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"There Is a Big Question Mark": Managing Ambiguity in a Moroccan Maternity Ward

In Morocco, where extramarital sex and abortion are illegal, single mothers' ambiguous status before the law inflects medical decision-making. Leaky boundaries between the court and the hospital required doctors and administrators to work with multiple forms of documentation while anticipating external surveillance. Gaps between everyday experience and legalized forms of identity created confusion across multiple institutions. When discussing single mothers, hospital staff often spoke of "question marks" that flagged tensions between legibility and liability, disappearance and documentation. Managing question marks ramified surveillance and categorization. Ultimately, however, attempts to administratively resolve single mothers' ambiguity created gaps and inconsistencies that allowed vulnerable patients to disappear from view. [single motherhood, Morocco, ambiguity, documentation, maternal health]

During my first rotation in the Family Planning Unit at Public Maternity Hospital[1] in Rabat, Morocco, a midwife named Malika struck up a conversation with me about my research. When I explained that before beginning my hospital fieldwork I had worked with single mothers in Casablanca, she related the following story to me:

> Two single women came in wanting *sterilet* [IUDs]. I asked them whether they were married. When they said no I sent them away. I told them to go to the main hospital reception. Then I went to tell a supervisor about the situation. If I give a sterilet to a single mother. . . . She could go with one, two, three men. I don't want to do it.

The midwife dusted off her hands and wrinkled her nose. As she continued with her afternoon consultations, Malika repeated this story in tones of disbelief to her coworkers.

In deferring to a supervisor and rerouting the single women through another node of the hospital, Malika articulated the multiple forms of oversight characterizing single mothers' medical treatment in Morocco, where extramarital sex and abortion

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are illegal. Decisions within the hospital coordinated with practices elsewhere—in courtrooms, legal tribunals, NGOs, and the media. These decisions also reflected desires to manage and deflect single mothers' socio–legal ambiguity. Managing ambiguity required triage and inscriptive practices that created tensions between patients and staff members, and among different levels of the hospital hierarchy.

My focus on single mothers in the hospital highlights how ambiguity and anxiety motivated decisions designed to mitigate liability. When discussing single mothers, hospital staff often spoke of "question marks" that flagged tensions between legibility and liability, disappearance and documentation. Administrators demanded clarification as some doctors studiously avoided probing into single mothers' circumstances. Meanwhile, heated debates and media coverage surrounding abortion and extra-marital sex raised the stakes of treating and documenting single mothers. Ultimately, attempts to administratively resolve single mothers' ambiguity created gaps and inconsistencies that allowed vulnerable patients to disappear from view. Unlike the negative connotations that it carried for health care professionals, disappearance was a positive outcome for patients seeking to avoid scrutiny.

Legislating Single Motherhood

During my fieldwork, protests surrounding Morocco's "morality crimes" legislation gained traction with politicians. Moroccan laws governing sex, abortion, and adoption consist of mutually reinforcing jurisprudential traditions. Whether consulting the penal code (based on French colonial laws) or the family code (based in *shariʿa*), one will find the criminalization of extra-marital sex (*zinā*), abortion, and child abandonment (Bargach 2002; Freeman 2012; Morocco 1962, 2004; Naamane-Guessous and Guessous 2005; Newman 2018). Contraception, including emergency contraception, is available over the counter at pharmacies. Still, divorced and never-married women face stigma and other obstacles to accessing these medications because purchasing contraception is generally considered to be synonymous with admitting to sexual activity.

Medical staff face jail time, fines, imprisonment, and loss of employment if they provide illegal abortions or if they are construed as facilitating zinā. Contrary to widespread misreporting, penal code statutes still allow for the fining and imprisonment of a woman seeking an illegal abortion and anyone who helps her (Morocco 2018, art. 453). Hospital staff faced reprisals, including loss of employment, for mishandling cases involving single mothers. And yet, there are few guidelines outlining exactly how to properly manage these cases. A legal circular mandates that hospital staff must call the police if a single woman indicates her intention to surrender her infant (Ramid 2012). According to the circular, these women must appear in court, where they may be officially charged with child abandonment (Bargach 2002; Morocco 1962, art. 453).

Although laws were unevenly enforced, arrests prompted rumors and insecurity. During my research, police raided private gynecology offices suspected of providing illegal abortions (Moujib 2014). A husband sued two physicians for terminating a pregnancy without first obtaining his consent as required by Article 453 of the penal code. The hospital where I worked was threatened with an audit for its handling of a case involving a medically necessary abortion.[2] Police arrested staff at a hospital in

Tangier for facilitating the clandestine sale of unmarried patients' babies to Spanish couples (*Bladi.net* 2015; La Vanguardia 2015).

