WAITING CAN KILL YOU

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> One burden of this introduction concerns the claim that it took some fourteen years for me to grasp what Ilongots had told me about grief, rage, and headhunting. During all those years I was not yet in a position to comprehend the force of anger possible in bereavement, and now I am. Introducing myself into this account requires a certain hesitation. . . . If classic ethnography's vice was the slippage from the ideal of detachment to actual indifference, that of present-day reflexivity is the tendency for the self-absorbed Self to lose sight altogether of the culturally different Other. Despite the risks involved, as the ethnographer I must enter the discussion at this point.
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> — Renato Rosaldo, "Grief and a Headhunter's Rage"

I started fertility treatments in 2017. One month before my mother was diagnosed with terminal cancer. Her waiting would eventually kill her. It might have killed me too. I had settled into Toronto for what I thought was going to be a long, slow decline to cancer for my mother, but she had gone quickly. The night I drove in, the last of my long road trips back from California, I woke to

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her screaming in the hallway, gripping the walls, asking me to help her. "Huyyy Lali—help me," she cried. I ran to the bathroom to get her Tylenol, the only medicine she would take. Held hostage by the public fear of the opioid crisis, and her concern at becoming addicted, even though the doctors said there was no risk, she was treating stage 4 cancer with extra-strength Tylenol. I handed her the pills. "Thank you," she wept, "thank you." She died a few days later, ignored by hospital staff and a doctor who herself admitted, on what would be her last day, "she seems really sick." No shit.

The next day I took a pregnancy test. The test was positive.

I spoke to a friend: "Guess what, my mom died, and I'm pregnant." "I wouldn't get too attached," she said. I was devastated.

Six weeks later, I woke up with cramps. I could feel the cramping in my lower belly and it felt different, like my insides were loose. I had tried a week earlier to get an ultrasound at a local fertility clinic to check everything was OK, but as I told the nurse that I was feeling really dizzy and hoping I could be seen soon, I heard the doctor yell at another that I'd have to wait like everyone else. I turned to the doctor and said, "I'm feeling really dizzy, so I'm just going to go." "No, you're not," she barked, "sit down. You're going to wait because you've already signed the check-in forms." "No, I didn't," I said and walked out. My friend who had reluctantly recommended her doctor, warned me that this could happen. She has a bad temper.

I was just six weeks pregnant, six weeks past the death of my mother, and three months into fertility treatments as a "single mother by choice." But that day, I knew something was wrong. An ultrasound would reveal a problem. Hunched over, I had to take the ultrasound to my doctor, since the technicians weren't allowed to tell me what it said. But they told me to go right away. The doctor, who had been treating me for free,[1] out of pity maybe, opened the paper. "It's bad news," he said. As I sat sobbing in the emergency room of Mount Sinai Hospital in Toronto, I waited all day in the ER as the fetus with a heartbeat of 141 beat its way through my right fallopian tube. I had arrived that morning, and two IVs had been attached to my hands immediately. "In case you pass out," the nurse said before walking away. I sat in the ER as my stomach filled with blood and I got woozy and did almost pass out. That day of waiting, that six hours after an initial ultrasound caught it, almost literally killed me as I had to submit to the Ontario health insurance system, which would later send me a bill and weekly calls from Ayaz in hospital billing, threatening to send my case to collections before my scars had even healed, while I negotiated with my U.S.-based health insurance, HealthNet, which later paid. My doctor told me I lost one-third of

the blood in my body, and that if the rupture had happened in the ER instead of in the elevator on the way to the operating room, I would have died. The resulting emergency surgery severed my right fallopian tube and what I hoped would become my baby. Later I thought, they must have been sent to medical waste, my fallopian tube and my baby.[2] Waiting can kill you.

Since then, I've been thinking a lot about waiting. As I convalesced in my mom's apartment for three months after she died, trying to recover from the ectopic, lying among her things, sleeping in her sheets on the bad mattress she wouldn't let me replace. Did my back hurt from the ectopic, the resulting nerve damage, or this shitty Ikea mattress? Looking at the big bloodstain on the middle of the carpet from one of her falls, covered with a thin tea towel that she also wouldn't let me replace, I waited. I waited to feel better, to recover as I had to do things like pick out a gravestone and sort out her affairs. I found a suitcase filled with love letters for someone I didn't know existed. I found old pictures of us as time slowed to something heavy and strange.

This article is about medical racism in the birth experiences of people of color in California, but it began with my mother's death in Toronto. I do not write as a neutral observer but as someone who has lived through the failures of medical institutions, witnessing how they harm and abandon people of color. Her story was not an isolated tragedy. It was part of a broader pattern in which time itself is rationed differently for different bodies: whose pain is believed, whose symptoms are taken seriously, whose urgency is recognized, and who is made to wait. She was not listened to; she was ignored. My perfect English made me the go-between. I overheard doctors describe her as "non-compliant" to cover for their own mistakes. Long before I began studying obstetric racism, I had already learned that waiting is not neutral. It is one of the ways institutions distribute care, harm, and the possibility of survival. This research grew out of that reckoning.

I began fieldwork in California,[3] where I would later have my own baby, and learned that in the Global North, even before COVID-19, women of color suffered worse birth outcomes than white women. From 2011 to 2013, Black women in the United States experienced 43.5 deaths per 100,000 live births, compared to 12.7 deaths for white women. According to the Centers for Disease Control and Prevention (CDC), pre-pandemic, Black women in the United States died of pregnancy-related causes at a rate three times higher than white women, and regardless of the mother's education level or income, Black babies are twice as likely to die before their first birthday than white babies (Effiong, Hogan, and Okorie 2020). As I conducted interviews and sat in waiting rooms, I witnessed how time operated as a form of triage: some patients were made to

wait endlessly, others rushed through appointments, all in ways that reflected hierarchies of race, class, gender, sexuality, and immigration status.

