as the richest black street in the world, and black Atlantans represented a large and growing portion of the city’s electorate (Inwood 2010). This capital was leveraged into a tenuous alliance between Atlanta’s black and white bourgeoisie classes that has and continues to shape the city. For example, In the 1950’s and 60’s, during a time of widespread and well-documented racial unrest that threatened to disrupt the massive flows of capital in the city, Atlanta’s black and white business elites negotiated limited and carefully circumscribed civil rights reforms in exchange for black votes, economic growth, and civic order. Whereas civil rights gains throughout the United States were achieved by a combination of grassroots resistance and landmark court decisions, Atlanta’s racial “progress” was accomplished via bilateral negotiations and patronage relationships that maintained elite business interests. Simply put, when city officials were “forced to choose between the social customs of segregation and the economic creed of progress, they readily chose the latter” (Kruse 2013: 37). As a result, Atlanta branded itself as a bastion of racial tolerance within the recalcitrant Deep South. Its reputation for civic order, economic growth, and racial moderation inspired its mayor William Hartsfield to declare it a city simply “too busy to hate.”

Although Atlanta's black and white elite coalition is credited with many of the city's accomplishments, the alliance proved fragile in the face of growing white working-class rebellions against Atlanta's expanding black community and its civil rights victories of the 1950s and 60s. And while small cells of rabid white supremacists garnered media attention and were ultimately suppressed by judicial and legislative measures, the toned down ideological rhetoric of neighborhood defense strategies, property rights and whites' rights to "freedom of association" were far more successful in skirting the demands of the Civil Rights Movement. This successfully facilitated white flight out of the city and maintained residential segregation (Kruse 2013). White suburban Atlantans were thus primed for a hostile resistance to any physical or symbolic bridge to black Atlanta.[13]

Although Kruse focuses primarily on housing segregation, the battle to desegregate the city was waged on multiple fronts. Grady was no exception. The hospital had, since its inception, been open to poor patients of all races, but segregationist roots remained deeply entrenched. This tension played out on the hospital's wards, which remained segregated even after the hospital integrated its staff. In 1965, a Supreme Court ruling ordered the integration of hospitals' facilities and services and threatened to withhold payments of hospitals that did not comply with the order. After years of consternation about how whites would react to the integration of hospital rooms, the hospital was integrated with a flat, unmemorable announcement: "All phases of the hospital are on a non-racial basis effective today.

---

[13] Although this narrative may be used to reinforce notions of Northern elitism, Kruse is also careful to point out that the white response to desegregation in Atlanta is hardly unique. Throughout the US, overtly racist and segregationist ideology gave way to docile, acceptable (and much more successful) discourse of property rights and personal freedoms (see also: Darden, et al. 1987; Sugrue 2014).

We are grouping patients strictly on their medical needs. All outpatients, all inpatients, and all heart patients, etc." (Moran 2012: 193).

Yet the desegregation of the hospital occurred as white residents were leaving the city of Atlanta in droves. Ironically, in 1970, in the wake of desegregation, Atlanta was of only three black-majority cities in the US and was three times more segregated than it was in 1940 (Dameron and Murphy 1997; Moran 2012). Having confined themselves to the suburbs and successfully framed this under a neutral—even upstanding—property rights discourse, white Atlantans had created an even more deeply segregated metropolis (Moran 2012). Grady's patient population reflected this demographic shift, becoming a space for black people of all classes and representing urban blight for white people of all classes.

As an extension of the black bodies it served, Grady became the target of white Atlanta's racism and resentment for having to support city services that they ostensibly didn't use. In the same way they didn't want to pay for Atlanta's schools and parks, they argued that Grady was simply another service they did not use. The success of this rhetoric was built largely upon an association with Grady as an emblem of Atlanta's poor black core. Grady, much like its constituency, could only be seen as a liability, rather than a vital city and state resource. Consequently, the institution was repeatedly maligned as a corrupt and wasteful hinterland whose only useful function was to harbor the undesirable.

Space, Pride, and Community

This section turns to present-day Grady, and the politics that constitute it as a black space, one that is alternately maligned and tolerated for the role it plays in Atlanta.

Hostility to Grady and its support mirrored responses to the convergence of the city's other public resources. Put simply, white suburban Atlanta wanted nothing to do with the facility or its funding. Elaborating on this problem, one administrator compared Grady to its public hospital counterparts across the country:

> There are only a handful of institutions like this in the country. If you look at the major funding streams for other places: in New York Bellevue, you have the New York City Hospital Corporation, which is like its own local healthcare entity. It's its own social security network basically. You look at a place like Shock Trauma [in Baltimore, Maryland], which is funded by state taxes. We're a state a resource without the state resources and there's just no political will to get [funding for Grady].

The financial abandonment of Grady matches Atlanta's (and Georgia's) general disinvestment in the poor and their institutions. "The problem," notes physician historian Martin Moran, "was that the poor didn't like going to public hospitals, local officials didn't like to raise taxes to support them, and 'taxpayers resent their taxes going into facilities for the poor'" (Moran 2012: 222).Moran's pithy summary captures the general disinvestment in the poor and the disdain for poverty alleviation programs that persists today. Yet Moran's assertion that the poor don't *like* going to public hospitals rests on two interrelated assumptions: first, Grady is inherently a second-rate institution and, second, that one would only go there as a last resort. Thus, Moran assumes that the marginalized and the elite are in agreement that the hospital is failing and degenerate. What separates them is only the choices available to them.

It is worth noting, however, that the hospital cannot be separated from the patients it serves. Another Grady administrator described it in the following way:

> People still see Grady as the safety net, so it's still the place to go if you can't go anywhere else. That's both inside the city, inside the county, but even external counties. I think there's still a perception that Grady's the place to go if you don't have any options, if you don't have any choices, if your economics are limited or none.

As this quote points out, impoverishment and disenfranchisement constitute Grady's patient population, and they, dialectically, constitute Grady as a "backwards" and "substandard" space. Thus, like the ideological constructions of "inner city" problems, Grady is synonymous with corruption, violence, gangs, drugs, and the endless perils of urban poverty. Grady—and particularly its ED—is represented as a space of "pathology," "crisis," or "disorder." These connotations—all thinly veiled references to race—stand in stark contrast with white spaces associated with modernity, development, and stability.

These stereotypes manifest themselves in outright disdain by some Atlantans who simply refuse to be treated at Grady due to broadly held views that render the hospital akin to "the heart of darkness."[14] Much like Joseph Conrad's

---

[14] Based on Joseph Conrad's (1902) own experiences traversing the Congo River, *Heart of Darkness* details the harrowing journey of an English ivory trader through the African jungle, in

(1902) depiction of the menacing jungle, descriptions of Grady are often rooted in images of destitution and mayhem. When I first moved to Atlanta in 2003, and in the months before I began my residency, respectable Atlantans warned me not to judge the whole city by what I would surely see at Grady—drugs, shootings, and general "craziness." These were just the city's bad apples that didn't represent the respectable portions of the city. Some simply said that Grady was *the* place to train in emergency medicine; it was a place where you would see *everything* (surely another euphemism for the pandemonium of urbanity). Others still shook their heads and offered their sympathy in the same way they would express it over the tragedies showcased on the evening news.

Conversely, for those who dare tread into the "heart of darkness" and survive to tell about it, the experience confers instant legitimacy. In a recent example, Republican lawmaker Tom Price became Donald Trump's Secretary of Health and Human Services. As a former US senator, Price was no stranger to politics or publicity, but his nomination caused renewed media interest in his career and his political record. In the process, his experience as the medical director of the Grady orthopaedic clinic became a major talking point in the media. Drawing on depictions of Grady as a "vast, chaotic, aging complex," his supporters argued that he had a firsthand knowledge of healthcare's deepest problems, while his opponents lamented his betrayal of the people whose struggles he had witnessed firsthand

---

which he witnesses firsthand colonial brutality and came away critical of the artificial divide between the "civilized" and the "savages" created to maintain and justify colonialism. Though widely celebrated in the first half of the 20th century, the novel was first condemned by Chinua Achebe in 1975, and by many scholars since. Achebe's criticism was that Conrad's critique of colonialism dehumanized Africans by recapitulating racist notions of the "dark continent" and its primal jungle people.

(Goodnough 2017). Despite their deep ideological divisions, Price's advocates and detractors both drew on similar imageries of social decay. For conservatives, this was incontrovertible evidence that government intervention had failed and the fix was a withdrawal of subsidies and support. For liberals across the aisle, this was irrefutable proof that the status quo must not only be defended, but expanded.

It is notable that politicians across the ideological spectrum took for granted that Grady is associated solely with poverty, destitution, and isolation. Though they disagreed bitterly about the next steps, lawmakers and journalists alike agreed that Grady's woes are products of a putative social "sickness," one that must necessarily be "cured." In the process, they overlooked the reality that Grady—and its woes—are products of a long history of a simultaneous and paradoxical neglect and exploitation of its resources. For them, Grady was simply a poorly run medical institution, a corrupt and failing business—a case study in American healthcare, but detached from Atlanta writ large.

How, then, can we reconcile narratives of Grady as a hospital in perpetual ruin and the pride that comes with declaring oneself a Grady Baby? To answer this question, it is useful to return to Billy, who, despite his pride in calling himself a Grady Baby, did not actually *want* to come to the hospital. He was a construction worker, a job that conferred no benefits or stability, and left his fate at the whims of forces outside his control (e.g., unexpected illness, economic downturns, etc.). On the day I met him, his illness had caught the attention of his supervisor and he was made to come to the hospital at the risk of losing his job. Billy didn't consciously think about where to go. That he would go to Grady, where he had been going his whole life, was a foregone conclusion. The grueling wait times and overcrowded facilities were part and parcel of the experience.

For Billy, most of the circumstances that converged to make him a patient on the day we met were outside of his control: his illness, the precarity of his employment, the deficiencies of American healthcare, and the historical peculiarities that made Grady the place for him to receive care. Declaring himself a Grady Baby, thereby personalizing his experiences at the hospital and ordering his life history was a way by which he could reconcile these factors into an orderly narrative. Moreover, taking on the label of being a Grady Baby was a way in which Billy could place himself within a collective experience that often goes unacknowledged in Atlanta.

Psychiatrist Mindy Fullilove offers an instructive framework to help understand why one would cling fiercely to a hospital with widely documented shortcomings and ostensibly no redeeming qualities. Fullilove turns her attention to urban ghettos, and the people living their lives within them. She writes,

> Urban ghettos were vilified as places of shame and dysfunction. Though filled with the poor, though incorporating red-light districts, though inhabited by con men and robbers, residents taught me that those neighborhoods were places where people shared with one another… People had in common the pressures of daily life. People had in common the struggle to survive in the face of racism. And though such pressures might turn people against one another, in

> those places it made for a great deal of kindness. (Fullilove 2005: 121-22)

Indeed, this is reminiscent of Grady, a place vilified and pathologized, but where people similarly marked with shame and dysfunction can bring together their individual lives into a collective experience. Fullilove further describes the personal and collective trauma associated with the loss of these spaces:

> It was the loss of a massive web of connections—a way of being—that had been destroyed by urban renewal; it was as if thousands of people, who seemed to be with me in sunlight, were at some deeper level of their being wandering lost in a dense fog, unable to find one another for the rest of their lives. It was a chorus of voices that rose in my head, with the cry, "We have lost one another." (Fullilove 2005: 4)

Noting that psychiatric diagnostic categories such like post-traumatic stress disorder (PTSD) were too limited to capture the complexities of displacement, Fullilove terms this "root shock." In contrast to PTSD, which is experienced and identified at an individual level, root shock derives its power from its attention to *collective* experience. Fullilove not only shows how surroundings (or, to use her word, ecosystems) are an integral part of relationships between people and across generations, she demonstrates that these surroundings are themselves extensions of the collective bodies that inhabit them.

In turning our attention to the surroundings to the setting in which social life happens, Fullilove powerfully illustrates the distinction between space and place.

Place is more than a brick and mortar backdrop to daily life; it is the “fusion of space and experience” (Friedland 1992: 13). In other words, space is a physical setting or a backdrop detached from social life, whereas place is produced by social life (processes of exclusion, discrimination, solidarity, and protest, to name a few). As Henri Lefebvre writes,

> Space is neither a mere “frame,” after the fashion of the frame of a painting, nor a form or container of a virtually neutral kind, designed simply to receive whatever is poured into it. Space is social morphology: it is to lived experience what form itself is to the living organism, and just as intimately bound up with function and structure. (Lefebvre 1991)

Places are not shaped by faceless forces; they are actively accomplished by people acting in groups and coalitions to achieve (or resist) various ends. In the process, qualities are ascribed to the physical features of a space: beautiful or ugly; safe or dangerous; public or private; rich or poor; black or white; accessible or not (Gieryn 2000). The very divisions of a space into “neighborhoods” is not a logical or inevitable byproduct of spatial arrangement of streets, houses or buildings. Rather, it is an ongoing production of local histories, economies, and imaginations. Simply put, social organization and spatial organization are integrally connected, fundamental components of social structure and action.

Even when they have not paid explicit attention to place, anthropologists have nonetheless signaled its importance in human life (cf. Cassell 2005; Geertz 1972; Latour and Woolgar 1979). Every ethnographic context and its social interactions—inequality, difference, memory, and so on—is emplaced. In *Yearning: Race, Gender, and Cultural Politics*, bell hooks (1990) illustrates this in describing the trauma she experienced in the wake of her school's desegregation. Though careful not to romanticize the savage realities of the Jim Crow era, hooks argues that black schools represented a place of community and shelter, where children didn't fully understand the reality and brutalities of racism and, for a brief period, were allowed to maintain their innocence and ignorance of the discrimination to come. She relates, for example,

> With no shame, I confess to bearing a deep nostalgia for that time, for that moment when I first stood before an audience of hundreds of my people in the gymnasium of Crispus Attucks and gave my first public presentation. I recited a long poem. We had these talent shows before pep rallies, where we performed, where we discovered our artistry. (hooks 1990: 34-5)

She recalls the subsequent trauma of desegregation and the pain of attending an integrated school, "I sat in classes in the integrated white high school where there was mostly contempt for us, a long tradition of hatred, and I wept. I wept throughout my high school years" (hooks 1990: 34). Integration therefore represented a sense of profound loss—a loss of community, history, and shared experience.

For hooks, black schools were laden with the power to produce counter hegemonic practices, to question the limits and possibilities that exist within an otherwise hostile world. She terms this “homeplace,” in which she denotes that safety and radical, transformative potential of black place. She writes,

> Historically, African American people believed that the construction of a homeplace, however fragile and tenuous (the slave hut, the wooden shack) had a radical political dimension. Despite the brutal reality of racial apartheid, of domination, one’s homeplace was the one site where one could freely confront the issue of humanization, where one could resist. Black women resisted by making homes where all black people could strive to be subjects, not objects, where we could be affirmed in our minds and hearts despite poverty, hardship and deprivation, where we could restore to ourselves the dignity denied us on the outside in the public world. (hooks 1990: 42)

In other words, homeplace is a means by which political collectivity could be realized, formulating strategies and acts of resistance to persevere and progress in the world. In a society with ever-widening class differentiation and racialized inequalities, homeplace allows resistance and struggles, particularly with regard to what it means to live, work, and struggle in a space removed from racist aggression.

As expressions of overt and violent racism retrenched in the post-Civil Rights era, these black spaces were ostensibly desegregated and depoliticized. Simultaneously, a “colorblind” approach to racial difference came to predominate, which posited that an examination of racial difference was, in itself, racist. Widely advanced in schools, institutions, and the judicial system, the colorblind position perceives differences as either trivial or unmentionable. This colorblind stance Cornell West argues,

> sets out to show that black people were really like white people—thereby eliding differences (in history, culture) between blacks and whites. Black specificity and particularity were thus banished in order to gain white acceptance and approval… These responses rested upon a homogenizing impulse that assumed that all black people were really alike—hence obliterating differences (class, gender, region, sexual orientation) between black people. (West 1993: 17)

In the process, hooks argues, they have advanced a more insidious, albeit more sterile and outwardly acceptable, white supremacist narrative—one "informed by the very structure of racist domination black civil rights struggle sought to change" (hooks 1990: 36). In other words, this colorblind politics perpetuated inequality not by demanding that black subjects conform to a certain standard of whiteness, but by demanding that they identify with a narrowly defined standard of blackness. This representation of black people as an undifferentiated mass acting together through civil society is, at best, over schematized (Williams 1997). Homeplace provides the opportunity to interrogate and defy these systems of power.

In defining homeplace within black communities, hooks defies popular conceptions of space as vacuous and apolitical. She contends that environments are not only built, they are imagined, interpreted, and lived (Gieryn 2000). Similarly, Hunter et al. (2016) present more recent examples of placemaking in Chicago, where the onslaught against public housing has led to the “wholesale evisceration of the apartments, streets, playgrounds, corners, hallways, and community centers where thousands of black families once lived” (Hunter et al. 2016: 40). Despite the concerted efforts to erase the legacy of these communities, former residents gather annually to celebrate one another, share joyful memories of friends and family members, and to honor the legacy of loved ones lost along the way. “It’s about home,” remarks an attendee of one reunion, adding, “Even though it’s not physically here” (Hunter et al. 2016: 41).

For these residents, gathering together is to remember the past is a way to make a claim about belonging in the present—a way to defy city leaders’ attempts to redraw the map and scrub it clean of their collective memories and experiences. These reunions therefore deliberately celebrate and create sites of pleasure as modes of asserting belonging. Like claiming oneself a Grady Baby, this personalization of difficulty is posed in direct response to a spatialized political order that renders certain groups unworthy of stable housing, full access to healthcare, steady employment, and so on. And while this is easily read as a vehicle for stigma, inequality, and discrimination, hooks and others remind us that this is also has the potential to produce conditions of solidarity and mobilization (hooks 1990; McKittrick and Woods 2007; Zhou 2010). Said differently, spatial segregation paradoxically breeds both alienation and solidarity. Thus, proudly asserting belonging to these purportedly failing places and institutions is a way to make sense of forms of spatial organization that are constantly changing, while nevertheless maintaining their exclusionary forms (Massey 2001; McKittrick 2011).

Insofar as Grady is an extension of Atlanta's public space, it is constitutive of the same kinds of race and class fissures that compose the city itself. Its wards and ED have historically played out the city's ever-evolving race and class dynamics, putting a spotlight on the wealth and influence of Atlanta's black community, as well as the rampant poverty untouched by its reputation for affluence. This class- and race-based segregation is based on two interrelated exclusionary processes: First, on a "politics of fear," which facilitates the policing and displacement of menacing others; second, on a "politics of forgetting" in which certain bodies are rendered invisible (Fernandes 2004). In Atlanta, and in cities across the US, these process unfold through the spatial reconfiguration of race and class inequalities (Massey and Denton 1993). Indeed, Grady's existence has been a product of these configurations since its inception over a century ago.

Despite these attempts to render the poor invisible, the "quality of life" that Atlanta leaders pride themselves in maintaining is depends on the manual labor of the urban poor like Billy. Arjun Appaduri points out, for example, that "in all societies based on financial apartheid, one wants the poor near at hand as servants but far away as humans" (Appadurai 2000: 637). In Atlanta, a city emblematic of financial apartheid, Grady plays a key role in keeping the poor available for servitude and invisible as humans.

Yet Grady is also a place in which that invisibility is contested and challenged. Consider, for example, the case of Michael, an elderly man I met during an otherwise uneventful day of fieldwork. It was a hot summer day and the waiting room was teeming with patients, many of whom were bored, irritable, and vocally expressing their resentment at the long wait times. Michael walked into the waiting room from the triage area and looked around for an empty seat. Seeing few options, he chose a vacant chair next to me. Michael had a small frame, light brown skin, and white, neatly combed short hair. He was just over five feet tall, but he stood tall and had an undeniable presence. His collared shirt and slacks were pressed perfectly and I could smell his cologne as he sat down. I smiled awkwardly as he approached me, unsure if he would want to talk or if he would rather be left alone. As he settled into his chair, the evening news blaring on the television overhead provided a convenient icebreaker.

As we talked, Michael eyed my wrists. Noticing that I had no patient wristband on, he asked if I was here with someone. “No. I’m actually doing research here.” As I got ready to explain what I was doing in the crowded waiting room, I noticed his mouth curl into a smile. He nodded as I told him of my interest in Grady’s frequent visitors, responding eagerly, “I know all about that. I’m a Grady Baby. I’ve been coming here all my life, too. Going on 92 years December.”

I opened my mouth to clarify that his lifelong history of being a Grady patient was not exactly what I meant by “frequent visitor,” but his proud declaration of his age took precedence. “Wait, you’re 91?!” I blurted out, unable to contain my disbelief.

“Oh, yes,” he nodded, his smile getting wider.

As I told him that I never would have guessed his age correctly, I did some mental arithmetic, putting together that he had *lived* the Grady history with which I opened the chapter. Eager to review and validate this information, I asked him about the old hospital—a small, unassuming building that now houses the MRI suite—and followed up with questions about how the neighborhood and hospitals had changed in his lifetime. Michael obliged my questions about the physical space, but he was more interested in Grady as a *place.* He told me how his wife, now aging and chronically ill, was in need of more and more medical attention, all of which she sought at Grady. Their children, grandchildren, and great grandchildren had been born at Grady and received medical care here exclusively throughout their lives. He took out his wallet to show me pictures of his family—four generations of Grady Babies. "We're all Grady patients," he summarized. I probed for why Grady was his hospital of choice, versus so many others in Atlanta. "That's a good question. I don't really know. It's like something that's passed along in the family. It's just our hospital. We don't know about no other hospital…" He paused for a few seconds. "Well, of course *we know* about other hospitals. We just come to Grady. We're Grady patients," he repeated summarily.

My conversation with Michael went on for nearly two hours, until it was eventually interrupted by his name being called for further treatment. At the time, I thought it little more than a pleasant detour as I was waiting for *real* fieldwork to happen. No one, least of all me, would have identified Michael as a super-utilizer. But in the weeks and months following our meeting, I replayed our conversation frequently, noting that he did not mention race—nor the various stages of segregation, desegregation, and (re)-segregation that he had lived through. I didn't have the perspective during our conversation to bring it up explicitly or meaningfully. I knew however, from my fieldwork and years of being embedded at

Grady myself, that race was rarely offered up explicitly as reason to come to Grady or the reason that Grady is understaffed and underfunded. While some patients would complain openly and bitterly that racism was a factor in their mistreatment, few patients or staff openly acknowledged race as an explanation of why Grady has come to exist—and persist—in its current form.

As I have argued, however, the history of Atlanta has unfolded through complex interactions of race and class. Within these processes, Grady points to a central paradox in understanding the ways in which class and race politics operate in Atlanta. On one hand, Atlanta's black bourgeoisie represents a visible embodiment of the ways in which capital can transcend identity politics and confer benefits across races. On the other hand, Atlanta's history and the political dynamics of its black middle- and upper-classes rest on a political project of rendering the (mostly black) poor and working classes invisible. Within these active political processes of exclusion, Grady becomes one of many spatial practices that segregate and marginalize the poor. Yet rendering the poor invisible and severable is at best a contradictory process, for Atlanta, and even the rest of the state, depend upon Grady to naturalize these exclusionary practices.

A Safety Net for All

Thus far, I have considered how Grady is produced as a bounded space by the economic, social, and racial forms of Atlanta. Grady is simultaneously socially constructed by multiple framings drawing on historical, political and moral understandings of its role in the life of the city. But despite the social fact of these spatialized and racialized inequalities, it is not enough to simply divide Atlanta into various exclusive zones and simply categorize Grady as one of these. This would not sufficiently recognize the web of connections that characterizes everyday life in Atlanta, and would further the fallacy that Grady is a place unto itself.

I have primarily highlighted the ways in which many of ED patients derived dignity from being associated with Grady, and its undeniable legacy in Atlanta. To be sure, however, many of these same ED patients and super-utilizers also readily accepted the dominant narrative of Grady as a place of last resort—one that they had been relegated to due to their lack of healthcare coverage, poverty, or "excessive needs." Many told me that they tried to seek care at other hospitals, only to be told that there was no help to be offered without insurance or exorbitant cash payments. Given the choice or resources, they would have readily gone somewhere more "efficient." Their narratives mirrored dominant narratives of Grady as a site dysfunction that had been produced and reproduced across decades in Atlanta. They also mirror my informants' personal experiences of having attempted to seek care at more reputable institutions, only to be turned away and told to go to Grady, where "care is free."[15] Discussing the idea of providing "free" care to patients, one doctor compared healthcare to the fast food industry. He explained,

> A place like McDonald's would yell at you if you came and didn't pay. We [at Grady] don't yell at people if they come. We can ask for money, but the truth of the matter is it comes with some legal issues, and who we are. We don't kick you out if you can't pay. So even if you did go back to McDonald's every day and you didn't

---

[15] In fact, care at Grady is not "free" and often requires many bureaucratic hurdles to obtain.

> pay, they would yell at you. We don't do that, so it's safe for people.

Within this quote, "who we are" stands in for Grady's role as the metro Atlanta region's safety net health care provider—*the* place tasked with caring for poor that are turned away from other hospitals or excluded from other domains of social life.

Grady patients, despite their critiques and complaints, remain deeply dependent on its services, as is the rest of the city and state. Atlanta's white population (and the rest of the state of Georgia) continues to benefit from Grady's services while consistently arguing that it should not have to fund an institution that it ostensibly does not use. These services range from regional trauma care, to the only burn center in north Georgia, to city-wide ambulance services, among many others. However, this narrow definition of "use" ignores the various ways in which these populations utilize Grady's services. These populations draw on regional trauma and burn centers, and its education of nearly a quarter of the state's doctors and healthcare providers.

These modes of utilization are rendered invisible in ways that mirror other forms of resource exploitation and extraction throughout the world. Capitalist accumulation operates through translocal systems of surplus extraction and uneven development, while masking this extraction under the dichotomy of the "developed" and "developing" worlds (Soja 1989). Similarly, Grady's resources are exploited by other Atlanta hospitals in a way that maintains a dichotomy of the "failing" and the "successful" hospital, where in reality these are mutually dependent phenomenon. For example, other hospitals have consistently sent their indigent and uninsured patients to the “Grady Curve” along the I-85/75 highway to get medical care. The result is a form of segregation by race and class, whereby Grady is the warehouse for the subaltern sick. No matter how far away from Grady, those who are deemed a “drain” on resources—poor, black, undocumented, homeless, or uninsured or underinsured—will likely be referred to Grady.

Hospitals in the region continue to balk at caring fully for the poor and uninsured, who are often advised to simply go elsewhere to seek care. This maintains the solvency of hospitals but also puts a financial strain on Grady, which has been under-resourced and under-funded throughout its history, despite funding from Fulton and Dekalb Counties, as well as state and federal agencies and private donors. And while Atlanta’s white suburban population was unified in its opposition to funding Grady, voices in support of the healthcare system now primarily responsible for caring for Atlanta’s sick and indigent was ironically left with few voices of support. Their EDs remain available for the direst forms of care, but they do little to counteract the reality that we’ve abandoned the sick and the downtrodden among us.

The practice of diverting the poor and the uninsured to Grady not only maintains the solvency of other hospitals but adds to the chronic financial strain on Grady. And while those in support of Grady often decry that “Grady is just different” (because of its mission, its patient population, or its lack or resources), I maintain other hospitals—indeed, Atlanta’s healthcare system—are the way that they are because Grady keeps them afloat, often shouldering their responsibilities for their uninsured patients. Many people came to the ED after long and disappointing waits at other hospitals, having been denied necessary (even if "non-emergent") treatment for their conditions.

I took care of a woman who had traveled from Gainesville, Georgia (over an hour north of Atlanta), to be seen at Grady for vaginal bleeding that had been troubling her for over a year. Three times over the past year, she had to go to the ED. The bleeding was severe enough that she needed blood. She was given a blood transfusion, diagnosed with fibroids and told that she would need a hysterectomy at a later date. Although her bleeding was considered an emergency, but the underlying cause of her bleeding—the fibroids—were not. She was instructed to make an appointment for a hysterectomy at a later date—an impossibility since she was uninsured.[16] Eventually a doctor told her to go to Grady because she could access "free" care there. Like other patients that had traveled great distances to come to Grady, she told me that she was there because "nowhere else would help." For them, the emergency department represents a door ajar within an otherwise convoluted and inaccessible healthcare system.

In a particularly egregious example of this, I was called over to see a patient who drove from Valdosta, nearly four hours south of Atlanta, at the behest of her doctors. As I introduced myself to Maria and asked for the reason for her visit, I was met with a most unexpected answer: "I'm here for a heart transplant." I stood in front of her quietly, knowing that we wouldn't be able to meet her request and wondering how best to move forward.

---

[16] Although the ACA expanded access to health insurance across the country, many people were left without insurance. For further information on this, see: Garfield, et al. 2016.

“Okay…” I began slowly. “Can you give me a little bit of background on what’s been going on and how you ended up here today?”

Maria explained to me that she was originally from El Salvador. She had been living in a small town in South Georgia for ten years, traveling to Valdosta for her medical care. She had made a home in Valdosta, but had no papers or legal claims to her new home. Almost two years ago, Maria welcomed her daughter into the world but her joy was soon overshadowed by a diagnosis of postpartum cardiomyopathy, a rare form of heart failure that left her having to keep track of a complicated and expensive medication regimen in addition to her new responsibilities as a mother. Somehow, she had managed to take her medications, she told me, but her condition only worsened. She now found herself breathless with even the most mundane tasks; she was struggling to keep her job and take care of her child.

“I’ve been getting worse and worse. The doctors at Valdosta, they said that the next step is to get a heart transplant. But they don’t do that over there, especially since we don’t have insurance or the money for it. They told me to come to Grady for a transplant. They said that you guys take care of people for free. That you’d be able to help.”

I searched for words silently as Maria held my gaze expectantly. Getting a transplant of any sort is a long, painstaking process involving bureaucratic, financial, and medical considerations—all of which were unavailable to her as an undocumented person. Moreover, organ transplants are performed at select medical centers, of which Grady was not one. I finally began, “I’m sorry to tell you that you won’t be able to get a heart transplant today…” My explanation of the process of getting on the heart transplant list, and the bureaucratic process of being seen at Grady was ultimately unsatisfactory. “But I’m sick *today. Now,*” Maria reiterated, her voice rising to match the gravity of her situation.

“I know. And I wish there was something I could do today…”

“But if I go home, I keep taking my medicines, I know that I’ll keep getting worse,” she interrupted me, clearly exasperated. “If something happens to me… I did what I was supposed to do. *Who will be responsible?*”

Invariably, Grady is held responsible—by its patients, by other hospitals, and by politicians who expect the hospital to buffer the effects of profound poverty and inequality in Atlanta and the rest of Georgia.

Ironically, it is Grady, which is produced as a site of lack and dysfunction that is simultaneously tasked with caring for Atlanta—and Georgia’s—most vulnerable populations. This longstanding contradiction eventually proved unsustainable, eventually coming to a head with a highly publicized crisis in 2007. Spurred by increasing patient volumes and resource demands, along with financial and political disinvestment from Atlanta and Georgia’s governing bodies, its budget deficit topped $60 million at the peak of this calamity (Dewan and Sack 2008). Inspections revealed nonfunctional medical equipment, sanitation troubles, and record keeping problems that threatened to close the hospital permanently.

Local and national media spotlights were fixed on the flailing institution. One *New York Times* article highlighted broken equipment, outdated modes of healthcare delivery, and poor patient outcomes in the face of stagnant fiscal support and growing uninsured populations (Dewan and Sack 2008). Yet another highlighted the hospital's strained dialysis unit, which was also forced to close due to financial constraints—though not without a protracted and highly-publicized legal battle (Sack 2009a).

The media coverage focused primarily on Grady's technical failings as a hospital: its inability to measure up to standards required of all hospitals receiving state and federal funding. On some level, this constituted a point of pride for those of us working to provide care under these circumstances. Practicing in this environment required a "MacGyvering,"[17] or making due with a little to no resources for patient care. Paperclips were fashioned as x-ray adjuncts, and clinical decisions had to be made in the face of delayed or absent diagnostic tests. For example, on one night in 2006 when I worked as a resident, I was informed at the change of shift that we did not have the capability to run routine tests because Grady was so behind on its bills that the supplier refused to renew our supply until the bill was paid. Vials of blood had to be sent to a nearby hospital—a process that added hours to diagnoses and medical decision making. Bedside urinals were absent on another shift, and saline bags another shift after that. The hospital was clearly in dire straits.

Yet the storm was not simply about rescuing a safety net hospital or reckoning with the region's commitment to the care of the indigent. Much like the politics that preceded Grady's construction, the hospital's bailout exemplified Atlanta's ongoing difficulties with race and class. Embroiled in the debates of

---

[17] Angus MacGyver was the main character of the CBS television show, *MacGyver*. He was a resourceful secret agent who could get out of difficult predicaments using only a Swiss Army knife and duct tape.

Grady's future was the subtext of its racial and class politics, and all of their accompanying tensions and contradictions. When the Fulton-Dekalb Hospital Authority, made up of political appointees plagued by accusations of corruption and conflict of interest, asked the Metro Atlanta Chamber of Commerce to convene a taskforce to rescue the hospital. True to Atlanta's history of biracial coalitions, the taskforce was headed by Herman Russel, a prominent black businessman and a Grady Baby himself, and A. D. Correll, a successful white businessman and former chairman of Georgia Pacific. The coalition proved insufficient to quell protests of racism and conspiracies by white elites to take over one of the city's longest standing and most prominent black institutions.

Faced with impending closure, the Fulton-Dekalb Hospital Authority (FDHA), a ten-member public body created in 1941 to oversee operations at Grady, voted to turn over control of the hospital to a newly formed nonprofit corporation. Creation of the nonprofit corporation came with multiple stipulations, including requiring the consent of the FDHA for any significant deviation of the hospital from its historic mission. But this was not enough for local community members who fought to keep Grady open as a *publically* operated hospital (Springston 2007). Amidst heated debate reminiscent of the controversy in which Grady was created, local activists and community leaders angrily denounced the change in hospital operations. Though eagerly invested in the survival of the hospital, local activists argued that the inevitability of privatization was a construct created by local business interests. Others argued that the people tasked with the transition to a the tax-exempt 501(c)(3) Grady Memorial Hospital Corporation had financial conflicts of interest that would inevitably lead to the rationing of care to the poor and a fundamental shift in Grady's commitment to serving the city's most neglected populations. Market-based logics and caring for the poor, they argued, were contradictory and mutually exclusive priorities. Rationing and exclusion would inevitably take precedence and, further, would occur without direct accountability to the public or the local legislatures. The state legislature and hospital stakeholders retorted that the hospital's dire straits left them with no options. It was a matter of simple accounting and balance sheets. Responding to this criticism, Russel, co-leader of the taskforce appointed to save Grady, responded, "We stirred the pot, no question about it. I hope the old Atlanta way will lead to some degree of progress and we can get Grady on the right footing" (Dewan and Sack 2008).

