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PRODUCING EQUALITY:

CITIZENSHIP, SCIENCE, AND MEDICINE IN THE NEGEV/NAQAB

by

Na'amahRazon

DISSERTATION

Submitted in partial satisfaction ofthe requirements for the degree of

DOCTOR OFPHILOSOPHY

in

Medical Anthropology

in the GRADUATE DIVISION of the

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO AND

UNIVERSITY OF CALIFORNIA, BERKELEY

Copyright (2013)
By
Na'amah Razon

For Nechama (Nelly) Klainer (1925-2011)

And

Um Raed

Two sages who have taught me most about family, tenacity, and wit

Abstract

Producing Equality: Citizenship, Science, and Medicine in the Negev/Naqab

Na'amah Razon

In 1994 Israel passed the National Health Insurance Law (NHIL), guaranteeing universal and equal healthcare services to all citizens. Universal healthcare, while unprecedented in Israel, did not have a significant impact on the country's Jewish majority. Yet for minority citizens such as the Bedouin community in the southern Israel, the NHIL transformed access to medical services, increasing insurance coverage from 60% to 100%, and changing the patient demographic in the regional hospital. Nonetheless, since 1995 when the law was implemented, disparities in health outcomes between Jewish and Arab citizens in the country have widened.

Healthcare reform took place within a geo-political landscape that continues to marginalize its Arab citizens. Thus the paradigm of equality of healthcare intersects with national policies that create a differential citizenship in Israel. This dissertation, *Producing Equality: Citizenship, Science, and Medicine in the Negev/Naqab*, examines the impact of Israel's National Health Insurance Law as a site to understand how Israel's policies of inclusion and exclusion of Bedouin Arab citizens become entangled. My work highlights the tensions that exist between expansive and technical medical care that the state allocates to its Bedouin citizens, and the limited financial and political support the Bedouin community receives from the government in other spheres. Healthcare in southern Israel provides an important site to study the active production of the boundaries of citizenship, medicine, and reconfiguring of discrimination. I argue that the emphasis on scientific discourse in the medical arena ignores the social and political problems that

place much of the Bedouin community in poor health. Therefore social, political, and historical questions that are central to understanding health disparities in the region remain beyond the scope of what providers view as relevant to their work. This bounding of medical care allows for the continuation of discriminatory policies towards the Bedouin citizens, while permitting the state and healthcare providers to assert they provide equal care to all patients.

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My deepest gratitude goes to my committee. My chair, Sharon Kaufman, has read and commented on multiple versions of this dissertation. Her dedication to students, her insistence on clarity, and her profound understanding of the importance of anthropological research within medicine have been crucial throughout the research and writing phases. Ian Whitmarsh chaired my orals committee and helped ensure that I continue to grapple with the challenges of writing, research, and the ambiguity of both. His generous readings often helped clarify my own thinking, and he drew connections to works and themes I often failed to see. Charles Briggs' immense knowledge of language and health disparities profoundly shaped my thinking about the intersection of public and vulnerable populations. His comments on an earlier version of the thesis helped sharpen the analytical arguments throughout. Lochlanne Jain continues to be a model of how writing and theory contributes to addressing critical questions of health and science.

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both think through of equality and marginalization continue to inspire our work in education and medicine.

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Chapter 1: Orientations- Medicine's Boundaries and the Negev/Naqab Bedouin

It's evening in Southern Hospital's (SH) emergency department (ED) waiting room. Men, women, and children sit on chairs throughout the shared space—staring at the evening news on the television. A few gather around the coffee cart in the corner, others sit in a circle on the grass outside, adjacent to the ambulance bay.

There is an inverse relationship in the ED between the number of patients waiting and the department's level of calmness. It is but a matter of time until someone explodes, like a wildfire on a dry, summer day. A spark ignites: "She [the nurse] can't decide who goes in!" A man suddenly begins to yell. "The file has been here for fifteen minutes!" Everyone looks up, staring at the speaker, a Bedouin man, holding a young girl. "Things go in based on acuity not time, and the girl is bleeding from her mouth!" The father hurls accusations at the nurse—peppering his speech with threats and curses—declaring that his family is waiting *because* they are Bedouin. Another Bedouin woman chimes in, "The Arab and the Jews are sitting… and all the Jews finish and the Arabs are still waiting…. Maybe this happens in the bank, the market, but in the hospital?"

Having experienced this drama in the past, the nurse calls security. "There are many in the Bedouin sector who think they are discriminated against because they are Bedouin," Rachel, one of the triage nurses tells me when we talk of these routine incidents. "And I explain to them, 'Listen, the same way that I am treating you, I also treat that Jewish woman, or this Jewish man, or that Ethiopian man, and even to people coming from Gaza. I will behave the same way to the child. Because he is a sick child

and I came to help him.'" But as always, it's a scene—albeit a typical one in Southern Hospital's emergency department.

This encounter—while frustrating to everyone involved—family, patient, staff, and security guard—highlights the tension at the center of this dissertation. On the one hand Bedouin families experience medical care in Southern Hospital as an extension of their larger marginalization in Israeli society. Healthcare providers, on the other hand, insist that they provide the same care to all patients. As Dr. Mara, one of the medical residents in the ED stressed to me, "In the emergency department there is no Ethiopian, Arab or Jewish, all are the same…. The work in the ED is binary: the kids are either sick or not." Medical care in the Negev/Naqab, the southern part of Israel, becomes the pivot around which contradictory claims of national membership and exclusion play out.

Since the founding of Israel in 1948— or the Nakba, catastrophe as it is called by Palestinians— Israel's government has negotiated the place of Negev or Naqab Bedouin— part of the Palestinian minority— within its borders.[1] While in 1954 Israel granted citizenship to the Bedouin, the government has used an array of methods—at times more explicit and at others more insidious to marginalize and segregate the Bedouin from the larger Jewish population. James Holston's concept of "differentiated citizenship" aptly describes citizenship in this context as well as "universally inclusive membership and massively inegalitarian in distribution" (Holston 2008, 6).

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[1]Throughout the dissertation, I use Negev, the term for the region in Hebrew, and Naqab, the term in Arabic interchangeably. In regards to naming, I have decided to use a number of terms to describe the Bedouin throughout this dissertation to give readers a sense of the array of terms that the community itself, as well as Jewish-Israelis, government officials, and researchers have described the Negev/Naqab Bedouin. This includes Arab, Palestinian, Arab-Israeli, Palestinians citizens of Israel, Bedouin. For an excellent analysis of the political implication of this naming see Dan Rabinowitz (1993).

Thus in 1994, when Israel passed the National Health Insurance Law, it overlay atop this differentiated citizenship. So while all citizens, including the Bedouin, are guaranteed access to universal healthcare services, these medical services emphasize biomedical interventions that fail to attend to the factors that perpetuate the Bedouin community's poor health (namely poverty and long term neglect). Universal healthcare therefore intersects with a terrain in which marginalization has been chiseled into the landscape. This is one of the reasons why since 1994, health inequalities between Jewish and Arab populations in Israel have only increased.

In the pages that follow, I examine how this tension, between an ideal of egalitarianism and the practice of marginalization, is mediated in the daily experience of receiving and providing medical care in southern Israel. I argue that in order to provide "equal" or "the same" medical care in this setting, as providers assert and as the NHIL mandates, the scope of equality has been restricted. This restriction of equality's borders permits on the one hand for providers, like Rachel and Dr. Mara above, to argue that they are providing the same care to patients. Yet this same care effaces the social, political, and historical marginalization of the Bedouin that created and maintains unequal distribution of health. Thus my argument is that in claiming to treat their patients the same, providers disregard essential aspects of their patients' social world that inform their health. I argue that in southern Israel biomedicine has become the means by which medical providers negotiate this tension of universal healthcare in a setting of deep inequalities. They hold on to evidence based medicine and biomedical understanding of disease and treatment—announced as a political and neutral—as a means to claim they

are providing equal care. But this equal care sustains existing inequalities and reconfigures discrimination.

***

This chapter serves as an orientation to the topics at the center of this dissertation. I begin by providing an overview of the writing and construction of the Negev/Naqab Bedouin. In part II, I introduce the National Health Insurance Law (NHIL). While the NHIL guaranteed healthcare services to all Israeli residents, it specifically transformed healthcare infrastructure and access to the Bedouin. In Part III, I explain my methodological positioning throughout the research component of this work—living in a Bedouin town, conducting participant observation research in the regional hospital, and interviewing Bedouin families and healthcare providers in the medical setting and their homes. I conclude with an overview of the five additional chapters of the dissertation.

I. Writing with the Negev/Naqab Bedouin

Writing and researching healthcare in Israel and the Negev/Naqab Bedouin has meant that I have inherited a corpus of literature on the topic. My engagement with this material, and my decision to include it here, is one linked to my interest in delineating the role research and researchers play in constituting the Bedouin. Throughout the dissertation I trace the links between this literature on the Bedouin and healthcare today. Thus a thread connects earlier characterization and studies of the Bedouin with the manner providers today address Bedouin patients, and how medical studies are conducted and designed.

My engagement with the literature on Negev Bedouin and Arab-Jewish relations in Israel is twofold. First, I want to examine how the Bedouin were represented in texts over time. I organize this section into four different time periods: a) Pre-1948 and the

founding of Israel, b) Military Rule (1948-1966), c) Planning Era (1966-1980), and d) Resistance and Critique (1980-Present). In each of these sections I am interested in considering the dominant themes discussed concerning the Bedouin and in particular the relationship between the government and the community. I draw these boundaries only as a way to organize material, not because the themes and writing in each period remain bound to this time period. Discussions of nomadism leak into writings on resistance, and planned towns inform how the military rule is discussed today. Furthermore, as the Israel Defense Forces, Ministry of Security, Israel Land Authority, and other institutions of power often fund academic literature on the Negev Bedouin, this scholarship was, and continues to be, highly enmeshed with government and security forces.

a. Pre-1948

Even prior to the founding of Israel in 1948, scholars published research on the Negev Bedouin community (Al-Aref 1937). These early works (and later studies of this time period) concentrate on Bedouin traditions and customs, tribal land distribution, and the Bedouin's relationship to various authorities governing the regions (Ashkenazi 2000; Kressel 2003; Marx 1967). As S. Abu-Rabia highlights in her recent study on memory among the Negev Bedouin, these authors characterize the Bedouin as "rootless wanderers" (Abu-Rabia 2008, 95). These early texts present a mummified image of the Bedouin: a "native" that remains unaltered until his or her encounter with the Israeli state (that also remains wholly unaltered). Historian Kurt Goering (1979) in an article entitled "Israel and the Bedouin of the Negev," exemplifies this frozen image. He writes:

> From ancient times, during four centuries of Ottoman rule, and finally under the British Mandate, the life of Bedouin in the Negev remained generally unaltered… To be sure, there were differences in the degree to which this was the case, but the Bedouin lived truly in a "world without time" (1979, 3).

This mummified image of the nomad became redeployed later by the State of Israel to justify interventions to settle and to civilize the community. In addition, the nomadic characterizations of the Bedouin legitimated the Israeli government's policy of land seizure. The State continues to claim that as nomads the Bedouin lack a connection to land and therefore could not have legitimate land ownership rights (Amara 2012; Yiftachel 2012).[2]

Toviyah Ashkenazi's *Bedouin Tribes* serves as an example of these early writings on the Negev Bedouin (Ashkenazi 2000). Ashkenazi was a Jewish-Israeli anthropologist and government official who began his work with the Negev Bedouin in the 1930s (his first monograph is based on fieldwork conducted between 1931-1937, although published only in 1954). Ashkenazi was commissioned by the Jewish Agency and the Zionist movement to gather intelligence on the Bedouin on how to best purchase land to support the mission of building a Jewish state in the region. Ashkenazi's work in his academic and political roles contributed to transforming the Negev into an empty landscape, erasing the communities of people who had been living in the region (Shamir 1996). Ashkenazi's text begins with a chapter on the geographical characteristics of the desert. He writes: "This is empty land [*shmama*] in all aspects, and in reality it is completely empty today of inhabitants" (2000, : 20) .[3] But as Ismael Abu-Saad aptly notes: "The desert was only empty because the Zionist colonizers chose not to see its indigenous inhabitants" (2008a, : 6). Ashkenazi's characterization of the land as empty was essential

[2]I capitalize State in several places in this dissertation to highlight the role of the government beyond its bureaucratic role. Specifically, I want to draw attention to its affective power in shaping the daily life of citizens. Patients, family members, and providers that I interviewed often referred to the government/state, *(doula* in Arabic, *medina* in Hebrew), as an actor separate from government officials or politicians. I here draw on the work of Michael Taussig (1997), Yael Navaro Yashin (2002), and Artexega (2003) that highlight the emotional role of the state as well.

[3] Translation from Hebrew is my own. The text reads: "Zohi admat shmama mikul habhinot, ve lema'ase hi reika hayom kula mitoshavim."

to what has been referred to by numerous scholars as *Judaization* of the land, the transformation of the geographical landscape into a Jewish homeland and the elimination of Palestinian/Arab/Other histories. In the process, Jewish immigrants became the new indigenous community in Israel while Arab land rights and claims were erased (Stein 1998; Yiftachel and Yakobi 2004; Abu-Saad 2006b). Nadia Abu El-Haj (2001) traces archeology's role in asserting Jewish claims to Israel. She characterizes the transformation of land and people from Arab to Jewish as follows: "[T]he Arab (even if a misnomer) no longer occupied the category of native. That which understood to be indigenous was, by definition, Jewish" (2001, : 94). But this transformation of Israel into Jewish was contingent on representing the land as empty (Shamir 1996). Ashkenazi's text reflects not necessarily the real or even a correct representation of the Negev landscape or the Bedouin, but more the desire of the Jewish Agency and the Zionist movement at the time to build a Jewish homeland.[4]

Colonial history provides many examples of land being seized without turning to the trope of emptiness. In other contexts, the character of the indigenous population—as uncivilized, backward, not pious—justified occupation (Anderson 2006; Chakrabarty 2000). While the Israeli state also employed such tropes of civilization to dispossess Bedouin of their land, in the case of the Negev the land also needed to be written about as empty. How does this emptiness come to insert itself in the manner the Israeli government, Israeli citizens, researchers and others imagine the region today? The Bedouin are still not "seen" by the government in many ways. As I expand below, half

[4] Samer Alatout's (2009) writing on water distribution in the region prior to 1948 provides another perspective on the representation of land and natural resources in the region to promote a Jewish homeland in Palestine.

the population lives in "unrecognized" towns which the State does not recognize as residential and therefore are not provided with access to water, electricity, public transportation, among other services. Therefore to some extent the land is still characterized as empty. This marked emptiness justifies the placement of chemical dump sites, polluting factories, and army bases in the region (Negev 2012; Tal 2002). Furthermore, emptiness serves as a precursor to transform the Bedouin from an indigenous population to a community illegally taking over the region, a characterization often used to describe land relations in the Negev (Yiftachel 2012). Therefore the initial writing of land as empty by anthropologists and archeologists did not reflect an empty land, yet today it takes an active role in shaping the politics that makes and keeps the land empty and the Bedouin as invisible invaders.

Ashkenazi's texts also links to a long trajectory of writers characterizing the Bedouin as "transitioning" – from nomadic to settled, tribal to individual, and uncivilized to modern. As I discuss in detail in Chapter 3, the trope of the Bedouin as transitioning is one that has remained within texts written on the Bedouin, placing them on an earlier temporality than the dominant European and later Jewish settlers. According to Ashkenazi, the Bedouin in the Negev, who he refers to as "half-Bedouin" (because they travel less than 600-800 kilometers a year (2000, : 22), are undergoing rapid changes as they shift to a more sedentary lifestyle.

> The civil and economic changes occurring in the countries of the close east and Mediterranean are forcing the Bedouin and half Bedouin to adapt to a new way of life. *Slowly they are approaching the falahin [pastoralists] and starting to strive towards a higher cultural level*: matches, primus, plows are found here and there in their use. The automobile is pushing out the heel of the camel, the doctor the magician, and the shirt the kiber, and the coat the abiya. The tribal organization is

> also disintegrating and the individual is taking apart the collective control and becoming self-sufficient (2000, : 186, emphasis added).

He similarly explains:

> Instead of the Bedouin coat—damer— the half-Bedouin wears a European coat and shaves with a shaving knife; the Bedouin already uses European soap and the groom brings his bride perfume, aromatic soap, and in secret even a box of powder (2000, : 14).

Thus the "modern changes" taking place in the region are forcing the Bedouin to transition into a more sedentary, settled, and modern way of life, which is equated with Western/European conduct (2000, : 187). Yet these transitions are not sufficient. Despite Bedouins adopting what Ashkenazi terms modern ways of life— matches and plows, and today pickup trucks and generators—the community is still characterized as not quite modern, as continuing to transition. Thus there is always a remnant of the Bedouin, the written Bedouin, that limits the scope of the category and its possibility to change.

This characterization of the Bedouin making their way down the linear path of modernization echoes Dipesh Chakrabarty's (2000) insight on colonial India in *Provincializing Europe*. Chakrabarty argues that Indians under colonial rule were continuously marked as undergoing a phase of transition, as a community "not yet" ready to be modern. He critics this transition narrative of history, which presents non-European histories as pre-history (2000, 32). This prefix places non-European and European histories on the same continuum, linking them into one all-encompassing timeline with the European being simply further along this trajectory. History, in this metanarrative framework, is presented as a universal entity— an empty "place holder"—that is used to translate between localities (ibid, 70). Despite different contexts, history is presented as a homogenous monolith, with European Enlightenment ideas about citizenship, subjectivity, and rights privileged as the goal. For Chakrabarty, this notion of transition

links to the manner history and time are used to reinforce social hierarchies.[5] The Bedouin, like the Indians Chakrabarty writes about, were characterized as "not-yet" ready for modernization, yet on the same continuum heading towards progress and modernization. What is crucial in the Israeli narrative, like the Indian case, is that this end point can never be achieved. The Bedouin are perpetually almost transitioned, yet not quite there since the origin, progress, and end goals are all defined by the Jewish majority.

While Ashkenazi's work links to the larger anthropological writing on the Bedouin as transitioning into a sedentary (also read as modern and civilized) lifestyle, his writings betray him. Ashkenazi notes that during the early twentieth century, prior to the founding of Israel, the Bedouin were already "half-Bedouin," sedentary, and no longer nomadic. As he explains, "The half-Bedouin have distanced from the nomadic Bedouin life in the desert ranges. They stopped roaming" (2000: 33).[6] Furthermore, the push towards settlement did not occur because of the Israeli state; instead, the initial sedentarization occurred because of the occupation of the French, British, and Ottomans in the area (Ashkenazi 2000:45). Yiftachel, Amara, and Kedar (2012) also note that individuals traveling through the Negev region in the 19th century noted cultivation and sedentarization practices of the Bedouin. Therefore the trope of the nomadic Bedouin who does not have a connection to land begins to be disassembled in the early twentieth century authors. Therefore writing, as Derrida (1998) reminds us, has a life of its own, detaching from its initial intention. Ashkenazi played a significant role in fixing the

[5] See J. Fabian (1983) on the role of time in anthropology; and A. Gupta and J. Ferguson (1992) on space.

[6] Other writers have similarly noted that the Bedouin living in the region had settled prior to the founding of Israel (Kressel 2003; Goering 1979).

Bedouin as a nomadic, transitioning community (he and Aref Al-Aref (1937) are two of the widely referenced early authors, whose "citing" appears as the backbone of many later anthropological texts). Yet his work does not remain bound to his characterization. It speaks back, challenging its own fixity.[7]

b. Military Rule

Prior to 1948, approximately 100,000 Bedouin lived in the Negev/Naqab; following the war, only 10,000 remained within the new Israeli state borders. The rest were killed, fled, or were forcibly evicted to what is today Jordan, Egypt, and the occupied territories in the West Bank and Gaza (Rego 2012; Morad 2006). The Bedouin who remained within the newly established state were forcefully relocated into the southern military zone known as the *siyag* (Hebrew for confinement, restriction). While the *sayig* was established for security purposes, the military administered most aspects of civil affairs including pasture lands, education, and healthcare (Marx 1967: 37). I discuss the military government and its links to healthcare in the region in Chapter 2.

The southern *siyag* was one of three military zones that interned most Palestinians remaining within Israel (Forman 2007; Abu-Saad 2006a; Robinson 2006). Ahmed, a physician in Beer Sheva who was a child during the military rule called 1948 "the demolition of a society." When I met with him, he explained, "There was a society with particular norms and it was destroyed. 10,000 from 100,000—10%. Everything fell apart." The military government controlled nearly all aspects of daily life but furthermore it presented the first encounter for most Bedouin, like Ahmed, with Jews.

[7] Furthermore, Ashkenazi adds another important aspect to rewriting the Bedouin. While the Bedouin were characterized as needing to be modernized, the Jewish immigrants to Israel at the time needed to be transformed into indigenous. Nadia Abu El-Haj (2001) elegantly reveals this transformation in her text *Facts on the Ground.* What Ashkenazi adds to this discussion is that in the early years of the relationship between the Bedouin and their Jewish neighbors, it was their Jewish neighbors who considered dressing more like the Bedouin as they had valuable experience of living in the Negev.

> It had serious ramifications about how your address Jews, how the Jews look to you from this standpoint. The Jews are only the army. The person responsible for supervising was the military governor. We never saw a Jewish citizen this whole period! It's a scary situation. The army is scary—they shoot—it was an atmosphere of fear.

The forced enclosure of the Bedouin into the military zone also removed most of the Bedouin from their ancestral land. The Israeli government then utilized Ottoman and British Laws of 1858 and 1921 respectively to transform Bedouin land into state land (Yiftachel 2008; Rego 2012; Shamir 1996; Yiftachel 2012; Kedar 2003). The military rule thus provided the government with the possibility of converting Bedouin land into State land (since in the process of relocating Bedouin into the *sayig*, areas previously occupied by Bedouin became "empty," providing evidence for the earlier written barren landscape). Despite the Bedouin being granted citizenship in 1954, the military government remained in place until 1966.

c. Planning and Sedentarization

Following the dismantling of the military government, the state of Israel began a process of forced sedentarization of the Bedouin, relocating the population to designated Bedouin towns (Dinero 1998; Fenster 1997; Marx and Shemu'eli 1984; Meir 1997; Boneh 1988; Ben-David 1988; Law-Yone 2003). Since 1966, sixteen Bedouin towns have been recognized by the government (eight of these since 2004). Any Bedouin who lives on land outside these towns is considered a "trespasser" (Shamir 1996) and "invader" (Yiftachel 2008) residing on what the state now claims to be legally its own land. As I mention above, it is the writing of the landscape as empty that allows the government to label the Bedouin as illegal invaders and trespassers and the state as the legitimate landholder.

One of the main policies that maintained the segregation of the Bedouin from the larger Israeli society after the dismantling of the military zone was the physical construction of the government planned Bedouin towns. The planning of Bedouin towns utilized the earlier description of the Bedouin as nomadic to justify land take over and the need to sedentarize the community in order to provide services. Furthermore, the urban town was discussed as an opportunity to implement civilizing interventions by the Israeli government to modernize the community (Belge 2009). Dan Boneh, who conducted ethnographic research in the 1980s in the first Bedouin town, Tel Sheva, concluded for example: "The change that we are observing [in the Bedouins' transition into living in towns] is called modernization" (Boneh 1988, 224-225). The discourse of modernization through sedentarization justified interventions in the form of urban planning, education, and health programs aimed to help the community progress along the "continuum from nomadism to urbanism" (Meir 1997, 2). Modernizing interventions are intertwined with ideas about caring for the population. The Israeli state continues to present itself not only as the entity in power, but also as the Bedouins' benefactor, bringing medicine, water, electricity, and education to the community.

Researchers working with the Bedouin during the initial sedentarization phase characterized the Bedouin towns as laboratories revealing the natural, unidirectional, and necessary transition of Bedouins from a nomadic to a settled way of life. As geographer Joseph Ben David writes, "There is no way back" for a Bedouin to return to his or her nomadic lifestyle once he or she moves into a town (Ben-David 1988, 2). Geographical movement for these authors translates into a temporal continuum, with the move from nomadic to urban residence paralleling a progressive trajectory from uncivilized to

modern. For example Law-Yone writes: “Denied the option to choose an agricultural lifestyle, Bedouin society was forced to leapfrog decades of cultural, social, and economic adjustments and adapt themselves to the imperatives of capitalist-industrial society” (Law-Yone 2003, 177). Many of the authors writing about the Bedouin during this period equate sedentarization, and specifically urbanism, with modernization and progress. Furthermore, being sedentary is characterized as incompatible with what it means to be “Bedouin” (interestingly, it was precisely the agricultural way of life that was promoted as necessary to advance Israel in the early years of the state). As Goering explains in his discussion of the impact of sedentarization on the Bedouin: "Nearly all aspects of Bedouin life have been affected, and these changes have shaken and now threaten the very roots upon which Bedouin culture is based” (Goering 1979, 4). But the Bedouin in these texts is an invention of the Jewish state and its own authors. There is a sense of nostalgia and sadness for these Jewish writers characterizing the transition. The Bedouin movement into towns meant a loss for these authors, as this movement would finally kill the protagonist they created. Thus it is not only the Bedouin community that is impacted by these changes, but also the state and researchers of the Bedouin. The movement towards modernization raises the possibility, and the anxiety, that the Bedouin would become illegible. As modern-urban-Israeli citizens, what would maintain the Bedouin distinct? As an entity that can be identified by Israeli authorities? This anxiety remains in the hospital today between the Bedouin discussed as *Bedouin* patients and as individuals no different than others seeking care in Southern Hospital. This tension between marking the Bedouin different and effacing their specificity hints at the anxiety of permitting the Bedouin to become fully included in Israeli society. For accepting

Bedouin as Israeli would also mean acknowledging the history in the region and permitting part of Israel to be Bedouin. As such it would require not only the government but also healthcare providers to potentially care for Bedouin patients differently, attending to the links between the longer history of dispossession and illness.

d. Contemporary Critique and Resistance

A growing critical scholarship on the Negev Bedouin has emerged critiquing these nomadic and modernization tropes, focusing instead on how these characterizations have been used to promote discrimination and inequality towards the Bedouin community (Abu-Rabia-Queder 2006; Abu-Saad 2006b; Falah 1989; Yiftachel 2008). In his most recent monograph, *Let Shepherding Endure*, Gideon Kressel (2003), an anthropologist who has worked with the Bedouin community since the 1960s, challenges the earlier claims that sedentarization (and modernization) of the Bedouin is the product of the State of Israel. Instead, he argues that sedentarization has always been part of the Bedouin community (and thus he rejects the linear progression of nomadism→ sedentarism → urbanism). Kressel utilizes previous texts to re-read the relationship between the Israeli state and the Bedouin community. He spends a considerable section of the book examining the written documents used by the Bedouin prior to the founding of Israel to establish land ownership claims. These agreements and contracts document negotiations between various tribes. Yet they have been declared by the government of Israel as illegible and irrelevant (see also Kram 2013). For example, in a Parliament committee meeting on land and the Bedouin community, the head of the Israel Land Administration (ILA), Yaakov Efrati, explained: "[T]here are 800,000 dunams[8] that are mostly in the qaser region [a particular area of disputed land]. The Bedouin are claiming

[8] One dunam equals 1000 square meters and approximately a quarter of an acre.

ownership on it. Of course they cannot define ownership *in the manner that the law demands that ownership be defined*" (Knesset 2007, emphasis added). But what does it mean for the government to claim that it cannot read these documents and that they are not legible? Who decides what can be read and furthermore how can a text be re-read? The process of writing and researching on the Bedouin has therefore inscribed a particular reality of the community; it hardens evidence into a decipherable form.[9]

Bedouin themselves have also begun to publish texts on the struggles of the community, utilizing the academic scholarship as a form to question the historical narrative placed on the Bedouin. Aref Abu Rabia (1994) has written extensively on the link between Bedouin life (in particular livestock rearing) and governmental authorities. He argues that daily life and practices—from the need to receive a permit for pasture to mandating veterinary visits—have been dominated by the "bureaucratic apparatus" (1994, 39). Ismael Abu-Saad (2004, 2006b) and Sarab Abu-Rabia-Queder (2006) have examined the educational system in the Bedouin community and the role of education in marginalizing the community. Abu-Saad and Abu-Rabia-Quedar dissociate sedentarization and modernity from the tropes of progress and development, and instead read governmental texts and policies as part of a larger apparatus of control imposed on the Bedouin population.[10]

Beyond academic circles, Bedouin community members themselves remain critical of the government imposed towns. Community members called the towns

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[9] This problem of what counts as text and legitimate writing resonates with Derrida's critique of Lévi-Strauss (Derrida 1976, : 101-140). Derrida argues that Lévi-Strauss' claim that the Nabikwara community could not read reflects the anthropologists' constricted definition of the term and not the illiteracy of the community.

[10] See also Safa Abu Rabia (2008) on the role of memory of the Nakba among Bedouin, and Mansour Nsasra the Bedouin's resistance to the British under the British Mandate (2011).

"prisons" and "refugee camps." Ahmed, the physician I quote above, directly raised the failure of Tel Sheva, the first Bedouin town, and the larger project of settling the Bedouin in a conversation I had with him.

> Ahmed: Tel Sheva was the first settlement in 67', 68'. They [the government] built the settlement and said, "Come buy." But no one came to buy. And they [the government officials] would say,"They [the Bedouin] are against modernization, they don't want to develop." Have you been in Tel Sheva?
> NR: I have.
> Ahmed: Entered into homes?
> NR: No.
> Ahmed: You need to go in. They built a refugee camp—rooms with low ceilings, in the middle no roof, because the Bedouin like to look at the stars. So someone had a stereotype and didn't consult the community and no one bought. Then, they built Rahat. And there everyone was allowed to build as they wanted. But who bought plots? Those who didn't have land. People felt that when I go and buy I need to sign all this paperwork that I don't know what I am signing. They planned seven settlements for 40,000 people, but didn't plan any industrial areas, places to work, or natural growth.

Ahmed here not only critiques the modernization discourse of the state, but also mocks the (un)planning of the towns. Indeed, urban planners themselves have become one of the most active critics of the government's sedentarization policy, questioning the intention and impact of their discipline on the Bedouin (Dinero 1998; Falah 1989; Yiftachel 2009; Fenster 1997). Not only have these authors emphasized the consequences of geography, mapping, and planning on marginalizing the Bedouin community, but it has also helped change planning into a tool that today is used by the community to challenge state authorities (Meir 1997). Oren Yiftachel exemplifies planners' new role in the region (see also Yiftachel and Yacobi 2003). Yiftachel terms the unrecognized Bedouin areas "gray spaces," zones where borders and recognition constantly shift (Yiftachel 2009). The analytic of "gray space" challenges the characterization of the area as invisible, empty, or excluded. As "gray spaces," the Bedouin villages exist "partially outside the gaze of state authorities and city plans" (Yiftachel 2009, 88). The unseen aspect of the region provides

an opening for mobilization against the government through the state's own mechanisms. While on the one hand the use of state frameworks by Bedouin community members and activists strengthens the Israeli government's authority, at the same time it reveals the fluidity of state policies.

I have traced this literature not necessarily as a trajectory or a cumulative amassing of knowledge on the Bedouin. Instead, I suggest that this literature creates a topography that molds the Negev Bedouin through particular acts of representation. It is only by attending to this topography, and the manner it changes, solidifies, disappears, and reemerges over time that I believe a more complex engagement with texts and figures in the region can emerge.

The written texts make the Bedouin legible; they create sites for intervention. Yet the written text, as it is not a reflection of the "real," cannot fully capture A Bedouin; there is always an aspect that escapes. This text, like its predecessors, also presents a particular image of the Bedouin. But my intention is to maintain the multiple ways that Bedouin emerge at citizen, patient, friend, and family member, and how these multiple images question a singular representation.

II. National Health Insurance Law (NHIL)

In 1994, Israel instituted the National Health Insurance Law (NHIL) mandating equal access to medical services to all residents (Borkan 2000; Ministry of Health 1994).[11] Prior to the law's passing in 1994, there had been twelve previous attempts to pass a national health care legislation and six professional committees on the matter (See:

[11] It is of significance that the law granted access to medical care to Israeli *residents* not citizens. The difference between an Israeli citizen and resident is based on where the center of an individual's life is located. Only those citizens whose life is located in Israel permanently are considered residents. Therefore an individual may have Israeli citizenship but not reside in Israel and therefore not be guaranteed access to healthcare.

Bin Nun 2010, for details on the passing of the NHIL). The NHIL guaranteed healthcare coverage to all Israeli residents by one of the four sick funds (*Clalit, Macabbi, Leumit,* and *Meuhedet*). According to the NHIL, each resident is guaranteed a defined basket of health services; sick funds must admit all patients and cannot deny membership due to preexisting medical conditions. The NHIL changed the funding structure of health insurance such that tax money now funds the National Insurance Institute of Israel (*Mosad le Bituach Leumi)* which in turn pays to pay each sick fund per insured member (based on age, sex, and residence).

While legislators declared the NHIL revolutionary—"instituted on the principles of justice, equality, and mutual support" (article 1 of NHIL), most Israelis were not impacted by the NHIL. Ninety-five percent of Israeli residents already had health insurance. Of the five percent that were uninsured, twelve percent were Palestinian-Israeli residents. But within the Negev/Naqab Bedouin community that makes up approximately two percent of the national population, because of the marginalization and lack of employment options as I discussed in the previous section, about half did not have health insurance. Ahmed, a Bedouin pediatrician who grew up in the area recalled to me what would happen in the days prior to the NHIL:

> Before 50-60% [of the Bedouin population] didn't have health insurance. They wouldn't be hospitalized—only in emergency cases of life or death. Because they had to pay 800NIS [about $200] per night. So they would do different things like be hospitalized under someone else's names… There would be all sorts of problems—like someone came in for a surgical procedure and then he came again [for the same procedure]. Or someone would die and then they would find out he is still alive. Living and they were dead or the dead and they are living.

The demand to pay for services led many Bedouin to delay or reject seeking medical care. When the regional hospital was opened in 1960 many Bedouin refused to go because of the financial barrier. Ahmed recalled:

> They would only come if it was terminal or the situation was very difficult. There must have been an agreed upon order, not written, [that stated]: *Every Bedouin, hospitalize*. Because he [a Bedouin] doesn't *just* arrive.

Salim, another physician also spoke to me of the impediments to receiving medical care prior to the NHIL:

> I'll tell you the defects prior [to the NHIL] because I really know them; I come from the Bedouin community. The economic status is bad so listen, children are usually healthy and you don't expect, you don't pay on time if you forgot, and then you fall in the middle of your child's hospitalization for ten days and need to pay a set amount of money, and sometime it leads to less than optimal behavior or you take the child to private doctors or to medicine in other places, and you endanger the child because of money… or you run off in the middle of treatment because you need the money. And the National Health [Insurance Law] was supposed to be for everyone. That everyone will get the same [treatment] in a similar manner.

The NHIL therefore specifically changed Bedouin's access to healthcare. Furthermore, since each sick fund receives payment per insured member—based on age, sex, and residence—the NHIL encouraged sick funds to insure Bedouin citizens and build clinics in the community. Thus from five clinics in 1966 (Shuval, Um Batin, Tel Al-Milh, Sgieb, and Beer Sheva), to approximately eight in 1995 (one in each government planned Bedouin town), according to a 2008 Ministry of Health report there are fifty-one clinics serving the Bedouin community (Ministry 2008, 25).

The NHIL therefore specifically impacted the Bedouin community in terms of healthcare access and medical infrastructure. In addition, the implementation of the NHIL changed the demographic of the regional hospital. While prior to the NHIL, as Ahmed and Salim stressed, many Bedouin would come to the hospital only due to emergencies,

today 60-80% of the patients in Southern Hospital are Bedouin. This is despite the fact that Bedouin consist of only a quarter of the regional population. In the pediatric departments where I conducted fieldwork, Bedouins made up close to 80% of the patients. In contrast, the authors of a 1963 article on pediatric injuries and poisonings in the same hospital where I conducted fieldwork reported that 4.4% of the total pediatric hospitalizations are Bedouin (Rachmilewitz 1963).

The National Health Insurance Law provided legal leverage for Bedouin citizens to petition the Supreme Court to demand the Ministry of Health build clinics in their communities.[12] The use of medical access to attain additional social services such as clinics or electricity could be discussed as a form of what Adriana Petryna termed *biological citizenship,* "The massive demand for but selective access to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it" (Petryna 2002, 6).[13] Yet biological citizenship in southern Israel is not a quest for services in a tense economic climate. It is also not the use of one's biological body to gain recognition. On the contrary, in southern Israel biomedical care has been increasingly detached from the social and political environment in which is located. In this context, medical care has a different role—one that challenges thinking about providers as gate keepers, or that places the ill body as the site of citizenship. Precisely because in Israel all residents have access to medical care, and for the most part

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[12]See for example Lavad Abu Afash etc vs. Minister of Health, Clalit Health Services, Israel Land Administration (4540/00). In addition, the NHIL has been used to petition the connection of Bedouin homes in the unrecognized villages to the electricity grid (8062/05), connecting Mother and Child Clinics to the electricity grid (6602/07).

[13]See Rose (2006) and Rose and Novas (2005) for another formulation of biological citizenship, and Ticktin (2011) for a critique on the inegalitarian aspect of characterizing biology as hope and opportunity. There has been a growing body of literature examining citizenship through a medical lens, for examples see:
(Heath, Rapp, and Taussig 2004; Fassin and D'Halluin 2005; Ticktin 2006; Nguyen 2010; Rabinow 1996).

very advanced healthcare, biomedicine reconfigures how equality and discrimination are understood. Analyzing healthcare in Israel provides an entry for understanding how advanced biomedical technologies and practices (such as evidence based medicine and protocol guidelines) implemented to standardize healthcare are reconfiguring how vulnerable populations are understood in the medical system. Throughout this dissertation I examine the role of healthcare providers, patients, and families in producing equality in a context of entrenched inequalities. One of my main arguments is that a growing emphasis on biomedical technologies has helped construct patients as commensurable within the healthcare setting, yet this commensurability, or equivalence, requires an active excision of the social, political, and historical worlds of patients. My work has focused on examining the tenuous borders of this equality and how its borders are constantly disrupted.

III. Methodology

My dissertation draws on twenty-seven months of research in Israel. I spent eleven months conducting participant observation research in two departments within the single regional hospital, a place I call Southern Hospital (SH). Southern Hospital is a massive medical complex. It is the only tertiary care hospital in all of southern Israel, and the second largest employer in the region. It sees approximately 200,000 patients through its emergency department each year. There are 14,000 deliveries annually in SH, the most of the entire Middle East. In addition, to the expansive medical services it provides, SH is also a major teaching facility, training medical practitioners, nurses, social workers, physical therapists, and paramedics. While repeated policies of segregation in southern Israel have resulted in geographically dividing Jewish and Arabs residents (see Chapter 2), because SH remains the only medical facility in the region, it is one of the few places

where these communities interface routinely. My decision to locate much of my fieldwork in the hospital stemmed from my search to find a site where interactions between the Bedouin and Jewish community occur daily, where it is not viewed as a problem, anomaly, or surprise. My goal has been to try to understand the process by which such encounters are made familiar. And furthermore, to consider what aspects of being Bedouin are allowed to enter into these spaces? Do healthcare providers—nurses, physicians, social workers—who deal intimately with patients treat these patients as Bedouin? In a biomedical practice where protocols and standardized medicine are stressed, what does it mean for patients and provider to care for Bedouin patients? Does their experience with men, women, and children whose community has been marginalized within Israel society see this as relevant to their work? What do they come to learn of this community? And what experience of the community can be uttered by families and can be heard by providers?

Providers and families repeatedly asserted that medical care in the hospital was the same for all patients, whether Arab, Jewish, Bedouin, Gazan. These categories, that seemed so solid in much of the day-to-day life in Israel, seemed to blur into a "universal patient" in the hospital. The hospital therefore provides a rich analytical site to understand the construction, complexity, and blurring of the categories that seem to be taken as a given in the region. This dissertation is my attempt to make sense of the conflicting relationship between equality/sameness and discrimination/difference that I viewed within and beyond the hospital.

The hospital component of my fieldwork was based in two departments in SH. The first was the pediatric emergency department, which treats an average of 34,000

patients a year and admits around 10,000 of these visits. The emergency department suffered from a shortage of staff most days, and nights, and thus nearly all families waited several hours to be admitted, triaged, examined, and finally either discharged or hospitalized (see Chapter 6). Most afternoons physicians juggled up to four or five patients simultaneously, while thirty patients sat impatiently in the waiting room. A constant negotiation between families' inquiring on their wait status and nurses checking on their arrival time marked the emergency department. This tension occasionally escalated to physical and verbal violence with the security being called to settle parents down and close the doors separating the waiting area from the exam rooms.

Funding from a philanthropic donation provided the money to build Southern Hospital's pediatric emergency department. The ED constituted the first floor of the pediatric hospital that was in the process of construction during my fieldwork. The ED consisted of a large waiting room—equipped with rows of chairs, a coffee and snack cart, a large Spiderman figure hanging from the ceiling, bathrooms, and the administrative desk. Just inside was a small laboratory where physicians and nurses checked urine and blood samples.

When the pediatric emergency department was established in 2005, its designers envisioned it working dually as an ambulatory clinic and an emergency center. This dual role, they presumed, would reduce the workload of emergency room staff and allow them to focus on emergencies: patients needing immediate attention and suffering from potentially life threatening conditions. The hospital administrators envisioned patients arriving into the emergency department's main waiting area where a nurse triaged their symptoms and redirected them either to the ambulatory care clinic on the right side of the

department, or the emergency center located in the left hallway where two trauma rooms were located.

In reality, the dual model of the emergency department did not function during my fieldwork, largely because there was not enough staff to deal with the massive volume of patients. Not only were there not enough physicians on staff, but the ED staff felt that community physicians referred patients unnecessarily. As one physician remarked one afternoon out of frustration:

> We need to change the way we are working in the emergency room, because 50% of the patients we see should not be here! There is such an overload of patients. And maybe we should make community physicians come here… And it's dangerous because we are going to miss something. At some point you become apathetic. Fifty percent should not be here.

As I discuss in chapter 6, the entire Israeli healthcare system suffered from a shortage of physicians and nurses, resulting in increased wait times, as well as staff and patient frustration. Dalia, a seasoned nurse in the emergency room described the healthcare system to me as "a very very short and small blanket and everyone is pulling it in a different direction and wants to enjoy it." Because of these shortages, the right hallway functioned as an overflow station housing patients under supervision rather than an ambulatory care clinic. During the very busy winter months, one physician treated non-emergency cases in a room located behind the nurse's triage station to reduce the volume of patients.

Between the two hallways was a large nurses' station —where physicians, nurses, residents, and students (nursing, medical, medics) gathered to take new files, update existing files, examine lab results, consult with one another, sign lab slips, and shuttle blood tests to the laboratory through the internal shuttle service. Surrounding the nurses' station was a glass window where families and patients would gather to check on

the status of their wait-time, results of laboratory tests, and plans for discharge. Families' congregation around the glass window caused constant congestion in the emergency room that frustrated staff.

With the exception of ambulance arrivals, rushed directly into one of the two trauma rooms, an administrative clerk first greeted patients arriving to the ED. She would open a file for the patient, enter demographic data, and have the parent/guardian sign a consent form agreeing to remain in the emergency department until the completion of treatment. One of the triage nurses then collect the file and call the patient into an exam room located to the left of the waiting room. There one of two nurses would weigh the patient, take a short medical history, measure the patient's blood pressure, temperature, pulse, and conduct a quick physical exam. The nurses would then bring these charts to the main nurses' station located inside the ED and file them in a hanging bin based on time of arrival and the urgency of the case. Physicians would then take a file from this bin and announce over the loudspeaker a patient's name. The physician would examine the patient, provide an initial assessment, draw blood work, and send the patient either back to the waiting room until the results come back, refer the patient to another department in the hospital for additional diagnostics (for example, an ear exam in otolaryngology, x-rays and CT scans in the radiology department, a consult exam by a surgeon in the pediatric surgery department). Thus there was a constant movement back and forth between the exam rooms and the waiting room, until a final decision was reached either to discharge the patient or admit him or her into one of the three pediatric inpatient departments.

The pediatric hematology-oncology department (heme-onc) was my second

fieldsite in Southern Hospital. The heme-onc team provided treated patients from the early stages of diagnosis, through treatment, and remission for oncological (cancerous) and hematological (blood) diseases. Unlike the emergency department whose staff consisted of a core set of six attending physicians and a large pool of medical residents that rotated shifts, four attending physicians and two fellows worked in the heme-onc department. In addition, approximately a dozen nurses staffed the department, a psychologist, a social worker, a number of teachers, and an art instructor. A weekly staff meeting took place every Tuesday morning discussing all patients in the department. In addition, a number of social events – parties, dinners, lectures—took place throughout the year in which the entire team attended.

Because of the chronic treatment required of hematological and oncological diagnoses, staff developed long-term relationship with families and one another in this department. As the head of the department stressed, the problem for the heme-onc team is that "we are the family as well." The emotional connection between staff and families was particularly apparent when several children the team cared for passed away during my fieldwork. "You can't get used to it in children. Every time is like the first time," one team member remarked. Salim, one of the oncologists who occasionally worked in the ED, directly contrasted his work in the two departments during a conversation we had.

> There is a real connection in ninety-nine point nine [percent of patients in the heme-onc department], a positive connection, and a really normal connection. And then in times of loss, in times of loss you lose not someone you cared for, you lose someone you knew. A person that you say, it's like my neighbors son that I lived with for two years. I was his neighbor for two years and today no longer… Yes, you are a doctor but it's a person who was your patient for two years and suddenly you lose him, you miss him, you can't see him… When I was in the ED there was a trauma… I don't know, you go to the trauma room and the child dies. Everyone is angry, everyone sees the family, but it's really hours.

> Three, four, five, a day and then it passes. There are other kids that come. You don't have a connection with him. It's someone who came to the ED that you didn't know, you never saw him before. Something happened [*kara mikre*]. It's painful to all of us but in the end everything starts again the next day. But the kids here, in oncology, no, it's a process.

Therefore the process of providing medical care in these two departments, despite being housed in the same regional hospital, looked very differently. I therefore specifically mention the departments where my research draws from, as they shaped the pace and day-to-day work in the hospital, and the kind of connections that providers and patients created within this hospital.

The heme-onc department was physically split between an outpatient day treatment center located on the other side of the hospital complex, a brisk ten to fifteen minute walk from the pediatric hospital complex and the inpatient oncology department. In the day treatment clinic, nurses and physicians examined patients, conducted routine check-ups, and administered chemotherapy treatment and blood transfusions. Staff, patients, and families shuttled between the day-center and the oncology department to receive their medical care. The oncology department remained one of the departments with the best conditions in the hospital. As one staff member explained to a family whose son was diagnosed with cancer, "With these sorts of diagnoses, we get everything." And indeed, while Israeli hospitals were at the highest capacity of filled hospital beds among all OECD countries during my fieldwork (over 95%), the oncology department was well staffed and spacious. The other pediatric departments in the hospital during the winter cared for between 60-80 patients, nearly twice the intended capacity, with five beds in a room often separated by a curtain. In contrast, the nine-room oncology department was a site of luxury. Most patients had their own rooms, each equipped with a television and computer. The patients had their own learning center, with teachers ensuring that students

maintain their academics while hospitalized. A large computer and game station was at the center of the department where families gathered during the day to chat and play.

Like the emergency room, a circular nurses' station was located at the center of the department, with views of most rooms—but no glass covered the station and families had direct access to providers. Upon admission to the team's care, families received the department's direct phone number and were instructed to call with any question or concern, and to bring patients directly to the department with any signs of illness—thereby circumnavigating the emergency room.