This article theorizes racialized medical temporalities—embodied, often deadly experiences shaped by medical racism. For birthing people of color, waiting is not benign; it is abandonment as care, a bureaucratic delay that accrues over generations. Time is not neutral. It can be slowed to abandonment or sped to coercion. In obstetric care, the same racialized logics that slow care for some, rush care for others through hasty inductions, accelerated interventions, and decisions made without informed consent. Slowing down and speeding up are two sides of the same temporal framework, sorting whose lives are valued and whose can be risked.

Drawing from autoethnography, interviews, and fieldwork in California and Toronto, I situate racialized waiting within a broader temporal framework of obstetric care, where medical norms about timing, for instance, when to intervene or when to delay, signal whose bodies are deserving of care and whose are pathologized or dismissed. Theorizations of waiting as a social category have productively explored questions of affect, belonging, and citizenship (Chua 2011; Crapanzano 1985; Eisenstein 2021; Kwon 2015), and this research builds on the work of these scholars, as well as on the long literature on the anthropology of reproduction (e.g., Andaya 2019a, 2019b; Cottom 2019; Davis 2019, 2020; Morgan and Roberts 2012; Mullings and Wali 2012; Scheper-Hughes and Lock 1987) that contends with questions of bodily sovereignty within larger institutional structures. Temporality is a critical site for understanding how medical racism operates at the level of everyday encounters, bodily sovereignty, and reproductive justice. Waiting itself is a racialized form of governance—a way of enacting whose time, pain, and survival matter.

For many, waiting is not reflective or hopeful, but a refusal to intervene, a way of saying you do not matter yet. This story is also about memory, grief, and the afterlife of harm. Waiting can feel like suspended life, as Vincent Crapanzano (1985) writes, "without élan, vitality, creative force . . . numb, muted, dead." Jocelyn Chua (2011) offers a counterpoint: waiting can also constitute an active process of self-making. But in racialized medicine, the power to define waiting, its length, its conditions, rests with institutions, not patients.

It is the same racist structures that produce both the slowness of neglect and the rush of coerced interventions. These norms dictate how bodies *should* operate, and bodies outside those norms are pathologized. Many factors contribute to disparities in maternal health, from a two-tiered health-care system to health-care segregation, racism-induced comorbidities, and differential

treatment by providers. Here, I focus on that last factor: the everyday encounters between birthing people and the medical establishment.

Waiting is the potential or the experience before we put words to it, a lived bodily sensation, before it's experienced as a question of social inequality. It's a precarity, a tenuousness, a lived manifestation of the failures of potentiality. You feel it, and then come to understand it in a particular way, like sadness or melancholy. But I don't want to describe the actors in this study as passive. In the stories I relate later in this piece, women exercised agency: they resisted, fought back, challenged their doctors, but in the end, they relinquished control. How can you resist a doctor who with the backing of an entire establishment tells you that you're risking the health of your baby? What would you do?

Taking inspiration from Renato Rosaldo and his "Grief and a Headhunter's Rage" (1993), in which Rosaldo finally understood the rage of the headhunters he studied after he himself experienced the death of his wife, I really only came to think about racialized time as I sat in various oncology waiting rooms and doctor's offices with my mom, witnessing the poor care women of color receive at the hands of a medical system ill equipped to manage difference, and only prepared to communicate with Western accents—a lesson I perhaps learned too late.[4] I, too, am a product of Canadian post-racial colorblindness, and I spent my childhood discounting my mom's narratives of racism. She once told me about being asked to leave the Bay department store jewelry counter on Queen Street because they didn't think she could afford anything. I used to dismiss her stories of racism as "American problems." I see differently now.

ON POSITIONALITY AND WAITING

This research draws on multisited ethnographic fieldwork I conducted between 2021 and 2024 in Los Angeles, California, and Toronto, Canada, during and after the height of the COVID-19 pandemic. My methods included participant observation, semi-structured interviews, autoethnographic reflection, and informal conversations with doulas, NGO workers, and birthing people, mostly women who identified as Black, South Asian, Filipina, or mixed-race, navigating pregnancy, labor, postpartum care, and birth trauma. I recruited participants through parenting networks, birth-equity advocacy groups, personal connections, and snowball sampling. All names used here are pseudonyms.

Extended fieldwork in Los Angeles was conducted while I was on sabbatical and in residence at the UCLA Asian American Studies Center. It was grounded in parenting communities, fitness groups, and social media birth networks. I also engaged in digital ethnography through Instagram accounts, birth equity webinars, and group chats. My methods were necessarily shaped by my own role as a

mother, anthropologist, and former caregiver, which often blurred the boundaries between researcher and participant.

My approach was also informed by my own embodied experience of medical care in both the U.S. and Canadian systems, including a traumatic ectopic pregnancy and the loss of a parent to cancer. These experiences are presented as autoethnographic interventions—not to universalize, but to theorize waiting as a lived, racialized, and affectively charged phenomenon. I position these narratives alongside those of my interlocutors not to collapse them, but to place them in critical relation.

I remember being told two very different accounts of care by two women who gave birth in Los Angeles. A white, blonde woman originally from Oregon explained that when she arrived at the hospital in labor, she was told she would need to wait until her contractions were closer together before being admitted. She pushed back, and the nurses relented, checking her in, and giving her a private room in which to labor. Another woman, who was Black, described insisting that she was in labor but being turned away again and again. She went home, only to later call an ambulance when the pain became unbearable. By the time she arrived back at the hospital, she was rushed into an emergency C-section, barely saving her baby's life. The baby would spend a month in the neonatal intensive care unit (NICU).