Administrators assumed the inevitability of external interference and sought to reduce individual and institutional liability. They were concerned that staff could be accused of failing to prevent and report child abandonment. Providing single women with birth control could be construed as facilitating zīna, a key anxiety from Malika's story. Staff thus sought to reduce their personal exposure. For those lower in the hospital pecking order like Malika, this meant reporting cases to superiors. Administrators, in turn, used documentation to create records that might become necessary in legal proceedings. Unlike other contexts where abortion is illegal, the administrators I worked with were not concerned with "maintaining professional jurisdiction over abortion" (Suh 2014, 20). Far from resisting encroachment from other state institutions, writing charts was embedded in "coercive technologies of accountability" (Shore and Wright 2000, 58) that *facilitated* state oversight of the hospital.

The leaky boundaries between the hospital and the court support Seo's (2017, 489) analysis of prenatal care as "a form of bureaucratic state work" that "operates as an inscription device that produces a set of information regarding the parents and fetus." The public maternity director was acutely aware of this side of institutional reporting. Referencing political tensions, he warned staff during a meeting, "With the press and the police and the way things are right now, we have to be careful. When the police enter into an institution, whether it's a spice shop or a supermarket, it's to arrest people first and discuss later. We need to have traceability (*traçabilité*)." While the director voiced anxieties about police authority, his awareness that apparently arbitrary arrests could take place in "a spice shop or a supermarket" reflected the banality of state interference. As both a protective strategy and a matter of routine procedure, administrators sought compliance with legal statutes as they intersected with medical practice. Traceability was one way to ensure this compliance while managing uncertainty. However, creating what the director described as "a rationality of surveillance" was easier said than done.

Methods

The material I present here draws on two years of fieldwork between 2013 and 2015. During that time, I worked with single-mother NGOs and advocates in Casablanca and with abortion activists and physicians in Rabat. While living in Morocco between 2008 and 2010, I met Dr. Benhamid, then chief of Obstetrics and Gynecology (OB/GYN) of the public hospital that became my field site. He was an outspoken critic of Morocco's penal code statutes criminalizing abortion and extramarital sex. Over the years, Dr. Benhamid became one of the biggest supporters of my research, eventually facilitating my entrée into the hospital as a researcher. The hospital served primarily low-income patients from across the larger metropolitan area in addition to those who traveled from rural areas.

There was a strongly gendered division of labor in the hospital: There were no women in any senior medical or administrative positions, and no male nurses or midwives. Administrators were senior physicians. Attendings supervised the residents, interns, and medical students. There were several female residents and about half of

the medical students were women, while midwifery students were all women. The director determined that I should share a dressing room with the medical students, effectively placing me with them in the hospital hierarchy.

Following approvals from the Ministry of the Interior, the Ministry of Health, and the ethical review board of the Université Mohammed V, I spent eight months rotating between daily observations in the Pre-Conception Counseling Unit, OB/GYN, the Family Planning Unit, the At-Risk Pregnancy Unit, Emergency, and Post-Partum Care. I spent extra time in the Emergency, At-Risk Pregnancy (a term encompassing pregnancies with complications or other antecedents), and Family Planning units where I had more opportunities to observe referrals and follow-up care and to interact with patients seeking contraception and post-abortion care. I interviewed patients and staff, reviewed charts, and attended training seminars and daily staff meetings. With each patient's informed consent, I observed consultations and procedures in each medical unit except for the Delivery Unit. Other research activities consisted of media analysis and attending political and artistic events related to sexuality and women's rights more generally.

The Politics of Counting

There are no official government statistics for single motherhood or children born to unmarried parents in Morocco, nor any state inquiries into the numbers of abortions that occur annually. However, Moroccan social scientists and NGOs have studied single motherhood, and the results of one study was submitted to the government (Zirari and Cherkaoui 2002). Still, media outlets circulated unattributed statistics regarding both single mothers and abortion. One Canadian journalist included the following estimates in a list accompanying her exposé "Children of Shame":

> > 220,000: number of single mothers in Morocco who have given birth to 340,000 children between 2003 and 2009, according to the results of a study made public in 2011
> > 27, 200: number of pregnancies outside of marriage every year
> > 24: number of babies abandoned each day [. . .] (Vallet 2013, my translation)

Verifying these statistics is not my point here. As Storeng and Béhague (2014, 267) have noted, "the political power of numbers exists even when the validity of the numbers is contested." Shocking statistics allowed activists to grab headlines while making truth claims through evidence-based advocacy. However, people were generally skeptical of statistics published in the media, in part because they often proved unreliable or misleading. For example, maternal mortality rates became controversial when the Moroccan government reported a lower rate than the World Health Organization in 2015 (Storeng and Béhague 2014).