I spent one to two days a week in each department, shadowing providers, attending staff meetings, waiting with patients and families. Twice a week I joined the mobile clinic that travels to Bedouin and Jewish families in southern Israel to provide palliative care. I conducted participant observation with these three teams—shadowing their routine tasks, attending team meetings, journal clubs, morning grounds, conferences, visited their outpatient clinics, and accompanied them as they met with patients, families, and other healthcare providers. I conducted thirty-five interviews with physicians, nurses, social workers, and policy makers in the Ministry of Health. Aside from staff, I also accompanied Bedouin families as they made their way through the medical system. I joined them in the emergency room, escorted them to different departments, sat with them during chemotherapy treatments. I carried out twenty-three interviews with families at home and in the hospital. In addition I conducted archival work in the Israel Defense Forces Archive and the Tuviyahu Archive of the Negev and a literature review of medical studies published on the Bedouin between 1952-2012.

In order to gain a better sense of life in the Bedouin community, I moved to Bir

al-Sharq, one of the government planned Bedouin towns, and lived with a woman I call Um Raed.[14] Um Raed and her intricate network of children, grandchildren, and great-grandchildren provided a deep sense of how the tensions of equality and discrimination play out daily. As I discuss above, this project was largely hospital based. Yet in retrospect, it could have been organized around the daily flow and interactions between Um Raed's family and the healthcare system. During my time in Bir al-Sharq, two of Um Raed's daughter gave birth and made their way through the prenatal services provided by the government. Two grandsons broke their arms and visited the emergency department where one of them required surgery and hospitalization, and both required extensive follow up. Another cousin was hospitalized for pneumonia and stayed in SH for over a week. An uncle who lived down the road was diagnosed with cancer and began chemotherapy treatment. A sister-in-law had her gallbladder removed. And at least once a week a family member visited one of the town's clinics for routine ailments and pains. Health and medicine did not just enter our lives through visits to the clinic or hospital. Every day began and ended with Um Raed taking her cornucopia of medications, and many evenings the women in the neighborhood would meet at the basketball court across the street to walk – discussing nutrition and weight loss techniques. On weekends, I joined the family as we watched television shows discussed STDs and HIV, spurring conversations among viewers. Thus daily life was accented by interacting with and discussing health and medicine.

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[14]With the exception of Beer Sheva, all names and locations are pseudonyms.

When I moved to Bir al-Sharq in October 2010, the landscape of the Negev was still dry from the summer heat, fields of yellow and ochre hid the deep greens and majestic flowers that would appear in several months. My decision to move to Bir al-Sharq emerged from a desire to understand the landscape of the Negev region in Israel through a different lens. I was born in the United States, but had spent much time traveling back and forth between Israel and the United States as a child and later as an adult. I had lived in Beer Sheva, the capital of the Negev, for approximately two years before starting my fieldwork, first as an exchange student during my undergraduate degree and later after graduating from college.

In the Israeli national press and according to most Israelis, Beer Sheva and the Negev are considered poor, neglected, and peripheral (Motzafi-Haller 2012). Despite the Negev's remoteness in the national imaginary, Beer Sheva is an hour drive south from the metropolis of Tel Aviv. The express train connecting Tel Aviv and Beer Sheva boasts a fifty-five commute time. This peripheral status is amplified in regards to the Bedouin towns and villages in the area, several of which are located directly outside of Beer Sheva. Social and political distances between these spaces of residence are counted on a different scale; the barriers limiting movement are more internalized and less visible than separation walls and checkpoints (Alatout 2009; Weizman 2007). As I discuss in Chapter 2, an intricate history of segregation has taken place in the region that divided Jews and Bedouin. Nonetheless, as SH remains the only regional hospital, it is one of the places where these communities interact on a daily basis. Many of the nurses and physicians I came to know stressed to me that their interactions with Bedouin take place *only* in the hospital. Outside, as one retired physician told me in regards to the Bedouin towns, "It's a

different world." Medicine therefore remains a meeting point, a conflict point as I discuss throughout this dissertation, and a site to understand how medicine and citizenship reconfigure one another. My research therefore focuses less on 'The Bedouin', and more on the dynamic between the various communities in the region and how they became, and are sustained, as separate.

Bir al-Sharq is one of poorest towns in Israel (CBS 2006). According to the Central Bureau of Statistics, all of the seven original government planned Bedouin towns are in the poorest socio-economic ranking. The population in Bir al-Sharq stands at over ten thousand, over half of whom are under the age of eighteen. The average household lives below the national poverty line (only 52% of households earn more than minimum wage), over sixty percent of adults are unemployed, over eighty percent of children live in families that receive welfare support. Bir al-Sharq thus encompasses for many Jewish Israelis their fears of Arab communities: Muslim, demographically threatening, and poor. What struck me during my time in Israel were the comments friends, family members, and hospital staff made regarding my decision to live in Bir al-Sharq. These off hand remarks— "Do you live in a tent?" and "Aren't you scared?"— reflected how poverty, governmental neglect, underfunded schools, overpopulated classes, and water shortages, blend with the produced images of what an Arab and Bedouin town looked like. These images link to the published literature I discussed earlier, and reveal how the construction of the Negev Bedouin enters into the contemporary understandings of the Bedouin community. Furthermore, these images and statements in regards to the Bedouin and my decision to live in a Bedouin town help delineate how the boundaries of communities come to be etched in the region.

In his ethnography *In Search for Respect,* Phillip Bourgois (1996) writes that many of his friends refused to come visit him during his time living in East Harlem. Their responses indicated the fear, racism, and ethnic barriers carved into inner-city New York. Many of my own Jewish family and friends in Israel similarly resisted my decision to live in Bir al-Sharq. My residence in a Bedouin town raised eyebrows but also serious concerns for my well-being. On my first day in SH, nervous to meet the staff and introduce myself as an anthropologist, the chair of the emergency department introduced me to his fellow physicians. "This is Na'amah and she will be with us for a year and she has already done a heroic feat (*ma'ase gvura*)… She lives in Bir al-Sharq." One morning a nurse I came to know in the oncology department remarked, "She should be searched well; she lives in an Arab village." Over lunch a university student remarked to me, "I hear that you are living in some Bedouin town. What's wrong with you?" I learned through these conversations the threat Jewish Israelis feel from the discourse on the Bedouin. But it was not only Jewish-Israelis who expressed their uncertainty about my living situation. Salim, a Bedouin physician, raised my positionality during an interview.

> When I enter Bir al-Sharq, I expect to see all the girls Bedouin, all of them speaking Arabic, that's it… and then I see one [girl] who arrived from America, who speaks Arabic, speaks English, speaks a bit of Hebrew, lives there in Bir al-Sharq. It's a bit, like, [you] raise an eyebrow. Okay? You raise an eyebrow. Until you realize [kolet], listen, what is bad about that? It's good for her, it's, actually we are not raising an eyebrow because we are against. We are raising an eyebrow out of respect. We respect that you went out of the framework, and sadly, it is sad what exists. You exited one framework and entered another and we say good job, because it is a bit strange for us. Okay?

While Salim concluded that my place in the Bedouin town was strange and out of place, but potentially respectful, for many Israelis (and particularly Jewish Israelis), a Jewish-American-Israeli woman like myself was not supposed to live in a Bedouin town. And indeed with the exception of a South American, Jewish immigrant who came to live with

Um Raed's son, I knew of no other Jewish residents in Bir al-Sharq.

I traveled daily from Bir al-Sharq to Beer Sheva where the regional hospital, Southern Hospital (SH) is located, dropping off the friends and various members of Um Raed's kin at the Employment Department where nearly sixty percent of Bedouin men and women need to weekly check-in in order to receive their welfare payment. Beer Sheva also houses various governmental and private office buildings, a technical high school where one of Um Raed's grandsons studied, and the central bus and train station. One of my arguments in the pages that follow is that the complex relationship between the hospital, as a physical space, and the social and political forces that enter, or fail to enter its borders, cannot be understood without attending to the larger, and longer, dynamics that have shaped the relationship between Bedouin and Jewish communities in the region. What is permitted to be discussed in the medical space? What is considered a medical issue? I suggest that the active constructing of boundaries around what is labeled medical helps deflect essential histories and aspects that profoundly influence health. I argue throughout the dissertation that to understand medicine in Israel, and elsewhere, it is not sufficient to look solely within the biomedical space. Thus living in Bir al-Sharq, like for the patients and families I came to know, and whom you will encounter in the following pages, helped me trace the flows and impediments in the region.

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I drove east from the road heading out of Beer Sheva. After a few inquiries, and another few phone calls, I wound up a road, past the neighborhood mosque, its dome encrusted in gold paint, and made my way up the hill towards a large two-story stone house. A young woman, Ruwan, greeted me at the door, her daughter hugging her hip.

Laila, Ruwan's younger sister, joined us and shuttled me into the *shig.* The *shig,* an elegant living room surrounded with couches and floor mats was a space reserved for family events, when it would typically be occupied by men. But that first day, it was a meeting among women. As we sat on the couches sipping juice, al Haja Amira, Ruwan and Laila's mother and known to all as Um Raed (the mother of Raed, her first born son) joined us.

Laila heard I am a medical student and asked if I could help her decipher her discharge note. She was in the hospital over the weekend because she had been throwing up continuously since the beginning of her pregnancy. After receiving fluids and being examined by the physician, she was sent home; but she couldn't read what the physician's discharge letter. She handed over the note. The letter, written haphazardly, was impossible to read, even for Laila a Hebrew teacher in a nearby town. *What is beten keha? And ubar tnin?* She read aloud again, trying to make out the letters. We looked together trying to decipher the words. I shuffled medical diagnoses through my head, wondering what my role was here—explaining again to the group of women that while I am a medical student, I was here as an anthropologist. But the detail interested no one at the moment. "What does the note say? Is everything okay with the pregnancy?" Laila asked again. We read again, enlarging and shrinking letters, reshaping their contours. *"Beten raka?"* I suggested, meaning supple stomach rather than dark stomach, and *ubar takin,* healthy fetus. A sigh of relief.

The women gave me a tour of a house, a large private house—with two living rooms, one for men and one for women, a kitchen, two bathrooms, and four bedrooms. One bedroom acted as Um Raed's storage room—filled with blankets, mattresses, fruits

and candies; its key tucked away within her dress. The other bedroom was Laila's, filled with books, a single bed, and a computer. The next bedroom served as an extra sleeping room and storage—as everyone typically slept together in a second living room where the women typically gathered, where meals were shared, and where Um Raed hosted friends, neighbors, and family. Finally we reached my new room—with a single bed, a small dresser— painted bright pink. On the first floor of the house was a nursery rented out to a few teachers to supplement Um Raed's income. Previously, the space was rented out to a bakery, and the roof remained charred from the oven's smoke.

After we concluded the tour, Laila asked me to accompany her to the local clinic. On the way, she gave me a tour of the town—the school, the mosque, the hospital, the bus stop, the bakery. "The difference between our cultures," Laila said, "The Muslims we take care of others." I absorbed Laila's words, listening to the contrast in her language to what I had heard of the town until my arrival. After our drive, we returned home, ate lunch, finalized our rental arrangements, and I headed back to Beer Sheva for a meeting. As I was leaving, Laila looked at me and said, "You know now we will have two doctors at home as my mother is also a doctor, having learned modes of healing from her mother and mother before."

***

The first day I woke up in my very pink room, I heard the voices of men, women, and children, bustling in and out of the house, greeting their mother, grandmother, on their way to work and school. Um Raed was sixty four years old, the mother of ten children, grandmother to thirty-eight, and great grandmother to three. Eight of her children lived within a five kilometer radius of her house, and thus our house was the

center of activity and meeting each morning and evening, with meals eaten together, children lounging in front of the TV, and a continuous stream of daughters, daughter-in-laws, and grandchildren sweeping the living room, washing the windows, cleaning the stairs, cooking meals, all being navigated under the watchful, and playful eyes of Um Raed. I too would become part of the family and cleaning crew. On my first Friday in Bir al-Sharq, Um Raed asked me if I was leaving early for the hospital, and when I replied no, she smiled and announced, "*ningashed!"* I look at her, unfamiliar with the word. *Ningashed,* she repeated, and lifted her pant legs. A few minutes later, she handed me a mop, and we washed the floors together. "You're not angry at me?" She asked a few minutes later, smiling, as we swept the soapy water down the hallway. "Angry?" I responded, I couldn't be happier to have a role, even a minor one, in the household.

But that first morning, I still had little idea of the family's routine: *Who uses the bathroom? Where do people sleep? How does cooking happen?* I wondered. When I moved into Um Raed's, the water had been disconnected throughout the entire town due to trouble with the municipality, and thus bathing, cooking, and cleaning would be done via stored water on the roof or in large *barmeels* – plastic canisters- that would be filled in advance.

Three girls between the ages of five and eight—two of Ruwan's and their cousin Almas—entered my room in a storm. They heard last night from their grandmother that she had another daughter who was far away and was now back. But, and justly so, that made no sense to them. "Where did I come from? And how could their grandmother have another daughter, and one who was already so big? And was I Jewish or Bedouin? Was I

married? Did I come here to get married?" They fired away their questions, and I, groggy eyed, looked up to see Um Raed smiling.

Like Almas and her cousins' inquiries, the first question I would be asked throughout my research was "Where are you from?" And within this question, a number of other inquiries would unfold: "Where were you born? To whose family are you linked?" And Um Raed, with the power reserved only to matriarchs, added me into her family tree. Almas continued the interrogation: "Did I see the mouse outside? And why do I have a spoon in my bag?" Um Raed came in and shooed them away to allow me to get ready.

In the living room, Um Raed brought a large platter with *doga (*Origanum syriacum), a grounded spice made of dried, aromatic leaves, olive oil, tomatoes and bread, and I joined Um Raed, Laila, and Ruwan for breakfast. Almas, between bites, asked again whether I am Jewish. And Um Raed replied before I could say a word, "She is my daughter." "Well is she Bedouin?" Almas insisted, still uncertain how I joined her family overnight. "The Jews and the Muslim are brothers, *ihwa*," Ruwan stated, knowing Almas loquacious tendencies. Ruwan with a spark in her green eyes asked Almas, "Are you Bedouin?" And Almas, replied nonchalantly "No." Laila and Ruwan, smiling, turned to their five year old niece, "Well, what are you?" *"Yahud*, Jewish." Almas simultaneous insistence on the bounded categories (Jewish/Bedouin/Muslim) and their fluidity, points to the work I hope to move forward throughout this text. Rather than taking these categories as natural, I follow how they are constructed, disassembled, and entrenched over time, by whom, and to what end.

I have chosen not to dedicate a particular chapter to health in Bir al-Sharq. Given

that most anthropological research on the Bedouin focuses on life in these communities, I set to emphasize the Bedouin not as a bounded category or community located exclusively in Bedouin towns. Instead, my focus on the medical care reveals how multiple notions of the Bedouin become part of the daily work and lives of healthcare professionals in Southern Hospital. As a result, I consider how the category of Bedouin is destabilized such that at some points during medical care providers insist they are treating a *Bedouin* patient, while at others they stress it does not matter that a patient is Bedouin. Following where the category of Bedouin materializes and seemingly evaporates in the hospital has been useful in understanding its boundaries in the hospital, and as a practice of unhinging its assumed boundaries. Nonetheless, my time living with Um Raed informs my understanding of this work. She and her family served as some of the most astute analyzers of the dynamics of healthcare and politics in southern Israel. During my second week of living with Um Raed she asked me if I interviewed the old women in the hospital. She told me in her commanding voice: "Talk to the grandmothers. Talk to them and ask them questions and write everything they say down. *Ask them."* She insisted. "Ask them, the old ladies like me. And then write everything they say and then we will talk about it at home." She even instructed me the questions I should ask. *Where do you live? What do you do? What brings you here? Does your husband have one or two wives? How many children do you have?* Her questions reveal the contours of what has constituted research on Bedouin in the past—fertility, polygamy, and residence—but furthermore Um Raed highlights the active role that generations of Bedouin women like herself play in knowledge production.

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Five chapters follow this introduction, each examining different aspects of the healthcare system in southern Israel and its relationship to the dynamics between the Jewish and Bedouin communities in the region. I explore the intimate ties, obligations, boundaries, and relationships that come to define and to shape medical care in SH and the Negev/Naqab. Why are particular relationships permitted? Why are others obstructed? What is the work being done to construct equality (and inequality) within the medical framework? What are the borders and limits of this equality and inequality and how do they relate, co-define, and challenge each other? These are some of the questions at the center of this dissertation.

In Chapter 2, “Military and Medicine,” I examine the dividing lines in the region through the lens of medical allocation during the military government (1948-1966). I examine this period as a point of entry to unhinge the boundaries between communities that presently are assumed to be permanent. I focus on the early segregation that took place in the region through the decision to place all Palestinian Arabs who remained within Israel under military rule. Drawing on archives from the Israel Defense Forces, the Tuviyahu Archive in Beer Sheva, and interviews with individuals present at the time, I trace the complex relationship between military and medicine, care and coercion that began during this period. I begin with this chapter as this complex history is an important framework to understand the contemporary relations and tensions between the Jewish State and the Bedouin community. Furthermore, the division between Jewish and Bedouin residents implemented through the military rule echoes into the geographical and social distribution of the population today.

In Chapter 3, “Creating Bedouin Health,” I examine how the segregation

initiated by the military rule enters into how the Bedouin community has been characterized in medical research. Drawing on medical research published on the Negev Bedouin, I trace how political and social events that took place in the region enter – or remain obscure—from medical studies. I argue that these studies reveal the process by which Jewish and Bedouin populations, and the recognized and unrecognized villages were created as distinct medical and social categories. What I want to highlight is the manner that bureaucratic categories and historical processes are transformed into scientific fact through these studies and publications.

Despite the sharp divide characterized in medical articles between Bedouin and Jewish residents, throughout my fieldwork healthcare providers insisted that in the hospital there is no difference between their Bedouin and Jewish patients. In Chapter 4, I examine how the polarized landscape transforms into a discourse of equivalence within the hospital. In this chapter I examine the construction of equality within the medical arena and how it reconfigures discrimination. I examine how biomedical training and technologies create a fragile equivalence between patients that opens the possibility of "medical equality." I argue that the medical and scientific language, as well as a cultivated "active blindness", helps stabilize individuals in the hospital as equivalent patients, while constantly being disturbed by the (im)possibility of sameness. I argue that the medical and scientific language permits distinctions—social, political, cultural, and historical- to be discounted as crucial for medical care.

Chapter five focuses on the role of language and communication between providers, patients, and families in the hospital. While the majority of patients in SH are Arabic speakers, most of the providers are exclusive Hebrew speakers and no translation

service exists; nonetheless, providers did not view Arabic as a serious impediment to care. I therefore examine language as a site to understand how providers imagine – and construct—Bedouin patients. I argue that providers' dialogue with their Bedouin patients is mediated through their conception of what it means to be Bedouin. Arabic is discounted as a serious problem in SH because the difficulty in communication becomes associated with Bedouin culture rather than language.

The final chapter turns to questions of the "public" in Israel. In the spring of 2011, the Israeli Medical Association (IMA) launched a general strike against the conditions of work within the medical system. Shutting down medical departments, community clinics, organizing rallies in front of the parliament and various government hospitals, commencing in hunger strikes, and admitting medical residents into the Emergency Department due to exhaustion, IMA defined its campaign under the slogan: "Save the Public's Health!" The final chapter examines the physician strike as a lens to understand the limits of the public and public health in southern Israel. Along with the physicians' strike, I analyze the Negev health equality conference, and the collapse of the preventative health service in southern Israel as three sites revealing different iterations of the public. I argue that attending to the boundaries of the public in the Israeli medical system helps elucidate how equality is produced and how inequalities in medical care remain excluded from the scope of what healthcare providers and policy makers consider medical equality. The use of "the public" within the IMA campaign and the larger Israeli social justice demonstrations became a means to claim national inclusivity, while deflecting attention away from the exclusionary practices and policies that maintain and further entrench inequalities in the medical system and throughout Israeli society.

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I mentioned to Um Raed that I would be going to Jerusalem in the morning for an interview. As we drank our evening tea, and watched the news, we talked about maybe her joining me. But as I got ready in the morning she seemed torn. *Will it rain? Will it be cold? I have an eye doctor's appointment.* After much debate, she decided she would join me another time. A minute later, she returned, her eyes filled with motivation: "If the opportunity arises to go to Jerusalem, you can't refuse." As we headed out of Bir al-Sharq, Um Raed narrated the landscape, detailing to me what family lives in what house; proximity in distance mirroring closeness in kinship. "This is my brother's son, and his daughter, and this is my brother." We turned right onto the main road, passing the few vegetable stalls and falafel stands. "This is Abu Bader, and then Abu Saad." We turned left from Bir al-Sharq and Um Raed pointed out Alhuzeil, and then Alabide; communities not marked on the map, but whose boundaries and long-term presence are clear to Um Raed. We passed the *Joe Alon Center for Regional Studies and Bedouin Museum of Culture.* The Museum, founded in 1974, is named after Colonel Alon, one of the founders of the Israeli Air Force. Um Raed tells me how she knows the guide at the entrance, so she never pays the 20NIS to go in. She points out the *jeesh*, army, to our right in a dense pine forest —young soldiers gathered in a camp with an Israeli flag marking their presence. "The *jeesh* planted all the trees so they have a place to rest and shadow from the sun," she explained. And indeed, many men between the ages of 23-35 that I met in Israel knew Bir al-Sharq only because they navigated through the area during their army service. One university student added: "We didn't go to Bir al-Sharq, Bir al-Sharq entered into our navigation." This regnant statement places the army and Israeli state as

the legitimate owner of the region's land and the Bedouin in Bir al-Sharq as intruders. Yet it fails to attend to the roots and layers that Um Raed recalls in this area—ones that extend beyond these forests.

I turned right onto the main road north and Um Raed guided me as a confident navigator. Her attention directed towards the valleys and mountains. *Those mountains are Arab,* she stated. I look for signs towards Jerusalem, *al Quds*, and she laughed that I must rely on reading for orientation. Taking the new highway towards the capital, we traveled alongside the winter landscape of the region; wheat fields hiding the browns and yellows associated with the land. Um Raed looked left and right. "All of this is Arab land. To the left, to the right. It's all Arab land." I asked her who has it and she responds, "The state, but it's all Arab land."

Um Raed and this research have taught me to view different layers of Israel and the Negev/Naqab. For her, prickly pears served as evidence of Arab communities, abandoned homes on the sides of the road, now covered with graffiti, remained associated with former Palestinian tenants. She looked at the landscape and saw an additional narrative, an additional history. This narrative is woven into how medicine and citizenship are understood and experienced in the region today. It is detailing the links between these layers of history and contemporary medicine that I set out to do in this dissertation.

Chapter 2: Military and Medicine, Archives and Notes, Writing and History

I meet Mahmud Al-Shifaya in the hospital's cafeteria. Crowned the first Negev Bedouin physician, he is now middle aged and mostly retired. In an article from the San Francisco Jewish Chronicle dating back to 1967, Mahmud is pictured in the laboratory at the university. Adjacent to the picture is a second image of him standing by a bus stop in the desert, placing a *mandeel*, a kerchief, on his head. The two images, of the modern laboratory and of the "empty" landscape of the Negev, are positioned in seeming opposition, as if it is only Mahmud, the student and to be physician, who can bridge these two worlds.

"Why did you decide to study medicine?" I asked. "Crazy," he pointed to his head. "I got infected with something. Since I was twelve I liked people and biology."

In the Tuviyahu Archive of the Negev, located in a small room on the third floor of the university library, I found an interview conducted by the archive's staff with Mahmud in 1990. He told the interviewer of the deep significance of 1948, the Nakba, the catastrophe, as it is known to Palestinians, and the War of Independence as it is known to the Jewish community:

> This is very important for me…Suddenly for the first time in life we see the Jews. And we see trucks and military jeeps in our village. The family was scared. They thought they definitely want to do something. I remember that as a child I ran away, and until today they remind me that I am a coward. I ran away to the chicken pen and hid there because I was scared. Later we found out it was Moshe Dayan who came to visit.[15] I remember it was summer and they offered him [*kibdu oto]* watermelons. I ate from the same watermelons. My dad and uncles took me from my hiding spot and I sat with the visitors. The guests knew the tribe. They said, "You have nothing to be scared of, be quiet, we are not going to do anything bad, we are only conducting tours." From then on the ties with the Jews began (1990, 4).

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[15]Moshe Dayan was appointed in 1949 as Major General and was responsible for the Southern Command which included the entire Negev region and southern military government.

The "ties with the Jews" that Mahmud raised in the interview, led to his encounter with Dr. Binyamin Ben Assa, a Dutch physician who from 1954 until 1965 served as the sole "Minorities Physician" for the entire Negev Bedouin community. "As a child I read a lot of books, everything related to medicine I read, not professional material, but the material that I could understand in medicine. The idea of becoming a physician charmed me. In addition to the reading I had contact with Dr. Ben Assa, may he rest in peace."

> Interviewer (I): "As a child?"
> Mahmud Al-Shifaya (MAS): "As a child"
> I: "What sort of contact did you have?"
> MAS: "Very strong contact. He would come to the tribe as a doctor. He was a very nice person, a very sympathetic person, a person not just a doctor. He created strong ties with the entire community. When he came to care for patients, the people did not just look at his treatment of the sick... Slowly I began to ask Dr. Ben Assa how to study medicine. He said immediately that it is very hard. He said it requires a lot of effort and sacrifice… He said it will be hard and you advance one step at a time. He didn't encourage me in an emotional way, he didn't say, "Go run!" He told me, "You can do it." Yes, this actually helped me than if someone else would have told me, "Go run, it will be okay" (1990, 9-10).

Sixty years after his first encounter with the Jews, Mahmud now works part-time as an internal medicine physician and volunteers his time with a number of non-profit organizations advancing health in the Bedouin community. I drove with him to Rahat, the largest Bedouin town of nearly 60,000 residents and the second largest town in the Negev, for an *Eid Al Adha* party in the regional Clalit clinic. Clalit is the largest and historically the first sick fund in Israel. Since the implementation of the National Health Insurance Law in 1995, Clalit is one of the four sick funds that provide medical services to all residents of Israel (see Chapter 1). Clalit, because it is the largest, and because Southern Hospital is owned by the same sick fund, insures the majority of residents in southern Israel, including the Bedouin.

At the event there were many speeches wishing the Muslim staff a happy holiday. One of the sick fund's administrators greeted the audience: "I wish I could greet the Muslims a happy holiday in Arabic, but my mother was born in the wrong place." Mahmud, sitting in the audience called out, "There are private lessons." "It's not my strength," the man replied, continuing to talk of investment and growth in the region.

As we headed back to Beer Sheva, Mahmud said to me, "The reason for the large investment in the Bedouin community is because we started from zero. The population was neglected, so it looks like there is a big investment to those who don't know the reality. There was a big investment because there was none for so many years. There is built-in discrimination against Arabs. The state exists for sixty-two years but there is discrimination in budget, manpower, integration. Compared to the Jewish citizen, the state is not equal to the Bedouin population. There is racism and the state does not fulfill [its obligation]."

Mahmud's words stood in sharp contrast to our conversation just a few hours earlier in the hospital's cafeteria, in which he assured me that he felt like medicine was the only site of equality for the Bedouin community. And yet, mid-drive, heading back towards Beer Sheva, this equality seemed to be questioned, evaporating among charges of discrimination, inequality, and racism. How do these two statements sit together? What is the state's obligation to a population? To its citizens? When did this obligation emerge? And what kind of relationship and exchange does this obligation create between the Bedouin community and the Jewish state of Israel?

"So why is medicine equal?" I asked, thinking back to our conversation just a few hours earlier in the cafeteria.

> The team that works in healthcare is a team that from the power of reality *[koh hametziut*] is obliged… He [NR: the healthcare provider] is sworn to take care without different of race, gender. So he cannot do anything different. Second, as a human being in the health care system there are laws and morals [*matzpun*]. A doctor, nurse, learned and was educated that there is a law against discrimination. And morally [*matzpunit*], and fundamentally [*erkit*], they were born as such since they were medical students. The profession of medicine is a humanist one without differences between this or that. The reality continues because the basic data on the environmental level [*be ramat hasviva*]. But there is discrimination, for example if an Arab wants to be a manager. A patient, a doctor, a nurse cannot discriminate, cannot directly discriminate in the care they provide. Maybe he is Liberman, or Likud, or Kahana[16] but he cannot act different in the framework [*misgeret*] of the healthcare system. He cannot [act in discriminatory ways], he is responsible, obliged [*mechuyav*]. He is responsible he has no choice. In the Israeli public, discrimination [*haflaya*] in healthcare is talked about because it is the most important thing. For example, it's not just citizens. A suicide bomb attack [*pigua*], or Hamas or intifada, [individuals from these groups are] cared like they were Jews. In these absurd situations. That is the power of medicine. A physician needs to act that way and cannot act any other way. The fact that in the hospital people are hospitalized together—eat the same food, receive the same treatment [*tipul* – referring here both to medication and treatment], and attention [*yahas* in terms of care], you cannot change the treatment [*yahas*]… So indirectly there is encouragement of coexistence [*dukium*]. Being together they start to know each other and in the end they invite one another after they are discharged. It is a field [*sade*] that has lots of advantages – Bedouin and Jewish patients are together and end up visiting one another….It is very important. The humanistic aspect develops. The open-eness. The care and respect. It is a higher value [*pan enoshi mitpateach. Haptichut. Hayahas, ha'aharcha. Ze erech eliyun*].

I remained puzzled by Mahmud's insistence that medicine remained a site of equality. "But why does it stay in the hospital?" I wondered out loud. "Why don't providers extend this call for equality beyond the realms of their medical work?" Mahmud replied: "The doctor his work is defined. Your profession is to care for a disease [*rofe yisuku mugdar. Miktzua shelha letapel bamahala*]."

I carried Mahmud's words with me for a long time throughout my fieldwork. Here was a physician who succeeded in studying medicine within Israel forty years ago, an achievement that even today remains nearly impossible for most Palestinian-Israelis.

[16] All Jewish, right-wing, or center-right political parties, whose different members have in recent years advanced anti-Arab legislation.

Here was a man who experienced as a patient, as a community member, and as a medical provider the racism he discussed. And yet this racism seemed not to contradict the equality he assured me *must* be practiced in the hospital; equality that professionals are obligated, *mechuyavim,* to provide.

The equality that Mahmud discussed remained bound in the hospital and the "framework of the healthcare system." It is constructed and taught as part of professional training, and one that must be perpetually reconstituted and maintained. This concept of equality, that Mahmud and others throughout my research raised, was a term that did not, and could not, signify a particular relationship. Rather, equality, and with it sameness and equivalence, were terms actively created and sustained. In Chapter 4, I explore providers' "active blindness" in learning to not see particular aspects of patients that would challenge this sameness. Caring the "same" and "equally" for patients evoked a transformation process in which patients were not cared for *as* Hamas patients, or *as* intifada fighters, but specifically they were treated "like they were Jews." Therefore sameness always creates a hierarchy and requires a partial erasure of aspects of patients. It is not that these patients were treated *the same* as "Arabs" but rather they were treated the same as "Jews". Therefore Mahmud's comment highlights that attention needs to be drawn to the process of equality-making in the hospital, a process that in calling patients the same and naming their care equal, also captures within it, and simultaneously hides, a particular hierarchy of relationships and obligations between medical providers and patients.

If we follow Marcel Mauss (1990) insight in *The Gift,* and consider the provision of medical care as a gift, then this gift carries with it a series of obligations, relationships,

and hierarchies. As Mauss explains: “Through these gifts a hierarchy is established” (Mauss 1990, 74). This hierarchy and relationship is central to reconceiving medical care historically, and in the contemporary moment, in the Negev/Naqab. Medical care, and care itself, it always positioned as a relationship between the Israeli state and the Bedouin. As Mary Douglas summarizes the web created within the exchange of giving and receiving: “There is no free gifts; gifts cycle engage persons in permanent commitments that articulate the dominant institutions” (Mauss 1990, ix).

Mahmud utilized the Hebrew word *yahas to* signal the care, the treatment, the approach one has towards patients. But *yahas also* marks a relationship: between providers and patients and in Mahmud’s narrative between patients (Kisch 2009). Through the power between providers and patients, medical practitioners get to elide the hierarchy of doctor/patient, Jewish/non-Jewish, citizen/non-citizen by calling these relationships equal. But equality here remains bound within a specific limit of the term; using the term equality restricts the extent of this equality and designates what cannot be compared, what does not enter into the relationship. But in this process of border making, of exclusion, an excess remains. And this excess remains the haunting aspect of this relationship, the haunting that makes equality fragile. Medicine may have the power to mark people or aspects of people the same, but this sameness has a violence of neglecting the lived experience of difference.

A continual process of interpellating sameness (of patients, of food, of therapeutics) and difference (of citizens, populations, gaps) exists, a process that allows these various relationships to coexist. Sameness comes to be *bounded*, within the sphere of the hospital, within professional codes of ethics, and simultaneously comes to restrict

the limits of this term. According to Mahmud, a particular relationship emerged between healthcare staff and patients in the hospital, a relationship that many of the families and providers I would come to know echoed throughout my fieldwork. The hospital seemed to serve as a fulcrum that within its walls particular relationships, and obligations, emerged, that challenged the typical relationships, and obligations, existing beyond its walls. These relationships were contingent on a professional code of ethics and behavior of doctors, nurses, staff, and patients, that managed to sustain a particular type of equality, while governmental policies and individual citizens (including the same physicians, nurses, and patients) made discriminatory statements towards the Bedouin community. Therefore within the hospital a particular set of practices—ones related to how patients come to be defined through their disease and diagnosis and abstracted from their social conditions, and how inequality and discrimination seem to pushed aside—that permits patients and providers to call their care 'equal'. Yet in this movement towards a biomedical language of disease, diagnostics, and standards, inequalities come to be neglected, and furthermore, reified and created.

In this chapter, I bring together the two processes that Mahmud highlights: first, the historical neglect and marginalization of the Bedouin, and second, the declaration of medicine as a site of equality. I follow Mahmud's emphasis on the deep significance of the Nakba, and examine the debates surrounding the medical allocation to the Bedouin community during the military rule (1948-1966). Drawing on archival material and interviews with healthcare providers who worked in the region during this time, I examine this period as a point of entry to unhinge the divisions that are today taken as given in the region—boundaries between Jewish and Arab, non-citizen and citizen. I

suggest that examining medical care during this period helps clarify the process by which equality within medicine became bounded within the hospital and clinic, and furthermore why nonetheless medicine continues to remain saturated with politics. Unlike other contexts of war and humanitarian aid, the military rule in the Negev was part of the daily life of Bedouin and health practitioners alike. Thus, examining medical care during this period provides insight into the subtle ways medicine becomes militarized and the military becomes bound up in practices of care.

I. The Bedouin Doctor- From Van Asu to Abu Assa

I found Clara through the internet, looking for clues to a man named Dr. Binyamin Ben Assa, the same Ben Assa who encouraged Mahmud into the profession of medicine. Clara Ben Assa, a pediatrician by training, married Dr. Binyamin Ben Assa in the 1930s. While her late husband passed away in 1974 at the age of 58, Clara, having outlived Binyamin by almost forty years, now lived in Jerusalem. I found Clara's contact information in the Israel Graphology Association, an interest she took on after years of working as a pediatrician.

When I began to investigate the relationship between the state, medicine, and the Bedouin community in the early years of graduate school, I found Binyamin Ben Assa's name throughout material I read: his name appeared in interviews such as the one with Mahmud, his correspondences with the Military Governor dominated the Israel Defense Forces archive, and a file labeled *Ben Assa* that consisted of a number of bins was located the Tuviyahu Archive in Beer Sheva. I learned that Dr. Ben Assa, known to the Bedouin community as *Abu Assa*, served as the Ministry of Health's minorities' physician from 1954-1965, the sole doctor for approximately 20,000 Bedouin Israeli citizens at the time of his retirement. He was the Bedouin community's medical practitioner during the

majority of the military rule and played a significant role in shaping medical care and the relationship between medicine and the Bedouin community in the Negev. But how did a Dutch physician arrive to the Negev?

"Yes, he was an interesting man," Clara sighed, "Well, what can I say, it wasn't always easy to be with an interesting man." I met Clara on a late January morning in her apartment in Jerusalem. We sat across the kitchen table, drinking tea. Neatly arranged articles about her late husband were organized in files on the table: Newspaper clippings of his medical prizes, press releases of the "Bedouin Doctor's" achievement in reducing tuberculosis rates in the Negev, invitations to the grand opening of the Bedouin Clinic named in his honor (Figure 1), and medical journal publications concerning tuberculosis among the Bedouin community.

Clara and Binyamin met as medical students at the University of Amsterdam in the 1930s. He was the son of a physician in Amsterdam, and a prominent member in the Zionist Student Organization. Clara grew up in Rotterdam, where for many years she was the only Jewish student in her class. "One or two [Jews] here and there, but it was not common to be Jewish. My parents were Jewish, but they didn't announce it." How does a woman decide to study medicine seventy-five years ago, I asked her. "I started studying in 35', and there were a fair number of women in the class. I never felt alone. There were fifteen girls, so it wasn't rare at all. And many studied medicine and then went to Indonesia."

During the 1930s, Indonesia was a Dutch colony with a large coffee, tea, and rubber industry. "I don't know what drew me [to medicine]. I don't really remember. I actually always loved flowers and such things, but the Faculty of Agriculture didn't want

to admit me. Because there they [NR: all the students] went to Indonesia. Whoever studied agriculture went into coffee or tea, you know, or rubber plantations. So it was not acceptable and there were really no girls there. So I understood that was impossible. And I read all sorts of novels, about [Albert] Schweitzer, you know." And thus, unable to pursue a degree in botany and agriculture, Clara began to study medicine, years later living in the desert in southern Israel, far from the tropical landscape that filled her dreams.

In May 1940, the Germans invaded Holland. For a period, the universities remained open and studies continued as usual. In 1942, the couple, having just received their medical doctorates, escaped Holland via France, Spain, and Portugal and arrived in London in 1943. In England, Binyamin Ben Assa, then still known by his given name Benjamin Van Asu, joined the Royal Dutch Navy. He was stationed on a frigate ship in the Mediterranean as the crew's physician. During one of their dockings in Haifa, then under the British Mandate, he learned that his parents had escaped from the Bergen Belsen concentration camp in Germany and were still alive. In the meantime, Clara remained in England and found a position as a physician in North Wales. At the end of World War II, Benjamin returned to England, only to be drafted again, this time to serve as a Navy physician in Indonesia.

"After the Japanese left, the Indonesians wanted independence," Clara narrated to me the early years of the couple's relationship. "So they sent him as the Navy doctor again. They [the Military Forces] didn't send women to an area where there was war, so I told the Ministry of Health… that I wanted a job." There were many physicians leaving Indonesia at the time, and the Dutch government had a shortage of physicians and gladly

recruited Clara as a civilian physician. Clara arrived to Indonesia a month after her husband and agreed to run a pediatric clinic in the region. “It was very interesting, and really beautiful, until today I dream of it. And our eldest son was born there.” The Ben Assas were stationed in Surabaya for four and a half years. In 1949, Indonesia became an independent country, and the Ben Assas needed to decide whether to remain in Indonesia or return to Europe. “We needed to choose between Dutch citizenship or Indonesia. They wanted the physicians to stay, and they offered us to be physicians in Bali. But we had a baby, and to raise a Jewish boy in Bali? I don't know, I was really drawn to it, but my husband said it’s impossible. We were there until 1950 and then returned to Holland for a brief visit and then decided to move to Israel.”

Journalists writing about Dr. Ben Assa years later portrayed his decision to immigrate to Israel as following “the Zionist path, of course” (Lachish circa 1967). Yet, Ben Assa’s path to Israel and his experience in the country were more complex than a simple Zionist path. He indeed remained committed to establishing Israel as a Jewish state. Yet for Ben Assa, part of the responsibility of living in Israel entailed developing ties with surrounding Arab neighbors and local Palestinian residents. As I discuss below, despite much criticism, Ben Assa donated the prize money he received from the Schweitzer Award to a Palestinian refugee clinic. Ella Shohat (2003), Nadav Davidovich and Shifra Shvarts (2004), and other scholars extensively documented the discrimination Mizrahi Jews, *Mizrahim*, emigrants from Arab countries, experienced upon their arrival to Israel from the government in general, and from the medical establishment in particular (Motzafi-Haller 2012; Kahzoom 2003). The division, and hierarchy, between *Mizrahi* Jews and *Ashkenazi* Jews (Jews emigrating to Israel from European countries) is

often taken as a given in writing on Israel—with Ashkenazi Jews dictating policy and holding the material and symbolic capital in the country. But Ben Assa seemed to work in a different normative paradigm. Contrary to his contemporaries, Ben Assa felt that *Mizrahim* should not be termed or treated as "secondary" Israelis. He explained his reasoning as follows: "[T]he truth is that we, European born, we are 'second Israel'. They, the easterners [the Mizrahi Jews] are the first Israel. And the reason is clear- they can be a bridge between us and the Arabs in space, because they speak Arabic and they know the Arab and their culture" (Lachish circa 1967). Because Mizrahi Jews spoke Arabic and had closer ties to the region, in Ben Assa's view they held the symbolic capital in the country. Thus for Ben Assa, his experience in Israel was not dominated necessarily by a narrative that viewed the land as an empty landscape without a Palestinian past, but rather he seemed to see, even in the early 1950s, the importance of making links with Arab language and culture in general, and in the medical setting specifically. Clara explained to me that most physicians treated the Bedouin out of self-interest. They saw it as some investigative case that could produce interesting research. But her husband viewed medical treatment as part of a commitment to change civil society in Israel. Binyamin Ben Assa saw his work as potentially changing politics. He believed, Clara recalled emphasizing what she viewed as her husband's naivety, "that if we treat them well, we can make a difference."

The Ben Assas arrived to Haifa in August 1950, on a Swedish cargo vessel carrying American military jeeps purchased by the newly established Israeli government; they were the only passengers on the ship. In Haifa, Binyamin began his residency in Rambam Medical Center. "I think he was there for two years in Haifa," Clara recalled,

"And suddenly, he had enough. He wasn't being promoted, and he thought, *for this, I didn't come to Israel. It was like in Amsterdam, but worse*." It was around this time period that Binyamin traveled to Kibbutz Shuval, in the northern Negev, to visit Yossi Tzur, one of the Kibbutz's founders, leaders, and a designated *Mukhtar* whose task was to coordinate activities with the local Bedouin community (Tzur 2007).[17] During this trip, Ben Assa met Sheikh Musa Al-Ataouna whom Tzur was in close contact with (ibid). *The California Jewish Voice*, in a feature written on Ben Assa in 1967, characterizes this visit as the pivotal moment that drew Ben Assa south to work with the Bedouin community. *The Voice* describes Ben Assa's "Bedouin Encounter" as follows:

> It was during a week-end visit to friends in a newly founded kibbutz in the Negev, Israel's arid southland, that Ben Asa [sic] met his first Bedouin. Appalled by the contrast between their regal bearing and prodigal hospitality, and their backwardness and lack of the most elementary sanitation, he told his wife the same night, "This is a job for me. That's where I am needed" (Israeli Doctor Donates Scheiwter Award to Arab Refugee Children May 5, 1967).

Indeed, upon his return to Haifa, Ben Assa decided to apply for a position with the southern Bureau of the Ministry of Health, and to leave his surgical residency. Binyamin had started learning Arabic while in Indonesia (he had learned Chinese before), and was proud to tell reporters that, "I am the only Jew in the world who speaks Arabic with a Dutch accent" (Lachish circa 1967). Ben Assa remains one of the few providers that I encountered who actively learned Arabic as part of his medical work to care for Bedouin patients and saw it necessary for medical work with the Bedouin (see Chapter 5).

Clara, on her behalf, was not so thrilled about the move south. "I'm pretty European," she told me. "Every vacation I would ask my husband to go a bit north, a bit

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[17] Tzur (2007) describes his role as Mukhtar as follows: "First of all to protect the Kibbutz' property and prevent the pasture of Bedouin flocks on the Kibbutz's fields….The Kibbutz's clinic, as there was yet an organized clinic for the tribe, would provide first aid to the Bedouin."

of water." She narrated the move to Beer Sheva in less romantic terms: "He went to the Ministry of Health and they moved us to Beer Sheva. They were very interested, and he was really interested in becoming the Bedouin's physician. It's not that the Ministry of Health cared much about the Bedouin, but they were looking for someone, and a physician for the Mother and Child clinics (*tipot halav)* in all the moshavim." In 1954, the Ben Assas moved to Beer Sheva, with Binyamin hired as the Ministry of Health's minorities' physician in the southern Bureau, and Clara as a pediatrician.

II. Medicine under Military Rule

Prior to the establishment of Israel in 1948, medical care was limited in the Naqab/Negev region. According to Aref Al-Aref, the Beer Sheva district officer under the British Mandate, an eight person hospital existed in the city as well as three clinics throughout the district (Al-Aref 1937, 219). Dr. Henry Koslovski, the first physician to work in the region after 1948, reported that a twenty bed hospital was located in Beer Sheva, but serious medical cases were sent to Gaza or Hebron. In a report detailing medical services between 1949-1952, Koslovski (1952) writes that the British assigned a single medical physician to the region after repeated requests by the Bedouin. According to Koslovski, this physician acted more like "a government health official than a doctor practicing among his patients" (Koslovski 1952, 4). In October 1948, Israeli military forces occupied Beer Sheva, and all Palestinian-Arabs residing in the region were forced to relocate into the southern military zone, known as the *siyag*.

The military government, in place until 1966, provided the newly established Israeli state with surveillance techniques over the great majority of the Palestinian Arab population. According to Israel studies scholar Geremy Forman, the military government "controlled movement, law enforcement, political activity, and resource allocation in

order to facilitate Jewish settlement and assist in the manipulation of local government to prevent antigovernment forces from gaining power" (Forman 2007, 68). In 1956, 180,000 of the 200,000 Palestinian Arabs living in Israel lived in one of the three military zones administered by the Army's military government (Forman 2007, 71). The decision to transfer all Palestinian-Arabs into the military zone came as part of a significant debate surrounding how to balance an ideal of democracy, that required granting all residents, including Palestinian-Arabs, equal rights at citizens, while at the same time holding a deep suspicion towards the same group. Palestinian-Arabs residing in Israel were viewed as a "Trojan horse" that may collaborate against the Jewish state. As Rouhana and Sabbagh-Khoury (2011) note, since the Palestinians in Israel were viewed- and to various degrees continue to be understood— as "potential enemies" to the State of Israel, this limited their ability of "becoming incorporated into the fabric of Israeli society" (Rouhana 2011, 7).