Both women resisted, but the outcomes could not have differed. For one, pushback opened the door to care; for the other, it led to dismissal and near tragedy. The hospital staff willingly relented when a white patient insisted, even if they initially said they were following protocol. That flexibility wasn't extended to the Black woman, even when the stakes became life-threatening. The white woman's ability to successfully challenge the nurses shows how racialized perceptions of credibility, assertiveness, and worthiness of care shape outcomes. The Black woman's pushback was not only ignored; it ended with the near loss of her baby and an emergency C-section. Protocol flexed for one, and hardened for the other. That flex, granted or withheld, marks the difference this project tracks.

RACIALIZED WAITING

In much of the Global North, for Black, Indigenous, and other women of color, time is measured differently, often in longer waits, more dismissals, and delayed responses. The specific numbers are grim, even when income, education, and insurance are the same. In Los Angeles, I met many Black women fearful of giving birth. These fears were not unfounded: In the United States, between 2011 and 2013, Black women died from pregnancy-related causes at more

than three times the rate of white women: 43.5 per 100,000 live births compared to 12.7. Before the pandemic, the CDC reported that Black babies were twice as likely as white babies to die before their first birthday. The sociologist Barbara Gurr (2014) conducted research among Indigenous women and found that infant mortality rates were 28 percent higher for Indigenous women than for all other people of color in the United States combined. In the United States, 50,000 women per year experience life-threatening pregnancy-related complications; Black women are three to four times more likely than white women to die from these complications.

Asian American mothers, often left out of these conversations, experience their own risks. According to a report by the Department of Health and Human Services, Asian American infants are 40 percent more likely to die from maternal complications than if their mothers were non-Hispanic white women.[5] Researchers from the McGovern Medical School at UTHealth in Houston found that between 2014 and 2017, Filipina and Pacific Islander women were 35 percent and 45 percent, respectively, more likely to experience a negative outcome than white women, including when going to the ICU, having a uterine rupture, or an unplanned hysterectomy (Trovall 2020). Among Asian women, hemorrhage is the most frequent underlying cause of pregnancy-related death.[6] In the United Kingdom, older South Asian women who do not speak English are often brushed off as exaggerating their pain, a pattern so familiar to clinicians it even has a shorthand: "Mrs. Begum or Bibi Syndrome." I witnessed this pattern clearly in the treatment of my mother, whom doctors and nurses often referred to as *overly anxious*. These are not just statistics. These were things I heard from NGO workers, doulas, lawyers, and women of color themselves. They are created in moments when someone asks for help and doesn't get it, when nurses say it can wait, and when help arrives only after a crisis has begun.

Maternal mortality rates vary dramatically among racial groups; it's a known set of statistics. However, it is less known *how* these disparities happen. I use the term *racialized waiting* to describe these delays as a social and political phenomenon. Waiting is not simply the absence of action or an inevitable feature of an overburdened system. It is an instrument of triage, a way of allocating urgency unequally. It sorts patients into those whose needs are met right away and those whose needs can be postponed, into bodies understood as requiring immediate intervention and bodies that can be deferred without institutional consequence. For the patient, the cost can be catastrophic. Time, in this sense, is not neutral. It is made, distributed, and withheld according to logics that are

racialized, gendered, and shaped by histories of colonialism, capitalism, and medical authority.

While negligence can happen to anyone, for Black and Indigenous mothers the stakes are often deadly. In May 2023, at the age of thirty-two, the three-time Olympic gold medalist Tori Bowie died eight months pregnant and in labor at her Florida home. She was alone and found during a wellness check after she hadn't been heard from for several days. An autopsy found that she experienced complications including distress and eclampsia. The baby, a girl, was stillborn. Black women die from preeclampsia and eclampsia, a rare complication that leads to seizures, confusion, and disorientation, at five times the rate of white women (MacDorman et al. 2021). This means that Black women are bearing a disproportionate impact of the disease. Heart disease and stroke are the leading causes of pregnancy-related death in the United States, contributing to about 34 percent of such fatalities.[7] Bowie's death was not an isolated tragedy but an extreme point on a spectrum of neglect that often begins in quieter moments, when a request for help is postponed, a monitor is not connected, or a nurse decides to "wait and see." In those moments, time is rationed, sometimes in minutes, sometimes in hours, and the rationing is not random.

It's also important to note that I've heard stories of extreme negligence from birthing people that cut across racial lines. There are no doubt horrendous experiences of white women being told to wait, but the stats do tell a story. Robbie Davis-Floyd's *Birth as an American Rite of Passage* (1992) serves as a classic reference on the patriarchal nature of obstetric medicine. What does the before and after care look like? How many doctor's visits do people get, and what is the quality of those visits? Who is being listened to and when are they listened to? That negligence in relationship to Black and Indigenous birthing people translates into material differences, namely, the fact that women of color are frankly more likely to die.

This research and the ways I've framed it here move between the Canadian and U.S. medical systems, which differ particularly in their conceptions of time. In the Canadian context, waiting makes for a highly fraught debate, as the efficiency, indeed, the efficacy, are determined by wait times. In Canada, waiting has a value and a currency. In the Canadian ideal system, everyone should wait the same amount of time. In the U.S. private system of care, the idea is that one should never wait. And conservative U.S. politicians use mythological wait times in Canadian emergency rooms as a defense of privatized medicine. So, waiting and its meaning vary.