The intersection of single motherhood and clandestine abortion with infant and maternal mortality makes these issues of broader relevance. Like other developing countries, Morocco prioritized meeting the Millennium Development Goals (MDGs), which mainstreamed and politicized maternal health in the Global South

(Bowen 1997; Browner and Sargent 2011; DeJong 2000; Foley 2007; Jaffré and Prual 1994; Lane 1994; Suh 2018a, 2018b). Although the MDGs do not specify access to abortion, everyday actors discursively linked government aspirations to achieve the MDGs with clandestine abortion. Doctors blamed augmented maternal mortality rates on women who arrived in the ER following clandestine abortion attempts. Activists decried child abandonment as directly impacting infant mortality. Statistics were far from illuminating for my interlocutors because it was unclear what, exactly, they quantified. These slippages demonstrate how statistics, particularly those relating to reproduction, are inherently political tools (Berry 2013; Greenhalgh 2008; Kanaaneh 2002; Kligman 1998; Suh 2018a).

Before he was dismissed from his position as chief of OB/GYN, Dr. Benhamid claimed that 600–800 abortions took place per day in Morocco, and that 150–200 took place in extra-medical conditions. After his dismissal, detractors used national media outlets to question the "facts" of abortion in Morocco. Eventually, Benhamid revealed that he had generalized abortion rates based on cases he documented at three hospitals in the Rabat metropolitan area. Benhamid's "creative epidemiology" (Storeng and Béhague 2014, 268) prompted wider criticism of his activism.

The unreliability of statistics also exacerbated strained relationships among hospital staff. The interim chief of OB/GYN appointed after Dr. Benhamid's dismissal was staunchly opposed to his politics and professionally insulted by his methods. The first time I met with the interim chief, he said ironically, "[Benhamid] said that we have 600 abortions a day. If you stay here for six months you will see *thousands* of abortions." He argued that the media wanted "to shock regarding the health system in a more global manner. We're not hiding, but we show the truth. We need to give positive critique. Otherwise you are not a patriot. We must not ignore the laws. We must follow the rules, the steps."

For the interim chief, reporting questionable statistics was not simply methodologically suspect, it was unpatriotic. He therefore espoused a different form of evidence-based advocacy, one that carefully complied with existing laws and standards. The interim chief used adherence to "the rules, the steps" to manage his responsibilities as an administrator and fulfill his duties as a citizen. He instituted new protocols requiring physicians to create tables listing numbers of emergency deliveries and abortions—including spontaneous, induced, or suspicious—and other complicated cases. These tables became a key feature of staff meetings. They served both pedagogical purposes and were self-consciously outward-facing as they folded seamlessly into the "audit culture" (Strathern 2000) that permeated bureaucratic institutions. Still, counting proved difficult when the patients being counted eluded clear legal or social definition.

Single or Married? Doing and Undoing Single Mothers

Legal reforms that purported to empower women in fact complicated their marital status in ways that directly impacted their legibility. Although Morocco enjoys a positive international reputation for its reformed 2004 Family Code, single mothers' status before the law and in society more broadly remains largely unchanged. The reformed code, heralded as an unqualified victory for children's and women's rights, increased the marriage age for girls to 18 years (Morocco 2004, art. 19). Most

champions of the 2004 Family Code, however, overlook the fact that it administratively *creates* new single mothers

The reforms most tangibly—and negatively—impacted the single mothers I knew through the official prohibition of *mariage bil fatiḥa*, a ceremony in which reciting the Surat al-Fatiḥa, the opening chapter of the Qurʾan, effectuates the marriage. These ceremonies may take place without the presence of the groom or consent of the bride. Mariage bil fatiḥa are not legally binding; their authority derives from family agreement. The resulting marriages are therefore not legally recognized unions. Years after the reforms, hundreds if not thousands of girls are still married as minors through mariage bil fatiḥa. Single mother advocates told me that they thought the new family code's strictures against marrying minors had prompted an increase in these ceremonies, particularly in the countryside. As one NGO social worker lamented, "The new law was supposed to stop the marriages of minors. It's the opposite (*bil ʿax*). They've gotten more secret—under the table (*min teḥt l teḥt*)."

These ceremonies are neither reported to the state nor regulated by any official body. As a result, women married through mariage bil fatiḥa are legally categorized as single mothers, leaving them vulnerable to abuse and abandonment. Many of the women I worked with sought recognition of their fatiḥa marriages solely to obtain legal divorces from their husbands and establish their children's legal identity. When women married in fatiḥa ceremonies also lacked national identity documents required to pursue legal action, as was often the case, they undertook other bureaucratic itineraries to assemble necessary forms, photographs, and sworn testimonies.