The Negev Bedouin, like their Palestinian counterparts in the central and northern districts, were relocated into a military zone. All movement within and traversing the zone had to be approved by the Military Governor. Previous scholarship, as well as the Military Archive, details the extent to which the Military Government controlled movement—not only of Palestinian Arabs, but also of journalists, government officials, and medical personnel. Initially medical care during this period was provided by the Jewish Society for Human Services, a British based voluntary organization "which sought to assist projects in neglected areas" in Israel (Koslovski 1952, 4). In coordination with the Ministry of Health and military government, the Jewish Society for Human Services arranged for a medical team consisting of a "Jewish doctor [Koslovski], one

volunteer worker from abroad, an ambulance and a driver, provided by Magen David Adom" to provide medical care for the Bedouin (ibid) (Figure 2). After six months of work, the Jewish Society for Human Service's operation was transferred to the Ministry of Health. Therefore, an intimate relationship between the Israeli armed forces, including the military governor and his representative, relief workers, and the state's medical staff emerged during this period. The medical team needed to have a military or police escort at all times "for security reasons" (Koslovski June 8, 1949), and patients needed to get military approval in order to travel for medical care outside the zone. While medical care began to be provided in 1949, debates surrounding medical care to the Bedouin community specifically, and minority communities, generally, in Israel, were far from complete. Should care be given to all residents in the country? And what should this care consist of? Who should pay for medical services and hospitalization? Should medical care be given to Palestinians to reduce infectious diseases that may inflict the growing Jewish population in the region?[18]

Medical care during the military rule provides a site to examine the relationship between coercion and care, as it became the center of the tenuous relationship between aiming to provide equal care to all Israeli citizens and framing the Bedouin community as a security threat.[19] Military and medicine became entangled during this moment, and this web allows an interrogation of the tension between envisioning medical care as a tool to recognize the commensurability between individuals, and as a process of marking

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[18] It is important to note that in the early years of the state, medical services—and specifically public health interventions— were differentially allocated to different populations. Davidovich and Shvarts (2004) examine the role of public health and vaccination campaigns in instilling the hegemony of the Zionist state. It is of significance that public health nurses were sent to educate mothers and children specifically of emigrants from North Africa and the Middle East, positioning non-Western individuals as more primitive and less modern.

[19] This tension continues today in a different scope in regards to Palestinian patients from Gaza and the West Bank cared for in Israel. This is a topic that requires future research.

difference. The tension between military and medicine, equal service and security concerns, and the different obligation between medical personnel, government bureaucrats, military officials, and the Bedouin community can be traced through this time period. Advocates like Ben Assa insisted that as citizens the Bedouin must receive egalitarian medical care, and furthermore that they should contribute financially to their medical services. On the other hand, medical personnel and policy makers continued to bracket the Bedouin as of a different category of citizens (and thus justified secondary and differential treatment such as continuing to maintain the Bedouin within the military zone) (see Figure 3 and 4 for estimate of Bedouin population and medical visits to the Bedouin during the military government).

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On an early morning in the summer of 2009, I traveled to the Israel Defense Forces archive located in the Tel HaShomer Military Base outside of Tel Aviv. As the entire Bedouin population was under military rule until 1966, all correspondences and plans concerning healthcare to the Bedouin remain housed in the Israel Defense Forces archives. The tensions and webs of obligation between the newly established state, the military, and the medical establishment are documented in computerized files. I am set up in a computer on the first floor with the files containing the keywords: Negev, Bedouin, medicine, and healthcare. For a week, I sieve through the hundreds of electronic files, some partly blacked out, other covered in XXXXX or simply missing for alleged security reasons. The debates of medical care to the Bedouin community can be traced in letters and correspondences between the Ministry of Defense, responsible for the Military Government, the local Military Governor, the Ministry of Health, and the occasional

letter from a Bedouin sheikh. This archive provides crucial material to understand how the Negev Bedouin and medical care were conceptualized and constructed at the time.

One of the earliest file in the IDF archive concerning health and the Negev Bedouin dates to February 1949, less than a year after Beer Sheva was occupied by the Israel Defense Forces. The correspondence, between the head of the Minority Department in the Ministry of Heath, which was later dissolved, and the Military Governor of Beer Sheva, Michael Hanegbi, concerns a small pox vaccination campaign to the Negev Bedouin. Dr. Malchi, from the Ministry of Health, informed the military governor that starting February 6, 1949, medical personnel would travel by jeep to the Bedouin camps to vaccinate the entire population. According to Dr. Malchi, a military personnel would accompany each jeep to act as a "guide, contact and translator to help with the operation and its success" (Malchi February 6, 1949). The next several correspondences, between the military governor and the Ministry of Health, concern the delay of the team, who for weeks never arrived in Beer Sheva.

For the most part, during this early period of the military rule, the various government agencies were largely concerned about sanitation and preventative care. Hygiene unit number 4 writes in February 1949: "Beer Sheva, like any other occupied Arab city is a problem in terms of sanitation and hygiene" (Levizon February 12, 1949). The main concern therefore for the Ministry of Health, and the military rule, concerned minimizing population-level risk. Thus massive smallpox vaccines, tuberculosis screenings, as well as concern about rabies were central. It is crucial to note, that the Bedouin, in much of these correspondences, are discussed as a population, rather than individuals or citizens, and therefore the imagined responsibilities and obligations

between the group and the state are often characterized on this population level, hiding the specificity of individuals and of citizens. Attending to the specificity of the Bedouin would include discussing the differences between the various communities (who owned different amounts of property and wealth, who were impacted differently following 1948, and who desired different relations with the newly established state).

Michel Foucault's work is helpful in considering this shift away from the individual and toward the population. In the last chapter of the *History of Sexuality Volume I* , Foucault traces a transition of power from the Sovereign's right to "*take* life or *let* live," to a modern power which he characterizes as the "power to *foster* life or *disallow* it" (Rabinow 1984, 259, 261, emphasis in original). With the rise of biopower, power moves away from the sovereign and death and into the realm of life. Foucault organizes the new power surrounding life around two poles—one disciplining the body (the "*anatomo-politics of the human body*") and the other regulating the population ("*a bio-politics of the population*") (Rabinow 1984, 262, emphasis in original). Together, these two interlocking poles create a grid that Foucault terms "biopower"—a power focused on maintaining life for the benefit of the social body. The emphasis on medical care towards the Bedouin population by the Ministry of Health, and the military, was focused less on providing care to individuals but rather in protecting the Jewish population from illness and maintaining the health of the social body.

The Ministry of Health's limited involvement in advocating for the Bedouin can be traced within the archive. It was the Military Governor, Michael Hanegbi, who in correspondences often advocated on behalf of the Bedouin community. For example, after a rabid dog bit thirty-six camels, the military governor suggested the animals should

not be killed as required by law. The Negev Veterinary officer informed the Veterinary Service that the "military governor raised the social problem related to the execution of the law." He writes: "If we kill all the camels infected with the disease, the Bedouin will remain without a source of life" (Ra'at February 21, 1949). Hanegbi's request is significant not only for its attention to the Bedouin's needs, but also for his work in differentiating the Bedouin. The Bedouin are characterized as a community distinct from the Jewish population where different rules can, and should be, used.

Hanegbi's correspondences point towards the malleability and materiality of the law and bureaucratic categories. The military governor's involvement and intervention as *advocate* for the Bedouin community also highlights what Yael Navarro-Yashin has called the multiple faces of the state. As Navarro Yashin (2012) and Taussig (1993) both emphasize, the state *materializes* into a seeming unitary object. But behind this fictionary object there is no single "reality" behind the state. The concept of the state – and the manner it is fetishized into an object- is a particular construction that links reason and violence and that materializes in objects—maps, books, letters, correspondences. Therefore, while one government, 'Israel', ruled in the Negev during the military rule, different government authorities—the Prime Minister's office, the Ministry of Health, the Military rule—continuously debated the role, and form, of government for the Bedouin community. The correspondences between various government ministries during these early years of statehood highlight the flexibility of the state. The state emerges not as a stable, existing, or unitary object, but as a one of complexity, contradiction, and multiplicity.

In late February 1949, the regional physician, Dr. Sandler writes to the Military Governor that a nomadic [*nodedet*] clinic will begin treating the Bedouin (Sandler Febraury 20, 1949).[20] Yet the Bedouin prior to the military rule were not nomadic, and maintained land ownership and clear seasonal pasture movement (Kram 2012; Kressel 2003; Yiftachel 2008, 2012). Furthermore, following the establishment of the military government, the Bedouin were bound within the military zone. Thus government officials' defining these clinics as "nomadic" mimics the imagined realities, and needs, of the Bedouin community. The discourse of nomadism was used, and remains used, by the Israeli government and courts to dispossess Bedouin from their land, claiming that as nomads the Bedouin did not have any legitimate connection or ownership to the land. Without legitimate claims to land—the nomads could be uprooted and relocated in the national imaginary (Yiftachel 2012). Furthermore, claiming the Bedouin were nomads was used as justification for the failure of medical campaigns. Medical care was imagined as stationary (even when provided through a mobile clinic) and in contradiction to the nomadic way of life. Koslovski recalls that during the first six months of the medical service in the region was "experimental" since "no one at that time could guarantee the success of introducing among a semi-nomadic population, facilities which are normally dependent on static conditions" (Koslovski 1952). Medicine was (and continues to be) discussed as in tension with Bedouin way of life, and furthermore providing and receiving biomedicine is presented as requiring the relinquishment of some aspect of Bedouin-ness.

[20] Until February 1950, Beer Sheva itself was a military town, and therefore civilian services were not available.

But the nomadic clinic did not arrive as promised by Dr. Sandler, as "no vehicle for service and especially not one that fits travel in the Negev" was found (Sandler Febraury 20, 1949). Thus for an extended period of time, the Bedouin community remained without medical care. Finally, the Military Governor of the southern division, in a letter of frustration, wrote to the Department of Military Rule within the Ministry of Defense, demanding a solution:

> This is to announce that the health condition among the Arab population is very poor. Despite my inquiries, and the promises of Dr. Malchi and also the regional government physician, Dr. Sandler, I am yet to receive help from the State's Ministry of Health. I refuse to accept the situation. Is this not a state that cares for its citizens? Especially if the subject endangers the well-being of the entire population. I hope you act on my behalf to change this position and this strange treatment (Hanegbi February 23, 1949).

These early letters document that in the initial period of Israeli rule, no clear decision was made regarding whose responsibility it was to provide medical care to Palestinian Bedouins under its jurisdiction, and how these services would be provided. Interestingly while the Bedouin had yet to be granted Israeli citizenship formally, Hanegbi refers to the Bedouin as citizens and configures the relationship between them and the government through this framework.

In the spring of 1949, after nearly a year of military occupation of the region, Dr. Koslovski arrived in Beer Sheva with a jeep donated by the Magen David Adom (Israel's Red Cross), and a medical team supported by donations from abroad to "work among the Bedouin concentrations" (Koslovski May 15, 1949). Clara Ben Assa, sixty years later, recalled Dr. Koslovski as "old and Polish who didn't know Hebrew and didn't know Arabic. So every patient who came to see him he gave him some aspirin or gave him a note to Hadassah [the military, and later civilian, hospital in Beer Sheva]." The first

report submitted by Dr. Koslovski on May 15, 1949, concerns a Bedouin man from the Abu Ghegayig tribe who suffered from a serious injury due to a firearm:

> The bullet was through and through and probably the bladder was affected. He has been given antitetanus, morphine, penicillin, and the wound [was] dressed. The distance of the shot was more than five meters: no burnings visible. The exit wound was lacerated due probably to a splinter of bone. Owing to lack of facilities for observation the wounded man has been sent by ambulance to his tribe. He has been supplied with sulfathiazole for seven days until we can visit him in his tribe (ibid).

This initial medical report highlights the absence of medical services in the military zone and the continued violence taking place in the region during this time period. With the absence of clinics in the community, much of the care was provided within patients' homes or in Koslovski's home in Beer Sheva, a situation which Koslovski described to the Ministry of Health in August 1949 as, "an unforeseen development and is not all together desirable" (Koslovski August 8, 1949, 3). In addition, until 1950, the only hospital in Beer Sheva was a military hospital that was reluctant to admit Bedouin (Koslovski August 8, 1949, July 3, 1949). Only a few years later, medicine would become theoretically and practically bounded within sites such as clinics and hospitals. Yet at this moment, medical care, political violence, and personal spaces remained interlinked, with medical care was allotted in patients' or providers' homes.

By 1950, Beer Sheva was designated as a civilian city, and the administration of the military hospital was transferred to Hadassah (the military hospital closed and for six months there was no working hospital in Beer Sheva). According to historian Shifra Svarts, the establishment of Hadassah Hospital as a civilian hospital in October 1949 and the opening of a local sick fund clinic "were the first steps in transforming the city [Beer Sheva], that was until now under military rule, into a civilian authority" (Shvarts 1995,

393; Shvarts 2010, 131). Jewish emigrants from Europe and throughout the Middle East began to be relocated to the area. Dr. Koslovski noted in a memo that a large absorption camp had been set up as a temporary transition center for their arrival in Beer Sheva (Koslovski January 1, 1950). Yet health situation in Beer Sheva, like much of the new country, remained far from adequate. The Medical Office of the Negev region chastised the Military Governor for the disregard of the regional civilian population:

> I am writing to draw your attention to the neglect of medical care of citizen residents in Beer Sheva. Despite the distance of the place from organized, civil medical centers, the civil population has not been offered even a single ambulance by Magen David Adom. All emergency cases of difficult patients or injuries not only from Beer Sheva but from the proximate and distant regions are cared for in theory and practice by the army. The medical service of the army too often finds itself in difficult circumstances and of course we do our best, and even in all cases, but of course it should not be the site to dump the responsibility of the civil medical institutions. As such the general medical care of the citizens of Beer Sheva is far from adequate, as the care for children and especially infants is a true catastrophe... It is disheartening that the appropriate institutions have not seen it as necessary to addressed this to date. Even in these cases the army offers its help but it should not free those responsible from carry forth their responsibility (Division June 27, 1949).

After the Jewish Society for Human Services announced that it would end its voluntary services in August 1949, the Military Governor got involved to ensure the service continued through the Ministry of Health (Hanegbi July 24, 1949). The organization transferred its Mobile Ambulance Unit to the Ministry of Health and Dr. Koslovski became the sole MOH personnel in the region. He served as the regional physician for the entire Jewish community in and around Beer Sheva and provided medical services to the entire Bedouin community. This dual position was, as Clara recalled, an “impossible task.” The Military Governor himself wrote in August 1953: “Until now, the regional physician that took care of the Bedouin tribes was also responsible for the Beer Sheva

region. This work requires at least two physicians, one for minorities and one for the Beer Sheba department. In order to efficiently care for the tribes there needs to be a special physician who will be available for the minorities and deal only with this" (Kadish September 1953). Thus the health situation in the Negev generally, and among the Bedouin specifically, remained difficult.

The medical services to the Bedouin community in the early 1950s became more organized with the establishment of two clinics within the military zone: the first in Shuval and the second in Um Batin. Both clinics were housed in the military representative's regional office: an abandoned British Mandate police station. The clinics were established to provide more accessible medical care to the Bedouin, but also, to limit the number of Bedouin that needed to seek medical care in Beer Sheva. As the Bedouin were bound within the military zone, any trip beyond the *siyag's* borders to a physician or to the market required a permit from the Military Governor. Bedouin's movement outside the military zone posed a security threat, according to the military government, but also a public health threat, as the Bedouin were viewed as potentially harboring illnesses. In reality, as Dr. Ben Assa notes in his later reports, it was the Jewish population who most likely was an illness threat to the Bedouin.

The concern over Bedouin's movement was administered not only by the military, but this enclosure was reaffirmed by the Ministry of Health, whose officials were used to justify the limitations in movement. For example, in a letter to the Military Governor dated December 12, 1950, Dr. Malchi of the Ministry of Health wrote: "We agree with you, there is no need to open the city of Beer Sheva for the free entrance of Bedouin. We are certain that the two permanent clinics and the mobile ambulance will cover all their

medical needs" (Malchi December 12, 1950). Therefore the Ministry of Health played an important role in shaping a landscape, and discourse, of the Bedouin receiving medical care—and in general living—in separate spheres the growing Jewish community. Therefore in these early years of the military rule, we begin to see the bounding of medical care into the military zone and into medical clinics. These divisions, between Jewish and Bedouin populations, that would come to be naturalized over the years, become entrenched and created during this period (see Chapter 3). Furthermore, the links between the local medical services and the military rule highlight the imbrications of these spheres of state involvement within the Bedouin community's day to day life. This dual involvement of providing medical care to Palestinian-Bedouin now residing within Israel's borders, while maintaining the representation of Bedouin as hostile, or at least, uncertain residents, created a conflicting and tenuous relationship between the Bedouin and various state agencies.

The overlapping, and at times contending, roles of state actors—such a public health officials vaccinating Bedouin, veterinary medicine examining livestock, military personnel limiting movement, and Ministry of Health physician examining patients—worked not only to create tension towards the Bedouin community, but also transformed medicine into an extension of military presence. The military government escorted smallpox vaccination teams as well as the routine visits of the government physician into the military zone. Thus the military government advocated on behalf of the Bedouin to receive medical care, as noted above, but their presence militarized medicine. Medicine became a target of suspicion and violence directed towards the government and military. For example, in November 1956, the clinic in Um Batin was demolished after a bomb

was placed by border infiltrators in the building to destroy the military governor's office (Amir January 30, 1957).

The experience in southern Israel echoes Franz Fanon's writing on medicine and colonialism. Fanon (1965) argues that entering the clinic and entering the governor's office in colonial Algeria were equal moves. Thus the line for Fanon separating the two sites does not exist; there is no clear boundary marking the beginning and end of medicine or colonialism. As he explains, "In the colonial situation, to see the doctor, the administrator, the constable, or the mayor are identical moves" (1965, 245). Medicine is colonialism, militarized, and violent. Similar to Fanon's experience in Algeria, in southern Israel during the military rule a similar blurring can be traced between the sites of medicine and military. The equivalence therefore made in medicine proceeds not only in the direction of equating patients through disease categories (see Chapter 5), but also in exchanging military and medical personnel. This blurring of roles extends beyond the historical context of the military rule. In an interview conducted with a Bedouin social worker on her role in counseling Bedouin families post house demolitions she explained to me, "They see us as the establishment… We absorb this, the yelling, even though [we come to help]. I understand the anger… but what am I supposed to do when from one side we uproot? " Thus considering the role of medical care in shaping the place of Palestinian-Israeli must extend beyond the hospital or clinic, and examine its conflicting ties and allegiances to other government roles.

III. Constructing Equal Care

The debates surrounding medical care to the Bedouins—between providing healthcare as "equal citizens" or as "threatening residents" under military rule—paralleled the larger debates at the time concerning the social and political status of

Palestinian living in Israel. While the questions of equal rights versus security concerns were debated at length, ultimately, Palestinians who remained within Israel's borders were granted citizenship, and theoretically gained 'equal' standing in Israel. Yet in practice, this equality, as Sufian and Levine (2007) note, was "extremely limited" (70). Geremy Forman (2007) in an article examining Nazareth during the military rule aptly characterizes the tension as follows:

> The premise underlying Israel's policy towards its Palestinian citizens during the first few decades of statehood was that the perceived threat they posted could be held in check through close supervision... it aimed at maximizing surveillance and control by isolating Arabs from the country's political, administrative, and social systems (70).

This isolation permitted control, and with it a marking of difference within a framework of equality. Crucially this difference was not only for means of surveillance, but also as a means to create a hierarchy of services and citizens within the state. Sociologist Zeev Rosenhek argues that the exclusion of Palestinian-Israelis stems not only from the logic of the Zionist Israeli state the prioritizes Jewish citizens, but also, more insidiously, through what he calls a "stratificatory mechanism" within national legislation (Rosenhek 1999, 198). Rosenhek analyzes the child allowance legislation that while officially grants support to all Israeli citizens, in practice maintains an exclusionary principle that negatively impacts Palestinian citizens. As he writes in the case of child allowance, "The programme was legally institutionalized according to formal universalist principles, but exclusionary practices that limited the access of Palestinian families to benefits were carried out in actual performance" (ibid, 201). Legislators, for example, stipulated child allowance on army service. Since fewer Palestinian-Israelis serve in the Israel Defense Forces, they also received less welfare support. Following Rosenhek, I suggest that medical care in Israel has similarly been established on the basis of a universal ideal but

both implicitly and explicitly legislators and practitioners have worked to exclude Palestinian citizens. The mechanism of exclusion has worked historically - through military confinement until the 1960s and later through continued social, economic, and racial marginalization that places Bedouin at poor health.

The question surrounding how to incorporate the Bedouin, and the Arab community at large, into the newly established state played out in the allocation of medical service. Medical care to Palestinian was seen not only as necessary to protect the Jewish population from potential infectious diseases or as a humanitarian concern of military captives, but also as an important *political* goal. As Mordechai Gilon of the Ministry of Defense writes to the three Governors responsible for the military zones, "Medical care given to the Arabs is an important political issue and special attention should be dedicated to it" (Gilon January 2, 1952). While Gilon's use of "politics" remains unspecified in the archive, I understand this use of politics as a reference to the growing recognition among Jewish-Israelis of the permanent place of Palestinians within the Israeli state. As citizens, even marginalized and confined ones, Palestinian were granted suffrage and gained political clout to vote and to demand social services. Providing medical care became an important political goal as it was a means to win votes.

Despite having been granted citizenship in the 1950s, the terms used to define the Bedouin remained, and to this day remain, uncertain. Within correspondences between the Military Government and the Ministry of Health a constant blurring and negotiation of terms exists. The Bedouin are referred to as residents (*toshavim*), citizens (*ezrachim*), and minorities (*miyotim*). Policy makers, military personnel, and physicians used these terms to argue for a particular set of responsibilities, obligation, and rights of government

offices and the Bedouin. For example, the Military Governor requested that Dr. Koslovski to open a clinic in Nitzana and assured him the military would grant him help and accompaniment to provide medical care to the "regional residents" (Varbin October 8, 1953). Meanwhile, the Ministry of Health typically discussed the Bedouin community as "citizens," stressing that *as citizens* they also have responsibilities to the government: namely payment for medical services like all Jewish citizens. Other times, the Ministry of Health and Military Governor named the Bedouin "minorities." For example, the Ministry of Health requested the Military Governor to provide them with more accurate records of minorities' births (Moses August 1, 1951). Similarly, the Ministry of Health posted Ben-Assa's job title as "Minorities' Physician."

The complexity of names used for the Bedouins extends beyond the nomenclature of the Bedouin as a bureaucratic category. It also indicates the hierarchy of care that began to develop within the medical system. By discussing medical care of the Bedouin as providing care for citizens, government officials could maintain a discourse of equality promising medical services to all citizens. But this sameness existed in relation to a wider principle within Israel that elevated Jewish citizens as more worthy and deserving citizens. Naming Bedouin citizens and asserting to provide them with equal medical care allowed for the masking of limited resources allocated to the Bedouin citizens (in terms of the number of medical personnel and clinics). This tension between asserting an equal service while providing a differential practice is apparent in a newsletter published in February 1954 in the Ministry of Health's monthly newsletter. The editor explained the position of the Ministry of Health towards "Arab Minorities":

> Medical services to the Arab minorities (in this term all non-Jewish minorities are included) in Israel are no different or separate [*nevsalim o nifradim*]

> fundamentally from the rest of the healthcare services provided to the state's citizens [*ezrahei hamedina*]. The Ministry of Health's position on this topic is simple: the Ministry does not see any reason to discriminate between Jewish and non-Jewish population; the principle of equality to all citizens of the country requires an equal amount of medical services and medical assistance to all parts of the population and as such the services to the Arab minority are an integral part of the services given by the medical authorities (News February 1954).

Despite this official position, in practice, a complicated tension between equality and separation remained. In the case of the Bedouin "Arab minorities," medical care was provided exclusively by a "minorities physician" and was allocated in separate clinics designated for Bedouin. The isolation and separation of the Bedouin in the military zone, which fundamentally differentiated care, remains unmentioned in the article. Furthermore, medical services themselves were often designed as separate. For example, in regards to tuberculosis care, the Ministry of Health built a "special unit for Arab tuberculosis patients" (ibid). Meanwhile despite these different and separate services for "minorities", the Ministry referred to the Bedouin as "citizens" and therefore demanded they pay for the medical services they received (despite the fact that these services were of poorer standards than the Jewish citizens). In a correspondence dated October 18, 1953, the Ministry of Health explains that it was unable to allocate another physician for the southern district, and the Bedouin need to begin contributing monetarily to their medical care like "the rest of the citizens" (Halevi October 18, 1950; Shani May 18, 1954). The fluidity of the terms minority, resident, and citizen in characterizing the Bedouin, allowed government ministries to utilize these categories not only as a way to compare and equate, but also to demand a obligations, in this case financial payment, from its citizens.

a. Equality, Milk, and Humane Influence

The gap between the official discourse of equality and the daily practices and embodiments of the porous borders of equality are apparent in the following two examples. Minutes from an October 1954 meeting in the Ministry of Health outline the discussions surrounding the possibility of establishing a new dairy in Beer Sheva. Four Jewish entrepreneurs proposed to the city that they would open this new dairy using milk from local Bedouin sources, as well as Jewish ones. They explained to the Ministry of Health officials, from whom they needed public health permits, that they received the support of the city authorities, and furthermore, the Military Governor assured them they would receive all necessary permits to export milk from within the military zone. Yet the Bedouin, discussed above by the Ministry of Health as equal and not different or separate from other Israeli citizens, remained interned and restricted in movement and commerce by their segregation through the military zone. Mr. Frank, responsible for the National Milk Sanitation division within the Ministry of Health rejected the proposal stating that the "the Ministry of Health cannot agree to producing milk from Bedouin sources because sanitary inspection is impossible" (A New Dairy in Beer Sheva October 17, 1954). Despite the entrepreneurs' assurance that they would bring clean vessels to the Bedouin, the Ministry of Heath representative disregarded this effort claiming, "There is no value to this as long as the Bedouin's equipment remains dirty, and there is no possibility of refrigeration on site" (ibid). The project was rejected and the meeting concluded with the entrepreneurs agreeing to seek "milk sources in Jewish villages" (ibid).

Rather than questioning the absence of electricity or water in the Bedouin encampments that limited sanitation in the military zone, the Ministry of Health ruled that

such a project could not even be proposed because a sanitary inspection was impossible and the Bedouin's equipment remains *fundamentally* dirty. The problem became one of individual hygiene, not social and political marginalization. The Bedouin became, as Charles Briggs and Clara Mantini-Briggs' suggest in their work on the Cholera epidemic in Venezuela, "unsanitary citizens" (2003, 10). Warwick Anderson notes that in the case of the Philippines, American's obsession with Filipinos defection practices became a way to "render invisible the contribution of economic exploitation and social disruption" (Anderson 1995, 644). Similarly in this context, emphasizing the cleanliness (or lack thereof) of the Bedouin became a means to deflect attention away from the military rule and the poor conditions of the Bedouin. The Ministry of Health, in its role as inspector and service provider, played a pivotal role in separating the Bedouin community, and marking it as different and contaminated.[21]

Like the milk proposal, which the Ministry of Health rejected for fear of contaminating Jewish milk, Bedouins received separate medical care based on the assumption that Jewish and Bedouin communities must be divided. During the course of the military rule, four Bedouin clinics were established within the military zone. In addition, one designated "Bedouin clinic" was opened in Beer Sheva that operated on Thursdays when Bedouin men and women would travel to the city to buy, sell, and trade commodities during market day. All of these clinics were designated as specifically, and solely, for Bedouin. Binyamin Ben Assa, upon his inauguration into the position of Minorities' Physician, proposed to the Ministry of Health that Bedouin receive "sanitary and humane" training from Jewish kibbutzim (Minutes from Meeting with Mr. Johnson,

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[21]It is of importance to highlight that in all of these meetings and discussions a Bedouin representative remained absent.

Head of Region 4 and Dr. Ben-Assa May 19, 1955). The kibbutzim are quintessentially Jewish cooperative living and working spaces. As a number of kibbutzim were founded prior to the establishment of the State of Israel in the region, they had existing infrastructure and clinics that Ben Assa viewed as available for use by other citizens in the Negev. For Ben Assa, allocating medical services to the Bedouin in disparate clinics did not make sense, as he saw the kibbutzim as a means to save costs on constructing additional clinics, and as preestablished sites that could provide training and education. Ben Assa also demanded that mother and child clinics (*tipot halav)* be opened in the kibbutzim for the Bedouin in order to reduce administrative and building expenses. Yet, Dr. Yafe, the Ministry of Health's representative, rejected Ben Assa's proposals noting that *if* the Ministry opened a mother and child clinic it would do so in the Bedouin concentration, meaning within the military zone (ibid). Thus a policy of separate care, largely justified under the rubric of security, became established. Crucially, this separation remains entrenched today with separate Bedouin towns, schools, and clinics in place.

b. Tel Al-Milh

By 1955, seven years after the establishment of the military rule, only two medical clinics operated for the Bedouin community. These two clinics, one in Shuval and the second in Um Batin, operated one day a week and were to provide medical care for approximately 12,000 citizens. The confluence of politics, voting, and medical care played a role in the inauguration of the third Bedouin clinic in Tel Al-Milh.

On January 19, 1955, the clinic was set to be officially opened by the Ministry of Health. But the event, rather than a marking an achievement of improved health for the community, became the focus of a voting scheme led by the Minister which a journalist

cynically called an election campaign tour to “win the hearts of the Bedouin minority” (Correspondent January 19, 1955). The dilapidated clinic, even after its renovation, “consist[ed] of two room, small in an old building where the military governor’s representative also reside[d]” (ibid). The clinic was to be operated by the Ministry of Health, but was renovated at the Bedouin’s expense and its equipment was donated by United Nations (Correspondent January 20, 1955). In preparation for the Minister’s arrival, the Abu Rabiya tribe was asked to prepare a meal for the Minister, his staff, and press who arrived for the clinic’s grand opening. One journalist aptly captured in a mocking tone the Minister’s “trip” in the following piece, worth quoting in length:

> **“**Where is the fantasy of horses and camels?” Asked the Minister of Health Y. Sirlin at the end of the meal in the Bedouin tent in the Abu Rabiya tribe the military rule officer accompanying the Minister. “But I promised my son a real fantasy!” The officer mumbled words of apology and explained to the Minister that the fantasy didn't work out. The Minister of Health abandoned his office work, gave up attending the parliament meetings on Wednesday and traveled to the Negev to the Bedouin tribes to inaugurate a clinic in Tel Al-Milh… The clinic which was already in existence and was renovated by the Bedouin themselves at the expense of 700 Lira and the MOH equipped it with medical supplies of a few hundred liras it received from UNICEF. To mark the “event”, the Minister bothered himself and took with him over 100 individuals, workers and officials from his office, their wives, journalists, photojournalists, and film makers. Fifteen vehicles traveled with the Minister and his convoy…
>
> In the clinic’s inauguration— which consists of two rooms— the guests of honor – the Bedouin sheiks who represented their tribes—were not allowed to enter. The Minister’s entourage filled every available space… The photographers entered the clinic first and began to “immortalizing the event.” … At the end of the ceremony…everyone again got into their cars and continued their way to the Abu Rabiya tribe for a fancy lunch in a long tent as used in the infamous holidays of the Bedouin. But even here a small error took place: again the press and the photographers were late. After he [the Minister] shook the sheikh’s hand the Minister didn't want to enter the tent without the photographers documenting the ‘event’…The meal ended and the guests got up and left the place, accompanied by a sense of wonder. How do we want to educate a minority tribe if with the expense of 1000 Lira to build a clinic we permit ourselves to waste two or three

> times that amount on this futile campaign? I am disturbed by a Minister who has an entourage of over 100 individuals. Journalists and photographs hurt the feelings of the Bedouin tribes and undercut the efforts of years of education to respect and appreciate the country which the representatives of the military rule strive to provide… Why did this commotion come? Is it because in another seven months these residents will be asked to go to the polling stations? (Yacobi January 23, 1955).

This article, notes the almost hyperbolic nature of the intermingling of medicine and election politics. The Minister, who had neglected to attend to the draught and absence of medical services of the Bedouin, transformed the opening of the clinic into a festival of the Wild West—bringing such a large entourage of government officers that the Bedouin themselves were asked to wait outside of the clinic during the inauguration ceremony. Furthermore, this story captures the continued power of the imaginary Bedouin for Jewish Israelis—the Bedouin as nomadic, as fantasy, and as host.[22] While for years the Ministry of Health claimed to lack funds to renovate clinics, allocate a second physician to the district, or fully fund medical care, the Minister in his election mania neglected to attend to the financial burden incurred by the community that renovated the clinic and fed and hosted one hundred guests. Another journalist aptly captures the absurdity of the scene in the following quote: "The Bedouin asked: how much did this trip cost of the long convoy from Jerusalem and Tel Aviv to Beer Sheva? [...] Did it not cost more than the clinic itself?" (Correspondent January 23, 1955).

In response to the Tel Al-Milh Clinic inauguration, the Military Governor, who did not attend the event, informed the Ministry of Defense headquarters in a confidential memo that he was displeased by the Minister's improper behavior (Varbin January 1955). The guests of honor were left outside the clinic during the inauguration, and during lunch

[22] Interestingly, the desire of the Bedouin to play the role of host continues today. One of the medical residents in Southern Hospital, for example expressed disappointment to me that the Bedouin he met were not welcoming.

the Minister asked the Bedouin, “Why is there not a horse race and camels and gun shots to honor the visit?” The event, the Governor continued, was not coordinated with his forces and accounted for a “great expense” to the hosts. He concluded that the event “left strange, negative echoes among some of the escorts and the tribes’ dignitaries” (ibid). Thus it was the Military Governor, again, rather than the Ministry of Health that defended the Bedouin, noting the difference in treatment the community experienced. Furthermore, the Military Governor attested to the continued separation of the Bedouin— who live in the enclosed military zone—from the Jewish citizens in the Negev.

Tracing medical care during this period helps unpack how the borders of citizenship are actively constructed. James Holston calls the complex manner in which inequality exists within democratic states “differentiated citizenship” (2008, 6). Drawing on Holston’s insight in contemporary Brazil, the case of Bedouin citizens in southern Israel similarly reveals how citizenship remains far from a stable category characterizing a group of individuals. Citizenship itself becomes a tool to create relationships—of duties, right, and obligations. But citizenship also hides the deep fissures it inaugurates within a society. The official equality and sameness granted through citizenship, also permits a marking of difference and hierarchy. Following the debates surrounding medical allocation during this period, reveals the limits of who enters and who is excluded from citizenship. Is medical care the responsibility of the military, as Palestinian Israeli citizens were living under military rule and therefore should have received humanitarian medical care as those under occupation? Or were Palestinian citizens, particularly because they were granted citizenship, able to demand equal care from the government offices responsible for such services? This tension, that continues to

play out in the contemporary debates of citizenship and medical care, has important roots in this initial medical-military encounter.

c. Payment

One of the main dilemmas that the Ministry of Health and the Military Government faced in regards to medical service to the Bedouin was the question of payment. The subject of fees overlaps with the above debate regarding citizenship and equality. Starting in January 1951, the issue of payment arose within the documents in the archive, with the Ministry of Health demanding the Bedouin contribute to these services like other communities in Israel. For example, in regards to the clinic in Um Batin, Dr. Malchi requested that the Bedouin contributed to the funds to prepare the clinic. In a letter to the Military Governor, Dr. Malchi wrote, “In the entire country our medical service typically places the expense of the apartment and cleaning on the local people and it [The Ministry of Health] carries the expense [of medical equipment] and it will be dangerous if we make this an exceptional case” (Malchi December 12, 1950). It was the Military Governor who rejected the Ministry of Health’s request, explaining that the Bedouin could not afford to pay for such a clinic because of their economic position:

> Because of the draught and the difficult financial situation of the Bedouin I see no possibility in requiring the Bedouin to contribute monetarily to building a clinic, and I see it only as correct if the government finds the funds to help them by creating the clinic, even if it will require it to invest a small sum of money. There is no threat that this act will serve as a precedent, because other government institutions (such as the Ministry of Education) waved the contribution of this population because of their special circumstance (Hanegbi January 31, 1951).

Therefore the tension of how to place the Bedouin—as equal to other communities in Israel who contribute, or as different and requiring special circumstances— remained active throughout this period. The Ministry of Health throughout the military rule continued to demand the Bedouin to contribute financially towards their medical

expenses. This call for funding overlapped with the debates discussed previously regarding citizenship and equality. As citizens, the state used this legal category to demand their equal contribution to funding medical care *as Jewish citizens.* This was despite the fact that unlike their Jewish counterparts, the Palestinian Arab citizens were living under military rule and with little economic opportunities and limited physical movement.

The cost of medical service to the Bedouin community was initially estimated at around 6,000IL a year (by February 1954, this amount increased to 20,000IL) (Halevi March 8, 1953; Koslovski February 22, 1954). The Prime Minister's adviser on Arab issues wrote to the Ministry of Health claiming that the Prime Minister's office saw "no justification for the huge expense that the government is investing [among the Bedouin community]. … [T]here is no justification for the Bedouin tribes to enjoy it [medical services] without any monetary contribution" (Halevi March 8, 1953). One method of payment collection proposed was to tax the Bedouin, via the military government, for the medical services at a cost of twenty-five cents per individual. The proposal was rejected by the Prime Minister's office reporting that such a tax was illegal without Parliament's approval (Palmon December 21, 1952). Dr. Koslovski, the regional physician suggested a more draconian approach calling to suspend medical care, since the "halting of medical care will force them to pay" (To Governor February 16, 1954). The Bedouin, on their behalf, resisted such a tax claiming that the current medical services were insufficient as only one physician was allotted for the entire Bedouin population in the region, unlike the ratio of physicians for the same number of Jewish citizens (Herman April 1953). Furthermore because of the regional physician's multiple responsibilities— within and

beyond the military zone— the Bedouin leaders reported that at times he did not arrive at all and the entire Bedouin community was left without a physician. Ultimately, the Military Government rejected the suggestions to collect taxes, arguing that this was not within the scope of the Military Governor's responsibilities (Herman April 1953).

Despite the continued growth of the Bedouin population, the size of the medical service unit was not expanded (see Figure 4). In late 1951, the Military Governor informed the Negev Regional Command that "one physician is not sufficient for the scope of this problem [of 12,000] Bedouin, and my many requested have not been answered, I demanded that a physician or at least a nurse be transferred" (Hanegbi November 25, 1951). Again in September 1953, the head of the Military Government wrote to the Ministry of Health protesting the current situation. "The work among the Bedouin is great and one physician cannot do the work in the entire region and among the Bedouin. In order for the treatment among the Bedouin to be efficient we ask that you provide a special doctor that will be designated to work with the Bedouin" (Kadish September 1953). It was only in 1954, thanks to the combined personal interest of Dr. Ben Assa to be hired as the Bedouin's physician and the pressure from the Military Governor, that a second physician was finally appointed. In practice, this meant that the number of physicians caring for the Bedouin population remained the same: one. Dr. Koslovski, who had balanced serving both the Beer Sheva region and the Bedouin community for five years, now became solely responsible for duties as the Ministry of Health's southern Bureau director. Meanwhile, Dr. Ben Assa became the Bedouin community's sole medical physician.

IV. Medicine and Modernization

Medical care was not only entangled within concerns over citizenship, security, and contamination. In addition, it was conceptualized by the military government, the Israeli government, and popular media as a modernization technique (Arnold 1993; Prakash 1999; Sufian 2007b; Davidovich 2004). I analyze the contemporary link between medicine and modernity in the next chapter, but it is important to emphasize that modernity was a discourse already in place in the early years following the founding of Israel that justified differential treatment and service to the Bedouin. Aviva, who was a head nurse in the southern region following the military rule, described to me the role of medicine in the Bedouin community as follows: "[T]he Bedouin, for thousands of years lived like that, things were good for them. And then we wanted to bring them to civilization and make them like, like Jews. But they are not at all like Jews. Because they are built differently." Aviva, like her medical colleagues positioned the Bedouin in contrast to the Jewish population; the Jewish population was placed as a mark indicated modernity that the Bedouin needed to be directed towards. But within the aim of bringing 'civilization' to the Bedouin, Aviva also identified the impossibility of the task. The Bedouin in her narrative are fundamentally different and therefore unable to reach civilization and modernity.

Like Aviva's characterization of the Bedouin as "built differently", a Ministry of Health circular from 1954, characterized the Bedouin as "still stuck in a lifestyle of the Middle Ages" (News February 1954). The Bedouin, despite being granted citizenship and despite the Ministry of Health and the Prime Minister's office demanding them to act like other Jewish communities in Israel, were continuously marked as backward, remnants of the past, "isolated" and "primitive" (Negev Desert Doctor No Year), and "frozen for

thousands of years" (Artsieli No Year). The Bedouin were therefore placed in an impossible position where because of their essentialized difference could not achieve equality on par with their Jews peers.

These Orientalized descriptions of the Bedouin as nomadic, primitive, and isolated are folded into descriptions of medical care— focusing more on the romantic image of the Bedouin rather than drawing attention to life under Israeli military rule, and to the community's prior relationships with the ruling Ottomans and British. The Bedouin through these descriptions are positioned as outside of history, as a frozen and unchanging unit. Importantly, in these descriptions, the Bedouin are faulted for their social and economic position: it is the Bedouin who are stuck and not advancing. Meanwhile, the full terms of exchange and power, that would include the role of the Jewish military controlling movement and isolating the Bedouin from economic and social opportunities in the military zone, remain unaddressed. Thus modernization remained an impossible goal. Like equal citizenship, it marked an endpoint that could not be reached given the terms provided (Chakrabarty 2000; Said 1994).

Importantly, it was medical practitioners themselves who embodied this "modernization" and who were given the task to advance non-modern subjects like the Bedouin. Another newspaper article characterized the entry of medical services as the final erasure of darkness among the Bedouin tribes: "Slowly the light overcomes the darkness, progress over ignorance" (Artsieli No Year). Yet if we carry the above descriptions of the Bedouin fully, as permanently marked as different, the light could never fully reach the community. Equality relied on a notion of sameness which could not be achieved; therefore difference remained continuously present and justified the

maintenance of a hierarchy of services and treatment. By positioning the Bedouin as *fundamentally different*, equality in medicine morphed into a means of justifying separate, and typically unequal, services.

A discussion between one of the oncology department nurses and a medical student exemplifies how staff characterized Bedouin families as essentially different from Jewish ones to justify the circumnavigation of equality. As the team completed discussing the medical status of each patient in the department, a medical student asked the nurse why they do not physically examine the patients each morning. Rinat, the nurse, explained that the team typically relies on families to notice any physical changes. “We give the push, the chemotherapy, but it’s the parents,” Rinat stressed, that provide essential information on the patients’ status. They serve as the eyes and ears of the team. They report if their daughter suddenly develops a fever, a rash, if anything hurts. But with Bedouin families, she stressed, it’s a problem: “Bedouin, by definition, demand less. Complain less.” They receive different medical explanation (“more primitive, simple”), and according to Rinat they are easier to manage for staff because they often don’t bother the team with incessant questions, phone calls, complaints, and demands. But, as Rinat bluntly stated, this acquiescence translates into worse health outcomes: “There is a better chance of a child dying if the parents don’t develop a good relationship with us.” Rinat told us about the case of a Bedouin patient whose medical condition suddenly deteriorated to explain to us the impact she views between Bedouin and Jewish patients in the hospital:

> There was a girl… and with her mother it was difficult to communicate. And they put in a central line, a portacath, and the department as really busy and full. And it got infected and it sat there with the sticker and didn’t change it. One hundred percent it was the nurse’s fault. But you expect the mother to say something. It’s

> like twenty-first century medicine but behavior of the Middle Ages. You expect a child to shower every day or two but then find out she showers every two weeks. And the mother doesn't say anything.

While Rinat acknowledged the nurse's failure to attend to the girls' infection, she still located the responsibility of care on the families, and specifically "on the mother." Rinat's conclusion from this experience is that Bedouin patients should only receive portacath lines as they are less likely to get infected. Here framing Bedouin as having worse hygiene than Jewish patients becomes justification for placing different catheters in patients. So while medical care is framed as identical, it is the community that becomes the justification leading to difference.

V. Early Day of Abu Assa

Dr. Ben Assa arrived to Beer Sheva around August 1954, initially as a substitute physician while Dr. Koslovski was away on vacation or military service (Koslovski July 1, 1954, November 28, 1954). Only in 1955, was Dr. Ben Assa hired as the permanent "Minorities Physician." The ties between military and medicine, and the restrictions on medicine through this relationship, are apparent in the instructions Dr. Koslovski left Dr. Ben Assa on November 28, 1954, prior to his departure for military service.

> 1. With my departure to reserve service you will need to treat [*letapel*] the Bedouins starting next week. I informed the Bedouin that next week there will be no visits to the tribes.
> 2. You must travel to the territory along with a representative of the military rule or Israel police. You are requested to avoid traveling alone to the territory for security reasons.
> 3. On Thursday you will not be able to travel because you need to treat Bedouin who come to the city on market day.
> 4. Before sending a Bedouin to hospitalization you must ensure he/she has the means to pay for the expenses of the hospitalization.
> 5. Try as much as you can to avoid giving medications from the division and try to write prescriptions to the pharmacy in order to force them to pay for medication.

6. Additional problem that may arise: visits, licenses, etc. Don't work on your own behalf but first call the Military Governor (ibid).

These instructions point to the subaltern position of medical care in comparison to security concerns and the military rule. The primary responsibility of Dr. Koslovski remained to the Military Governor, rather than to the Bedouin community. Furthermore, the fact that the Bedouin would remain without a physician for a week because of Dr. Koslovski's absence was stated without question.

These instructions provide a bulleted summary of the scope of medical services at the time. Medical personnel travelled through the military zone by a mobile clinic, and care was dispensed in two clinics in the zone or in the Bedouin clinic in Beer Sheva that operated on Thursdays. In addition, as there was no official decision regarding payment at this time, Dr. Koslovski implores Dr. Ben Assa to "force" the Bedouin to pay (see Figure 5 and 6 for images of one of the rural clinic and Ben Assa's medical visits to Bedouin encampments).

In addition to medical care, illness provided access to the city of Beer Sheva, located outside the military zone, or any other city in Israel. The assistant to the Military Governor noted in a circular to the Department of Military Rule in the Ministry of Defense in June 1955 that "military rule personnel, beginning with the representatives and to the military officers are given instruction not to delay a Bedouin who needs a physician urgently and not be strict about licenses in such cases. It should be added that any note from a physician is respected as a document that the Bedouin receives a travel permit for the time period recommended by the physician" (Shvavu June 15, 1955). Medical care provided the possibility of movement and travel out of the military zone, in addition to curative and preventative treatment. Furthermore, the physician himself

received the jurisdiction of deciding the time period of travel allowed. Thus an important synergistic relationship between the military and the medical services developed that shaped the Bedouin community's interactions with the Israeli government and the Jewish population outside the military zone.

Upon Ben Assa's entry into the role of Minorities' Physician, he focused his attention on two main goals: First, renovation of the dilapidated clinics, and second, the unresolved issue of payment. In regards to the clinics' infrastructure, according to Ben Assa the clinic in Beer Sheva was "impossible to continue working… there is no storage, no waiting room, and the clinic is 3x7 meters in size" (Ben-Assa October 15, 1955). He constantly wrote to the Ministry of Health and Military Government demanding improved facilities. By 1957, the last year records exist regarding Ben Assa in the IDF archive, Ben Assa was working in five clinics: Tel Al-Milh, Um Batin, Shuval, Sgib, and Beer Sheva. None of the clinics had been renovated, but plans were in place for three (Ben-Assa May 17, 1957).

In regards to payment, Ben Assa explained in one of his triannual reports that "it remains unclear to me why the Bedouin, who are sometimes very wealthy, need to get penicillin, otomycin, nikotivin [isoniazid] etc… free. Does the state suffer from excess money?... [T]he lack of arrangement creates excess patients and makes my work difficult. I suggested to the [military] governor [to ask] that the Sheikhs collect money… but the governor did not agree—according to him the government needs to find a proper arrangement" (Ben-Assa October 15, 1955). In January 1956, on his own accord, Ben Assa began to sell stamps for medical care. The payment was arranged as follows: "Each patient receives a card with all the medical information. The first time he pays 500 cents

[*pruta*] and each subsequent visit 250 cents only. Only whoever forgets his card pays another 500 cents. A limited number of patients (indigent and convincing liars) get free treatment. This new arrangement has improved the relationship between doctor and patient- and only sick people arrive and not those who want free cinema" (Ben-Assa January 12, 1956). For Ben Assa, charging patients for medical care transformed his work into a professional service rather than a social theater for the community. Unlike many of the correspondences within the archive that characterized the Bedouin as a homogenous population, Ben Assa saw the gradations between the Bedouin—some who maintained a status of wealth, while others remained poor. For Ben Assa, providing medical care to the Bedouin citizens like the rest of the citizens was not only a suggestion, but a practice he strove towards. As a result, he felt that care should not be provided separately. As mentioned above, he wanted medical and mother and child clinics to be shared with Jewish kibbutzim in the area. Furthermore, Ben Assa suggested that Bedouin be permitted to join the Clalit Sick Fund in order to provide some insurance benefits to the community in case of hospitalizations (Ben-Assa January 1957).