The "Atlanta way" to which Russel was referring was Atlanta's civic order maintained by its commitment to business interests and economic growth—mediated by bilateral economic interests by its black and white leadership. This was the way that created a reputation of Atlanta as a beacon of progressive race relations, at the expense of deeply entrenched class divisions. Russel and others' assertion was that this was a *fiscal* crisis, one that was simply about dollars and cents. The only solution was one of more responsible accounting and financial management. Any protests to this approach could only be seen as irrational. Yet the protests were spurred on precisely because this approach had, throughout Atlanta's history, been used as a justification for racial segregation, poverty displacement, and the silencing and exclusion of Atlanta's urban poor. Valuing patients within a cost/benefit analysis could only undermine the principles upon which the hospital was built.

The unspoken question amidst this firestorm was this: what role does—or should—Grady play in Atlanta? On one hand, proponents of fiscal reform saw the hospital as simply another self-contained technocratic institution. While they acknowledged Grady's unique history and relationship with Atlanta, they pointed out that it had to sustain its own fiscal operations. Thus, the social historical relationship between Grady and the rest of Atlanta and Georgia were rendered irrelevant and, like its patients, invisible. On the other hand, local activists and proponents to the hospital pointed to the ways in which the hospital's financial woes were due to its systematic neglect and defamation. They argued that Grady's significance stretched well beyond its own walls and accounting ledgers. Moreover, they pointed out that Grady was a site of racial pride, cultural reproduction, and uplift in Atlanta's black community.

Yet these protests ultimately proved ineffective. Despite local protests and national media attention, control of the hospital was transferred in January 2008 from the Fulton-Dekalb Hospital Authority to the Grady Memorial Hospital Corporation, a nonprofit corporation charged with administering the hospital.[18] The final vote of the Fulton-Dekalb Hospital Authority, which transitioned Grady's day to day operations to a nonprofit board with the promise of the infusion of hundreds of millions of dollars into its operating budget, was marked by prolonged shouting and tense standoffs. Members of the public expressed their outrage and disgust with

---

[18] For more information on Grady's legal and governance structures, see: http://www.miamidade.gov/auditor/library/grady.pdf

the process. Leveraging the threat of imminent closure in order to privatize the hospital, they claimed, was an act of “extortion” (Springston 2007). After much contentious debate and local protest, the hospital underwent significant financial restructuring. In the process, it had to make difficult decisions about what constituted “vital” services, how to meet its mission of indigent care delivery and its mandates for financial solvency. This restructuring held Grady accountable under a rhetoric of fiscal responsibility. Paradoxically, enabling the hospital to continue caring for the city’s most marginalized populations sustained the practice of allowing other hospitals to forego their responsibilities to these patients.

Ten years later, Grady’s doors are still open. Some material aspects of its operation have improved (e.g., availability of tests), while others have remained the same. Grady remains a primarily safety net hospital, caring for Atlanta’s most vulnerable populations when the rest of the city’s hospitals and its welfare infrastructure could not, or simply would not. As defined by the Institute of Medicine, the health care safety net comprises hospitals and other providers that deliver a significant level of health care and other health-related services to patients with no insurance or with Medicaid (Altman and Lewin 2000). Often considered a last resort, safety-net hospitals like Grady have historically assumed a major role in the provision of comprehensive services to medically and socially vulnerable populations (Boehm 2005). This designation, however, considers hospitals simply as purveyors of healthcare. But hospitals are not simply self-contained entities tasked with healing bodies. They are vivid extensions of social life.

Conclusion: Reconsidering the Hospital

In this section, I explore the evidence and implications of thinking about hospitals beyond healthcare. Further, I argue that healthcare is not simply about mending bodily ailments. It is flashpoint for negotiating what it means to be human and, by extension, what kind of society we aspire to have.

Anthropologists produced much valuable scholarship on the hospital as an institution that reproduces the social world and its gender hierarchies (cf. Cassell 1998; Hinze 1999; McManus and Sproston 2000), socioeconomic divisions (cf. Rapport 2009; Sacks 1988), and racial stratifications (cf. Bridges 2011; Spitzer 2004). This body of work demonstrates that the hospital is not simply an “island” within the “real world” (cf. Coser 1962), but is a vivid extension of the real world and its hierarchies, inequalities, and tensions. Thus, life in the hospital is both created by its patients and workers and restricted by broader conditions under which individuals and the institution exist.

Grady, as an integral part of Atlanta, is unique in its history and its relationship with Atlanta’s urban poor, but it is not singular in its reflection of broader urban processes and how they relate to public hospitals. Throughout the US, one can find relatives of Grady: public hospitals existing alongside private ones, serving marginalized bodies and becoming marginalized themselves. If life had landed me within the walls of one of Grady’s relatives—Cook County Hospital in Chicago or San Francisco General Hospital, for instance—my work would likely have had echoes of similar processes of race, marginalization, and placemaking. Throughout the country, these safety net hospitals have been tasked with taking care of the most marginalized bodies as they weathered their addictions (cf. Bourgois and Schonberg 2009), were stricken with AIDS (cf. Farmer 2003), were afflicted by cancer (cf. Mattingly 2010), and so on.

Grady is therefore a stand-in not just for the struggling urban public hospital, but for “the hospital” writ large. One may place Grady in stark contrast with the private, wealthy hospital. This contrast would make important points about the race and class segregations omnipresent in American healthcare (and society) (Omi and Winant 2014). However, it is important to note that such a comparison is useful only as a heuristic device. Hospitals are not separable entities: the public and private; poor and wealthy; the urban and the rural are all deeply intertwined and interdependent. They are all places that are constantly being made and remade, each time reflecting larger historical and social processes. As van der Geest and Finkler (2004) observe, “Biomedicine and the hospital as its foremost institution is a domain where the core values and beliefs of a culture come into view” (p. 1995). Thus, the story of Grady is a story of Atlanta, its struggles with race and class and its ongoing reticence to provide for its most marginalized populations.

CHAPTER FIVE: OF HOSPITALS AND ALMSHOUSES

Introduction: Lucy

Lucy was woman in her mid-sixties who was born and raised in Valdosta, Georgia, about three hours south of Atlanta. Lucy had a dark, stoic face and wide set eyes, with salt and pepper hair that refused to be tamed into the pony tail atop her head. She was heavy set and friendly and would easily and quickly change the topic of conversation as we talked. I first met Lucy when I sat next to her on a bench on the sidewalk outside of Grady. She spent a lot of time out there, watching people walk by. She would always say that she liked to spend time around lots of people and couldn’t be alone for long periods of time, which she attributed to decades of homelessness and living on the street.

I first asked Lucy how she got along for so long as a woman on the streets, she told me that she “just learned to cope.” But then she quickly slipped into reminiscing about Philip, the man who she had married in her twenties and with whom she had three children. Lucy and Philip had a tumultuous relationship. He drank heavily and dabbled in using crack cocaine, which Lucy would also start using early in their relationship. Lucy and Philip would cycle between jobs, sometimes ending up on the streets or in local shelters for short periods. But then, as time went on, the periods got longer and longer, and Lucy eventually reconciled herself to a long-term life on the street.

And while her relatives were willing to take in their children, they refused to take the couple into their homes, citing their ongoing drinking and drug use. Philip and Lucy would fight, and their fights would usually escalate and become violent.

She would leave him, swear off crack, reconcile with family members who would take her in and try to help her get back on her feet. But then she would relapse into the drugs and into Philip. There would be arguments and disagreements and they would eventually end up back on the street together. Over time, Lucy said that she “got tired” of using crack and gradually stopped, even as Philip continued to drink and use drugs. The rift between them grew insurmountable and she decided to stay away from him once and for all when he left her for another woman.

To solidify their separation, Lucy decided she would move to Atlanta to join her children, who had been in Atlanta for years and had long been estranged from Lucy and Philip. Lucy liked the idea of moving to Atlanta because it was a “rich city,” where she thought she would reunite with her children and have an easier time getting by. Like many of the people I came in contact with, Lucy had heard much about Atlanta’s economic boom and the job opportunities it had to offer. Longtime residents of the city often state simply, “It’s changed a lot since I’ve been here.” When I interrogated this statement, they would answer with complaints about traffic, displacement of the city’s residents (usually away from public transportation), or the rapid disappearance of affordable housing throughout the city. These effects were felt in their own lives. Friends and family moved away, to surrounding suburbs and out of state. It was difficult to see each other regularly and difficult to help out one another in hard times. None of them, it seemed, had benefited from the city’s “booming economy.”

The lure of a booming and up-and-coming city was difficult to resist for many out-of-towners, even if its reality didn’t deliver on its promises. “You wouldn’t believe how people talk about Atlanta up north!” One man, who had recently relocated to Atlanta from New Jersey, exclaimed when I asked what brought him to Atlanta. “But it’s nothing like that here. They’re always talking about how Atlanta is putting up buildings here, and buildings there. Like they just can’t keep up with what’s going on down here. I thought for sure I’d be able to get a job just like that,” he continued, snapping his fingers for emphasis. “I thought for sure I’d be able to get *something* in construction if all else failed. But all those construction companies bring in their own guys, they’re not looking to hire people like me. And it’s not like it’s easy to get by in the meantime. Shelters are crowded. I can’t get an ID since I don’t have all the papers. It’s all been harder than I expected. So Atlanta hasn’t really panned out for me. Maybe if you have a master’s degree or PhD it’s a great place, but otherwise, not really. Definitely not for me.” And definitely not for Lucy.

A local Valdosta homeless outreach organization helped Lucy move and paid the bill for the bus ride north, and she gathered her belongings and headed to Atlanta. She planned to spend some time in a shelter when she got to Atlanta, biding time until she could get in contact with her children. This proved to be easier said than done. All of the women's shelters where Lucy could stay were full and she had a great deal of difficulty getting around the new and unwelcoming city. Shortly after arriving in Atlanta, she lost her diabetic medications and went to the Grady ED for refills. She was given prescriptions and dropped off at a nearby homeless shelter. At first, she managed to get by, carrying her duffel bag of meager belongings about town. But over time her belongings were either lost or stolen and getting by became increasingly difficult.

In Valdosta, Lucy had spent most of her time in a city park. There was a group of homeless people who resided in the park for years, she told me, and they would look out for one another. Lucy had no such luck integrating into a similar community when she arrived in Atlanta. She had a hard time getting around town, and she felt run down in the absence of her medications. She never was able to contact her children, as the phone numbers they had were disconnected and in the process of pursuing other options her health deteriorated. Where she had learned to cope and compensate for her ailments in Valdosta, she was unable to do so in Atlanta. She was frequently escorted out of parks by security, and street benches were (quite literally) few and far between.

Lucy fell nearly every other day due to a combination of arthritis in her knees and neuropathy in her feet that developed from uncontrolled diabetes. She had a hard time getting up, usually alarming bystanders nearby. If she fell in the street, police officers would transport her to Grady. If the fall happened in the shelter, staff to call 911 to transport her to the ED. She would be brought to Grady, either by her own request or the decision of the police or paramedics, even as they drove past several hospitals along the way. “Grady’s just where black people go. Everyone knows that,” she explained to me flatly. Finding nothing “emergent,” Lucy would get sent back onto the streets or to a shelter. Although she was eventually able to find friends in a few homeless women in the shelter who helped her get around, find food, and bathe, her falls became more frequent and her gait became increasingly unsteady, prompting a cycle of transport between the ED and the shelter. Lucy slowly became familiar to ED staff, many of whom became immune to her presence.

Like most of my informants, Lucy always felt sick (from a combination of her uncontrolled diabetes, sore knees that strained under her weight) but was never quite sick *enough* for the ED. Some of her visits were focused on these ailments, but a lot of times she would just sit in the waiting room and watch TV or sleep or spend some time talking with other people, knowing that she would simply be sent back if she went to the shelter. She was in the waiting room as little as once a week and as often as once a day for three months, depending on how she was feeling and/or her interactions with the staff, some of whom were more willing to have her there than others.

On one unusually slow night in the ED, Lucy was directed to an eager and well-intentioned social worker. She listened to Lucy's story and offered to help, but the options were limited. Her children's contact information was outdated, and she couldn't remember the contact information of anyone in Valdosta. Even if she could, she later told me, she never wanted to go back there. Though she never explained why, I suspect that her desire to stay in Atlanta was related to her inability to leave. After nearly an hour of conversation, Lucy said that the only thing she wanted was to get her medicines and to go back to the shelter and asked for cab fare to get here there. She was wheeled out to the cab, which met her on the street outside the ED and the driver dropped her off at a shelter two miles away.

When Lucy would go back to the shelter, she felt tired and run down, but was mostly sad that the women who'd been helping her get around had moved on and left the shelter in her absence. She sat on the steps outside, contemplating her next move when her body stiffened and fell backwards, jerking about the ground and catching the attention of horrified bystanders who scrambled to help and call 911. The ambulance arrived a few long minutes later, noting that Lucy's blood sugar was dangerously low, triggering her seizure and sending her back to the ED. This time, however, Lucy returned with a short note delivered by the paramedics:

> To Whom It May Concern:
>
> Ms. Lucy Peters cannot return to our shelter, as we are unable to meet her needs. She falls, she is incontinent, and she is not able to take care of herself fully here. Please do not send her back to our facility.

Lucy felt better when she arrived in the hospital. She could easily explain the drop in her blood sugar after taking her medications and not eating. But she was preoccupied with the note barring her from return to the shelter. She had a difficult enough time getting by with the help of the shelter's residents and staff. Now what would she do? Ironically, her seizure and low blood sugar provided temporary relief, as these meant that she would have to be admitted to the hospital for monitoring of her blood sugar. Lucy's acute deterioration helped her to be recognized temporarily as a "legitimate" patient with a "real" medical problem. Before this deterioration her condition was categorized as "social" and therefore "inappropriate," "non-emergent," or outside of the purview of emergency medical work.

The distinction between the "medical" and the "social," however, is problematic at best. For example, Joanna Latimer (2000) argues that, in contemporary medical practice, "social life is held apart from [the] medical condition, and in this move [a patient's] social life is reconstituted as both his own, and as (implicitly) the responsibility of community health and social services" (Latimer 2000: 399). Similarly, before her seizure, Lucy's many difficulties (her homelessness, falls, uncontrolled diabetes) were not constituted as interrelated pathologies that would lead to her gradual deterioration and eventually death. Rather, they were categorized as "social problems," separate and subordinate to the medical, thereby justifying her discharge from the ED back to the street or shelter. Ironically, her chronic medical problems simultaneously rendered her unable to receive shelter services and eventually contributed to her seizure and subsequent admission to the hospital.

Lucy's dangerously low blood sugar and its manifestation as a seizure legitimized her needs as medical and rendered her social problems as concerns of the hospital, since these would preclude her safe discharge and therefore prolong her admission. As she was being wheeled out of the ED to her hospital room, her nurse reassured her, "They'll see about your shelter situation upstairs." This reassurance was an implicit acknowledgement of Lucy's limited options. Unable to locate family members who could take her in and barred from returning to nearby shelter, Lucy's life circumstances would become an obstacle to her eventual discharge. Her case was therefore, in part, a "social admission," a term used to by health care providers to refer to patients with no acute medical needs who are admitted or remain in the hospital because no safe discharge arrangements could be made (Oliver 2008). Although Lucy's blood sugar could easily be stabilized and managed, her poverty presented a much more formidable problem—and one that could not be effaced or kept at bay once she was admitted to the hospital.

Indeed, the very existence of the category of the "social admission" illustrates that the hospital, despite its emphasis on high-tech medicine, serves an important role as a social welfare institution and a direct extension of the broader urban landscape. Thus, although Lucy's case may be characterized as a sign of the failure of the social and primary healthcare system, as well as an ongoing interplay of her chronic illness and social difficulties. Because Lucy's medical problems compounded her social difficulties, and vice versa, they could not be easily or neatly separated. To better explain the interrelatedness of Lucy's difficulties, a syndemic model is required. Merrill Singer introduced the term "syndemics" (synergistically interacting epidemics) to describe co-occurring and co-constituting health and social disorders that map onto individual bodies (Singer and Clair 2003). In doing so, Singer links the "who, what, where, and when" of epidemiology to the political processes behind "why." The concept of syndemics has been particularly useful in pointing out the complex interplay between disease (e.g., tuberculosis) and social problems (e.g., poverty). Building on Singer's framework, Emily Mendenhall (2012) uses ethnographic evidence from a safety net clinic in Chicago to argue that diabetes cannot be fully understood without attention to the structural, interpersonal, and psychological factors that contribute and result from the disease.

Likewise, Lucy's medical condition cannot be fully understood without attention to the broader conditions under which she lives. Her blood sugar could not be well controlled due to her homelessness and her consequent difficulty acquiring a steady supply of food, and coping with her homelessness was exacerbated by the manifestations of her diabetes (and other chronic medical conditions). Together, they eventually led to her seizure and precluded her discharge back to the shelter or the street and led to her sequestration in the hospital, thereby making her social circumstances a primary concern of the hospital's staff. Despite the myriad processes that serve to disaggregate the social from the medical, the acute from the chronic, the inappropriate from the legitimate, this task is not only complex, but often impossible.

In this chapter, I use Lucy's case and the "social admission" to argue that the hospital institution itself serves an important, non-medical function akin to the historical almshouse in the US. To illustrate what I mean by "almshouse," I begin with a brief history of the American hospital. Historians of the contemporary hospitals trace the birth of this institution to almshouses, or poorhouses, of the 19th and early 20th centuries (Rosenberg 1995; Rosner 2004; Sigerist 1936; Vogel 1980). Almshouses served primarily as warehouses for the poor and the destitute, thereby providing bodies for scientific experimentation and the codification of medical knowledge. Historians further contend that almshouses disappeared in the 19th and early 20th century, giving way to hospitals as we know them today: formidable scientific institutions or business centers. I argue that, instead of replacing the 19th century almshouse, hospitals have quietly subsumed its functions, thereby becoming (in part) almshouses themselves. I further argue that the hospital's function as an almshouse is closely related to the existence of a pauperized population that carries with it "connotations of danger, moral failure, pathology, and instability that are in excess of that indexed by class" (Bridges 2011: 165). I consider the ways in which super-utilizers like Lucy are discursively pauperized and their meagre demands for food and shelter are reframed as exorbitant. Finally, I show the ways in which this discourse, although riddled with logical fallacies, is powerfully leveraged to make sense of the world.

From the Almshouse to the Hospital

While much important work in anthropology and sociology has paid attention to the ways in which medicine is socially produced and constituted (cf. Mattingly 2014; Mol 2008; Salhi 2015; Saunders 2008), there are considerably fewer anthropological studies on the hospital as an institution for the management and sequestration of the most socially marginal populations. Yet the hospital evolved from the almshouse. It is therefore useful to briefly review the historical relationship between the almshouse and the hospital, and the purported disappearance of the former institution.

Born nearly three centuries ago, the hospital is now an unquestioned feature of contemporary American life (Sigerist 1936). It is the setting for birth, death, and episodic illness in between. Yet it was not very long ago when the hospital was a place exclusively for the downtrodden and the depraved rather than the ill.

Throughout the 19th and early 20th century, disease and depravity were considered sister ailments, and “pauperism” was despised as a disease unto itself.

As I elaborate later in this chapter, “pauperism” should not be understood simply as a synonym for “poverty,” or absolute material deprivation. Rather, as I detail in the following section, pauperism is poverty born of moral defectiveness. In the 19th century, this condition had all manner of explanation—from biological predisposition to structurally incentivized laziness—that were decoupled from the industrialized economy (Lock and Nguyen 2010). The term therefore ascribes those marginalized from the industrialism and post-industrialism with connotations of instability and malignancy. The deployment of pauperism as an explanatory framework for marginality and disenfranchisement thereby successfully detracts from broader social failings.

In the wake of industrialism, the number of paupers rose in the 19th century. Sensing this looming threat to the social order, government officials commissioned reports to examine the “pauper problem.” One of the most influential of these was the Yates Report, an 1824 study of poverty in New York state that concluded that dependency was a primary contributor to idleness, crime, and all manner of social pathology among the poor (Katz 1996). On the authority of this report, states restricted public assistance to the able-bodied poor and stressed that relief to the elderly or disabled be delivered in the form of “indoor relief,” or institutions dedicated to keeping the poor out of public space and out of view of respectable society (Willamson 1984).[19] To do this, the poor and sick were confined to

---

[19] This approach was not simply confined to the poor, but also applied to criminality and mental illness.

almshouses, or poorhouses, where “poverty and dependence were the operational prerequisites for …admission” (Rosner 2004: 163).[20] Describing conditions in almshouses at that time, Robert Bremner writes,

> Throughout the better (or worse) part of the [19th] century public almshouses remained exile colonies of all categories of the homeless and helpless. They were social pesthouses in which an undifferentiated collection of discards including the aged, the blind, the insane, feeble-minded persons, epileptics, alcoholics, orphans, foundlings, and chronic paupers were crowded together, as the novelist Edward Eggleston observed, “like chickens in a coop.” (Bremner 2009: 48)

Also aware of the stigma of this institution, the poor spent much of their time in fear of spending their lives in such dreadful confinement. Almshouses, along with the curing and management of pauperism made powerful pet projects for elites seeking to foster a positive public persona or participate in political life.

In their joint appalment and disdain for the deplorable conditions of the almshouse, all classes maintained a myth of the shiftless migrant or the idle able-bodied persons for whom the almshouse was a restful retreat. These images guided even the most well-intentioned philanthropists, who proclaimed their desire to help did so with some disdain and ambivalence. Bremner writes, for example, that these elites were invested in the alleviation of poverty—but only to an extent.

> They wished to improve the poorhouses, but not to such an extent

---

[20] Although the primary function of almshouses was the concealment of poverty from the view of respectable society, almshouses did not serve the overwhelming majority of the American poor.

> that people would cease dreading to be sent to them… They desired to do what was necessary to relieve suffering in *an efficient, economical, and businesslike manner*, and they wanted to do it by means of voluntary contributions and services rather than through tax-supported benevolence. It seemed to them—that is, to the well-to-do persons who had the leisure and resources to indulge in voluntary charitable work—that what the poor most needed was assistance in developing good character. In their scale of values, good character meant, first and foremost, ability to support oneself. (Bremner 2009: 51, emphasis added)

Thus, while public relief for the poor was neglected and vilified, private philanthropy was a flourishing pastime. Dictated by their money and prejudice, relief was delivered usually in the form of character development, where good character was synonymous with self-sufficiency, rather than any attention to the conditions under which poverty was produced and reproduced.

Stephen Ziliak points out that, despite elites' fear that the almshouse would become a lifelong retreat for the poor, the majority of residents were there for brief periods of time. However, this did not disprove the myth of the idle poor living in luxury in the almshouse. Instead, it served as fodder for the staunchest critics of the almshouse, who argued that the poor were "almshouse recidivists" taking advantage of an already too-lenient and overly accessible system. It is difficult not to see the parallels between the almshouse recidivist and the super-utilizer. Though these terms are separated by more than a century, both use the "recidivist" label to invoke images of “the degenerate poor,” who used the almshouse (and later the hospital) as “a winter resort for tramps… a place where the drunkard and the prostitute recuperated between debauches” (Ziliak 2002: 175).

Far from the idle, carefree poor of the popular imagination, inhabitants of almshouses were primarily aging and “defective” laborers (e.g., men who suffered industrial injuries, or disease-stricken women domestic servants unable to work) in need of physical, rather than moral, rehabilitation. Drawing on 19th and 20th century census data, for example, Ziliak concludes, “For some, the almshouse was a kind of hospice, a death watch. But more often, the almshouse provided economic and personal shelter for a lonesome lot of indigent and previously self-reliant adults” (Ziliak 2002: 169). Furthermore, the almshouse were a safety net for the urban poor, serving as their maternity homes, orphanages, workhouses, or homeless shelters depending on the conditions in other city institutions (Green 2003).

At the turn of the twentieth century, hospitals were not wide-spread institutions. When the poorest fell ill, they had few options except languishing on the street or confinement to the city almshouse. In the contrast, when the well-to-do fell ill, their families cared for them and their medical care (sometimes even surgery) was provided in the confines of their homes (Vogel 1980). Importantly, this class distinction was a necessary precondition for the invention of the hospital and the development of modern medicine as we know it. Almshouses supplied a steady stream of subjects for medical experimentation and the standardization of medical knowledge and practice (Crist, et al. 2017; Grogan 2007; Humphrey 1973; Lederer 1997). By the 20th century, confinement to almshouses was accompanied by the expectation that bodies be studied and experimented on in times of illness (Lederer 1997). Paupers' bodies were often dug up from graves and dissected after death in the name of medical student education and the standardization of medical practice (Humphrey 1973).

As the medical knowledge gained from these experiments was codified, the almshouse quickly transformed from a poorhouse to a hospital whose residents could expect medical care, in addition to being subjects for teaching and research (Katz 1996; Vogel 1980). This, coupled with the ascendance of the germ theory narrowed American conceptions of disease and changed the nature of the hospital. Physicians reinvented themselves as scientists and to subsequently transform the hospital into a place of medical diagnosis and disease treatment (Starr 1982). Thus the standardization of medical education, was linked to the rise of the hospital, where "diagnosis and therapeutic capacity as well as an individual's social location had begun to determine hospital admission" (Rosenberg 1995: 338). Thus, hospitals came to serve as clinical case repositories, enabling young physicians to be systematically trained in the scientific method.

The introduction of the scientific method into medical practice metamorphosed the almshouse into the hospital. The introduction of x-rays, blood tests, and other diagnostic modalities revolutionized medical care and drastically improved patient outcomes. No longer did physicians have to rely on personal impression to diagnose patients. Now they could definitively confirm or exclude disease. Now, the hospital offered tangible benefits over recovering at home, thus making it a place utilized by all classes. While this dissipated the stigma of the hospital, it also dissipated the philanthropic funds allocated to the rehabilitation of the poor.

Hospitals faced pressures to remain financially solvent, and they often adopted business practices (i.e., billing patients for services) as they expanded delivery of medical care. They became increasingly bureaucratized and began to request payment for formerly free services. With the increased demand for hospital services, and the increased supply of well-to-do clientele, “patients would [now be expected to] give as well as receive” (Vogel 1980: 12). The bureaucratization of hospitals was also accompanied by a formalization of hospital administrators, who—“much more than physicians—were expected to defend the interests of the hospitals original constituency of poor patients, whose care was coming now more often to be thought a drain on funds” (Vogel 1989: 247). While medicine was enjoying increased power and prestige, hospital administrators were simultaneously “searching for a body of objectifiable data, of certifiable knowledge” (Vogel 1989: 247). This search for scientifically grounded institutional practices ultimately gave way to a language of efficiency and cost control that persists today.

It is easy to see the connection between the scientific, bureaucratized hospitals of the Progressive Era and the contemporary hospitals we know today (Gamble 1995; Howell 1995; Sigerist 1936; Starr 1982; Vogel 1980). However, we should pause to ask: what happened to almshouses during this transformation? Historians tend to agree that almshouses quickly disappeared as hospitals adopted more advanced technologies in their quest for profit, disease cure, and patient recovery. They note that the demise of the almshouse was cemented by the New

Deal, which did not directly target almshouses for closure, but provided welfare measures targeted at its inhabitants that allowed them to live independently with federal assistance (Green 2003; Kusmer 2002). Simply put, historians and social scientists tend to agree that the almshouse from is simply a historical artifact.

The validity of this account, however, rests on two interrelated assumptions. First, that the programs of the New Deal eliminated the injuries and illnesses that plagued the poor of the Gilded Age.[21] Second, that the poor had unfettered access to the bounties of American medicine. Neither of these assumptions is true. The programs of the New Deal—much like access to healthcare—were unevenly distributed along race and gender lines (cf. Hoffman 2012; Quadagno 1994). Indeed, the historical and political peculiarities of healthcare in America has meant that EDs have been the most consistent provider of health services to the poor and uninsured (Hoffman 2006). Thus, I argue that contemporary EDs and hospitals retain vestiges of their almshouse predecessors.

Of course, since the Gilded Age we have abandoned terms like “pauper” in favor of the ostensibly neutral and scientific statistical variable of “poverty.” Both terms, however, mask the conditions under which discarded labor was produced as morally deficit then, and is produced as socially deficit now. In this schema, the category of the super-utilizer is homologous to the “almshouse recidivists” who abuse the “open-door” policy that characterizes ED care. Like almshouse recidivists, super-utilizers are a small group of people maligned as drains on precious resources, people who consume in excess of what they provide, specters of

---

[21] The Gilded Age describes a period in US history from the 1870s to about 1900. The term derives from Mark Twain's 1873 novel, *The Gilded Age: A Tale of Today*, which satirized an era of profound greed and social decay masked by a thin gold gilding.

the undeserving poor. In reality, super-utilizers, like almshouse recidivists, are produced by broader failings—uneven development, a receding welfare state, and an expansive carceral state. As in the Gilded Age, the management and sequestration of the poorest subsets of society has been taken up by jails on one hand (cf. Wacquant 2001) and, as my work suggests, by hospitals on the other. To further illustrate the hospital's hidden role in housing the poor and indigent away from the rest of respectable society, thereby mirroring their almshouse predecessors, it is instructive to return to Lucy's case.

Lucy, like many of my informants, was drawn to Atlanta by its far-reaching reputation as a prosperous city with a booming economy. Less advertised, however, is that Atlanta is also home to one of the country's highest rates of income inequality (Berube 2014), created by a long history of uneven development and an increasing hostility to the destitute (Beaty 2007; Kruse 2013; Rutheiser 1996). In Atlanta, as in other cities across the country, this discourse has successfully justified the criminalization (e.g., via laws against panhandling, loitering, and public urination), medicalization (e.g., combatting poverty through an emphasis on mental illness, alcoholism, and/or childhood trauma), and displacement (e.g., through gentrification and urban renewal projects) of impoverished populations (Amster 2008; Lyon-Callo 2000). Together, these have been accompanied by a powerful discursive process by which the poor are produced as diseased and deviant.

"Welcome to Grady. Atlanta's biggest homeless shelter!" A frustrated pointed angrily at Lucy, adding that not a shift goes by without seeing her. This nurse's anger stemmed, in large part, from the ways in which Lucy challenges the constant and precarious work of producing “real” emergency medicine as a purely clinical endeavor that tends to “true” emergencies. What this nurse elides in this narrative are the processes that make it easier for Lucy to find an agency to buy her a bus ticket to Atlanta than it was to get steady food or housing. These are the same processes by which Lucy was repeatedly brought to the hospital, only to be unwelcome and labeled a “super-utilizer,” a drain on resources, or a wily patient gaming the system upon her ED arrival. What Lucy’s myriad social needs highlight, is the role of the hospital and the ED as service institutions that provides shelter and care to the poor and pick up the slack of the welfare state that no longer professes to stabilize or buffer conditions of poverty. Put simply, Lucy’s presence in the ED highlights its role as an almshouse in addition to a place for medical care delivery.

Before she suffered a seizure, Lucy’s complaints were repeatedly deemed “non-emergent” or “inappropriate” reasons for being in the hospital. Her case was deemed outside the scope of emergency medicine and she was excluded from hospital admission. Lucy was pathologized in and out of the hospital, all the while her physical health deteriorating and her spaces of inclusion dwindling. Lucy’s seizure gained her access into a medically legitimate category and allowed her to temporarily cross that threshold of exclusion. However, this was also seen as a failure of the healthcare and social welfare systems that together left her ED providers no viable options but to admit her to the hospital. As her nurse reassured her that there would be time and resources, Lucy was relieved. Her relief turned into disbelief when she arrived at her hospital room. “Look how nice this is!” she exclaimed as she eyed the television and the bed.

Her nurse smiled as she completed the required checklist assessing Lucy's needs, risk of fall, and listing her goals for the day on a dry erase board: 1) monitor your blood sugar, 2) comfort, and 3) don't fall. After 24 hours in the hospital, Lucy was able to eat and take her medications and her blood sugar was well controlled. The goals listed became simply: 1) comfort, and 2) don't fall. Lucy's medical needs had been met. But her social needs precluded her from being discharged back to the streets. She would have to remain in the hospital until a safe living situation could be arranged. In other words, Lucy's case became a "social admission."

For a few days, Lucy took some comfort in being able to watch television and sleep, which she did for hours on end—longer than she had been able to sleep in recent memory. But she eventually grew bored with all the quiet time. Hospital staff would check on her to perform their requisite duties (i.e., checking vital signs and asking about her meal preferences). I was her only visitor for weeks, and she would grow impatient with my visits and my presence. "I want to go home," she would tell me repeatedly in tones varying from anger to resignation. Yet Lucy was not able to fully identify what "home" meant or even where it was.

Lucy's repeated falls and multiple chronic problems meant that she could not be safely discharged to the streets or a shelter. Although her acute problem had resolved, her inability to produce proper identification, accurately recall her social security number, or provide leads for her family members to be traced kept her sheltered in the hospital but still homeless. In this liminal space, she was the embodiment of the "social admission," the hospital a contemporary manifestation of the almshouse.

Many of my key informants, like Lucy, had few other places to go or to be at. They frequented EDs or spent time on hospital wards "awaiting placement" in nursing homes or willing family members as they had been deemed unable to live independently, either as a result of gradual decline made hastened by difficult life circumstances or precipitated by an unexpected catastrophic illness. Here, "awaiting placement" is used by health care providers as shorthand for the people like Lucy, who lingered in the hospital for non-medical reasons. In this context, the social is not seen as contributory to health, but is firmly outside of it. Thus, to state that Lucy was "awaiting placement" signified her placelessness in the hospital and in society. In other words, Lucy was neither a productive member of society nor a qualified clinical case. She was reduced to a parasitic spectator of social life, draining resources and giving nothing in return. Ironically, Lucy's social exclusion was, in part, compounded by her lack of exclusion from a positive medical category.

Medical anthropologists have challenged the normative pathologization of individuals[22] by arguing that observed disease or pathology is the internalization of a failed societal order (cf. Bourgois and Schonberg 2009; Farmer 1999; Farmer, et al. 2006; Lyon-Callo 2008; Page and Singer 2010; Scheper-Hughes 1993). Nevertheless, the discourse of medicalization is powerful. Eligibility for federal benefits or welfare income is often tied to diagnostic categories of mental illness or physical disability that are mediated and legitimated through the biomedical system. Medicalization is therefore a discursive tool deployed by social workers, healthcare

---

[22] The term "individual" implies the examination of persons outside of their social relations. Of course, individualism is a myth that ignores that each of us is entangled in larger networks within political and historical contexts. Moreover, social relations take many forms, from kin networks to acquaintances. I explore super-utilizers' social relations, and the role the hospital plays in their lives, in greater detail in Chapter Seven.

providers, policy makers, and the poor and homeless in navigating their material constraints.