These gaps between experience and legalized existence created confusion both bureaucratically and morally. Paper trails were comprised of consummately "make believe papers" (Navaro-Yashin 2007)—documents carrying authoritative seals and stamps but with tenuous relationships to daily life. These documents resembled patient charts that doctors filled in retrospectively or through creative deduction. Single mothers' legal and medical records were thus "efficient social construct[s]" (Jaffré 2012, 15) that were among the many practices that "do" single mothers, to borrow Mol's (2002) phrasing. Medical and legal inscriptions variously did and undid single mothers, but they did not necessarily certify the same kind of person.

Single mothers were thus slippery administrative subjects. The multiplicity of documents that purported to speak to the truth of a single mother's subjectivity supports Berg and Bowker's (1997, 514–15) assertion that reading and writing records produce not only bodies but also bodies politic and bodies of knowledge. A medical chart must therefore speak to the competing interests of individuals and institutions: "it is a record [. . .] a legal document, and a tool. [. . .] It must be able to do all these jobs at once for all those who work with it" (Berg and Bowker 1997, 528). In this way, medical files mirrored single mothers' multiplicity.

Furthermore, as Biruk (2012, 361) observes, "seeing is also not-seeing." Documents, expectations, and emotions all contributed to how doctors did their jobs, and by extension how they recognized, counted, and treated single mothers. Some staff practiced "seeing exactly what they intend[ed]" (Biruk 2012, 362) to avoid being bogged down by complicated legal and moral questions. This was certainly the case for Ilham, a resident who I shadowed on my first rotation in the At-Risk

Pregnancy Unit. After a busy morning of consultations, Ilham's brisk pace faltered when she saw a particularly young patient waiting to be seen. Ilham looked at her for a long moment before asking, "How old are you?" Mouna, the patient, replied that she was 17.

"Seventeen and pregnant," Ilham stated rather than asked. She shuffled through a stack of files until she found the right one. After a few moments of reading, she asked, "Where are your papers?" Mouna shrugged and gestured to her file.

"No, where are your marriage papers?"
Mouna answered quietly, "I don't have any."
"You don't have any or you aren't married?"
"I don't have any. I was married when I was sixteen."

"*Bil fatiḥa*?" asked Ilham, "In a fatiḥa ceremony?" Mouna nodded. Ilham raised her eyebrows, a look of wariness crossing her face. "Are you still studying?"

Mouna nodded again and said that she went to school every morning. "I'm supposed to have two more months of school, I'm not supposed to be delivered yet." She started twisting her fingers in her lap and said she was worried. "I came in to have a quick ultrasound before. . . . " Tears choked the end of her sentence.

Ilham touched her shoulder and said, "Enough of this talk." After studying Mouna's chart, Ilham found that she had been referred to the unit because she was asthmatic. Returning to the medical facts of the case restored Ilham's confident manner. She ushered Mouna to a table behind a curtain and began to perform her examination. When Mouna started to cry during the pelvic exam, Ilham clucked to her, "I'm not hurting you, I'm not hurting you." Finally, Ilham snapped off the two-fingered exam glove and announced that everything was fine.

Because Ilham had decided to treat Mouna without pursuing additional documentation attesting to her marriage, the consultation proceeded like any other. She pointedly saw only a patient with asthma, rather than a potential single mother. She ignored Mouna's signs of distress, dismissing her tears both before and during the exam. Ilham also focused on positive elements of Mouna's presentation while downplaying the importance of legal documentation. The fact that Mouna was still in school indicated that the pregnancy was neither a secret nor a source of shame. This supported Mouna's assertions that she was married rather than an unmarried teen facing an unplanned pregnancy.

Mouna's compliance with medical advice was perhaps the most important factor. Ilham valorized patient compliance and routinely referred to patients as either "*consciente*" (conscientious, compliant) or not. The fact that Mouna attended her previous appointment and returned for follow-up confirmed her as a responsible patient in Ilham's eyes. Ilham thus established the "preferred account" (Berg 1996; Berg and Bowker 1997; McKay 2012; Suh 2014) of Mouna's case by writing her file and treating her like any other (married) patient. She specifically did *not* see other complicated parts of Mouna's situation. Ilham compartmentalized other considerations, which influenced how Mouna's chart would be written and read in the future.

Inscription and Protocols

As Mouna's case demonstrates, documents were central to (un)doing single motherhood in the hospital. Identity cards, lack of marriage certificates, and inability to provide spousal identification could all expose single mothers. These ambiguities made it difficult to pin down seemingly straightforward demographic information. Hospital staff struggled to manage what they called "question marks" as they created files (*dūwasa*), a key first step in any patient consultation.