At the time Ben Assa arrived in Beer Sheva, there was only one sick fund in place in Israel, Clalit. Clalit was founded in 1911 working to "promise the health of the Jewish settlement in Israel" (Shvarts 1997, : 2, 186). Crucially, Clalit was not a national organization, but rather linked to the *Histadrut*, or the Zionist Workers' Union and was designed to provide medical care to Jewish laborers (Shvarts 1997; Filc 2009). Filc well characterizes the intimate relationship between the Jewish political goals and Clalit Sick Fund when he writes:

> The Israeli sick fund was, thus, not only part of a healthcare project but part of the labor movement's political project of building a Jewish national homeland.

> Although sick funds and other services were devoted to providing for the 'common good'—this common good was understood as answering to the goals, aspirations, and culture of the secular, social democratic, Zionist, Ashkenazi Jews (Filc 2009, 26).

With the establishment of the State of Israel, because of resistance from the Israeli Medical Association and the *Histadrut,* universal healthcare legislation was not passed and *Clalit* became the de facto provider of health care services in the country. Only in the 1950s did the *Histadrut*, and thus *Clalit*, began insuring Israeli Palestinians, including the Bedouin (Filc 2009, 27). Prior, Palestinians living in the region received medical care from private physicians in urban centers (both Jewish and Arab), medical services provided by the British Mandate, and from folk healers in the region (Shvarts 1997).

Unlike his predecessors who insisted that payment for medical services by the Bedouin should be identical to the rest of citizens, Ben Assa suggested that given the disparities in medical service fees should also be reduced. According to Ben Assa, "The payment can be smaller than the payment for Jews, as we cannot give them [NR: the Bedouin] all the services the Jews receive. For example, there is no way that Kupat Holim [NR: Clalit Sick Fund] will find six physicians for 13,000 Bedouin in the Negev, and I don't think that it will be possible to find enough clerks or to build enough proper clinics" (Ben-Assa January 1957). Simultaneously, Ben Assa increased the services and number of patients seen monthly. In 1950, an average of 273 patients were seen, while by 1957, an average of 853 patients were seen monthly (Figure 3).

a. Local Medics and Local Research

For Ben Assa, hiring a local medic or assistant was a priority upon his arrival to the service. In 1955, he requested the Ministry of Health to send Bedouin to receive training in the kibbutzim (Minutes from Meeting with Mr. Johnson, Head of Region 4 and Dr. Ben-Assa May 19, 1955). He similarly petitioned the Ministry of Health to

permit Bedouin to attend a medic training course in Nazareth (Ben-Assa January 12, 1956). Starting in September 1955, two Bedouin girls, both fifteen, joined Ben Assa's team as assistants in the Beer Sheva, Um Batin and Tel Al-Milh clinics (Ben-Assa October 15, 1955). Ben Assa explained their role to the Ministry of Health as follows: "The students do not receive any salary and help only among women and children. As this medical work is certainly against the Bedouin customs, it is difficult to know if these girls will continue to work and it is will be possible to find helpers for the two other clinics" (Ben-Assa October 15, 1955, November 25, 1955, April 22, 1956). Despite his concern, both girls continued to volunteer with Ben Assa twice a week for at least two years. Unfortunately, when Ben Assa tried to pay these students, the Ministry of Health was unable to find funding (Ben-Assa August 22, 1957).

Ben Assa hoped to send a Bedouin student to a registered nurse course, but this was ruled as unfeasible as he could not find a Bedouin who had finished eighth grade (Ben-Assa April 22, 1956). In addition, Ben Assa tried to arrange for candidates to receive training in Hadassah hospital in Beer Sheva, but the Military Governor rejected the candidates for security reasons (ibid). Ben Assa finally managed to send Halil Muhammad Abu Alhaj Al Quirnawi of the Al Uqbi tribe to receive three months of medic training in Nazareth (Ben-Assa August 14, 1956). Ben Assa wrote to the the Ministry that "the young man makes an excellent impression, [he] speaks and writes Hebrew and Arabic and I am hopeful he will be a good helper" (ibid). Halil, according to Ben Assa "worked for five years in the school… and is very interested in learning. He seems like the right type" (Ben-Assa April 22, 1956) and "can be trusted" (Pratt No Year). Nonetheless, upon the young man's return to the Negev, Ben Assa was frustrated

by Halil's lack of ability "to learn enough, as he did not complete eight grades of elementary school" (Ben-Assa August 22, 1957).

The conditions Ben Assa worked in continued to be challenging. The jeep he relied on to access the clinics completely broke down in 1956 to the point that Ben Assa reported to his superiors, "The jeep is present more in the garage than on the road… The roof and front windshield fell apart, such that we are enjoying the sunshine and sand storms straight into our face" (Ben-Assa August 14, 1956). The clinics in Beer Sheva and Um Batin remained run down, even after assurance of renovation and securing funding from the Ministry of Health (ibid). Only in 1958 was the renovated Bedouin Clinic in Beer Sheva opened (Figure 7). At the conclusion of a year and a half as the Minorities' Physician, Ben Assa summarized the situation as follows:

> After more than a year of work I need to conclude, sadly, that the level of medical services to the Bedouin is not satisfactory. I am not certain why the Bedouin who are citizens of the country need to receive treatment that is more primitive than the Jews. I know that there is a lack of physicians but one doctor for 13,000 people in the State of Israel is below the minimum. There needs to be the possibility to send me an assistant. The lack of transportation and unsuitable buildings make the doctor's work difficult. Of course I cannot continue in these conditions for much longer, and I ask you give the possibility to develop a better service (ibid).

But the conditions did not improve, and Ben Assa continued in his position. As Clara recollected, "He always took the Bedouin's side." Clara told me of the trouble Ben Assa faced in recruitment staff to the unit:

> No one wanted to come … The people were so dirty and they wouldn't work with them… [A]nd the Ministry of Heath also were not willing to, it was no longer the years when they sent physicians. That was when we arrived in the 50s but that ended quickly. Each physician found work for himself, but the work among the Bedouin was, first of all, the salary of a doctor in the government service which was very low. And usually they didn't have the option to also have private

practice because for that you needed a house or somewhere to see [patients]… They left and left and left without end or became sick or other reasons.[23]

Beyond the problem of staff and insufficient services, Ben Assa remained critical of Bedouins used as exotic research material for scientists. Because the Bedouin had a number of diseases not found in the Jewish population, they became objects of research, typically without compensation. Clara, on the subject of research, explained to me that her husband was furious on the emphasis of research rather than improved access to care. "My husband, I remember, was pretty angry. When the University was founded in the Negev, the Bedouin were for doing research, and writing about it… They [the experts] found that they [the Bedouin] had diseases we don't have. If you look there is research, research, research and very little services." The Bedouin even within the medical system were understood as different, and thus requiring different medical care and hosting different disease.

Following the Six Day War, Israel occupied the Sinai Peninsula. As part of its military rule in Sinai, as during the *siyag* in the Negev/Naqab, the Ministry of Health, in coordination with the army, provided medical care to the Bedouin civilians living in Sinai (see below).[24] Ben Assa was asked, following his departure from the southern Bureau, to serve as a consultant physician and to provide medical care to the Bedouin in Sinai. Ben Assa flew to Sinai weekly and spent two days visiting various towns and Bedouin encampments. In one of his monthly reports from these trips, Ben Assa wrote an angry

[23] In Ben Assa's quarterly reports to the Ministry of Health submitted between 1955-1957, he reported three different nurses. The first, "Rachel Chen went on vacation on 11.8.55 and never came back" (Ben-Assa October 15, 1955).

[24] The medical service was organized in a manner similar to that of the military rule in the Negev. There was a central clinic in St. Catherine where a nurse was permanently based. Physicians from Tel Hashomer or the military reserves would rotate for two week. The team, accompanied by military personnel for security, traveled by military jeep to visit patients. .I spoke with the nurse who worked in Sinai at the time. As she showed me pictures of the medical service she didn't want to show me the flag changes. She told her husband, "I am not about showing her occupation, this is about medicine."

letter to the Ministry of Health criticizing a genetic researcher who arrived from Tel Aviv and proceeded to collect 140 blood samples from Bedouin in the region despite his opposition. It is a shame," Dr. Ben Assa bemoaned, "that the administration of Tel Hashomer Hospital[25], Ms. Dr. Boneh, and her helpers, and the army administrators in the region saw it necessary to carry out a scientific study that is not for the benefit of the State [of Israel] or the Bedouin. And this is without heeding to my warnings! And I have some experience regarding treatment of the Bedouin. I am hopeful we will be able to gain the population's trust again, if not, we will need to stop the medical service in southern Sinai" (Ben-Assa March 11, 1967). Ben Assa, unlike his peers, medical establishment, and army felt he possessed a particular expertise of providing medical care to the Bedouin that required trust. Furthermore, he advocated that medical care to the Bedouin remain within the framework of medical professionalism, a framework that rejects scientific research that lacks attention to the risks and benefits to participants.

b. Orchids Don't Grow under the Ice

In 1967, following his retirement from the Ministry of Health, the Albert Schweitzer foundation conferred Ben Assa the annual award for working in the spirit of the Dutch physician who founded clinics across Africa for local communities and "serving humanity." Despite much critique, Ben Assa donated the prize money, approximately 800 Israeli Liras, to Palestinian refugee clinics in Jordan. His generous donation was met with a shower of criticism: "Are there no more needy people in all of Israel?" One newspaper quoted a disgruntled shop owner criticizing Ben Assa's decision. On national radio, a caller accused Ben Assa of "transferr[ing] [the money] to Palestinian

[25]Tel Hashomer, a governmental hospital in central Israel received responsibility to coordinate medical care to Sinai during this period.

refugees who plot against our peripheral towns and join our enemies" (Israeli Doctor Donates Scheiwter Award to Arab Refugee Children May 5, 1967). But Ben Assa envisioned his role as a physician and as a citizen in Israel as quite different in regards to the Palestinian community within and beyond the state's geographic borders. For Ben Assa, medical care was a political act, not a matter only of services or research. Clara explained to me her husband's vision of medicine as similarly linked to politics and social change: "My husband always thought that if we treat [the Bedouin] well it will have an impact, but it didn't have an impact… [M]y husband believed that with his example it might help, but I can't say it did. Many loved him, and wrote about him, and did research on the Bedouin instead of helping the Bedouin. I heard that until today people talk about him that he did something different. But he didn't really succeed."

In an interview following winning the Schweitzer prize, Binyamin Ben Assa told a journalist: "If we want to live in the Middle East we need to fulfill two requirements: 1. Knowledge of the language and culture of Arab nations. 2. Taking care of minorities based on the Old Testament's rules meaning learn to love Hagar, Hagar is within us. We ourselves are a small minority among the nations, and we need to prove that we are properly caring for our minorities" (Taito February 2, 1967). By employing the image of Hagar, the biblical second wife of Abraham who bore him Ishmael, to refer to the Bedouin, Ben Assa positioned minority groups as intimately tied to the Jewish nation, in livelihood, kinship, and obligation. Clara is quoted in a newspaper article published at the time were she explained her husband's vision: "My husband believes that many people believe, like himself, that what cannot be achieved, sadly, on the state level, can and must be done by groups and individuals, on the human plane. He was now given an

opportunity as a physician to provide a foundational donation to what he calls the need for environmental [*aclim*] change in the Jewish-Arab relations" (Dolev January 1, 1967). Binyamin Ben Assa explained in an interview to another journalist his reasoning for donating the money to a Palestinian refugee clinic:

> I know that 1000 Goldan (800IL) is not a significant sum, and I don't know at all if they received my donation, but I think it is something, not much, but a bit of good will. I think that they won't be able to reject us if we show them good will all the time. It will break them in the end. It will break their resistance- that's what I believe. No, no, I am not saying we should give up the army, but except for the army there is a lot of other things to do. I know it doesn't look okay. Yes, people look at me like I am crazy, but I am certainly not crazy... I think that we are not trying enough (Lachish circa 1967).[26]

Ben Assa saw his role as a physician and citizen as central to chip away the tension between Arabs and Jews. As he said, "I believe that every Jew in this country should help thaw the present frozen atmosphere… because orchids do not grow under the ice" (Ben Adi January 25, 1967).

VI. Critique of the Military Rule

It remains both obvious and perplexing that the military rule itself remains largely absent within the military archive. While the military rule interfaced in most interactions between providers and Bedouin patients, little material exists of the military rule in memos or letters. While the correspondences are addressed to and from the Military Governor and the Ministry of Defense, the question of why the military government was in place over a group of citizens was beyond the purview or topics discussed within these documents. Rather than challenging its presence, the military rule stayed present as a known fact, the background to the situation rather than a governmental decision.

While discussion of the military government remain largely absent from the archive, Ben Assa did write a letter to the Head of the Committee in regards to the

[26] See also an editorial written by Binyamin Ben Assa on the event (Ben-Assa March 28, 1967).

continued presence of the military government on December 15, 1955. In the letter, Ben Assa critiqued the military's current involvement among the Bedouin community. He eloquently expressed his ideals of democracy, while towing the line of security, in the following passage:

> I must conclude that the democratic and progressive government of Israel rules over the Bedouin through Sheikhs who are purely feudal and are not interested in the advancement of the nation [*am*]. An important role of our country, in my opinion, is to aim with as much energy as possible to advance education, agriculture, health, social assistance, emancipation of women, in short: to raise their quality of life in all aspects of the Bedouin and to introduce a democratic rule… In the Negev region, which is an essential territory in the Middle East, we need to fulfill these missions and begin immediately with education for the young Bedouin who are very intelligent... I understand there are security problems that require constant supervision and maybe limiting the movement of the Bedouin. But the security of the country cannot be used as an excuse to prevent any sort of action in the right direction. For example, [we can] supervise the implementation of the mandatory education law (which <u>does not</u> happen now) without granting free movement for all Bedouin…[T]he military governor in his current responsibilities cannot initiate these actions as long as he does not receive clear instruction from the government on the matter... I noticed that there is a growing bitterness among different Bedouin who complain that in the six years the government has yet to solve the compensation problem for land that was taken from them in 1949. I do not receive the impression—and I hope that I am wrong here— that the government is treating the problem in the necessary pace of <u>"tzedek, tzedek, tirdof!" (</u>emphasis in original) (Ben-Assa December 15, 1955).

Ben Assa concludes his letter with two biblical verses. The first *tzedeck, tzedeck, tirodof* –justice, justice, shall you pursue— connotes that justice should be pursued in multiple realms, pointing to the lack of justice the government pursued at the time in regards to its Palestinian-Arab citizens (Deuteronomy 16:18-20). The second, similar to the mention of Hagar above, Ben Assa writes: "And also the child of a gentile mark, for he is of your seed" (Genesis 21:13). This verse emphasizes Ben Assa's commitment to the other. According to Ben Assa, the other is not only separate from us but is also part of us. Thus

for Ben Assa, the call to provide improved service to the Bedouin community relied on a platform of justice, Jewish values, and an identification with the Bedouin.

VII. Final Days of the Military Rule and Ben Assa

Ben Assa continued working for the Ministry of Health until 1967, when he retired officially due to declining health. Yet journalists reported, and his wife confirmed, that he left due to prolonged frustration (Lahman 1976b). One journalist characterized his decision as follows:

> Those close to him know to tell that behind the formal reasons, hides deep disappointment. Dr. Ben Assa established the institutional foundation for the healthcare service in 'the Bedouin land.' He worked in the four regional clinics and one central clinic, where a mother and child clinic also operated. But he knows that for the proper service he needs three physicians, at least. He demanded from the Ministry of Health that they fill the need. But he also knows that with the difficult shortage in physicians that is present throughout the Negev region, the Ministry of Health cannot meet this demand (Dolev January 1, 1967).

In October 1967, Ben Assa was hired as a consultant of the Ministry of Health to provide medical care to the Bedouin in Sinai. After two months of weekly flights to Sinai, Ben Assa resigned due to "back pain" and "illness" (Ben-Assa December 1967). Ben Assa, having worked as the sole minorities' physician for over a decade, left the service a year prior to the dissolution of the military government in the Negev. He continued to see patients in his private clinic in the old city of Beer Sheva, until his early death at the age of fifty-eight.

In a eulogy published for Ben Assa, Prof. Lahman, the first director of Beer Sheva's Hadassah Hospital and later chair of one Southern Hospital's internal medicine departments, described Ben Assa as a "[L]iving legend that will live among us as an exemplar of a physician and man" (Lahman 1976b). Ben Assa can be read a romantic figure, who dedicated his energy and medical training to the Bedouin community. Yet I think a more accurate reading of Ben Assa, is that of a complicated man who saw

medicine as political and as having the potential to bring together diverse communities. Rather than viewing medicine as a means to sustain basic life, for Ben Assa providing medical services remained entrenched in trust, politics, and knowledge of language and local circumstances. Ben Assa, having served as military physician in Indonesia certainly carried with him Orientalized notions of the Bedouin. In an article to the Israeli Medical Association's journal *Harefuah* (The Medicine), Ben Assa published a piece entitled "The Bedouin as Patient" (Ben-Assa 1974) (see Chapter 3). Ben Assa explained in the article that his intention in publishing such a piece is there are unique aspects of caring for the Bedouin. As he explained, in the article he intended:

> To describe in brief, especially for the young physician working in the Negev or Sinai, the world outlook of the typical Bedouin, as in one generation it will be difficult to find him, his belief in terms of diseases and his access to his physicians….Knowledge of the thoughts and diseases of the Middle Eastern peoples, and their treatment, will bring us closer to them and help us to see them as cousins, dear family members. As such we can argue with them if we have significant differences (Ben-Assa 1974, 73-76).

Ben Assa therefore maintained a complex relationship of similarity and distance with the Bedouin. On the one hand characterizing their "thoughts and diseases" as different, and at the same time, as working to see his patients as kin.

What made Ben Assa unique in his practice is that he sought interaction between the Bedouin community beyond his medical profession. Clara told me how he would take their sons to sleep in the Bedouin tents, while she herself hardly had any interaction with the Bedouin community. When I inquired about the interactions between the Bedouin and Jewish communities who lived in the Negev, Clara replied, "Nearly none. It's a different part of the Negev." Dr. Kline who arrived to Israel after the Second World War from Germany, and worked in both Hadassah and Southern Hospital, said to me in an interview that there was no influence on what happened within the hospital to the larger

political-social situation in the Negev. “There is no relationship,” he asserted. “I had no relationship.” He continued:

> Sometimes a Bedouin woman would successfully go through an operation and the Bedouin husband would invite us to his tent and a few physicians and nurse from the department and threw a party, that would happen. But the rest, no. We didn't have a special bond. I know my relationship to a Bedouin was the same as that to a Jew.

As I discussed above, the use of ‘Jew’ as the standard category for the comparison of care inserts the hierarchy present in the region into health practitioners’ work. Dr. Kline like other providers I came to know and interviewed in SH, folded ethnic divisions into their answers regarding medical care.

For Ben Assa, his work with the Bedouin community extended beyond the clinic. Binyamin, his wife explained to me, was part of a group she termed *bedophiles*: “They were really excited about the Bedouin. In their vacations and life.” Ben Assa’s waiting room was decorated with Koranic verses and a large sword given as a present (Lachish circa 1967). He viewed the Bedouin Dervishes as his colleagues and he would refer patients to them; they in turn refer patients to his practice. In an interview, Ben Assa recalled how in his early days as the Minorities’ Physician he would use techniques of the dervishes, after he observed the work of one for an extended period of time. “I sometimes wrote with chalk the name of Allah on one hand of such a patient, and my name on the other. Then I told him: ‘With both God and the desert doctor working for you, you can’t miss’” (Negev Desert Doctor No Year). His interactions with the Bedouin community therefore extended beyond the hermetic realm of biomedicine and the hospital, and in that Ben Assa remains quite unique. Other providers who worked in the region at the time, characterized their work as confined, with little direct influence on themselves from the Bedouin.

The challenge of providing ‘different’, yet simultaneously identical, medical care emerged beyond the medical community. One nurse I interviewed who worked with emigrants from North Africa during the 1950s, recalled that she would cover pills in chocolate or spicy flavors, or dip cheese balls in chocolate in order to increase protein intake. Medicine needed to be molded to fit immigrants’, and the Bedouin’s, culture and background with little impact on medicine, or medical practitioners. For the other providers I spoke with, medical care was discussed as flowing from expert to patient, culturally coated to be absorbed better. Furthermore, difference, as characterized in the case of the Bedouin or Jewish immigrants, was located in the patient not within medicine itself.

VIII. Later Medical Care

By the mid-1960s, a fleet of ambulances would leave the central Ministry of Health in Beer Sheva each morning and travel to various Bedouin clinics. Aviva, who was the head nurse in the region during the 1960s, recalled this time during an interview in her home as one of ideological work, of “Zionism in the full sense of the word.”[27]

> We didn't complain. Believe me we didn't complain. When it was hot we would take ice for the vaccines. We would go crazy in the car, singing in the car, knitting.

The Bedouin community similarly saw the links between Zionism and medicine, and therefore did not always accept it as benign or beneficial to the community. For example, a week after the Ministry of Health opened a clinic in the Bedouin town Kseife, Bedouins destroyed it. Dr. Manor, who worked in the Ministry of Health’s southern Bureau, recalled in anger this demolition when I interviewed her about medical services to the Bedouin.

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[27] For further literature on the links between medicine and Zionism see: Davidovich 2004 and Sufian 2007a.

NR: "Why [was the clinic destroyed]?"
Dr. Manor: "Because. They weren't always very…. And I remember the Minister was at the opening."
NR: "What do you mean they weren't always, what?"
Dr. Manor: "Um, they had some sort of hatred, you know, that we are controlling them [*sholtim*]. Instead of appreciating this [*ma'arichim et ze*] that we come. You think it's easy for me to come with the station and drive in the rain? They were, sometimes, they felt that they weren't full residents [*toshavim shlemim*]. But it wasn't true."

Dr. Manor's choice of words of *toshavim* (residents) rather than *ezrachim* (citizens) points to the tenuous relationship of the Palestinian Bedouins in the Negev, as discussed above. Later in our conversation, Dr. Manor remarks that things have changed in the Negev and for the Bedouin. There are high schools in the Bedouin community with local teachers, not ones brought from the north. "Look… they are citizens of Israel and they deserve everything. But they themselves cause crime [*osim pashayim*]. For example, it's our land. If you drive to Tel Aviv, you see Rahat, a big city, but next to Rahat, just next to it, you see a settlement that is illegal… full houses, you see the tent, and they have electricity they have generators and it's all illegal."

"And why does it exist?" I asked, curious of her understanding of the unrecognized villages and the absence of infrastructure in these communities.

"Because they want to capture the territory" [*litfos et hashetach*].

Sarah Willen (2007), writing on migrant laborers in Israel, discusses the use of illegality as a discourse to expel laborers from the national discourse of rights. Similarly, Dr. Manor's use of the term 'illegal' transforms the Bedouin into nationalistic criminals, and discards the historical land dispossession on behalf of the state. "They don't love us like they did," she continued. "And do you think people love them like they did?" I inquired, referring to the Jewish community's earlier "bedophile" sentiment.

"If I speak for myself," Dr. Manor continued, "I really love them. But I can't say mistakes were not made. It was really difficult. There were no schools. They were illiterate… But then I remember, for example, we were also better. But these illegal buildings."

"But what they say, from what I understand, is that this is land that was theirs," I raised the counter argument, having learned to be hesitant about how to broach such issues.

"There was a law that the land from one tent to the next tent is their land. And I remember when they started building the settlement, *yeshuvim*, in front of Ramat Hovav… And I remember visiting there and telling him [one of Al Azzazme residents], and he said, this is my grandfather's land. It was my grandfather's land and it's my land and I am not going to move from here."

> NR: And what did you say to him?
> Dr. Manor: What could I say? The problem then was also air pollution in Ramat Hovav. And I said for your benefit the industry is going to grow, and where there is industry there is pollution in Israel and in Austria, despite everything that they do. [And] they didn't do everything, now it's a lot better. "No." He said it simply. "This was my grandfather's and this is mine and I am not moving."

For Dr. Manor, the man's refusal to move and to relocate away from air pollutants seemed unreasonable. Yet the longer history of land rights in the region, the history of the military government and forced dislocation, remained absent from her discussion. Her position posited the Bedouin community as illogical, purposely placing their families at risk to pollution. Alon Tal writing specifically about Ramat Hovav and the Bedouin community argues instead that it is the government that placed the Bedouin at risk: "There is little doubt that when Israel sited Beer Sheva's most-polluting chemical industries, as well as the nation's only hazardous-waste facility, it did so because it felt

that there was nobody there" (Tal 2002, 332). Therefore the role of government offices in conceptualization of the region as empty, in choosing not to see the Bedouin community as present, fails to be included in Dr. Manor's narrative.

But why did Dr. Manor discuss her work in terms of love? Dr. Kline, the surgeon I quoted above who is now in his mid-nineties also told me: "Yes there are more instruments/technologies [*machshirim*] today. *Machsirim* we didn't have, but heart we did. We had a heart [*haya lanu lev*]." Was medical care, for Ben Assa and for the Jewish medical practitioners I met during my fieldwork in the hospital, provided through a notion of love? And if love was the driver of this relationship, how does the relationship between love, security, and control merge in this notion of care provision? Angela Garcia writes that one might imagine love also as a type of care: "One based on principles of commensurability, which is ultimately a kind of care that does not, indeed cannot, end" (Garcia 2010, 199). While Garcia writes of interpersonal love and care, I find it useful to consider how this type of love-care sustains the ongoing relationship between the Jewish state and the Bedouin community.

IX. Conclusion- Where are the Bedouin in the Archive and Medicine?

The archive provides threads of sorts, directions of the relations that existed between the military, the Ministry of Health, and the Bedouin community. But the archive also casts a shadow, precisely because of its source. As these records are found in the Israel Defense Forces archive, the central library of a university named after Israel's first Prime Minister, David Ben Gurion, and Ben Assa' private collection, these materials emerge within a particular militarized format, in a bureaucratic form that cannot account for the day-to-day life of the families that visited clinics and received care from Dr. Ben

Assa, Dr.Kline, Dr. Manon, Aviva, and others. How did the Bedouin experience of medical care?

There are few notes in the archive mentioning or written by Bedouin themselves. A brief one entitled “Relocation” [*ha’avara*] is by man, Suliman, asking the Ministry of Health to relocate his family to another area where Palestinian-Israelis live. He explained that his wife has been sick with a pulmonary illness, most likely tuberculosis, and after being hospitalized in Nazareth for over a year she could not walk the five kilometers to collect water, could not live in a tent, and could not care for the five individuals in their family. The nearest doctor, Ben Assa in Beer Sheva, was at least fifty kilometers away. “I have hope that the dignified minister will fulfill my wish and take pity on us and will assist us” the man wrote (Suliman circa 1955). No response exists. A second handwritten letter addressed to the Military Governor reports that a school teacher from Al-Azzazme requests that a physician visit the area immediately due to the spread of disease from student to teacher. He informed the physician, but the physician did not arrive to visit the area (Representative February 24, 1953). But mostly, the Bedouin community remains absent from the archive. I therefore conclude this chapter with the experience of Ahmed.

I find Ahmed in the front table of a coffee shop not far from the hospital. “Let’s meet there,” he said to me over the phone earlier that same day, “the parking is easier.” Ahmed was an ophthalmologist, nearing middle age, who grew up in the Negev during the military government, and received his medical training in Italy in the 1970s through the sponsorship of the communist party. I met him to hear about the larger context of medical care in the Negev, but also to understand what it was like to be a provider who

grew up in this area. Who knows the longer history of the community, who could tell me about what it meant to receive and to provide care from beyond the archive.

The military correspondences, Ministry of Health announcements, and Dr. Ben Assa's reports, maintain a particular literary structure, a form with its stamps, seals, and letterhead that carry significant political clout (Feldman 2008; Navaro-Yashin 2012; Riles 2006). But unlike the symbolic pomp and official clout of these letters, Ahmed suggests that documents were seen as tools, for the government and for the Bedouin:

> It didn't bother people if they weren't registered [*rashom*- NR: literally written]. Whatever was written didn't matter to them. The paperwork didn't mean much [*hanayert ze lo tofes*-literal translation: the paperwork, it doesn't catch]. Paperwork, that's the state's framework [*hanayeret ze bichlal tfisa shel hamedina*].

Ahmed's attention draws me back to the role of writing—both as a state practice, a medical practice, and the practice of the anthropologist. What is being inscribed in medical files and in the archive? And what are the consequences when the writing is of no significance? When the "paperwork doesn't mean much", when it *doesn't catch*, what purpose does it then hold? It didn't bother anyone that formally on the paper one thing was written, whether someone was dead or alive, whether she had a particular illness, or whether he had a different kinship status. These practices challenge the permanence and truth claims of the paperwork, of the identification number, and the centrality of the written archive.

Ahmed continued, "The paperwork itself doesn't have value. It represents the state and they [the Bedouin] don't feel belonging. You know, I'll tell you a story. When a child was born, [the parents] didn't register/write him [*lo roshem*]. They [the Bedouin] say, 'The English were here, the Turkish were, the Israelis [are now here]. The former left, and they too will leave.' But then his kids turn seventeen and then he goes to register

them and then it can be a problem… *What is written is written but the reality is the reality*… You see such things—unreal thing. So now if someone wants to look for their roots, they won't figure this out, and a few generations no one will know. This only shows how they treat the institution [*mimsad*]. They mock [*mezalzelet*] the paperwork and in the *mimsad*. It's an external direction [*megama hitzonit*]."

Ahmed's narrative casts a shadow on the archive, on the assemblage of paperwork, questioning its authority. But furthermore, it places all forms of the writing under the lens of suspicion. Like the questioning of documents in the hospital, Ahmed raised the problem of demanding formal paperwork for land recognition among the Bedouin.

> The Bedouin have land and there was internal paperwork [*nayeret*]. The state [Israel] took over these lands and said these lands are not yours, you didn't write it in the tabu [NR: the land registration under the Ottomans, and is still used today by the Israeli government]. And when people came and said you can register your land at some point, people would say, why would we register our lands, for what? But whose paperwork is it? On the one hand they say, if you don't have paperwork, documents, but documents was the fact that we lived here. One of the Bedouin explanations [in regards to show proof of land ownership] is that to sell was okay— to sell to the state to the *Keren Kayement* [NR: Jewish National Fund]—was okay and you [Jewish agencies] would buy [from the Bedouin] but now you say that it [the land] is not yours [Bedouins']. Even today when people want to sell, they [the Israel Land Administration] immediately buy. So this is the treatment [*hityachasut*] to the paperwork. The registration is nothing. It's nothing. But it links to all sorts of places.

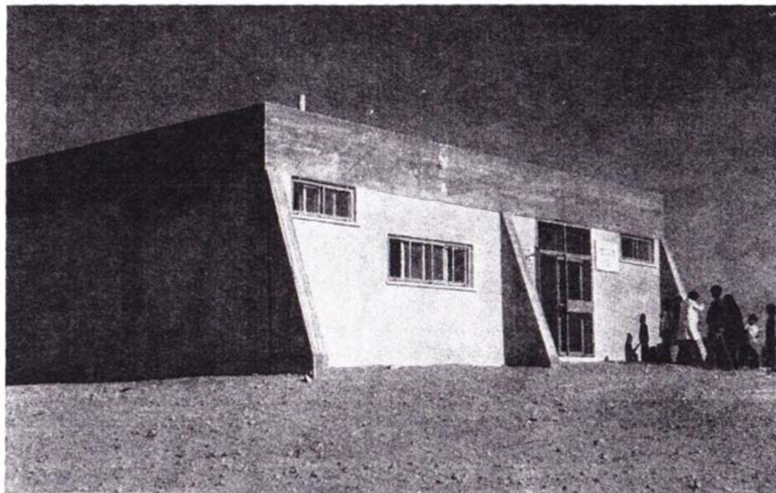
I kept Ahmed's link between medicine, births, registration, and land purposely here. This chapter has explored the links between medicine and military, tracing medical allocation during the years of military government. Yet what I argue in this chapter as well are the debates surrounding citizenship, minorities, sameness, and difference—debates that echo into the contemporary movement. Ahmed's movement between medical care, registration in the Ministry of Interior, and land rights provides a way to imagine how the realm of

medicine extends and links into the various spheres of life and community. Documentation within the hospital, presented and circulated as a fact, may be faulty and certainly is partial: having the wrong name, the identity of a deceased individual, or carrying a mockery that bureaucrats and medical personnel are not aware of. Medical care is not just medicine; it is always linked to the larger politics of division in the region.

Figure 1: Kseife Clinic named in memory of Dr. Binyamin Ben-Assa

מרפאה ותחנת אם וילד בכסייפה ע״ש ד״ר ב. בן־אסא ז״ל
תכנית פתוח סביבתי

CLINIC IN MEMORIAL OF DR. B. BEN-ASSA AT KUSEIFE
GARDEN AND PLAYGROUND PLAN



Courtesy of Tuviyahu Archive of the Negev 0764.03.010

Figure 2: Ambulance Jeep donated by Magen David Adom

Courtesy of Tuviyahu Archive of the Negev, 03794.

Figure 3: Average Monthly visits by medical team to the Bedouin 1950-1957

	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**	**Average # patients/ month**
1950	199	346											545	273
1951														
1952													5027	419
1953									889	739	343	331	2302	576
1954	314	367		419	578	413	502		867	929			4389	549
1955	801		337	399	302	1029	899	1365	874	872	639	681	8198	745
1956	332	435	447	394	711	900	984	1361	429	845		602	7440	676
1957				706	975	878							2559	853

Data drawn from IDF Archive.

Figure 4: Total Naqab/Negev Bedouin population 1955-1957

1.1.55	12234
1.1.56	12847
1.7.56	13134
1.10.56	13339
1.1.57	13359
1.4.57	13593
1.7.57	13735

Data drawn from IDF Archive

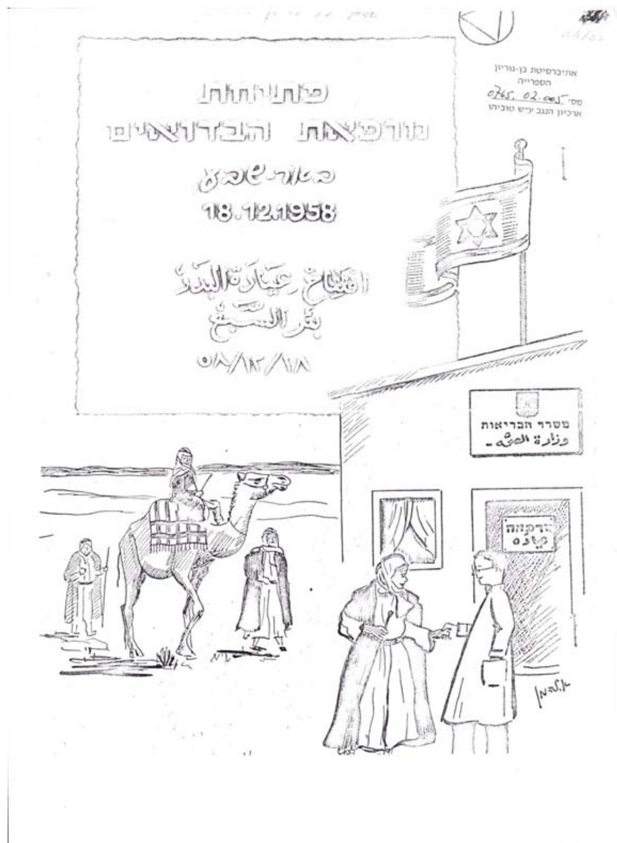
Figure 5: Bedouin Clinic under military government

Characterized as 'Rural Clinic' – *mirpa'a kfarit.* Courtesy of Tuviyahu Archive of the Negev

Figure 6: Dr. Binyamin Ben Assa visiting Bedouin tent

Courtesy of Tuviyahu Archive of the Negev

Figure 7: Invitation to the Openings of Bedouin Clinic in Beer Sheva



Courtesy of Tuviyahu Archive of the Negev 0765.02.005

Chapter 3: Creating the Bedouin and Bedouin Health

"Knowledge no longer requires application to reality; knowledge is what gets passed on silently, without comment, from one text to another. Ideas are propagated and disseminated anonymously, they are repeated without attribution; they have literally become idées reçues: what matters is that they are there, to be repeated, echoed, and re-echoed uncritically" (Said 1994, : 116).

"Perhaps the greatest achievements in Israel's efforts to convince the Bedouin of the benefits of civilization have been in the sphere of health services" (Israel Circa 1960, 5).

In the previous chapter, I examined the role of the military government in shaping medical care to the Negev Bedouin. I focused on how the tension between providing medical care to the Bedouin as citizens intersected with politics of segregation. In this chapter, I examine how the dynamics instituted by the military government shape research conducted on the Bedouin community. As Clara Ben Assa recalled, "The Bedouin were of interest to medicine. They found disease we don't have. And if you look there is research, research, research and very little services." In this chapter I bring together the corpus of medical studies published between 1952 to 2012 on the Negev Bedouin. I specifically place these medical articles at the center of this chapter as a tool to examine how ideas about "Bedouin" health emerged and changed over the past sixty years. What pasts do these medical studies carry (or neglect)? And how do particular histories enter into medical texts and circulate beyond these articles? My interest is not in the representation of the Bedouin in these texts, per se, but rather to examine the texts as a way to understand what researchers assumed the category of 'Bedouin' to entail and the threads that link these descriptions to how the past and future of the region are imagined. While I am interested in the data produced by these studies, for they begin a succession of interventions on the Negev Bedouin, my focus is on how the category of 'Bedouin' has been produced and solidified and how it circulates into the public discourse and

specifically in the healthcare domain. Research on the Bedouin, I argue in this chapter, was important not only to medicine but to the larger understanding and construction of the category of the Bedouin.

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On the first floor of the government office complex in Beer Sheva, the Regional Ministry of Health (MOH) is located. Tucked away between the Department of Planning and the Ministry of Interior, the regional office has been at the center of providing and documenting healthcare in southern Israel. I scheduled a meeting with the regional director to understand, from the policymaker's perspective, the causes of poor health among the Bedouin community. What are the interventions MOH employees see as necessary to rectify, or at least to improve, the situation? After months of emails and faxes to schedule the meeting, I arrived at the office on a scorching summer morning. The secretary shuttled me into a large conference room—a large table took up much of the space and bookshelves lined the perimeter, filled with government reports and public health textbooks. On one of the walls, the regional ministry's motto's was prominently displayed:

> *We in the regional ministry of health are proud to work with dedication and commitment to preserve and to advance public health in the Negev, while judicially relying on professional consciousness and knowing the limits of human resources available to us.*

Next to the office's motto, various placards from local towns adorned the wall, thanking the Ministry and the regional director for opening clinics in various communities throughout the Negev. The regional director for the Ministry of Health, Dr. Mankin, joined me after a few minutes. A physician and public health specialist, Dr. Mankin worked in the Ministry for over twenty years. Immediately upon beginning our meeting,

he requested his secretary photocopy articles his team published. A few minutes later the secretary returned with a stack of articles and reports from the *Lancet*, *Harefua* (*The Medicine*-The Israeli Medical Association's journal), and Ministry of Health circulars: studies examining the rates of measles among the Bedouin community, vaccination campaigns, and the impact of opening mother and child clinics. With these articles at hand—and the data they carry— we began to discuss the health of the Negev Bedouin. One of the biggest problems his office faces, he emphasized, is the absence of accurate numbers in regards to the Bedouin population. Because the Central Bureau of Statistics does not count Bedouin living in the unrecognized community, the Ministry does not have definitive numbers. "The issue of data collection is very very problematic," Dr. Mankin explained. "Two or three years ago the General Sick Fund [*Kupat Holim Clalit*] decided to eliminate nationality [*leum*] from their documents nationally, maybe also to eliminate religion. That means that when I look at their data I can't know if there is a Bedouin or not." But what does it mean *to know* if there is a Bedouin in the data?[28]

Despite the problem of data collection that Dr. Mankin raised in our meeting, hundreds of studies on the health of Negev Bedouin have been conducted since the 1950s. Yet these publications carry with them more than data on the health of the Bedouin community. They contain narratives linked to political decisions (such as not collecting data on religion or nationality) and historical trajectories of the region (such as the military rule). Yet in the case of the medical literature on the Negev Bedouin a very

[28]Krieger and colleagues argue that in the US context, the shortage of data on socioeconomic status, race/ethnicity, and immigration present impediments for addressing health disparities. "These gaps in data are not accidental, even if they might not be willful. Instead they reflect the priorities and frameworks (conscious and unconscious) of the groups who design and implement the data systems" (Krieger N 2007, 260). Kreiger has worked to improve data collection methodologies. And while data collection can certainly be improved, in the US context and in Israel, much work still remains in understanding why particular categories are utilized, others neglected, and their historical emergence.

consistent narrative, a "discursive consistency" to use Said's (1994, 273) term, of the Negev Bedouin emerges. This narrative tells a particular story of the Negev Bedouin and helps create a distinct idea of the Bedouin as research subject, as patient, and as citizen. And this narrative, as Ann Stoler (2011) stresses, is linked to the discounting of other narratives.

This chapter is divided into three sections. I begin by examining the manner two significant historical processes in the region enter into medical articles: the military rule (1948-1966) that I discussed in the previous chapter, and the construction of the government planned Bedouin towns (beginning in 1966). These two processes fundamentally altered the spatial distribution of the Bedouin in the region and enclosed the population into distinct 'Bedouin' spaces (Abu-Saad 2008b). Critically these processes launched, I argue, a narrative of 'transition that continues to haunt the idea of the Bedouin. In the second section I turn to the "state of transition" that emerged from these studies. I argue that this transition follows two trajectories that separate the Bedouin from the Jewish population as markedly distinct—in terms of bodies and spaces—and created a division between recognized and unrecognized Bedouin villages. I examine how these divisions are utilized as methodological starting points for research projects in the Negev, thus further entrenching these differences. In the final section I return to Dr. Mankin's problem of data collection and consider the type of future imagined by these narratives and the types of pasts that are discounted. I argue that the ambiguity of data may help trouble the discursive consistency of the Negev Bedouin. The uncertainty of medical studies challenges the seeming boundary dividing Bedouin from Jewish, and as

such this ambiguity may become a way to challenge the binary between Bedouin and Jew and to address some of the neglected histories of the region.

I. How Historical Events Enter into Medical Literature

In his classic study *Orientalism* (1994), Edward Said traces how a "discursive consistency" emerged around the orient in eighteenth to twentieth century literary texts (1994, 273). He argues that the representations of the orient have less to do with some "real" orient, but rather reflect the dominance of the occident over the orient. "Orientalism," Said explains, "is after all a system for citing works and authors" (1994, 23), it is a "system of European or Western knowledge about the Orient… synonymous with European domination of the Orient" (1994, 197). Western European authors penned these descriptions, casting them as fact and through the process of citationality transformed these politically charged representations into knowledge. The descriptions and characterizations of the orient become detached from their historical production. It is their presence and existence within texts that comes to matter most. Yet how did particular historical events enter—or remain excluded from—texts? In this section I focus on two events that significantly altered the spatial distribution of the Negev Bedouin and their relationship with the Israeli state: the military government and the state-planned government towns. I examine how these events are described within these texts, why their narration takes a particular form, and what echoes they carry into the present discussion of these events and the Negev Bedouin.[29]

[29] It is important to emphasize that while 1948 had significant impact in the region – politically, physically, emotionally—one of my intentions is to try to move discussions away from 1948 as an origin point. It is not that the relations between Bedouin and Jewish citizens suddenly transformed overnight—although indeed many Bedouins were killed, fled, and relocated in 1948 (Rego 2012). Yet even the events of 1948 only became significant, as Badiou (2003) suggests of another date made significant, in retrospect. In order rethink the dynamic in the region requires bridging histories through 1948, pulling threads through this cemented origin. For even the Israeli state shapes its policies and relations to the Bedouin using laws

a. Dangerous Medicine: Military Rule (1948-1966) and its Reverberations

In 1959, Dr. Benyamin Ben Assa, the Medical Officer of the Negev Bedouin (see Chapter 2), published a study entitled "Tuberculosis among the Bedouin Tribes in Southern Israel." The report, awarded the 1962 Pliskin Award, aimed to address the high rates of tuberculosis among the Negev Bedouin. Ben Assa begins the study with a description of the Negev Bedouin under the subheading "Some particulars about the Negev Bedouin":

> The Bedouin population in the Negev, the Southern dry part of Israel, was estimated in the year 1931 as between 50,000 and 70,000; only a relatively small part of these live now in the territory of the State of Israel (Ben-Assa 1959, 1).

The enumeration of the Bedouin and their link to the Negev—*the Southern, dry part of Israel* – becomes a trope that emerges throughout the medical literature, linking the Bedouin as closer to the natural elements of the desert and nomadic communities. Yet what remains different in Ben Assa's description—and those published during this period—is the specificity of the community. For Ben Assa, like his predecessor Dr. Koslovski, it was essential to "know" the Bedouin prior to providing medical care.

In his file in the Tuviyahu Archive in Beer Sheva, Ben Assa lists fourteen articles in his personal bibliography. These articles—which represent a large portion of the medical research on the Bedouin at the time—have a consistent organization. Ben Assa begins each article with enumerating the Bedouin. He then goes on to explain that the Bedouin consist of twenty tribes (later he amends this to 19 and 18). Of these tribes, according to Ben Assa, "the most important are Abu Rugayig (about 2,600), Abu Rabi'a (1,900), El Husaiyil (1,950) and Abu Quareinat (1,300). Each tribe is divided into a

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from the Ottoman and British Mandate (Yiftachel 2012). For example, the state relies on British and Ottoman rulings to justify seizure of Bedouin lands. Thus one of the tasks of writing the history of medicine in the region is looking beyond the origin and narrative told by the Israeli state.

number of clans and every clan into a number of families" (ibid. 2). He goes on to characterize Bedouin's living arrangement ("Most Bedouin still live in tents of black goat hair and move with their flocks, according to the season; but a small number of them already have stone houses. As many of them are occupied with agriculture and sheepbreeding, they are considered semi-nomads" (ibid). While the Bedouin's historical ownership and link to the land would be constantly questioned in subsequent eras, already in the late fifties, Ben Assa defined the Bedouin as semi-nomadic—having strong ties to the land and actively participating in agriculture in the region.[30]

Following the characterization of living arrangements, Ben Assa discussed family structure ("the head of the family lives in one tent with his wife or wives (up to four) and his children, widowed mother, unmarried brothers, and sister" (ibid). He then painstakingly explained the "great difficulties" of registering Bedouin patients ("One has to record the individual's name, father's name, grandfather's name, the name of the family and that of the tribe. E.g Mohammad Ismail Abdalla El Nassasre Abu Rebi'a; all these details are necessary to identify the patient" (ibid, 2-3). These details were necessary, according to Ben Assa, in order to properly register Bedouins so their medical cards could be located for follow-up purposes and for payment.