For example, Vincent Lyon-Callo’s study of a homeless shelter in Massachusetts shows that, for shelter workers, “helping” often takes the form of taking a medical case history, diagnosis, and offering treatment. Further, shelter workers utilizing this model, much like ED staff, prioritize “helping those who can help themselves,” in the process ironically reproducing the distinction between the “deserving” and “undeserving” poor (Lyon-Callo 2000). As one of his informants observed, “It's like they're saying, ‘We can’t change the economy, so we have to change you’” (Lyon-Callo 2000: 340). Similarly, there was little that Lucy’s health care providers and social workers could do to change her circumstances or their material constraints.

Lyon-Callo offers a powerful critique of the ways in which the medical gaze is extended to all aspects of the poor’s bodily, mental, and material existence. While some of his informants actively resisted such a narrative, refusing to take the blame for a failing economy or be labelled as “ill” or “disabled,” others resigned themselves to diagnostic categories as their best options for income or housing. Lucy was an example of the latter. Her inclusion into a positive medical category was the only mechanism by which her social needs could be addressed, but addressing these needs required a complicated negotiation of existing bureaucracies.

In response to one of Lucy’s many demands to be sent “home,” the social worker assigned to her case explained that she couldn’t be discharged because she was too frail to be on the street. “We just have to find the right place to send you,” she added.

“Why’s it taking so long?” Lucy asked, growing impatient.

“It’s complicated. You need to have the right diagnosis to be placed. Without your social security number or your information, we can’t determine your eligibility. And you don’t really need medical services in your case, so there aren’t many places you can go.”

Lucy remained quiet and stared out the window as the social worker gathered her papers and left the room. Outside the room, her social worker told me that options were limited because Lucy needed “custodial care,” or help with daily activities like bathing and dressing, and not “skilled care,” which delivered medically necessary services like wound care or medication administration. Custodial care usually had to be paid for out of pocket, which was out of the question in Lucy’s case. Lucy’s absence of “the right” diagnosis severely narrowed her options and protracted her time in the hospital.

Lucy sat in the hospital, amidst a plethora of unused high-tech devices used to monitor her heart rate, her blood pressure, and blood sugar, her stay an example of an under-examined function of the hospital: where state services are absent and private philanthropy inevitably falls short, hospitals absorb the side effects. For these people, the hospital provides a social service to these individuals as well as “polite” society by quarantining them away from the street. They act as surrogate housing or shelter, providing respite or care unavailable elsewhere. In other words, hospitals functionally remain the heirs of their almshouse predecessors, as institutions “used for the shelter of persons who are without means of self-support and who have no relatives able and willing or legally bound to aid them” (Ziliak 2002: 165). And while some people would rely on this episodically, a subset of the poor and the homeless in Atlanta would use Grady in the same way as their Gilded Era counterparts—as a poorhouse for the ill and aging in the absence of a more robust public welfare system.

On the surface, the world of the late 19th and early 20th centuries looks nothing like our contemporary era. Nevertheless, they have much in common—from the remarkably similar levels of race and class stratifications, to their shared ideologies that stressed privatization over public welfare, and market economics above all else. Most importantly, they are both characterized by a paradoxical co-existence of social abandonment and economic investment in the poor. Hospitals do not assume this role in isolation. Much like their Gilded Age counterparts, they exist in a broader society in which philanthropy has ascended as a popular pastime in response to receding state services. This philanthropy is often deployed in as investment, whose success is measured in efficiency and cost-saving metrics. More importantly, the success of this philanthropy was measured in its moral rehabilitation of the poor and its defense of the virtues of the larger social order. These activities depend upon the existence of not just a poor, but a pauperized population and its requisite danger and disorder. In the following section, I consider my informants not simply as poor, but “pauperized.” To illustrate this, I begin with an ethnographic case of a woman who, much like Lucy, was the object of such pauperization.

Maggie

"Do you know Miss Cruz?" Oscar asked me in response to my summary of my research. Oscar was an emergency physician I had known for years. He had bright eyes and a jovial demeanor, and he often joked that he spent more time with the super-utilizers than his own family. I shook my head in response to his question. He persisted, "Maggie Cruz. You'll meet her soon, I'm sure. She's here all the time. She basically just wants to hang out somewhere warm at night. She doesn't take her insulin so her blood sugar will go through the roof and she has an excuse to be here. And once she's here, you can't ignore the number [of her blood sugar]. You have to get labs and give her fluids. By the time that's done she's gotten what she wanted." According to Oscar, what Maggie wanted—the only thing she wanted—was to sleep in the ED all night and have the ED staff cater to her demands for food.

According to Oscar, Maggie was cunningly manipulating her own disease to gain shelter in the hospital. Her behavior was summed up by the diagnoses listed in her medical records: 1) Poorly controlled diabetes; 2) Homeless; 3) Malingering.[23] Oscar noted the difficulties she encountered living on the streets in her medical records, offered as her true motivations for being in the ED—motivations for her malingering. I found descriptions such as "Patient is here on a daily basis for the same complaints" and "Patient appears more interested in getting a sandwich than her symptoms and/or work-up" throughout her chart. Much like Oscar's description of Maggie, these were character sketches that designated one worthy or unworthy, reasonable or difficult, stoic or hysterical, and so on. Most medical records are

---

[23] Malingering is the fabrication of symptoms of mental and physical disorders for personal gain.

devoid of such caricatures. In contrast, few of my informants' records were spared them.

It is important to note that medical records serve multiple purposes in healthcare. Most obviously, the provide an objective of an interaction with the medical system to be used at a later date for billing purposes or review of a patient visit. A later review of a patient visit may happen in the process of routine medical care or in the case of a poor or unexpected patient outcome. In the latter circumstance, this review may be done by an internal committee or by an external entity such as a medical board or a court trial. With this in mind, the medical record is a communicative tool, providing justification for medical decision-making, either in favor of providing or denying medical treatment. The medical record is therefore constructed as an archive, subject to its own internal logics, partial truths, and prejudices (Kaplan 2002; Zeitlyn 2012). In Maggie's case, the prejudices of the medical record and the implication for later readers were clear: here is a woman feigning illness to leech hospital resources.

As Oscar predicted, I did meet Maggie a few weeks later. She was a woman in her early sixties with a heavy-set frame and a thick New York accent. She had pale skin, hazel eyes, and wispy brown hair with only few gray hairs. "Don't let my looks fool you," she warned, "I'm Puerto Rican through and through." She beamed proudly when people told her that she didn't look her age, adding without a hint of irony, "I try to take care of myself." Maggie came to the ED frequently because she would check her blood sugar and would usually find it "really high." To explain Maggie's frequent visits, ED staff echoed Oscar's sentiments, telling me that she would choose to not take her insulin or medications knowing that the spike in her blood sugar would justify her presence in the ED so that she could "hang out all night." Her medical chart echoed this sentiment, summing up her predicament in a few sentences: "Patient is a very frequent utilizer and has presented to the ED at least once/day, sometimes multiple times/day for the same. Blood glucose was 400 today in triage, but [labs not abnormal]. Feels fine, has no other complaints, is asking for a sandwich."

While she waited for her requisite bloodwork in light of her high blood sugar, Maggie happily offered up a more detailed version of her story. She told me that she had always been independent and self-sufficient. She had held various jobs working in grocery stores or retail in Atlanta and the surrounding suburbs. Sure, she had been met with hard times throughout the years, but she was always able to make ends meet. In the year before I met her, she found herself feeling progressively more sick and tired. She thought she could "just power through it," and continued to go to work.

She was stocking shelves one day when she felt lightheaded and collapsed to the floor. Her coworkers called the ambulance that took her to the hospital where she was diagnosed with diabetes. "My blood sugar was high. Through the roof. They kept me there overnight, gave me fluids and treated me. My blood sugar got better, but when I got back to work, it was like they didn't want me there. My manager kept being afraid that I'd fall out again and kept checking on me and looking over my shoulder. I didn't want to be treated any different and I'd get mad. We argued a few times and I eventually got fired."

Maggie tried to find work, but in the process got behind on rent and had to move in with her daughter and her two small children in a small one-bedroom apartment. “We were pretty cramped,” she laughed as she recalled the months in that apartment, “but we made it work.” Their landlord was not amused by the arrangement, and threatened to evict all four of them if anyone who was not on the lease was living in the apartment. Maggie left voluntarily, telling me that she didn’t want to be a burden to anyone. Her daughter dropped her off at a local homeless shelter and offered to help in any way she could. “But how’s she gonna help? She’s got two little ones to take care of. Anyway, I’ll figure it out.” Maggie stuffed her belongings into a large suitcase that she would wheel around for months to come.

Staying at the shelter proved difficult. Maggie and the shelter personnel fought frequently. They wanted her to go to a transitional program, which would house her and provide her with a case worker for three weeks. But the program was in Forest Park, a ninety-minute bus ride away from the city. She resisted but eventually went to the program, where she found herself isolated from her daughter and any public transportation to the jobs she was trying to get. Maggie stayed for three days at the program and eventually convinced them to send her back to the shelter in town.

She was intent that staying in town, and at the shelter, until she got back on her feet. But the shelter staff were furious upon her return. “They told me I was being difficult because I didn’t want to stay at the program. But what am I supposed to do? It’s in the middle of nowhere. I can’t be out there for three weeks. What am I going to do after that? They told me that I was being difficult and that they wouldn’t work with me anymore. They said they couldn’t help me if I couldn’t help myself. What kind of help is that? I can’t go back there.”

Maggie told me that she used the last of her money in a nearby motel. When she couldn’t stay there anymore, she tried to stay on the street. She slept in the park and under the freeway overpass but she quickly gave up on those options when the police would stop her or she would feel threatened by other homeless people on the streets. One day she felt weak and lightheaded and came to the ED. She was treated but was reluctant to go back out on the street when she was discharged. “It’s nice and warm in here, I want to stay here inside.” She figured she could bide time in the ED until she could figure out her next steps. When her nurse told her that her medical condition was treated and that there was no need for her to be in the hospital, she protested weakly. “I don't want to go.” She returned a few hours later, noting again that she felt weak and that her blood sugar “was really high.” Maggie would repeat this cycle for months to come, much to the chagrin of everyone who knew her.

“She just won’t let us help her. She’s happy living like this,” Oscar said, summarizing Maggie’s life and the difficulty in caring for her in the ED. “She’s just one of those people who just takes, takes, takes. Nothing is ever enough.” Never mind that she had—quite literally—nothing to show for all she had taken. She was, according to him and many others, egregious in her expectations of what a hospital should and could do. For this intemperance, she was one of the undeserving poor, who should be deterred, in contrast to the deserving poor, who should be helped. But referring to Maggie as “poor,” or simply lacking material possessions, is insufficient to describe her condition nor does it explain the disdain she evokes amongst ED staff.

Maggie is more accurately described as "pauperized." Here, I use pauperization to refer to a discursive process by which poverty comes to be characterized as a quality intrinsic to an individual—a form of moral lack or biological inefficacy of the poor. For example, Nancy Fraser and Linda Gordon (1994) point out that the pauper was an icon of industrial dependency. By being excluded from wage labor, "the figure of the pauper was like a bad double of the upstanding workingman, threatening the latter should he lag" (Fraser and Gordon 1994: 316). Paupers are therefore not simply occupiers of an economic category. Rather, they constitute an amorphous category of individuals tenaciously impervious to the demands of civil society. This discourse successfully detracts attention from the failures of industrialization by making paupers paragons of indolence. To give a more contemporary example, one may talk about "the homeless" as a population synonymous with drug addicts, mental health patients, and so on. This discourse seamlessly places homelessness squarely in the domain of the medical and makes housing irrelevant to homelessness. For example, on any given night, the waiting room would be crowded with people with housing problems and the electronic tracking board for patients would routinely list some patients as being there simply for a complaint of "homelessness." This, in turn, makes possible Maggie's "diagnosis" as "homeless" in her medical records, thereby reinforcing her extreme poverty as a condition peculiar to her.

Similarly, Giovanna Procacci (1991) makes an important distinction between poverty, an economic category, and pauperism, a social category. She writes that inequality, and therefore material excess and deprivation, are part and parcel of capitalist society. As inequality is normalized, it is the poor themselves who become objects of analysis and intervention. To illustrate this point, she quotes the nineteenth century lawyer and philanthropist Firmin Marbeau, who writes:

> Poverty… derives from inequality of conditions… It is humanly impossible to destroy inequality. There will always therefore be rich and poor. But in a well-governed state, poverty must not degenerate into indigence… It is in the interests of the rich as much as of the poor that this should be so. (Marbeau 1847, quoted in Procacci 1991, p. 159).

Building on Marbeau's insistence that hard work and happiness be cultivated even in the setting of crushing poverty, Procacci elaborates that "compared with poverty, then, pauperism appears immediately as 'unnatural' as well as antisocial, a deformity which insinuates itself into the natural order which the discourse of political economy, the discourse on wealth, purported to establish" (Procacci 1991: 159). The category of the pauper therefore extends beyond an economic category and functions discursively to denote a polymorphous and indistinct group whose existence puts the rest of society and its requisite order at risk.

Maggie, like Lucy, is not simply poor. She is pauperized. In her illiberal demands for food, shelter, and proximity to her family, she is paradoxically marked by severe material deprivation and unreasonably excessive demands. While the historical and social conditions that produced Maggie's condition are normalized, the only way to make sense of her existence is to pathologize her as a self-indulgent person with unreasonable expectations and demands. Put differently, the only way to apprehend her existence is to caricature her as an undisciplined presence saps scarce resources through her incessant demands on ED (and shelter) services. Thus, the pauperization obviates the need for critical analysis of inequality, poverty, or the conditions that produce them. Inordinate amounts of time and resources are therefore spent asking what to do about the poor rather than what to do about poverty.[24]

Although pauperization rests firmly upon a host of contradictions and logical fallacies, the irrationality of pathologizing the poor is of secondary importance. More important is the way in which these narratives are powerfully deployed to make sense of the world. Describing how narratives and social categories reinforce preexisting prejudices, Wahneema Lubiano writes:

> [These categories] are not simply social taxonomies, they are also recognized by the national public as stories that describe the world in particular and politically loaded ways—and that is exactly why they are constructed, reconstructed, manipulated, and contested. They are, like so many other social narratives and taxonomic social categories, part of the building blocks of "reality" for so many people; they suggest something about the world; they provide simple,

---

[24] Fraser and Gordon note that the US is exceptional in its embrace of dependency as a moral defect. "Because the country lacked a strong legacy of feudalism or aristocracy and thus a strong popular sense of reciprocal obligations between lord and man, the older, preindustrial meanings of dependency—as an ordinary condition—were weak and the pejorative meanings were stronger… But the American Revolution so valorized independence that it stripped dependency of its voluntarism, emphasized its powerlessness, and imbued it with stigma" (Fraser and Gordon 1994: 320).

> uncomplicated, and often wildly (and politically damaging) inaccurate information about what is "wrong" with some people, with the political economy of the United States. (Lubiano 1992: 330-31)

Lubiano's analysis encapsulates the power of the pauper category—its ability to offer an uncomplicated "truth," along with a justificatory power to rationalize, reproduce, and cement existing inequalities. This sheds light on the ED staff's frustration with Maggie. Blaming her reinforced their belief in a pure and uncomplicated medicine and positioned Maggie in contradistinction to "legitimate" patients who fit easily into obviously recognizable medical categories. Thus, Maggie (like Lucy) exists not as an individual, but as a social narrative—her existence a synecdoche for the pathology of urban poverty.

A critique of these narratives should not be understood to imply that those who deploy them are inherently malevolent. I am reminded that I am not immune to the lure of this illogic. Over the years, I have expressed sentiments that echoed Oscar's exasperation with Maggie. Working in the ED is a precarious in maintaining order. Blame and pathologization is a salient mechanism by which sense is made of the work and of the world, and futility is narrowly avoided. These narratives are further normalized by the rest of the world that places blame squarely within individual bodies, so much so that they cannot be understood as anything but reality. Consequently, this critique is not of ED staff as such, but rather the nationally circulating discourses, politics, and prejudices that also affect Grady and the staff and patients who populate it.

This scapegoating of the poor is closely related to their construction as a broad collective. Here, too, Procacci offers important insights, noting that paupers are an inherently diverse and amorphous body. Among them are children and the elderly, men and women, the working poor and the unemployed. Thus, any attempt to address the paupers' difference requires that they be divided into coherent, manageable sub-groups. This manageability is what distinguishes "poverty," an ostensibly neutral statistical variable, from "pauperism." Procacci explains,

> Poverty constitutes a development area for techniques designed to structure an organic social order which, whatever the concrete localization of the human subjects it deals with, is able to bring under its management those zones of social life which have hitherto remained formless. (Procacci 1991: 164)

In other words, "poverty" crystallizes "pauperism" into manageable, seemingly scientific subcategories (e.g., homeless teens or super-utilizers). Much like pauperism, poverty erases personal and collective histories, concerns, and motivations and allows the reproduction of the status quo. Moreover, the ostensibly scientific discourse of poverty does not negate the discourse of pauperism. The two discourses coexist, further naturalizing the existence of inequality.

Thus, Maggie and Lucy are on the one hand poor, suffering from extreme material deprivation, and on the other hand pauperized, stand-ins for an unruly and disorderly population. They are simply two individuals in a long line of paupers, who differ widely in their personal and demographic features, but are linked by their categorization as super-utilizers. For them, Grady picked up where Atlanta left off, providing shelter, safety, and life-saving services when the city simply turned a blind eye and comforted itself with its images of urban revitalization.

Maintaining Atlanta’s image depends heavily upon ignoring the existence of the poor and, when this proves impossible, pathologizing their existence. The hospital plays an important role in accomplishing this twofold process. First, it functions a “warehouse” of last resort for people like Lucy and Maggie, who are unable to participate in the wage economy and, further, unable to subsist on meagre available welfare resources. For them, the hospital provides no technological cures or interventions, but instead resorts to functioning as its almshouse predecessor, a “warehouse” of bodies that exist outside the system of productive labor and, consequently, outside the bounds of respectable society.

The hospital’s role as an almshouse is not performed freely or charitably. ED staff act as important gatekeepers for this almshouse within the hospital. The labor expended in sorting the emergent from the non-emergent, the appropriate from the inappropriate, the medical from the social, keeps the social at bay and the hospital’s charitable resources carefully rationed. In extreme cases, however, the medical cannot be neatly sorted from the social and the hospital’s staff must address the social and the medical together. When this happens, the encroachment of the social into the medical constitutes a “pollution” that drew the ire of many of the staff (Douglas 2003). They would regularly state in frustration, “This is not what the hospital is for.” Or, “There’s no *true* emergency here.” The implication for these statements was clear: the hospital is for healthcare—even when it isn’t.

Conclusion: Super-Utilizers Revisited

Making sense of the hospital-as-almshouse requires the discursive pauperization of the recipients of the hospital's charitable care. This occurs, in the case of my informants, translating their vast and unmet needs into "inappropriate demands," "abuse of the system" or a "waste of resources." Thus, the charitable care that Lucy or Maggie receives is dispensed even as both of their cases are used as narrative stand-ins for poverty and all its pathology. Further, this stigma is maintained though an uneasy marriage of contradictions. She is a person so destitute that she must subsist on a steady diet of hospital sandwiches, yet so cunning that she is able to leverage her uncontrolled diabetes into ready shelter. She is a person too cognitively impaired to recall her own social security number, yet so wily that she can readily leech on hospital largesse. Although contradictory, these characteristics are embodied by the shorthand labels attributed to people like Lucy and Maggie: frequent fliers, regulars, Gomers, or, more recently, super-utilizers.

Ironically, the recent introduction of the word *super-utilizer* was intended as a substitute for longstanding pejorative terms explicitly to destigmatize the dependence on ED services. Further, the category of the super-utilizer emerged as a way to create a population of people who are defined in terms of their excessive needs and demands upon the healthcare system and facilitate interventions upon these individuals. And while the term has gained popularity in ED literature and popular press, I argue that it remains laden with stigma. Talk about poverty and medical needs slides easily in and out of moral condemnations, largely because the super-utilizer category is itself constructed from contradictions. To better understand the ways in which the super-utilizer category evolved, and its implications, we must inquire as to the significance of inscribing excess onto the neediest and most marginalized members of society. Further, we must inquire as to the ways in which this excess is linked to their shared marginality and pauperization. The next chapter takes up these questions.

PART THREE: THE LIVES OF SUPER-UTILIZERS

We use the Hartsfield slogan, 'A city too busy to hate,' but equally as important, we must ask during the difficult days ahead, are we a city too busy to love? That is no mere rhetorical question. For if we are to make this evening a meaningful beginning, we must make a conscious decision to start to change the way we live. We must do more than say we are concerned and that we care. We must begin to translate that concern into action, because we know that injustice and inequality are not vague and shadowy concepts that have no tangible dimensions.

Maynard H. Jackson
Inaugural Address
January 7, 1974

CHAPTER SIX: AN OVERVIEW OF HOMELESSNESS & EMERGENCY MEDICINE

What is Homelessness?

Early in my fieldwork, I was invited to an administrative meeting called to address the "super-utilizer problem." I hesitantly accepted the invitation. I had many ideas swirling in my head about my subjects, my data, and my fieldwork in general. One of these ideas included the problem of empirically delineating *who* counted as a super-utilizer, and what subset of this population would comprise my research subjects.

During my research-design, I had decided to include individuals with at least ten emergency department (ED) visits in a 30-day period to my study. In doing so, I honed in on a small subset of Grady's super-utilizer population, all of whom were homeless and, for all intents and purposes, living in the ED for varying periods of time. The idea was to focus on a manageable but representative sample, but also, in doing so, to question the given-ness of the category "super-utilizers."

Surely, the administrators who had invited me to the meetings would not be interested in the equivocality of categories. In fact, I was not even sure they were interested in my subjects at all. Rather, the administrators were, I expected, primarily concerned with decreasing “inappropriate” ED utilization and maximizing cost efficacy. My research, on the other hand, had quickly revealed that this focus on super-utilizers was inappropriately medicalizing homelessness and urban poverty in Atlanta. Thus, early on in my research, I had become skeptical of the very label of the “super-utilizer,” let alone the development of targeted interventions to decrease ED utilization.

When the day of the meeting came, I decided it would be best if I simply walked the attendees through my research. I explained my inclusion criteria, described my findings, and outlined the implications of my research. The “super-utilizer problem,” I summarized, was a manifestation of broader social forces at play in Atlanta. This included an acute lack of affordable housing, shrinking homeless services, and increasing hostility towards the homeless, among many others. I expected to be met with blank stares or pointed inquiries about what homelessness had to do with emergency medicine; after all, the ER is for *emergencies.*

Instead, I was met with knowing nods. Most of these administrators had worked in the hospital clinically before they moved into their current roles. Those who hadn’t worked as health care providers had been at Grady long enough to recognize the small subset of people living on hospital grounds. They all stories of the relationships they’d developed with certain super-utilizers over the years—how they stopped to talk to them outside the ED, offered them food, or had over the years learned their stories and developed some relationship with them. “They *get* *it*!" I thought to myself as I took in their reactions. But as I prepared to move on to other points, I was caught off guard by an off-handed question: "Are these people technically even homeless? I mean they are *living* here!"

There were a few muted chuckles in response, but I turned over the question in my mind for weeks to come. I had been in the field for months with people I easily recognized as homeless: they were *literally* without homes. But I had never fully interrogated the label or its implications; yet another category to ponder. In thinking about homelessness, and my subjects, I inadvertently thought that I would "know it when I see it," thereby relying on stereotypes and asserting my conclusion and validating it with self-referential confidence. While I had always rejected notions of the homeless as "undeserving" or "inherently deviant" (Ruddick 2014; Sparks 2012; Willse 2010), I had nevertheless accepted the homeless as a fixed and self-evident category of individuals that could simply be measured, studied, and described.

In this chapter, I show that homelessness is not simply about material deprivation. While I use the term "homeless" as shorthand for people who lack a fixed, regular and adequate residence, I do so knowing that to be "homeless" entails much more than being unsheltered, unhoused, or simply excluded from a housing network. Homelessness is at once a signifier of exclusion and stigma, as well as a product of deeply entrenched racial and class hierarchies. Indeed, housing is a critical mechanism of racism in the United States (US) (Desmond 2012b; Massey and Denton 1993). This is, of course, not to say that housing discrimination exclusively targets people of color. Much like the carceral system, the US housing system disproportionately preys upon people of color but is similarly destructive of the poor whites caught in its web.

I also explore what it means to be homeless, its longstanding racialized history in the US in general, and Atlanta in particular, and the implications of homelessness for EDs, which are not only the de facto providers of healthcare for the homeless but also part of an omnibus service system designed to keep the homeless out of sight and out of mind.

Homeless in America

The US Department of Housing and Urban Development (HUD) estimates that over 560,000 people experience homelessness on any given night (Henry, et al. 2015), and up to 1.5 million individuals experience homelessness over the course of a year (Housing and Development 2010). Contrary to popular stereotypes of the lone male vagabond, the homeless population is comprised of a wide range of people, including single women (40%), families (36%), and unaccompanied adolescents (6.5%) (Henry, et al. 2015). Despite the fact that homelessness is a substantial and ongoing problem in the US, there is no universally accepted definition of homelessness. Regulatory definitions, which define policy interventions and eligibility for public assistance, vary between agencies. For example, the US Department of Health and Human Services (HHS) has a broad definition of homelessness, which includes:

> An Individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private

> facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing… An individual may [also] be considered to be homeless if that person is “doubled up,”… [or] unable to maintain their housing situation and forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are released from prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. (National Health Care for the Homeless Council 2011)

In contrast, the HUD employs a more limited definition:

> An individual who lacks a fixed, regular, and adequate nighttime residence; or an individual who has a primary nighttime residence that is a public or private place not designated for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground.

HUD’s narrow definition has been widely criticized for attempting to downplay the extent of homelessness in the US (Del Casino and Jocoy 2008; Schiff 2003). Homeless advocates argue that, while millions of Americans experience housing insecurity and deprivation at any given time, these definitional inadequacies ensure that not everyone “counts” as homeless. Drawing on a variety of methods, including health information exchange data, registered address with a known shelter or church, advocates argue that contemporary homelessness affects nearly one percent of the population, thereby rivaling rates of homelessness at the height of the Great Depression (National Coalition for the Homeless 2009; Saul 2013).

Instead of outlining the various merits or limitations of these approaches, I argue that that these definitions are neither fixed nor self-evident. Furthermore, I evaluate the idea of the “new homeless,” a category that emerged in the 1970s and 80s to describe the unsheltered persons that flooded streets across the US. These persons were usually depicted as destitute people of color who were disenfranchised from the shifting economic engines. While the term does denote a significant historical shift, I show that housing deprivation is a longstanding phenomenon in American history, and that the notions of “the new homeless” that emerged in the early 1980s is, at best, a gross misnomer.

Consider a brief history of homelessness in America. Not only have unsheltered people populated North America since the early days of colonial settlement, they have been generally considered a problem to be dealt with by local customs and institutions since the very beginning (Kusmer 2002; Rossi 1989; Willse 2015). These “institutions” varied from church-based lodging houses, almshouses (which I consider in greater depth in a later chapter), or in jailhouses that allotted space for non-incarcerated persons.

Housing deprivation became a problem of national interest during the Great Depression, when skyrocketing numbers of unemployed and underemployed people were unable to afford private housing. Shanty towns and homeless encampments sprang up across the US, named “Hooverville’s” to emphasize that Herbert Hoover was responsible for the Depression and its consequences (Gregory 2009). In response, the federal government instituted the Federal Emergency Relief Administration (FERA) in 1933, which established urban Federal Transient Centers and camps in rural to supplement the overcrowded private and municipal lodging houses throughout the country. FERA was dismantled less than two years after its founding, even as the program continued to serve nearly a million people. In place of FERA, New Deal administrators enacted the National Housing Act of 1943, also called the Capehart Act, to make housing and home mortgages more affordable. To quell the tide of bank foreclosures on family homes during the Great Depression, the Act created the Federal Housing Administration (FHA) and the Federal Savings and Loan Insurance Corporation (FSLIC).

The FHA and the FSLIC were the backbones of the mortgage and residential construction industries well into the 1980s. Together, they made home ownership easy and affordable and, in turn, made home ownership a mass phenomenon for the first time in American history. For instance, between 1934 and 1969, the percentage of families living in owner-occupied homes increased from 44% to 63% (Massey and Denton 1993). Home ownership, in turn, was closely linked to access to opportunity (e.g., public schools and neighborhood infrastructure) (Rohe, et al. 2002). The expansion in home ownership, coupled with public works projects and an expanded Keynesian welfare state made the New Deal one of the most successful poverty alleviation programs in history.

However, while the New Deal is widely lauded for its far-reaching successes, it is notable that its benefits were unevenly distributed and mirrored the racial and gender hierarchies of the 1930s (Manza 2000; Quadagno 1994). For example, the Social Security Act provided entitlements to White male laborers and their families, but excluded agricultural laborers, who were primarily black, and domestic workers, who were mainly women. As Ruth Wilson Gilmore observes,

> Under the New Deal, white people fared well compared with people of color, most of whom were deliberately excluded from opportunities and protections, men received automatically what women had to apply for individually, and normatively urban, industrial workers secured rights denied agricultural field workers even to this day. (Gilmore 2002: 18)

Blacks and women denied federal entitlements were relegated to state and local assistance programs, which varied widely and "were amenable to arbitrary and discriminatory policies and practices that allowed whites to remain superordinate to local black populations" (Willse 2015: 39). Simply put, racial and gender hierarchies strongly influenced and were strongly influenced by social provisions under the New Deal.

Similarly, New Deal housing programs were a key mechanism for the racialization of housing inequality. For example, the FSLIC refused to insure mortgages in black neighborhoods (Cloud and Galster 1993). Moreover, the FHA *Underwriting Manual* specified, "if a neighborhood is to retain stability, it is necessary that properties shall continue to be occupied by the same social and racial classes" (quoted in Massey and Denton 1993: 54). In doing so, the FHA directly contributed to segregated housing patterns, suburban white flight, and the underdevelopment of black neighborhoods and urban centers (Massey and Denton

1993). Thus, black Americans and black neighborhoods were excluded from the real estate boom of the post-WWII era, which facilitated wage discrimination, environmental racism, and educational inequality, to name a few mechanisms of structural racism of the twentieth century. These unequal spatial and racial concentrations of wealth set the stage for racialized housing insecurity and patterns of homelessness that persist today.

As homeownership and suburban development became normalized in the post-war economy, the phenomena of the unsheltered poor and housing insecurity retreated from national attention. Nevertheless, they persisted mostly in the skid rows of urban centers, usually in lodging houses and single room occupancy hotels (SRO). SROs were by no means the only infrastructures of skid row. They were part of an urban network of all-night bars, labor pools, blood banks, and mission houses reaching across urban America. But as the "place where homelessness had a home," SROs were emblematic of homelessness urban decay (Hock and Slayton 1986, as quoted in Steffen 2016). Even as they were dismissed as enclaves of urban depravity, skid rows were nonetheless integral parts of the larger urban infrastructure.

To illustrate the ways in which skid rows were synonymous with urban blight, historian Charles Steffen points to an in-depth feature in the *Atlanta Constitution* published in 1974, in which, reporter Jim Merriner presents a detailed, albeit sensationalized, account of human indignity and the difficulties of life on skid row. For example, Merriner's account demonstrates that Atlanta's skid rows housed a pool of precarious laborers on which the rest of the city relied. Steffen notes,

> An ex-convict and recovering alcoholic, the “chaplain of Atlanta’s Skid Row,” as he was nicknamed by an admiring municipal judge, turned his Recovery Center into a treatment facility for alcoholics and a night shelter for “penniless men who would otherwise sleep in alleys.” It is unlikely that Gardner would have been able to launch his street ministry or keep it afloat without the help of George Zakas, a local businessman who owned the building in which the Recovery Center was originally housed. Zakas also owned and operated AAA Labor Service, located a few doors down from the Recovery Center. Asked by a reporter why he allowed skid row’s chaplain the use of his building rent-free after spending thousands of dollars on its renovation, Zakas explained, “Well I’m in the labor business… We’ve got to deal with these people all day, you know, and we know what predicament they’re in. (Steffen 2016)

In other words, Zakas knew that his profit was dependent on access to skid row’s cheap labor. With the recovery center nearby, his AAA Labor Service could capitalize on a steady supply of workers whose sobriety was encouraged and monitored.

While Zakas was by no means alone in his reliance on and exploitation of the labor of local men, Merriner, the local elites, and the public writ large were quick to dismiss residents of skid row as people who would rather drink all night and sleep all day. Merriner recounted how these men cycled between jail and the ED of nearby Grady Hospital, while in between donating their plasma to pay for alcohol and rummaging through dumpsters and scavenging for dead pigeons to survive. Grady staff told Merriner that the men of skid row had to pass the "three-fly sign" to gain admission to the ER. They explained, "When a patient allows three flies to land on him without swatting, the doctors conclude that he needs immediate attention" (Merriner 1974, as quoted in Steffen 2016). This quote illustrates the ways in which ED staff utilize socially constituted patient categories in conjunction with biomedical disease categories to judge the legitimacy of patients and their complaints. Patients deemed socially undesirable (e.g., alcoholics, homeless persons, and drug users) are derided by staff (see also Jeffrey 1979). Further, this quote demonstrates the ways in relations how moral and professional organizational values, derived from broadly held beliefs and biases, factor in the evaluation and treatment of patients (see also: Roth and Douglas 1983).

Merriner's narrative, while voyeuristic in its emphasis on human degradation, points to the simultaneous abandonment and surveillance of the poor that persists today. One ED physician described it as follows,

> I think if you go into the liquor store on the corner and you drink your fifth [of alcohol][25] and you are on the ground, the store doesn't want you out there, the police get a call. Whereas even if you're homeless, if you take your liquor under the bridge or wherever it is that you stay and you drink it there, probably no one is going to call the police and you probably won't end up in the ED.I know there is one guy, I can't think of his name, but he has an amputated leg and

---

[25] A "fifth" is a unit of volume used to measure alcoholic beverages in the US. It is approximately one fifth of a US liquid gallon, or approximately 750 mL of alcohol.