Racialized waiting is not always dramatic. It can happen in the minutes a nurse spends deciding whether to call a doctor, in the hours between triage and a labor room, or in the quiet refusal to extend the flexibility granted to a white patient. Sometimes care is slowed until an emergency forces acceleration. Both can cause harm. Both reveal the politics of time: who is worth the rush, and who can be asked to wait because the system has decided they can afford to. The same structures that slow some patients, keeping them in waiting rooms, sending them home from triage, also speed up others, pressing for induction or surgical birth. These are not separate logics, but two expressions of the same temporal framework that organizes birth as a racialized process. Normative timelines for labor and delivery become yardsticks against which certain bodies are measured and found wanting. The concept of racialized waiting emerged for me from my participants' narratives and from echoes in my own experience. For Sarah, a queer Black woman, and Seema, a South Asian American woman, waiting was not just the space before care. It was the form that care took.

PATHOLOGICAL SUBJECTS

Again and again in my research, I found that a critical, life-or-death juncture was the decision of whether someone was "really" in labor—or whether they had to wait. I met Sarah because of an article she'd written in a local paper about birth equity in California. She was a young Black lesbian woman living in Santa Barbara—a small, wealthy, and overwhelmingly white coastal town. She had her first child there, in a place with only one hospital, one birth center, and for years, one celebrated doctor—Dr. Blake—who has since retired into concierge medicine at $20,000 per patient. She noticed that people had issues with the hospital, such as a ban on vaginal deliveries after C-sections. Dr. Blake and the midwives seemed like the only good options. She had tried to engage with people in the birth worker community, but as it's a very white town, she told me, with very low numbers of people of color, she found this represented with no discussion of race.

Wanting to give birth at home, Sarah started seeing midwives at the local birth center. While she didn't have great experiences with them, things seemed fine in the first few months of her pregnancy. Yet she ultimately found the whiteness of the space too Othering, and decided to go the hospital route. Because it was during COVID, she only met with her doctor two times, doing three-quarters of her visits online. At around twenty-one weeks pregnant, she began having odd symptoms. She was in pain, thought she was losing her mucus plug, and reached out to them. They told her it could happen, "but it's not a reason for

concern. You can come in, or just do your next visit in a week or two in person." Sarah felt strange about it, and her therapist encouraged her to get herself examined. "My therapist saved my baby," she said. The therapist pushed her to go to Dr. Blake's office, who got her in right away. An ultrasound, they said, looked fine. She asked if someone should check her cervix, but the medical said it was too risky and didn't want to do it.

Sarah was in the foyer checking out when the team called her back to do the exam. Because Dr. Blake was with another patient, someone else examined Sarah, discovering that she was two centimeters dilated. "This person was freaked out," Sarah said. She told her to go straight to the hospital, to labor and delivery. Sarah texted her partner that everything was not OK. They went to the hospital and stayed overnight, during which time the medical staff there gave her steroids, which ultimately saved her daughter's life. That was Friday. She went back to see her doctor Monday, who said to do minimal activity, a form of modified bed rest. She woke up with really bad cramping and lower back pain, which started to get more intense.

Her partner started using their contraction-timing app. The next morning they went to the hospital and told staff what was going on. As it was her first pregnancy, Sarah didn't know what contractions felt like. These moments of pain felt intense to her, and they mirrored descriptions of contractions. "It got really intense, to the point where in the hospital I had to hold onto whatever I could; I couldn't speak because it hurt so bad," she explained. Sarah described the attending nurse as "horrible . . . really very dismissive, an older white woman, who said it was probably fine because this could just be normal pain." Staff told Sarah they didn't really worry until contractions were x amount of minutes apart. Sarah's partner kept a record of what was happening, and the app she was using noted, "Congratulations, your baby is on the way, go to the hospital."

Sarah said the nurse was busy and seemed annoyed that she was there because she didn't think she was in labor. The nurse also made homophobic comments, clarifying that there was to be no sex during her bed rest, commenting as well about not using sex toys. Her attempts to make jokes during the interaction did not make Sarah feel cared for. The hospital monitored her for a few hours, during which she was in pain. They did a cervical exam and said she was fine. Dr. Blake came and seemed comforting, saying they'd keep an eye on it, but that there was nothing they could do. "She didn't do the cervical exam, just the nurse." Sarah was told to go home, take a high dose of Ibuprofen, and wait. Ibuprofen relieves pain, but it can also help stop contractions.

Being told to wait has deep roots in racialized obstetric care. Black feminist scholars (Cottom 2019; Davis 2019, 2020; Mullings and Wali 2012) have long shown how racism shapes whose pain is believed and whose emergencies are recognized. Waiting, as anthropologists like Chua (2011) and Anna Eisenstein (2021) note, is not simply a pause, but a social practice: it allocates urgency unequally, often along racial lines. For patients of color, it is not neutral time; it is deferred care, sometimes until crisis. In obstetric racism, waiting is not liminal; it is triage by other means.

Waiting can be a hopeful act, a solitary act, some people have to wait longer, and the experience of waiting is not the same for everyone. Crapanzano (1985) describes waiting as "a sort of holding action—a lingering. (In its extreme forms, waiting can lead to paralysis.) In waiting, the present loses its focus in the now. The world in its immediacy slips away; it is derealized. It is without élan, vitality, creative force. It is numb, muted, dead. Its only meaning lies in the future—in the arrival or the non-arrival of the object of waiting . . . feelings of powerlessness, helplessness, and vulnerability—infantile feelings—and all the rage that these feelings evoke" (cited in Chua 2011, 125–26). In contrast to this depiction of waiting as devoid of agency, in her research, Chua (2011, 126) argues that waiting can be an active process of self-making, "an opportunity for empowerment and self-improvement."