Despite the contemporary centralization of identification numbers in Israel that are shared across all bureaucratic departments (including healthcare), the difficulty of identifying Bedouin patients remained a concern for medical staff. Daniella, a pediatrician who worked in one of the unrecognized Bedouin clinics explained to me that

[30] H. Koslovski, the physician working in the region prior to Ben Assa, similarly describes the Bedouin as settled. Koslovski writes in a 1952 report: "The Bedouin cultivate the land by ancient and primitive methods of dry farming. At harvest times the whole family, including the women and children, are involved in gathering the crops by hand" (Koslovski 1952, 3).

her communication with Bedouin women is very one sided: "They know who I am and I don't recognize them. Even when I see the name. So it's less personal." Ahmed, who I introduced in the previous chapter, began working in Rahat in the late 1980s after completing his medical studies abroad. While Rahat was established in 1972, and would gain status as a city in 1994 (indicating it has over 50,000 residents), when Ahmed began working there was only one clinic in town. "I went to Rahat on Friday to fill in for someone. And I said, 'I don't want to stay here.'"

> When I got there it was hard. It was a trauma…. [There was] no phone so all the womenwould arrive in the morning and people would be given numbers. And to enter the room you would have to clear a path [*lefales*]. And people were stressed they all want to go home. And there is a pile of people. Mothers, children. I don't remember, but the families all looked alike and you had to see seventy children a day. In the ED seeing five is a lot and here seventy, eight children… There are big families of a thousand people. There are severe problems. First, they are similar—in terms of behavior and in one's memory you confuse who is who. And also in the name and so someone tells you, "No, that is my sister's son, not me."

Even for Ahmed, who grew up speaking Arabic and is familiar with naming nomenclature, because of the volume of patients needing to be seen in the single clinic serving a community of over 10,000 individuals, he confused patients. Furthermore, because until 1995 nearly half of the Bedouin did not have health insurance, at times patients would seek treatment under another individual's name that had insurance (see Chapter 1). Someone would come in for surgery that already underwent the same surgery, or someone who passed away would suddenly appear in clinic. Identifying Bedouin patients remained a challenge for Ahmed, but his explanation for this difficulty is different than Ben-Assa's. Ben Assa explained that Bedouin do not know their date of birth and sometimes "give the family name instead of the tribe's name" (Ben-Assa 1959, 3), Ahmed criticized the understaffing of the clinics in Bedouin towns that forced him to

see dozens of patients each day. "It's not a clinic," he explained to me, "It's life endangering. Dangerous medicine [*Ze lo marpea ze sakanat chaim*. *Refuat sakana*]."

Ben Assa's obsessive and detailed writings of the kinship organization of the Bedouin, naming practices, and living arrangements seem strange within a medical article today. Yet these descriptions served not as mere characterizations of the Bedouin, but rather as significant factors structuring his work. As I discussed in the previous chapter, during the 1950s and 1960s when he collected data on tuberculosis and traveled to patients by jeep (and at times camel), the entire Bedouin community was under military rule, living in a closed military zone (*siyag)*, and organized based on tribes. Ben Assa wrote in 1959:

> The Bedouin live in a closed territory of 1100km^2 North-east, East, and Southeast of Beer Sheba… They may come to Beer Sheba every Thursday (market day); in order to travel on other days and to other places they require a permit from the Military Governor. Travel permits for medical purposes (visits to hospitals, medical examinations, etc.) are always granted (Ben Assa 1959: 2).

Ben Assa remains one of the only authors to explicitly name the military government and the history of internment within medical articles. And while he does not explicitly name the violence the Bedouins experienced during this period, by writing that the Bedouin live in a "closed territory" and that 50,000-70,000 Bedouin lived in the Negev prior to the establishment of Israel and that "only a relatively small part of these live now in the territory of the State of Israel," Ben Assa hints at these events (ibid, 1). I return to the absence of the military rule and violence of 1948 within the medical literature below, but at this point I want to highlight that part of the reason Ben Assa (and Koslovski writing in 1952) included mention of the *siyag* was that as medical personnel they interfaced with the military government daily. The medical team needed military permission to travel into the *siyag*. For example, Koslovski wrote that the establishment of medical services to

the Bedouin in 1949 hinged on the agreement "of a Government Department and the Military Governor in Beer Sheva" (1952, 5).[31] A military officer initially accompanied the medical team during their medical visits, pointing to the security concerns the government had towards the Bedouin. The Bedouin themselves needed a permit from the military governor to travel anywhere outside of the *siyag*.

The links between military and medicine also organized the manner medical care was allocated (see Chapter 2). As the military zone was organized by tribe, medical care and research also followed this classification. Koslovski explained in his 1952 report that once he received the military's permission, "The team based in Beer-Sheba began to pay regular visits to all the tribal assembly points for the purposes of treating ailments, locally hospitalizing serious cases, wherever possible, and launching a campaign of preventive medical care" (ibid). These preventative measures included vaccination campaigns and tuberculosis monitoring (through Mantoux tests and radiographic screenings) were similarly organized by tribe.

The merging of military and medical categories is exemplified in a study conducted by Igal Zilber for the completion of his medical doctorate in 1961. Zilber's study examined medical reports in various hospitals throughout Israel to assess the prevalence of disease among the Negev Bedouin. On page seven of the study, Zilber presents a table outlining the number of Bedouin hospitalized in each tribe and the size of each of the eighteen tribes in the Negev (Zilberg 1961). Similarly, in a 1960 study on osteomalacia during pregnancy, the authors note that the three cases they present "were

[31] Interestingly, Koslovski characterizes the services as "experimental": "No one knew at the time the success of introducing among a semi-nomadic population, facilities which are normally dependent on static conditions" (1952, 1). Thus despite characterizing the Bedouin as 'semi-nomadic' and recognizing that they were in an enclosed military area, Koslovski still maintain the trope of nomadism.

discovered in the same tribe of Bedouine [sic] in the Southern Desert of Israel" (Salzberger M 1960, 114).

While organizing or describing research on the Bedouin through "tribes" has largely disappeared from the medical literature, this classification does haunt the characterization of the Bedouin. For example, when I requested the data on emergency department visits and hospitalizations, the excel files the head of the ED sent me were organized based on "general hospitalization" and "hospitalizations in the *migzar*."[32] Under the *migzar* heading there was a list of "tribes"- ten being the same tribes that Zilber characterizes. While medical staff did not refer to Bedouins based on a specific tribe (with the exception of associating particular diseases with particular last names), staff often evoked the term *hamula*- or clan/extended family- to describe Bedouin families. Two examples help illustrate the persistence of this notion of the Bedouin as tribal or exceeding the individual. During a family meeting in which a young Jewish woman was told her leukemia diagnosis, Smadar, one of the oncologists, told the family that the patient will be moved to the oncology department where she will be exposed to fewer infections: "It's also nicer," Smadar added, "with a computer and a TV and we try to minimize visitors, although *hamulas* still come and then we have to kick them out." While Smadar does not explicitly name *hamulas* as Bedouin, it is an assumed reference. Furthermore, characterizing the Bedouin as *hamulas* relays a particular tribal imaginary. Furthermore, stating that they need to be "kicked out" by the staff re-evokes violence as a means to deal with the Bedouin. Like Smadar, Sammy, another oncologist on staff similarly discussed the Bedouin as tribal. After a particularly difficult conversation with a

[32]*Migazar* in Hebrew literally means sector or segment, but is a term often used to describe the Arab population generally in Israel, and Bedouin specifically when used in the south.

father who wanted to terminate his son's chemotherapy treatment, Sammy turned to the medical students rotating through the department that morning. "Who does he trust?" He asked the medical students. "The older brother? Elders? Bring those people. Because [we] have to translate [the medical treatment] to the whole clan." Here Sammy depicts the father as bound within a larger kinship framework, unable to make decisions by himself. Thus the idea of the Bedouin as members of a "clan" or "tribe" still loops back into the manner the Bedouin are described and characterized today. As I discuss below, this matters as it maintains the Bedouin—despite a growing focus on transitioning— as still anchored to a tribal, non-individual past.

Beyond the emphasis on the tribal organization of the Bedouin, during the 1950s and 1960s, authors presented a view of the Bedouin as isolated—enmeshed within customs and habits. Jewish researchers assumed that Bedouins' exposure to the Israeli/Jewish society would transform the former to being more like the latter. Joseph et al in a 1964 article on pediatric tuberculosis among the Negev Bedouin sums this view when they describe the Bedouin's interaction with the Jewish-Israeli population as a first contact with modernity: "Only now they [the Bedouin] are beginning to change their thousands years old way of life and to settle on the land and learn modern agriculture. Their cultural pattern is rapidly changing under the impact of their Jewish neighbors" (Joseph 1964, 220). Researchers discussed the hospital in particular as a site for transformation. Ben Assa, in his 1959 tuberculosis study, writes: "In his well-known work on the Sinai Desert, C.S. Jarvis declared that prison life had a strong educating influence on the Bedouin in Egypt. In Israel we see a very great civilizing effect of a prolonged sojourn in a Tuberculosis hospital" (Ben-Assa 1959, 9). Hospitalization was

depicted as a means to transform the Bedouin into civilized subjects through enclosure in the confined medical space imagined as clean, hygienic, and modern (in contrast to the mobile, crowded, and unhygienic tents). The hospital, according to Ben Assa, "leaves a bold impression on the Bedouin. This is the place the Bedouin learns the Israeli manners [*minhagim*] and loves them" (Ben-Assa September 15, 1961, 212). Learning the Israeli manners was typically equated with "habits of hygiene and sanitation."[33]

Researchers discussed the impact of the hospital as particularly powerful on Bedouin women and children who were characterized across Israeli society as "the cornerstone revitalizing and building the nation" (Davidovich 2004, 164). In the hospital, according to Ben Assa, women learn to shower, wear pants, and speak Hebrew (Ben-Assa 1962, 337). The hospital was positioned as a space where Bedouin women could be liberated—wearing pants and "tak[ing] off their head-gear of golden coins." Hospitalized Bedouin children, like women, "lose their Eastern/Oriental manners and become free in their behaviors to a certain degree" (Ben-Assa September 15, 1961, 322). Medical practitioners discussed hospitalization as distancing Bedouin from their Bedouin way of life and made it difficult for patients—and especially children—to return to live within the Bedouin culture. Crucially, this transition was discussed as unidirectional, a one-way ticket towards modernity and away from the confines of tradition and Bedouin lifestyle. As Ben Assa explained: "Women get accustomed quickly to cleanliness and after long stays in the hospital they always remain cleaner" (Ben-Assa 1974, 75).

During this initial period, while the Bedouin remained confined to the military zone—and vestiges of this enclosure would continue to describe the Bedouin— it was

assumed that the exposure and living within the Israeli-Jewish environment would lead Bedouin to quickly transform into Israel/Jewish-like citizens. As Ben Assa wrote in a 1962 article, prolonged hospitalizations brought the Bedouins to be "closer to our culture" (Ben-Assa 1962, 337).

b. Transition into Bedouin Towns

In 1966, the military government officially ended and the Israeli government began implementing plans to relocate the Bedouin into government-planned Bedouin towns (Falah 1983). The first of these was Tel Sheva, located immediately outside of Beer Sheva (see Chapter 1 for further detail on the sedentarization policy). As I discussed in the previous section, prior to the existence of the Bedouin towns, the Bedouin were characterized as isolated in the *siyag* and influenced by their interaction with the Jewish-Israeli society—through the hospital and employment. With the beginning stages of planning the Bedouin towns in the mid-1960s, a theme of 'transition' began to dominate the characterization of the Bedouin. The politics of building the Bedouin towns percolated into the medical literature and medical studies of the Bedouin.

The transition narrative worked along two main trajectories: nomadic/semi nomadic → settled/permanent and traditional → modern/western/urban. I explore these continuums below, but at this point I want to stress that both trajectories remained tied to the government's desire for the Bedouin's to relocate into the government towns and into houses. The house, like hospitalization above, was viewed as the intervention needed to enclose the Bedouin from their nomadic lifestyle and to usher them into a modern space. Furthermore, relocating the Bedouin into the towns translated into confining the Bedouin into designated areas while the state could gain control of previously owned Bedouin

land. One Bedouin woman summarized this policy when she said to me that the government "want[s] the land. More people in less land. That is the policy in Israel. That's what it was and that's what it will be." The transition from tent to houses in government towns become central in medical articles as it represented the type of patient and body imagined to be treated. The hospital and home, like the laboratory that Anderson (1995) discusses in the Philippines, represents an abstract space that could be controlled.

The dominant assumption during this period was that once the Bedouin moved into the towns, they would quickly transform into modern Israel citizens no different than average Jews. The transition from tent to house and from traditional to modern lifestyle was assumed to be short lived. The certainty of this transformation is best exemplified by Ben Assa who in 1974 penned an article entitled "The Bedouin as Patient." The article, published in the Israeli Medical Association journal *Harefuah, The Medicine,* targeted young physicians working in Sinai and the Negev. "I would like to describe in brief," Ben Assa explained, "the world outlook of the typical Bedouin, as in one generation it will be difficult to find him, his belief in terms of diseases and his access to his physicians." Ben Assa characterized the Bedouin's transition as follows:

> In the last decade many change took place in the Negev Bedouin's way of life, whose number has increased during this period from 20,000 to 30,000 individuals. Most no longer live in tents, but in huts or stone buildings. One village for the Bedouin has been built near Beer Sheva [Tel Sheva], the second [Rahat], near Kibbutz Shuval, is in advanced stages of building. The modern Bedouin does not sit for hours in his guest-tent, dressed in traditional clothes, sipping coffee, and listening to the latest news while his wife does most of the work. Today the young Bedouin tends to dress in modern clothes, to drive his private car, and work in kibbutzim, moshavim and gas stations, factories, security, and construction; some even serve in the police and army. Often he speaks Hebrew well, better than the Western physician who examines him (Ben-Assa 1974, 73).

Ben Assa positions the "modern" Bedouin as behaving like the Israeli Jewish citizen—wearing modern clothes, driving a car, working in Jewish spaces, and even serving in government positions such as the police and army. As Ben Assa wrote: "The young Bedouin feels— and justly so—as an Israeli for all things. His access to physicians, his disease and his complains are similar more and more to those of the average Jew" (ibid).

Despite Ben Assa's prophecy, the "typical" Bedouin has far from disappeared from the medical sphere. Instead, both the Bedouin as subject of medical studies and the theme of transition continue to dominate and haunt descriptions of the Bedouin. Starting in the 1960s and continuing through the present, the Negev Bedouin are characterized as transitioning—and furthermore as *rapidly* transitioning. Articles ranging in topics on rotavirus, pain during labor, couple's decision to terminate pregnancy, utilization of the emergency department all characterize the Bedouin as transitioning. For example, the authors of 1990 study on the *Haemophilus influenza* in the Negev write that "most of the Bedouin in southern Israel (the Negev) are presently in a state of transition from a seminomadic way of life to a more permanent form of settlement" (Dagan 1993, 382; Halfon-Yanai 1990, 322; Dagan 1990, 315). In article after article authors repeat this theme of transition. I provide a few examples to illustrate the dominance and ubiquity of this description:

- "The transition from nomadic and semi-nomadic to permanent settlements in Israel challenges the traditional Bedouin lifestyle" (Carmel 1990, 558).
- "The Bedouin society in the Negev is in a process of transition from nomadism to life in permanent settlement" (Bilenko 1997, 699).
- Bedouins are "undergoing a rapid transition from a seminomadic to a sedentary way of life" (Sheiner 1998, 141).
- "Moslim Bedouins are in transition from their traditional nomadic life to settlement" (Levy et al. 1998, 198) .

- "The Bedouin society has been experiencing a very rapid process of sociocultural transition, moving from a seminomadic to a sedentary lifestyle" (Shoham-Vardi 2004, 870).
- "A culture in transition from a semi-nomadic to urban lifestyle" (Bilenko 2007, 426).

The theme of transition has become common knowledge among Jewish-Israelis, so often invoked that it is rarely cited—within articles and in daily conversation. For example, Jacob, a pediatrician working in Rahat explained to me that the Bedouin "are undergoing a rapid transition and [they] can't absorb all the changes in such a short period of time. Think about it, forty years [ago], that's two generations, they were in the desert." Jacob re-narrates the past of the Bedouins as living "in the desert." He thus imagines the Bedouin as living in some other space, some undefined *desert*. Yet the Bedouin that live in Rahat (and their parents and grandparents) lived in the same Negev fifty and a hundred years ago. In contrast to earlier texts that mentioned the military rule and government planned towns, now "transition" is the main characteristic of the Bedouin. But rather than transition described as a temporary process, for the Bedouin it has become a permanent state.

II. The Ongoing Transition

On the second floor of the faculty the School of Medicine, I joined a group of international health policy makers, ready to hear a lecture by the Dean entitled "Health in the Negev." The group, an eclectic assortment of American and Israeli researchers, was touring the region to learn of the current medical conditions and health programs in the Negev. After a brief tour of Southern Hospital, learning of the history of the faculty of medicine (founded on "the spirit of Beer Sheva"), and seeing the construction of the new pediatrics department, the group returned to the classroom for the Dean's lecture. The Dean began his PowerPoint slideshow with a picture of sand dunes and camels. "The

Bedouin," he explained, "is a population in transition from nomadic, semi-nomadic to settlement." The problem, he stressed, is this transition. He put up a slide with the following trajectory:

> Rapid changes from nomadic life to city → rapid change in lifestyle ancient Bedouin lifestyle to Western Modernization → Increase in MI [myocardial infarction], Stroke, Diabetes, Hypertension

The transition the Dean summarizes in his slide combines the trajectories used to describe the Negev Bedouin (Figure 8). The first moves along the axis of residence: tent to house, nomadic/semi nomadic to settled/sedentary, and rural to urban. The second trajectory operates along the continuum of traditional/ancient lifestyle to modern. This second trajectory draws into the discussion themes of development, advancement, and progress. Thus moving from tent to house and from semi-nomadic to settled become shifts towards modernization and progress. I discuss the overlap between these two trajectories below, but here I want to note that because 'transition' has become the permanent adjective describing the Bedouin *neither* transition can actually be complete. Furthermore, the endpoints of both trajectories parallel how Jewish residents of the region are described. Since Bedouins cannot become Jewish residents, this transition becomes not only the dominant theme to characterize the Bedouin, but also a dead-end.

a. Trajectory 1: From Tent → Hut → House

The first transition characterizing the Bedouin follows the trajectory of moving from tent to house (with hut often located as an intermediary residence). The dominance of this transition is evident in the methodology sections of a number of research studies. For example, in a 1984 study entitled "Infant feeding practices among Bedouins in transition from seminomadic to settlement condition in the Negev Area of Israel," the

authors compared "infant feeding practices of Bedouins in transition from seminomadism to settlement with those of urban Jews in the Negev" (Dagan 1984, 1030).[34] The researchers explain that while forty percent of the Bedouin population lives in "planned settlements in houses with electricity and running water" the remaining forty percent are "still in transition." These "transitional" Bedouins, according to the researchers, "live in tents in small isolated encampments or in sub-tribal 'shanty town' clusters of asbestos or wooden huts without plumbing or electricity" (ibid, 1029). Under the methodology section of the article, the authors explain that as their study examines transitional Bedouins, they excluded those living in permanent towns. As they write, "We excluded from the study children living in modern settlements recently built" (ibid,1030; see also Dagan 1983, 748). Type of residence (tent versus house; encampment/cluster versus town) becomes proxy for one's location along a transitional trajectory. Transitional Bedouin are assumed to be those living in tents or huts, while those living in modern settlements (aka not huts or tents but concrete houses) are stated to have completed their transition and thus not eligible to be included in the study. By linking type of residence (hut and tent = transition; house=modern), residence and developmental stage become tied.[35]

[34] And nearly identical article by the same group was published in 1983 : "Growth and nutritional status of Bedouin infants in the Negev Desert, Israel." (Dagan 1983)

[35] Interestingly, 'hut' becomes an interesting term in articles. While authors consistently characterize the tent as traditional and transitioning, and the house as permanent and modern, the hut shifts along this continuum. While in the 1983 Bedouin Infant Feeding Study the hut is linked with transitional, in other studies the hut is positioned as a permanent residence. For example in a 1990 study, the authors write: "Most of the Negev's Bedouins no longer maintain the traditional way of living in tents, but rather, they live in permanent settlements consisting of concrete houses and huts" (Halfon-Yanai 1990, 322). Again in 1998: "More than half of the Negev's Bedouins no longer maintain the traditional migratory lifestyle of living in tents, but reside in permanent settlements mainly in huts and brick houses" (Levy et al. 1998, 179). Here hut is positioned as permanent and closer to brick and concrete houses. Yet in other articles, authors describe huts as non-permanent residences. For example in a 1994 study on *Shigella* the authors characterize the Bedouin population as "in transition from nomadic lifestyle to permanent residence. Many, however, still live in huts and tents in large family units under poor hygienic conditions resembling a

A similar methodological organization is employed in the 1991 Bedouin Infant Feeding Study (BIFS) (Naggan L. 1991). Here the researchers stratified the Bedouin population based on place of residence (tent, hut, or house) and housing type (traditional, transitional, and established) (Figure 9). In a 1990 study examining cardiovascular risk factors among Bedouin men, the researchers explained that they compared the prevalence of cardiovascular risk factors among Bedouins "at different levels of adaptation to Western-like lifestyle" (Fraser 1990, 274). They contrasted a "traditional tribal group" (characterized as "very traditional" and "liv[ing] in tents widely dispersed and far from main roads") to "settled Bedouin" living in townships and other permanent settlements (Figure 10). This conflation between unrecognized villages and traditional/tribal settlement obliterates the government's role in pressuring the Bedouin to relocate into the towns and maintaining the conditions of those living outside of the towns abysmal. Instead, what the authors emphasize is the relation between Bedouin men's type of house and their "adaptation to Western-like lifestyles." Furthermore, while in the 1983 Bedouin infant feeding study "transitional" Bedouin are defined as those living in tents, in this study the authors define "transitional" Bedouin as those living in towns. Thus while these studies highlight the assumed link between housing type and development, they also display the uncertainty of these categorizations and transitions. According to the data collected by the BIFS team, in 1981, 10% of "traditional" families lived in houses, while 12% of "established" families lived in tents. Similarly, in the cardiovascular risk study,

typical developing world population" (Finkelman 1994, 367). In a 2008 study on fibromyalgia, the authors explain that "a high proportion [of the Bedouin population] that live in nonpermanent domiciles such as huts or tents" (Peleg 2008, 400). Here hut is positioned as non-permanent and closer to the tent.

11% of the "settled" population lived in tents. Thus the strict trajectory between tent to house (with hut somewhere in between) remains blurred.

Despite the blurring of this division, the trajectory from tent to house remains a dominant trope characterizing the Bedouin. In a conversation with two nurses, Mira and Sigalit, in the hematology-oncology department they explained to me that part of the problem they encountered in the hospital in treating Bedouin patients is that the Bedouin still needed to transition, to live more "like us" (echoing Ben Assa's claim that the Bedouin need to become closer to "our culture"). But becoming more "like us" translated into needing to move from tent, to shack, and then to house.

> Sigalit: The Bedouin until a few years ago were
> Mira: Until today some of them are
> Sigalit: Nomads, not a settled nation.
> Mira: It's not a nation, it's, yes, it's nomadic, they are nomads.
> Sigalit: It's their nature, it's their character [*ze haofi shelahem,ze hatchuna shelahem*]…. It will not happen in the next year, two years, next decade, it will occur after a few good generations, if at all, and it depends on their will. If in Arabic there is no such thing as tent, right? A tent is a house. They don't have such a thing as living in a tent, they live in a house. A tent is their house.
> Mira: No, there is a tent and there is a house.
> Sigalit: But a tent is a house. It's not that someone lives in a stone house then he lives in a house and the one [who lives in a tent] doesn't live in a house. That's his house! ... A person who lives in a tent and that's his house so I, think about it that for him to move and live in a house he needs to change his entire outlook [*tfisa*] of customs, of culture.
> Mira: He needs to pass through the shack and then arrive to the house.
> Sigalit: Yes, it doesn't matter
> Mira: No, I am saying yes it's just another step in the process, like he can't just
> Sigalit: The question is if he wants, if he needs this at all… Maybe their kids will be born and will really move into a house *[bayit]* and will go to the university. Maybe another generation will be born that no longer feels that his tent is his house.

The transition the nurses describe from tent and house overlaps with an imagined progress of the Bedouin developing and becoming closer to what is imagined as a contemporary form of dwelling (and crucially one similar to how Jewish families like

themselves live). This shift from tent to house is discussed as fundamentally altering the Bedouin way of life. As one of the nurses explained, "So think that for him to move and live in a house he needs to change his entire way, customs and culture." Thus the movement into a different type of residence is claimed to alter the essence of being Bedouin. But this transition is more complicated than a unidirectional movement from tent to shack to house. In stating that the Bedouin don't differentiate between tent and house, the nurse implies that even when a Bedouin lives in a house, she is still *Bedouin*. Thus even within houses, the Bedouin continue to be imagined to live like they did in a tent. Thus the earlier notion that relocating Bedouin into enclosed spaces like houses or hospitals would transform them gets stuck, and the transition becomes the permanent state of the Bedouin. The Bedouin are positioned as unable to move beyond what is imagined and discussed as 'Bedouin-ness'.

Thus even though an increasing number of Bedouin families live in permanent houses (although many of these are under threat of demolition, and thus their temporary status is imposed by the state), the link between being Bedouin and living in a tent is still imagined by many Jewish Israeli. For example, after hearing that I lived with a Bedouin family, a family acquaintance asked me whether I lived in a tent. When I replied that I live in a house he shrugged, "So they are *meturbatim*- cultured- so what's the point?" This speaker equated Bedouin with tent, and like the nurses above, moving into a house meant abandoning a perceived set of Bedouin customs and culture and becoming *cultured*—here indicating that prior to living in houses the Bedouin were uncivilized. Similarly, during the middle of my fieldwork I received an email from a close friend, Laura, from Guatemala. Laura had met a Jewish Israeli woman during her travels and

told her about my research. The woman explained to Laura that it was impossible that I lived with a Bedouin family as they all live in tents. The continued assumption that living with a Bedouin family meant living in a tent indicates the intimate tie between place of residence and Bedouin-ness.

But there is another crucial aspect to this transition. The nomadic/semi-nomadic way of life and residence (aka tents) are cast as temporary, while the settled lifestyle in concrete houses is described as permanent. Equating "settled" and "sedentary" with "permanent" re-narrates Bedouin's past in the region as temporary. It transforms the Bedouin into the non-settled residents of the Negev, who are only now moving into concrete houses and becoming permanent dwellers of the region. Permanent buildings – and specifically concrete houses—stand in for long-term presence in the Negev. Thus the relationship between Jewish and Bedouin in the region is swapped—such that the Bedouin become the temporary residents while the more recent Jewish resident who lives in a concrete houses comes to have permanent roots in the region. This transition narrative retells a story of this region as barren and empty prior to the establishment of the state of Israel (see Chapter 1). The 50,000-70,000 Bedouin who lived in the region—as they lived in tents—were not *permanent* residents of the Negev.[36]

But unlike the assumed directionality of the move from tent to house as leading to progress, Bedouin families questioned this trajectory. Fadi, a Bedouin man I interviewed in his home stressed to me that he, like many other families, refuses to move into the towns. We stood on a ridge next to his house, after he gave me a tour of his yard. I met

[36] Interestingly, according to the Dean's narrative, this transition led to worse health among the Bedouin (heart disease, diabetes, and hypertension). In his trajectory, the transition and the shift towards westernization/modernization is characterized as detrimental to health (and a romanticism of a healthy Bedouin past).

Fadi and his wife several weeks earlier in the emergency room, and I spent the morning with their family to hear about their recent experience in the hospital. Fadi looked around the desert landscape: it's windy and there is a sense in the air of openness. "In the city it's like a prison with all the houses," he said to me. Fadi has two camels, sheep, goats, pigeons, and a dog named Rex. "You like living here," I remarked. "This is the only place to live," he replied immediately. Yet it is hard living in the Negev, he stressed, there is no electricity and no transportation. But these decisions that impose uncertainty on the community are those of the government, not the Bedouin.

b. Trajectory 2: Traditional → Modern

The link between types of residence (tent versus hut versus house) parallels the second transition trajectory characterizing the Bedouin: traditional → modern. The move into the towns was assumed to transform the Bedouin into modern Israeli subjects. Like hospitalization above, the movement into the enclosed space of the town and houses was imagined to usher the Bedouin into a modern way of life. As the authors of one study explain, the Bedouin are located on the "the traditional-modern-western lifestyle continuum" (Weizman 2000, 67). The Bedouin are therefore positioned as moving from tent to house and from traditional to modern lifestyle. Through the employment of these transitional narratives, the experience of the Bedouin since the founding of the state shifts away from being linked to the military rule and the government planned towns to focusing on a discourse of modernity and abandoning traditionality. The authors of a 1994 study illustrate this narrative in the following quote: "Until the 1950s, Bedouins were a traditional and patriarchal society of nomads. During the last three decades, they have become more modern: settling in permanent villages (and building houses)" (Al-Kernawi 1994, 416). Thus moving into houses is not only linked with becoming *more*

permanent but also as becoming *more* modern. As the authors of a 1990 study write: "The urbanization process of the Bedouins cannot be differentiated from modernization" (Carmel 1990, 558). But in discussing this change as a *process* of modernization, and characterizing the Bedouin as becoming *more* modern, authors position modernity as an ever slipping goal. The Bedouin are always positioned as "not yet" modern, as Chakrabarty (2000) writes, never able to actual become modern (or permanent or settled).

The assumed distance of Bedouin from modernity was exemplified during the next leg of the policymaker's tour.[37] After the Dean's lecture, the group traveled by bus to visit one of the government planned Bedouin towns. On the way, Larry, one of the researchers, came up to me. "From your experience with the community," he asked, "And I know it's a small sample. Do they want modernity?" The question caught me off guard. "What do you mean modernity?" I replied. "You know, to advance, because there is this tension to advance but also to keep tradition." I answered that the families I know want what is best for their children and family. "It's a similar tension for Tel Aviv Families, no?" I tried to push Larry a bit, seeking to understand his meaning of modernity. "Do they let their kids watch TV?" He remained uninterested, my question comparing apples to oranges. But by questioning whether the Bedouin *want* modernity, Larry indicated that the Bedouin are not yet modern. Furthermore he positioned modernity and traditionality as mutually exclusive: Becoming modern meant *advancing* beyond tradition, it meant leaving behind tradition. But beyond questioning Bedouin's modernity, Larry raised a second issue. He characterized modernity as a personal

[37]I draw on the notion of modernity from the work of Chakrabarty (2000), and specifically the notion of the modern as equivalent with advancement or progress. As Chakrbarty and others have stressed this notion of modernity is suffused with power dynamics, such that modern marks less progress but instead becomes a proxy for the dominant group (see also Briggs (2003) for the link between language and modernity discourse).

decision. Another physician echoed this view when he said to me, "It's up to them," whether they will modernize.[38] I too in my question to Larry presented modernity as a personal decision, like choosing whether to let your kids watch television. As such I failed to actually answer Larry's question and to trouble his assumptions about modernity and the Bedouin. What remained absent from his question, and from my reply, was the government's historical role in maintaining the Bedouin as marginalized, transitional, and non-modern. One father made the link between government policies and Bedouin marginalization explicit as we waited together in the ED for his son to be seen: "They say the Bedouin stink, but it's because there is no electricity or water. They take the Bedouin's land and plant forests [*ghayarat*]. The state [*doula*] decides when to turn on the faucet [*masura*] and when to turn it out." The reason the Bedouin are "not yet" modern, according to this father, is not because the Bedouin are tied to tradition or because they don't want modernity. Instead it is the government that maintains the Bedouin as transitional and non-modern. One reading of this father's comment would be that the trajectory between traditional and modern remains the same, with the Bedouin remaining non-modern because of the government. Yet I believe this father's comments highlights that the misleading direction of the traditional → modern trajectory. Here the father does not place the Bedouin as traditional, but rather challenges what modernity entails. Modernity does not require advancement from traditionality, but can be a critique of what it is to be modern, and it can highlight the loaded power dynamics of modernity. Modernity here is removed as an end point, and becomes the entry for a dialogue of the relationship between the state and Bedouin citizens.

[38] The nurses I quote above similarly voiced this sentiment when one of them explained: "It depends on their will… The question is if he wants [this change]? If he needs it all?"

The persistence of the trope of transition can be understood through attending to how the Jewish community is described within the medical literature. While the Bedouin population is characterized as transitional, semi-nomadic, and traditional, the Jewish community is described as modern, industrial, and western. Settlement and sedentary serve as proxies not only for modernity and westernization, but crucially become equated with Jewish citizens' way of life (Figure 11). For example, in a 2000 article examining the factors influencing Bedouin women's decision to undergo prenatal testing the authors write:

> The Bedouin-Arab ethnic minority is a traditional community undergoing a rapid process of sedentarization, shifting from a semi-nomadic society to a semi-urban one… Indeed the transitional process of this formerly isolated community is going through has been accompanied by its exposure to the Israeli modern-western society and the various services such as modern prenatal health care provided by the government" (Weizman 2000, 63).

The Bedouin are described as transitioning from a semi-nomadic to a semi-urban/sedentary way of life, and contrasted to Israeli (assumed to be Jewish) modern-western society. I suggest that the overlap between the endpoint of the transition narrative and the manner Jewish citizens are characterized highlights the impossibility of this transition. This transition is ongoing as the Bedouin *cannot* become Jewish citizens. And as such, they will continue to be transitional subjects. Thus despite Ben Assa's prophecy that the Bedouin would soon disappear, the category of Bedouin and the transition of the Bedouin remain the dominant characterization of the community. The transition is a Sisyphean endeavor, doomed to perpetually elongate. Rather than Bedouin lifestyle becoming similar to the lifestyle "of the average Jew," as Ben Assa suggested, the Bedouin and Jewish populations in the region have been increasingly constructed as distinctly different categories and populations. Yet, as I discuss in the next chapter, this

difference is far from stable. It comes to be erased at moments within the hospital—when providers declare their patients to be the same, for example, or when government agencies declare that the Bedouins are treated as equal citizens. Following this difference – where it is asserted, in what form, and when it is effaced—becomes a means to understand the dynamics of categories in the region.

III. Creating Methodological Populations-The Negev as a Natural Laboratory

In the previous section I highlighted the two transitions characterizing the Bedouin community within medical literature. Researchers, medical providers, government officials employ these trajectories to justify re-narrating the Negev as empty of permanent residence prior to the founding of Israel, and to position the Bedouin as *not yet* modern. But these transitions have a second consequence: they transform the Negev into a natural laboratory to conduct comparative studies between Jewish and Bedouin citizens and between Bedouin living in the government towns and unrecognized villages. The transition narrative—and specifically the permanent transition narrative—solidifies for researchers the differences between and within the Bedouin community. These divisions, as I explore below, enter and inform how medical research is conducted. As a result, these divisions are further entrenched into scientific knowledge.

a. Comparing Jews and Bedouins: Two Distinct Populations

During the late 1980s researchers began to describe the Negev as divided between "two distinct populations." While initially the Jewish population was divided into categories based on different types of residences and countries of origin, by the 1980s a narrative emerged that collapsed the populations in the region into a binary: Jews and Bedouin. For example, in 1983, the authors characterize the region as "inhabited by two distinct populations, Jews and Bedouins, who differ markedly in their cultural, education

and socioeconomic backgrounds" (Dagan 1983, 747). The authors go on to characterize the differences between the two populations:

> The 226,000 Jewish inhabitants represent heterogeneous ethnic origins coming from different parts of the world, live in small towns or agricultural settlements and can generally be compared to a low middle-class European population. On the other hand, the 49,000 Bedouin inhabitants of the area are a Muslim population in transition from a semi-nomadic to a settlement state (ibid).

Comparing the Jewish population to "low middle class European population," casts the Jews as a cosmopolitan population, while the Bedouin remain in transition. Furthermore, while the authors acknowledge the "heterogeneous" background of Jewish inhabitants in the region, by describing the Jewish population in the Negev as similar to Europeans, the authors erase links of Jewish emigrants from non-European countries who settled in the Negev. A 1994 study comparing *shigella* characterized the two populations as follows:

> Bedouin population lives in separate towns and settlements, in transition from nomadic to settled life style. Most of the Jews enjoy Western living and economic standards, including sewage infrastructure and running water… Although some interactions occur at work, market day or hospital stays, the two communities live separately, they do not socialize together and the children attend separate schools (Finkelman 1994, 368).

Studies characterized the Jewish population as of "strikingly different ethnic, genetic, and cultural background than the Bedouin patients currently studied" (Peleg 2008, 401) and having "different sociocultural and sociodemographic characteristics" (Sheiner 2001, 453). Rather than describing the specificity of each community, authors begin to describe the Negev as "a unique area where two different ethnic groups, Jews and Bedouin, live side by side" (Gurtzk-Ozen 1998). The Jewish population in medical articles is described as "Westernized", "urban" , "modern", "compared to any developed western culture, socially and economically" (Sheiner 2001, 453) and "industrialized" (Levy et al. 1998, 179). Meanwhile, the Bedouin population is described as "resembling a typical developing world population" (Finkelman 1994, 367), "similar to Third World

populations" (Dagan 1990, 315), and "in transition to a Western lifestyle" (Fraser 2001, 421; Barkai 2005, 829). These divisions between Jewish and Bedouin population become an assumed separation of the Negev, rather than the result of historical and political decisions to keep these communities segregated. While researchers characterized the Bedouin as in permanent transition from nomadism/semi-nomadism/traditional to settled/modern way of life, the transition narrative actually set up a dichotomy between Bedouin and Jewish citizens. This dichotomy became a methodological starting point for many studies in the region, sedimenting a particular understanding of each population, and their relationship to one another. Furthermore, it eclipsed all other possibilities of methodology and comparison.[39]

Studies comparing disease or utilization of the hospital between these two groups draw on the historical division between Jews and Bedouin. Dozens of articles began to be published starting in the late eighties contrasting diseases between Jews and Bedouin. The titles of these articles themselves point to the assumed distinction between Bedouin and Jews in the region (Figure 12). These articles contribute to a narrative characterizing the two populations as completely different from one another, and yet inhabiting the same geographic space. The history of segregation, military rule, forced relocation into towns and the prolonged tension of land dispossession that created this segregation becomes

[39]It is important to highlight that one of the challenges of my own work is how to employ distinctions of these categories. For I too in my methodology and research compare Bedouin and Jewish patients, Bedouin and Jewish citizens, communities, etc. Throughout my research I have tried to maintain a relationality between these two groups rather than seeing them as a dichotomy. By this I mean that I have tried to attend to sites/conversations where characterizations of 'Jewish' and 'Bedouin' become muddled or asserted. What makes a particular patient or disease *specifically* Bedouin? What might the same encounter look or sound like if another category was used? Tracing why particular categories are salient and others marginalized has been useful in questioning particular conventions and imagining why they may look like otherwise. For example, it may be useful to consider why rural communities in southern Israel are not grouped together in research studies and compared to the urban localities? How might drawing similarities that cut across the typical divisions reorient understandings of citizenship, the state, and the Negev/Naqab? Thank you to Ian Whitmarsh for continuously encouraging me to maintain this dynamics in my research and writing.

recast as an opportunity—a natural laboratory— to study two different populations using the same hospital and medical services.

One of the results of this division is that the data collected from studies are organized in graphs and tables along this division. The complex social and historical processes that separated the population in the Negev into two seemingly mutually exclusive categories of Jew or Bedouin become further naturalized in these graphs (Latour 1986). In another study examining bacterial meningitis by "ethnic group" the authors present a table comparing their data between Jews and Bedouins (Rosenthal 1988, 631) (Figure 13). The authors of a 1993 study concluded that "they observed a striking difference in risk for hospitalization among Jews and Bedouin" (Dagan 1993, 385) (Figure 14). In a 2007 article, researchers compared hospitalization for community acquired pneumonia between Bedouins and Jews (Figure 15). These tables and graphs are ubiquitous throughout articles. And like the narratives I discuss above, they collapse the history of the region into a binary, a binary that strengthens the assumed division between these communities.

The division between Jews and Bedouin extends beyond the medical studies and shapes how diseases and spaces are described in the Negev. For example, Bedouin towns were viewed as spaces that Jews do not enter (see Chapter 1). During a dinner party that one of the Bedouin physicians hosted in his home, the Jewish staff of the oncology department worried about how they would travel into a Bedouin town at night. "Will there be a bus?" a few asked during the morning staff meeting. After several phone calls and debates over whose car to take, a number of nurses organized a car pool leaving from the parking lot of a supermarket on the outskirts of Beer Sheba. After a five minute drive

we entered the town. “It’s so close?” one of the nurses remarked. “This is the first and last time I will be here,” another one of the nursed added. Thus Bedouins towns were seen as distinctly different and separate spaces than Jewish locals. Furthermore, diseases were also classified as “Bedouin.” For example, during an interview with one of the emergency department nurses she explained to me that when she hears a particular last name is thinks of particular diseases. “Even based on the last name of the child we know that they have a lot of x disease. Because there are so many. For example, you have someone with the last name Al-Said it directly jumps at you cardiomyopathy.” Thus not only are spaces marked as Bedouin (and not Jewish) but disease come to be similarly marked. This was particularly apparent one morning in the ED when a Jewish family was admitted whose son was the only Jewish patient to have a particular genetic disease. “Only Bedouins have this disease,” the physician treating the boys kept remarking, and in this comment she asserted the assumed division between Bedouin and Jewish.

b. Transforming the Unrecognized Villages to Traditional Tribal Settlements

I have argued above that the transition narrative led to researchers dividing the region between Jewish and Bedouin. The creation of the government planned towns—and their failure—led to a second division: the emergence of the unrecognized villages (both as a physical space and a medical/research category). As I discussed above, many Bedouin, like Fadi, refused and continue to refuse to relocate into the towns. In part, this is due to the quality of the towns. Today all seven of the original Bedouin towns are among the ten poorest towns in Israel, with much of the population unemployed and supported by the state. Yet the main reason many families refuse to move into the town is the unresolved issue of land. Bedouin families who owned land prior to the establishment of Israel and whose land was seized by the State continue to seek compensation or

recognition of their ancestral land. According a report issued by the Goldberg Commission, in the 1970s, the government solicited Bedouin to petition the state for recognition of their ancestral land rights. Bedouin citizens filed 3,220 petitions summing a total of 776,856 dunams (2009, 13). Over the past forty years, government officials reviewed only 18% of these claims, and not once ruled in favor of the Bedouin. As a result, from a population of approximately 12,000 Bedouin who were forcibly relocated into the *siyag*, today approximately 100,000 Bedouin live in government planned towns and 100,000 reside in what are known as the unrecognized villages, or area the government does not recognize as residential.[40] These villages—ranging from tens to thousands of individuals—lack basic infrastructure such as roads, transportation, electricity, sewage, water, etc. Education and basic health services are provided by the state following a number of supreme-court cases, but are in dire state (Almi 2006, 2003; Abbas 2009; HRW 2001).

While activists and academics have called the unrecognized villages "invisible" (Swirski and Hasson 2006), "present but absent" (Noach 2009), and "grey spaces" (Yiftachel 2009), they appear as distinct entities within the medical literature. The separation of recognized and unrecognized villages becomes—like the division between Jewish and Bedouin population— a naturalized, rather than produced, division of in the Negev. The separation of recognized from unrecognized village in medical studies is discussed under a range of names. These include: planned versus temporary, suburban/urban versus rural, permanent versus spontaneous/non-permanent, non-typical versus typical, and established permanent settlement versus traditional tribal settlement.

[40] For comparison, despite the narrative of the Bedouin taking over the Negev, the Bedouin are petitioning for approximately 12% of land in the Negev and presently unrecognized villages make up 130,000 dunams (2009, 14).

For example, in a study published in 1990 examining cardiovascular risk factors in Negev Bedouin men, the researchers stratified the Bedouin "in relation to degree of traditionality" (Fraser 1990, 276). Bedouin men were included from two groups:

> The first, settled Bedouins from two townships, one 25Km and the other 10Km away from Beer Sheva, the largest town in the Negev… The second group, tribal Bedouins, were drawn from a very traditional tribe that lives in tents widely dispersed and far from main roads, and as a result their lifestyle has changed considerably less than that of the settled group (ibid, 274).

In the methodological organization of the study, Bedouins living in the unrecognized villages are described as "tribal Bedouins" and assumed to be more traditional than Bedouins living in government planned towns. What the authors do not mention through this description are the political decisions that maintained this division. Repeated government policies to concentrate the Bedouins into towns, to refuse recognition of Bedouin land claims, and to fail to adequately address the issue of the unrecognized villages created a population of 100,000 citizens who live without water and without the ability to build permanent homes. Thus tribal-ness and traditionality stand in (and deflect) for government neglect and poverty. The "traditional Bedouins" aka those residing in the unrecognized town are characterized by the researchers as "controls"—depicting the unrecognized villages as the prototypical Bedouin (ibid, 276). Medical research becomes intertwined with government policy as researchers utilize these divisions as legitimate categories rather than questioning their validity. The authors echo the government's concern that the Bedouin are taking over the Negev when they characterize 'traditional' Bedouin as "widely dispersed."[41] Furthermore, studies make invisible the government's role in neglecting to attend to the problem of the unrecognized villages by choosing to

[41] The authors cite an earlier article that divided the Bedouin community between "'typical' Bedouins (living in tents and working in and around the encampment) and "non-typical" Bedouins (with western-type working regardless of living condition) (Fraser 1990, 277).

term these communities "tribal" and "traditional." For example in a 2008 study examining the impact of a large industrial pollution complex on the health of the Bedouin population, the unrecognized Bedouin communities are named "traditional tribal settlements" – conflating the imagined nomadic past of the Bedouin into the contemporary unrecognized villages (Karakis I 2008). The authors of a 2006 study on the same industrial complex describe the difference between the two types of settlement as follows:

> Bedouin permanent localities are suburban settlements, erected by the state as part of the effort to stabilize the semi-nomadic Bedouin tribes. These settlements provide modern residence and municipal services. The traditional tribal settlements, on the other hand, are widespread spontaneous amassments. The inhabitants practice arid land agriculture and reside in tents or shacks with no running water or electricity (Bentov 2006, 3).

In depicting the Bedouin towns as governmental "effort to stabilize the semi-nomadic Bedouin" and suburban, the study authors portray the government planned towns as stable and safe sites of residence. The unrecognized towns on the other hand are characterized as widespread, spontaneous amassments (also discussed as "scattered" in a 2001 study), and carry forth imaginings of the Bedouin taking over the Negev, with encampments mushrooming throughout the landscape (Sheiner 2001, 453).

In naming the unrecognized villages tribal and traditional, the political history that crafted these spaces remains absent from discussion. Even when the villages are named as 'unrecognized', the reason or meaning of this unrecognition remains absent. I asked Dr. Mankin, the regional director of the Ministry of Health why in the Ministry's 2008 report on the health of Bedouin children in the unrecognized villages they did not specify the history of the unrecognized villages (Ministry 2008). "First of all, Israelis know [the meaning of the unrecognized villages]," he responded. "And it's not in English; it's not

for international publication." When I asked him to elaborate why this exempted the Ministry of explaining the details of the unrecognized villages, explaining that even within Israel many individuals, including the medical staff in Southern Hospital, do not know the history of the unrecognized villages or their current status, he turned the question to me, "You don't know the difference?" When I replied that I do, Dr. Mankin shifted the conversation to discussing the difficulty of collecting data. His failure to directly address the historical and political events that resulted in the emergence of the unrecognized villages highlights the tension that exists for Jewish providers in the Negev. Naming the history would mean needing to deal with a past that Jewish Israelis are not yet ready to address, a past of land dispossession, of internment, and of neglect. Acknowledging this past would destabilize medical categories employed in data collection for decades. Dan Rabinowitz's insight into why Jewish-Israelis refusal to name Arab-Israelis Palestinians is relevant in this context as well. Rabinowitz writes that for Jewish-Israelis to refer to Arab-Israelis as Palestinians would mean acknowledging the existence of Palestine.