Physician and patient had to navigate intake questions that prompted a cascade of other decisions about when to care, when to document, and when to report. All patients responded to a standardized set of demographic questions. Responses were ticked off in highly formatted sections at the beginning of the chart. When a patient was called in for a routine examination, nurses recorded information into patient charts, either asking questions before the doctor arrived or recording responses as the doctor asked questions. Physicians repeated questions, verifying answers and looking for inconsistencies. In urgent cases, staff dispensed with demographic questions. Similarly, if no nurse was available, physicians made sparse, if any, notes and reconstructed cases in the free-form sections of the medical chart when they had time. These recording practices relied on routinization and interpersonal coordination, while building on and influencing other protocols (Berg and Bowker 1997; Suh 2014; Timmermans and Berg 1997).

As the foregoing sketch indicates, staff could identify single mothers based on responses or nonresponses to intake questions. Establishing the social emplacement of the patient allowed doctors to move on to questions related to previous pregnancies, miscarriages, and other aspects of the woman's reproductive history. If an intake script revealed that a woman had had previous miscarriages, this prompted the physician to ask additional questions about whether these had been induced or spontaneous, whether the previous pregnancies had been desired, and whether the present pregnancy had been planned and was desired.

Whenever intake revealed that a patient was unmarried, doctors called the hospital social worker. The social worker usually spoke to the patient for less than 10 minutes and gave her the phone numbers and addresses of single-mother associations. The social worker succinctly described her main task in these consultations as "preventing child abandonment." Crucially, the social worker not only prevented child abandonment, she documented its prevention. The notation "patient was consulted and will keep the baby" appeared verbatim in single mothers' charts. Paradoxically, this inscription fixed single mothers in medical records as pointedly *not* abandoning children, so the hospital had no clear obligation to report them. This kind of inscription crystallizes patient charts' legal and medical functions.

At the same time, Mouna's case reveals triage and inscription as flexible processes. Indeed, Timmermans and Berg (1997, 289) argue that protocols only become "'doable' in light of patient and staff trajectories." Ilham did not need to call the social worker because she did not "see" a single mother. Insofar as "thinking medically" requires material records (Jaffré 2012, 15), Ilham controlled both material and ideological conditions for producing Mouna as a patient. In this regard, Ilham asserted her professional authority over the case (Suh 2014). Moreover, flexibility allowed staff to do protocols while treating single mothers. As a result, both

patients and front-line workers managed medical encounters through self-conscious positioning and interpretation in order to achieve their own ends (Brodwin 2012; Giordano 2014; Nguyen 2010).

Document, Question, Repeat

These routinized practices were more complicated than simply establishing "administrative types" (Hacking 1996) that could render single mothers more assimilable. Single mothers were "bureaucratically indigestible" (Biruk 2012, 351) because their cases complicated referral and review. Multiple levels of oversight and documentation ramified and fed back into each other, creating a circuitous set of institutional logics that enacted single mothers as specifically troubling patients.

Staff meetings structured my sense of how question marks accrued around a given patient. The tables that the interim chief required at these meetings could only be properly constructed if triage produced clear information. However, the tendency to focus on ambiguous cases in staff meetings reflected the continuous disruption of tidy categories. Two factors immediately flagged a patient as potentially single or facing an unwanted pregnancy: arriving at the Emergency Unit in advanced stages of labor and leaving the hospital immediately after giving birth. Clinical treatment in these cases was often frenetic, leaving little time for cohesive chart notations. When these cases came up at staff meetings, senior physicians grilled residents about what they had asked the patient, how the patient had responded, how they had recorded it, and what had been done. When the presenter provided insufficient explanations, attendings demanded to see the medical chart.

When a chart raised more questions than it answered, attendings handed it back to the treating physician with instructions to comprehensively rewrite it. This kind of remedial work produced revisionist accounts of medical encounters (Jaffré 2012; Melberg et al. 2018; Suh 2014). After listening to senior physicians' criticisms of their handling of a given case, residents corrected their chart notations, retroactively including attendings' treatment plans and observations. This process obliterates the conditions of the record's production until all that remains is "a text which aims at being read as 'what actually happened'" (Berg and Bowker 1997, 526).

It was not unusual for charts to lack information, but only a few came under scrutiny in staff meetings. I had access to charts accompanying each of the 10–15 consultations I observed each day. I read most of these to verify my understanding of events. On average, four charts per week (about 130 total) piqued my interest enough for me to follow up with the patient and physician. In addition, I also reviewed on average three charts per week (about 95 total) that staff meetings brought to my attention. After a staff meeting, a file had already passed from residents to attendings and back. Residents then took the chart to their lounge to make the necessary revisions before passing it off to me. Charts that I received this way were thus "cooked" (Clifford 1990) in comparison with other supposedly "raw" records that I read.