Waiting is also indicative of different relations of power and is a political question. Johannes Fabian (1983, 2) has argued, "It is by diagnosing anthropology's temporal discourse that one rediscovers the obvious, namely that there is no knowledge of the Other which is not also a temporal, historical, a political act." Drawing on Bourdieu's observation that waiting is a key modality through which power is experienced, Chua argues that who waits, under what conditions, and in what affective state reveals how temporal practices produce differently situated subjects (Chua 2011, 128). Eisenstein (2021) argues that waiting is not merely a form of inactivity but also a social and political practice through which people negotiate belonging, meaning, and future possibility amid conditions of economic insecurity. Being taught to practice, or withstand racialized waiting is a critical part how medical racism operates. To second guess one's symptoms, to accept that long wait times are simply a part of getting medical care, to accept when whiteness affords patients different care.

Sarah went home and remembered getting a few hours of sleep before waking up in the middle of the night in horrible pain. She went to the bathroom to find "something coming out'; something had ruptured. The couple drove back to the hospital. When they returned, Sarah said, "the vibe was like, she's back again." She waited in the lobby until 4 or 5 a.m., and kept asking for help. She

couldn't stand or sit, and kept moaning. They didn't give her a wheelchair. She had to pause walking down the hallway, and felt the nurse was impatient with her rather than empathic. When the team finally examined her, the surprised nurse noted, "her hand is coming out!"

Sarah was twenty-five weeks and three days pregnant and giving birth. It was "really scary," she told me. The team didn't know what to do. Among themselves they floated the idea of giving Sarah magnesium, but then decided it was too late, since the baby was coming out. They brought Sarah to different rooms with different people: a small exam room, a delivery room, an operating room. NICU staff in the delivery room expressed surprise: "Oh, my gosh, we didn't realize the baby was coming!" Because the baby was transverse, Dr. Blake performed a C-section. They had a difficult time getting the baby out. They baby wasn't breathing, so they intubated her and took her to the NICU. The little girl was going to be in intensive care for sixteen weeks.

Sarah felt rage about not being listened to and being told to wait. She had told staff that she was in labor, yet no one had listened. She could have given birth in the car or at home and she and her daughter might have died. She's grateful they didn't. At first she wasn't mad at Dr. Blake; she said the doctor was fine, did a good job, delivered the baby alive. It took Sarah a couple of weeks to think that Dr. Blake, too, saw her and didn't take her seriously. Her growing anger also came from hearing of very different experiences of mainly white women who had been monitored closely or hospitalized for an extended period when they were found to be dilated at twenty-two weeks. Sarah wondered what it would have taken for her to be admitted to the hospital. Why didn't the medical staff listen? Why did they tell her to go home and wait?

Saidiya Hartman (2007) has written beautifully about the afterlife of slavery as experienced in contemporary Black life. Hartman (2007, 6) defines the afterlife of slavery as follows:

> Slavery had established a measure of man and a ranking of life and worth that has yet to be undone. If slavery persists as an issue in the political life of Black America, it is not because of an antiquarian obsession with bygone days or the burden of a too long memory, but because Black lives are still imperiled and devalued by a racial calculus and a political arithmetic that were entrenched centuries ago. This is the afterlife of slavery—skewed life chances, limited access to health and education, premature death, incarceration, and impoverishment. I am the afterlife of slavery.

Dána-Ain Davis (2019, 425) extends this notion to think of this afterlife of slavery as a situatedness that makes it possible to talk about how these historical legacies continue in the racism experienced by women like Sarah: "The dystopian past inhabits present practices, including the practice of medicine." Davis (2019, 451) argues that these women's experiences can be understood as an "extension of tropes, practices, and beliefs that can be traced back to antebellum and postbellum periods. What we see is that racism is continuously recalibrated—a racism that is a reinterpretation of enduring processes of slavery."

Sarah believed that if she had been listened to, and not told to wait, she might have had better, more thorough care. After this realization she didn't feel great about Dr. Blake, the celebrity doctor of Santa Barbara. She missed post-operative appointments with her because COVID-era NICU policies stipulated that she could only leave once per day, and she didn't want to leave the NICU and not be allowed to return. So she sacrificed her care. The more she thought about it, the more rage she felt. She ultimately went elsewhere for follow-up care.

Sarah's rage was matched by her clarity: waiting had nearly killed her baby. She had been subjected to racialized waiting, a governance of time that decides whose emergencies are real, and when action is justified. As Crapanzano (1985) writes, waiting can be paralyzing, stripping the present of vitality. Chua (2011) reframes it as potentially active, a space of self-making, but in the context of medical racism, it too often becomes a practice of withholding, a quiet but devastating refusal to intervene.

Sarah ended up sending Dr. Blake a letter about her experience after River, her daughter, was able to leave the NICU. The doctor had definitely seen her after her complications had begun, and while she was seemed warm and heartfelt, and had promised to listen to her, when the time came, she didn't, in fact, listen. That is, until Sarah's daughter's hand was emerging from her body. Sarah told Dr. Blake in her letter that she didn't understand why she wasn't taken seriously. She also got her medical records from when River was in the hospital to see what was documented on the day she was sent home. The lab work performed that day indicated some kind of infection, a high white blood cell count in her urine. The cause of her preterm birth had been flagged in medical records. She remembered thinking it so strange that no one had told her.

Sarah did her own research to see the standard treatment for these symptoms, and it's usually immediate antibiotics because of the importance for the baby. River was septic when she was born, and the NICU staff admitted it really affected her chance of survival. Maybe things would have been different if Sarah had been given antibiotics? It all confirmed to her that if they had paid attention,

they would have done more. She and her baby didn't feel like a priority. In her letter to Blake, Sarah asked about all of this.

She also wrote a letter to the midwives, asking what their plan was for caring for women of color, and Black women specifically. She wrote, "I hope you're aware of this disparity, what's your plan if you know being Black is a risk factor for giving birth prematurely, what are you doing to address this?" In her response, the director of the birth center was kind, but offered nothing of substance.