> the police bring him to the ED because he doesn't have a leg. And they think that somehow that's a medical condition. Because he'll get here and he'll be drunk but he's not that drunk. And he'll say that he was sitting on a bench outside and [the police] just picked him up and he had to come.

This quote mirrors Merriner's characterization of homeless men as cycling between jails and the ED, as well as the parallel processes of the criminalization and medicalization of poverty and homelessness that continue today. For Merriner and a slew of politicians and businessmen, these men were not evidence of the failures of industrialization. They were failed souls who lacked the morality and work ethic necessary to be productive members of the economy.

Yet Merriner's piece also coincided with a crisis in downtown Atlanta that mirrored those of downtowns throughout the country. White migration to the suburbs, fluctuations in the increasingly financialized market and governmental divestment from the urban centers resulted in a feedback loop of downtown decay, disinvestment, and devaluation. Unable to raise maintenance and operating costs, SROs across the country closed down. In Atlanta, the number of SROs dropped from twenty-three in 1970 to four in 1986, thereby eliminating an important supply of low-income housing (Steffen 2016). Atlanta was thus lockstep with what has been identified as the neoliberal restructuring of urban life, and much like the rest of America, this restructuration had a racial bias (Harvey 2008).

Although Atlanta's white elites would have, by most accounts, happily separated themselves from the problems of the urban core, they could not completely segregate themselves from downtown. Many core institutions (e.g., hospitals, universities, business centers) remained populated by white elites. Unable to relocate these institutions, they turned to federal “urban renewal programs” to “acquire slum properties, assemble them into large parcels, clear them of existing structures, and prepare them for ‘redevelopment’” (Massey and Denton 1993: 55). In Atlanta, this meant the establishment of a rail system via the Metro Atlanta Transit Authority (MARTA) and expressway expansion, which destroyed a highly visible black, working-class shopping district along with a third of the city’s housing supply, displacing primarily poor black families in the process (Steffen 2012). As was the case across the country, newly constructed units were not enough to absorb the displaced tenants, thereby crowding neighborhoods and contributing to further housing instability.

The increases in housing instability eventually made way for a mass of unsheltered homeless persons in the 1980s. With SROs demolished, public housing unable to absorb the newly displaced urban poor, and emergency shelters at capacity, the number of people living on the streets surged and the “homeless crisis” reentered the public discourse (Burt 1992). Even more striking was the appearance of people previously thought to be immune from homelessness: women and children, and people with stable work histories. They were dubbed the “new homeless” to signify the seismic shift in homelessness from a place-bound condition on skid row to a condition of *literal* homelessness, or displacement, on the streets across the US (Rossi 1990). While the old homeless were largely invisible in their confinement to skid row, the visibility of the “new homeless” marked a new and disquieting phenomenon in the minds of most Americans.

At the beginning, people rationalized this crisis was an expected byproduct of the recession of 1980-82, until then the greatest economic crisis since the Great Depression. They explained that high rates of unemployment, increasing cost of living, and shrinking public assistance programs culminated in a sharp rise in the number of people seeking homeless services. However, even as the economy improved, the number of homeless continued to rise, indicating the decoupling of homelessness from the notional concept of “economy” and generating widespread debate about the causes of this “new” phenomenon and the best ways to address it. In response, two lines of explanations emerged.

The first invoked structural causes of homelessness, of which the most widely advanced arguments included the effects of widespread deindustrialization, the expansion of the service economy, retrenchment of the welfare state, and the deinstitutionalization of mental health services.[26] Proponents of structural explanations argued that stagnant wages and skyrocketing prices placed decent housing squarely out of reach of many Americans. Further, they argue that discriminatory housing policies and draconian government policies did nothing to buffer the difficulties of homelessness or housing insecurity.

The second line of argument was forwarded by proponents of a more individuated and less structural causal framework (Main 1998). They argued that housing was widely available to anyone who could hold a job and maintain a steady

---

[26] The extent to which each of these contributed to homelessness is widely debated. However, it is notable that the deinstitutionalization of mental health services lent much credence to the individuation of homelessness.

income. They enthusiastically advanced the notion that homelessness is a byproduct of individual vulnerabilities, namely mental illness, alcoholism, and/or drug abuse. This triad of impairment, they argued, led to failures of self-management and basic financial planning, which naturally culminated in homelessness.

Interestingly, both of these lines of explanations take for granted that the homelessness crisis of the 1980s was “new.” In fact, as indicated above, homelessness and housing insecurity are as old as the US itself, having been entrenched and exacerbated by discriminatory housing policy, racial biases, and uneven development. These characteristics of US housing—not individual vulnerabilities—were the necessary precursors for the mass of unsheltered people that we recognize as the homeless today. What was “new,” therefore, about the homelessness of the 1980s was not homelessness itself, but rather its unsettling visibility (i.e. its appearance as an emergent problem of the urban poor that needed to be addressed). No longer did people need to read about the urban underworld in exposés like Merriner’s. They were taking notice, as homelessness spilled over into their parks and on their streets. They did not like what they saw, and pressingly demanded action rather than explanations.

These responses to homelessness are manifestations of what Michel Foucault termed governmentality, or “’the conduct of conduct’: that is to say, a form of activity aiming to shape, guide or affect the conduct of some person or persons” (Gordon 1991: 2). Foucault uses governmentality to direct attention to *ways* of governing. His idea of governmentality as a mode of power is simultaneously “individualizing” and “totalizing.” That is, governmentality is as much about what it means to be an individual as it is about a society of individuals to be governed or governable. Taking power as an omnipresent feature of human life, he further demonstrates that governmentality is not simply about directing the actions of others. People have developed techniques of governing themselves as well. Implied within this logic of governmentality is a notion that society could transcend the need for both force and politics. As Paul Rabinow notes, “Implicit here is the assumption that… that an inverse ratio existed between the welfare of a society and its dependency on overt forces of order. Order achieved by force was less desirable and more costly than a well-tempered social regulation” (Rabinow 1995: 231). Obviously, force and politics remain critical features of social life. But we are still ruled by our conceptions of ourselves, the homeless, and our respective places in the world.

Within this framework, the homeless person is constituted as simultaneously as a failed rational subject and a threat to the broader group. This characterization of the homeless emerges in conjunction with a public sensibility towards the deviant or the abnormal. Within this context, “abnormal” is posited in direct contrast to the “normal,” which is more than simply a state of health. “Normal” is the purified state that everyone must constantly strive to achieve. As such, “normal” holds much power in consequence in the social world. Summarizing the consequences of this power, Colin Gordon writes, “The postulation of an interior domain of mental norms parallels and presupposes [the] promotion of an alert public sensorium of civil vigilance” (Gordon 1991: 36). It is exactly this “public sensorium of civil vigilance" that would inform the response to the homeless crisis in Atlanta and throughout the US.

Homeless in Neoliberalism

Importantly, the homeless crisis and any action against it would both arise within the broader context of neoliberalism, which David Harvey defines as "a political project to re-establish the conditions for capital accumulation and to restore the power of economic elites" (Harvey 2005: 19). In contrast to Keynesianism, which attempted to mitigate the hazards of living under capitalism, the neoliberal reforms of the 1980s shifted responsibility of navigating these dangers away from the state and onto individuals. Of course, navigating these conditions has progressively become more difficult (cf. Ehrenreich 2010) and has precipitated widespread social disarray and deepened racialized inequality in the US.

As a city on the cutting edge of neoliberal reforms in the 1970s and 80s, Atlanta is an excellent case study of the campaign against homelessness and its consequences (Steffen 2012). Indeed, Atlanta's business elites, represented primarily by the Central Atlanta Progress (CAP), had longstanding relationships with local governing powers that enabled them coordinate their interests in ways unimaginable in other cities.[27] Atlanta also lacked the strong labor organizations and coordinated community response to counteract the organization and its long-term vision, which sought federal funding to establish public-private partnerships (hallmarks of neoliberal governance) to reshape housing and "revitalize" the city's

---

[27] For more detailed treatments of business and governing partnerships in Atlanta, see: Stone 1989 and Hunter 1953.

urban core.[28] Atlanta was at the forefront of this shift in housing policy, which turned its priorities away from securing and subsidizing housing for the poor and towards putative neighborhood revitalization and improvement.

For example, HUD instituted a tenant-based Housing Choice Voucher Program in 1983.[29] This program was instituted as public housing was being declared a failure and "housing choice" was being promoted as the future of rental assistance, ostensibly allowing low-income tenants to move into more desirable neighborhoods and facilitating upward mobility for participating individuals and families. Matthew Desmond describes the program:

> For each metropolitan area [HUD] sets a Fair Market Rent (FMR): the most a landlord could charge a family in possession of a federal housing voucher. FMRs were calculated at the municipal level, which often included near and outlying suburbs. This meant that both distressed and exclusive neighborhoods were thrown into the equation. New York City's FMR calculation included SoHo and the South Bronx. Chicago's included the Gold Coast and the South Side ghetto. This was by design so that a family could take their voucher and find housing in safe and prosperous areas in the city or its surrounding suburbs. But… voucher holders more or less stayed put,

---

[28] This may appear counterintuitive given the strength and coordination of the Civil Rights movement within Atlanta. It is, however, noteworthy that protest and resistance were not as instrumental within Atlanta as they were outside of it.

[29] As part of Section 8 of the Housing Act of 1937, more commonly referred to simply as "Section 8." This program was instituted during the Great Depression and has since been repeatedly modified and amended.

> upgrading to slightly nicer trailer parks or moving to quieter ghetto streets. (Desmond 2016: 148)

While the program did not bring about racial or socioeconomic integration, it did allow landlords to charge tenants with housing vouchers higher rents. This drove up prices for unassisted renters and narrowed the rent gap between "desirable" and "undesirable" neighborhoods across the US (Desmond 2016). Ironically, the result of these rental assistance programs was an increase in housing insecurity, eviction, and homelessness.

Drawing on the push for such programs and public-private collaborations, the Atlanta Housing Authority (AHA) was able to exercise greater flexibility in its use of federal funds to phase out public housing and fundamentally reshape the housing market. For example, the AHA was at the forefront of HUD's HOPE VI (Housing Opportunities for People Everywhere) Program, which transformed public housing by demolishing the large, spatially concentrated developments and replacing them with mixed-income housing (Tester, et al. 2011). Using HUD funding, the AHA built ten nationally "acclaimed" mixed-income projects between 1994 and 2004, thereby gaining reputation as a leader in addressing public housing's perceived failures, such as high unemployment rates, high crime rates, and poor physical and mental health amongst tenants.[30] Thus, the AHA, reflecting the change in national housing priorities, transformed itself from a welfare agency and to an economic-development one leveraging federal funds with private dollars. In the process, Atlanta's *housing* authority played an active role in

---

[30] Such arguments ultimately amount to little more than a repackaging of the culture of poverty thesis, as they attribute features of poverty onto housing residence rather than failures of the broader social order.

displacing residents and contributing to the city’s already widespread homeless problem.

Atlanta’s destabilization of the housing market was not limited to the AHA. It also extended into its response to the homeless crisis. Steffen (2012) details CAP’s response to the homeless crisis between 1973 and 1988, arguing that, through CAP, the city’s upper echelon “set out to reconfigure public safety and social provision along neoliberal lines… to control the turbulent politics of the new homelessness” (172). Though the CAP had long been involved in efforts to transform the city’s infrastructure, Steffen nonetheless observes,

> For the first time since World War II the corporate sector turned its attention from modernizing the city's physical infrastructure to improving its “quality of life,” an innocent-sounding phrase behind which gathered the angry forces of urban revanchism. *Quality of life* would be invoked again and again to justify the most audacious plan yet conceived by the corporate sector to remove homeless people from downtown Atlanta. In rolling out this radically punitive assault on the *street people*… the corporate sector revealed how far it was prepared to go in order to secure a “liveable” [sic] downtown. (Steffen 2012: 184)

Seeking to remake downtown into a glitzy area of consumption and conspicuous capital accumulation devoid of the displaced mass of humanity that betrayed its darker side, the CAP established a two-pronged approach. The first was to criminalize homelessness by instituting punitive strategies of the revanchist state

(Smith 1996). This included city ordinances against panhandling, loud noise, and public alcohol consumption, among others. By targeting a predominately black male homeless population, these punitive measures directly fueled the engines of mass incarceration, which Michelle Alexander (2012) calls the “new Jim Crow” and Loïc Wacquant (2000) describes as the “surrogate ghetto.”

CAP’s second approach was a strategy of mass displacement—the latest in a long series of dispossessions that characterized Atlanta’s urban renewal projects. To do this, the city’s planners sought to funnel the homeless out of downtown and into the suburbs by recommending the establishment of additional shelters “in neighborhoods contiguous to downtown” and “all over the metropolitan area” (Steffen 2012: 182). In an effort to ostensibly alleviate the hardships of homelessness, the city called upon various purveyors of social services (the Fulton County Health Department, Grady Hospital, Georgia Nurses Foundation, among others) to expand their homeless services. While this was done under the guise of providing greater social services “options” to the homeless, it just as importantly removed them from public view within the city. Moreover, this approach spread the burden of addressing homelessness and serving the homeless, rather than letting it fall squarely on the city of Atlanta. By shuttling the homeless from one service center to the next, the city ostensibly provided much-needed assistance to the homeless, while shifting the responsibility for this population onto these institutions and successfully deflecting attention away from the specific conditions that produced homelessness in Atlanta.

However, the CAP ran up against difficulties in operationalizing this plan of homeless criminalization and displacement, largely because it came up against the tense racial politics of the 1980s as well as the activism of faith-based communities as they advocated for a response to homelessness that stressed compassion and relief over punishments. As an example, Steffens points to an *Atlanta Journal* article with the headline “Vagrant-Free Zone Urged for Downtown Atlanta,” in which,

> The word ‘vagrant’ struck a raw nerve, not only because it dredged up an ugly history of criminalizing black poverty that reached back to the hated black codes of Reconstruction but also because it suggested that the [Public Safety Task Force] was less interested in going after law breakers than in sweeping the streets of people whose only crime was that they had nowhere else to go. (Steffen 2012: 186)

CAP and city officials found themselves scrambling to control the press coverage and public opinions of their response to the homeless crisis. In the process, the social cohesion that had previously characterized the relationships between the political and business elite in Atlanta showed rare cracks. Ultimately, their efforts would fail to adequately address the homeless crisis or to achieve the urban renewal according to plan. However, the failure of the neoliberal reforms did not mean that the homeless crisis was any closer to resolution or even stabilization, and as Steffens argues, already this initial failure was a short-lived one. CAP's two-pronged approach to homelessness would ultimately prove effective in the 1990s when the roll out of the “partnership state” coupled with the sense of urgency introduced by the coordinated preparation for the 1996 Olympics would serve to stigmatize, medicalize, and criminalize the most vulnerable segments of the urban poor.

Indeed, the most dramatic developments in Atlanta’s housing policies and systematic urban displacement came in the 1990s in anticipation of the 1996 Olympics. As Atlanta sought to promote itself as a global city, it had to create an urban demographic that matched its narrative as a prosperous, cosmopolitan, multicultural metropolis. This narrative not only excluded the poor and the homeless from the city’s citizenry, its actualization relied on their displacement and erasure from the city’s urban core. The demolishment of public housing, the forced evictions of thousands of low-income residents, the arrests of thousands of homeless persons, and the displacement of homelessness Atlantans were critical to the “cleanup” of the city.

Between 1990 and 1996, nearly 30,000 Atlantans were forcibly evicted or displaced (Gustafson 2013). From 1995 to 1996, approximately 9,000 homeless persons were arrested for crimes that included reclining in public, blocking sidewalks, public urination, and removing items from any public trash container (Beaty 2007). Nearly 1,000 homeless shelter beds were eliminated from the heart of downtown Atlanta to make way for Centennial Olympic Park. None of these beds were replaced, but the homeless were recompensed with one-way bus tickets out of Atlanta (Gustafson 2013). However dramatic these statistics may be, the Olympics were only a moment in Atlanta’s ongoing efforts to portray itself as a wealthy, racially harmonious city. Within this mythology, the urban poor in general, and the homeless in particular, do not figure as part of the city's citizenry to whom its officials or leaderships are responsible.

Economists and policymakers may argue that a robust economy, far more than housing, is necessary precondition for addressing homelessness (c.f., Freeman 2001). However, it is notable that, since the 1980s, homelessness has been a permanent feature of postindustrial urban America, in boom years or bust. This is not to suggest that homelessness and poverty are independent of the vicissitudes of economic fluctuations endemic to late capitalism. Rather, it is to point out that homelessness has not subsided despite major economic upturns and downturns over the past thirty years. It serves to show that homelessness is not simply epiphenomenal to an economic crisis, but is also rooted in the socio-spatial transformations wrought on the American city since the Great Depression. Today, homelessness and housing insecurity are embedded features of our population dynamics rather than a byproduct of transient economic downturns (Brown, et al. 2016; Greysen, et al. 2012; Hwang and Dunn 2005; Shinn, et al. 2007; Williams, et al. 2010; Willse 2010).

Yet, the naturalization of homelessness has fueled more interest in counting and charting the homeless than in interrogating the social relations that define housing conditions and produce homelessness. For example, in 1987, Congress passed the McKinney-Vento Act, which allocated funds to be administered by HUD to track and manage homelessness through various initiatives.[31] The Act established

---

[31] For more detailed treatment of the McKinney-Vento Act and HUD homeless policy, see: Willse 2015.

parameters on what constitutes homelessness and which subsets of the population can qualify for services, thereby laying the groundwork for the aforementioned administrative definitions of homelessness. In order to administer the earmarked funds, HUD requires homeless service agencies to use Homeless Management Information Systems (HMIS) to track and characterize homeless populations nationally. Through these narrow definitions and onerous requirements, HUD focuses on surveilling and regulating the homeless. Rather than addressing the root causes of homelessness and housing insecurity, the "problem" of homelessness has been converted into a series of bureaucratic and technocratic functions and procedures untethered from the set of relations that maintain and exacerbate homelessness.

Consequently, homeless service delivery has concentrated on "rehabilitating" the homeless rather than addressing the structural relations that produce homelessness. In the process, homeless people are funneled into programs and interventions that fix their purported deficiencies—alcohol or drug treatment programs, job training, or psychiatric counseling—in order to make them "housing ready" (Lyon-Callo 2008). Here, housing "readiness" effected through extensive psychosocial assessments and treatment plans including mental health and addiction counseling (Wright 2009). As such, "readiness" is synonymous with "deservingness" through a demonstration of moral worth and a commitment to integrating in respectable (i.e., housed) society. Ironically, this discourse posits homelessness as independent from housing. As Craig Willse observes, "what to do with the homeless, rather than what to do about housing, has become the obsession of government policy, social service practice, and social scientific inquiry" (Willse 2015: 54). In the process, homelessness is not viewed as an extreme manifestation of poverty. Rather, it is a contemporary synonym for "the mentally ill," "the addicted," or "the alcoholic."

This conflation of the homeless with medical illness made management of the homeless a matter of medical concern. Medical diagnoses are one of the few avenues to receiving relatively stable, albeit meager, government sponsored benefits (Hansen, et al. 2014). The management of these diagnoses is an important component of homeless outreach services (Lyon-Callo 2000). Moreover, the expansion of services for the homeless within the hospital helped reinforce the institution's role as a primary service provider for the indigent.

"I'm not homeless! I just don't have anywhere to stay."

A narrow focus on regulatory definitions and statistical patterns obscures, on the one hand the social relations that those definitions and patterns produce and maintain, and, on the other hand, the tenacious stigma that accompanies homelessness.[32] Indeed, the word "homeless" usually connotes an archetypal figure of a mode of poverty: single (often black) male, disheveled and malodorous, always slightly out of touch with reality, and posing an imminent threat to the rest of "respectable society." This archetype renders the homeless either pitiable, deplorable, or both, but in any case a known, or at the most an easily knowable entity. This characterization renders homelessness a manifestation of poverty that is specific and separate from other forms of disenfranchisement, such as the kinds of

---

[32] For further treatment of stigma related to homelessness and its long-term effects, see: Link, et al. 1997 and Schneider and Remillard 2013.

structural inequities governing housing, job opportunities, and education in America. The difficulties of housing and thus homelessness in general is a structurally produced American problem—not just an "urban" one (Cloke, et al. 2007; Cloke, et al. 2002).

In part, the figure of the homeless person as an urban nomad has been shaped by decades of discursive fodder fueling the notion that homelessness is a character flaw rather than a product of nonrandom distribution of life chances. The archetypal figure of the homeless and its attendant misapprehensions reinforce our notions that homelessness is simultaneously self-evident and intractable. Robert Desjarlais observes, for example,

> To describe someone as "homeless" announces a lasting identity. When used, the adjective is lasting and all-encompassing: journalists and others often speak of a "homeless" woman or man with the same certitude that they identify someone as a doctor, a politician, or a white man. Homelessness denotes a temporary lack of housing, but connotes a lasting moral career. Because this "identity" is deemed sufficient and interchangeable, the "homeless" usually go unnamed. The identification is typically achieved through spectral means: one knows the homeless not by talking with them but by seeing them. (Desjarlais 2011: 2)

The homeless are rarely represented as full, deep, or complicated human beings—let alone "citizens." Instead, they are represented as cautionary tales: this is what happens when one's life gives way to insobriety, madness, or moral failure. The archetypal homeless therefore serves as the “other” to the socially produced images of a healthy life and moral restraint. The othering of the homeless, however, serves to obfuscate the fact that health and homelessness in contemporary America exist relationally, as a duality; the very existence of the former is evidence of the failings of the social structures the latter relies upon.

To be sure, the poor, the homeless do not exist in an alternate universe (cf. Toth 1993). They exist in close proximity, which is why elaborate discourses must be devised to belie this proximity, to avert the gaze, and maintain the illusory normality of “our” social order. Tellingly, it is precisely as a product of the social relations that tie health and homelessness that the homeless often consume and internalize the prevailing discourse about *their* moral failure. As I learned in my fieldwork, they are intimately aware of the assumptions of depravity, and all the stigma associated with the condition of homelessness.

Oftentimes, those who are housing insecure, doubled up or living in motels to avoid being on the street actively resist being labeled as homeless and echo the stereotypes and stigmatizations that would so easily be extended to themselves given the prevailing social condition. To distance themselves from being labeled homeless, my informants would go to great lengths to pay attention to their clothes, the way they speak, their grooming and their appearance. They would stow away their meager belongings at the homes of friends and family members or in locked closets at nearby shelters. When I inadvertently referred to one of my informants as homeless, she indignantly protested, “I’m *not* homeless! I just don’t have anywhere to stay!” Her protests came precisely because she had taken great pains not to *look* homeless, so as not to be confused with “those people.” She went on to elaborate that “those” homeless people were the ones who “just like living in shelters” because of how “easy” it is to be there—a free place to stay, a steady supply of meals, and an overall carefree life. This was not the first time I had heard this characterization of the carefree homeless. Though no ED staff offered laziness or carefree living as a reason for homelessness, two super-utilizers and many more ED patients regaled me with stories of people too “lazy” to “get a job” or “pay their bills.” This image was always conjured up in direct contrast to the storyteller, who would go out of their way to paint him or herself as a person who had fallen on hard times and couldn’t catch a break. I regularly asked for names of people living this homeless high life, but my efforts were to no avail. When I pressed for examples, the storyteller could never offer me a name or a specific example of a person taking advantage of homelessness. Usually, the story would end in some reaffirmation of distance, “I don’t try to stay around those people. They just bring you down and I gotta keep my focus and get out of this situation.”

As indicated above, the phenomenon of homelessness has been stigmatized and systematically untethered from the structural inequities built into the problem of the affordability and availability of housing in America since the Great Depression. This stigma has made homelessness synonymous with moral, mental and physical insufficiencies and untethered homelessness from the conditions of housing.

Homeless in the Emergency Department

The question remains: What does homelessness have to do with medicine in general, and emergency medicine in particular? The first and most obvious way to answer that question is to point out that Emergency departments (EDs) are the de facto healthcare providers for the homeless, who suffer from extensive and well-documented adverse health effects of homelessness (Brown, et al. 2016; Brown, et al. 2012; Fazel, et al. 2014; Strike, et al. 2014; To, et al. 2015). The homeless suffer from mortality rates 3-6 times those of the general population, and homelessness is an independent risk factor for mortality (Baggett, et al. 2013; Hibbs, et al. 1994; Morrison 2009; O’Connell 2005). Homeless persons have an estimated life expectancy between 50 and 64 years old depending on the methods employed (compared with 78.8 years average life expectancy in the US) (Culhane, et al. 2013a; O’Connell 2005; Xu 2016). Homeless persons also experience higher rates of chronic illness, chronic injury, infectious disease (e.g., tuberculosis, HIV, and hepatitis C), and mental illness than their low-income housed counterparts (D'Amore, et al. 2001). These not only contribute to higher increased mortality, but also to vulnerability to assault, accidental injury, and acute exacerbations of their chronic disease. The risk of death is highest among those living with HIV infection, renal or liver disease, arrhythmias, or those with a history of previous incarceration or chronic homelessness. However, even episodic, time-limited homelessness is associated with an increased risk of mortality (Hwang 2002).

My super-utilizer informants did not display the full range of medical diseases from which the homeless suffer. They varied in their diagnoses of mental illness and chronic diseases such as diabetes or liver disease. The one thing they all had in common, however, was vulnerability to accidental injury and/or assault. Super-utilizers’ vulnerability to accidental injury came from simply walking on uneven pavement, which predisposed them to regular accidental trips and falls. Franklin had the most dramatic injury when he was hit by a car while he crossed the street. He was tall, thin, and soft-spoken with a Caribbean accent. Though he had spent months on the street, Franklin took great care in his appearance, making sure his shirt was always tucked into his slacks and his hair was neatly combed. He was therefore hardly recognizable the evening of his injury. His face was scraped, and his clothes were torn and bloody. Franklin suffered no serious injuries, but he told me that his doctors advised him to go to a shelter and rest in the days following. He accepted the documentation they gave him to prove his medical needs, but he dismissed their suggestion outright. “Do you know what kind of people stay at these shelters? I stayed there for a week before. One night, I woke up and saw two guys standing over me. One of them was holding a knife and my wallet. If I go back there looking like this,” he pointed to his bandages for emphasis, “God knows what will happen to me.”

Exacerbating the ill effects of homelessness on health is the aging of the homeless population since the 1980s. The median age of single homeless adults is 50 years today, compared with 37 years in 1990, and is predicted to continue to rise (Culhane, et al. 2013b). This is particularly important since homeless adults are considered “elderly” at age 50, as they have health conditions comparable to persons ten years their senior (e.g., frequent falls, frailty, or cognitive impairment) (Brown, et al. 2012). In Franklin’s case, his age made him vulnerable not only to accidental injury, but also assault. And while elderly homeless persons have a greater risk of dying than their housed counterparts, the mortality risks are just as dramatic in younger age groups. In other words, homelessness is hazardous to one's health, regardless of age or the presence of other medical conditions.

For example, younger homeless women have between 4 and 31 times the mortality risk of their housed counterparts (O'Connell 2005). Even the widely touted competitive advantage of women's increased life expectancy seems to disappear, as homelessness equalizes the risk of premature death across gender. Simply put, homeless persons suffer from more frequent and more severe illnesses than the general population. The EDs have come to be the primary mode by which they seek and receive health care.

However, despite the clear contribution of homelessness to poor health and the historical role that EDs have come to fill as a primary health care provider for the homeless, their presence in the ED poses two significant challenges for the ED staff and administrators. First, homeless patients' presence in the ED does not reinforce the value of ED work. One doctor summed it up in the following way,

> All super-utilizers have a kernel of a healthcare need. The people that we know by name, the reason that we started seeing it in the first place is because they had health problems. Frequently complex health problems. But if, Mr. Wheen came every day because he was an asthmatic and he was really sick every time he presented and you intubated him every third shift or something then I don't think you would find that interaction to be value-less, right? I think none of us would be annoyed. But you know, you would act on that. There would be something you would see and you could do A or B, and

> you would go forward with that. I think the issue for us becomes when there's nothing to do. We have one gentleman in particular who is mentally ill, and he comes to complain about one of his ten toes on close to daily basis. We're doing nothing to address his mental health. We're addressing his chronic foot complaint so there's no value in that. And he's fine. His foot is fine.

Note that value here—the worth of the interaction—is based on the ability to intervene medically and to see some improvement in a patient's condition. In this way, social problems present themselves as fruitless patient complaints, with no immediate improvement in a patient's condition possible. ED staff do not have the means at their disposal to provide housing or to ease the difficulties of homelessness since the social condition of homelessness, is structured through factors external to the body and person of the patient. To illustrate, Marc Berg (1992) demonstrates the importance of framing medical work in terms of "solvable problems." By using laboratory studies, in conjunction with patient histories, a vague complaint (e.g., shortness of breath) is reinterpreted as a single diagnosis (e.g., bronchitis). Consequently, a concrete plan of action emerges from the narrowing of possibilities. Berg argues that together, the type of question a doctor asks and the interpretation of the answers, steer the conversation in order to "correspond to the transformation she has in mind" (Berg 1992: 156). Just as scientists undertake one type of experiment over another in order to prove a given hypothesis, for Berg doctors similarly select certain examination procedures and omit others.

Berg outlines how both patient histories and examination data can be given more or less validity depending on their usefulness in determining the desired transformation. He contends that the character of a patient may be brought into question by medical staff, which serves to downgrade the data derived from patient histories (see also: Holmes and Ponte 2011). This may be accomplished by the addition of phrases such as "according to the patient" to the patient's note or simply adding quotation marks to their comments. Moral questioning of a patient's character occurs as part of the narrative construction: if the data is useful, the patient can be described as "intelligent or "reliable"; if it is not, the patient is labeled "incoherent" or his or her symptoms "atypical" (Berg 1992: 158-9). Patients who can be assessed, diagnosed, and successfully cured (or treated) are useful subjects for demonstrating competence and good medical practice.

Homeless people's presence in the ED fundamentally challenges this framework. They are people who are already deemed "unreliable" or "untrustworthy" by ED staff—even before they walk into the ED. To complicate matters, unlike other patient groups, their needs are necessarily multiple and complex. Among ED staff they are notoriously difficult to diagnose quickly, for their needs span the spectrum from the chronic to the acute, the social to the medical. Their circumstances pose extraordinary barriers to medical plans, as many avenues of self-care extending outside the ED interaction are foreclosed to the homeless. Instructions such as rest, icing an injured extremity, or taking care of a wound become more complex and difficult to manage in the absence of stable housing. More significantly, the underlying cause of their illness i.e., the lack of adequate housing and shelter cannot be addressed in the context of an ED visit (or through medical tools in general). These complexities pose a challenge for medical care providers, for the needs of homeless persons fall outside normative patient categories or to count them as “appropriate” medical visits. To illustrate, it is useful to return to Cornell, whose case I mentioned at the outset of this dissertation. Cornell was brought to the ED by ambulance for a complaint of chest pain—a common complaint with potentially serious consequences. It eventually became obvious, however, that Cornell’s presence in the ED was, in fact, related to his unstable housing situation and his vulnerability to violent victimization on the street. I had tools by which to assess to treat his chest pain, but the rest of his circumstances were well outside of my control.

For Cornell and other homeless patients, the deplorable living conditions under which they live mean that the factors affecting their ill health would continue to affect them even if momentarily addressed by the ED. Relatedly, their illness is often not a matter of “medical” concern. The inextricability of the social component of homeless persons’ health concerns means that their troubles are social rather than medical. Subsequently ED care is offered begrudgingly, while, yet again, appearing as a problem to be solved. Ironically, only in the cases where their condition precipitates in an acute and/or life-threatening affliction do they obtain inclusion into a “normative” medical category that can be addressed and treated.

The problematic status of the homeless in the ED is exacerbated in light of the increasing rationalization of healthcare delivery, which stresses the achievement of maximum efficiency. This turn in the logic of healthcare, emphasizes the role of the ED as an important gatekeeper for access to medical services. Policymakers repeatedly maintain that the ED offers "the most expensive care there is,"[33] and follow up the potential cost savings if patients are adequately kept out of the hospital and rerouted to appropriate outpatient clinics or kept out of the healthcare system altogether (Baker and Baker 1994).

Following this logic, the ED literature has focused primarily on measuring and describing patterns of ED use among the homeless rather than addressing the root causes and consequences of homelessness (Salhi, et al. Forthcoming). For example, studies have reported that homeless persons utilized the ED 2-3 times more frequently than non-homeless persons—without mention of the significant morbidities that accompany homelessness and necessitate ED care (Coe, et al. 2015; Tadros, et al. 2016). Other studies have described that homeless adults are more likely to arrive to the ED via ambulance, presumably due to high rates of injury, limitations in available transportation, and high rates of bystander use of ambulance services to attend to homeless persons' needs (Brown and Steinman 2013; Coe, et al. 2015; Hammig, et al. 2014; Ku, et al. 2010; Oates, et al. 2009; Pearson, et al. 2007; Tadros, et al. 2016).

Additionally, the ED literature has devoted much time attempting to link homeless persons' ED use to their lack of health insurance (Han and Wells 2003). Homeless persons are more likely lack health insurance or access to primary care services than the general population (Coe, et al. 2015; Ku, et al. 2010; Oates, et al.

---

[33] This characterization of the ED is based on higher prices charged by EDs than other ambulatory care settings. This depiction ignores the complex role that EDs play in American healthcare, and the statutory obligation of hospital EDs to provide care to all in need without regard for their ability to pay. For more detailed treatment of this, see: Morganti et al. 2013.

2009). This has led many to hypothesize that increasing the availability of health insurance would increase utilization of primary care settings and decrease reliance on ED services (Chwastiak, et al. 2012; Kushel, et al. 2001).

In reality, however, insurance status and access to primary care have consistently been shown to have no effect on ED utilization as far as homeless adults are concerned (Burt and Sharkey 2002; Han and Wells 2003; Lin, et al. 2015; Mackelprang, et al. 2015; Niska, et al. 2010; Wang, et al. 2015). For example, in two studies of homeless US veterans who have health insurance and access to Veterans' Administration services, the major differences found between homeless and non-homeless ED users were high rates of comorbid illness (Tsai and Rosenheck 2013; Tsai, et al. 2013). This strongly suggests that factors other than insurance are the drivers of ED visits among the homeless.