Disagreements also arose over the methods of categorization in the tables, themselves. On several occasions, the interim chief and director disagreed strongly enough with how a case had been classified that they instructed the presenting physician to stop and modify the table as the assembled residents, students, nurses, and

midwives all sat watching. During one staff meeting, for example, the interim chief re-categorized a spontaneous abortion as "image of [placental] retention." Although placental retention always indicated the need for post-abortion care, it was a neutral signifier because it could relate to any kind of pregnancy loss. Language and clarity were thus sometimes at odds.

Terms of varying specificity could refer to spontaneous and induced abortions. In French, the term for abortion is the same for miscarriage: *avortement*. Thus, in patient files, avortement was generally qualified as "spontaneous" or "induced" [*provoqué*]. The phrase *fausse couche provoquée* was used interchangeably with but less frequently than induced abortion (*avortement provoqué*). In cases where staff had doubts about the reasons behind a miscarriage, avortement might stand alone.[3] In Darija, things were a bit clearer: *kortej*, a gloss on the French *curettage*, connoted an induced abortion, while *khssr* referred to miscarriages. The Fusḥa term *ijhaḍ* was only ever used in official discourse or Arabophone media about abortion. When staff wanted to put a very fine point on matters, they used medical jargon: Voluntary Interruption of Pregnancy (IVG), Medical Interruption of Pregnancy (IMG) or Therapeutic Interruption of Pregnancy (ITG).

While this linguistic terrain sometimes complicated things for staff, it could provide patients with a degree of cover. If an avortement or placental retention remained unqualified in a chart, it might help the patient avoid scrutiny. However, ambiguity might also prompt further questions from administrators. For example, staff usually used ultrasounds in placental retention cases strictly to ensure womb vacuity while pointedly *not*-seeing potentially unmarried women or induced abortions.[4] However, because ultrasounds were not part of routine prenatal care, simply performing one could invite attention.

A week after the staff meeting mentioned above, the director lectured Ilham regarding her handling of another placental retention case. He admonished her, "Be very, very precise and maniacal [*maniaque*] in what you do. That is a general remark. Four ultrasounds with no precise analysis, that is insufficient." After several digressions, the director concluded, "You need to present a complete dossier otherwise you will make baseless decisions. There's no coordination!" The director thus collapsed Ilham's medical rationality into her ability to write and present a clear chart.

Much to my dismay, I found that residents were not the only people in the hot seat during these meetings. The interim chief often frustrated my attempts to be inconspicuous by interrupting a presentation, fixing me with a stern look over his glasses and saying, "This case might interest you. What is going on here?" I became implicated in certain cases, which could, in turn, prompt heightened degrees of scrutiny during staff meetings and follow-up care. Residents came to anticipate which files I would be interested in reading after staff meetings and would instruct me to wait in the hallway by their lounge for reconstructed charts. Sometimes they filled me in on the details of the case as we walked to the patient's bed for follow-up, while other times they tried to dissuade me from reading a file because they didn't believe it would prove interesting. As a result, my own forms of questioning and documentation were folded into and informed by medical interventions into patients' lives.

I was thus bound up with the recursive enactments of certain cases. Heightened focus on patients' circumstances revealed more question marks that prompted additional speculation. This speculation flagged a case as interesting to me, and my own notes and interviews constituted additional documentation and questioning. Although I never shared a patient's marital or post-abortion status with anyone, nor was I ever asked to, it would be naive to think that my interest went unnoticed by staff members. At the very least, my attention to certain patients confirmed them as interesting to an anthropologist working on single motherhood and abortion.

Disappearances

As I mentioned above, disappearance was another diacritic of single motherhood in the hospital. These patients arrived late in labor, delivered, and left before staff could complete charts or make a treatment plan. It was only through discussing patient presentation or comportment that staff raised questions about whether a woman was unmarried or a pregnancy unwanted. Disappearing patients thus became intelligible through this process of speculative categorization.

When I asked the interim chief about ambiguous cases like these, he often referred to "the question mark" to express his uncertainty about the circumstances surrounding a pregnancy or miscarriage. He alerted me to cases that he thought were shadowed by "the big question mark" and told me to look into them. The interim chief thus recruited me as another instrument in the service of the hospital's "will to knowledge" (Foucault 2006 [1976]), regardless of the fact that I did not share my findings with him. The cases that I looked into at the interim chief's direction usually involved divorcées, single mothers, suspected abortions, and pregnancies with no documented prenatal care.