> The problem that arises for most Israelis in describing citizens of the state as "Palestinian" stems from the hinted link of this category to the people and territory upon which the state of Israel was founded and exists, that which is known in Arabic as "Palestine" (Rabinowitz 1993, 144).

Like the threat of naming Israeli citizens Palestinians, detailing the emergence and significance of the unrecognized Bedouin would require implicating Jewish-Israelis in this unrecognized history.

III. Conclusion: Textual Aphasia and Re-seizing Narratives

Ann Stoler (2011) offers the term "colonial aphasia" to describe the process by which certain questions, certain histories are asked while others remain ignored. She uses the term aphasia, rather than amnesia or forgetting, to capture the active process by which

certain words are not uttered, and particular histories remain present yet inaccessible. There is a blockage that prevents their emergence and maintains their loss. "In aphasia," she explains, "an occlusion of knowledge is the issue. It is not a matter of ignorance or absence. Aphasia is dismembering, a difficulty speaking, a difficulty generating a vocabulary that associates appropriate word and concepts with appropriate things" (ibid,125). For Stoler, the issue at hand is why particular French histories—those of colonialism and racism—remain unspoken of in the contemporary discussion of immigration and security in France. Stoler gives social scientists the task to inquire why particular questions and problems are "rendered safe for public consumption" (ibid, 144) while others are pushed aside, and "how certain narratives are made 'easy to think'" while other are neglected or actively discounted (ibid, 130).

Stoler's questions in regards to French scholars' relationship to their colonial past resonates with my own work in trying to understand why particular narratives of the Negev Bedouin are ubiquitous while others remain occluded. It is not by chance that the issues brought up by Jewish-Israelis that I encountered pivoted around questions of housing, fertility, and polygamy. These three terms indexed an imagined Bedouin backwardness—as living in tents (not in modern concrete houses) and not controlling their fertility and body. Meanwhile these same individuals never inquired about the military rule, land dispossession, and the continued neglect of the Bedouin.

In Chapter 2, I focused on the historical role of the military in shaping medical care in the Negev to consider how the links between medicine and military continue today. The segregation that began under military coercion extends into the medical literature I focus on in this chapter. The separation between Bedouin and Jews and land

dispossession instigated under the guise of military control initiated the unrecognized villages that today continue to haunt how the community is understood and researched. In this chapter I interrogated the medical literature on the Negev Bedouin since the 1950s to trace how particular categories and narratives come to be inserted in the descriptions of this community. Because these descriptions are located in medical articles they come to stand as scientific fact. But precisely because of their location within medical texts—as decontextualized entities – they come to speak not as a particular discourse of the Negev Bedouin but rather as objective knowledge. As such, they become much easier to speak of, much easier to circulate, much easier to cite—seemingly removed from the military past that isolated this population and from the continued segregation of the community that makes the Bedouin population "distinctly different than the Jewish population." Medical studies and research projects—including my own—sit embedded within a trajectory of narratives, a history of stories, told and retold of the Negev Bedouin. My aim has thus been to examine what links have been severed from these histories, and to consider how reinscribing these links might change the type of narrative told of this community. Furthermore how might the health of the Bedouin community – and the type of interventions and problems raised—be different if the Bedouin were not discussed as transitional or distinct from Jewish patients?

In her text *Excitable Speech* Judith Butler (1997) theorizes the subject of hate speech. Butler forcefully argues that the problem with hate speech is not the manner that words injure or the context in which they wound, but rather the complex history they carry, cite, and sediment. What she means by process of citationality—and which I draw from—is that words carry with them a past and lead to a future. They have a temporal

horizon that is beyond their action (Koselleck 2004). As such they do not have a particular origin or end point. Butler is clear that her argument by no means intends to absolve responsibility from individuals employing hateful words, but rather her intention is to attend to the openness of words, to their possibility not only to reinstall traumas but also to open the possibility that they can be taken up and changed.

How is hate speech related to medical articles on Bedouin health in Israel? Like hate speech that is powerful because it names, these articles substantiate and materialize past histories. The repeated inscription of the Bedouin as "semi-nomadic" as "traditional" keeps these tropes tied to the community. The added volumes, studies, and articles citing one another turn these descriptions into further "scientific evidence" of Bedouin's semi-nomadic, traditional, and transitional manner. As Butler acknowledges in regards to hate speech, names can be re-seized. Precisely because they are open, their future unknown, their trajectories can change. Rather than further solidifying their marginalizing status, they can be used to point to inequalities. Because they cut out the social and political history of these categories, they can be placed within a different narrative—one based on social and political marginalization rather than blamed on Bedouin culture. Different trajectories can be imagined that do not move along a unidirectional axis from semi-nomadic → settled and traditional→ modern. For example, rather than comparing rates of disease between Bedouin and Jews, in a few articles the Bedouin have been compared to indigenous groups such as Australian Aborigines, Native Alaskan, Maori, Pacific Island, and other minority populations (Fraser 2001, 426; Lubetzky H. 2004). As such these numbers may help buttress the Bedouins claim of native rights and indigenous status.

The issue of numbers returns us to my meeting with Dr. Mankin in Ministry of Health with which I began this chapter. In stressing to me that gaining accurate data on the Bedouin community is a very serious problem for his office, Dr. Mankin acknowledged the issue of ambiguity and the openness of words and numbers. “It is very very difficult to collect data, and there is no exact data on the number of Bedouin… and on the Bedouin population generally, there is no denominator.” Dr. Mankin explained to me that the best way his office has found to assess the size of the Bedouin population is to ask Bedouin directly. The Ministry of Health has employed Bedouin interviewers in the maternity department to ask Bedouin women in regards to where they live. The uncertainty of numbers becomes a way to include Bedouin families in data collection and in specifying where and how they live, rather than these categories being imposed by researchers. Like the lack of accurate data on the size of the Bedouin population, Dr. Mankin stressed that his office also lacks data on the economic status of the Bedouin community. “I’ve been trying for years to get an index assessing the economic situation of the Bedouin, and I have no measurement!” Instead, the closest his office has found is a report published by the Israel National Council for Child on the number of families receiving supplementary income from the government (and living under the poverty line). By looking for proxy figures to better quantify the Bedouin population, Dr. Mankin raised issues of poverty and governmental neglect. By acknowledging the ambiguity and uncertainty of these numbers and studies, Dr. Mankin flags how discriminatory state policies haunt data’s apolitical and ahistorical position in medical texts. Yet as scholars have forcefully revealed, the lack of citing and the absence of data has itself been used to naturalize power relation.

In this chapter I examined medical literature on Bedouin health published from 1952-2012 and their circulating links to understand how the "Bedouin" emerged as a distinct entity that is constantly compared to, and distinguished from, Jewish citizens. I argued that through repeated medical studies, Bedouin health—and through it also the Bedouin— become a naturalized entity that is distinctly different from "Jewish". Yet despite this persistent division, within SH providers insisted that Bedouin and Jews, Bedouin from government towns and unrecognized villages, receive the same medical treatment. If Bedouin patients and Bedouin health are positioned as a unique and distinct from Jewish patients and health—how then are these bodies made equivalent in the hospital? It is to this question that I turn to next.

Figure 8: Transitions

Nomadic/semi-nomadic→ Sedentary/ Settled/Permanent/(semi-)Urban
Traditional→ Modern/Western
Developing→ Developed
Third world→ First world
Tent→ Huts→House

Figure 9: Stratification of Bedouin based on placed of residence

Table 3. Housing type by place of residence and follow-up cohort

Place of residence	House		Hut		Tent	
	n	%	*n*	%	*n*	%
Traditional (*n* = 530)						
Cohort 1981	36	10	165	48	145	42
Cohort 1982	26	14	108	59	50	27
Transitional (*n* = 443)						
Cohort 1981	32	13	161	66	50	21
Cohort 1982	21	11	149	74	30	15
Established (*n* = 579)						
Cohort 1982	162	52	114	37	36	12
Cohort 1981	171	64	71	27	25	9

Source: (Naggan L. 1991, 436).

Figure 10: Stratification of Bedouin to “Settled” versus “Traditional Tribal”

TABLE 1. – Distribution of selected characteristics of the study population groups (in percent).

	Population Group		
	Settled (n = 132)	Tribal (n = 62)	p
Age group:			
30-44	43.5	43.6	
45-59	27.5	27.4	
60+	29.0	29.0	n.s.
Dwelling in:			
Tents	11.2	53.3	
Huts	18.4	46.7	
Houses	70.4	0.0	< 0.001
Baking their own bread	56.8	96.6	< 0.001
Smoking self-rolled cigarettes from home grown tobacco	10.5	21.2	n.s.
Years of education:			
0	53.4	74.2	
1-8	16.0	11.3	
9+	30.6	14.5	0.026
Self reported Health Status:			
Excellent	17.4	20.4	
Very good	37.1	23.7	
Fair	27.3	35.6	
Poor	18.2	20.3	n.s.

Source: (Fraser 1990, 275).

Figure 11: Descriptions of Bedouin and Jews in medical literature 1952-2012

Bedouin	**Jew**
Nomadic/semi-nomadic	Modern
Non-Western	Western
Transitioning	Low Middle class European
Traditional/Patriarchal	Permanent
Tribal	Urban
Religious	
Ethnic minority	
Isolated	

Figure 12: Division of Medical Research between Bedouin and Jews

- Differences in the epidemiology of childhood community-acquired bacterial meningitis between two ethnic populations cohabiting in one geographic area (Rosenthal 1988).
- Emergency Department Utilization in Two Subcultures in the Same Geographical Region (Carmel 1990).
- Epidemiology of invasive *Haemophilus influenza* type b infections in Bedouins and Jews in Southern Israel (Halfon-Yanai 1990).
- Hospitalization of Jewish and Bedouin infants in Southern Israel for bronchiolitis caused by (Dagan 1993).
- Perinatal mortality in hypertensive disorders of Jewish and Bedouin populations (Leiberman, Kasis, and Shoham-Vardi 1993).
- Epidemiology of *Shigella* Infections in Two Ethnic Groups in a Geographic Region in Southern Israel (Finkelman 1994).
- Gestational diabetes among Bedouins in southern Israel: comparison of prevalence and neonatal outcomes with the Jewish population (Fraser 1994).
- Hospitalizations for Infectious Diseases in Jewish and Bedouin Children in Southern Israel (Levy et al. 1998).
- Differences in preterm delivery rates and outcomes in Jews and Bedouins in southern Israel (Melamed et al. 2000).
- Compliance with home rehabilitation therapy by parents of children with disabilities in Jews and Bedouin in Israel (Galil 2001).
- A Decade (1989-1998) of Pediatric Invasive Pneumococcal Disease in 2 Populations Residing in 1Geographic Location: Implications for Vaccine Choice (Fraser 2001).
- Lack of Prenatal Care in Two Different Societies Living in the Same Region and Sharing the Same Medical Facilities (Sheiner 2001).
- The Use of Developmental Rehabilitation Services. Comparison between Bedouins and Jews in the South of Israel (Lubetzky H. 2004).
- Differences between Bedouin and Jewish populations in Incidences and Characteristics of Patients Hospitalized with Community-Acquired Pneumonia (Novack 2007).

Figure 13: Distribution of bacterial meningitis

TABLE 2. Distribution of bacterial meningitis by etiology and by ethnic group in the Negev region, Israel, 1981 to 1985

Organism	No. of Cases		
	Jews	Bedouins	Total
Haemophilus influenzae type b	22 (41)[a]	20 (43)	42 (42)
Streptococcus pneumoniae	13 (25)	16 (34)	29 (29)
Neisseria meningitidis	14 (26)	6 (13)	20 (20)
Other Gram-negative bacilli	3[b] (6)	2[c] (4)	5 (5)
Group A hemolytic streptococcus	0	2 (4)	2 (2)
Staphylococcus aureus	0	1 (2)	1 (1)
Streptococcus fecalis	1 (2)	0	1 (1)
All organisms	53 (100)	47 (100)	100 (100)

[a] Numbers in parentheses, percent.
[b] Includes one case of each: *Escherichia coli*, *Klebsiella pneumoniae* and *Enterobacter cloacae*.
[c] Includes two cases of *Escherichia coli*.

Source: (Rosenthal 1988, 631).

Figure 14: Age distribution of infants admitted with RSV

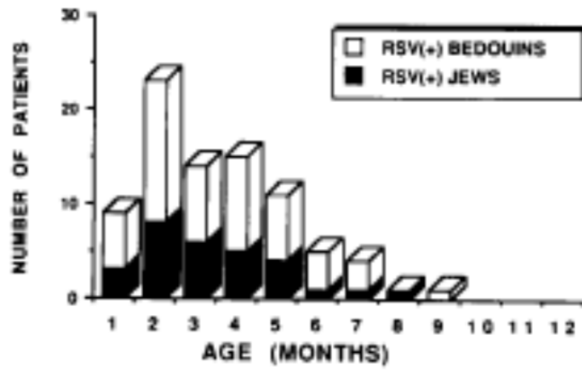
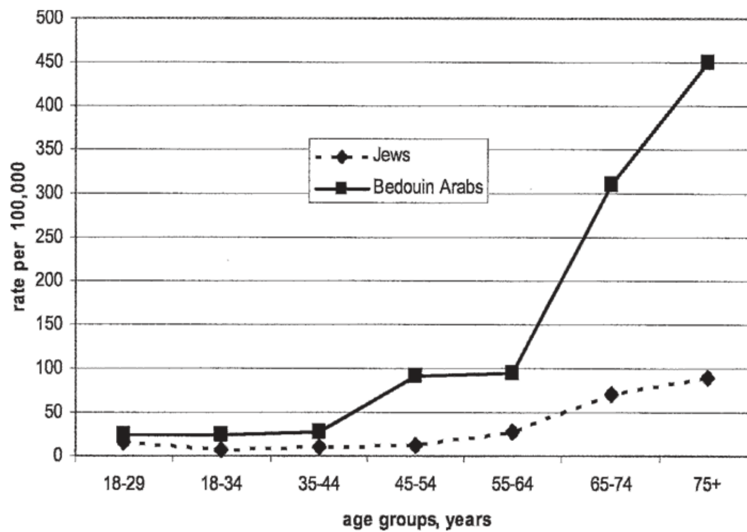


FIG. 1. Age distribution of Jewish and Bedouin infants admitted with bronchiolitis during the study period.

Source: (Dagan 1993, 383).

Figure 15: Hospitalization for community acquired pneumonia stratified by Jewish and Bedouin



Source: (Novack 2007, 443).

Chapter 4: Equivalence in the Clinic- Sameness, Difference, and Substitution

In the previous chapter, I examined the production of a distinct Bedouin people and thus, a distinct Bedouin health. Despite this produced difference that emerges through historical decisions of segregation and medical research, healthcare providers in SH asserted throughout my fieldwork that they provide the same medical care to all patients. Not only was medical care the same, but also they saw their patients as the same while under their care. Dr. Mara, a pediatric resident, exemplified this perspective when she said to me one evening: "I can tell you [that] in the emergency department [*miyun*] there is no Ethiopian, Arab, or Jewish, all are the same… The work in the ED is binary: the kids are either sick or not." I argue in this chapter that the sameness asserted by providers pivots around a "clinical subjectivity" that requires providers to learn to see particular aspects of patients while simultaneously effacing or making others aspects invisible (Holmes et al 2011). The production of sameness is therefore something that needs to be actively learned and maintained to make it possible to assert sameness in a context of social, political, and economic inequalities.

In this chapter I argue that providers employ a myopic vision to produce equivalence within the medical setting. They disaggregate patients from their social and political environments and draw specific boundaries around what and who is being treated. Patients (not people) are viewed as the same because of providers' specific biomedical interventions, the work flow in the hospital and clinic, and healthcare professionals' expressed moral responsibility to patients. These actions and attitudes contribute to making patients equivalent, or as providers declare, "the same."

I begin this chapter by presenting two different modalities through which sameness and equivalence is crafted in the hospital such that particular aspects of patients become invisible: biomedical intervention and active blindness. I argue that it is not that patients are treated and viewed as identical units, photocopies of textbook pathologies. Instead, providers bring to the fore particular parts of patients and themselves—such as diagnostics or personal connections— that make them 'the same' *within* the clinical encounter. Discussing sameness through a lens of partial erasure acknowledges that difference remains. Equivalence is therefore not a permanent status but a produced, temporary reality that remains fragile, yet necessary for the workings of biomedicine and of working as a clinical provider in a context where difference is constantly asserted.

I. Biomedical Equivalence

As the morning rush of patients subsided in the oncology department, I joined Salim, one of the staff physicians, to discuss the treatment protocol of a young Bedouin boy named Muhammad. A few patients remained in the outpatient clinic—playing board games or sitting on the computer while an IV bag hung over their head; others, too tired to play, lay on gurneys waiting for their weekly chemotherapy treatment ritual to end.

I asked Salim earlier that morning to explain to me the treatment protocols the staff used. The treatment protocols accented much of the work and interactions in the department: providers obsessively checked the protocols to know what day of treatment patients where on, whether a patient responded well to chemotherapy, what medication should be given, and continuously updated the protocol based on laboratory and imaging test results. These protocols mediated the relationship between providers, patients, and families. As one provider stated, when asked about a patient by her first name, "Tell me the treatment and I'll tell you the child." The protocol thus became the focus for families

and providers alike. As the department's social worker said to me, "The treatment [protocol] becomes the center and it becomes something strong and real."

In SH, once a patient received a confirmed cancer diagnosis, they were entered into a treatment protocol. Sammy, another one of the staff oncologists, explained to a family: "The minute we have a signed answer we open the book, we go to the page [of a particular disease diagnosis] and work from what is written. It's pretty office-y [*misradi]*." All patients in the department, with very few exceptions, were part of a treatment protocol. "It's a waste of children who are not treated in a protocol," the head of the department liked to remind the team. These protocols acted as road maps for patients and providers, dictating what chemotherapy medication patients must receive at each point in treatment. But in addition, these protocols were components of larger clinical studies designed to improve treatment regimens and cancer survivorship.

With the exception of Muhammad's hospital identification sticker and the dates of his diagnosis and treatment, nothing about Muhammad personalized his Acute Lymphoblastic Leukemia (ALL) protocol. It was a standard sheet of paper, organized into different blocks and arrows. Salim began his explanation: "When a patient with ALL arrives they [sic] are divided into three areas: standard risk, intermediate risk and high risk." A patient's risk category was assessed based on discrete criteria such as age, blood count, and genetics. Once a patient's risk was ascertained, she began a course of treatment that continued for approximately two years. During these two years her response would be assessed at several key days, according to Salim:

> There are a few critical days. Day 8- need to have peripheral blast [blastocytes] and no less than 1,000. Day 15, and Day 33, and Day 64.... *Everyone gets the same induction, there is nothing to play around with*.

Thus despite the diversity of individuals entered into these protocols, their rigid framework transformed these patients into "homogenous units" (Jain 2011, s48). Protocols, like the clinical trials Jain writes of, "eliminate any factor other than the one being tested"(Jain 2010, 99) . Thus protocols in SH actively transform individuals like Muhammad into units that can be exchanged and compared with other patients diagnosed with ALL.

The transformation of individuals into standardized patients through biomedical interventions such as protocols and diagnosis is not unique to SH. Anthropologists in an array of contexts have examined the role of protocols and clinical trials in producing equivalence among patients. Andrew Lakoff (2005) illustrates how diagnostic criteria make the illness experience of patients in Argentina commensurable with bipolar patients throughout the world. Ian Whitmarsh (2008) examines how FDA and NIH categories and genetic conceptualization of race convert asthma patients in Barbados to be equivalent with African American bodies in the United States. S. Lochlann Jain (2011) in her research on cancer survivorship forcefully writes of the cultural work of statistics and clinical trials in effacing the specificity of the lives and deaths of patients in the United States. The practice of entering patients into treatment protocols or clinical trials becomes one means by which patients are converted into equivalent units: they are diagnosed with the same disease, receive the same treatment, and become the same units within researchers' data. Meanwhile, the specificity of their lives (which may have exposed them to carcinogens) and their quality of life while receiving treatment become irrelevant once a unit of statistics. As Jain writes: "Statistics don't carry these fleshy references; statistical deaths are separated from bodies" (ibid, s49-50). This is, to use Charles

Rosenberg's (2007) phrase, "the tyranny of diagnosis" that magically converts the diversity and specificity of patients into exchangeable units.[42]

This biomedical understanding of disease echoes one way that equivalence is created in the hospital. Each protocol scheme funnels patients into their treatment regimen based on laboratory results, bone marrow samples, age, and chromosomal abnormalities. These flow charts followed patients throughout the entire treatment process, a process that took approximately two years. But while the experience of going through chemotherapy treatment is essentially personal, the biomedical intervention remains standard. Muhammad, like all ALL patients' in Southern Hospital receives the same chemotherapy treatment. Indeed, as Salim and I discussed the ALL protocol, Salim quickly stopped talking about Muhammad's specific case. He did not discuss whether the family could afford care, whether Muhammad's parents understood the regimen of taking medication, whether their house was connected to the electricity grid where some of his medication needed to be stored. Rather, Salim placed Muhammad, as the rest of the children in the department onto a track based on age, genetics, and laboratory tests that dictated each patient's level of risk. As Salim noted, *everyone gets the same induction, there is nothing to play with.* These categories and the numbers they produced cannot absorb the life histories of patients. "A number," Jain writes, "will not mold to your arches; it will not record the quality of your life" (2011, s50). Diagnostic protocols do not account or attend to a history or biography, but they do slot patients into evidence based treatment regimens that produce the capacity to claim sameness.

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[42]Anthropologists have done critical work in revealing the fluidity of these diagnostic categories—for example Dumit (2006) and Murphy (2006) examined how patients converts their symptoms into diagnostic categories that are equivalent bureaucratically so they are able to receive medical care and recognition. Whitmarsh (2010) writes of the ambiguity of asthma diagnostics, highlighting the contradictions—and changing nature—of this category.

But there remains a problem with the protocols. Rarely are they exactly followed.[43] Chemotherapy would be delayed based on laboratory results— changing the critical days dictated by the protocol. Treatments would be added depending on a patients' biomedical response. And sometimes a treatment would be altogether skipped because of missed appointments or unexpected illness. For example, as Salim and I finalized discussing the ALL protocol, he returned to Muhammad's case. Muhammad was on week seven of treatment. After surgeons excised his growth, the pathologists examined the sample and found clear margins, indicating that the surgeons completely circumscribed the tumor. The pathologist relayed this information back to the oncologists who entered Muhammad into the ALL protocol. After seven weeks on the ALL protocol, Muhammad needed to undergo a PET/CT to assess his response to treatment. "But I see in his file that earlier the dad refused to go to PET/CT because it was too far," Salim remarked. At the time of my fieldwork, there was no PET/ CT in Southern Hospital. Patients needing this diagnostic test needed to travel to another city, typically Jerusalem, about an hour and a half drive from Beer Sheva. I asked Salim what they would do if the father again refused, as a key mark in the protocol would remain unknown. "It's like a trend. Twenty years ago it was Advil, and everyone took Advil. Now it's PET/CT. There are some diseases we know it [PET/CT] is the standard- lymphoma. But a lot, glioma, teratoma, it's not the gold standard yet." So Muhammad would skip the PET/CT altering the uniformity of the protocol and in turn the sameness of data. But what Salim does not raise is the reason why the father refused to go to Jerusalem. Many Bedouin families lacked transportation to the hospital or childcare to leave other children at home for

[43] Jain makes note of this as well in a version of "The Mortality Effect" reprinted in Feldman and Ticktin (2010).

extended periods of time. Furthermore, going to Jerusalem meant navigating new roads, and an unknown medical space. While many Bedouin families did make the long trip to Jerusalem, what I want to point out is that for providers these limitations—which are tied to the political history of the region and the socioeconomic conditions among the Bedouin community—are cast as irrelevant. There is no arrow along the treatment protocol for "Patient Refuses to go to the PET/CT." The father's refusal to travel to Jerusalem hints at the manner patient differences are pushed outside of what providers view as the framework of biomedicine which allow them to maintain that Muhammad would receive the same treatment as another patient.

II. A Learned Blindness

Sammy liked to call medicine a "universal language." It's the middle of summer and we are sitting in the staff's tiny office in the outpatient department. Bookshelves of protocol manuals and medical textbooks line the windowless room. A large table takes up nearly the entire space—covered in journal articles, paper, and mounted with two microscopes. As the only room with a door in the outpatient clinic, the office/laboratory also doubled as a space to hold family meeting to tell families of a new cancer diagnosis.

Sammy caught up on his medical charting as we began our interview. "Health is one of the most elementary things that is universal enough that I can take this bible and implement it in Timbuktu and Chile," he told me. "I need to adapt it to local ability, geography, conditions, diseases, but health is the ultimate experience that does not depend on either the provider or patient." Sammy's description of health stressed that medicine is imagined as uniform—a practice that can be implemented throughout the world; its categories and epistemological underpinnings remain the same despite location. As he explained to me, "It's not that you are Bedouin and you therefore deserve such and

such laboratory tests different than those for Jews. If you are doing the work right, then you are doing it to everyone. That is why there is no division." Medicine and health in Sammy's narrative are presented as a practice of learning to treat all patients the same. As I discussed in the previous section this sameness emerged through biomedical interventions such as diagnosis, protocols, and clinical trials, but it also relies on cultivating a particular myopic view—an active blindness that suspends differences among patients. In this section I therefore shift away from the manner protocols contributed to creating sameness in the hospital and effacing difference, to the cultivation of an "active blindness" adopted by providers that permitted them not to see aspects of patients—such as social, political, economic, and historical specificity—that would undermine an claim of sameness.

Dalia began working in Southern Hospital twenty years ago. Originally from Haifa, she initially worked as a nurse in the neonatal intensive care unit (NICU), but transferred to the emergency department thirteen years ago. Like most team members in the Emergency Department, Dalia stressed that all patients get the same treatment in SH. "Everyone does the same MRI… there is no need to differentiate between population to population, not to discriminate, not to create difference." She continued:

> Dalia: I think everyone has the elementary right to receive the best treatment, the optimal treatment without, without difference of race, sex, weak or strong population. It's something that is very very important. Our culture as people, it doesn't matter if I see someone on the street. It doesn't matter to me if he is Jewish, Christian, or Ethiopian, or from my nation [*ha-Am sheli]* or from there or here. It doesn't matter. I am going to go treat him. I will give him the optimal treatment. Something like that actually happened to me. It didn't matter; I didn't look at the face of the person I resuscitated.
> NR: It happened on the street?

> Dalia: Yes, it happened on the street. I didn't even look if he was male or female. It principle it doesn't matter.

In Dalia's description, the technical practice of providing medical care—through MRI or resuscitation—produces sameness in medical care; a technical equivalence mediated through protocols, diagnostics, and interventions (such as blood draws, MRI scans, antibiotics, CPR, etc.). But Dalia also hints at a second aspect of the production of equivalence. When she recalls her experience of resuscitating a stranger on the street, she explained that she did not look at the individual. In the process of providing medical care, Dalia detailed the active *not* seeing the specificity of the individual. What mattered to Dalia was that this individual needed treatment, echoing Mara's motto that treatment is a binary: "The kids are either sick or not." This binary transforms individuals into the narrow definition of whom and what a patient entails.

Like Dalia, many providers emphasized the act of not seeing or discounting particular aspects of their patients as a critical tool for providing medical care. Salim, who carefully outlined the oncology protocols above, characterized his work in the hospital as a particular form of blindness.

> I don't look at who you are, I don't look at who he is, I don't look at anything [except] that you are sick, and you need help, and I will treat you if you helped me with a million dollars or if you killed my father. There is no difference. During the time that I treat you, I treat you. Maybe I will kill you, but not during treatment. Okay? Maybe I will seek revenge because I am human and you killed my father, I don't know, maybe I will catch you somewhere else but not while you are my patient.

According to Salim practicing medicine requires cultivating a means to suspend relations outside the hospital. Doron, a former emergency department nurse, also stressed that within medical care he learned to treat patients the same because they are *his patients*.

> In my eyes a person is a person, that's it… I address people. You are a human being… There are Jews that I can't stand. Like Haredi [Jews].[44] When I see the Haredi sparks fly out of my ears. But if he comes to me and he needs to receive treatment I will treat him.

For Doron the entrance into the medical establishment—and the relationship between healthcare provider and patient— suspends the various social/political/religious affiliations. Sigalit, a nurse in the hematology oncology department, also explained to me that providers don't see the individuality of patients but rather work to save lives. "Maybe SH is weaker in a lot of fields [in comparison to other hospitals," she told me—relating how medical technologies are not up to date and the computer system is still not the most advance. "But in terms of the motto, what drives the physicians and all of the teams is to save life."

> It doesn't matter which [life]. It doesn't matter how much it will cost. We don't see anyone. Don't see color, don't see, don't see anything. Catch and save. [We] save here from the grave. It's like they don't let anyone go unless they tried everything. Health and life, life is the highest value… and everyone gets the same treatment really without difference.

In suggesting that providers "don't see color, don't see anything" while saving life, Sigalit points to the learned blindness that makes it possible to claim sameness. As one nurse stressed to me, "I get a file and a child. I don't know where he comes from, to what sick fund he belongs. It doesn't interest me." Dana, another oncologist, shared a similar perspective when she said to me, "We don't differentiate between a Bedouin child and a Jewish child and a child whose mom is Bedouin from the territories and a father who has citizenship or without citizenship. We do all the possible detours to give the children treatment and don't ask." Sima, another emergency department nurse stressed to me:

> You have to treat without difference in religion, gender, or nationality. The background of someone doesn't matter, what the person or what his political or

[44] A form of Orthodox Judaism.

religious view is; it's saving life. A Bedouin mother or a Jewish mother is a mother. *I see them all the same.*

In stating that she sees all 'mothers' the same, Sima highlights that she actively focuses on particular aspects of the patient while discounting others in her work as a nurse. She argues that religion, gender or nationality do not matter within the medical space. In this process certain aspects of individuals are disaggregated (their political or national affiliations) while others are emphasized (a physical injury, for example).

Providers' rhetoric that they treat all patients the same echoes humanitarian organizations' claims that they work to save a shared, universal human. But as a range of anthropologists have articulated, the scope of life being saved by organizations such as Medicines sans Frontiers remains tied with interventions to maintain biological health such as food, sanitation, and housing (Fassin and D'Halluin 2005). In the context of humanitarian crisis, Redfield writes, "human zoology exceeds biography" (2005, 345). MSF workers focus on providing adequate nutrition, sanitation, and shelter, and actively distance themselves from the political and ethical questions that made particular lives as more vulnerable. As a result, while they work to "save lives" the scope of that life remains linked to the basic biological process—such as food and sanitation. This life takes the form of what Giorgio Agamben (1998) terms *bare life* and Arendt (1958) terms *zoe,* or the biological functions shared across species. This form of life is different than *bios*, or the life linked to politics that exceeds one's individual functioning (Ticktin 2006, 2011). The blindness that providers in Southern Hospital spoke of is partly that of a shared biology. Yet understanding shared humanity as equivalent to *zoe* does not adequately address how sameness is crafted. In SH it is not that providers only discuss patients as their disease or their treatment. They routinely raised the specificity and

diversity of their patients. Learning to view patients as the same is therefore not necessarily a reductive move, but instead it required a cultivated practice of constructing patients to be the same.

It is important to note that the sameness was not only evoked by staff. Jibril, for example, whose son was diagnosed with an aggressive form of cancer four months earlier, also claimed that within the space of the hospital all patients are treated the same. "In the hospital," he stressed to me, "There is no difference between Jewish and Arab or any human. The normal treatment is for Jewish, Christian, Muslim, all of them are the same. There is no difference."

> Listen, it enters humanity. You enter the hospital there isn't a difference between Jews and Arabs. I would cry about Jewish kids and their families. You enter here humanity. You forgot the problems outside and [in the] country. In the situation, you don't think bout anything. Outside it's something different, people, community, Arab, Jewish, Christian, Druze…. In the hospital there are human beings, you are human, Arab, Jewish, you are human. For me, there isn't a difference between Arab, Jewish, American, British… We are all humans.

When I asked him if he feels that way outside of the hospital he laughed, "That's a different story. We entered politics." For Jibril, the human within the hospital is not tied only to biology. What made patients the same, was not only that they were all receiving the same treatment or had the same technical diagnosis, but rather that they were experiencing the difficulty of supporting families together. They took care of their sick children together. Jibril suggests that being together in the hospital created a shared sensibility among parents like him that suspended not only politics but the politics of difference as well.

III. Producing Equivalence through Partial Erasure

In the previous sections I explored two different directions through which equivalence is produced in the hospital and in the larger literature in medical

anthropology. The first is through standardized diagnosis and technical regimens. The second suspends difference through the assertions of a shared humanity. Both of these aspects are present in SH: providers utilize biomedical categories and moral claims of the human in asserting sameness. Yet these directions fail to attend to the fact that providers assert an equivalence of care despite the fact that the homogeneity of patients is constantly disturbed. I therefore want to suggest that sameness in SH requires making particular aspects of patients invisible. Rather than sameness being mediated through an abstract humanity that is related to sickness but not politics or regimented protocols and diagnostics, I argue that the production of sameness can be thought of as a process of partial erasure in which particular aspects of patients are discounted. Sameness is not about crafting identical care or identical patients but rather about cultivating a particular relationship between patients and providers whose scope remains bounded.

In the clinic, very different people are transformed into equivalent units in the statements: "*I treat all Patients the Same," or "A Bedouin mother or a Jewish mother is a mother. I see all of them the same*." When a physician tells me that she treats all patients the same because they are 'mothers' or 'humans' and she works on 'saving lives', she is speaking of a specific type of 'mother', 'human', and 'life' with clearly marked boundaries. Here the category of mother, human, and life permits a rationale of equivalence between two different individuals. In this process of equivalence making that permits calling patients the same, particular aspects of patients are highlighted to make them 'equivalent' while others are erased. This process permits providers—and patients— with the possibility to put together a narrative of a patient based on a particular collection of data that can be equivalent to that of another patient. Therefore it is not that

patients are wholly the same as a pre-existing state, but rather through medical technologies, interventions, and the space of the hospital patients are made to be the same. I therefore turn to two examples of the process by which partial erasure permitted providers to transform their patients into units that could be imagined and claimed as receiving the same care.

a. Kinship Metaphors

Lina was a second year pediatric resident when I met her in the emergency department. She explained to me that one of the significant changes she experienced between medical school and residency is the personal connection that develops with patients and families. "For me," she stressed, "that personal connection is really important."

> The trust that you build with the parents, it's something different. It's like, each time I tell a father or a mother that their kid, for me, it's like my kid is here, my kid is sick and I need to care for him like I care for my kids. And I really mean it. And so I think that the connection is more personal. It's beyond some investigative case. My responsibility as a physician is a responsibility for everything. I think the medical aspect from A to Z is also the social aspect. The family support for the child, everything… Not only to treat his pneumonia, but also to take care that he has a proper place to return to, that he has someone to care for him, financial assistance.

Lina's description challenges any notion of medical care being limited to biomedical protocols. It is not that physicians, nurses, or for that matter any medical staff only see protocols or diagnostics, or imagine their patients as a series of physiological processes. For Lina, by transforming the patients she cares for into her children, she is not caring for some abstract, universal patient with a fixed biology, but rather for a child she imagines to be like her children. This emotional connection that Lina emphasizes touches on the shortcomings of the framework of equivalence through diagnostics or through

humanitarianism. While statistics and biological *zoe* craft patients into identical units, they cannot attend to how individual practitioners mediate medical care through individual patients. By considering her patients as her children, even briefly, Lina highlights that caring for patients requires an emotional connection, an empathy that is also part of calling patients the same.

Lina was not the only provider to speak of the personal connection that develops within the medical encounter. Providers stressed the intimacy and proximity they cultivated with families. Part of their work was providing—and experiencing—this connection. During a team member where a staff member expressed frustration that the family was not thankful for his work, the team social worker remarked: "One of the reasons that we are here… is not altruism. The recognition of thanks has significance. And not receiving the thanks is difficult to keep working here." During a difficult staff meeting to discuss the recent deaths of several patients in the oncology department, Michael one of the physicians, spoke of the emotional privilege that comes with his work:

> I ask myself, and my wife asks me, what is this masochism? We are not here by accident. The warmth and love and privilege of healing in the final hours are a specific privilege that we enjoy it.

The emotional connection that providers stressed, and sought, adds a layer of complexity to discussions of equivalence.

Like Lina, Miriam also discussed her work in SH as treating patients like they are her children. "I treat patients lie they are my kid. What would I do if it was my kid? And that can get you into trouble. It's not like a car. In medicine there are no rules. Everything is in the grey rules which means there is a lot of discretion but you can make mistakes."

For Lina and Miriam comparing patients to their children was a means to acknowledge the scope of care that is demanded of them that was anything but detached. Thus while Redfield (2005) writes that physicians end up reducing the lives of patients to a biological minimum in their attempts to advocate for a moral stance of shared humanity, in the context of Southern Hospital—which is not a humanitarian crisis by any means—caring for patients is not about biology as pathophysiological process. It is about drawing equivalence between lives, or more aptly, parts of lives.

During a particularly difficult period in the oncology department when a number of children passed away, Avraham, the head oncologist, also stressed to staff the emotional aspect of their work:

> I, we, are not just machines, unfortunately. We have our own families. There is identification with the family. There is trauma. We know the families. *They are our families*. I know what they eat for lunch, and what the grandmother cooks, and we need to know how our team can handle [these deaths]. Technical [knowledge] is a great thing, but what is the team's response? ...The problem [is that] we are the family as well.

While the technical work in the department creates a particular homogeneity in patient data, it does not eliminate the specificity of patients and the personal connections that develop between provider and patient. Caring for a patient in the same way is not necessarily about doing the same action or procedure to a patient, but also managing these emotional connections.

Salim for example, a physician in the hematology oncology department, spoke to me at length about the emotional challenge of working as an oncologist. While he put together patients' treatment protocols daily—reviewing recent studies, signing off on orders, and tracking how patients were responding to their chemotherapy— the majority of his responsibilities required working with families. During the course of patients'

treatment, Salim stressed, providers develop a relationship with the patient and his or her family. “It’s not an easy department,” he reflected.

> A connection develops, whether you wanted or didn’t want, it exists. It’s a human that you are seeing every day. A human that you speak with, a human that you live with, a human that a large part of them communicates respect to you. This means that when they see you, they smile. They radiate a particular respect that you are treating their child, and they see that you are making an effort. So a particular connection is formed, a connection, like I said, whether you wanted it or not… And then in times of loss, you don’t lose a person you treated, you lose a person you knew, a person that you say, it’s like my neighbor’s son, [who] I lived with for two years. I was his neighbor for two years and today no longer… True, you are a doctor, but it’s a human that was under your care for two years and suddenly you lost him. He is gone. You don’t see him.

Here the human that Salim discusses is not a human imagined through a biological lens, but rather one deeply embedded in personal connection. Thus sameness is reconfigured not only through the emphasis on the biomedical but also through how one would imagine treating or caring for a neighbor or a family member.

b. Holding Hands

Thinking through equivalence as a process of partial erasure, in which particular aspects of patients (like personal connection or kinship relations that I discuss above) are highlight while others are suspended pushes us to move away from thinking about sameness as a preexisting relationship to instead to consider it as a process. Equivalence making takes place by temporarily making particular aspects of patients commensurable. This active process of crafting medical care as ‘the same’ by erasing or suspending particular aspects of patients was evident during a meeting with the palliative care team. A new nurse, Yona, joined the team and had recently visited a Bedouin family in their home for the first time. The patient spoke to the nurse of the deep support he draws from his eldest son. “And then he started crying,” she added. She moved closer to him as he

continued talking. Yona explained to the team that if this was a Jewish patient she would hold his hand. But in this specific context, sitting with a Bedouin man, she was not sure what was culturally appropriate. “Can I touch him? Can I hold his hand? What are the cultural boundaries?” In the ensuing conversation, rather than addressing Yona’s comment through a lens of “culture”, the team discussed the process by which patients and medical interventions can be made, even temporarily, equivalent by partially erasing aspects of patients that would challenge equivalence.

“It’s a hard question,” one of the team physicians replied to Yona’s questions. The physician, a Bedouin man himself, explained that he never holds Bedouin patients’ hands. Yet a second a physician disagreed. “I tend to check the territory. I first do the most universal thing, reach out my hand and see. If that’s okay, I can hold someone’s hand.”

A second nurse on the team, Omar, told the staff about how he had a Bedouin patient recently who was in a lot of pain and he held her hand while her husband was there. “When someone is present, it’s okay. He knows the context. In nursing it’s key. Nurses learn the notion of communication and [in communication] the idea of touch is found. They always touch.” He told us about a Muslim woman who came to the clinic and when he checked her blood pressure she kept jumping, uncomfortable as Omar’s touched her arm to arrange the cuff. He related to us his conversation with her: “You came here to clinic, of course I will check your blood pressure and [therefore] I need to touch you.” Here Omar reveals the manner he negotiates the universal principle of touch into the context of caring for a Bedouin woman. Omar disaggregated the aspect of the patient – her religious affiliation which forbids her from being touched by a foreign

man— from the aspect coming to receive medical care. By focusing on only particular aspects of the patient, Omar could provide the same medical care in the clinic. "Also in the Bedouin sector you can touch. I wouldn't say a priori no," the head physician added to the conversation:

> There are very clear codes. If the intention is erotic you don't need to be a genius to know them. And yet, there are cultural codes. But people who we care for are so, as they say in English, vulnerable, hurt from the healthcare system that communicates coldness, lack of empathy, as if [it is] objective.

In his explanation, the physician critiques the sameness of "objective" medical care as communicating a lack of empathy rather than equivalence. Instead, he highlights that providers cannot know patients a priori. Sameness transforms into being not about 'equivalent care' in the sense of the same tests or procedures. Instead, the palliative care team worked closely with patients and families to be able to assess how to best support families. As the head of the team stressed, "You can't detach a person from his surroundings." Providing medical care for the palliative care team meant holding patients hands, bringing video cameras for patients to record their narratives. At times it meant helping families cope with the stress of visitors. Thus sameness in the context of palliative care is not about producing identical care, but finding the means to provide the care that patients and families need. Rather than suspending the patients' context, here the partial erasure was oriented towards the expectations of what "objective" medical care entailed.

V. Conclusion

Didier Fassin, writing on the work of humanitarian organizations, argues that "humanitarianism is founded on an inequality of lives and hierarchies of humanity" (2010, 3166). Despite humanitarian workers' moral imperative to "treat everyone in the

same way," they confront a reality in which particular lives are more vulnerable and exposed to violence while others are protected. For Fassin this difference is the aporia of humanitarian work—where the ideal of a shared, universal humanity confronts the structural inequalities of our contemporary world. "This is," he reflects, "probably the most painful reality many humanitarian agents experience in their work" (ibid). But this differential evaluation of life, as Fassin points, is often made invisible. Jain, writing of the transformation of lives into equivalent units in clinical trials, also acknowledges the practice of making invisible the painful deaths that individuals experience in the process of becoming a statistic for hope. Thus regardless of the means of transforming individual lives into equivalent units of humans, their specificity needs to be hidden, effaced, and sidelined.

In this chapter I have purposely sought to attend to how providers continue to assert sameness despite the presence of specificity and difference among patients. Sameness, I argue, requires learning to aggregate particular aspects of patients, while placing others—often the more disturbing—aside. But because they are cast aside they remain. They are not absent. And as a result, patients are never wholly transformed into a diagnosis or a fixed unit in clinical trials. As one physician remarked, "Diagnosis is the tool but it is also the golden cage that we are working in." Thus while diagnosis is necessary for medical care, patients continue to exceed the definitions of diagnosis. While clinical trials can sever the deaths of patients from data, in the clinic providers encounter difference daily. Sameness is produced momentarily and temporarily, a constellation actively crafted by providers.

The specificity of patients brings us back to the scene I began this dissertation with, of the father accusing the triage nurse that he is waiting *because he is Bedouin.* I want to suggest that the reason providers and patients experienced this interaction as distinctly different—with the medical and nursing staff asserting that medical care is the same and the fathers crying discrimination—is because the boundaries of what is experienced as the same and equivalent differs. Thus while providers might assert sameness by focusing on the diagnosis provided, or the emotional care delivered *like* a family member, families, in contrast, live in a political world, outside the boundaries of equivalence that medicine constructs.

Chapter 5: Who Speaks for the Bedouin- The Problem of Comprehension

"A lot gets cut out in matters of life and death."
- SH physician at cultural competency workshop to medical students.

In 2002, Maha and Salim Dalasha, two Palestinian citizens of Israel, sought medical care in Poriya Hospital, a government hospital in northern Israel. The couple visited the hospital on three separate occasions for routine fetal monitoring towards the end of Maha's pregnancy. According to the couple, at each visit they were discharged without being instructed to count fetal movements, as reduced movements could indicate a prenatal complication. The fourth time the couple arrived to the hospital the fetus was found dead.

The Dalasha's case became newsworthy in Israel after the couple sued the government, who operates the hospital (Darel 2007). The lawsuit pivoted around the claim that an explanation was not given to the couple in a language they could understand. In the verdict, Judge Darel noted that Maha "almost does not understand Hebrew at all while Salim's control is better. He knows to read and can understand more but does not know the language fully." Nonetheless, the physicians and nurses who examined, treated, and discharged Maha spoke to the couple only in Hebrew.

The Dalasha's case seems like a straightforward lawsuit of medical negligence. Yet what I want to draw attention to is that the providers who examined and spoke with Maha and Salim testified that they know *enough* Arabic to communicate with patients. For example, Dr. Dik, one physician who examined Maha, stated that she knows the relevant words in Arabic to communicate with Arabic speaking patients. During her

testimony she was asked to explain to the court how to conduct a fetal movement exam in Arabic. She refused explaining:

> I cannot speak sentences, but I know the word for movement is 'haraka'. I know the word 'hasi' is to feel. I emphasize that I work in Arab villages. If we see that a woman does not understand we ask for help.
> Question: Except for these two words, can you say another word so we can understand the technique in regards to the movement?
> Dr. Dik: I explain, and if the woman does not understand I ask for help. To ask if she feels or doesn't. It's very rare that an Arab woman does not understand a word in Hebrew (ibid, 4).

Despite Dr. Dik's insistence that she can assess whether a patient understands her Arabic (or Hebrew), Maha and Salim did not understand her instructions and she did not understand their incomprehension.

Like Dr. Dik, the majority of providers in SH are Jewish, Hebrew speakers, who know little, if any, Arabic. And like the physicians in Maha and Salim's case, the majority of providers in SH stressed that 1) they speak enough Arabic to communicate with Bedouin patients, 2) they understand Arabic speaking patients, and 3) they do not need translators. This is despite the fact that three-quarters of their patients are Bedouin who are primary Arabic speakers, many with limited knowledge of Hebrew. This was particularly true in the pediatrics department where children often did not speak any Hebrew, and mothers who typically accompanied them to the hospital similarly spoke limited Hebrew. According to a report published by the Ministry of Health, 33% of Bedouin women living in recognized villages had no or only elementary education; this number increased to 57.6% among women from the unrecognized villages (Ministry 2008, 19).[45]

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[45] Because the educational system in Israel is segregated based on both language and religious affiliation, the primary language of schooling in Bedouin community is Arabic. Therefore, even women who received primary education may still have limited control of Hebrew. I. Abu Saad (2004) writes of the contemporary and historical neglect of the educational system among the Bedouin community. Sarab Abu

When patients and providers do not speak the same language, how do the quotidian practices of providing and receiving care take place? Maha and Salim's case provides an entry point to thinking about this question. It flags the assumptions that medical providers hold about medicine (that they can understand patients regardless of the language they speak), Arabic (as a simple language that can be communicate using a few words), and Arabic speakers (as always knowing *some* Hebrew). My argument in this chapter is not to retell the story of the perceived universality of biomedicine. On the contrary, what is interesting about considering the Dalasha's case and language in SH is that providers do not discount language as necessary for their work; instead they claim they understand Arabic and their Arabic speaking patients. In this chapter I therefore examine language as a site to understand how providers imagine – and construct— Bedouin patients. Arabic is discounted as a serious problem in SH because the difficulty in communication becomes associated with Bedouin culture rather than language. And in shifting to discuss culture, the problem of language becomes effaced.