Indeed, in this study, the primary drivers of super-utilizers' use of ED services were the needs and difficulties that arose from living under conditions of crushing poverty. Franklin, for example, told me that he first came to the ED after being assaulted outside the homeless shelter. He didn't remember much of the incident, but bystanders later told him that he passed out and they called 911 to bring him to the ED, where he was diagnosed with a concussion. He suffered memory lapses and falls in the weeks following his head injury, which prompted shelter workers and residents to call 911 to bring him back to the ED. The root cause of Franklin's assaults and injuries were his homelessness, specifically the difficulties associated with living on the street and in a shelter. Until he could figure out his housing situation, he resolved that it was safer for him to stay near hospital grounds. ED staff, on the other hand, were better equipped to deal with Franklin's injuries than his homelessness.

The culture of the ED, like the academic ED literature, takes it as self-evident that the ED is a place for the treatment of acute medical problems and injuries, and not the place for managing inappropriate (i.e., social) complaints. In thinking about this assumption, it is useful to reflect back on Atlanta's response to the newly unsheltered homeless of the 1980s. Like cities across the country, Atlanta focused on expanding homeless services rather than addressing the widening wealth gap and the inaccessibility of housing. This included expanding mental health services and substance use counseling to rehabilitate the deviant, or what has also been termed the "medicalization of homelessness" (Lyon- Callo 2000).

Thomas Osborne (1998) frames medicalization in a way that is particularly useful. Instead of understanding medicalization as a conspiracy that casts medical authority as holding dominance over other fields of knowledge, he suggests that it should be considered an *ideology* that has principles of functioning that are refracted, extracted and used in those other fields. This suggests that medicine's principles of functioning are multiple, which I demonstrate throughout this dissertation. More importantly, the ideology of medical knowledge is also permeable and permeated by other regimes of knowledge and perspectives that can be used to help it carry out, or conversely hinder the achievement of, its core principles.

For example, Peter Conrad (1992; 2005) illustrates how medicalization as a form of social control can (and often does) occur without the active participation of the medical profession. His analysis is particularly useful in understanding how medical ideas can be influenced by issues of wider social concern, such as deviant behavior. Conrad also shows that the boundaries of medicine are increasingly elastic and extend beyond the powers of a single professional group. Rather, medicine itself relies on an adoption and adaptation of dominant ideas within wider society. As an example, Conrad (2010) points out how masturbation was framed as an illness in the nineteenth century in order to control what was then widely seen as deviant and unacceptable behavior.

Conclusion

The ED literature produces an account of emergency medicine as a purely "medical" domain, a setting with its own distinct ways of knowing and practicing. It therefore makes sense that the homeless person appears in this literature as an element that destabilizes the purity of clinical medicine by bringing with them to the ED the complexities of their social problem. In contrast to the characterization of Emergency Medicine as a "purely medical" domain, it would be more accurate to think about the ED as a space "in-between" the medical and the social, the hospital and the world outside of it. The ED may be more usefully considered a threshold that reflects the contradictions of a neoliberal order that made it incumbent upon the EDs to expand their homeless services in order to buffer the effects of a shrinking public space, and then punished them for inefficiency and excessive cost expenditure. Similarly, homeless persons are patients in-between the medical and the social, with multiple health care needs compounded by the poor social circumstances. Often, their presence in the ED is not a matter of "rational choice" attributed to patient-consumers and all of its respective flaws and shortcomings (c.f., Sen 1977).

The continued presence of the homeless in the ED is a product of lives lived in the context of structurally produced precarity, life histories that consequently predispose them to ill health, and a social order that repeatedly stigmatizes and medicalizes their poverty and homelessness. The examination of homeless persons in the ED lays bare the flaws in our systems of social valuation, and the forms of knowledge and power that mediate them.

CHAPTER SEVEN: KINSHIP, WEAK TIES, AND THE URBAN POOR

Introduction: Clive

I first met Clive on an uneventful night in the ED. It was the first frost of the season, and the staff was enjoying a much-needed reprieve from the usual onslaught of patients and I was scrolling through email on my phone to pass the time. “Are you new here?” I heard a booming voice from behind me. I turned around to confirm that the question was directed towards me and saw him standing there, smiling expectantly.

“No, I’m not new. But I don’t think we’ve met before,” I smiled back and responded, noticing Clive’s bright eyes, and wide grin that revealed only a handful of remaining teeth in his mouth. He had a dark, weathered face with deep lines across his forehead and cheeks that hinted at the difficulty of his 74 years. He was a tall man, standing nearly six feet tall even with his aging back slightly hunched. His frame was draped with loose fitting clothes and a large, tattered black wool coat and he wore black construction shoes that were missing shoe laces.

“No, I guess not. But I just got out, maybe that’s why,” He followed up, referring to a recent stint in jail that had kept him from frequenting the ED. “Am I going to be seeing you from now on? I like seeing familiar faces,” He continued.

“I hope—” I started before Mia, a nurse standing nearby and overhearing our conversation, interjected.

“Don’t go stealing my boyfriend, now!” She warned me jovially as the two of them exchanged a nod and a smile.

“You know you’re my girl!” He shot back at her. Clive had been coming to the ED regularly for about a year and a half, usually on the night shift and usually for his emphysema, which would flare with the Atlanta pollen, the change of weather, and his never-ending quest for food and shelter. Eventually, Clive's emphysema had gotten bad enough that it restrained him within a few blocks of the ED and kept him coming back for breathing treatments. Over this time, he and Mia became familiar with one another. She developed a fondness for him, giving him extra orange juice and bologna sandwiches whenever she took care of him. In return, Clive would promise to take her out for a fancy dinner when he won the lottery.

When Mia was not around, Clive would ask for her by name, his shoulders stooping disappointedly if she was not working. Being around Mia—and much of the other staff he had come to know—had patterned his daily routine over the years. This was especially important to him since he had a strained relationship with his wife and son.

Clive had worked as an airport baggage handler for much of his adult life. In the late 80s, he injured his shoulder and unable to work his job—or any other manual labor job for which he was eligible. He was approved for federal disability benefits and spent the bulk of his meagre checks on alcohol. His wife complained loudly and frequently about his growing dependence on alcohol and threw him out. "I think she thought it would set me straight," he recalled, "but things just got worse." She filed paperwork to become his designated payee, dispersing funds to him as he cycled in and out of her household, shelters and the streets. Federal benefits (Clive's totaled $1,200 per month) are generally dispersed directly to the individual to spend as they see fit. However, persons who have a diagnosed mental impairment that interferes with their ability to manage their funds, a representative payee may be designated to receive the benefits on behalf of the disabled individual. The expectation is that this person, who is often a family member, will directly pay third parties (i.e., landlords), or return the funds disabled person while assisting with budgeting and payments.

Clive’s wife was not exceptional in withholding his check. This was a common and bitter complaint among my key informants who qualified for federal benefits. As a result, Clive’s relationship with his wife became more and more contentious, especially as he began cycling between the streets and jail, usually getting picked up for offenses like panhandling and public urination. Ironically, it was precisely this pattern that also made him unable to reclaim his check or any semblance of stability. Clive eventually stopped drinking, telling me simply, “It just got old,” but this was not enough to turn things around.

I replayed this moment frequently in the subsequent months, wondering if he meant to say, “*I* just got old.” He was in his early seventies and it had been decades since he had a stable job; his body had deteriorated from years of drinking and living on the street. His feet and knees would hurt from walking up and down the hills that made up Atlanta’s urban terrain. Eventually, his breathing would give out before his knees and he would make more and more frequent visits to the ED to get by. Through all this, his wife remained his payee and he saw less and less of his funds and his family.

“They’re on drugs, spending all that money on drugs,” he told me once matter-of-factly. When I asked how he knew, since he had been estranged from his wife and kids, he replied, “I just know. I see how they act when I go up there looking for my money. Where else could all that money go?” Clive often spoke distrustfully of his wife and son, as he did of other relationships that he characterized as remnants of a past life when he was not homeless. Sometimes, Clive spoke more fondly of ED staff (nurses, security guards, techs) than he did his only family—even when he didn’t know their names explicitly.

And while Mia (and other nurses) had a more affectionate disposition towards Clive, others weren’t quite so kind. While everyone would do their job in caring for him, the variability was in the interpretation of their job requirement. Some, for example, would refuse him the crackers or bologna sandwiches available. Others would demand that he leave the premises as soon as he was discharged, sometimes having him escorted out by security guards, who explained,

> You get to know who [people like Clive] are and what they’re about. And see here’s the problem: one guy says, ‘Oh, I just want to go to the cafeteria and get something to eat.’ You let them in and you say, OK, and next thing you know they’re sleeping in the lobby, sleeping in the cafeteria, sleeping in the cath lab and in the surgery waiting room. It’s not secure. You can’t just have them laying around wherever.

These attempts to drive Clive off or deny him a sandwich in an attempt to “discourage bad behavior” would precipitate some loud and heated arguments, some of which were diffused with a sandwich or friendly mediation, others which ended with Clive storming off the premises (only to be back a few hours later).

Clive knew that, although sometimes he would be treated badly, he wouldn’t definitively be turned away.

When he was not praising the staff as his friends, he would brush them off entirely. “I don’t need them no how. I can get by on my own. Always have.” Clive was not alone in his estrangement from his family or his paucity of friends. Although my informants varied widely in their demographic characteristics (e.g., age, gender, race), they were alike in their alienation from friends and family members. Often, they would name friends and family as pivotal members of their support network, yet they would falter when asked for surnames, phone numbers, or addresses. Those who had seen their family recently did so only briefly, and commonly only by chance meeting. On multiple occasions, I was asked to contact family members at disconnected or incorrect phone numbers. The few times I was able to get a friend or family member on the line, they would tell me plainly that they hadn’t been in contact for months (or longer). The ED staff I spoke with described similar experiences throughout my fieldwork. When this would come to light, my informants would either downplay their estrangement as temporary and a fact of life, accuse the other person of lying out of anger or spite, or simply name other friends in their network. While none of the staff proved this in greater detail, most of them concluded that super-utilizers like Clive were “isolated” or “lacking relationships.” Clive’s own declarations of “getting by alone” made good fodder for these claims. Yet how does one reconcile the plethora of ethnographic work on individualism and isolation, with the cross-cultural fact that individuals do not (and simply cannot) exist independently?

Regardless of the variability of my informants' accounts of the important members of their social networks, what they did have in common was their (usually temporary) estrangement from friends and kin networks and their reliance on ED staff and resources in their lives. My informants spent much time interacting with staff, who would vacillate between being friendly familiar faces and hostile guards, depending on individual moods, the workload on any given day, or preexisting personal relationships. These interactions would comprise the bulk of their interactions for weeks and months on end and had, for better or worse, become their primary social network. Yet Clive was the only person I met who openly named ED staff as part of his social network. Others (staff and patients alike) simply discounted these interactions as unimportant. This discrepancy between my informants' accounts of their social networks and what I observed is far from unique. Informant bias has been well-described throughout the social sciences in a wide variety of settings (cf. Bernard, et al. 1981; Freeman, et al. 1987; Knoke and Yang 2008). Nevertheless, the discrepancy raises important questions about the nature of relationships among the urban poor and the institutions charged with their management.

I begin this chapter with a brief review of relationships and kin networks among the urban poor in the US. I show that this framework has produced important insights into the lives of the urban poor, but is nevertheless insufficient to understand people like Clive who are not embedded in strong friend or kinship networks. While it is tempting to characterize individuals alienated from these networks as "isolated," I show in the subsequent section that this label generates numerous confusions and is a troubling analytical concept. To better understand what is usually labeled "social isolation," I argue that we should reconsider the nature of relationships themselves. Specifically, I argue that, more than sites for service provision and meeting places for the poor (cf. Desmond 2012a; Small 2009), the ED itself constitutes a set of relations and an important survival strategy of the urban poor. Finally, I demonstrate that these relationships are not simply interpersonal interactions, but are mediated by the urban environment in which individuals reside. I conclude this chapter by reflecting again on the nature of "ties" and "relationships" and the importance this has for future research directions.

Getting By: Relationships, Friends, and Kin Networks

How do self-proclaimed "loners" like Clive get by? To answer this question, anthropologists have largely turned their attention to social support networks, focusing in particular on people's close, important, trustworthy, and supportive contacts—especially kin networks built around the nuclear family unit of a husband, wife, and their offspring (Fox 1967; Murdock 1949; Radcliffe-Brown and Forde 1950; Strathern 1992). This, they argued, was the basic unit of survival, social structure, and well-being. This line of inquiry gained much traction in the context of urban poverty in the United States, being used widely in descriptions of poor family structures and survival strategies.

This was first described by W.E.B. DuBois in *The Philadelphia Negro* ([1899] 1967). Having been commissioned University of Pennsylvania to illuminate the "negro problem," which many held responsible for crime and urban disorder, DuBois instead emerged with a thorough survey of Philadelphia's Seventh Ward, arguing that its black community was a complex, multifaceted society governed by its internal class structure. This structure, he argued, was formed by historical legacy of slavery and maintained by the ongoing discrimination and structural racism of the Jim Crow era. More importantly, DuBois argued that "Negro problem" was a figment of the white imaginary, having less to do with a monolithic black "social pathology" than with whites' consistent enforcement of systemic racial discrimination and prejudice (Du Bois [1899] 1967: 53). To endure the hardships of poverty and discrimination, DuBois described household units comprised of various friends and kinship members who would alternately exchange money, child care, food, and domestic services to survive.

DuBois' findings were echoed by many subsequent scholars, who found similar patterns of kinship and survival strategies among poor and working-class families throughout the US (Drake and Cayton 1945; Frazier 1939; Gans 1982; Hannerz 1969; Howell 1973; Keil 1966). In noting these strategies, scholars like Drake and Cayton made important claims challenging the naturalization of racial hierarchies. Moreover, these scholars repeatedly noted that the "Negro Problem" was a misrepresentation of American society's ongoing troubled history with race—notions that were fundamental to *American* history rather than isolated concerns of the black community.

But America changed greatly in the decades after the publication of *The Philadelphia Negro,* and DuBois' proclamations fell on deaf ears. The Progressive Era and the subsequent War on Poverty poured much money and effort with the ostensible goals of eliminating poverty and mitigating the consequences of the rampant racism DuBois railed against. Yet poverty was never eliminated and racism fluidly adjusted, and the socioeconomic gap between blacks and whites in the US was never closed. Astounded at the persistence of racial and class inequalities in the face of social adjustment programs, policymakers turned to the "culture of poverty" to explain the persistence of poverty within an otherwise thriving nation. Within this framework, researchers conceptualized poverty as a subculture with its own beliefs and values characterized by fatalism, aversion to delayed gratification, and a generalized psychological inability to take advantage of available opportunities—all of which conspire to perpetuate "poor choices," antisocial behavior, ineffective education, and lower levels of occupational attainment that would go on for generations (Lewis 1966a; Lewis 1966b; Office of Policy Planning and Research 1965).[34] Proponents of the culture of poverty also focused on the lack of social cohesion and civic engagement among the poor, especially within black communities. Thus, in contrast to DuBois, they portrayed the social networks of the poor as disorganized and frayed, and this, in turn, they maintained, attributed to the prominence of female-headed households and lower rates of marriBut Amny urban anthropologists have since challenged this framework. Far from serving as a sympathetic ethnographic description or theorization, they argued, the "culture of poverty" was a highly politicized thesis that served to normalize the values of the rich rather than criticize the historical and economic conditions that produce and reproduce the urban poor as a distinct group (cf. Piven and Cloward 1971; Ryan

---

[34] This is an abbreviated list description of the Culture of Poverty, which was based on extensive ethnographic fieldwork. Lewis identified seventy traits characteristic of the Culture of Poverty. These traits, he argued, were influential in the lives of the poor, but were also outside of their control.

1971; Stack 1974; Susser 1996). Stack (1974), serving as a prominent critic of this thesis, observed,

> The culture of poverty notion explains the persistence of poverty in terms of presumed negative qualities within a culture… An underlying assumption of the culture of poverty notion is that the social adaptation of the poor to conditions of poverty would fall apart if these conditions were altered. It is assumed that the subculture would be left with no culture, or with wholly negative qualities. But… many of the features alleged to characterize the culture of poverty—unemployment, low wages, crowded living quarters—are simply definitions of poverty itself, not of a distinct "culture." (Stack 1974: 23)

Writing against prevailing tendencies to characterize black families as unstable and pathological, Stack gave special attention to kin networks in the Flats, the poorest section of a black community in the Midwest. Stack argued that, much like Dubois observed in Philadelphia and Drake and Cayton outlined in Chicago, the stability of exchange networks was critical to her informants' survival.

> Few if any black families living on welfare for the second generation are able to accumulate a surplus of the basic necessities to be able to remove themselves from poverty or from the collective demands of kin. Without the help of kin, fluctuations in the meager flow of available goods could easily destroy a family's ability to survive. Kin and close friends who fall into similar economic crises know

> that they may share the food, dwelling, and even the few scarce luxuries of those individuals in their kin network. Despite the relatively high cost of rent and food in urban black communities, the collective power within kin-based exchange networks keeps people from going hungry. (Stack 1974: 33)

Thus, swapping and adaptive cooperation form the basis of stable networks; this stability aids in the daily survival of the poor, whose needs consistently outweigh their means.

Stack’s work was particularly important for the ways it challenged a patriarchal ideal of the “family” as comprised of a father, mother, and children. Although this ideal had become normalized by scholars and policymakers by the time of Stack’s writing, it is important to note that this notion of the family was a product of the normalization of wage labor in the industrial era. For example, Fraser and Gordon (1994) note that the rise of wage labor brought with it the invention of “the housewife.” They write, “the independence of the white workingman presupposed the ideal of the family wage, a wage sufficient to maintain a household and to support a nonemployed wife and children” (Fraser and Gordon 1994: 318). Not only was this ideal leveraged to socially and legally codify women as dependent figures, but it was also used to cement racist stereotypes of black men unable to provide for (and dominate) black women. This worked on largely ideological grounds, for few families were able to subsist without the labor of women and children. Nevertheless, this ideal held much sway for scholars and policymakers. Throughout the 1960s and 70s, discourse abut poverty centered around “the black family,” in which black kinship networks were measured against white norms and inevitably portrayed as deviant (Billingsley 1968; Greenbaum 2015; Hannerz 1969; Harrington 1962; Lewis 1975). This caricature of the pathological black family has been used to explain everything from the crime to unemployment to teen pregnancies, in the process neglecting the structural and historical causes of racial inequality first posited by DuBois in the nineteenth century.

Although the work of Stack and others (cf. Aschenbrenner 1983; Sudarkasa 2007) does much to highlight the stability of female-headed and multigenerational households and cross-residential cooperation, the trope of black familial instability has remained entrenched in the American imaginary. In the 1980s and 90s, the pathology of the black female-headed household was manifested in the frenzy over the “welfare queen.” The invention of the welfare queen is usually attributed to Ronald Reagan, who introduced the term at a campaign rally in 1976: “In Chicago, they found a woman who holds the record. She used 80 names, 30 addresses, 15 telephone numbers to collect food stamps, Social Security, veterans’ benefits for four nonexistent deceased veteran husbands, as well as welfare. Her tax-free cash income alone has been running $150,000 a year” (Levin 2013). Reagan’s story proved an effective coded reference to black indolence, criminality, and familial pathology. Although repeatedly proven to be an ideological construction, the imaginary of the welfare queen justified an onslaught of public welfare and housing policies that discouraged and/or disallowed the multigenerational households and extended kinship networks described by Stack (Jewell 1988). Ironically, this retrenchment of the welfare state was accompanied by a persistent hysterical paranoia around family values. This may be understood in large part as an understanding of the family as a private entity that is an extension of the state. Writes Lubiano,

> What welfare mothers/queens and black ladies—as cover stories that draw our attention away from the abuses and failures of our political-economic structure—also do is to undermine the notion of family (actually existing families as well as normative ideas about the family) as entirely private, individual, and not connected to the state or the collective public. (Lubiano 1992: 336)

That is, families are expected to buffer the consequences of a shrinking welfare state that has actively destabilized them. In the aftermath of these draconian reforms, the linkages that characterized Stack's classic ethnography are now more difficult to find, forcing social scientists to explore alternative models of social networks and survival strategies.

Contra Stack's emphasis on the strength of her informants' ties and kinship networks, others have insisted that *weak* ties, rather than strong ones, are key to understanding social cohesion and survival. In one of the most widely cited articles in sociology, Granovetter (1973) lays out this proposition, in which he makes an interesting and widely repeated distinction between bonding ties, which form the basis of kin networks, and bridging ties, in which acquaintances cross ethnic or group boundaries to bring groups together. Granovetter holds that acquaintances, far from being trivial or inconsequential individuals with whom one comes in contact, are instead critical “bridges” between tightknit friend and kin networks, or otherwise closed communities. Thus, weak ties extend beyond past kinship networks and serve a function that close relationships simply cannot. To illustrate his argument, Granovetter draws on Herbert Gans’ ethnography of the Italian community of Boston’s West End, which was displaced by widespread urban renewal (Gans 1982). Granovetter argues that the community’s abundant close ties and scarce weak ties were responsible for its failure to mobilize against the political forces intent to displace it.

Notably, Granovetter’s argument was disputed by Gans, who argued that, although he had paid little attention to bridging or weak ties, that these were still present in the West End community in the form shopkeepers and bartenders (Gans 1974; Gans 1982). Gans further argues that the “neighborhood” or the “community” is a construct that exists in the mind of the observer and does not necessarily correspond to the ways in which people socialize. He points out that the West End, although located on a single street, was subdivided by income and housing conditions by its own residents. These demarcations were illegible to politicians and urban planners intent on carrying out their “urban renewal project” without. Further, Gans points out that the project of urban renewal was carried out largely in secret and had no historical precedent among West Enders, thus precluding the possibility of successful organizing against local politicians. Finally, and most importantly, Gans argues that Granovetter’s analysis lacks a historical, cultural and political frame that “suggests that these factors can be left out, thus creating the danger of setting up an apolitical frame of reference that ignores influence of powerlessness and lack of information on the behavior of poor people" (Gans 1974: 526).

According to Gans, the West Enders did not lack contact with the outside world, nor was their displacement brought on by a lack of weak ties. Instead, it was a result of asymmetric distributions of information, power, and resources that left the community unable to effectively foresee and mobilize against its displacement (Gans 1974). Indeed, information and resources are usually distributed differentially along class, ethnic, and gender lines. Attributing the neighborhood's demolition and forcible displacement of its residents to a paucity of weak ties, Gans argued, was a reductionist argument tantamount to blaming the victim. Although Granovetter's argument is logically and clearly constructed and has formed the basis of a plethora of subsequent social network analyses (cf. Forrest and Kearns 2001; Friedkin 2004; Granovetter 1983), it nevertheless has important shortcomings. First, as Gans' critique highlights, what constitutes "ties" is subject to observer biases as relationships are artificially held as static and independent of one another (e.g., familial ties and acquaintances). Second, a focus on a particular type of tie (i.e., weak ties) renders other ties invisible to the outside observer. Finally, Granovetter's framework relies on the implicit assumption that individuals' ties are "positive and symmetric"; negative and/or asymmetric ties are deferred (Granovetter 1973: 1361). As Gans' critique highlights, people exist in complex and dynamic relations—many of which are distrustful and/or characterized by animus. Likewise, Nigel Thrift convincingly argues that scholars have mistakenly conflated sociality and camaraderie, thus overlooking people's pervasive negative tendencies. He writes,

> Though it hardly needs saying, sociality does not have to be the same thing as liking others. It includes all kinds of acts of kindness and compassion, certainly, but equally there are all the signs of active dislike being actively pursued, not just or even primarily as outbreaks of violence (e.g., road rage or Saturday night fights) but more particularly as malign gossip, endless complaint, the full spectrum of jealousy, petty snobbery, personal depreciation, pointless authoritarianism, various forms of schadenfreude, and all the other ritual pleasures of everyday life. (Thrift 2005: 140)

Certainly, we needn't look far to see examples of dysfunctional relationships and behaviors in our own lives. Even Stack, whose primary focus is on tight kinship networks, alludes to relationships that are less stable and trustful than others. She writes, for example,

> Even in newly formed friendships, individuals begin to rely upon one another quickly, expecting wider solutions to their problems than any one person in the same situation could possibly offer. As a result the stability of a friendship often depends upon the ability of two individuals to gauge their exploitation of one another. Everyone understands that friendships are explosive and abruptly come to an end when one friend makes a fool out of another. (Stack 1974: 56-7)

Thus, a focus on positive and symmetrical ties obscures the realities and complexities that shape the circumstances around which relationships are formed (cf. Tilley 2005).

Returning to the question posited at the beginning of this section, it is clear that a focus on extended kinship networks and/or weak ties is insufficient to explain and describe the world in which Clive resides. How then should we think about people such as Clive, who are not embedded in networks of reciprocity, and instead describe themselves in terms of raw individualism and isolation? In other words, how do we conceptualize social networks that are defined primarily by exploitation, distrust, and animosity? I address these questions in the following section.

The Loners

In contrast to the stable, cooperative relationships that comprise the focus of *All Our Kin,* the idea of rugged individualism, especially among the urban poor, has piqued scholarly interest for over a century, generating dramatic images of alienated and atomized individuals struggling to survive within increasingly crowded and dismissive modern metropolises (cf. Howell 1973; Liebow 1967; Ozawa-de Silva 2008; Parsons 2014; Putnam 2000). For example, in *Hard Living on Clay Street,* Joseph Howell described the families he studied as living on a “continuum,” with “hard living” families on one end, and “middle class,” “settled” families on the other. While cautioning against strict typologies, Howell does describe the hard living families as being characterized by heavy drinking, marital instability, toughness, political alienation, rootlessness, present-time orientation, and a strong sense of individualism. Howell writes,

> The transitory nature of human relationships seemed to be an accepted fact. The feeling was that you have a close friendship, but when it’s over, it’s over… New people would appear in the

> neighborhood, be treated like old friends, and disappear without further mention. Lifelong friends would suddenly become enemies… Relationships… often had a pattern of forming very quickly and intensely and stopping abruptly… Human relationships were warm and intense, but not permanent. (Howell 1973: 334-5)

These families, Howell contends, are often estranged from their extended families (i.e., rootless) and often characterized themselves as "loners" (i.e., individualistic).

However, interrogating Howell's use of "loners" and "individualism" reveals important conceptual difficulties. A close reading of Howell's description reveals that he, like most urbanists, does not use "individualism" and "isolation" as descriptors of a strict absence of social contacts. Instead, he is describing limited contact with people, groups, and institutions that he has deemed necessary for upward mobility or a desirable way of life. Howell is not alone in his conflation of isolation and a lack of "desirable" social contacts. Clive would frequently comment in passing that "people ain't no good" and that "you can't trust anyone." In his many assertions that he was a "loner" or that he was intent to "make it on my own," Clive was not making a statement about the lack of people in his life. Instead, he was making a statement about his lack of close, intimate relationships and an observation that his social network was comprised primarily of negative and/or asymmetric ties. Unstated, but always implied in Clive's claims, was a reference to the ideal type of the nuclear family and trusting relationships. Similarly, ED staff would describe Clive as "isolated" and "alone." When I asked them for clarification on what this meant, I would get muddled and contradictory answers, sometimes involving examples of friends and close family members to clarify.

Erick Klinenberg (2002) notes that social isolation as an analytical concept has a troubled history that has generated more confusions and misconceptions than it has clarified. He points out that isolation is often conflated with living alone, being lonely, and having few friends; rarely does it refer to a literal lack of contacts (see also: Klinenberg 2001). Klinenberg argues that, like Howell, most social scientists use social isolation to describe a lack of contacts with the *right* people, rather than a true lack of contacts. Moreover, isolation is usually extended to the community level, leading to the conflation of isolation with spatial segregation, ghettoization, and access to jobs. This has, in turn, fueled the specter between “mainstream society” and the isolated “alien other” within it. Importantly, this idea has been called into question by urban anthropologists who have pointed out that inequality, an indelible feature of American life, necessarily breeds interdependence. This oversight, according to Klinenberg, is perpetuated by researchers that isolate individuals from the environments in which they are embedded, “and then forget [their] own role in constructing the segmentation [they] uncover” (Klinenberg 2002: 20). Most importantly, Klinenberg points out that social isolation “has rendered invisible or irrelevant the roles of economic exploitation, political conflict, or social abandonment as agents of metropolitan segmentation, thereby marginalizing political economy from the urban dynamic” (Klinenberg 2002: 5).

Thus, in making such judgments about relationships and social networks, scholars have emphasized either stable kinship networks or exaggerated, narrowly defined conceptions of “isolation.” Neither of these is sufficient to understand Clive’s circumstances—estranged from his family and reliant on relationships forged within a safety net institution to survive. Importantly, Clive’s estrangement from family and friends should not be understood as exceptional. Unlike most city dwellers who have many sources of support to offset the difficulties of urban life (Fischer and Mattson 2009), the poor lead precarious lives and have few buffers in the face of unemployment, loss of income, and economic downturn. This renders them unable to provide for or support even the most intimate family members—especially those with disability or chronic illness. They are therefore more reliant on non-kin networks (often strangers) and institutions to meet basic needs (e.g., food and shelter) and to simply survive. This reliance on strangers is not limited to acts of kindness or handouts, as in Clive’s panhandling, but is instead characterized by short-lived relationships maintained by resource exchange and varying degrees of reciprocity and exploitation.

These ties stand outside of conventional kinship networks and defy any attempt to label the poor as “isolated.” Seeking an alternative framework to understand these relationships, Matthew Desmond offers up the idea “disposable ties” as an alternative to overstated notions of stark isolation and thick kinship networks among the urban poor (Desmond 2012a). In his study of individuals caught in webs of unstable housing and cycles of eviction, Desmond describes disposable ties as those in which his informants would meet and quickly mimic high-intimacy situations, referring to one another as “fiancées” or “sisters” after short periods of time. Desmond writes,

> They established new ties quickly and accelerated their intimacy. Virtual strangers became roommates and "sisters." Once a disposable tie was formed, all kinds of resources flowed through it. But these bonds often were brittle and fleeting, lasting only for short bursts. This strategy of forming, using, and burning disposable ties allowed families caught in a desperate situation to make it from one day to the next, but it also bred instability and fostered misgivings between peers. (Desmond 2012a: 1296-7)

He describes that his informants would frequently find one another at institutions whose primary function was to serve and manage the poor (e.g., welfare offices, food pantries, homeless shelters). Because these institutions involve virtual mass-gatherings of the poor, along with hours of waiting, they naturally lend themselves to the formation of disposable ties. "A need meeting a need [facilitates] the conditions for a formation of a collaborative, if temporary, union" (Desmond 2012: 1313). These short and fleeting relationships enabled individuals involved to obtain emotional support and material resources necessary for survival when their biological kin were either unwilling or unavailable to provide these.

Like the strong kinship ties described by Stack, disposable ties provide day-to-day subsistence needs. Desmond describes that people who knew each other for mere days would move in together, pool money, and share childrearing responsibilities. Unlike kinship networks, however, these relationships were usually fleeting. Relationships often ended due to uncontrollable circumstances (e.g., imprisonment) or withered when the expectation of reciprocity went unfulfilled (e.g., when someone refused to pay rent or repay a loan). Desmond summarizes, “strong ties often were treated like weak ones, disposable ties like strong ones” (Desmond 2012: 1311).

Of course, these types of relationships are not new. Although they are not the focus of Howell and Stack’s analyses, they are plainly described in *Hard Living on Clay Street* and *All Our Kin.* What the term “disposable ties” describes is not a novel form of sociality. Rather, it offers a bridge between well-formed kinship networks and so-called isolation. In my own work, I regularly observed such meetings in the ED waiting room. Amidst the hours of endless waiting people facing hardships would meet, commiserate and often make plans that would extend outside of the hospital (e.g., carpooling or sharing other resources). Moreover, my patients would regularly be accompanied by such companions in the ED in times of illness and vulnerability. Sometimes, the relationship would be exposed as tenuous with further questioning (i.e., asking for addresses, birthdays or phone numbers) or when one person’s needs made the burdens of the union outweigh the benefits. Relationships would sometimes simply end when someone was dropped off and left alone in the ED, leaving staff scrambling to take into account their patients’ mercurial circumstances. For these patients, the ED was simply a meeting ground—a place that brought them together with people with similar needs and limited resources.

For a few patients like Clive, however, the ED was more than a backdrop for these tenuous unions; it was a union in and of itself. People like Clive are distinguished from Desmond’s informants in their inability to participate even in the frail material exchange networks necessary to sustain disposable ties. For example, Desmond notes that his informants formed close, intimate relationships and that their intimacy mediated necessary resource exchange: “Once a disposable tie was formed, all kinds of resources flowed through it… They exchanged money, housing, food and food stamps, drugs, sex, bus passes, furniture, and children’s toys” (Desmond 2012: 1314). Clive, like most of my informants, could not participate in such networks. His check, for example, was withheld by his wife and could not be exchanged for shelter or other resources. Having aged on the streets, he was long unable to exchange his labor for money or other subsistence needs. He had no domestic skills to leverage, and he could hardly keep up with small children. Indeed, Clive’s relationship with ED staff and reliance on the ED intensified when he couldn’t participate in the reciprocal relationships described by Desmond. For him, the ED was not simply a gathering place to meet others likewise in need, it was the primary place by which his needs were met.

As he aged, Clive’s emphysema would flare up regularly and require him to visit the ED just to maintain his breathing. He got to know the staff as he sat for his breathing treatments and waited for hours to be discharged. At first, he would walk a mile to a nearby homeless shelter to sleep after he was discharged, but his mobility was limited by his shortness of breath and incessantly aching body—both of which made him the target of assault and robbery that would land him back in the ED for treatment. These acts of cruelty against Clive usually yielded little to nothing for his assailants. He rarely had more than five dollars on his person, and his wallet was usually filled with single-use public transportation cards, most of which were expired.

Over time, Clive gave up on staying in shelters and eventually confined himself to linger within a 2-3 block radius around the hospital. When he was not in the ED, he was sitting on the steps or the benches in front of the hospital, and soliciting passersby for food or money. Only staff members would greet him by name—although many recognized but would not acknowledge him directly. At night, he would sleep on the benches or, when it was cold, in the chairs in the ED waiting room. The only time he traversed that radius was when he had been jailed for panhandling or loitering. Because the bail money was beyond his means, he would spend days or weeks in jail before he was released to a homeless shelter and would eventually make his way back to the hospital.

Clive's list of needs was short, rarely went beyond true basic necessities, and met within the confines of the hospital grounds: the water fountain, the public restrooms, and the ED waiting room. On good days, he would treat himself to a meal at the nearby McDonald's with the money he made panhandling. When this was not enough (i.e., most days), he would supplement his food with premade sack lunches in the ED, with orange juice, an apple, and a bologna sandwich. He would spend most of his time watching television in the ED waiting room or idly chatting with other patients and staff. This was how Clive met and got to know Mia. Their relationship was built and sustained by brief, repetitive bureaucratic processes: triage protocols, vital signs checked, and treatments administered. In their short, repeated interactions, they would share mundane details of their lives. Mia would volunteer updates on her children's illnesses or progress in school, Clive would share his thoughts on the presidential election or comment on the evening news broadcast on the waiting room televisions. Mia was Clive's closest friend.