These were all cases that hospital administrators and medical staff found anxiety-provoking, not least because disappearances were unacceptable from an administrative perspective. Regardless, disappearing patients were a routinized part of working in this overburdened public hospital. When Ilham lost track of a patient who had gone home after waiting over two hours for her appointment, she exclaimed, "Why do all of the patients that we see disappear? I already do the work of a doctor, and nurse, and midwife. Next I have to be security!" Doctors struggled to keep patients from being "lost to follow-up" (McKay 2012, 545), constantly impressing on them the importance of returning for subsequent appointments even if their pregnancies seemed to be going well. As a broader administrative problem, disappearing patients helped single mothers blend in as they entered and exited the hospital. If single mothers answered intake questions satisfactorily and delivered without complications, then they could leave the hospital quickly and quietly before staff meetings raised questions. For many single mothers, disappearing was the goal.

Although disappearances flagged generically problematic patients, other inconsistencies could specify single mothers. On a hot summer day during Ramadan, an ER nurse gave me the file of a single mother whose swift arrival and departure from the hospital I had missed the previous afternoon. At the top of the file a doctor had written "IDENTIÉ À VÉRIFIER"—identity to be verified (see Figure 1). This, along with a note that the patient had been admitted without any documents, took up the space normally devoted to recording personal details. With this new header

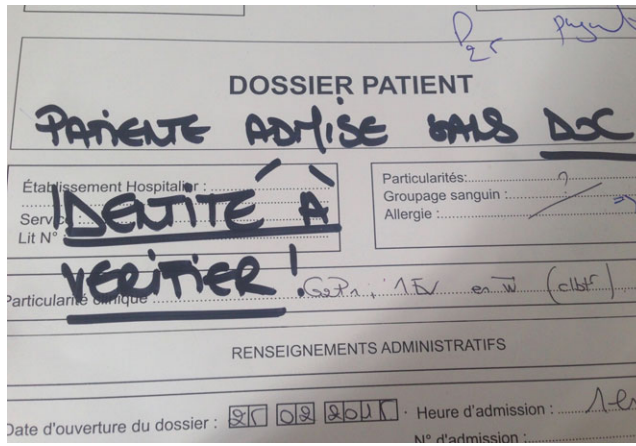

Figure 1. Notations on patient file. [This figure appears in color in the online issue]

on the file, the patient's disappearance and the gaps in the file became significant. Instead of a photocopy of the patient's identity card, there was a copy of a female friend's card and an accompanying explanatory note. The patient was designated *payante*; someone paying out of pocket. In this context, an insurance card would have provided another way to trace and identify the patient. Below the large writing in permanent marker was a highlighted sentence: "The patient says she is divorced." Despite this notation, someone had written and circled "clbt[r]," an abbreviation for *célibataire* (single woman) rather than divorcée.[5] There was a brief notation that the birth had been uncomplicated. However, doctors recorded the pregnancy as at-risk because they could not verify that the patient had received prenatal care. The notations ended abruptly with "discharged."

Risk Management

When I later asked the interim chief about the case, he emphasized the fact that the pregnancy had been "unfollowed" (*non-suivie*). He was also frustrated that the woman had waited to come into the hospital until "the very last minute." The interim chief extrapolated from the documentation when attempting to make sense of the patient's apparently incomprehensible behavior. He exclaimed, "We need to have ten people like you to do this sociological work to understand why women act this way. Was this an unwanted pregnancy or just resignation? What was going through her head? She came in 8cm dilated!" The patient's 8cm dilation led the interim chief to conclude that she had intentionally delayed going to the hospital. He therefore viewed this patient as a potential single mother who was irrational at best and deceitful at worst.

He made similar comments regarding a case where the patient had come to the hospital a week after miscarrying: "This case causes questions: How much time went by between the miscarriage and today? Was this an induced abortion? Did she