I. A few words

Let us return to the court room for a moment where Dr. Dik, under oath, refused to explain in Arabic how to conduct a fetal movement exam. "I cannot speak sentences," she stated, "but I know the word for movement is 'haraka.'" Like Dr. Dik, many of the providers that I encountered during my fieldwork emphasized that by speaking a few words of Arabic they sufficiently communicated with Bedouin patients. The scope of Arabic is collapsed into a few words that stand in for full communication. Rachel, who

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Rabiya (2006) has examined the high drop-out rates among Bedouin girls. In the IDF Military Archive, Dr. Ben Assa writes that he was asked by the Ministry of Education to assess the schools in the *siyag* and finds them in a decrepit state (March 6, 1956). Human Rights Watch published a report in 2001 on the education system in the Negev which strikingly echoed the same concerns some forty years later (HRW 2001). Thus the poor educational system in the Bedouin community feeds back into the medical system.

moved to Israel from Russia in the mid-nineties, worked in SH for fifteen years when I met her in the emergency department. While outside the hospital she said she could not hold a conversation in Arabic, at work, she explained to me, she "understands Arabic very well." Lara, the mobile clinic nurse, similarly said that she "hardly had a problem" communicating with Arabic speaking patients. Lara had worked as a nurse in the pediatric departments in SH for many years prior to transitioning to the mobile clinic. While many of her patients both in the mobile clinic and in SH spoke only Arabic, she had not studied Arabic and felt that this did not hinder her work. "I know a word here and a word there," she explained to me. "In the department [in SH], I didn't have a problem, usually there was an [Arabic] speaker and the basic words that I need in Arabic I know." To demonstrate her Arabic skills, Lara began listing the words in Arabic she knew: *al amalia, al doctora, al wazen*—the surgery, the doctor, the weight. And like Dr. Dik in the Poriya case, Lara too presented her ability to "speak words" as sufficient to communicate with Bedouin patients.

I joined Lara on many home visits as part of her work in the mobile clinic. On a particularly cold January morning, the mobile clinic – a four wheel drive jeep—pulled up to a large building made of corrugated metal: a Bedouin family's *shig* where guests are typically welcomed. Inside, Salem was lying on a mattress. Salem had been sick for five years now, his father Tawfik told me, and for a nine year old that meant most of his life. In 2006, Salem was diagnosed with a particularly aggressive cancer. After multiple surgeries, rounds of chemotherapy, and a failed bone marrow transplant the oncology team concluded that the cancer returned and they reached the end of curative treatment.

At that point, Salem's case was transferred to the mobile clinic's palliative care team, and the morning we pulled up to the *shig* was the team's first encounter with Salem.

Salem's father and mother joined us in the *shig*. The father spoke a little Hebrew, the mother spoke none, and the boy looked exhausted and scared. Lara, in her limited Arabic, began to assess how Salem was feeling and the family's concerns. The father explained that Salem had a fever. "Did you buy a thermometer?" Lara asked in Hebrew. When the father didn't answer, Lara turned to me and said in Hebrew: "The father is a bit of an idiot. He doesn't really speak Arabic." Through this side comment, Lara positioned herself as the individual understanding Arabic, while the father—an Arabic speaker—is claimed to not "really speak Arabic." Furthermore, in her Hebrew sentence to me she marks her recognition that the father does not understand Hebrew—and thus feels comfortable making such an aside.

After trying to understand several times whether the parents measured the boy's temperature with a thermometer, Lara requested Musa, the driver and translator, to ask the father in Arabic if they purchased a thermometer. While Musa was officially the team's translator, typically Lara spoke directly with families.[46] Lara's insistence that she speaks Arabic made it challenging for the families and for Musa to know when *she* was not able to understand patients. Musa, rather than asking about the thermometer asked the father whether the boy had a fever. The father replied in Arabic that the boy's temperature was 37ºC. Lara, understanding this response given the context and similarity of Arabic and Hebrew numbers, announced: "That's not a fever!" She walked back to the

[46] This differed from the departments in the hospital where there were no official translators for Arabic speakers.

car and brought back the team's thermometer to measure Salem's temperature: 38.3ºC. The result, in numerical form, finally served as proof of the boy's fever.

In the encounter between Lara and Salem's family a particular process of translation occurs: from lived experience to medical condition. The families' experience of the boy's fever remained uncertain until measured by a medical instrument that clarified the boy's fever. It is the thermometer—and not the father's concern—that declares the boy's medical state. But this translation also relies on a translation from Arabic to Hebrew. Salem's father's insistence that the boy has a fever—assessed through physical signs and intimate knowledge of his son's body and disease— remained unheard until the thermometer made real, for the nurse, the father's concerns. By discounting the father's ability to speak Arabic and relying on her own 'basic' Arabic (and the authority of the thermometer and professional training), Lara positioned herself as the expert that can name the boy's condition. While Lara asked Musa to speak with the father, Lara located the problem not as an issue of language but rather in the father's inability to know what a fever entails.

The following week we again visited Salem. Salem and his parents were again in the *shig*—Salem on a mattress on the ground covered by a thick blanket. Lara asked the mother what medication Salem was currently receiving in Hebrew. After a few failed attempts, she gestured for the mother to bring the medication bottles. Salem's mom walked over to a closet in the other side of the large room and returned with a bag filled with bottles and papers—prescriptions, referrals to doctors, discharge papers from previous hospitalizations, a paper trail detailing Salem's prolonged illness. Lara took out the antibiotics from the bag. The bottle was still half empty and the second script was not

filled. “Who explained this?” she demanded to know in Hebrew. “Who is the pharmacist? How is it possible [that the boy received the medication] only once a day when it’s twice, when it’s written twice?” Like the thermometer that did the work of ‘speaking’ for Salem’s medical condition, here the medication bottles that had not been used properly were positioned as better able to communicate the medical situation to the team than the parents. Unlike the parents that remained opaque to Lara, the bottles were transparent—the antibiotics either consumed or not. Yet Lara did not assess whether the parents knew how to read Hebrew or Arabic or what was explained to them at the pharmacy. Instead in her frustration towards the family—“how is it possible once a day when it’s twice, when it’s written twice”— Lara placed the blame of not following medical instruction on the family, without acknowledging how language—both written and oral may— limit that knowledge.[47]

Lara continued to go through the medication bottles in the bag. She found the anti-pain medication bottle empty. “Why didn’t you tell us to bring more?” she asked in Hebrew, her inquiry almost rhetorical, assuming that the parents could not understand. Lara walked back to the car and returned with a new bottle and gave Salem the medication using a small syringe. As she finished, Lara said to the mother in Arabic: “*bjib lo*.” Salem’s mom picked up the syringe and was about to give Salem the medication, again, before Lara stopped her.

Musa, seeing Lara, intervened: “What did you tell her?”

[47] The assumption that patients can read medical instructions in any language was illustrated one afternoon when I met a mother in the emergency room whose son was recovering from a head injury. She had been given an information sheet—written in Arabic and Hebrew—on warning signs to remain watchful of following head injury. But she had never gone to school and thus could not read the information sheet. Thus the historically poor educational system in the region folds into her inability to act as the presumed medical patient.

"I told her I already gave him. *Bajib lo."* Musa explained that *bajib lo* means to give him. "So it's not what you said," Musa remarked. As the Arabic speaker and Bedouin on the team, Musa was often positioned as the 'expert' on Arabic matters. For example, on the drive one morning, one of the team members asked him why some Bedouin communities are so welcoming while others are angry. The nurse told the team one afternoon that she asked Musa if it was okay to touch Bedouin men's' hands (see Chapter 4). Thus on the one hand Musa was positioned by the team as the spokesperson for the Bedouin community. At the same time, he often resisting giving general answers in regards to 'Bedouin culture'.

Unfazed by her misuse of words, Lara inquired whether Salem used the opioid stickers to help relieve some of his pain. As she asked the parents about the dosage and usage, she referred to the stickers as *dabkas*. She explained to the parents how to use the dabka and where to put the dabka. Yet dabka is not a word in Arabic (or Hebrew) meaning sticker. Instead, *dabka* sounds like a hodgepodge of the Hebrew words for glue and sticker: *devek* and *madbeka.* Musa again interrupted and corrected Lara, saying "It's *lasga*."

The interaction between Lara, Salem's parents, and Musa demonstrates the assumed ability of Hebrew speakers to understand Arabic speakers and to communicate with them despite not speaking Arabic. In Lara's case, Musa intervened a number of times to correct her use (and misuse) of Arabic. Yet by not acknowledging her inability to speak Arabic (and her insistence that she gets along very well), Lara often did not seek help in translation. Misunderstandings routinely took place, and yet when medical instructions were not followed the blame would be positioned on families. Furthermore,

like the Dalashas case in which Dr. Dik insisted she spoke enough Arabic to get by and that Arab women speak (and read) enough Hebrew to communicate, the issue of language remained peripheral to healthcare interactions.[48] Lara's inability to speak fluent Arabic, or rely on Musa for assistance, constructs the dialogue between provider and family as unidirectional. Lara directs the tone of the conversation, the questions asked, and the scope of issues addressed.

a. Listening to Medical Histories

Like Lara who felt that she needed only basic Arabic to get by in her interactions with Bedouin patients, Jacob explained to me that "very basic" Arabic was sufficient for his work as a pediatrician. Jacob emigrated from Russia to Israel in the mid-nineties. He had dreamt of living in Jerusalem, but sixteen years ago when he and his wife decided to move to Israel there was a special program for physicians in the Negev and his wife decided they are moving south. "What?!" Jacob told me his surprise at his wife's plan:

> Why do we need Beer Sheva now? I had been to Beer Sheva and it was a place [that was] grey, yellow. I wanted to be in Jerusalem with the Wailing Wall and all the mysticism and things like that. I am secular, but I loved these things. But no [she said], we are going there where there is a good university, a good hospital. And she was right.

After relocating to Beer Sheva, Jacob began working in SH and a few clinics in the region, in both Jewish and Bedouin towns—what he called the Jewish and Arab "third world." Known as "the music doctor," Jacob typically played classical music in his office, occasionally humming with the melody as he examined patients. In one of his

[48] This disjuncture between language and medicine is addressed by Betsy Brada (2011) writing of the production of global health and medical education. She argues that the disjuncture of medical anthropology from linguistic anthropology has accepted the distance that medicine has taken from language. Language is deemed unnecessary to practice biomedicine. As a result, North American medical students and physicians traveling to Botswana to work and study in the hospital do not need to learn the local language.

clinics he had an espresso machine. “We spend at least half of our life at work, so we need to enjoy it,” he declared.

He had wanted to learn music, but his parents felt that piano was a woman’s pursuit. And since the field of musicotherapy did not yet formally exist, he played tennis (the appropriate men’s pastime) and studied medicine. Unlike most Jewish medical providers, Jacob enrolled in an Arabic course on his own at the local university. “But I only studied part 1,” he explained to me, “As for me it’s sufficient. I need something very basic. I don’t need… not to read, nothing.” While Jacob was one of the few providers who had studied some Arabic, he too characterized the scope of Arabic needed to communicate with Bedouin patients as rudimentary.

One of the reasons why so many medical practitioners feel that only a basic level of Arabic is sufficient to communicate with patient relates to the larger place of Arabic in Israeli society. As Abu Saad (2006a) notes, Arabic and Palestinian-Arabs remain “present absentees” within the educational system:

> Palestinian Arabs remain present in the Jewish school curriculum through majority representation (or misrepresentation), but absent in terms of any significant self-representation through their own language, culture and literature (ibid, 46).

Arabic has progressively been removed from educational curriculum, with less than five percent of Jewish students studying Arabic. Abu-Saad argues that educational system has be utilized to marginalize Palestinian Israeli citizens, while simultaneously harvesting hostility in Jewish citizens towards Palestinians through the negative depiction of this community in textbooks and curriculum. The marginalization of Arabic extends beyond the educational system. Despite Arabic being an official language of Israel, road signs—

land even signs throughout the hospital— were not in Arabic.[49] Therefore the absence of Arabic is not unique to medical providers, but links the larger discourse of Arabic language across Israel into the hospital and clinic. But like the medical practitioners I discuss who speak *some* Arabic or *a few words*, Arabic has not been completely erased within Israel society or landscape. Its remnants and form become crucial sites to understand the unease and dynamics between inclusion and exclusion in Israel.

After getting lost in Rahat for over an hour, I finally pulled up to a clinic in the one of the city's new neighborhoods. The Clalit Sick Fund built the clinic a year ago, and the staff was planning a celebration marking its establishment. It was a small building with a few exam rooms and a stylish reception area. I sat next to Jacob as patients and their parents stopped by. As he told me how much he enjoys the quiet of the Negev, without the traffic jams of his past life, a woman entered the room with her son, Akram.

"*Ahalan wa Sahalan!* Hello!" Jacob greeted them in Arabic. "*Ma kore?* What's going on?*"* He asked, switching to Hebrew. The receptionist, who accompanied the family into Jacob's office, said to Jacob in Hebrew that the family visited the clinic earlier that same day. "Please, *bevakasha,*" Jacob continued in Hebrew, gesturing to the woman to sit down. The boy, fidgety and wiggling in the chair, wanted to leave. The mother, trying to sooth him, spoke to him in Arabic, "*Shater, shater,"* meaning smart but indicating good boy. "*Istana,* wait," the mother again said to the boy in Arabic, "*Al-doctor yashuf al rukba*- the doctor will see the knee." "*Shalom lach*- hello," Jacob greeted the mother again, this time in Hebrew. "*Ma ani yachol la'azor lach*- What can I do to help you?" he continued in Hebrew. She gave the physician the boy's health insurance

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[49] The absence of Arabic on road and street signs has reached the Supreme Court on several occasions. See: High Court 4112/99 and High Court 4438/97. In both cases, the court ruled that Arabic must be included in street and road signs within a predetermined time period.

card—with the boy's name imprinted in Hebrew. Jacob entered Akram's card into the computer system and his medical history come up. "Akram, Akram, Akram!" Jacob declared the boy's name, looking through the medical notes. "Akram, you were here today?" Jacob asked in Hebrew. "Because of an ear infection?" He continued in Hebrew. The mother did not respond and Jacob nudged her, "Hu?" "*Ken*-Yes," she finally answered in Hebrew. "And found this [ear infection] and the doctor sent you to an otolaryngologist," Jacob read from the computer screen summarizing the visit from this morning. "So what is the problem?" Jacob asked in Hebrew. The mother showed him Akram's leg. "So it's not in the ear," Jacob remarked in Hebrew. "He has a boil on his leg - *lu hab fi rijelhu*," the mother explained in Arabic. But her statement did not lead Jacob to solicit further information regarding the wound on the boy's leg. "Okay, let's see," the doctor says in Hebrew. The mom sat the boy on the exam table and Jacob examined the boy's leg—humming Beethoven's fifth and making Donald Duck noises. "It's cellulitis media," he announced. "*Sawet tor*? You booked an appointment" Jacob asked – using the word "to book" in Arabic and appointment "tor" in Hebrew. "*Bukra*," tomorrow, the mom replied in Arabic. "For this, water and soap and scrub well," Jacob said in slow Hebrew. "Scrub well I'll give him *barham.*" Jacob spoke the entire sentence in Hebrew except for the final word for ointment, *barham,* in Arabic. "Okay?" he asked, seeking to confirm the mother's understanding. "Okay," the mom replied. "*Halasna*" she said to Akram in Arabic- "we are done."

Back at his desk, Jacob began to type his note on the computer—dictating in Hebrew: "Lesion on the right leg. Red wound with purulent content. Cellulitis. To clean with soap plus syntomycine 3%. *Barham. Marten fi yom.* Ointment, twice a day," he

added in Arabic. "*Beseder?*- Okay?" he switched again to Hebrew seeking the mother's confirmation. He printed the prescription and handed over the paper to the mother. "*Shukran* , thank you," she said in Arabic. "*Afwan*." Jacob replied in Arabic, and Akram and his mother headed out of the office.

In some ways Akram's mother and Jacob were able to somewhat communicate in this interaction: Jacob examined the boy's leg, set a diagnosis, and gave him ointment which will hopefully heal the wound. It could even be argued that this was the doctor's best effort to cope within a medical system that does not provide translators. But the scope of the conversation between Akram's mother and Jacob remained limited to single words and phrases. Most often the mother assented, saying "yes" or "okay" in Hebrew, or simply remained silent to Jacob's questions or instructions. Jacob understood her replies or silences as understanding, yet he had no ability to assess what she understood from his instruction and whether she had any questions. Furthermore, the information that Jacob received about the boy emerged from the computer system and the physical body: the typed computer note in Hebrew from the previous visit for an ear infection, and a red wound on his right left.

Jacob did not view this interaction as troubling or frustrating. He did not seek out a translator or try to assess whether the mother had any questions or understood his instructions. Akram's mother may have also not viewed this interaction as troubling. On the contrary, in all likelihood such interactions were part of daily life for Jacob as a physician in the Negev and for Arabic speakers like Akram's mother seeking medical care. As a Bedouin woman I met in the emergency department reminded me it's not just the hospital, "It's the supermarket, the bank, the store." Thus this interaction was a non-

event for both patient and provider, and as such it requires attention. I want to consider not only the misunderstandings that emerge from the interactions between Hebrew and Arabic speakers, but also to the assumptions providers' have of Bedouin patients that make it possible for them to claim that fluency in Arabic is not necessary for their work. Providers assume that they can gather all the information they need without speaking to Bedouin patients. Jacob made this point explicit when I visited him at his clinic in a neighboring Jewish town. As he introduced me to one of his patients, he explained that I speak both Hebrew and Arabic. The woman replied, "You have to speak Arabic." Jacob retorted, "No, you don't have to." "But so many Bedouins live here," she stated, surprised as Jacob's comment. "No, you don't have to," Jacob repeated again. "I took a course," he added, placing him in a better position than most of his colleagues. Thus patients are excluded from these conversations—but their exclusion occurs not only through language but also through providers assumptions that they cannot add medically relevant information.

As I listened again to the recording of the interaction between Akram's mother and Jacob, I was struck by the chatter between mother and son: her soothing words, her encouragement of him to wait, telling him over and over again that they will soon go home, that the doctor just needs to examine his leg. Yet this conversation between Akram and his mother remained unheard or unacknowledged by Jacob. The interaction between Jacob and Akram's mother highlights the strange movement between Hebrew and Arabic that takes place in the clinic. There are seemingly two conversations happening—linked every so often through a word or gesture. But if the conversation between Akram and his

mother remains beyond the scope of medical care, what else remains unheard and what assumptions are amplified?[50]

II. Proxy Translators, Gendered Communication

In her testimony in Salim and Maha Dalasha's case, Dr. Dik explained that if she finds that a woman does not understand her instructions in Arabic, she asks for help. This help entailed requesting an Arabic speaking staff member or a patient's family member to translate. In Maha's case, the staff presumed her husband would serve as the translator for the couple—not assessing his level of Hebrew comprehension. Like in Poriya Hospital, where the Dalasha case unfolded, no official translation service exists in SH. A laminated list of volunteer translators for an eclectic range of languages (Thai, Mandarin, Russian, Amharit, French, Arabic) hung on the corkboard of most hospital departments. But as these volunteers were employees in other departments they were typically unavailable for immediate assistance. Salma, a Bedouin woman who grew up in one of the government planned Bedouin towns, would occasionally be called to translate for doctors. While she was happy to translate to help families, she felt she needed to put boundaries in terms of when she was willing to translate.

> There were periods when I would be shuttled from one side [of the hospital] to the other and it was very difficult. It was very difficult for me. I felt that it wasn't fair towards me. Because I am here as a professional, not a translator. And somehow the professional part was pushed aside and I became a translator in other departments, and it was something I needed to experience, some sort of personal process to put a boundary. I am not willing anymore… It can't be a systemic solution.

[50] Another issue that permits further research is the link between the medical history narrated and that which is documented. If the medical record inscribes what is heard between patient and provider, how does the medical record then reflect this silencing? For questions in regards to the archive see Ilana Feldman's (2008) *Governing Gaza.*

Salma's experience reveals the problem, and unsustainability, of relying on Arab staff members for translation services. Not only did providers need to wait until the volunteer was free, but volunteers needed to leave their own work. Furthermore, as Salma stressed, this volunteer service failed to provide an actual solution to the problem of language in the hospital. Nava, a nurse in the emergency department explained that she had never used the volunteers as it takes them "an hour to arrive." With SH being at or beyond capacity most of the year, waiting an hour for a translator was not feasible.[51] She explained to me the various ways she speaks with families:

> You take what is available. It's families, cleaning staff. It's everything that you can for every language needed… There is no such a thing a translator twenty-four hours a day in the hospital. I haven't gotten to see such a thing in SH.

While staff like Salma assisted in extreme cases, typically 'help' entailed relying on Bedouin families to translate for one another. The large volume of Bedouin patients in SH thus became a de facto pool of unofficial translators for providers. Leonard, one of the physician in the emergency department, deemed an official translation service unnecessary as "all the time, a non-professional translator is at hands reach," referring to the many Bedouin patients in the hospital. Sigalit, a nurse in the hematology-oncology department similarly explained, "I just go ask someone, from some mother or father." While providers often complained of the many family members that would escort Bedouin patients, they relied on these individuals for translation. As I discussed in chapter 3, the notion of *hamula* – that of extended family, clan, or tribe— remained tied to clinical understanding of the meaning of Bedouin within the clinic. The patient remained tied—through language as well— to an image of the Bedouin that extended beyond the individual body.

[51] As I wrote this chapter in the winter of 2013, SH was at 120% capacity—with patients lining the hallways in gurneys. This is despite a physician strike in 2011 and a nurse strike in 2012 (see chapter 6).

Bedouin patients knew of the problem of language in the hospital and would typically have someone escort them who spoke Hebrew. Dana, a second year resident recognized this phenomenon and told me that Bedouin families “come with their own translator.” And because Bedouin men typically speak more Hebrew than Bedouin women, they usually acted as translators. This reliance on men created a gender dynamics within the hospital that positioned men as the spokesmen for the entire family and rooted providers’ notion of the Bedouin family and male/female relationships.

The assumed role of men as intermediates between staff and patients was evident one morning when Avraham, an attending physician in the hematology oncology unit, called Suhaila’s name from the list of patients. Suhaila, a six year old Bedouin girl, was accompanied that morning by her grandmother, sister, and father to clinic. Suhaila’s mother, grandmother, and older sister served as her primary care-takers, as I came to know them personally when Suhaila’s care was transferred to the mobile clinic, and none of them spoke Hebrew fluently. Thus Suhaila’s father played a critical role in mediating communication between the staff and these women. Suhaila lay on the gurney, while her father stood closest to Avraham. Avraham, a middle aged Jewish man asked, in Hebrew: “When did Suhaila receive her last treatment?”—directing the question to the father. The father responded that he did not know.

Avraham began to go through Suhaila’s medical file—in search for the answer to his question. Like Salem’s medication bottles or the computer file in Jacob’s case, here the physical medical record become the means to ascertain medical knowledge. But furthermore it was used to discount the need to speak directly to patients or the people (most often women) who care for them. ”It’s all here,” Avraham remarked in Hebrew,

flipping through the chart, "but I don't want to go through the whole thing." As Avraham searched the chart, Suhaila's father asked the grandmother the doctor's question in Arabic. The grandmother responded to her son, in Arabic, "She was diagnosed in December and twelve days later began treatment." Avraham, who does not speak Arabic, remained oblivious to the grandmother's response and the father did not translate the response back to Avraham. I do not know why the father chose not to translate the grandmother's response. He may have felt that the physician already could find the answer to his question, or that the woman's response was irrelevant, or incorrect, or that Avraham (or I) understood the grandmother and therefore this did not need to be repeated in Hebrew. But regardless of reason, this encounter questions the assumption that male family members can and will translate for their families.

Avraham continued in his assessment of Suhaila, asking the father in Hebrew what medication she is currently receiving. The father turned to the grandmother and asked in Arabic the same question. The grandmother responded that there is a pink pill and a white pill. Again, the grandmother's answer was not translated back to Avraham (and Avraham did not inquire what she said). Instead the father asked the physician if he would like to speak to Suhaila's mother. The father, positioned as the mediator, filtered the type of information he thought that the provider would like to know. A response such a "pink pill and white pill" was deemed by the father to be not medically specific enough and thus was not even disclosed to Avraham. Furthermore, Avraham— by not addressing the grandmother and not asking the father what she said—also reveals his assumption that the grandmother does not have any pertinent medical information.

The father called the mother and she read out loud over the phone the names of the medication bottles. Avraham wrote this list down, and said to the father, “Next time I want to see the medication.” In asking the family to bring Suhaila’s medication to the next appointment, Avraham disclosed what he felt was absent from this encounter: the prescribed medication. His inability to communicate directly with Suhaila’s primary caretakers—the women in her family—was not raised; instead the pill bottles were assumed to be able to “speak” the pertinent medical information.[52]

Like Suhaila, Nur’s family arrived to the emergency department with their own translators. As the evening shift began, I joined Leonard in the Emergency Department. It was only 4pm, but the lobby was already packed with patients and parents, impatiently waiting. I followed Leonard into an exam room where Nur, a 1 year old Bedouin girl, her mother, father, and older brother were gathered around the hospital bed. Leonard asked in Hebrew what brought them to the hospital. The father, who spoke fluent Hebrew, explained that they visited the doctor yesterday and she instructed them to go to the Emergency Department if the girl’s fever did not subside. Leonard asked the father again what happened, seemingly not content with this answer. The father turned to the mother and asked her Leonard’s question in Arabic. The mother replied in Arabic to her husband that the girl vomited twenty times. The father translated this response into Hebrew for Leonard. “What she threw up twenty times?” Leonard replied in disbelief. The father, not translating Leonard’s skepticism, changed the mother’s response and said in Hebrew: “Yes, 10 times.”

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[52]While beyond the scope of this chapter, it is important to add that as uncertain as the patients’ history remained for physicians, the certainty of pharmaceuticals is also something that requires cultural work to be produced.

Like in Suhaila's case above, here the patient's father is positioned as the translator for the family. He acts as a mediator between the patient's mother, the patient, and the provider. Yet the father acts a sieve, not translating Leonard's second inquiry into how many times the patient threw up and altering the mother's response. Furthermore, by directing his question to the father, Leonard presumed the father would speak for the family. Bedouin men are positioned as the speakers for Bedouin families—and as such providers sustain the assumed patriarchal status of Bedouin families. Yet by not speaking Arabic, they fail to acknowledge the central role that women play in care-taking.

The absence of Arabic speakers among the medical staff raises an important point in regards to the gendering of care and the silencing of this care in the medical system. While women in the Bedouin community are most often the caretakers of the ill and thus know the intimate bodies, experiences, and illnesses of patients, women who do not speak Hebrew often cannot relay this information to healthcare providers. The absence of translators in the hospital, an educational system that historically made is difficult for Bedouin women to study, and until recently women's limited employment outside of the household has limited Bedouin women's formal education in Hebrew. In addition, providers assume that Bedouin women cannot speak, that they are passive, that they are controlled by their families and especially husbands—automatically directing their questions to fathers and brothers and not insisting that women remain involved. Thus Bedouin women are positioned as non-speakers in the medical space.

This view of Bedouin women was characterized by Batya, one of the hospital psychologists. She explained to me that with the exception of educated women, most Bedouin women are "passive" and medical care is funneled through men: "The entire

understanding [*tfisa*] of treatment is different, everything is through the father…. The place of women in the Bedouin culture is of an object." Naming Bedouin women as an 'object' permits providers like Batya to marginalize the issue of language in the hospital, and instead focus on Bedouin men's control of women. When I asked Leonard how he communicates with Arabic speaking patients he responded that "the dad always speaks Hebrew; mom speaks some that is much reduced. So dad is the person who speaks." Bedouin men are thus positioned as the voice of the family.

Several weeks after the incident between Leonard and Nur's family in the hospital, I met with the father, Zinadin, to hear about his experience in the ED. Born in 1970 outside of Beer Sheva, Zinadin lived his entire life in the Negev. As a child he recalled that there was one clinic in the entire area where he grew up, around Kseife, today one of the recognized Bedouins towns[53]. He lives in Beer Sheva and works as the facilities manager of a large absorption center. Jewish immigrants from around the world who move to Israel—what is called *aliya* or ascending in Hebrew—are given temporary, subsidized housing in such centers located throughout the country upon their arrival.

Zinadin and I sat at the picnic tables in front of the absorption center. It was January, but the strong sun disguised the official winter season. Zinadin recalled what brought his family to the ED that afternoon. His daughter had been sick with diarrhea and a fever two days before their visit to the hospital. His wife took the girl to the family doctor at their local clinic who said: "I'll give you this medication and everything will pass." Zinadin continued:

[53] The clinic around Kseife was likely Tel Al-Milh (see Chapter 2). A renovated clinic and mother and child clinic were opened on October 12, 1976 and named in memory of Dr. Binaymain Ben Assa (see Figure 1) (Lahman 1976a).

> The next day the fever didn't go down, and she [his daughter] started throwing up. In the afternoon my wife called me, I told her to call to see if the clinic was open. She called, it was closed. So I told her to take her to the hospital. She took her to the hospital and when I got off of work I came there.

Despite the mother's primary role in caring for her daughter's illness—taking her to the clinic, calling the physician, and going to the ED—providers and patients alike assumed that to receive medical care in the hospital you need to come with your own translator, typically a man. But while hospital staff presumed family members could serve as sufficient translators, Zinadin disagreed with this approach. Doctors, he explained, typically called another patient who speaks the same language—be it Arabic, Russian—if they run into difficulty. But the problem, he emphasized, "is not the customer's [*lakoach]* or of the citizen, the problem is of the state." Zinadin inserts into the encounter between patient and provider the larger language dynamics within the state:

> If I go [to the hospital], I am an Arab living in the state of Israel. Right? My child understands Hebrew … but they don't understand the Arabic. Why? The Arabic language is recognized by the State of Israel, like the Hebrew language, recognized. So [the hospital staff] needs people that will also understand the Arabic language… You know what? I don't want to speak… Like an elderly woman, like Um Raed that you live with, who doesn't understand any Hebrew, is that her problem? It's not her problem!
> NR: So whose problem is it?
> Zinadin: It's the state's problem. The state needs to make sure there is a translator everywhere... Or the doctor himself needs to understand the language of the person before him. How will he speak to him about his treatment? How will he speak to him, how will he [know] his problem?

Zinadin located language as a central problem in the hospital and state. As such he links the problem of language in the hospital the larger marginalization of Arabic in Israel. But not only does Zinadin question whether medical care can take place without providers speaking directly to patients or using official translators, he also challenges the responsibility that providers (and according to Zinadin, the state) place on Bedouin men.

"You know what," Zinadin continued, offering another hypothetical situation. "Say my wife doesn't understand Hebrew and she went alone. Suddenly, I'm busy. She went alone to the hospital. She's not allowed to go alone? She's allowed to go alone. And they won't understand her so it's a problem."

Zinadin provides an important contrast to the typical rhetoric of Bedouin women's dependence on Bedouin men—for transportation, housing, security, decision making, language, and income. Zinadin inverts this narrative by suggesting that it is the hospital and the state that create Bedouin women's dependence on men. By not speaking Arabic and assuming that Bedouin women do not have relevant medical information, providers silence Bedouin women's experience, knowledge, opinions, and questions. Furthermore, in their assumed position of men as translators—and as having the authority to speak for the family— providers construct Bedouin women as "dependent on men" and "passive."

The extent of this assumption was evident when I visited a clinic located in one of the unrecognized Bedouin towns. As women could walk to the clinic and did not rely on men for transportation, they often came to the clinic alone. The clinic's physician, Daniella, was a Jewish woman who began working at the clinic six months earlier. She explained to me that it was the first time she realized that she does not understand Bedouin patients.

> It's the first time we have run into the problem of language. Because usually in the larger clinics they [the women] need a ride so a man drives them so there is someone who speaks Hebrew.

The Supreme Court forced the Ministry of Health to establish a medical in this community, based on the National Health Insurance Law. Building the clinic resulted not

only in providing medical services to the Bedouin, but also highlighted the issue of language to medical providers.

III. Speaking for the Bedouin

When men did not accompany women to the hospital, often other Bedouin families – typically other Bedouin men accompanying their own family members—were used by staff for translation. But like providers' assumption that Bedouin men speak for Bedouin women, they similarly suggested that it was okay to utilize other families to translate for one another, often learning intimate details about one another, because of the "open-ness of Bedouin culture". Mira, a nurse in the hematology oncology department, explained to me that she routinely asked Bedouin families to translate for one another as they are "very open, or maybe that's just my feeling. Like there isn't a problem to ask a dad to translate." While Mira initially suggested that *families* translate for one another, in her explanation she marked the speaker as "a dad". Thus not only are men positioned as the speakers for a single family as I discuss above, but Bedouin men are assumed to be able to speak for other Bedouins. Providers thus collapse the individuality of Bedouin patients into a unitary, and collective, idea of the Bedouin.

Sigalit, another nurse in the department, was sitting with Mira and I in the lunch room where I interviewed both nurses. Sigalit, concurring with Mira's point that Bedouin families can translate for one another, brought up Bedouin's eating practices as an example of their open-ness. "They eat together so it's not that I am entering their privacy." Sigalit and Mira's observation of Bedouin families eat together, led them to conclude that Bedouin are 'open' and 'lacking privacy'—seemingly one group sharing language, food, but also medical interactions. But the issue of food was not only

discussed as a means to justify Bedouin communal-ness but also Bedouins' lack of advancement and hygiene.

In Bedouin families, a large table cloth is placed on the floor and the family gathers around a large plate of food- often with a number of smaller bowls of shared soup and salad. Bedouin families in the hematology oncology department, where patients would be hospitalized at times for weeks—and where a patient often had a private room--often ate in this manner in the hospital. For Sigalit and Mira this shared manner of eating indicated a lack of cleanliness—but also the lack of individual boundaries:

> Sigalit: Think about it that in the room they eat on the floor and we pass by and walk there and are horrified […]
> Mira: No, but it's education. It's education from a young age.
> Sigalit: But it's not education. It's not that they are not educated or something, *it's their education,* you know.
> Mira: Okay, but if you want to create change, you want that there will be less infections, so you educate them to wash their hands more.
> Sigalit: Right, I educate correctly.
> Mira: Or you want there to be less disease so you educate them that there is at thing called IVF [in vitro fertilization].
> Sigalit: Right, right. But the question is if I in this role really educate and they accept it? The question is whether we are really educating them or force [*kofim*] this on them? Because if they return home, where they sleep and where they eat on the floor and sleep where they want and they eat milk from a sheep because that's what they are.

Sigalit and Mira positioned Bedouin families as an earlier generation than Jewish providers (and the unstated Jewish patients and their families). As Sigalit emphasized, it is not that Bedouins are uneducated, but rather their education is fundamentally different than their Jewish counterparts-*it's their education*. They position the Bedouin as closer to nature—not knowing proper hygiene, drinking milk directly from livestock, and eating and sleeping on the floor. The manner they eat becomes a justification for their 'tribalism' where Bedouin men can serve as the spokesperson for the undifferentiated group.

My conversation with Sigalit and Mira began around the question of how as non-Arabic speakers they communicate with Bedouin patients. Yet the nurses shifted to speak of the inability to *educate* Bedouin patients. As such, the challenge of communicating with Bedouin patients transformed from a question of language to one of development and culture. With the effacement of language as a problem, Bedouin patients became responsible for the lack of understanding and poor health. Charles Briggs and Clara Mantini Briggs (2003) writing on the cholera epidemic in Venezuela, similarly note the manner that 'culture' is used to silence minority communities' health concerns. Public health campaigns and the historical marginalization of minorities help transform these communities into "unsanitary citizens" and thus their illness becomes the result of their own non-modern way of life rather than government neglect.

The extent that culture was used by providers to explain misunderstandings (and disease) was evident when Sigalit and Mira explained what they saw as Bedouin families' repeated mistakes in terms of medical compliance. While doctors like Avraham assessed *what* medication was being taken, nurses needed to explain *how* to take medication. Sigalit recalled her frustration in instructing Bedouin families how to take their medication:

> They return and we see what he [the patient] isn't receiving [medication] at home. It's amazing. Not matter how many times you explain, it gets missed. And it gets missed while in the Jewish population it's not like that. Maybe they [Jewish patients] miss in the beginning but then there is order. Here [among the Bedouin] there are a lot more misses, a lot more misses. Because of a lack of communication and difficulty of language and understanding. And again how they see [disease]. It's not that important… There is a really, really, really big gap between how we see disease and how we see what is important… and how to treat and how to behave and how we see these things and how they see these things, and things are completely different. I instruct patients about hygiene. What I know as hygiene is washing hands with soap and water… Something basic [like bathing] every day. [Even every] two days, okay we will concede. Among them,

> it's once a week and it's okay. That's how they live, that's what they know, that's how they are. And we don't understand it because we look at from our eyes with what we are used to, with what we were raised, and that is our expectation. Meanwhile they have no idea what I am talking about and why I need this. And the change will take another hundred years. Need a few generations to move into homes. Into how I live. Only then can we treat them properly.

Sigalit's narrative raises several points central to understanding how language and culture come to be interchangeable in SH. Here, Sigalit again does not actually name 'Bedouin' patients—instead Bedouins remain an undefined "they" contrasted to Jewish patients. Another nurse who discussed the issue of giving medical instructions to parents told me she gives different instruction to Bedouin families than Jewish families. When I asked how the two differ, she explained that she gives "more primitive, simple" explanations to the Bedouin.

The gap that Sigalit places between herself and Bedouin patients positions Jewish, Hebrew speaking staff as fundamentally different—and more advanced— than Bedouin patients. In chapter 3, I discussed the historical processes that led to the construction of a divide between Jewish and Bedouin population in the region. There I focused on how these differences informed and shaped medical research. Here I want to highlight how these differences enter into providers' understanding of their patients in the clinic as not only different from one another but also from themselves. Bedouin's "way of seeing things" creates an incommensurability of perspectives according to this narrative. It is of significance that Sigalit states that she and her colleagues "don't understand" Bedouin patients "because we look at it from our eyes, with what we are used to."[54] By positioning understanding as a manner of outlook, and not language, Bedouins' poor health—and

[54] This is an interesting relation to the active blindness I discuss in the previous chapter. Sigalit's outlook and explanation that the staff sees things from "their eyes" highlights the restrictions placed in the practice of healthcare. Sigalit raises these blinders as markers of difference rather than creating commensurability. I suggest that this marking of difference is actually the remainder of creating sameness. It is the difference that remains and disrupts notions of equivalence.

inability to comply with medical instructions— is blamed for lack of modernity and progress. In order for their health to improve, Bedouins, within this narrative, need to transition into the kind of life she leads, into something that she can recognize. I return to this evolutionary narrative in the next section, but at this point I also want to highlight that Sigalit and Mira's focus on hygiene as a manner of Bedouin's innate education, neglects a very real absence of water in the Bedouin communities that forces many families to save water and not shower daily. In SH, medical staff's emphasis on Bedouin families' hygiene, deflected attention from the longer historical marginalization that places Bedouin in poor health.

In the recognized Bedouin town where I lived we did not have water for days and at times weeks at a time (Koriel March 1, 2009; Igne January 9, 2012). Families would store water on rooftops or fill plastic containers with water from a neighbor who had running water. A few mornings during the water shortages, Um Raed's grandson and I drove to her daughter's house to fill large *barmeels* with water. I would take a dozen plastic bottles with me to the hospital, so I could stop by a gas station on the way home to fill them with water for cooking, cleaning, and drinking. Several times I showered at the university's sports facility adjacent to the hospital, not knowing whether there was running at water at home. While I had previously considered myself water-conscious— closing the tap while I brushed my teeth— I was repeatedly chastised by Um Raed for my blatant waste of water: not showered into a plastic bucket that could then be recycled to water the trees and flowers planted around the house and using too much water to wash dishes. In the unrecognized villages many Bedouins did not have official connections to the water grid—often illegally siphoning off water. In recognized towns like my own, the

municipality blamed residents for not paying their water bills and residents blamed the municipality for not transferring payment to the water company. Regardless of the culprit, the entire town would be shut off from water supply in retribution. Thus the nurses concerns about Bedouins' lack of bathing links to a bodily condition resulting from structural tensions between the government and the community that also needs to be addressed (and that was never raised by medical staff). As Anderson notes regards to American public health officials obsession with Filipino excrement, the emphasis on hygiene "render invisible the contributions of economic exploitation and social disruption…to the spread of disease" (1995, 644).

IV. Slippery Words: How Bedouin Families Navigate Language in the Hospital

When words are permitted to stand on their own, or providers assume men will serve as translators, strange slippages and creative movements occur. This movement between words said and understood was evident during Nasiha's visit to the emergency department. Nasiha grew up in Rahat, the only Bedouin city and the second largest municipality in the Negev. Six years ago she got married and moved to one of the recognized Bedouin towns. The day I met Nasiha, she had taken her youngest daughter to the local clinic due to a continued cough. The primary care physician who examined the girl instructed Nasiha to take her directly to the hospital as he was concerned for the girls' condition. Nasiha's husband was at already work, so her husband's brother drove her to the hospital and dropped her off at the ED.

After the routine waiting and shuffling that marked visits in the emergency department: from reception to nurse triage, then back to reception and finally to the physician, Nasiha and her daughter were sent to radiology. I walked down the hall with Nasiha, showing her the way to the ED's radiology room. There we found four other

Bedouin women waiting. We joined the group—chatting about what brought each family to the hospital. A few minutes later, the radiology technician opened the door and announced in Hebrew that he was done for the day and that everyone must go to the *machon.* The women looked at one other, trying to ascertain the technician's instructions. One of the women assigned me, the Hebrew speaker, to inquire the meaning of the technician's words. I walked back to the emergency department with Nasiha to ask about the machon—similarly not knowing what the technician meant. Nasiha whispered to me, "Don't say that word, it's a bad word." I knew that machon in Hebrew meant institute or facility—such as "machon kosher" (fitness facility) or "Machon Van Leer" (The Van Leer Institute)— but a bad word? "What does it mean?" I asked, confused about her concern. "I don't know," she replied, "but it's a bad word." When I asked another nurse what the technician referred to by 'machon' she explained to me that the patients need to walk to the *machon radiologia*- the radiology department— in the main building of the hospital.

When I got home that evening I told Laila, Um Raed's youngest daughter, about what had happened in the hospital and the confusion around the meaning of *machon*. She explained that Arabic speakers in Israel use the word to mean sex shop. "There are different uses for the word, but some people that is the use they have for it." Thus the absence of language not only was a way to prevent direct communication with patients, but it also allowed a type of slippage of words.

This slippage also worked the other way around—with Hebrew speakers clinging to particular Arabic words uttered by Bedouin families while the larger context was missed. One afternoon in the emergency department, a nurse and a medical student were

drawing blood from a Bedouin infant. The student, trying to find a vein in the girl's small arms, had pricked her twice without success. The mother, accompanied by her paternal uncle's son, was looking above the bed where her daughter was crying. In Arabic she said to her cousin: "They are learning on her, they are letting him learn on her." The nurse and medical student neither of who spoke Arabic, remained oblivious to the mother's anxiety. The process continued and the mother said something which I didn't hear, but the nurse looked up at the mom and said, "No one is going to *dabah* –kill—your daughter." The mother's concerns about the role of medical students in the emergency department were not attended to in this encounter. Instead, the nurse responded to the one word she understood- *dabah*- defensively responding to what she thought she heard and unable to have a conversation with the mother about the process of drawing blood from her daughter.

The matter here is not only a multiplicity or misconstruing the meaning of singular words. Rather there is an inability of Bedouin patients—and especially Bedouin women— to ask questions in the hospital from Hebrew, non-Arabic speaking providers. When individual words are placed as sufficient to communicate with patients, misunderstandings and collisions such as these occur and patients have no ability to ask for clarification. Furthermore, when providers assume they can understand and communicate through a few words they find themselves constructing their own narrative—one intimately tied with who and what they imagine a Bedouin patient. Yet this imagining is a type of guess work—assuming disease based on a patient's last name, on the meaning of a word, on previous hospital visits, mediation bottles, and various

translators. But as Musa, the mobile clinic driver said, “even the best doctor, without language can only guess.”

Yet Bedouin patients find means to speak to providers. During my visit to Jacob’s clinic, an emergency case arrived. Jacob ran over to see a young girl. The mother requested from the nurse that the Arab doctor in the clinic examine her daughter. Jacob, walked out of the exam room frustrated. He said to me in English, “I understand what she has, and he probably doesn’t even remember. I was his tutor!” Despite being a specialist in pediatrics and having much more experience, Jacob has found that Bedouin parents often prefer their children to be seen by his Arab colleague. “Is it because he is Arab or because he speaks Arabic?” I asked. “Because he is Arab,” Jacob immediately relied. “They trust [Arab physicians] more.” He felt that patients view him like “little red riding hood wearing a stethoscope.” Like the wolf in the story of little red riding hood, Jacob explained that Bedouin patients view him as a danger, shrouded under a cloak of care. While Jacob’s explanation for this preference as a matter of trust disregards the problem of language in the medical setting, it brings into relief the tensions that circulate around medical care. Bedouin families would routinely travel to West Bank cities such as Dahriyya or Halil (Hebron in Hebrew) for medical care (Parziot 2001). In addition, it was common for Bedouin families to visit private physicians in the Bedouin community rather than go to the government run clinic. On her way home after a brief hospitalization, Samaher, Um Raed’s daughter-in-law stopped by Dr. Mansur’s clinic down the street from our home. I asked Laila why, upon her discharge, Samaher went directly to the local doctor. “Sometimes people come to be heard. For the doctor to listen. For example when I was in the ED because of throwing up I was scared. It was the first

time I was pregnant, and for them it wasn't a big deal. It was *'adi'* normal." Laila inserts the important aspect of listening that patients, like herself and Samaher, seek. Seeking care in private clinics—even through these cost additional funds—becomes a means to speak and to be heard by providers.

V. Pre-modern Subjects

In an article on memory and the Nakba, Samera Esmeir (2003) questions what voices, what memories can be utilized as evidence in the courtroom. "How legitimate," she asks, "are the memories of Palestinian survivors within the fields of law and history?" (ibid, 29). Esmeir argues that the legal system itself "shapes the story admissible into law" (ibid; see also Das 1995). The manner evidence is evaluated and presented effectively discounts the narratives and memories of those who survived the violence that took place in 1948, while further sedimenting the state's narrative as legal fact. The courtroom thus extends the Jewish state's effacement of the Nakba, adding a legal level of erasure.

The violence that took place in 1948 in the Negev is rarely, if at all, discussed by Jewish Israelis. Within the medical system itself, the history of the relationships between the state and the Bedouin community are not seen as relevant to physicians or for treating Bedouin patients. I want to suggest that the discounting of the Arabic language in the hospital links to the larger neglect of the history, and specificity, of the Bedouin community in the area. I find Esmeir's insight useful in considering why particular voices are allowed to enter the clinic and why Arabic is discounted as necessary for care. The conversation between Jewish providers and Bedouin patients remained curtailed not only because of the provider's limited Arabic or the mother's limited Hebrew, but just as crucially because Bedouin patients are assumed by providers to be unable to provide

relevant medical information. Like Lara's comment above that Salem's father was too much of an idiot to understand her Hebrew, Bedouin patients were routinely characterized by providers are primitive, backward, and not understanding medical information. This discounting of Bedouin narratives often began with positioning Bedouin patients in an earlier time period than their Jewish medical providers and modern medical technologies. One provider summed this perspective when she declared to me over lunch: "The problem is that they still live in the middle ages but want 21st century medicine!"