When I asked Mia about her relationship with Clive, she told me that he was a sweet man for whom she felt badly. They were friendly, she said, but she hesitated to call him a friend. Indeed, most people would agree with Mia's assessment. Outside the bounds of the ED, she had no means to meet or interact with Clive. She played a much more central role in his life than he played in hers. Clive depended on deeply on her kindness and the hospital's resources. The nebulized medications kept him breathing, the sandwiches kept him fed, and the hospital itself kept him sheltered. Mia and Clive were friendly and familiar and she was a consistent lifeline to him. She didn't feel that giving him a sandwich or letting him linger longer than necessary in the ED exploited her time or labor or the ED's limited resources. Instead, she felt that it was an act of charity or kindness. Yet her relationship with others she didn't find as charming or amusing were characterized by distrust, and feelings of exploitation and she was not consistently as generous in those cases. Their relationship was generally positive, but it was hardly symmetrical.

It is therefore important not to romanticize Clive and Mia's relationship. She did not interact with Clive outside of work, unless she happened to see him on the street. She did not go out of her way to locate him when he was gone for weeks on end—despite his advanced age and relative frailty. Moreover, the friendliness of their relationship was largely arbitrary. There were others like Clive with whom

Mia didn’t get along, and most ED staff weren’t as welcoming of Clive’s presence as Mia. They would either ignore him, limit their interactions to the confines of their bureaucratic or medical responsibilities, or (less frequently) would attempt to disincentivize him from returning to the ED by denying him food or hurrying through his medical treatment. When Clive insisted on his sack lunch, they would simply refuse, citing the presence of vending machines in the waiting room and his responsibility to feed himself. For Clive, however, paying a dollar for two ounces of salted peanuts or a single packet of peanut butter crackers was usually impossible. In fact, for most of the people waiting endlessly in the overcrowded waiting room, the vending machine food was unaffordable—especially in light of limited or non-existent income and lost days of work.

Yet another portion of staff members refused to give out sandwiches to Clive or others like him, noting feelings of exploitation and a Pavlovian logic to discourage repeated visits or the reliance on the ED and its staff for non-medical needs. “I just won’t do it. I won’t encourage bad behavior,” one doctor told me plainly. “You can’t have people coming around here like it’s a homeless shelter. That’s not what we’re here to do.” One nurse gave me an amused smile when I asked why he didn’t give people sandwiches. “You know what David Cannon [another super-utilizer] does now? He takes the sandwiches we give him and he sells them in the waiting room. He’s hustling straight out of the ER. He thinks it’s *his* ER. Like we’re just here to help him hustle. You can’t just let people run all over you like that.” Thus, Clive’s want of the most basic necessities—his abject poverty—was reframed as excessive and exploitative.

Clive’s medical records told a similar story. In addition to documenting his persistent wheezing and need for nebulizer treatments, they listed under his diagnoses “homelessness” and “malingering” and tersely documented his inappropriate and disproportionate ED use. Sometimes the narrative in his medical records would describe his fixation with a sandwich or crackers, noting that he prioritized this over his reported symptoms. Other times, his medical record would include notations of how he would nod off in the waiting room—all to imply that his symptoms were less severe than he implied or to categorize him as a non-emergent case. These charts would document that he didn’t need not received any emergent interventions and was simply given discharge paperwork to close the bureaucratic process. Clive would repeat the process the next day or even later the same day, his cycle serving as irrefutable proof of his deviance.

In spite of valiant and consistent efforts to discourage “bad behavior” and combat the exploitation attributed to people like Clive, these designations were arbitrary. Antagonism and camaraderie were determined not based on qualities inherent to individuals (staff or patients), but rather processes outside of their control: individual moods, the number of patients in the waiting room, the overall flow of the ED, and so on. Amidst all of this disorder, there always seemed to be someone available to hand out a sandwich or to permit a fitful sleep in the waiting room.

Despite the importance of the ED in Clive’s life, these relationships did not fully protect him in times of severe illness or extreme vulnerability. In these times, the ED and the hospital were the only bridges between people like Clive and true isolation. In the following section, I consider an extreme version of the hospital as a tie, rather than simply a place for the management of the poor.

Annie

Annie was a woman in her early sixties. She was short and thin, with a golden complexion, disheveled gray hair, and a sullen face. She wore a tattered jersey knit dress, tennis shoes that had worn down and let her big toes peak through, and a coat that doubled for a blanket. She walked slowly and cautiously, sometimes steadying herself against the wall for support. For reasons she never fully elaborated, she was evicted a few weeks before I met her. Her closest living relative was her daughter. Annie would often use the ED phone in vain attempts to contact her daughter, who would either not answer the phone or would promise to come to the ED but never showed up.

Unlike Clive, who went out of his way to interact with people around him, Annie was reserved and reticent to initiate any conversation. Although the ED staff knew her by name, she hadn’t been outgoing or assertive enough to develop a reciprocal relationship with them. She had been diagnosed with colon cancer years before I met her, and while extensive surgery and months of chemo had saved her life, they left her frail and unsteady and even more susceptible to the side effects of her poverty. Before she was evicted, she was well enough to take care of herself well enough in her one bedroom apartment, going out to the corner store once a week to get any food she needed.

Although she was independent at home, she was not steady or resilient enough to care for herself at a shelter. She was not able to go up and down stairs, and carrying her belongings in a bag just made her more unsteady on the uneven pavement. The heat of the Atlanta sun would regularly make her dizzy, and she suffered multiple falls. Sometimes, strangers would take the time to help her get back on her feet. Other times, they would simply call 911. Over the years, Annie had learned to live with her symptoms. She was able to get by at home and therefore never considered going to the ED for her ailments, but when she was asked what brought her to the hospital she listed the many symptoms that she had lived with, but that had become unbearable since she was evicted from her home. Her knees were scraped and bloody from her falls, the residual effects of the chemotherapy left her legs burning constantly, and her shoulders and elbows were sore from lugging her belongings around town.

Eventually, Annie realized that staying at a shelter was not a viable option for her and she focused on trying to get a hold of her daughter to transition herself to stable housing. Like Clive, Annie's habitat gradually became confined to the hospital grounds and its resources and staff were her lifeline. But while Annie had no shortage of ailments, she, unlike Clive would state plainly that she was in the ED for temporary shelter and to be safe while trying to get back on her feet. The nurses and doctors on staff would reiterate this to me with a shrug. "Annie's just here because she's homeless. She'll sign in and write down that she fell, but if you ask her she'll just tell you flat out that she's here because she's homeless. She was falling at home and then staying there. But now that she's falling on the street she has to come to the hospital." In contrast Clive, who relied on mild flirtation, Annie's relationships were sustained by pity and a begrudging appreciation of her honesty. Although Annie’s visits were deemed “inappropriate,” her admissions were taken as acknowledgement of the nature of “true” emergency medicine. Her honesty was felt to mitigate the waste of scarce resources.

Then, there was the night in January, when it was unseasonably cold, and Annie signed in for her usual complaint of a fall. It was icy outside and she slipped, she reported to the nonplussed staff who shuttled her through the usual bureaucratic machinery and led her to the overflowing waiting room. With few chairs available, patients and their family members were standing, sitting in wheelchairs, sitting on the floor, or on tables. Some were staring at the blaring television; others were listening intently for their names to be called over the commotion.

Annie eventually found a seat in a crowded corner. As she settled in, the woman in the next chair surveyed Annie’s tattered clothes and unkempt hair and recoiled at the smell emanating from her bag of belongings. Unpleasant smells were not uncommon in the ED. The fumes radiating from vomit, unwashed feet, or body odor would wax and wane throughout the day. Still, the odors associated with the homeless like Annie offended patients and staff members alike. Most days, she would try to stay in a secluded corner away from the contemptuous glares of other waiting room occupants, but tonight the waiting room was too crowded for that strategy.

Annie sat for an hour, trying to get as comfortable as she could in the hard chair. Eventually, she got up and walked to the bathroom. The waiting room hummed as usual until another patient waiting behind Annie noticed that the bathroom had been occupied longer than it should be and her angry knocks had gone unacknowledged. Security guards opened the bathroom to find Annie collapsed on the floor and rushed her back to a resuscitation room, where her homelessness disappeared into the background as she was rushed to the operating room for emergent brain surgery.

Annie recovered well from her surgery, but her hospital stay was protracted. Although she had initially shown signs of a promising recovery, she suffered a massive stroke while she was hospitalized that would render her unable to live independently for the rest of her life. While arrangements for her transfer to a nursing home were being made, her daughter was contacted and asked to provide her signature for the necessary transfer. True to form, her daughter never showed up to the hospital and subsequent efforts to reach her yielded only the automated messages of disconnected lines. Efforts to find other friends or members of Annie’s family were futile, and eventually the courts had to appoint a guardian to transfer her to the city’s nursing home for the indigent, a place so neglected and underfunded that an online review claimed it had “more roaches than patients.”

I never did meet Annie’s daughter, and Annie gave me little information about her to make any valid claims or even speculations. It was clear, however, that their relationship could not sustain Annie’s material needs. Unable to rely on friends or kinship networks, Annie was left to rely on strangers and the ED—not for its medical services, but for the relationships the institution supplied. These relationships bear much of the same negative sociality described by Thrift. Moreover, these relationships are much like the disposable ties described by Desmond in their asymmetry, their transient nature, and the disproportionate burden placed on these episodic relationships. But while the ties described by Desmond were fleeting, with the "threat of termination [looming] above all relationships," these ties differed in that the legislative mandates of the ED (and later the hospital), conferred some stability to the interactions (Desmond 2012: 1328). Although staff's reactions to Annie (and Clive) ranged from fondness to bitter resentment, they were nevertheless unable to fully terminate their relationships. Thus, the ED, largely assumed and equipped to be a medical institution, nevertheless serves a critical non-medical role in the survival of the poorest and the most vulnerable among us. This role is particularly pronounced in the era of the mass incarceration, rampant inequality, and the retrenchment of public services—all of which have destabilized friendship and kinship networks.

To be sure, the ED should never be considered an adequate substitute for kinship networks. Annie's case illustrates the razor-thin line between disposable ties and disability or death. If Annie had access to a more stable housing situation, it is quite possible that her most serious fall, and consequently her devastating head injury, could have been avoided. Though others in her position treaded this line and later rejoined more stable and protective networks, Annie's case nevertheless represents a form of severe vulnerability that plagued super-utilizers. Yet this vulnerability quickly becomes mundane to ED staff, whether or not it is tolerated or regarded as a nuisance. Only in exceptional circumstances like Annie's, in which her chronic dependence on ED services quickly turns into a debilitating or immediately life-threatening condition does this present as a pressing problem for ED and hospital staff. Annie's need for emergent brain surgery, and later her stroke, left her deeply dependent on the hospital’s staff and its resources for her very survival. And while these were unquestionably recognized as “appropriate” uses of hospital resources, they were not entirely unlike her use of the hospital for subsistence needs in that they all helped her endure the conditions of destitution. Like Clive, Annie was sustained first by her ties to the ED, and later by her ties to the inpatient staff. These ties, however, were neither fully protective against her profound vulnerability nor a buffer against her catastrophic illness. In the end, these ties were not enough to keep Annie from being permanently dependent on a formal healthcare institution, and a shockingly neglected one at that.

It may be tempting to view Annie’s condition as an example of isolation. She had been abandoned from her daughter and dependent on a healthcare institution to survive. After her stroke, she was unable to communicate or interact with anyone and therefore reduced to a sum of physiologic measures (e.g., vital signs, electrolyte abnormalities). Annie’s condition can be understood as a social death: “that point at which socially relevant attributes of the patient begin permanently to cease to be operative as conditions for treating him, and when he is essentially regarded as already dead” (Sudnow 1967). Yet, qualifying Annie’s dire condition as *true* isolation requires the erasure of the many people tasked with keeping her alive and neglecting the fact that human subjects research (like healthcare) is a relational endeavor that, by definition, cannot include or detect the truly isolated. Thus, *true isolation* is apparent only as a postmortem entity (Archer, et al. 2005) rather than a stage of life or state of being.

Instead of focusing on social isolation or rugged individualism as an alternative to kinship networks or positive relations, it is more fruitful to discuss the myriad ways that relationships are formed and sustained. Equally important to relationships are the material conditions that mediate them. In the following section, I consider the urban environment as an important mediator of relationships for the urban poor like Clive and Annie.

Alone in Atlanta

Thus far, I have considered Annie and Clive's relationships with the ED as a survival strategy that fills the role of friend and kinship networks described by Stack. While it is tempting to think about these relationships as purely interpersonal (i.e., byproducts of reciprocal interactions between individuals), it is important to consider the ways in which these relationships are mediated by the urban environment.

Consider, for example, the heat wave that struck Chicago in 1995. Temperatures reached record highs. The humid air settled over the city and compounded the heat index. The city's infrastructure and its people buckled in the heat. The end result was an epidemiological crisis that found over seven hundred (mostly elderly) persons dead over the course of a week, the "equivalent to having one fatal jetliner crash per day for three consecutive days" (Klinenberg 2015: 8). Most epidemiologists attributed these fatalities to the physiology of aging, arguing that that the elderly were inherently too frail to handle the blistering heat. Arguing that this line of reasoning was inadequate to explain the mass casualties, Klinenberg turns his attention to Chicago's urban environment. He notes that "the *social* *conditions* that made it possible for hundreds of Chicago residents—most of them old, alone, and impoverished—to die in the one week heat spell" (Klinenberg 2015: 18). Klinenberg's ethnography convincingly demonstrates that it was Chicago's asymmetric "development," rather than physiologic frailty, that left many of its elderly and impoverished residents dead in the wake of this heat wave.

Klinenberg throws the complexity between individual circumstance and the urban environment into sharp relief. He argues that most of the victims of this heat wave were poor and lived in sub-standard housing (often in transient hotels or one-room apartments with shared bathrooms). Surviving this devastating heatwave required the elderly and the frail to leave their homes, buy supplies, and seek respite in air-conditioned environments. They had to rely on relationships with family, friends, and strangers as alternatives to their own homes. While most Chicagoans could take these options for granted, they were simply not available to the city's most vulnerable residents, who lacked strong support networks and were afraid to rely on strangers in their crime-ridden neighborhoods. Unable to take refuge with friends, family, or neighbors, they found themselves imprisoned in their overheated homes. Thus, Klinenberg shows that the urban environment was an important mediator of people's relationships and, consequently, their ability to survive the heat wave.

Klinengberg's claims are strengthened by his mapping of Chicago's neighborhoods, in which he compares two adjacent neighborhoods, North Lawndale and South Lawndale. The two neighborhoods bear many similarities: they have comparable elderly populations, with similar proportions living alone and in poverty. However, the two neighborhoods differ demographically. North Lawndale, where nineteen people died, was 96% black. In contrast, South Lawndale, suffered only three casualties, and was 85% Latino.[35] While many people posited that Latinos had stronger family networks than blacks, Klinenberg dismisses this as an exercise in stereotyping. US-born Mexican-Americans, he points out, are much more likely than Mexican immigrants to be estranged from their kin networks.

More important than kin networks, Klinenberg argues, are the neighborhoods people lived in. South Lawndale was a vibrant place: a neighborhood with bustling street life that facilitated all manner of interaction between neighbors and strangers. Municipal services were readily available. In stark contrast, North Lawndale was an abandoned neighborhood: empty lots, absent street life, and high rates of violent crime. Like the housing conditions, city services were substandard and usually provided in a delayed manner. Seniors were distrustful of strangers and afraid to leave their homes, which, in turn, rendered them more vulnerable to the effects of the heat wave.

Klinenberg's insights demonstrate how urban structure mediates relationships and, in times of crisis, can mean the difference between life and death for the most marginalized members of society. His findings have been reproduced both in the United States (cf. Gusmano and Rodwin 2006; Pantell, et al. 2013) and abroad (cf. Keller 2015). My work took place thousands of miles and was over 20 years removed from the devastating heat wave Klinenberg describes. Nevertheless,

---

[35] Although the differences in fatalities may seem minimal, North Lawndale's casualty rate was 40 per 100,000. In contrast, South Lawndale's casualty rate was 4 per 100,000—a ten-fold difference.

the point that the urban environment is an important mediator of personal relationships remains important.

Atlanta, an ostensibly thriving metropolis with high residential density, commercial activity, and community organizations, was actually an urban space that fostered the marginalization of people like Clive and Annie. Both of them endured the consequences of rising housing costs, stagnant and inadequate wages. To find cheaper housing, Clive’s family moved to the suburbs. Though they were physically nearby, they were away from public transportation and therefore inaccessible to Clive. Clive’s arrests and transportation to the hospital or the homeless shelter told him that these were the only places in the city he was “allowed” to be, further restricting his mobility and relationships. Like Clive, Annie was physically unable to traverse through the city and had no options to rely on aside from the hospital. In sum, Clive and Annie’s relationships were discontinuous in space and time and this was, in large part, a result of Atlanta’s urban environment. I consider this in greater detail in a later chapter.

Annie and Clive’s destitution was further compounded by their age (Culhane, et al. 2013b) and medical problems, both of which excluded them from the relationships and exchange networks that have commanded the attention of anthropologists. With these options unavailable to them, Clive and Annie used the ED’s staff and resources as an alternative to friends and kinship networks. Although this drew the ire of staff and was a strain on the rest of the hospital’s resources, Annie and Clive’s use of the ED represents a necessary survival strategy given Clive and Annie’s severe material constraints.

Conclusion: Do These Count as Ties?

In this chapter, I have shown that institutions concerned with servicing the poor, specifically EDs, are more than a mere meeting grounds or backdrops in the lives of the poor. They represent important ties in and of themselves. This has three important implications. First, it adds to contemporary understandings of social networks and urban poverty. Thus far, anthropologists have focused much on the reciprocal relationships that facilitate resource exchange and survival of the urban poor, be they in the form of tight-knit kinship networks or fragile, disposable ties. Those who fall outside of these networks receive little analytical attention or are mistakenly characterized as “isolated.” Thinking about institutions in terms of the relationships they produce, rather than the services they supply, provides an important analytical framework by which to understand the conditions of poverty and the survival strategies of the urban poor. Second, this framework challenges us to seriously consider relationships that are negative and asymmetric as important components of social life. More important than the symmetry, congeniality, or strength of relationships is what they accomplish. As Annie and Clive’s cases demonstrate, much can be accomplished in through negative or indifferent relations. Finally, my findings provide an important alternative to thinking about what services a hospital provides and why people come to the hospital. While medical anthropologists have produced many accounts of the hospital as a cultural institution (Bosk 2003; Hahn 1985; Konner 1987; Lock and Nguyen 2010; Lupton 2012), they have, like healthcare providers, largely presumed that healthcare is the primary reason that people use the hospital. My findings suggest that this framework is useful, but ultimately incomplete. In an era of welfare retrenchment and market triumphalism that have destabilized families and relationships, hospitals play an important role in facilitating the survival of those alienated from these networks.

In the conclusion, I turn my attention to these “alternative” function of the hospital. Rather than characterizing them as inappropriate or superfluous, I show that they are byproducts of broader historical and political processes that have destabilized the lives of the poor and limited their options for survival. Stated more simply, the fewer the resources to which people have access, the more their relationships are destabilized, and the more their circumstances dictate the ways in which they participate in organizations and institutions (cf. Allard and Small 2013).

CHAPTER EIGHT: WHAT HAPPENS TO SUPER-UTILIZERS?

An Update on Super-Utilizers In This Dissertation

This dissertation has detailed the difficulties in individuals’ lives that led them to become ED super-utilizers. As I have noted throughout this dissertation, this label more accurately describes a finite time in a person’s life rather than a type of individual taking advantage of ED services. A common question that follows this assertion is: What happens to super-utilizers? This chapter attends to this question.

After I concluded my fieldwork in December 2016, I returned to Grady to work in the ED part-time as I analyzed my ethnographic data and completed this dissertation. At first, I was able to keep in touch with some super-utilizers whom I saw regularly on hospital grounds. Over time, however, regular contact proved more difficult as they moved on to other stages in their lives. As of March 2018:

Lucy spent over a month in the hospital. During this time, Lucy struggled to remember her social security number and social workers struggled to get in contact with her friends and family members in Valdosta. A breakthrough came when Lucy recalled that she would go to a church nearby the city park she frequented in Valdosta. Members of the church located Philip, Lucy’s ex-husband, who put hospital social workers in touch with Lucy’s cousin, Mary.

Lucy and Mary’s relationship was strained. Mary remembered the fights they had over Lucy’s drug use and her tumultuous relationship with Philip. Lucy said that Mary was “making a mountain out of a molehill.” After much discussion and long telephone conversations with Lucy, Mary agreed to care for Lucy in her home and Lucy reluctantly agreed to return to Valdosta to live with her.

I called Lucy after she arrived in Valdosta. At first, she was in good spirits, telling me that Mary was treating her well and that she was happy to be with her. When I called a few months later, Mary told me that living with Lucy became progressively more difficult. She would leave the house at night and Mary would have to call the police to find her and, when they did, she protested at being taken home. Eventually, this came to be too much for Mary and she took Lucy to the hospital in order to have her placed in a nursing home.

Maggie disappeared from the ED midway through my fieldwork. I tried to call the telephone number listed in her medical record, but it was disconnected. I was pleasantly surprised when I was working a shift in February and saw her name appear on the electronic tracking system in front me. “She’s back!” I said to myself out loud, happy that nothing tragic had happened to her in the preceding months. When I approached Deborah, the NP taking care of Maggie, I realized that I might be the only one in the ED happy to see her back. “I don’t know what I’m going to do with this woman,” said Deborah. “She has a million things going on and it’s hard to tell what’s old and what’s new.” I offered to help, telling her that I knew Maggie from my research.

Maggie was nearly unrecognizable laying in her hospital bed. Her hair was grey and disheveled. The skin on her face sagged into folds and wrinkles. I remembered her pride in being told that she looked much younger than a woman in her sixties. Now she looked easily in her seventies. She frowned as I entered the room, her face softening when she recognized my face. She told me that I looked different in my white coat. When I asked her where she had been over the past few months, she told me that her daughter and grandchildren were evicted from their home. Maggie was devastated for them, but she said that she was also relieved to "have someone again." Together they were able to pool their meager funds and live in an extended stay motel for a few weeks.

Eventually, her daughter was able to secure a place at transitional housing program for homeless families. Maggie was thrilled until she found out that the program's definition of "family" did not include her. She was back on the street, only to find that Atlanta's largest homeless shelter—the one where she had argued with staff about her placement options—had closed (for more information on this, see: Martin and Ray 2017). She had fewer options than she did a year before. In the meantime, her health deteriorated and so did her ability to live on the street. She eventually found herself back in the ED.

I discussed Maggie's case with Deborah, noting that her condition was the result of gradual deterioration expected from long term life on the street. What she really needed was a stable home—something we would be unable to provide. Having this conversation and seeing Maggie again made me realize that I had lost my defense mechanisms to normalize or look past personal suffering in order to "get the job done."

Clive was arrested in August of 2016 for panhandling. Unable to afford bail, he spent nearly two months in the Fulton County Jail. While he was in jail, Mia left Grady to work in another hospital. Clive returned to the ED after his release from jail. He continues to be friendly with some ED staff, though he is not as close with anyone as he was with Mia.

Annie is still a nursing home resident. She remains unable to speak and communicate with others around her. Since her placement in the nursing home, she has hospitalized periodically for pneumonia. Each time she has responded to antibiotics and been discharged back to the same nursing home.

These brief follow-ups capture neither the complexity nor the suffering experienced by super-utilizers in this research. Nor do these follow-ups include the full range of what happened to super-utilizers in this study. One super-utilizer in this study suffered from complications of pneumonia and died after the completion of this research. Three others were incarcerated. Five others reconciled with family members and were taken into these family members' households. I have no further follow-up data on the remaining super-utilizers in this study.

Of these people on whom I have no information, one still weighs heavily on my mind. Grant was a man in his late forties. He stood well over six feet tall, with broad shoulders and dark brown skin. He wore many layers of clothes and the only thing he carried was his wallet, which he stuffed under his clothes close to his body. I met Grant in the waiting room. When I explained my research to him, he told me that his main issue that he did not have a stable housing situation. He blamed this on his sister, who was his payee and who would withhold his benefits check from him. Grant told me that he was still in regular contact with his sister, but most of the time their conversations would quickly turn into fights about his check.

The last time I saw him was on my shift at Emory University Hospital. He said that he called the ambulance because his legs hurt and he couldn't walk, and that he requested to come to Grady but that the ambulance drove him all the way to

Emory instead. “What am I supposed to do up here?” He asked me rhetorically, referring to how far he was from familiar surroundings.

Having developed a relationship with Grant, I felt motivated to do whatever I could do to help him that day. My first thought was to try to find a medical reason to admit him, but his chronic complaints did not fit into a discrete medical category that justified admission. Knowing the difficulty of his housing situation, my second thought was that I could admit him for placement (much like Lucy’s admission). When I reviewed his chart, however, I noticed that he had been admitted multiple times for placement. Each time, he became angry at being kept in the hospital and walked out. I then attempted to call his sister, but no one answered my calls and the phone numbers listed in his medical record were disconnected.

Nearly eight hours later, I went back to Grant’s room to explain the situation to him—to tell him the list of things I tried and that I would have to discharge him from the ED. Grant’s mood changed quickly from calm to angry. He stomped his feet and pounded his fists against the gurney, shaking its metal frame. “I need housing!” He shouted.

I had never seen Grant this angry, but I had repeatedly been told that he had a bad temper by others who knew him. “I’m sorry, that’s not something I can do right now,” I explained, trying to keep my voice even. “What I can do to help… I know that you’re completely out of your way up here. Let me have one of our social workers get you a cab voucher to wherever you would like to go.”

Grant was unhappy with my suggestion. “I need housing!” He shouted again, his voice growing louder and his face angrier. I reiterated my offer, telling him that I would leave the room to give him some time to think about it. When I returned half an hour later, Grant begrudgingly agreed to take the taxi voucher and he was discharged from the ED.

I have not seen Grant since then. I have reviewed his medical record periodically, tried to call his sister, and asked other staff members, to no avail.

Grant’s case weighs particularly heavy on my mind for two interrelated reasons. First, because I often ask myself if there is more that could have been done for him on my shift. Second, and more importantly, because his story highlights the limits of emergency medicine the demands placed on the ED by our ailing healthcare and other social service institutions.

In the concluding chapter, I review the “super-utilizer problem” presented in this dissertation and discuss possible solutions.

CHAPTER NINE: CONCLUSION AND DISCUSSION

Introduction

Through a concentration on homeless patients labeled “super-utilizers,” this thesis has provided a detailed description and analysis of the ways in which hospital life, and specifically emergency medicine, reflects broader social processes of exclusion, disenfranchisement, and deprivation. This chapter brings together the different facets of this intersection that have been drawn out and discussed in each chapter. In considering these different elements of urban life alongside one another, it becomes clear that the hospital in general, and the ED in particular, has a complex relationship with history, economics, and society writ large. On one hand, despite its many claims of scientific objectivity and rationality, the ED is subject to the same prejudices and exclusionary processes that characterize the rest of society. As my fieldwork demonstrates, the super-utilizer label carries with it a stigma that closely resembles the stigma associated with poverty—namely, that it is a societal burden borne of laziness, opting out of the responsibilities of civilized life, and gluttonous consumption of precious resources. On the other hand, medicine is also expected to shoulder, perhaps even cure, the inevitable ailments that arise from austerity and social abandonment. For example, as I have noted in chapters five and seven, the hospital serves an almshouse function while its staff can form the primary social networks for individuals “isolated” from the rest of society. Thus, my work has shown that the ED is continually constituted as an “in between” space, one where there is constant negotiation over the limits and the role of medicine and its institutions.

Of course, these negotiations are always emplaced. In this dissertation, I have argued that place is an important lens through which social life can be understood, and not simply an interesting backdrop or sideline focus. Extending this argument, I have shown in chapters four and six that the interrelated historical processes of race and class formation in Atlanta and Grady are integral to understanding how super-utilizers are produced and how the ED comes to serve as a vital urban safety net and a place of last resort. Despite Atlanta's widely lauded reputation as a "Black Mecca," home to unprecedented amounts of black capital, its rising tide of prosperity did not lift all boats. Poverty in Atlanta remains deeply racialized and spatialized, with disproportionately high numbers of black people living in poverty and concentrated in shrinking areas of the metropolis (Housing Justice League and Research Action Cooperative 2017). As a place tasked with caring for and safeguarding the city's indigent population, Grady is itself neglected and stigmatized in ways that mirror the race and class divisions that characterize urban life in Atlanta. These processes are particularly pronounced within the ED, which is tasked with being open to all and simultaneously subject to the political, historical, and economic realities of life outside the hospital as well as the real fiscal pressures of the hospital itself.

As a space in-between, the ED is an ambiguous space, one in which there is no clear distinction between the outside world attempting to gain access to emergency treatment and the inside world of emergency medicine expertise. Despite this ambiguity, or perhaps because of it, much of the work of emergency medicine is produced by continually sorting "real" from "inappropriate" cases, in drawing sharp boundaries between the “emergent” and the “non-emergent” cases. Significantly, this involves not just the triage and ordering of patients for treatment and emergency medical provision, but also the sorting and ordering of patients in terms of their moral worth. As the most disenfranchised members of society, super-utilizers are nearly always categorized as “matter out of place” (Douglas 2003), people who represent the social creeping into the “truly medical” and must continually be separated from “real” emergency cases.

For Douglas, boundaries exist that uphold the wholeness or completeness of individual categories and keep them separate and distinct from one another. Nevertheless, she suggests that in the social world, instead of there being definite hard barriers that separate one category from another, there are “marginal” spaces in which categories blur into one another and people “’are somehow left out in the patterning of society... are placeless” (Douglas 2003: 96). Thus, the ED is a place in which staff continually order patients and clinical work in relations that best help establish emergency medicine as a space for clinical expertise and a space in which “real” emergencies are attended to. Super-utilizers have no space within this system of ordering and are therefore classified using pejorative terms such as “gomers,” “frequent fliers,” and “super-utilizers” to signify their alienation and placelessness within the medical system. Despite their ostensible placelessness, I have shown in chapter three that gomers, frequent fliers, and super-utilizers are longstanding fixtures within medicine. They are people who reflect the broader societal expectations that medical knowledge can cure social ills—as well as the failure of such expectation. Super-utilizers are therefore not simply people who are placeless within medicine’s system of ordering; they are people who are placeless within society writ large.

Super-utilizers are not just metaphorically placeless, however. As people who have been alienated from housing and labor markets with no social safety net to assure even their most basic subsistence needs, they are people who are physically placeless as well. Moreover, they are people alienated from normative friend and kinship networks, making dependence on the hospital a function not merely of unmet medical needs, but of “almshouse” needs in an age of increasing austerity and rapidly shifting roles of hospitals. Significantly, this almshouse role depends upon the pauperization of the poor and the deviant. As I noted in chapter five, pauperization is a discursive process by which super-utilizers are produced as diseased, deviant, and in need of intervention. Moreover, this discursive process simultaneously produces super-utilizers as people cunningly manipulating the triage processes and accessibility of the ED to gain shelter in the hospital and drain precious resources.

In part, the pauperization of super-utilizers is dependent on their production as “loners” or individuals alienated from friend and kin networks and living on the social margins. Indeed, many of my informants characterized themselves as “loners” and spoke about themselves as people who would prefer to be “independent” rather than to rely upon or burden others. Such characterization usually made good fodder for people looking to prove that super-utilizers were either inherently incapable of participating in civilized life or, conversely, people in desperate need of salvation. Rarely was the isolation itself interrogated. Yet my work demonstrates that super-utilizers are not simply abandoned. Instead, I argue that their relationships with hospital staff constitutes important and unexamined social ties that provide an important lens by which to view the hospital and the functions of healthcare. Moreover, this function can shed light on the nature of social ties and what they accomplish.

Heretofore, this function of the hospital has been labeled as “misuse” or “inefficiency.” More recently, attention to such processes has characterized them as “fiscal waste” responsible for the fiscal crisis in healthcare. As the purported primary drivers of this crisis, super-utilizers have been the subject of intense focus by researchers and policymakers eager to use the provision of social services as way to address poverty at an individual level in order to decrease healthcare expenditures. This shift has largely been lauded as a revolutionary expansion of medicine’s traditionally narrow boundaries and a welcome concurrence between the social good and economic gains. Nevertheless, the provision of social services based on the profit motive has important adverse consequences. First, it reconfigures the social determinants of health as individual-level risk factors rather than deeply ingrained structural problems. This arrangement distracts from the fact that poor health results from a combination of toxic economic arrangements, inadequate social programs, and pervasive social injustice. Second, and more importantly, a focus on social service provision as an instrument of cost savings perpetuates the prejudicial misnomer that the poor as the principal drivers of exorbitant healthcare costs and distracts from the inefficiencies and inequalities inherent to a profit-driven healthcare system.

Indeed, it is no accident that insurance companies and their foundations have been major funders of research and strategies for implementing super-utilizer interventions. Thus, when talking about strategies of cost savings and maximizing efficiency, we must ask: Cost savings for whom? Efficiency at whose expense? When considering the latter question, it is clear that the discourse of efficiency is deployed against the most marginalized segments of society, portraying them not as people maltreated by the current order, but as hurdles to its maximal functioning. As has been found in other settings, a focus on cost containment disproportionately harms the most vulnerable people—poor patients with complex medical needs and with preexisting barriers to accessing timely, appropriate healthcare (Maskovsky 2000; Mulligan 2014).

One of the primary reasons that a market-based approaches to healthcare fails the poorest and most disenfranchised segments of society is that they are based on very specific ideas about health care as a commodity and patients as consumers with equal access to all commodities. My informants in this dissertation defy this assumption, demonstrating that the healthcare system is the only means by which they can access subsistence needs. Thus, a focus on super-utilizers illustrates that a discourse on cost-savings and efficiency may seem intuitive or good, but ultimately serves as little more than a vehicle for health care rationing and profit maximization—falling short of the promises to improve health outcomes or achieve an altruistic end. To maximize profits, this discourse further draws upon already existing race and class subordinations and intensifies their effects on individual lives and bodies. That the bodies most adversely affected are also the most vulnerable is therefore neither arbitrary nor accidental.