A week before our conversation, Sarah had attended a maternal health panel in town. Dr. Blake was on the panel, as well as one of the midwives Sarah knew, and the entire panel consisted almost exclusively of white people, with one Latino doctor from Los Angeles, who seemed to have been added on only after Sarah had asked about people of color participants beforehand. At the discussion, Sarah asked how each of them dealt with racial disparities in practice, leaving the panel awkwardly silent. The midwife offered, "We're really lucky we've been able to learn from people of color patients, and trans patients too." Sarah agreed this was important, but not the same thing.

Sarah said she tried to talk about these experiences and about what happened to her in this community, but people in her town don't feel accountable for racism. Sarah suggested it felt far-fetched to this community, and that even the large Latina population was not envisioned as a group of people to be cared for there. The pregnant person in Santa Barbara is just white middle or upper class. "It's been weird to be here amid all this and try to heal from that experience while in a place that people don't want to hear they're responsible or have a responsibility to at a bare minimum think about these things," Sarah lamented.

Her daughter was in the NICU for four months. She felt good about the care she got there, describing the nurses as amazing and kind. The neonatologist present at birth, an Asian American doctor, was the only other woman of color in the room, for which Sarah felt grateful. She was introduced to the Black woman neonatologist who came on board next. She loves them for saving her baby. Sarah was curious about their experiences and how they factored into the whiteness of Santa Barbara. She had lots of questions: Do they know the larger context of the day River was born? What do they think about what happened?

I admitted to her that I myself was tired of feeling like a pathological subject when pregnant in Santa Barbara. Sarah agreed the bar was low. I told her that I would always wonder whether a medical person was going to treat me like I'm human.

Midwifery care also didn't serve Sarah; she lost weight during her pregnancy because she was throwing up the whole time. She has two friends who are pregnant now, both Black women, which makes her scared for them. She herself also wants to have more kids, but feels she cannot go through a similar experience again. Her experience also made it hard for her to relate to other new mothers, to attend new parent groups. She finds it hard to hear about other experiences that do not involve having a micro preemie. Her story has made her feel bitter. She couldn't relate to the normal things other parents would bring up, such as breastfeeding or lack of sleep. Sarah couldn't breastfeed River until she was 2.5 months old, as she couldn't eat before.

The hospital policies around COVID exacerbated her already terrible experience. She and her partner were the only ones who could visit River in the NICU, but they couldn't go at the same time. The hospital also had a once in and out policy, so they'd have to stay at the hospital for eight hours straight because they couldn't leave and return. While Sarah is COVID-safe and understands policies, she found these restrictions intense. They meant that she had to face many deeply scary moments alone. Sarah felt the policies didn't help prevent the spread of COVID, and they negatively affected her and her family. She had restricted visiting hours and couldn't be there twenty-four hours like before; she'd have to leave at 10:30 p.m. She asked, "Under what other circumstances would someone say to someone postpartum that they have to leave their baby?"

She told me that the national conversation, especially around COVID, was very different in terms of discussions around race and birth. She made attempts to reach out to Dr. Blake and the midwives after her experience. She was mad. She wanted people to know that not everyone had the same experience. Hers was a narrative I heard often, women being told they were not ready to be admitted, that is, not really in labor, or in the right stage of labor. That is, they had to wait, and that waiting nearly killed them or their babies.

PANDEMIC BIRTHS AND THE COST OF NOT LISTENING

The bulk of this research happened while I was on sabbatical in Los Angeles, on fellowship at UCLA and housed in the Asian American Studies Research Center, although I had done early fieldwork in the summers before, once COVID lockdowns softened and my daughter and I both contracted COVID. I recruited interviewees through the parent networks at my daughter's school, even finding a core group of Desi moms who talked about these issues over breakfasts in the morning, weekend playdates, and late-night drinks. Priya assured me that before I left California, I would go out ten times at night alone, since I had only been

out twice at night in the five years since Sophie, my daughter, was born. I also joined a mom fitness group, where I met some of my closest friends, and I attribute me getting my groove back to our trainer. I also followed numerous social media accounts around birth equity and followed long email chains, which is how I came to reach out to Andrea.

Andrea, a thirty-five-year-old Filipina woman I interviewed, ended up with a C-section she did not want, after a long and unsuccessful labor. As she was wheeled to the OR, the hallway fell silent and nurses began crying, fearing the baby didn't make it. The surgery was rushed, but the baby was healthy. Yet that night, Andrea awoke to blood pooled around her as she sat up in bed—the doctors had to remove a piece of her placenta that had been stuck in her uterus.

The average number of pregnancy-related deaths in the United States between 2007 and 2016 hovered around 700 per year. In 2021, during the pandemic, more than 1,200 women died in the United States during pregnancy or shortly after childbirth (Hoyert 2021). Some of these deaths resulted from the coronavirus, as pregnant women with the virus were eight times more likely to die than their uninfected peers. "The bodies of pregnant women are already under strain, their heart forced to pump harder. Other health problems can make their condition more fragile. And then on top of that, COVID is going to make all that much worse," said Elizabeth Cherot, the chief medical officer at the March of Dimes.[8] Pregnant women were also less likely to be vaccinated, in part due to vaccine availability, in other part because the CDC didn't fully recommend the vaccine for pregnant women until August 2021.

The pandemic also introduced further key barriers. Hospitals began to impose limits on who could be in the labor and delivery rooms for pregnant women; New York originally barred all support people, including partners, but later rolled back the policy and allowed one support person. Doulas were largely shut out of births during the pandemic, but data has shown that doulas dramatically improve birth outcomes for pregnant women (Ford 2025). The role of the support person is to help advocate for women at their most vulnerable; their absence has a detrimental effect on birth outcomes. Many pregnant women were also choosing to give birth at home for fear of contracting COVID-19 in the hospital. This choice also likely contributed to poor health outcomes because women this way lost access to emergency medical care if they developed a life-threatening complication, such as a post-partum hemorrhage.