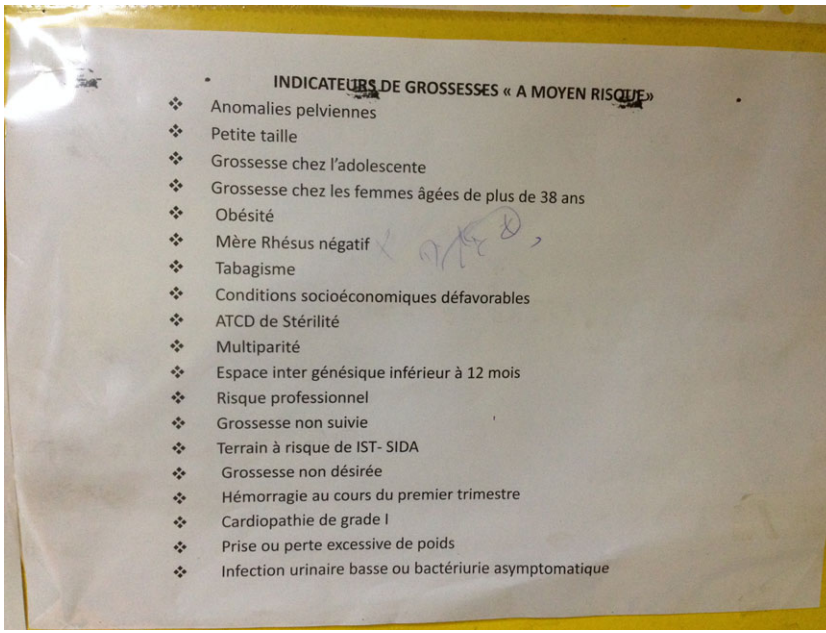

Figure 2. Indications for "Medium Risk" pregnancy [This figure appears in color in the online issue]

go see her doctor before coming here? This could have been an unwanted pregnancy. There is a big question mark."

Single mothers and abortion seekers thus bled into one another along moral and medical lines. Doctors and nurses were unsettled by women who they believed had intentionally waited until the last minute to seek medical care. Questioning a patient's marital status or her investment in her pregnancy supplied staff with scripts to dispel ambiguity. This narrative, however, glosses over the overlapping obstacles to care that single mothers face.

Moreover, hospital referral policies for medium-risk pregnancies included multiple factors that might pertain to single mothers (Figure 2). The most salient categories on the list were low socioeconomic status, unfollowed pregnancies, and unwanted pregnancies. Physicians' referrals, ultrasounds, and follow-up appointments were all coordinated to medically manage the ambiguity embedded in these categorizations. Beyond simply medicalizing single mothers, referral guidelines were yet another way that the hospital managed its own risk. As long as doctors rigorously documented referrals and their adherence to medical protocols, they could manage their liability should further complications develop.

Assigning risk categories and maintaining charts were practices aimed at creating coherence. As Bridges (2011, 168) argues, "Shared risk makes poor, pregnant, uninsured women into a coherent population." By designating unwanted or unplanned pregnancies as medical risk categories, the hospital administration created

a diagnostic feedback loop that enacted single mothers with great specificity. Risk-assessment criteria prompted staff to read between the lines of patient files to discern whether a pregnancy was desired. In staff meetings, presenting physicians sometimes attempted to clarify pregnancies as "a desired but poorly followed pregnancy" (*une grossesse désirée mais mal suivie*) or "an unplanned but desired pregnancy" (*une grossesse non-planifiée mais désirée*) in contradistinction from single mothers' presumably undesired and unfollowed pregnancies. This proliferation of categories reinforced the circularity of administrative attempts to manage single motherhood through referrals and chart notations.

Conclusions, Refusals

Political and legal anxieties were everywhere apparent in single mothers' treatment in the hospital. The recursive nature of documentation and questioning was central to how administrators instituted protocols as protective strategies for the hospital and its employees. Doctors refused "the question mark" by attempting to solidify details of patients' lives or by ignoring ambiguous situations altogether. Individual decisions could thus be at odds with how marriage certificates, identity documents, legal circulars, chart notations, referrals, and presentation tables variously enacted or disappeared single mothers. Single motherhood, like other ambiguous positionings, confounded medical impulses for simplification and clarification. Moreover, the contradictory bureaucratic traces that single mothers left behind frustrated administrative attempts to rationalize surveillance and treatment protocols.

Single motherhood in the hospital lays bare the ways in which "smooth narratives that seek to bring coherence will miss the point" (Mol and Law 2004, 58). Chart notations revealed frustrated attempts to resolve ambiguous cases. "Patient was consulted and will keep the baby" straddled medical, social, and legal worlds. "IDENTITÉ À VÉRIFIER" evidenced the tumult of an emergency room while indexing administrative concerns with documentation and liability. Single motherhood in the maternity ward thus shows the critically leaky boundaries between supposedly distinct institutions and jurisdictions. These leaks, however, also point to administrative cracks through which vulnerable and ambiguously positioned patients might escape proliferating modes of surveillance and discipline.

Notes

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1. All names have been changed.

2. Article 453 of the Penal Code allows for abortion in cases of threat to the woman's health. However, fear of legal reprisal led to conservative evaluations of "health" such that pregnancy terminations usually only occurred when a patient's *life* was threatened.

3. For more on how medical staff use strategic classifications and language in recording post-abortion care, see Suh (2014).

4. A full discussion of the negotiations surrounding abortions and post-abortion care is the subject of another article in preparation.

5. A divorced woman in the maternity hospital poses challenges thanks to normative expectations that sex only occur in the context of marriage. However, a divorced woman's extramarital sex does not carry the added weight of indexing loss of virginity.

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