Contributions of this Thesis

Ideas of governing health and health care at the level of the individual and the population are well documented (cf. Lyon-Callo 2000). These contributions have to some extent reflected the shift in medical knowledge practice and political developments in favor of not only individual choice and freedom but also individual responsibility for promoting health and securing oneself against the risks of ill health. The impact these have had on scapegoating the poor and promoting health care rationing is well documented (cf. Hansen, et al. 2014; Levine and Mulligan 2015). The responsibility to manage health risks through personal actions such as increased exercise, smoking cessation, and nutrition have all become part of our responsibilities as individual citizens. Researchers have further documented how patients themselves participate in the management and regulation of their individual health risks such that they reproduce accounts of the good citizen in order to justify their claims to resources (cf. Hillman 2014). Yet there has been comparatively little attention paid to people such as super-utilizers, for whom health care and the ED are not simply commodities to be purchased, but lifelines claimed as a right (Hoffman 2006).

This dissertation has therefore added to this literature by illustrating the ways in which some patients are excluded from the patient-as-rational-consumer discourse, and access healthcare resources not by displaying knowledge of their duties to get well and stay well, but by accessing the ED as the last place that remains a right within American healthcare. Thus, super-utilizers stand in stark contrast to the health responsible citizen and shed a new and important light on the specific relations between medicine and management. Super-utilizers' presence in the ED continually challenges the premise of "real" emergency medicine and illustrates the limits of this assumption. The ways in which patients become particular types in staff's accounts and interactions with them are caught up in the belief that emergency medicine is either purely clinical, efficiently managed, or a space of correct and responsible health care use. Contra these images, patients become "gomers," "frequent fliers," or "super-utilizers," embodying the metaphorical hurdles that prevent the practice of a purely clinical, efficient, cost-effective medicine. As such, super-utilizers are attributed with pejorative labels and reduced from their full selves.

Where this research departs form earlier works that focus on the hospital as a bounded entity and reduce patients to a passive presence within healthcare, is in its focus upon broader urban processes that produce the hospital as a safety net institution that provides services in excess of the medical. The placement of patients and staff within a broader political and historical context constitutes the practice of emergency medicine as a dynamic social process rather than a purely medical or interpersonal endeavor. Thus, the practice of emergency medicine necessarily reflects broader processes that may bolster investment in some populations and withdrawal from others. These processes of investment and withdrawal, I have argued, match historical, economic, and political processes that code segments of the population as unproductive and costly.

A significant way that super-utilizers depart from this model is in the fact that they are comprised of socially abandoned populations who also serve as the basis of economic investment and social service provisions. This upfront investment is made with the expectation that it would yield long-term cost-savings. My research has delved into the assumptions that underlie this logic, first noting that the costs associated with super-utilizers is exaggerated and pale in comparison with the bureaucratic costs associated with privatized healthcare. Second, I have shown that interventions on such populations yield minimal savings because the observed reliance on ED services does not denote a type of person, but rather a particularly vulnerable period in an already vulnerable person's life. Thus, while interventions may be effective for individuals, they do not yield significant effects on the level of populations. Finally, and most importantly, my work has argued that a cost- and profit-motivated investment in disenfranchised populations must be interrogated as a reflection of broader societal transformations. Specifically, I argue that economic investment in previously abandoned populations is more accurately seen as an expansion of market logics and mechanisms into new territories rather than a purely altruistic endeavor. Seen this way, super-utilizers are therefore not simply unproductive drains or hurdles towards an efficient economy. Instead, their invention as a population enables the expansion of a neoliberal economy, making this population a site of economic production rather than waste.

The justification for this economic expansion, however, depends on the production of super-utilizers as figures in contradistinction to ideal patients who are expected to have knowledge of their responsibilities and duties as moral citizens to limit their claims to resources. The expectation of citizens to better oneself and one’s family for the good of society has historically been part of what was considered good, decent, moral behavior. Notions of betterment have thus been inherently linked to economic success whereas economic failure has been viewed synonymously with moral lacking. In contrast to these attributes, super-utilizers are figured as individuals who are incapable of self-management and therefore require interventions in order to mitigate the adverse effects of their behavior on themselves and others.

I have shown that the national economic burden of health services has become individualized as the moral responsibility of patients who must limit their personal contribution to this national burden. Where aspects of health and well-being have been reconstituted as part of an individual’s choice and moral responsibility as a good citizen, those in the greatest need of health and social services are deemed to be deviant and lacking in moral worth for failing to guard against the risks of ill health and thus increasing the burden on the health care economy. People’s troubles and misfortunes are individualized and understood as personal shortcomings rather than being products of political and historical conditions outside the realm of an individual’s control.

Even when these conditions are understood to be outside of an individual’s control and a sympathetic narrative is constructed to explain people’s dependence on healthcare resources, the proposed explanation remains at the individual level and is justified by an end goal of cost containment rather than a claim to rights. Thus, super-utilizers show that the pursuit of citizenship has shifted from simply being a question of rights and building a sense of community to encompass a quest for a self that is both personally and publicly acceptable. My work has shown that super-utilizers, in being unable to account for their claims to services upon a personally and publicly acceptable self or upon the attributes of good citizenship, are deemed objects of health care rationing and placed in negatively constituted patient categories.

Finally, an important contention of this thesis is that the ED, and the hospital in general, is simply not a standalone institution where bodies are mended and ailments are cured. Anthropologists have previously demonstrated that the hospital reproduces broader social processes, such as gender hierarchies (Cassell 1998) and race- and class-based inequalities (Bridges 2011). Extending on these insights, I have shown that the hospital does not simply reflect processes happening outside of it but is an integral part of the social safety net and has had to play an increasingly prominent role in mending the social whole. In chapter five, I outlined that the hospital, in part, serves as a contemporary almshouse. As such, the hospital serves not just as a warehouse of socially abandoned bodies, but also as a safety net for a receding social welfare infrastructure.

This role of the hospital is, in part, enabled by the medicalization of poverty in the US and elsewhere, in which improving the health of the poor was proposed as a mechanism to cure poverty. This approach has been widely criticized by medical anthropologists for its focus on individual bodies and obscuring the historical and structural factors that render some bodies unemployable and unproductive in the current economy (Baer, et al. 2003). Anthropologists have noted, for example, how a diagnosis of permanent medical cognitive pathology becomes a survival strategy by making individuals eligible for disability benefits, thereby enabling them to fulfill social obligations (e.g., contributing to their households, providing for their children). The medicalization of poverty made medical authorities the gatekeepers of welfare benefits and made poverty management part and parcel of health care delivery.

Despite the immediate viability of this strategy, however, bureaucratic requirement that the poor must repeatedly prove their “disabled” status through therapy and psychotropic medication also produced an ongoing obsession with “malingerers” and “over-consumers” of welfare services, with it resurrecting the early 20th century specter of the “undeserving poor” (Hansen, et al. 2014). This discourse naturally spilled over into the medical realm producing a focus on, and panic over, “over-utilization” and the inappropriate use. With some notable exceptions (see, for example, Levine and Mulligan 2015; Mulligan 2016), anthropologists have not engaged the narrative of over-utilization and exorbitant costs ostensibly associated with caring for the poor. This dissertation has shed light on this discourse, demonstrating that the medical costs incurred by the poor are much smaller than imagined. More importantly, however, this dissertation has focused on how a shifting discourse has first placed poverty squarely in the realm of the medical, turning hospitals and EDs into omnibus service institutions for the homeless. This work has outlined how this turn has coincided with a retrenchment of other welfare services, eventually making the medical and carceral systems the primary overseers of the poor in America (Alexander 2012; Willse 2015). This discourse has since shifted, however, turning the presence of the poor into a cost that must be contained and a presence to be curtailed. This shift and its consequences for people who rely on ED services for survival has been a primary focus of this dissertation. In particular, I have sought to highlight how the ED as a "place of last resort" results in an ongoing tension between the medical and the social for staff, and how super-utilizers become the objects of frustration and disdain as a result.

Consequences and Next Steps

Whenever I have presented my research to healthcare administrators, medical students, and residents, I have been surprised at how receptive they are to think about how historical and political factors manifest themselves in the ED. It is not difficult to convince them of things they witness every day, and they usually welcome the opportunity to contextualize think about their clinical practice more broadly. More difficult, however, is answering their inevitable questions about what is to be *done.* In part, this question is difficult because I regularly struggle with this question myself. Throughout this dissertation, I have highlighted Atlanta's historical and political developments that have reproduced poverty and alienated its most marginalized populations from housing, employment, and even public space. Short of making me more empathetic and accommodating of my patients, however, this realization has not significantly impacted my clinical practice. This is not because I don't want to do more, but because, as I discussed in the preceding chapters, there are few resources at my disposal to address individuals' social woes.

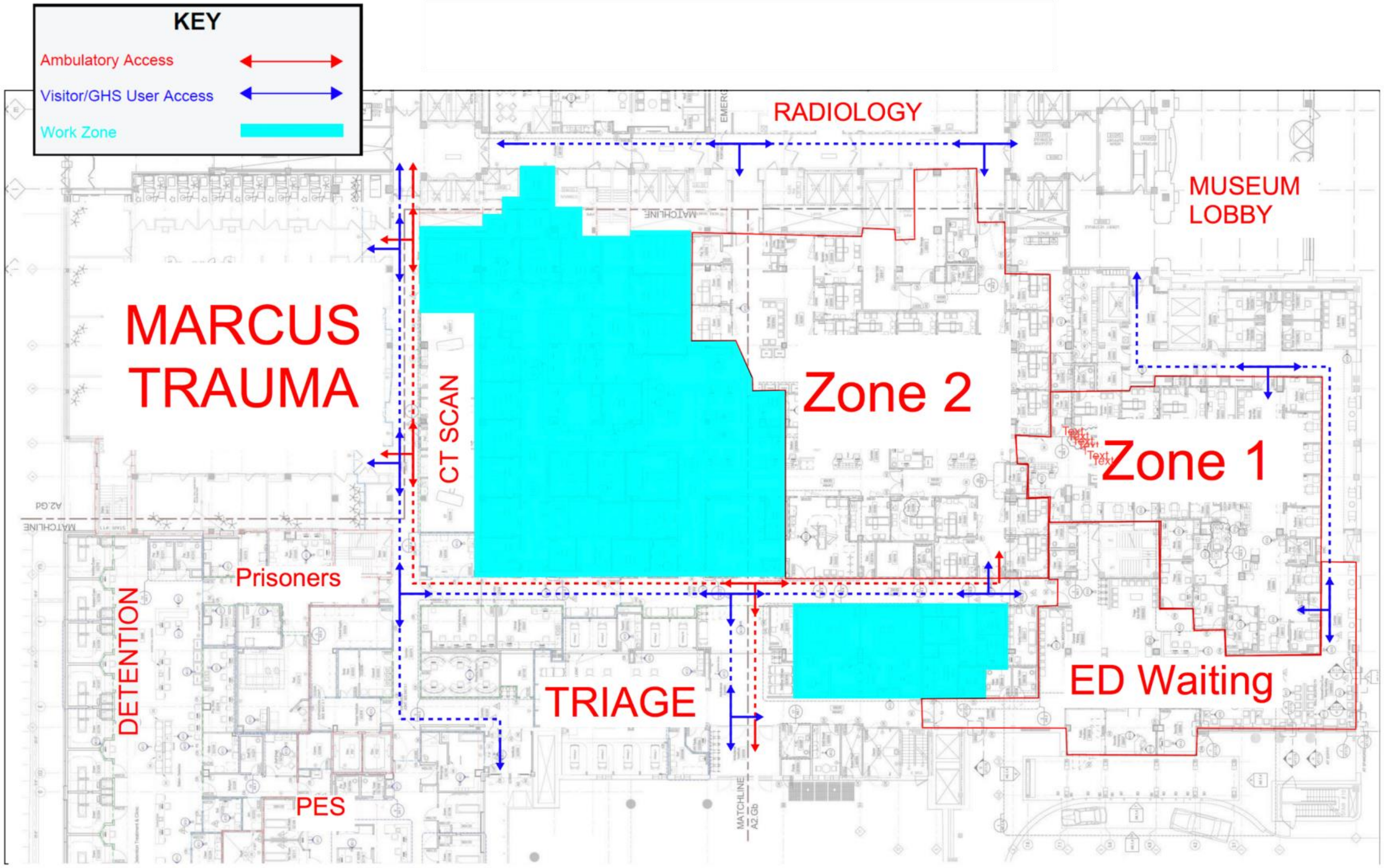
Perhaps the question is difficult because it presumes a power for medical authority that does not exist. This is not to say that physicians—or any medical practitioners—are powerless or to deny their clout, social capital, or their potential to affect change. Instead, I want to draw attention to the fact that medical practice comes with its own constraints, which cannot be extricated from a free market system in which profit and demand, rather than social welfare and public health needs, direct the distribution of critical resources. Thus, one can be personally empathetic to patient's suffering and motivated by social justice, and simultaneously constrained in their ability to help in a meaningful, long-term way.

One may ask in response: What about reforms to the ACA, the expansion of Medicare, Medicaid and other social welfare reforms? Surely these would have a profound impact on the daily lives of individuals whose lives make up the bulk of this dissertation. It is easy to see the merits of such reforms and to get lost in the intricacies of policy debates. It is important, however, that we do not overestimate the power of policy efforts to transform social life. Certainly, policy measures can have profound amelioratory or destructive effects on daily life, especially the lives of the poor and disenfranchised. However, these should not be viewed as the only avenues for change. In the case of super-utilizers, I have argued in this dissertation that this a complex, multifaceted problem that can be solved simply with a policy solution. Where policies regulate hospitals as monadic social fields, I have shown here that the social writ large will always permeate healthcare's boundaries. I have further argued that the current state of affairs, in which some people are systematically and continually excluded from the human collective, has occurred as a byproduct of centuries cumulative, interrelated developments that have been fundamentally uneven and exclusionary—be it on the basis of race, class, gender, and so on.

These conditions do not exist in a vacuum but are products of a world in which some people are systematically valued more than others and a shifting economy that places employment and basic subsistence needs squarely out of reach for some. More fruitful than asking what kinds of healthcare policies can make or cure super-utilizers is a recognition that every social sector—education, housing, employment—is, in effect, a health sector. These social sectors have greater potential to produce long-term health outcomes than even the most radical overhauls of the health sector (Bradley, et al. 2011). Here, I believe that health care professionals, especially doctors, have an unrealized opportunity for advocacy. There is, already, a movement to think of "housing as health care" (Doran, et al. 2013; Mackelprang, et al. 2014). This movement is important and deserves a more prominent place in the public discourse. Moreover, "what counts as health care" should be expanded to other sectors, such as food availability, labor policy, and educational opportunities.

Such a change cannot come piecemeal. It requires widespread changes in housing, labor, educational, and welfare policy. On a more abstract level, this kind of change requires a meaningful reckoning with what it means to be human in the contemporary US and who among us has the "right to have rights" (Somers 2008). Only by coming to terms with our legacy of inequality and then putting fairness and humanity to the fore will we reduce health inequalities and cure the social ailments that haunt us all.

Appendix A: Map of Grady ED during Construction



REFERENCES:

Abadía-Barrero, César
2016 Neoliberal Justice and the Transformation of the Moral: The Privatization of the Right to Health Care in Colombia. Medical Anthropology Quarterly 30(1):62-79.
Adler, N., et al.
2008 Social status and health: a comparison of British civil servants in Whitehall-II with European- and African-Americans in CARDIA. Social science & medicine 66(5):1034-1045.
Agamben, Giorgio
1998 Homo Sacer: Sovereign Power and Bare Life. Stanford, CA: Stanford University Press.
Alexander, Michelle
2012 The new Jim Crow: Mass incarceration in the age of colorblindness. New York: The New Press.
Allard, S. W., and M. L. Small
2013 Reconsidering the Urban Disadvantaged: The Role of Systems, Institutions, and Organizations. The Annals of the American Academy of Political and Social Science 647(1):6-20.
Allen, Arthur
2017 The “Frequent Flier” Program that Grounded a Hospital’s Soaring Costs. Politico, December 16, 2017.
Allen, Susan M., and Alison L. Croke
2000 The faces of Medicaid: the complexities of caring for people with chronic illnesses and disabilities. Center for Health Care Strategies, Inc.
Altman, Stuart, and Marion Ein Lewin
2000 America's health care safety net: intact but endangered. Institute of Medicine Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. Washington, DC: National Academies Press.
Amster, Randall
2008 Lost in space: The criminalization, globalization, and urban ecology of homelessness: LFB scholarly publishing New York, NY.
Anderson, Gerard F., et al.
2013 It’s The Prices, Stupid: Why the United Sates Is So Different From Other Countries. Health Affairs 22(3):89-105.
Ansell, David A, and Robert L Schiff
1987 Patient dumping: status, implications, and policy recommendations. JAMA 257(11):1500-1502.
Appadurai, Arjun
2000 Spectral Housing and Urban Cleansing: Notes on Millenial Mumbai. Public Culture 12(3):627-651.
Archer, MS, et al.
2005 Social isolation and delayed discovery of bodies in houses: The value of forensic pathology, anthropology, odontology and entomology in

the medico-legal investigation. Forensic science international 151(2):259-265.

Aschenbrenner, Joyce
1983 Lifelines: Black Families in Chicago. Long Grove, IL: Waveland Press.

Ash, Arlene S., et al.
2017 Social determinants of health in managed care payment formulas. JAMA Internal Medicine 177(10):1424-1430.

Atlien
2008 Attention All "Grady Babies", Vol. 2017. Atlanta, GA: http://straightfromthea.com/2008/07/15/attention-all-grady-babies/.

Baer, Hans A, Merrill Singer, and Ida Susser
2003 Medical anthropology and the world system: Greenwood Publishing Group.

Baggett, Travis P, et al.
2013 Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA internal medicine 173(3):189-195.

Baker, Laurence C, and Linda Schuurman Baker
1994 Excess cost of emergency department visits for nonurgent care. Health Affairs 13(5):162-171.

Baker, Tom, and Jonathan Simon
2010 Embracing Risk: The Changing Culture of Insurance and Responsibility. Chicago: University of Chicago Press.

Barrow, Susan M, et al.
1999 Mortality among homeless shelter residents in New York City. American Journal of Public Health 89(4):529-534.

Bayor, Ronald H
1988 Roads to racial segregation: Atlanta in the twentieth century. Journal of Urban History 15(1):3-21.

Beaty, Anita
2007 Atlanta's olympic legacy. Atlanta, USA: Centre on Housing Rights and Evictions (COHRE).

Berg, Marc
1992 The construction of medical disposals Medical sociology and medical problem solving in clinical practice. Sociology of Health & Illness 14(2):151-180.

Berk, Marc L, and Alan C Monheit
2001 The concentration of health care expenditures, revisited. Health Affairs 20(2):9-18.

Bernard, H Russell, Peter Killworth, and Lee Sailer
1981 Summary of research on informant accuracy in network data and the reverse small world problem. Connections 4(2):11-25.

Berube, Alan
2014 All Cities Are Not Created Unequal. Brookings Institute.

Biehl, Joáo

2005 Vita: Life in a Zone of Social Abandonment. Berkeley: University of California Press.

Biehl, João Guilherme, Byron Good, and Arthur Kleinman

2007 Subjectivity: ethnographic investigations. Volume 7: Univ of California Press.

Billings, John, and Maria C Raven

2013 Dispelling an urban legend: frequent emergency department users have substantial burden of disease. Health affairs 32(12):2099-2108.

Billingsley, Andrew

1968 Black Families in White America. Englewood Cliffs, NJ: Prentice-Hall.

Bodenheimer, Thomas

2013 Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs. Center for Health Care Strategies.

Boehm, Deborah A

2005 The safety net of the safety net: how federally qualified health centers “subsidize” Medicaid managed care. Medical anthropology quarterly 19(1):47-63.

Bosk, Charles L.

2003 Forgive and remember: managing medical failure. Chicago: University of Chicago Press.

Bourgois, Philippe I, and Jeffrey Schonberg

2009 Righteous Dopefiend. Berkeley: University of California Press.

Bradley, Elizabeth H, et al.

2011 Health and social services expenditures: associations with health outcomes. BMJ quality & safety:bmjqs. 2010.048363.

Brattain, Michelle

2001 The politics of whiteness: Race, workers, and culture in the modern South: Princeton University Press.

Bremner, Robert Hamlett

2009 The Discovery of Poverty in the United States. New Brunswick: Transaction Publishers.

Brewer, John D

1994 The ethnographic critique of ethnography: sectarianism in the RUC. Sociology 28(1):231-244.

Bridges, Khiara

2011 Reproducing Race: An ethnography of pregnancy as a site of racialization. Berkeley: University of California Press.

Brown, Rebecca T, et al.

2016 Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study. PloS one 11(5):e0155065.

Brown, Rebecca T, et al.

2012 Geriatric syndromes in older homeless adults. Journal of general internal medicine 27(1):16-22.

Buck, D. S., et al.

2012 Comparing homeless and domiciled patients' utilization of the Harris County, Texas public hospital system. J Health Care Poor Underserved 23(4):1660-70.

Burson-Tolpin, Anne

1989 Fracturing the Language of Biomedicine: The Speech Play of US Physicians. Medical Anthropology Quarterly 3(3):283-293.

Burt, Martha M.

1992 Over the Edge: The Growth of Homelessness in the 1980s. New York: Russell Sage Foundation.

Burt, Martha R, and Patrick Sharkey

2002 The role of Medicaid in improving access to care for homeless people. Washington, DC, Urban Institute.

Byrne, Molly, et al.

2003 Frequent attenders to an emergency department: A study of primary health care use, medical profile, and psychosocial characteristics. Annals of Emergency Medicine 41(3):309-318.

Cassell, Eric J

2004 The nature of suffering and the goals of medicine: Oxford University Press.

Cassell, Joan

1991 Expected miracles: Surgeons at work: Temple University Press Philadelphia.

—

1998 The Woman in the Surgeon's Body. Cambridge: Harvard University Press.

—

2002 Social Scientists Studying Doctors: 1951 to 2001. Reviews in Anthropology 31(3):243.

—

2005 Life and death in intensive care: Temple University Press.

Chavez, Leo R

2012 Undocumented immigrants and their use of medical services in Orange County, California. Social Science & Medicine 74(6):887-893.

Chisholm, C., et al.

2009 Reflections about "burn-out". Academic Emergency Medicine 16(6):567-71.

Chwastiak, L., J. Tsai, and R. Rosenheck

2012 Impact of health insurance status and a diagnosis of serious mental illness on whether chronically homeless individuals engage in primary care. Am J Public Health 102(12):e83-9.

Clifford, James

1983 On ethnographic authority. Representations 1(2):118-146.

Cloke, Paul, Sarah Johnsen, and Jon May

2007 The periphery of care: Emergency services for homeless people in rural areas. Journal of rural studies 23(4):387-401.

Cloke, Paul, Paul Milbourne, and Rebekah Widdowfield

2002 Rural Homelessness: Issues, experiences and policy responses. Bristol, UK: The Policy Press.

Cloud, Cathy, and George Galster

1993 What do we know about racial discrimination in mortgage markets? The Review of Black Political Economy 22(1):101.

Coe, A. B., et al.

2015 Homeless patients' use of urban emergency departments in the United States. J Ambul Care Manage 38(1):48-58.

Conrad, Joseph

1902 Heart of Darkness.

Conrad, Peter

1992 Medicalization and social control. Annual review of Sociology 18(1):209-232.

—

2005 The Shifting Engines of Medicalization*. Journal of health and social behavior 46(1):3-14.

Conrad, Peter, and Joseph W Schneider

2010 Deviance and medicalization: From badness to sickness. Philadelphia: Temple University Press.

Coombs, Robert H, et al.

1993 Medical Slang and its Functions. Social Science and Medicine 36(8):987-998.

Cooperative, Housing Justice League and Research Action

2017 Beltlining: Gentrification, Broken Promises, and Hope on Atlanta’s Southside. Housing Justice League and Research Action Cooperative.

Coser, Rose L.

1962 Life in the Ward. East Lansing, MI: Michigan State University Press.

Council, National Health Care for the Homeless

2011 Frequently Asked Questions About Health Care for the Homeless. H.R.a.S. Administration, ed. Nashville, TN.

Crane, Diana

1977 The sanctity of social life: physicians' treatment of critically ill patients. New Brunswick, NJ: Transaction Publishers.

Crist, Thomas A, Douglas B Mooney, and Kimberly A Morrell

2017 “The Mangled Remains of What Had Been Humanity”: Evidence of Autopsy and Dissection at Philadelphia’s Blockley Almshouse, 1835–1895. *In* The Bioarchaeology of Dissection and Autopsy in the United States. Pp. 259-278: Springer.

Culhane, Dennis P, et al.

2013a The age structure of contemporary homelessness: evidence and implications for public policy. Analyses of social issues and public policy 13(1):228-244.

—

2013b The aging of contemporary homelessness. Contexts.

D'Amore, Jason, et al.

2001 The Epidemiology of the Homeless Population and Its Impact on an Urban Emergency Department. Academic Emergency Medicine 8(11):1051-1055.

Dameron, Rebecca J, and Arthur D Murphy

1997 An international city too busy to hate? Social and cultural change in Atlanta: 1970-1995. Urban Anthropology and Studies of Cultural Systems and World Economic Development:43-69.

Darden, Joe, et al.

1987 Detroit: Race and Uneven Development. Philadelphia: Temple University Press.

Del Casino, Vincent J, and Christine L Jocoy

2008 Neoliberal subjectivities, the “new” homelessness, and struggles over spaces of/in the city. Antipode 40(2):192-199.

Demko, Paul

2017 How Iowa Became an Obamacare Horror Story, Vol. 2017. Washington, DC: Politico Magazine.

Derlet, Robert W, and John R Richards

2000 Overcrowding in the nation’s emergency departments: complex causes and disturbing effects. Annals of emergency medicine 35(1):63-68.

Desjarlais, Robert R

2011 Shelter blues: Sanity and selfhood among the homeless: University of Pennsylvania Press.

Desmond, Matthew

2012a Disposable Ties and the Urban Poor. American Journal of Sociology 117(5):1295-1335.

—

2012b Eviction and the reproduction of urban poverty. American Journal of Sociology 118(1):88-133.

—

2016 Evicted: Poverty and Profit in the American City. New York: Crown Publishers.

Dewan, Shaila, and Kevin Sack

2008 A Safety-Net Hospital Falls Into Financial Crisis. The New York Times, January 8, 2008.

Doran, Kelly M, Elizabeth J Misa, and Nirav R Shah

2013 Housing as health care—New York's boundary-crossing experiment. New England Journal of Medicine 369(25):2374-2377.

Douglas, Mary

2003 Purity and danger: An analysis of concepts of pollution and taboo. New York: Taylor & Francis e-Library.

Doupe, Malcolm B, et al.

2012 Frequent users of emergency departments: developing standard definitions and defining prominent risk factors. Annals of emergency medicine 60(1):24-32.

Drake, St. Clair, and Horace R. Cayton

1945 Black Metropolis: A Study of Negro Life in a Northern City. New York: Harcourt, Brace and Company.

Du Bois, WEB

[1899] 1967 The Philadelphia Negro: A Social Study. New York: Schocken Books.

DuBois, William Edward Burghardt

1965 Souls of black folk: Hayes Barton Press.

Durkheim, Emile, and Marcel Mauss

1963 Primitive Classification. R. Needham, transl. Volume 273. Chicago: University of Chicago Press.

Ehrenreich, Barbara

2010 Nickel and dimed: On (not) getting by in America: Metropolitan Books.

Ellis, John H

2015 Yellow Fever and Public Health in the New South. Lexington, KY: University Press of Kentucky.

Farmer, Paul

1999 Pathologies of power: rethinking health and human rights. American Journal of Public Health 89(10):1486-1496.

—

2001 Infections and Inequalities: The Modern Plagues. Berkeley, CA: University of California Press.

—

2003 Pathologies of Power: Health, Human Rights, and the New War on the Poor. Berkeley, CA: University of California Press.

Farmer, Paul E, et al.

2006 Structural violence and clinical medicine. PLoS Medicine 3(10):1686-1691.

Fazel, Seena, John R. Geddes, and Margot Kushel

2014 The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. The Lancet 384(9953):1529-1540.

Fernandes, Leela

2004 The Politics of Forgetting: Class Politics, State Power and the Restructuring of Urban Space in India. Urban Studies 41(12):2415-2430.

Fischer, Claude S, and Greggor Mattson

2009 Is America Fragmenting? Annual Review of Sociology:435-455.

Fischer, Sean N, et al.

2008 Homelessness, mental illness, and criminal activity: Examining patterns over time. American Journal of Community Psychology 42(3-4):251-265.

Fisher, Elliott S, et al.

2007 Creating accountable care organizations: the extended hospital medical staff. Health Affairs 26(1):w44-w57.

Floyd, C. Timothy

1981 Attitudes in The House of God. New England Journal of Medicine 305(7):411-412.

Forrest, Ray, and Ade Kearns
2001 Social Cohesion, Social Capital and the Neighbourhood. Urban Studies 38(12):2125-2143.

Foucault, Michel
2002 The order of things: An archaeology of the human sciences. New York: Routledge Classics.

Fox, Renée C.
1980 The Evolution of Medical Uncertainty. The Milbank Memorial Fund Quarterly. Health and Society 58(1):1-49.

Fox, Robin
1967 Kinship and marriage: An anthropological perspective. Cambridge: Cambridge University Press.

Fraser, Nancy, and Linda Gordon
1994 A genealogy of dependency: Tracing a keyword of the US welfare state. Signs 19(2):309-336.

Frazier, Edward Franklin
1939 The Negro Family in the United States. Chicago: University of Chicago Press.

Freedman, David H.
2018 Health care's "upstream" conundrum, Vol. 18. Washington, DC: Politico.

Freeman, Linton C, A Kimball Romney, and Sue C Freeman
1987 Cognitive structure and informant accuracy. American anthropologist 89(2):310-325.

Freeman, Richard B.
2001 The Rising Tide Lifts…? *In* Uneven Tides: Rising Inequality in America. S. Danziger and R.H. Haveman, eds. New York: Russell Sage Foundation.

Friedkin, Noah E.
2004 Social Cohesion. Annual Review of Sociology 30(1):409-425.

Friedland, Roger
1992 Space, Place, and Modernity: The Geographical Moment. Contemporary Sociology 21:11-15.

Friendly, Michael, and Gilles Palsky
2007 Visualizing Nature and Society. *In* Maps: Finding Our Place in the World. J.R. Akerman and R.W. Karrow, eds. Pp. 207-53. Chicago: University of Chicago Press.

Fullilove, Mindy
2005 Root shock: How tearing up city neighborhoods hurts America, and what we can do about it. New York: Ballantine.

Funds, The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust
2017 The 2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust

Funds. The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Gamble, Vanessa Northington

1995 Making a Place for Ourselves: : The Black Hospital Movement, 1920-1945: Oxford University Press.

Gans, Herbert J

1974 Gans on Granovetter's" Strength of Weak Ties". American Journal of Sociology 80(September):524-7.

—

1982 Urban Villagers: Group and Class in the Life of Italian-Americans. New York: The Free Press.

Garfield, Rachel, et al.

2016 The coverage gap: uninsured poor adults in states that do not expand Medicaid–an update. Kaiser Family Foundation.

Gawande, Atul

2011 The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? The New Yorker 86(45):40-51.

Geertz, Clifford

1972 Deep play: notes on the Balinese cockfight. Daedalus 101:1-37.

Gentry, Jerry

1999 Grady Baby: A Year in the Life of Atlanta's Grady Hospital. Jackson, MS: University Press of Mississippi.

George, Victoria, and Alan Dundes

1978 The gomer: a figure of American hospital folk speech. The Journal of American Folklore 91(359):568-581.

Gieryn, Thomas F

2000 A space for place in sociology. Annual review of sociology 26(1):463-496.

Gillette, Robert D.

1981 More on the House of God. New England Journal of Medicine 305(21):1288-1289.

Gilmore, Ruth Wilson

2002 Fatal couplings of power and difference: Notes on racism and geography. The Professional Geographer 54(1):15-24.

Gladwell, Malcolm

2006 Million-dollar Murray. The New Yorker 13(February 13):96-107.

Good, Byron

1986 Explanatory models and care-seeking: a critical account. *In* Illness Behavior. Pp. 161-172: Springer.

Good, Byron J

1994 Medicine, rationality and experience: an anthropological perspective: Cambridge University Press.

Good, Mary-Jo Delvecchio

1995 American Medicine: The Quest for Competence. Berkeley and Los Angeles, California: University of California Press.

Good, Mary-Jo DelVecchio, et al.

2005 The culture of medicine and racial, ethnic, and class disparities in healthcare. The Blackwell companion to social inequalities 13:396.

Goodnough, Abby

2017 Trump Health Secretary Pick’s Longtime Foes: Big Government and Insurance Companies. The New York Times, January 17, 2017.

Gordon, Colin

1991 Governmental Rationality: An Introduction. *In* The Foucault Effect: Studies in governmentality. G. Burchell, C. Gordon, and P. Miller, eds. Chicago: University of Chicago Press.

Gordon, David Paul

1983 Hospital Slang for Patients: Crocks, Gomers, Gorks, and Others. Language in Society 12(2):173-185.

Granovetter, Mark

1983 The strength of weak ties: A network theory revisited. Sociological theory 1(1):201-233.

Granovetter, Mark S

1973 The strength of weak ties. American journal of sociology:1360-1380.

Green, Elna C

2003 This business of relief: Confronting poverty in a southern city, 1740-1940: University of Georgia Press.

Greenbaum, Susan D

2015 Blaming the poor: the long shadow of the moynihan report on cruel images about poverty. New Brunswick, NJ: Rutgers University Press.

Gregory, James

2009 Hoovervilles and Homelessness, Vol. 2018. Seattle: University of Washington.

Gregory, James R

1984 The myth of the male ethnographer and the woman's world. American Anthropologist 86(2):316-327.

Greysen, S Ryan, et al.

2012 Understanding transitions in care from hospital to homeless shelter: a mixed-methods, community-based participatory approach. Journal of general internal medicine 27(11):1484-1491.

Grogan, Colleen M

2007 Healthy Voices, Unhealthy Silence: Advocacy and Health Policy for the Poor. Washington, DC: Georgetown University Press.

Gusmano, Michael K, and Victor G Rodwin

2006 The elderly and social isolation. Testimony to the New York City Council Committee on Aging.

Gustafson, Seth

2013 Displacement and the Racial State in Olympic Atlanta 1990–1996. southeastern geographer 53(2):198-213.

Hacking, Ian

1982 Biopower and the Avalanche of Printed Numbers. Humanities in Society 5:279-95.

Hahn, Robert A.