Birth under normal conditions can be an unpredictable experience. However, during the pandemic, women had to labor in masks and had limited birth and postpartum support, including from doulas, lactation consultants, and other

advocates or providers of hands-on care. Prenatal care was also negatively affected during the pandemic. In the United States, a pregnant woman would typically have fourteen in-person prenatal visits, but during COVID, these were likely reduced to half, and mostly virtual. Such conditions made it harder for obstetrician-gynecologists to identify potential problems. And after giving birth, women had to leave hospitals sooner, sometimes twelve to twenty-four hours later, rather than the standard forty-eight or more hours. Such a situation can create serious, potentially life-threatening risks: about one-third of pregnancy-related deaths occur during the first year postpartum, and most are preventable—often caused by high blood pressure, severe bleeding, or infections (Petersen et al. 2019).[9]

Maternal mental health challenges are common in the United States. Prior to the COVID-19 pandemic, approximately one in eight women reported symptoms consistent with postpartum depression (Bauman et al. 2021). Research conducted during the early months of the pandemic found that roughly one-third of postpartum women screened positive for depression, nearly triple pre-pandemic estimates, while rates of anxiety and psychological distress also increased substantially among new mothers (Shuman et al. 2022). Ethnographic fieldwork proves critical to understanding these disparities primarily visible through statistical data, helping to shine a light on the lived experience of people of color. Statistics tell part of the story, but ethnographic fieldwork, listening to the experiences of women of color, reveals how these numbers take shape in lived reality. Andrea's case speaks to the vulnerabilities created when systems are overburdened and care becomes fragmented. Seema's shows how those same systems, combined with racialized assumptions, can move with a dangerous kind of speed.

Seema is a forty-two-year-old woman from New Jersey who identifies as Asian American. She went to law school in California and now practices criminal law. She and I met through my daughter's daycare. We became instant friends when I made an off-color joke in the playground. We met for lunch one day near her office, so she could share with me her experience of birthing her first child.

Before her pregnancy, Seema had high blood pressure. When she was pregnant with her son, no one checked her records, even though she had gone to doctors in the same network so they would have access to her records. When she went in for a routine check in 2019 at 36.5 weeks pregnant, the doctor determined that her high blood pressure was a sign of preeclampsia. Since it's so dangerous, her doctor decided on an immediate induction. Seema tried to explain that high blood pressure runs in South Asian communities, that her family has a history of it, and that it thus wasn't necessary to induce her. She had gone in for a regular stress test. She was ignored. She felt disempowered and still blames

herself for not advocating appropriately for herself and her son. She said, "They see me as this small, timid South Asian woman, and they didn't take me seriously." The rhetoric of personal responsibility and advocating for yourself runs across borders, and you find it in the heavily bureaucratized medical system of Canada too, but not everyone feels it, or feels it in the same way.

Seema was at Cedars in Los Angeles. She was admitted on November 19, and gave birth on November 21. Once the diagnosis of preeclampsia had been made, she felt there was no way back. She had a vaginal birth and an epidural that didn't work. It was a horrible experience. "Once they diagnose preeclampsia, they don't see you anymore," Seema said, echoing Foucauldian theorizations of the medical gaze and the separation of the person from the body (Foucault 1973). Since her blood pressure wouldn't come down, she was stuck in a hospital for a week. "It's never gonna come down in the hospital," she told them. Her baby was born at five pounds. The medical staff continued to call it preeclampsia, although she kept telling them she just had high blood pressure. Her son was born 3.5 weeks ahead of his due date. She traces his overall small size and some of his behaviors to being premature. She told me she wished they had let him "cook a little more" before being born.

A day later she told me via text:

> Btw, I've been thinking about how my birth story fits into the narrative of different outcomes in pregnancy vis a vis racism. And it's like I experienced a kind of colorblindness, which is a racist construct in and of itself.

In this text and her narrative, she suggests that the doctors and nurses both did and didn't see her. They made her feel like she was, in her words, a small brown woman, but also didn't take into account racialized patterns of health issues. And yet still she felt the responsibility. She kept reiterating, "if only I had advocated more for him." By not taking into account her history, by not listening to her, the medical establishment made her feel unseen.

Preeclampsia can be life-threatening, and Seema herself recognized why the doctors were alarmed. She remembered that they seemed frightened by what might happen if her blood pressure continued to rise. Yet she still felt dehumanized in the process. She forwarded me her documentation from the day she was admitted, where staff wrote: "[Patient] asked appropriate questions, appeared to understand." She told me, "Yeah, it was a shitty start to his life, but he's alive. I'm alive. And the world over has had a much worse start in life than that."

She later told me:

> Meanwhile I remember that morning. I was so tired and I was dressed nicely because I had a meeting that evening. I remember thinking, "I just have to get through this meeting, it's my last major thing work-wise, and then I can focus on sleeping."
>
> Yeah. And when she told me to go to hospital I stupidly thought . . . hey the beds are adjustable so I can sleep sitting upright for my heartburn and be supported
>
> And I was actually . . . excited
>
> I was fucking delirious
>
> They should've ordered me to sleep and give it a day.

I said, "OMG, they really don't listen." She said:

> Nope. I kept saying I hadn't slept, I hadn't slept.
>
> But yeah. I guess the opposite was worse, I go home to sleep and stroke out because my BP [blood pressure] is too high
>
> I guess inducing him was a better/less risky outcome since I was 36 weeks and a few days. So . . . pretty close to full term.
>
> I just wish . . . I wish I'd said no.

I said: "It's so hard though. There's so much pressure." She said:

> I know. It's weird when the doctors look . . . scared.