1985 A World of Internal Medicine: Portrait of an Internist. *In* Physicians of western medicine: anthropological approaches to theory and practice. R.A. Hahn and A.D. Gaines, eds. Dordrecht ; Boston : Hingham, MA: Kluwer Academic Publishers.

Han, Beth, and Barbara L Wells

2003 Inappropriate emergency department visits and use of the Health Care for the Homeless Program services by homeless adults in the northeastern United States. Journal of Public Health Management and Practice 9(6):530-537.

Hannerz, Ulf

1969 Soulside: Inquiries into Ghetto Culture and Community. New York: Columbia University Press.

Hansen, Helena, Philippe Bourgois, and Ernest Drucker

2014 Pathologizing Poverty: New Forms of Diagnosis, Disability, and Structural Stigma under Welfare Reform. Social science & medicine 103:76-83.

Harrington, Michael

1962 The Other America: Poverty in the United States. New York: Simon and Schuster.

Harris, L Jeff, et al.

2016 Characteristics of hospital and emergency care super-utilizers with multiple chronic conditions. Journal of Emergency Medicine 50(4):e203-e214.

Harvey, David

2005 A Brief History of Neoliberalism. Oxford: Oxford University Press.

—

2008 The Right to the City. New Left Review 53(September-October):23-40.

Hasselman, Dianne

2013 Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs. Center for Health Care Strategies.

Henry, Meghan, et al.

2015 The 2015 Annual Homelessness Assessment Report (AHAR) to Congress: Part 1, Point-in-Time Estimates of Homelessness. The U.S. Department of Housing and Urban Development.

Hibbs, Jonathan R, et al.

1994 Mortality in a cohort of homeless adults in Philadelphia. New England Journal of Medicine 331(5):304-309.

Higashi, R. T., et al.

2013 The 'worthy' patient: rethinking the 'hidden curriculum' in medical education. Anthropology and medicine 20(1):13-23.

Hillman, Alexandra

2014 ‘Why must I wait?’The performance of legitimacy in a hospital emergency department. Sociology of health & illness 36(4):485-499.

Hinze, Susan W

1999 Gender and the body of medicine or at least some body parts. The Sociological Quarterly 40(2):217-239.

Hoffman, Beatrix

2006 Emergency rooms: The reluctant safety net. History and Health Policy in the United States, Stevens AR et al.(eds). New Brunswick, NJ: Rutgers University Press.

—

2012 Health Care for Some: Rights and Rationing in the United States Since 1930. Chicago: University of Chicago Press.

Holmes, Seth M

2012 The clinical gaze in the practice of migrant health: Mexican migrants in the United States. Social science & medicine 74(6):873-881.

Holmes, Seth M., and Maya Ponte

2011 En-case-ing the patient : disciplining uncertainty in medical student patient presentations. Culture, medicine and psychiatry 35:163-182.

Homeless, National Coalition for the

2009 National Coalition for the Homeless Newsletter. National Coalition for the Homeless.

Hood , Rob Reid

1996 Review of The House of God. New England Journal of Medicine 335(15):1165-1166.

hooks, bell

1990 Yearning: Race, gender, and cultural politics. Boston: South End Press.

Horn, Brady P, et al.

2017 What Happens to High-Cost Patients? An Analysis of the Trajectories of Billed Charges Over Time. Population health management 20(5):362-367.

Horst, M, et al.

2011 Predictors of emergency department super-utilizers. Journal of Lancaster General Hospital 6(3):81-88.

Horton, Sarah

2004 Different subjects: The health care system's participation in the differential construction of the cultural citizenship of Cuban refugees and Mexican immigrants. Medical Anthropology Quarterly 18(4):472-489.

Horton, Sarah, and Judith C Barker

2009 “Stains” on their self-discipline: Public health, hygiene, and the disciplining of undocumented immigrant parents in the nation's internal borderlands. American Ethnologist 36(4):784-798.

Housing, US Department of, and Urban Development

2010 The 2010 Annual Homeless Assessment Report to Congress: Office of Community Planning and Development, HUD Washington, DC.

Howell, Joel D.

1995 Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century. Baltimore: Johns Hopkins University Press.

Howell, Joseph T

1973 Hard Living on Clay Street: Portraits of Blue Collar Families. Volume 956. Garden City, NY: Anchor Books.

Hsia, Renee Y, Arthur L Kellermann, and Yu-Chu Shen

2011 Factors associated with closures of emergency departments in the United States. Journal of the American Medical Association 305(19):1978-1985.

Humphrey, David C

1973 Dissection and discrimination: the social origins of cadavers in America, 1760-1915. Bulletin of the New York Academy of Medicine 49(9):819.

Hunter, Floyd

1953 Community Power Structure: A study of decision makers. Chapel Hill: University of North Carolina Press.

Hunter, Marcus Anthony, and Zandria F Robinson

2016 The sociology of urban black America. Annual Review of Sociology 42:385-405.

Hwang, Stephen W

2002 Is homelessness hazardous to your health? Obstacles to the demonstration of a causal relationship. Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique:407-410.

Hwang, Stephen W, and James R. Dunn

2005 Homeless People. *In* Handbook of Urban Health. Pp. 19-41: Springer US.

Inwood, Joshua FJ

2010 Sweet Auburn: Constructing Atlanta's Auburn Avenue as a heritage tourist destination. Urban Geography 31(5):573-594.

Jewell, K. Sue

1988 Survival of the black family: The institutional impact of US social policy. Westport, CT: Praeger Publishers.

Jiang, H. Joanna, Audrey J. Weiss, and Marguerite L. Barrett

2017 Characteristics of Emergency Department Visits for Super-Utilizers by Payer, 2014. Agency for Health Research and Quality (AHRQ).

Johnson, Tracy L., et al.

2015 For Many Patients Who Use Large Amounts Of Health Care Services, The Need Is Intense Yet Temporary. Health Aff (Millwood) 34(8):1312-9.

Joynt, Karen E, et al.

2013 Contribution of preventable acute care spending to total spending for high-cost Medicare patients. Jama 309(24):2572-2578.

Kaplan, Elisabeth

2002 ‘Many paths to partial truths’: Archives, anthropology, and the power of representation. Archival Science 2(3-4):209-220.

Katz, Michael B

1996 In the shadow of the poorhouse: A social history of welfare in America: Basic Books.

Keil, Charles

1966 Urban Blues. Volume 291. Chicago: University of Chicago Press.

Keller, Richard C

2015 Fatal isolation: The devastating Paris heat wave of 2003: University of Chicago Press.

Kellermann, Arthur L, and Bela B Hackman

1988 Emergency department patient'dumping': an analysis of interhospital transfers to the Regional Medical Center at Memphis, Tennessee. American journal of public health 78(10):1287-1292.

Klass, Perri

2008 You Gotta Know the Territory. *In* Return to The house of God : medical resident education, 1978-2008. M. Kohn and C.C. Donley, eds. Kent, Ohio: Kent State Publishers.

Kleinman, Arthur

1988 The Illness Narratives: Suffering, Healing, and the Human Condition. New York, NY: Basic Books, Inc.

—

1991 Rethinking Psychiatry. New York: The Free Press.

—

1995 Writing at the margin: Discourse between anthropology and medicine. Berkeley: University of California Press.

Klinenberg, Eric

2001 Dying alone: The social production of urban isolation. Ethnography 2(4):501-531.

—

2002 Alone in the city? An intellectual history of social isolation. Institute for Policy Research Working Paper. 2002a. http://www. northwestern. edu/ipr/publications/papers/2002/WP-02-15. pdf.

—

2015 Heat Wave: A Social Autopsy of Disaster in Chicago. Chicago: University of Chicago Press.

Knoke, David, and Song Yang

2008 Social network analysis. Thousand Oaks, CA: Sage Publications Ltd.

Ko, Michelle, et al.

2014 Residential segregation and the survival of US urban public hospitals. Medical Care Research and Review 71(3):243-260.

Kocher, Robert

2013 The Downside of Health Care Job Growth, Vol. 2018. Boston, MA: Harvard Business Review.

Konner, Melvin

1987 Becoming a doctor : a journey of initiation in medical school. New York: Viking.

Kronick, Rick, Melanie Bella, and Todd P. Gilmer

2009 The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions. Center for Health Care Strategies, Inc.

Kruse, Kevin M

2013 White flight: Atlanta and the making of modern conservatism: Princeton University Press.

Kuhn, Clifford M, Harlon E Joye, and Bernard E West

2005 Living Atlanta: An Oral History of the City, 1914-1948: University of Georgia Press.

Kuo, Dennis Z, et al.

2015 Comparison of health care spending and utilization among children with Medicaid insurance. Pediatrics 136(6):1521-1529.

Kushel, Margot B, Eric Vittinghoff, and Jennifer S Haas

2001 Factors associated with the health care utilization of homeless persons. JAMA 285(2):200-206.

Kusin, Shana

2009 Get out of my emergency room: thirty years spent inside The house of God. Academic Emergency Medicine 16(6):565-6.

Kusmer, Kenneth L

2002 Down and out, on the road: The homeless in American history. New York: Oxford University Press.

Latimer, Joanna

2000 Socialising disease: medical categories and inclusion of the aged. The Sociological Review 48(3):383-407.

Latour, Bruno, and Steve Woolgar

1979 Laboratory life: The social construction of scientific facts. Beverly Hills: Sage.

Lederer, Susan E.

1997 Subjected to Science: Human Experimentation in America Before the Second World War. Baltimore: Johns Hopkins University Press.

Lee, Barrett A, Kimberly A Tyler, and James D Wright

2010 The new homelessness revisited. Annual review of sociology 36:501-521.

Lefebvre, Henri

1991 The Production of Space. . Cambridge: Blackwell Publishing.

Leiderman, Deborah B. , and Jean-Anne Grisso

1985 The Gomer Phenomenon. Journal of health and Social Behavior 26(3):222-232.

Levin, Josh

2013 The Welfare Queen, Vol. 2017.

Levine, Deborah, and Jessica Mulligan

2015 Overutilization, overutilized. Journal of Health Politics, Policy and Law 40(2):421-37.

Lewis, Diane K

1975 The Black Family: Socialization and Sex Roles. Phylon 36(3):221-237.

Lewis, Oscar

1966a The culture of poverty. Scientific American 215(4):19-25.

—

1966b La vida: a Puerto Rican family in the culture of poverty-San Juan and New York. Volume 13: Random House New York.

Liebow, Elliot
1967 Tally's Corner: A Study of Negro Streetcorner Men: Little, Brown and Company (Inc.).

Lin, Wen-Chieh , et al.
2015 Frequent Emergency Department Visits and Hospitalizations Among Homeless People With Medicaid: Implications for Medicaid Expansion. American Journal of Public Health 105(s5):s716-s722.

Lindsey, Linda L.
2015 Gender roles: A sociological perspective. New York: Routledge.

Link, Bruce G, et al.
1997 On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. Journal of Health and Social behavior:177-190.

Lock, Margaret M
2002 Twice dead: Organ transplants and the reinvention of death. Volume 1: Univ of California Press.

Lock, Margaret, and Vinh-Kim Nguyen
2010 An Anthropology of Biomedicne. Sussex, UK: John Wiley & Sons, Ltd.

Low, Setha M
2003 Embodied space (s) anthropological theories of body, space, and culture. Space and culture 6(1):9-18.

Low, Setha M, and Neil Smith
2006 The Politics of Public Space: Routledge.

Lubiano, Wahneema
1992 Black Ladies, Welfare Queens, and State Minstrels: Ideological War by Narrative Means. *In* Race-ing Justice, Engendering Power: Essays on Anita Hill, Clarence Thomas, and the Construction of Social Reality. T. Morrison, ed. New York: Pantheon Books.

Luhrmann, Tanya M
2000 Of two minds: The growing disorder in American psychiatry: Alfred A. Knopf.

Lupton, Deborah
2012 Medicine as culture: illness, disease and the body. London: Sage Publications.

Lynch, Colleen S, et al.
2016 Implementation science workshop: a novel multidisciplinary primary care program to improve care and outcomes for super-utilizers. Journal of General Internal Medicine 31(7):797-802.

Lynch, John W., et al.
2000 Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. British Medical Journal 320(7243):1200-1204.

Lyon-Callo, Vincent

2008 Inequality, poverty, and neoliberal governance: Activist ethnography in the homeless sheltering industry: University of Toronto Press.

Lyon-Callo, Vincent

2000 Medicalizing Homelessness: The Production of Self-Blame and Self-Governing within Homeless Shelters. Medical Anthropology Quarterly 14(3):328-345.

Mackelprang, J. L., S. E. Collins, and S. L. Clifasefi

2014 Housing First is associated with reduced use of emergency medical services. Prehosp Emerg Care 18(4):476-82.

Mackelprang, Jessica L. , Qian Qiu, and Frederick P. Rivara

2015 Predictors of Emergency Department Visits and Inpatient Admissions Among Homeless and Unstably Housed Adolescents and Young Adults. Medical Care 53(12):1010–1017.

Main, Thomas

1998 How to think about homelessness: Balancing structural and individual causes. Journal of social distress and the homeless 7(1):41-54.

Malone, Ruth E.

1998 Wither the Almshouse? Overutilization and the Role of the Emergency Department. Journal of Health Politics, Policy and Law 23(5):795-832.

Marmot, M. G., et al.

1997 Contribution of job control and other risk factors to social variations in coronary heart disease incidence. The Lancet 350(9073):235-239.

Martin, Jeff, and Robert Ray

2017 Homeless Wary as Atlanta Closes Its Last-Resort Shelter, Vol. 2018. Washington, DC: US News and World Report.

Maskovsky, Jeff

2000 “Managing” the poor: Neoliberalism, medicaid HMOs and the triumph of consumerism among the poor. Medical Anthropology 19(2):121-146.

Massey, Doreen

2001 Space, Place and Gender. Minneapolis: University of Minnesota Press.

Massey, Douglas S, and Nancy A Denton

1993 American Apartheid: Segregation and the making of the underclass. Cambridge, MA: Harvard University Press.

Mattingly, Cheryl

2010 The Paradox of Hope: journeys through a clinical borderland. Berkeley: University of California Press.

—

2014 Moral laboratories: Family peril and the struggle for a good life. Berkeley: University of California Press.

McKittrick, Katherine

2011 On plantations, prisons, and a black sense of place. Social & Cultural Geography 12(8):947-963.

McKittrick, Katherine, and Clyde Adrian Woods

2007 Black Geographies and the Politics of Place. Cambridge, MA: South End Press.
McManus, IC, and KA Sproston
2000 Women in hospital medicine in the United Kingdom: glass ceiling, preference, prejudice or cohort effect? Journal of epidemiology and community health 54(1):10-16.
Mendenhall, Emily
2012 Syndemic suffering: Social distress, depression, and diabetes among Mexican immigrant women. Walnut Creek, CA: Left Coast Press.
Mills, China
2015 The psychiatrization of poverty: Rethinking the mental health-poverty nexus. Social and Personality Psychology Compass 9(5):213-222.
Moerman, Daniel E.
2002 Meaning, Medicine, and the "Placebo Effect". Cambridge, MA: Cambridge University Press.
Mol, Annemarie
2008 The logic of care: Health and the problem of patient choice. New York: Routledge.
Moran, Martin
2012 Atlanta's Living Legacy: A History of Grady Memorial Hospital and Its People: Kimbark Publishing, LLC.
Morgen, Sandra, and Jeff Maskovsky
2003 The anthropology of welfare “reform”: New perspectives on US urban poverty in the post-welfare era. Annual Review of Anthropology 32(1):315-338.
Morrison, David S
2009 Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. International Journal of Epidemiology:1-7.
Mulligan, Jessica
2016 Insurance Accounts: The Cultural Logics of Health Care Financing. Medical Anthropology Quarterly 30(1):37-61.
—
2017 The problem of choice: From the voluntary way to Affordable Care Act health insurance exchanges. Social Science & Medicine 181(May):34-42.
Mulligan, Jessica M
2014 Unmanageable Care: An Ethnography of Health Care Privatization in Puerto Rico: NYU Press.
Murdock, George Peter
1949 Social structure. New York: MacMillan.
National Academies of Sciences, Engineering, and Medicine
2017 Accounting for Social Risk Factors in Medicare Payment: National Academies Press.
Navarro, Vicente, and Leiyu Shi

2001 The political context of social inequalities and health. Social science & medicine 52(3):481-491.

Neuman, Mark I, et al.

2014 Characteristics of recurrent utilization in pediatric emergency departments. Pediatrics 134(4):e1025-e1031.

Newton, Warren Polk, and Ann Lefebvre

2015 Is a strategy focused on super-utilizers equal to the task of health care system transformation? No. The Annals of Family Medicine 13(1):8-9.

Niska, Richard, Farida Bhuiya, and Jianmin Xu

2010 National hospital ambulatory medical care survey: 2007 emergency department summary. Natl Health Stat Report 26(26):1-31.

O'reilly, Karen

2012 Ethnographic methods. New York: Routledge.

O’Connell, James J

2005 Premature mortality in homeless populations: A review of the literature. Nashville, TN: National Health Care for the Homeless Council.

Office of Policy Planning and Research, US Department of Labor

1965 The Negro Family: The Case for National Action.

Oldani, Michael J

2004 Thick Prescriptions: Toward an Interpretation of Pharmaceutical Sales Practices. Medical Anthropology Quarterly 18(3):325-356.

Oliver, David

2008 ‘Acopia’and ‘social admission’are not diagnoses: why older people deserve better. Journal of the Royal Society of Medicine 101(4):168-174.

Omi, Michael, and Howard Winant

2014 Racial Formation in the United States. New York: Routledge.

Oorschot, Wim van

2000 Who should get what, and why? On deservingness criteria and the conditionality of solidarity among the public. Policy & Politics 28(1):33-48.

Osborne, Thomas

1998 Medicine and ideology. Economy and Society 27(2-3):259-273.

Ozawa-de Silva, Chikako

2008 Too lonely to die alone: Internet suicide pacts and existential suffering in Japan. Culture, Medicine, and Psychiatry 32(4):516-551.

Page, J Bryan, and Merrill Singer

2010 Comprehending Drug Use: Ethnographic Research at the Social Margins. New Brunswick: Rutgers University Press.

Pantell, Matthew, et al.

2013 Social isolation: a predictor of mortality comparable to traditional clinical risk factors. American journal of public health 103(11):2056-2062.

Parsons, Michelle

2014 Dying Unneeded: The cultural context of the Russian mortality crisis: Vanderbilt University Press.

Parsons, Talcott

1958 Definitions of Health and Illness in the Light of American Values and Social Structure. *In* Patients, Physicians and Illness: A sourcebook in behavioral science and health. E.G. Jaco, ed. Pp. 165-187. Glencoe, IL: Free Press.

Piven, Frances Fox, and Richard A Cloward
1971 Regulating the Poor: The functions of public welfare. New York: Vintage Books.

Porter, Michael E, and Elizabeth Olmsted Teisberg
2006 Redefining health care: creating value-based competition on results. Boston: Harvard Business School Press.

Procacci, Giovanna
1991 Social Economy and the Government of Poverty. *In* The Foucault Effect: Studies in Governmentality. G. Burchell, C. Gordon, and P. Miller, eds. Pp. 151-168. Chicago: The University of Chicago Press.

Putnam, Robert D.
2000 Bowling Alone: The Collapse and Revival of American Community. New York: Simon & Schuster Paperbacks.

Quadagno, Jill S
1994 The color of welfare: How racism undermined the war on poverty: Oxford University Press.

Rabinow, Paul
1995 French Modern: Norms and forms of the social environment. Chicago: University of Chicago Press.

Radcliffe-Brown, Alfred R, and Daryll Forde
1950 African Systems of Kinship and Marriage. London, UK: Oxford University Press.

Rapport, Nigel
2009 Of Orderlies and Men: Hospital Porters Achieving Wellness at Work. Durham: Carolina Academic Press.

Raven, Maria C, et al.
2013 Comparison of presenting complaint vs discharge diagnosis for identifying “nonemergency” emergency department visits. JAMA 309(11):1145-1153.

Reich, Adam Dalton
2014 Selling Our Souls: The Commodification of Hospital Care in the United States. Princeton, NJ: Princeton University Press.

Rhodes, Lorna A
1991 Emptying beds: The work of an emergency psychiatric unit: Univ of California Press.

Risse, Guenter B
1999 Mending bodies, saving souls: a history of hospitals: Oxford University Press New York.

Rivkin-Fish, Michele
2011 Learning the moral economy of commodified health care:“community education,” failed consumers, and the shaping of ethical clinician-citizens. Culture, Medicine, and Psychiatry 35(2):183-208.

Rohe, William M., Shannon Van Zandt, and George McCarthy

2002 Home Ownership and Access to Opportunity. Housing Studies 17(1):51-61.

Roschelle, Anne R.
1997 No More Kin: Exploring Race, Class, and Gender in Family Networks. Thousand Oaks, CA: Sage Publications, Inc.

Rosenberg, Charles E
1995 The care of strangers: The rise of America's hospital system. Baltimore: Johns Hopkins University Press.

Rosner, David
2004 A once charitable enterprise: Hospitals and health care in Brooklyn and New York 1885-1915. Cambridge: Cambridge University Press.

Rossi, Peter H
1989 Down and Out in America: The origins of homelessness. Chicago: University of Chicago Press.

—
1990 The old homeless and the new homelessness in historical perspective. American Psychologist 45(8):954-59.

Roth, Julius A., and Dorothy J. Douglas
1983 No Appointment Necessary: The Hospital Emergency Department in the Medical Services World. New York: Irvington Publishers, Inc.

Rowe, Michael, et al.
2001 Homelessness, mental illness and citizenship. Social policy & administration 35(1):14-31.

Ruddick, Susan M
2014 Young and Homeless in Hollywood: Mapping the Social Imaginary. New York: Routledge.

Rutheiser, Charles
1996 Imagineering Atlanta: The Politics of Place in the City of Dreams. New York: Verso.

—
1997 Making place in the nonplace urban realm: notes on the revitalization of downtown Atlanta. Urban Anthropology and Studies of Cultural Systems and World Economic Development:9-42.

Ryan, William
1971 Blaming the Victim. New York: Random House.

Rylko-Bauer, Barbara, and Paul Farmer
2002 Managed Care or Managed Inequality? A Call for Critiques of Market-Based Medicine. Medical anthropology quarterly 16(4):476-502.

Sack, Kevin
2009a Atlanta Judge Rules Dialysis Unit Can Be Closed. The New York Times, September 26, 2009.

—
2009b Hospital Falters as Refuge for Illegal Immigrants. New York Times, November 21, 2009.

Sacks, Karen Brodkin

1988 Caring by the hour: Women, work, and organizing at Duke Medical Center: University of Illinois Press.

Salhi, Bisan

2015 Management of Medical Risk and Displays of Physician Competence: The Case of Emergency Medicine. Anthropology in Action 22(1):36-45.

Salhi, Bisan A, et al.

Forthcoming Homelessness and Emergency Medicine: A Review of the Literature. Academic Emergency Medicine.

Sandel, Michael J

2012 What money can't buy: the moral limits of markets. New York: Farrar, Straus and Giroux.

Saul, Michael Howard

2013 New York City Leads Jump in Homeless. Wall Street Journal, March 3.

Saunders, Barry F

2008 CT suite: the work of diagnosis in the age of noninvasive cutting. Durham: Duke University Press.

Scheper-Hughes, Nancy

1993 Death without weeping: The violence of everyday life in Brazil: Univ of California Press.

Schiff, Lisa

2003 The power to define: definitions as a site of struggle in the field of homelessness. International Journal of Qualitative Studies in Education 16(4):491-507.

Sen, Amartya K

1977 Rational fools: A critique of the behavioral foundations of economic theory. Philosophy & Public Affairs:317-344.

Shatin, Leo

1966 Medical Care and the Social Worth of a Man. American Journal of Orthopsychiatry 36(1):96-101.

Shem, Samuel

1978 The House of God. New York: Putnam.

Shinn, Marybeth, et al.

2007 Predictors of homelessness among older adults in New York City disability, economic, human and social capital and stressful events. Journal of Health Psychology 12(5):696-708.

Shortliffe, Ernest C, T Stewart Hamilton, and Edward H Noroian

1958 The emergency room and the changing pattern of medical care. New England Journal of Medicine 258(1):20-25.

Shulkin , David J.

2008 Like Night and Day — Shedding Light on Off-Hours Care. New England Journal of Medicine 358(20):2091-2093.

Sigerist, Henry Ernest

1936 An outline of the development of the hospital: Bulletin of the Institute of the History of Medicine.

Singer, Merill, and Scott Clair

2003 Syndemics and public health: Reconceptualizing disease in bio-social context. Medical anthropology quarterly 17(4):423-441.

Singer, Merrill

2009 Introduction to syndemics: A critical systems approach to public and community health: John Wiley & Sons.

Singer, Merrill, and Arachu Castro

2004 Unhealthy health policy: A critical anthropological examination: Rowman Altamira.

Singh, Sukhbir S, and Glenn Posner

2015 Doctors Behaving Badly and the Tyranny of Peer Pressure. Journal of Obstetrics and Gynaecology Canada 37(12):1113-1115.

Sledge, William H, et al.

2006 A randomized trial of primary intensive care to reduce hospital admissions in patients with high utilization of inpatient services. Disease Management 9(6):328-338.

Small, Mario Luis

2009 Unanticipated Gains: Origins of Network Inequality in Everyday Life. New York: Oxford University Press.

Smith, Neil

1996 The new urban frontier: Gentrification and the revanchist city. London: Routledge.

Snow, David A, et al.

1986 The myth of pervasive mental illness among the homeless. Social Problems 33(5):407-423.

Soja, Edward W

1989 Postmodern Geographies: The reassertion of space in critical social theory. New York: Verso.

Somers, Margaret R

2008 Genealogies of Citizenship: Markets, Statelessness, and the Right to Have Rights. Cambridge: Cambridge University Press.

Sparks, Tony

2012 Governing the homeless in an age of compassion: Homelessness, Citizenship, and the 10-Year plan to end homelessness in King County Washington. Antipode 44(4):1510-1531.

Spitzer, Denise L.

2004 In Visible Bodies: Minority Women, Nurses, Time, and the New Economy of Care. Medical Anthropology Quarterly 18(4):490-508.

Spradley, James P

1999 You Owe Yourself a Drunk: An Ethnography of Urban Nomads. Long Grove, IL: Waveland Press, Inc.

Springston, Jonathan

2007 Security, Police Tackle State Sen. Fort, Others Before Grady Privatization Vote (Update 1), Vol. 2017. Atlanta, GA: http://atlantaprogressivenews.com/2007/11/26/security-police-tackle-state-sen-fort-others-before-grady-privatization-vote-update-1/.

Stack, Carol B.

1974 All our kin: Strategies for survival in a black community. New York: Basic Books.

Starr, Paul

1982 The social transformation of American medicine: Basic Books.

Steffen, Charles G.

2012 The Corporate Campaign against Homelessness: Class Power and Urban Governance in Neoliberal Atlanta, 1973-1988. Journal of Social History 46(1):170-196.

—

2016 The Rise and Fall of Atlanta's Skid Row, Vol. 2017. Atlanta, GA: Atlanta Studies.

Stoline, Anne, and Jonathan P Weiner

1988 The new medical marketplace: A physician's guide to the health care revolution. Baltimore, MD: Johns Hopkins University Press.

Stone, Clarence N.

1989 Regime Politics: Governing Atlanta, 1946-1988. Lawrence, Kansas: University Press of Kansas.

Stone, Deborah

2011 Moral Hazard. Journal of Health Politics, Policy and Law 36(5):887-896.

Strategies, Center for Health Care

2016 Programs Focusing on High-Need, High-Cost Populations, Vol. 2018: Center for Health Care Strategies.

Strathern, Marilyn

1992 Reproducing the future: essays on anthropology, kinship and the new reproductive technologies: Manchester University Press.

Strike, Carol, et al.

2014 Emergency departments and street-involved youth: factors influencing utilization. journal of social distress and the homeless 23(1):42-50.

Sudarkasa, Niara

2007 African American female-headed households: Some neglected dimensions. *In* Black Families. H.P. McAdoo, ed. Pp. 172-183. Thousand Oaks, CA: Sage Publications.

Sudnow, David

1967 Passing On: The Social Organization of Death. Englewood Cliffs, NJ: Prentice Hall Inc.

Sugrue, Thomas J

2014 The origins of the urban crisis: Race and inequality in postwar Detroit: Princeton University Press.

Susser, Ida

1996 The construction of poverty and homelessness in US cities. Annual Review of Anthropology:411-435.

Sweet, Elizabeth

2010 "If your shoes are raggedy you get talked about": symbolic and material dimensions of adolescent social status and health. Social science & medicine 70(12):2029-35.

Szymkowiak, Dorota, et al.
2017 Persistent Super-Utilization of Acute Care Services Among Subgroups of Veterans Experiencing Homelessness. Medical Care 55(10):893-900.

Tadros, Allison, et al.
2016 A 5-year comparison of emergency department visits by homeless and non-homeless patients. The American Journal of Emergency Medicine.

Taylor, Janelle S
2003 Confronting "Culture" in Medicine's "Culture of No Culture". Academic Medicine 78(6):555-559.

Tester, Griff, et al.
2011 Sense of place among Atlanta public housing residents. Journal of Urban Health 88(3):436-453.

Thomas-Henkel, Caitlin, Allison Hamblin, and Taylor Hendricks
2015 Opportunities to Improve Models of Care for People with Complex Needs: Literature Review. Robert Wood Johnson Foundation

Center for Health Care Strategies, Inc.

Thrift, Nigel
2005 But malice aforethought: cities and the natural history of hatred. Transactions of the institute of British Geographers 30(2):133-150.

Tilley, Charles
2005 Identities, boundaries and social ties. Boulder, CO: Paradigm Publishers.

To, M. J., et al.
2015 Healthcare Utilization, Legal Incidents, and Victimization Following Traumatic Brain Injury in Homeless and Vulnerably Housed Individuals: A Prospective Cohort Study. J Head Trauma Rehabil 30(4):270-6.

Toth, Jennifer
1993 The mole people: Life in the tunnels beneath New York City. Chicago: Chicago Review Press.

Trzeciak, Stephen, and EP Rivers
2003 Emergency department overcrowding in the United States: an emerging threat to patient safety and public health. Emergency medicine journal 20(5):402-405.

Turner, Victor
2008 The Ritual Process: Structure and Anti-Structure. New Brunswick: Transaction Publishers.

Updike, John
2008 Mayhem at the Hospital. *In* Return to The house of God : medical resident education, 1978-2008. M. Kohn and C.C. Donley, eds. Kent, Ohio: Kent State University Press.

van der Geest, S., and K. Finkler
2004 Hospital ethnography: introduction. Soc Sci Med 59(10):1995-2001.

Vogel, Morris J

1980 The invention of the modern hospital, Boston, 1870-1930. Chicago: University of Chicago Press.

—

1989 Managing Medicine: Creating a Profession of Hospital Administration in the United States, 1895-1915. *In* The Hospital in History. L. Granshaw and R.S. Porter, eds. New York: Routledge.

Wacquant, Loic

2000 The New "Peculiar Institution": On the Prison as Surrogate Ghetto. Theoretical criminology 4(3):377-389.

—

2001 Deadly symbiosis when ghetto and prison meet and mesh. Punishment & Society 3(1):95-133.

Wang, Hao, et al.

2015 The role of charity care and primary care physician assignment on ED use in homeless patients. The American journal of emergency medicine 33(8):1006-1011.

Wear, Delese

2002 The house of God: another look. Academic Medicine 77(6):496-501.

Wear, Delese, et al.

2006 Making fun of patients: medical students' perceptions and use of derogatory and cynical humor in clinical settings. Academic Medicine 81(5):454-462.

Weisburd, David, and Cynthia Lum

2005 The diffusion of computerized crime mapping in policing: Linking research and practice. Police Practice and research 6(5):419-434.

Weiss, Audrey J., et al.

2014 Overview of Emergency Department Visits in the United States, 2011. Agency for Health Research and Quality.

West, Cornel

1993 Keeping faith: Philosophy and race in America: Psychology Press.

Whitney, Fay W.

1981 How to Work with a Crock. The American Journal of Nursing 81(1):86-91.

Willamson, John B

1984 Old age relief policy prior to 1900: the trend toward restrictiveness. American Journal of Economics and Sociology 43(3):369-384.

Willen, Sarah S

2012 How is health-related "deservingness" reckoned? Perspectives from unauthorized im/migrants in Tel Aviv. Social Science & Medicine 74(6):812-821.

Willging, Cathleen E.

2005 Power, Blame, and Accountability: Medicaid Managed Care for Mental Health Services in New Mexico. Medical Anthropology Quarterly 19(1):84-102.

Williams, Brie A, et al.

2010 Coming home: health status and homelessness risk of older pre-release prisoners. Journal of General Internal Medicine 25(10):1038-1044.

Williams, Patricia J

1997 Seeing a Color-Blind Future: The Paradox of Race. New York: The Noonday Press.

Willse, Craig

2010 Neo-liberal biopolitics and the invention of chronic homelessness. Economy and Society 39(2):155-184.

—

2015 The Value of Homelessness: Managing surplus life in the United States. Minneapolis: University of Minnesota Press.

Winick, Stephen D.

2004 "You Can't Kill Shit": Occupational Proverb and Metaphorical System among Young Medical Professionals. *In* What Goes Around Comes Around: The Circulation of Proverbs in Contemporary Life. K.J. Lau, P. Tokofsky, and S.D. Winick, eds. Logan: Utah State University Press.

Woolhandler, Steffie, and David U Himmelstein

2017 Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower CostsSingle-Payer Reform. Annals of Internal Medicine 166(8):587-588.

Wright, James D

2009 Address Unknown: The Homeless in America. New Brunswick: AldineTransaction.

Xu, Jiaquan, et al.

2016 Mortality in the United States, 2015. Centers for Disease Control and Prevention.

Zeitlyn, David

2012 Anthropology in and of the archives: Possible futures and contingent pasts. Archives as anthropological surrogates. Annual Review of Anthropology 41:461-480.

Zhou, Min

2010 Chinatown: The socioeconomic potential of an urban enclave. Philadelphia: Temple University Press.

Ziliak, Stephen T

2002 Pauper fiction in economic science:" Paupers in Almshouses" and the odd fit of Oliver Twist. Review of Social Economy 60(2):159-181.

Zink, Brian J

2006 Anyone, anything, anytime: A history of emergency medicine: Elsevier Health Sciences.