She sent me some pictures of his birth and a video with the note: "He was just so small and frail. He fit in our hands the length of my forearm. The last video was taken after I'd almost fainted. I had to put him down while I recovered and I was struck by how thin he was, it just sent me in a panic again. Gosh I'm having palpitations just looking at these pictures."

Andrea's rushed surgery, Seema's rushed induction, different circumstances, but each marked by systems moving too fast, without fully hearing the woman in front of them. In pandemic and pre-pandemic contexts alike, time was taken out of their hands. This "colorblind hurrying" exists alongside racialized waiting, as two ends of a temporal spectrum that can harm in different but equally dehumanizing ways. Also important is how these women *see themselves* in relation to what happened to them. All presented a version of wishing they had done things differently, advocated more for themselves or their baby, taking blame for what happened. But these women were also agentive subjects; they pushed hard for themselves and their babies, but when faced with doctors who looked scared, I echo Seema, "what would you do?" Andrea's rushed surgery and Seema's rushed induction are not anomalies; they are the fast end of the same temporal regime that delayed Sarah. Different harms, same clock.

CONCLUSION: Temporalities of Care

When I was finishing up my book, my mom told suggested that we should go on the Oprah Show together to talk about it, because "Lali, no one cares about these women." After she died, I found among her things, a copy of my book, read, with a few question marks in the margins. I wish I'd asked her about them before she was gone. What did she wonder? Was she asking about herself? About me? What I was afraid of, because I never asked her what she thought of my book, was that it was about her. And me. And all the messiness that was before. In the four or so autobiographical pages at the beginning (the pages my friends tell me students are most interested in when the work is taught), I wrote that as soon as I could, I ran fast and far from the projects in which I grew up. And admittedly, far from her. I felt that it was a truth I was ashamed of, so I never asked her if she had read my book. And now I'll never know what she thought of it, except that she was proud I was a writer and wanted us to go on Oprah to talk about women's lives. Waiting can kill you.

I sat in those waiting rooms in the cancer hospital for months, watching people die. They were dying in front of me, before the nurses and doctors. The hospital waiting room is the home of racialized temporalities, where people sit waiting to die because doctors refuse to understand them, their accents, their foreignness. I watched doctors lean in and say loudly and clearly, "Are you OK? You need help?" I helped countless immigrant women fill out forms they barely understood as I tried to interpret their pain into palatable language for them. One woman lamented that there was no space for "I wish I would just die."

But rather than reading this waiting as a passive process, it should be clear now that it is a dialectical process, one that produces subjects at the same time

that their presence changes the landscape and terrain of multicultural racial politics. The presence of Brown birthing bodies makes clear the lie of a racist and sexist medical establishment that claims equality. These processes also form part of a larger temporality of care, one that slows down and rushes some bodies at certain times, both as the result of a racist system.

In writing this, I've moved through memory and grief, trauma and survival, pandemic births and pandemic deaths. Pathological bodies, aberrant bodies, and not just the bodies of people of color, but it wasn't until I was trying to get pregnant that I learned how little research has been done on birth. How much is guessed at. How much harm has been done in the name of care. Historically, obstetrics has been criticized for the widespread adoption of interventions before strong evidence of benefit existed (Davis-Floyd 1992). These bodily experiences tell us something about time and waiting, and how they become sites of deep inequality and social suffering imbued with racialized logics of belonging and indifference.

So, I end here with racialized waiting. An ordinary affect (Stewart 2007), a space in which people of color live. It's a space of radical uncertainty and desperate inequality. Desperate. I wish I could end with hope, with a neat lesson, but the only one I've learned is that the world is cruel and race still matters. My mom wouldn't want to end it there. Don't get me wrong, she would agree, but she would also say:

> You have to be tough. You have to be brave. You made it so far. Don't let the bastards get you down.

ABSTRACT

This article examines the lethal consequences of delayed obstetric care through the lens of maternal temporalities. Drawing from ethnographic fieldwork and autoethnographic narrative, I trace how racialized patients are asked to endure uncertainty, dismissal, and bureaucratic delay even as their medical conditions worsen. Focusing on my experience of an ectopic pregnancy alongside interviews with Black and Brown birthing people, I argue that waiting is not a neutral temporal state, but a racialized and gendered form of harm. Situating these experiences within the anthropology of reproduction, I show how waiting becomes both a medical directive and a disciplinary demand that erodes trust, safety, and survival. The article contributes to debates on obstetric racism, maternal mortality, and refusal by foregrounding waiting as an analytic of harm and a site of ethnographic witnessing. [waiting; temporality; obstetric racism; maternal mortality; refusal; ethnography; reproduction]

NOTES

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1. Access to OHIP (the Ontario Health Insurance Plan) is only reinstated once someone who has lived away re-establishes residency, with a waiting period of three months. I was in this liminal state.
2. I am pro-choice, meaning I support the legal right to access abortion. I know it wasn't a baby, only a fetus, but I thought about it as my baby. The emotional tie to that first pregnancy was strong, stronger even than to my later pregnancies, including the one that brought me my daughter, because, until then, I had never experienced pregnancy loss.
3. This research was approved by the York University Research Ethics Board (Certificate #e2021-207). This research was funded by a $96,293 grant from the SSHRC Insight Program.
4. In this article, I use the term *people of color* to describe communities that face systemic racism and structural inequities in societies organized around whiteness. The term includes Black, Indigenous, Asian, Latinx, Middle Eastern, and other non-white groups, while acknowledging the distinct histories and experiences of each. In Canada, *racialized people* is the term more often used in public policy and academic writing, but I use *people of color* here for consistency and to align with the broader transnational literature that informs this work.
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8. CBS News, "Maternal Mortality Rate for U.S. Women Dropped in 2022 after COVID Surge," November 16, 2023.
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