This temporal positioning of Bedouin as pre-modern, justified for providers the community's poor health but also discounted the need, or ability, to speak to patients in the clinic. Jacob, the music doctor, explained to me that the Bedouin were still located in a different era, they "still have not accustomed to what they must."

> They still continue with their old opinion, with the folk medicine, with all sorts of things. They don't care that the doctor is a specialist. People come here [to the clinic], but I am telling you, sometimes I feel like I give information, things, for no reason, for no reason... They need to pass a generation. Each generation is about twenty years. A Generation needs to pass. They are undergoing rapid transition and can't absorb the changes in such a short period of time. Think about it. Forty years ago, that's two generations, they were in the desert. Rahat is a city of 20 or 30 years. It is the biggest city in the Bedouin community. It's really dramatic. And what we are doing to them is occupying [*kovishim*][55] them with all of our things. If we want to help they don't accept it like that.

Jacob positioned Bedouin patients on an evolutionary trajectory—stuck with their old opinions and ways, still decades behind. Like Lara and Sigalit's characterization above,

[55] Jacob's use of the Hebrew word *kovishim*—to occupy— again employs a military imagery and power dynamic towards the community. *Kovishim* has strong connotations of military prowess in Israel – of seizing territory—and in particular in regards to the territory of the West Bank. The term was initially used by the Israel Defense Forces during the 1967 War to refer to the region that Israel conquered from Jordan. Today the term is used largely by individuals who view this land being illegal controlled by Israel and need to be granted to the Palestinians.

Bedouin patients are positioned as unable, or unwilling, to absorb providers' medical instructions. This description of the Bedouin as still needing to "pass a generation" links to the challenge, or more aptly providers' insistence of the lack of challenge, of Arabic in medical encounters. The insertion of the evolutionary narrative of the Bedouin—as still transitioning, unable to absorb, recently emerging from the desert —removes the issue of language from medical encounters (see Chapter 3 for further discussion of the transition narrative). The problem of delivering health care within this framework stems from Bedouin patients (and their parents') inability to understand medical information, and not due to government neglect of the community or providers' inability to take a full history even when a parent is present. It is not language according to this description that makes medicine difficult to practice, but rather Bedouin's position as not-yet modern.

The evolutionary trajectory that providers employed in their description of Bedouin patients was similarly used by Europeans to justify colonialism. Dipesh Chakrabarty (2000) writing of India highlights how the positioning of Indians as 'not yet' modern by the British solved the contradiction of the ideals of universal equality and the practice of colonialization. Europeans could deny suffrage, rights, and freedom to Indians because the "natives" were understood to be in "waiting room" of modernity (Chakrabarty 2000, 8). Furthermore, by characterizing colonialization as a process through which natives may advance, the project was characterized as one of benevolence and development (Anderson 2006). Johannes Fabian (1983) critically examines the role of anthropologists in the subjection of non-European subjects. Fabian outlines how anthropologists' use of temporality positioned "natives" on an earlier time scale, while anthropologists themselves were narrated as modern subjects present in the "here and

now.” Through this temporal disjuncture, the subjects of anthropology’s research were denied as “coevals” with anthropologists themselves. But where does language fit in this process? Chakrabarty (1992) famously asks “who speaks for Indians pasts?” Yet his question is directed more towards ideology than the practice of speaking and listening itself. Following up on Chakrabarty’s inquiry in this context has led me to interrogate who speaks for Bedouin pasts and what pasts can be uttered. Considering language as a critical site for understanding medicine helps clarify how equivalence can be asserted in this context and the role of partial erasure in creating this sameness (see Chapter 4).

Bauman and Briggs (2003) in *The Voices of Modernity* directly address the role of language in creating modernity and justifying inequality. Language and the manner one speaks becomes a mark of one’s social position. Yet it was those in power who designate what form of language is marked as modern and whose language would be marked as backward—all the while claiming language to be neutral. In the Israeli context, language has similarly played a role in marking modernity. Prior to the establishment of the Israeli state, but more so upon its founding, speaking Hebrew was a central component of becoming a modern Jewish subject. The establishment of the Modern Hebrew language became a national project to create a Jewish community. For example, Hebrew names were established for existing towns (literally erasing Arabic names) (Benvenisti 2002; Abu El-Haj 2001). In the realm of medicine, a committee was established to create Hebrew names for diseases (Sufian 2007a). Emigrants from around the world were taught and encouraged to speak in Hebrew.

Ella Shohat (2003) has forcefully illustrated that while Arabic is an official language of Israel, Jewish emigrants from North Africa and the Middle East were

encouraged to not speak Arabic- as it was marked as a sign of backwardness. Arabic has progressively been removed from the Jewish school curriculum (Abu-Saad 2004). Throughout Israel, as well as in SH, many signs are not translated into Arabic (Sone 2010). The updated Tel Aviv municipality website failed to be translated and updated into Arabic (Eilon 2010). The assumed neglect of Arabic in the Israeli public sphere was poignantly revealed to me one evening when I was doing English homework with Sara, one of Um Raed's granddaughters. The exercise required students to mark "agree" or "disagree" with each sentence. The first one read: "The street signs in my city are in a language I understand." Sara checked off "disagree." When I asked her why she replied: "All the street signs are in Hebrew."

Thus the absence of Arabic in the Israeli public space was part of daily life for Arabic-speakers in Israel. But unlike the supermarket or bank, in the context of medicine miscommunication can have deadly consequences, like in the Dalasha's case. Furthermore, the absence of Arabic in the medical space produces particular data that circulates as knowledge about the Bedouin community in the form of journal articles and medical studies (see Chapter 3). By insisting that they speak 'enough' Arabic through relying on a few words or ad hoc translators, providers characterized Arabic and Arab patients as something already known. The issue of language which limits providers ability to understand and to speak to patients shifts to be discussed as an issue of Bedouin culture—as Bedouin being not yet modern, simple, primitive—and reconfigures the scope of what is relevant medical information. This derogatory language discounts Bedouin narratives, and removes responsibility from provides in regards to health disparities since evolutionary narrative justifies existing differences. Discussing Bedouin

patients as not yet contemporaries with the Jewish population circumnavigates the need to address the issue of language in the clinic—and providers' inability to understand Arabic, or their patients.

VI. Conclusion

In 2007, Judge Darel ruled in favor of Maha and Salim Dalasha's case. The Dalasha's case is but one of a series of legal cases debating the status of Arabic within Israel (see 4112/99; 4438/97). Israel adopted the British 1922 Order-in-Council that recognized Arabic as an official language, yet Arabic language remains marginalized within Israeli society. The Dalasha's case set an important legal precedent, but it did not address why Hebrew speaking providers without training in Arabic feel they can communicate, speak, and understand Arabic speaking patients. Only one physician I encountered during my fieldwork strongly emphasized that Arabic posed a significant challenge to her work. Lina was a third year resident in pediatrics when I met her in the emergency department. Originally from Jerusalem, she was a religious Jew who had gone to medical school in southern Israel. While most of the residents I met throughout the year were tired, frustrated, and disgruntled by the volume of patients they needed to see and the little time they had to learn, Lina still enjoyed her work. On her last day in the ED before she continued to her next rotation, I interviewed her in of the exam rooms.

Early in the morning the ED was still quiet—the last few patients from the night shift headed home or were admitted to one of the hospital's inpatient department—and the wave of new patients had yet to arrive. We made coffee in Styrofoam cups in the kitchen and sat in one of the exam rooms to conduct our interview. The main problem in SH, Line stressed, is communication.

> Ninety percent of the people here speak Arabic. So yes, usually the mother is accompanied by an uncle, or some nephew, or someone who speaks Hebrew… It's impossible to take a history like this. It just damages [*pogea*]. It's the basis. I see it, it's the basis and I can't [take a history] so it's really hard.

In her narrative of the challenge of communication in SH, Lina outlined the manner men becomes mediators and speakers for Bedouin women in the hospital. But she also stressed the impossibility of gathering a medical history without a shared language. If a history cannot be taken, what is heard by medical staff? What is treated? And what is documented in the medical record? What is interesting in Lina's narrative is that despite her recognition of language being a main problem in SH, she too did not speak Arabic. Nonetheless she treated Bedouin, Arabic speaking patients routinely. When I asked her if she remembered a case where she felt that that her inability to speak Arabic was a problem she replied, without hesitation, "It's every case. There isn't a specific case." She began to tell me of a recent trauma activation of a boy who arrived hardly breathing:

> I ask her [the mom] what happened to the kid and she is screaming because she's stressed, but mostly she is screaming in Arabic and I don't understand what happened. This is an extreme case but, there are those cases that you need a history, that you need to know to help the child in an acute manner and you don't have it. And you don't have it because you don't understand.
> NR: So what did you do?
> Lina: You run to look for someone, and pantomime … and run to look for someone who speaks Arabic. In this specific case it was okay, but again, you see this a lot and this is an extreme example. For example, take not an acute kid, a kid that you are trying to understand what he has. He has a fever for some reason. And the history is really difficult. Communication here is really difficult…I can tell you that sometimes I think that I understand but then… I read [in the computer note that] in the department say they were admitted by a doctor who speaks Arabic and he got a completely different history.

Lina details how the inability to speak Arabic limits the care she can provide to Bedouin patients. Lina acknowledges that she thinks she can understand patients but then finds out that she "got a completely different story" upon reading the hospital note. I would add to

Lina's comment that not only does a different story arise, but a different conception of the Arabic language and of Bedouin patients.

Ludwig Wittgenstein writes that "to imagine a language means to imagine a life form." Wittgenstein's insight is helpful to understand how the perception of Arabic links to how providers imagine Bedouin patients in SH and the Negev more generally. It is providers themselves who often end up narrating medical cases—drawing upon remnants of their perception of who and what it means to be Bedouin. This perception links to tropes of modernity, tribalism, primitivism, and gender as I discuss in this chapter. And because of providers' inability to speak Arabic, these notions become entrenched and cannot be challenged or questioned by Bedouin patients themselves.

Chapter 6: Who is the Public in Public Health?

"No one really inhabits the general public" (Warner 1992, 396).

In the previous chapter, I examined how healthcare practitioners in Southern Hospital discount the Arabic language as necessary for providing medical care to Bedouin patients. I argued that the marginalization of Arabic within medical care parallels, and extends, the excluded place of Arabic within Israel at large. This marginalization works alongside the ability to craft patients as equivalent in the hospital. As a result, the specificity of Bedouin patients is actively excluded from medical care—both through language and through the biomedical framework. In this chapter, I turn to another domain of exclusion embedded within a claim of universality, that of the public. I draw on the Israeli Medical Association strike as an entry point to analyze how the discourse around the public healthcare crisis in Israel transformed the movement into a national struggle, but as such deflected attention away from the health inequalities in the Bedouin community.

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On a billboard high above the *Hof HaCarmel* train station in Haifa, a series of advertisements were displayed across the side of an overpass. "574 anesthesiologists are missing in surgery rooms," one read. "A family physician has only four minutes for each patient," a second declared. A third announced to daily commuters that "600 doctors are missing in the internal medicine departments." *And we are all paying the price! The public health must be saved!* (Image 1).

The Israeli Medical Association (IMA) distributed ads like the ones displayed in the Haifa train station during the spring and summer of 2011. The IMA's campaign—

narrating the collapse of the Israeli medical system through these slogans of shortage—quickly became part of the landscape of highways and main intersections throughout the country. In April 2011, the IMA launched what would become the longest physician strike in the country's history. Unlike previous physician strikes that focused on increasing physicians' wages, the 2011 strike—while also seeking pay increases—pivoted around the call: "To Save the Public Health!" One journalist made note of this shift in the early days of the strike:

> Unlike earlier physician strikes, this time they [the IMA] are asking to emphasize the need to significantly strengthen the public health system, in addition to their demand for increased wages. The demands to add positions, hospital beds, and medical units in the periphery, they hope, will help recruit the public's support that will be hurt by the strike (Even 2011d).

In his statement, the journalist stresses two aspects central to the IMA strike: First, the link the IMA drew between improved conditions for physicians and the health of the general public. Second, by specifically emphasizing the need to improve the health conditions in the *periphery* (like Southern Hospital), the IMA helped constitute the periphery as a central part of the public. This reorienting of the strike away from physicians and towards the public was apparent in the speech delivered by Parliament Member Rachel Adatto, herself an obstetrician and gynecologist, to a crowd of physicians demonstrating before the Knesset: "The Israeli Medical Association did well when it tied [*karcha*] the struggle for just and appropriate [*hogen v holem*] wages to changing the face of the public health system."[56] A family physician attending the same rally told the press: "We are here for the public health system, not our wages."[57] By emphasizing the need to improve the *public* health, the IMA engendered an idea of the

[56]Israeli Medical Association. "Doctors' Demonstration in Jerusalem- April 2011." Uploaded April 27, 2011, accessed June 21, 2013. Available: http://www.youtube.com/watch?v=wKMOzPoe-Uk
[57]Ibid.

public that 1. Needed saving and 2. Supported the strike. The IMA transformed the strike into a strike *for* the public and *by* the public.[58] The public thus became a central figure during the strike: the object physicians were saving, the victim of a collapsing medical system, and according to the Israeli government the IMA's hostage not receiving medical care because of the strike (Even 2011e).

But who is included in this public? While the public was configured as an inclusive term during the strike, I argue in this chapter that the strike's public—and the public of public health in Israel—reflects the same marginalization of the Bedouin that I have examined throughout this dissertation. The IMA utilized the idea of a public to transform its campaign from a physicians' strike into a national struggle. Yet the boundaries of this public—and the imagined nation—track along the contours of social privilege in Israel. Crafting the strike around the goal of saving the *public* became a means to entrench exclusion while declaring inclusivity.

I utilize the strike as a point of entry for considering how the idea of the public gets mobilized within discussions of a collapsing medical system in Israel. I draw on the work of Michael Warner (1992, 2002) in considering the paradoxical role of the public as both declaring inclusivity while implementing exclusion. Following a brief introduction to Warner's work, I turn to three examples where the boundaries of the public were negotiated in my fieldwork: the IMA's campaign during the 2011 strike, the annual Conference on Health Equality in the Negev, and the MOH preventative health service to

[58] It is important to emphasize that not all physicians agreed with the IMA's decision to orient the strike as a "public" issue. One resident in SH expressed his disagreement with the strike's motto. "I don't really stand for what is behind it. It's [the strike] in the headline to save the public health system, but it's about our wages. Reduce the number of night calls, but this is not for the public health system." Whether for or against the involvement of the public in this manner, my emphasis on understanding the contours of this public remains.

the Bedouin community. Each example reveals a different aspect of the public in Israel and its shifting borders. Furthermore, through these examples I elucidate how providers', policy makers', patients', and researchers' emphasis that healthcare is a "public" issue in Israel (and in the Negev specifically) circumnavigates the reasons why for so many years health has not been publically shared.

I. The Public's Illusion

In an essay entitled "The Mass Public and the Mass Subject" (1992), Michael Warner argues that the circulation of printed material such as newspapers in 18th century England brought about the emergence of a public subject. While previously, authors penned their work from their specific context and positionality, the increase in mass printing of weekly circulars and newspapers changed the role of the author in these texts. Rather than authors viewing their publications as a "personal extension" and reflection of themselves, authors now began to write as universal speakers and for a universal audience: author and audience were imagined as a joint public (ibid, 382).

Warner argues that technologies such as the printing press and mass circulation of publications initiated this change in the relationship and positionality between author and audience. But Warner additionally stresses that the ability to speak and to write *for* the public and *as* the public remained available only to a minority of authors. Unsurprisingly, these 'public' authors overlapped with those possessing social privilege and capital, namely white, literate men who owned property (ibid). Yet, according to Warner, these authors' advantaged identity remained unmarked in their writing. Instead they published not from their localized, and elevated, social position but rather on behalf of the public. They employed their power to claim what Donna Haraway (1991) has called the "conquering gaze from nowhere" (176). Thus while theoretically, "any person would

have the ability to offer an opinion about them [public issues] and submit that opinion to the impersonal test of public debate without personal hazard," the public sphere and the ability for self-abstraction remained, and continues to remain, a "differential resource" (Warner 1992, 382) .

The notion of the public therefore has a dual function: it creates the idea of universality while implementing, and effacing, a practice of marginalization and domination . Charles Briggs (2004) draws on Warner to emphasize the exclusionary role of public health campaigns in Venezuela in dividing "sanitary" from "unsanitary" citizens. As Briggs forcefully emphasizes: "The ideological construction of 'the public' permits the illusion that public discourses reach out to all possible readers, listeners, or viewers" (ibid, 177). Minority groups remain in a bind for on the one hand they rely on the public discourse (such as national media and the national court system) to make claims and demands of universality, equality, and democracy. Yet to make demands of the public, to be included in the public, requires them to erase claims of specificity. Minority subjects therefore exist in tension with public discourse. For as Warner writes, "The very mechanism designed to end domination is a form of domination" (1992, 384). Within a claim of universality that the public offers, only particular individuals gain access to this positionality.

The public in the IMA's strike, and in discussion of the collapsing medical system in Israel more generally, became a tool to claim inclusivity while enacting the same boundaries that divide the country. This seems like an obvious point, and yet in discussions of the public (and in particularly those made in the name of public health), the differential allocation of who gets to speak for the public, who is included in the

public, and who benefits from public health campaigns, too often goes unaddressed. Furthermore, who is included in this public—and how the lines of privilege change remains critical for understanding the work of the idea of the public. I therefore turn to three examples to help discuss the contours of the public in Israel.

II. The Strike's Differentiated Publics

The Israeli Medical Association (IMA) announced on the morning of April 5, 2011, that it would launch a two day precautionary strike throughout the country's medical system. I drove to Southern Hospital that morning listening to the radio as commentators debated how long the strike would last. This was not the first time physicians were striking in Israel: the 1976 strike lasted 58 days, in 1983 doctors protested for 117 days—going on a hunger strike and shutting down hospitals. The 2000 strike lasted four and a half months before an agreement was signed with the government.[59] I picked up Osama, Um Raed's cousin and neighbor, on the way to Beer Sheva. Osama worked at the local university and I occasionally gave him a ride to the city. As we listened to the morning news, we chatted about the problems of the healthcare system and particularly of the long wait times. The problem, he explained, is that for the diagnosis, he used the word *avchana* in Hebrew, "you need to know the person." Osama's off-hand remark addresses the core tension that would appear throughout the IMA strike. While the IMA discussed the public as an inclusive concept—claiming to encompass all Israeli citizens—the concept of the public elided the "hierarchies of clinical medicine and public health" that actually inform the practicalities of receiving and providing care in Israel (Briggs 2004, 181). Bedouin citizens like Osama officially

[59] Israeli Medical Association. "Physicians' Strikes in Israel 1976-2000, Part B." Accessed June 27, 2013. Available: http://www.ima.org.il/MainSite/ViewCategory.aspx?CategoryId=6192 (Hebrew).

remain part of the public: they are Israeli citizens who have access to the medical system, who are garneted equal health service, and who utilize the medical system. They are also part of the public impacted by the national strike. But because, as Warner highlights, the public carries with it the status quo relations of society, those marginalized remain marginalized within the public. The public therefore become a means, in the case of the IMA, to claim to be speaking for the entire public utilizing the medical system (in this case all Israeli residents insured under the NHIL), while in practice it mirrored Arab-Israelis' marginalization. In this section, I therefore examine how the IMA "Save the Public Health" campaign marked an exclusionary public in Israel.

The strike intermittently curtailed health services for nine months. Once, twice, at times even four days a week different services of the medical system shut down. Some days the entire hospital system closed. Other days surgeons performed only emergency operations. During the month of June, on alternate days hospitals shut down in the north, south, and center regions of the country. The strike created such confusion for patients and providers alike that at times doctors themselves showed up for work only to discover the strike (Hadad 2011). After an initial agreement was signed in August, medical residents who felt the agreement did not improve the public's health or their own working conditions went on a massive campaign to renegotiate their contract. Residents hospitalized themselves for exhaustion, went on hunger strikes, and filled resignation letters en mass. Medical students throughout the country announced they would not begin their internship under the current work conditions, and interns signed a petition declaring they would refuse to begin their residency. In early September after the residents' resignation letters went into effect, hundreds of residents did not show up for work. In

solidarity, specialists also filed resignation letters to pressure the Ministry of Health and Finance Ministry to meet the residents' demands. As one journalist wrote, these acts lead to the "collapse of hospitals in a few days" (Even 2011b).

A massive crisis in the medical system ensued. Departments closed or unified. Physicians who had not taken call for decades were forced to work night shifts in the hospital (Even and Blumenfeld 2011). The National Labor Court declared the residents' resignation illegal (Even 2011g) and the Prime Minister threatened to import physicians from India if the residents did not return to work (Kainan 2011). After four additional tremulous months, the strike culminated in a discussion at the Supreme Court. In early December, the Finance Ministry and medical residents reached a second agreement that officially concluded the strike (Even 2011a).After the official signing of the agreement, the residents refused to attend the press conference stating that the agreement is good for the Finance Ministry but terrible for the public. [60]

But on the morning of April 5th, the first day of the strike, the length and impact of the strike remained but a matter of speculation. I dropped off Osama and headed to the emergency department. A large banner adorned Southern Hospital's main entrance. The Hebrew sign read: *STRIKE TODAY. The physicians are striking to save the healthcare system. Thank you for your understanding* (Image 2). Inside the outpatient clinics, a cardboard cutout in the shape of a doctor greeted visitors. The cardboard doctor, wearing a white coat and adorned with a stethoscope had a paper print out covering her face. The

[60] Overall the physicians received an average pay increase of 24%, differentially distributed based location and specialty. This increase reached up to 70% for some physicians. More beds and positions were opened. And the number of call was limited to six per month and an overall work week of 41.5 hours. Physicians were required to clock in—as a way to incentivize physicians to work in the public health sector. The residents' received additional grant of 60,000NIS distributed throughout their training and the possibility to discuss the agreement prior to its expiration in 2019.

paper read in Hebrew: “I represent a missing doctor in the hospital. That is why you are waiting longer.” Cut-out doctors distributed throughout SH intended to illustrate the shortage of doctor in SH and throughout the country for patients and their families. But by writing the sign in Hebrew, these cardboard physicians hint at the boundaries of the public imagined and enacted by the IMA.

The title of the IMA’s campaign—“To Save the Public’s Health”— highlights the paradoxical role of the public as both theoretically all-embracing and in practice restricting. Across its billboards, pens, pins, and banners the IMA branded its material with the slogan: “To save the public health” [*lehatzil et harefua hatziburit]* (Image 3). In the Hebrew phrase, the subject of the campaign remains undesignated. The statement can be understood to mean: ‘We must save the public health’, interpellating all of its readers into action. But by not specifying who must do the saving, the public appears open yet remains undefined. The use of the term public here works as what Michael Warner calls “a flexible instrument of interpellation” (1992, 385): it embraces all under the umbrella of ‘we’ or ‘the public’, while in practice this subject mirrors its authors’ unmentioned social position.

In addition to its banners and slogans, the IMA solicited a video clip and song to garner support for the strike.[61] The song was a re-lyricized version of an early nineties Israeli hit, “In a Newspaper” (*betoch niyar eiton).* The original song, written by the Israeli band *Tipeks* (Hebrew for White-Out), critiqued the changing character of the Israeli state and citizens’ growing apathy. The re-dubbed song, sung by *Tipeks’* lead singer Kobbi Oz, again aimed to awaken citizens into action, but this time to rattle them from a slumber to save the public health system. The animated clip accompanying the

[61] Tipeks. *Betoch Niyar Eiton.* Available: http://www.youtube.com/watch?v=JsApDnKh42g

song portrayed the daily events in the emergency department of a typical hospital in Israel: Men, women, and children sit in the hallways. Physicians wearing white coats yawn in exhaustion. An IDF soldier appears in several shots. Evoking the original lyrics, “Here are people rolled up in a newspaper,” the doctors’ song begins, “Here are people curled up, lying in a hallway.” An image of an elderly man lying on a gurney appears. Oz continues:

> And doctors are missing. The residents are exhausted and tired.
> And in our health gaps of a new kind.
> If you live far, it’s on your flesh, you will recover less.
> If we don’t address this we will wake up into a nightmare.
> They say that health is central, so enough of the recalcitrance [*atimut*]
> A public health, equal and of high quality for all of us.

The song highlights the main concerns the physicians’ strike put forth concerning the public: the absence of hospital beds, the shortage physicians, and increasing gaps in healthcare. But what is also blatant in the clip is the depiction of the hospital as a Hebrew space. The song lyrics are in Hebrew, all signs in the caricature hospital are in Hebrew, and only two words appearing in a language other than Hebrew are “EXIT” and “Ambulance” in English. The clip ends with the strike’s slogan—“the public health must be saved”. The intention of the clip is to interpellate “the public” to support the strike—to call “all of us” into action, to demand a public health system that is “equal and of high quality for all of us.” Like the strike’s slogan, the clip utilized “we”, “our”, and “us” as flexible instruments of interpellation— claiming to include all and yet oriented towards a particular audience, namely a Jewish-Hebrew speaking one. The clip highlights the boundaries of the public for the IMA, but also who is included in the idea of the public in Israeli society.

In addition to the cardboard doctors, and video clips, the IMA launched a massive billboard campaign. The ads, displayed prominently along highways, emphasized the shortage of medical staff throughout the healthcare system. One campaign, which I introduced in the beginning of this chapter, focused on the numerical shortage of staff throughout the medical system. A second campaign displayed an outlined figure of a doctor hovering over a patient (see Images 4-7). In one version, an elderly woman lies on a hospital bed, breathing with a nasal cannula*. "When there are not enough doctors in the emergency departme*nt, there is no one to take care of your mother," the ad read in Hebrew (Image 4). A second iteration of the campaign portrayed a crying newborn: "When there are not enough neonatologists, there is no one to take care of your baby" (Image 5).Two additional versions of the ad read: "When there are not enough anesthesiologists, there is no epidural in your birth" (Image 6), and "when there are not enough doctors in the internal medicine departments, there is no one to take care of your father" (Image 7). Along the bottom edge of each ad the strike's slogan was displayed: *The public health must be saved*.[62]

Like the rest of IMA's campaign, the public in these ads is portrayed as Hebrew literate. But beyond the issue of language, these ads portray the public injured by the lack of medical providers through a series of familial relations and key lifecycle events: birth (epidural and neonatal intensive care unit), aging, and death. Furthermore, the ads portray how within a deteriorating medical system the responsibility to care shifts from healthcare system towards family members. It is the family that needs to be concerned

[62] As the strike continued, an ad emerged protesting the PM's, Benyamin Netanyahu, lack of involvement in ending the protests. The revised ad depicted a prototypical picture of the Prime Minister but with his image cut out. "Bibi, where did you disappear?" (Image 8).

whether their child or parent is not getting adequate care. The imagined family member (son, daughter, parent) becomes the individual injured by the lack of medical providers. These ads expanded the impact of the Israeli medical system's deterioration from patient to anyone related to a patient. But because of the language of the campaign, the question of which families are responsible for caring for the sick and who is imagined to be a patient within the medical system is highlighted. As I discussed in the previous chapter, by discounting Arabic as a necessary means for care by healthcare providers, family members—and in particular Bedouin women—are removed from their role in providing and caring for the sick. The IMA ads similarly engendered a public injured by the collapsing healthcare system that was Hebrew speaking. As such, it reoriented the longer structural marginalization of the Bedouin—and Arab communities.

III. The Public's Periphery

One of the main goals of the IMA's campaign entailed strengthening medical care in Israel's periphery. In May 2011, during the IMA strike, a conference on "Health Equality in the Negev" took place in Mitzpe Ramon. The conference was one of a series of events during my fieldwork that focused on the growing healthcare gaps between the "center" of the country (often used synonymously with Tel Aviv) and the periphery (most often discussed as the south). Healthcare providers in Southern Hospital as well as the media and policy makers stressed the hierarchy of funding, health, and medical care between center and periphery. If the public is indeed discussed as an inclusive entity, how did the periphery figure into the discussion of the public health crisis?

The Health Equality in the Negev conference aimed to initiate a conversation among academics, policy makers, the sick funds, and community members on how to improve health in the country's southern periphery. On the first day of the conference,

healthcare professionals, researchers, and academics met in four working groups to brainstorm solutions to the challenges conference organizers' identified facing the southern periphery. On the second day of the conference, each working group presented their proposed plan of action.

I joined various students and faculty at the university train station where an organized bus took participants from Beer Sheva to the conference. The conference organizers told us that they chose to hold the conference in Mitzpe Ramon—located an hour south of Beer Sheva and two hours south of Tel Aviv— as a social statement. They wanted participants to experience firsthand the difference in providing and receiving care in the Negev.

In a large auditorium in Mitzpe Ramon's community center, Rivka Carmi, president of Ben Gurion University, took the podium. "The periphery, the Negev, is not on the public's agenda," she began her speech.

> What is present [on the agenda] is the center [*merkaz]* of Israel who dictates the tone and the agenda… There is inequality in the Negev because it not on the agenda of the public, of the government, [or] of the Ministry of Health. The promo for this conference spoke of inequality between center and periphery…. Today we are literally not part of the State of Israel.

In her speech, Carmi turned to the idea of the public in Israel. Carmi directly addresses the exclusionary role of the public – stating that the public is located elsewhere, outside the periphery, beyond the south. Rather than discussing a unified public needing to be saved like the physicians' strike, the public represents the individuals at the center of the country who dictate the tone and the agenda and get better services from the south. The public is not a unitary public that is inclusive of all citizens, but rather the public becomes fractured through the division of center and periphery.

Carmi echoed the concerns of many physicians I interviewed in SH who emphasized the marginality of SH as a hospital in the periphery. Dana, an oncologist, said to me, "Without a doubt you see and feel, sometimes gently and sometimes crudely, where [people] get more… In the periphery they invest less." On a daily basis, the poor investment in SH emerged. During my research, there was no PET/CT in SH and families needed to travel to Jerusalem to complete this medical test (see Chapter 4). Sigalit, a nurse in the heme-onc clinic, explained how when she began working in SH she was shocked that a computer system was still not in place. Nava, a student-nurse, also complained of the facilities in SH: "Most of our equipment is old that works slowly. I need to measure [the blood pressure] for a child three times!" While SH had the most emergency department visits, it had the least hospital beds in the country. "It's simply discrimination [*aflaya]* of the periphery," Lee a physician in the ED lamented, visibly upset as she spoke to me of the neglect she felt as a physician in SH and resident of the region. Until she began caring for patients of sexual violence, all pediatric cases having experienced sexual assault needed to travel to a hospital in central Israel for care. She continued:

> The discrimination/neglect [*kipuach*] the population here experiences on the level of positions, resources is unacceptable. Really, it is unacceptable. People need to wait, I don't know, how long for some exam, four times what [people] wait in the center.

Lee, like her colleagues and the university president, were not the only ones to contrast healthcare in the Negev to country's public located in the center. At the Health Equality Conference, during a panel on the contribution of local authorities and the third sector to closing gaps in health, the Mayor of Beer Sheva, Rubik Danilovich, announced:

> Health is the most important thing, it is not extra. This country needs to understand that it needs to invest more in the south… The residents of the Negev

> need to receive exactly the same thing as those of the center. This is our country! ...We want what a citizen deserves in Tel Aviv and Ramat Gan [two wealthy Israeli cities in the center], not more and not less.

In imagining the goal of health equality as equivalence between the center and periphery, the two sites are positioned in contrast to one another, with the former setting the tone and the contours of the public. When Danilovich stressed, "This is our country!" He pushed the boundary of the public—calling attention to the exclusionary power of the public—demanding a place of the periphery within the public. On the one hand, Danilovich stressed the differentiation between center and periphery within Israel—questioning the unity of a public. At the same time, in demanding that he and his constituents receive what the same services available to individuals in the center of the country, Danilovich actually further asserts the division between center and periphery.

Despite the attempt to change the contours of the public to include the periphery, what remained eerily absent in the conference for health equality in the Negev were Bedouin speakers. The Bedouin remained outside even the peripheral-public, reminding me of their exclusion from the inauguration of the Tel Al-Milh clinic in the 1950s. In an article summarizing the conference, Rami Udot of the Public Network for the Advancement of Health Equity in Israel commented that "equality in health in the Negev is a Negev without Arabs."

> There was no representation of Arab residents of the Negev who consist of a quarter of the population in the Beer Sheva district. Once or twice when they were raised, more as a problem, a nuisance that lowers averages, and not as potential partners in the struggle for equality (Udot 2011).

A roundtable panel with local mayors of Negev towns did not include a single Bedouin representative. Bedouin were not included in how the future, and solution, of health equality in the Negev might look like. By not including the Bedouin population, the

conference the public mirrors the exclusionary practices of the region/country—marginalizing the periphery and the neglecting the Bedouin population.

IV. The Periphery of the Periphery

While the Bedouin remained marginalized from the Negev Equality Conference, they materialize daily in SH, as the majority of patients needing care, as family members accompanying these patients, and as the topic of numerous research studies (see chapter 3). In addition, the Bedouin remain the focus of many public health interventions implemented by the Ministry of Health.

For over a decade, the MOH under the leadership of the regional physician, Dr. Mankin, has collaborated with the local university to implement programs to reduce infant mortality rates in the Bedouin community. "One of the things that most influences the Minister [of Health] and Knesset Members are gaps in infant mortality," Dr. Mankin explained to me during our interview. "This for some reason is the most influential measure. No other measure moves anyone." After a gradual decline in rates over a number of consecutive years, Dr. Mankin and his team began to think the decline was real. But in 2009 and 2010 rates began to increase again. In April 2011, the national newspaper *Haaretz* reported that Bedouin infant mortality rates were again between three to four times the average rates of Jewish infants (13.6 versus 3 deaths per 1000 live births) (Even 2011f). I asked Dr. Mankin why he supposed the rates increased again, despite the Ministry's continued interventions. "I attribute it, but again it is only a speculation, to the collapse of our service."

He got up from the table and walked over to a bookshelf of binders. "I'll find the right number so I won't say something incorrect, okay?" He pulled out a thick binder. The spine read: *Collapse of the Preventative Service* [*krisat hasherut hamone'a*]. "This is

the second binder of the collapse of the system," he explained. "Once some high up official in Jerusalem told me that I am forbidden from calling it the collapse of the service... In the beginning I wrote difficulties [*kshayim*], shortage [*hoser*], significant shortage [*hoser meshavea*]," he paused, "Is there even such a word?" He continued, describing the decline of the Ministry's services:

> And then severe shortage [*hoser hamur*]. And then at some point when there was a massive departure [of nurses] I said the service is collapsing. And they told me I am forbidden from using that word. But I still use it.

Dr. Mankin spoke to me of the deep challenge he faces as the regional physician. According to Dr. Mankin the problem is missing nurses: "It's simply collapsing everywhere," he stressed.

> There is a worldwide shortage of nurses and there is [a] shortage of nurses in the country here that is not being talked about. It's being swept under the rug, and when you have a shortage you feel the shortage in the periphery of the country… and the Bedouins are the periphery of the periphery, because that's where you see it first, and everyone wants to help the Bedouin and everybody wants incentives but the basic problem is that we don't have enough nurses.

According to Dr. Mankin, the problem of health in the Negev is a problem of missing personnel—what health practitioners in SH liked to call the problem of "missing bodies." These were the same bodies missing in the IMA campaign and represented by the card - board doctors distributed around the hospital. While Dr. Mankin raised the problem of the periphery (and the Bedouin as the periphery of the periphery) as a central component of the collapse of the preventative service in his region, the discourse of "missing bodies" transforms the problem of healthcare in the Negev to one based on missing numbers that are presented as standardized units that can be exchanged throughout the region, country, and world.

Based on the Ministry of Health's standards, Dr. Mankin needs 135 nurses to run the Mother and Child Clinics in his district (T*ipot Halav*).[63] The Ministry allotted 122 positions [*tkanim*] to Dr. Mankin's service. Of these available positions, 106 are filled. So the problem is not positions—he has both available positions and funding for these positions—the problem is missing nurses. Furthermore, he explained, even when a position is filled— when someone "sits on the line" – it does not mean someone is working. Of the 106 filled positions, in June 2011, only 93.5 nurses were coming to work every day. "And why is that?" he asked, not pausing before answering his own question:

> Because some are on maternity leave, someone is on sick leave… And as your workforce gets older … the more your nurses develop cancer, develop chronic illnesses… So if you look at the gaps between what we need, 135, and actually the number of nurses that are coming to work, I'm missing 41 nurses!

In Dr. Mankin's narrative, medical care is inadequate in his district because he doesn't have staff. It is not a matter of discrimination, or preferential treatment but rather a problem of too few nurses. The missing nurses impact the Ministry of Health's ability to provide medical services throughout the Negev, but especially in the Bedouin community, or what he calls "the periphery of the periphery." While Dr. Mankin acknowledges the marginalization of the Bedouin in this description, nonetheless he stressed that the Bedouin are not discriminated against in terms of medical care. The Bedouin and Jewish residents in his region suffer worse health than other regions in the country not because of discrimination, or lack of funding, but rather because of a shortage of human resources.

In Tel Sheva, for example, the first Bedouin town that has one of the largest *Tipat Halav* stations, Dr. Mankin told me that six to eight nurses should be employed. Yet, there are only two or three nurses. In Rahat, the largest Bedouin city, Dr. Mankin had two

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[63] Singular, *tipat halav,* Hebrew for drop of milk.

nurses. Then one broke her arm and the other went on maternity leave. And because he doesn't open a clinic with only one nurse—"You just can't leave one poor nurse by herself with the waiting room full. It's not good medicine"—he temporarily closed the clinic. In fact, approximately a hundred times a year Dr. Mankin closes a clinic in his jurisdiction (both in the Bedouin and Jewish communities) due to the absence of staff. The clinics in Rahat for example were able to remain open because nurse volunteers from another hospital in the center of the country came to support his staff. The shifting of nurses throughout the country—as volunteers and as shortages—presents the problem as a national shortage of nurses. Yet what I want to argue is that this national shortage, discussed as a public health concern and a public shortage that impacts the entire country, changes the scale of how the problem of healthcare is discussed and imagined. On the scale of the public and nation, the problem of the healthcare system is presented as one of missing nurses. This level of analysis of the problem permits the problem of the closure of clinics in the periphery to be discussed as a national problem. Dr. Mankin therefore employs the public to make demands of the rest of the country. It is this construction of the public as all inclusive that also, I would suggest, justifies why specifically infant mortality rates are the main intervention of the Ministry of Health in the region. These numbers, always compared to the rates of infant mortality of the Jewish population in Israel and around the world, become a reflection not of Bedouin health, but rather of the nation's health.

Yet the Bedouin community did not experience or narrate healthcare in their community as part of a public struggle. For example, in 2009 a number of Bedouin community members filed a lawsuit to the Supreme Court against the Ministry of Health

for temporarily closing three mother and child clinics in the unrecognized villages (Case 10054/09). The plaintiffs argued that the closure of the clinics specifically targets this population. Furthermore, because there are no roads in the community or public transportation, closing these three clinics would be particularly damaging to the Bedouin. Yet the Ministry of Health, and Dr. Mankin, argued that the closure of the clinics was *not* the result of discrimination but the unfortunate consequence of missing nurses and a national shortage of nurses. As Dr. Mankin stated emphatically to me: "There are no nurses in the country, what are [we] going to do?"

During out interview and in the defendant's statement, the MOH emphasized that the health status in the Negev is dire and that indeed the Bedouin community is the most marginalized in the Negev. Yet the closure of the clinics— a temporary move—was the best solution for a bad situation. The Ministry of Health explained its position as follows to the court:

> We decided to stop receiving patients in small stations and redirecting the public [*kahal*] to larger clinics and this is to pool our limited human resources. This decision comes due to a significant shortage of nurses in the field (Zilber 2010, 6).

In the MOH's statement to the court, the defendant's lawyer characterized the problem of clinic closures in the south as one impacting healthcare services across the region. "Everyone is on one sinking ship without difference of religion, race, sex or nationality" (ibid, 3). Yet what this discourse fails to attend to the reason why the Bedouin clinics are the smaller stations, why it is particularly difficult to recruit nurses to work in the Bedouin community?[64]

[64] Despite the ruling the there is no discrimination in the closure, Dr. Mankin requested to keep the case open in order to receive additional financial incentives from the government to bring nurses to work in the Bedouin sector. Currently each nurse that comes to work in his district gets 25,000NIS grant per year for three years, a higher grade in the pay scale, and assistance in rent. Yet these benefits have not solved the problem. "All I can say," Dr. Mankin explained, "is that the incentives prevented the massive departure."

Dr. Mankin's discussion of the Mother and Child Clinic closures highlights the crisis within the Israeli healthcare system. As he stressed, even within a comprehensive, universal platform, without staff he cannot provide medical services. Dr. Mankin spoke to me at length of the collapse of the public health preventative service—impacting communities and citizens throughout the region under his jurisdiction. But this crisis, I want to add, highlights the intersection between a discourse of a public collapse of medical services and the differential impact on the Bedouin.

Dr. Mankin presented the problem of the health service in the Negev as a matter of numbers, as a problem of missing nurses. His discussion echoes the IMA's slogans that "574 anesthesiologists are missing!" If we only his service had more nurses (of if the medical system had an additional 574 more anesthesiologists), everything would be resolved. By shifting the discussion of health care from claims of discrimination to a numbers problem, Dr. Mankin, the IMA, and the Ministry of Health present the problem as one shared throughout the Negev and the country. This discussion utilizes the logic of equivalence – here working on the level of provider—to argue that the challenge of providing health services to diverse communities and patients throughout Israel is commensurable. By calling the Bedouin the "periphery of the periphery", Dr. Mankin acknowledged the Bedouin's marginalization within Israeli society and the medical system specifically. But this comment helps explain the process by which the Bedouin's health problems are folded into the public. As I discussed in the previous section, the Negev *as periphery* is positioned as marginal to the center. Local residents, politicians, and healthcare professionals demanded healthcare services *like* in the country's center- "not more and not less" as one speaker said. This parallels the discourse I discussed in

previous chapters of healthcare needing to be *like* Jews. The claim of equivalence folds into a hierarchy between Jew and Arab and center and periphery. As the "periphery of the periphery" the Bedouin are further removed from the center, but they are positioned on the same trajectory of care.

During the Negev Health Equality Conference that I discussed in the previous section, one of the speakers compared the Bedouin to roses at the edge of a vineyard and to a canary taken by miners to warn of danger. These metaphors configure the Bedouin as more exposed (and more sensitive) to health dangers. The Bedouin are portrayed as an alarm bell, warning of the danger before it reaches the general public. But in these perverse metaphors, speakers do not acknowledge why Bedouin are more exposed to health hazards than other communities to begin with. Addressing such a question would require attending to a history of marginalization, making of invisibility, and long neglect of the community. As Mahmud, a Bedouin physician I introduced in Chapter 2, emphasized, "The reason for the large investment in the Bedouin community is because we started from zero. The population was neglected, so it looks like there is a big investment to those who don't know the reality. There was a big investment because there was none for so many years." Including the Bedouin as part of the general public suffering from a deteriorating medical system helps circumnavigate the more difficult questions of why it is more difficult to recruit nurses to work in Bedouin communities? This challenge is hinted in the court case when the defendants discussed the issue of transportation to the Bedouin clinics.

> In the absence of public transportation from towns in the Western Negev, and towns in the Eastern Negev to the Bedouin towns, it is not possible to relocate a nurse living in one of these towns to a [Mother and Child] station in the Bedouin towns by public transportation. Theoretically it is possible to relocate human

> resources from these towns to nearby Bedouin towns only if it [transportation] is available and accessible. Practically, even if available and accessible transportation was arranged, nurses living in a particular place are not interested in working in stations far from their place of residence and if they are forced to, they quit (Zilber 2010, 6-7).

The Bedouin towns remain inaccessible for nurses because of the continued issue of land recognition, the lack of maintenance of existing roads, and the historical segregation of Bedouin and Jewish towns. So while the MOH argues that the problem is human resources, in this explanation politics and history are actively excised and removed from discussion. Thus the problem is not only a lack of nurses, as even if the Ministery was able to recruit additional nurses the structural issues that continue to place Bedouin in poor health would remain.

V. Public Demands and the New Israeli-ness

In this chapter I have drawn on three examples to consider how the discourse of the public, and the idea of the public works to marginalize vulnerable communities like the Bedouin, while simultaneously effacing this marginalization. This notion of the public utilized in discussions of the public health crisis in Israel, appeared throughout the social justice demonstrations that took place during the summer of 2011. As the IMA strike entered its third month, a tent city sprouted in the midst of Tel Aviv. Running down Rothschild Boulevard, hundreds of students and young Israelis camped out across the affluent walkway. What began as a call for subsidized housing and a protest against the exorbitant cost of living, quickly transformed into the largest social movement to take place in the country. Crucially, the movement, like the physicians' strike, equality conference, and mother and child clinics pivoted around the idea of a public. Israeli rock singer Aviv Gefen told the crowd in one of the early demonstration in Jerusalem: "The

public opened its eyes and understood that he was a sucker [*fraier]* that was nourished for years from kernels, just like pigeons. Now we want to fly" (Efraim 2011).

In consecutive weekends during July and August, first thousands and then hundreds of thousands of Israelis filled the country's streets demanding the resignation of the Prime Minister, the return of a welfare state, and mostly calling for justice. *The people want social justice* became the movement's slogan. On July 30th, 150,000 people filled the streets of Tel Aviv, marching from *Habima*— the national theater—to the new Tel Aviv Museum. Dafni Lif, the first tent-dweller and one of the protest organizers, told the crowd: "Gluttony [*hazirut]* and egoism have been the prime symbol of Israeliness but now we have seen that there is another Israeliness. We have come to say to the public's delegates that the state has a responsibility towards its citizens" (Staff 2011). Journalist Gideon Levy described the July 30th protest as the new independence day of the state.

> It was a night where every Israeli can and should be proud of his Israeli-ness, as he has not been proud for a long time. Israel's real pride parade marched yesterday along the city streets …. The Israeli democracy celebrated yesterday… The people/nation *['am]* protested and said its statement in loudness, without fear, without need for fear… The people said? Yelled! […] There has never been such a protest in Israel. [This was] not a sectorial protest like all its predecessors. It was a people's [*ammai*] protest like no other. Young and this time also the elderly, left and right, Arab and Jews. The country born at the (old) Tel Aviv museum protested yesterday its strength and maturity in front of the current Tel Aviv museum (Levy 2011).

Levy stressed the appearance of new country—a country representing the country's entire body of citizens, a country not marred by divisions of age, politics, religion, or race. The social justice movement aimed to cultivate a "new" Israeliness and a new Israeli public—one that called citizens to action, that demanded government involvement, and that transcended the divisions typically organizing demonstrations and the country.

But the experience of the national demonstrations of 2011, like the public health interventions, strikes, and conferences I discussed above was strikingly different for Arab citizens. Arab communities did join the protests. But unlike Jewish protestors like Lif, Gefen, and Levy who spoke of a general public, of a need of a new Israeli-ness, Arab community members discussed their specific needs and the particular impact of government policies on their communities. Their protests and slogans were oriented towards improving their community, the long term marginalization of Arab townships. Like the court case above, their claims were about discrimination, not about national solidarity or the crafting of a new public. For example, in a demonstration in Baqa al-Gharbiya, a resident discussed the difficulty in housing residents face:

> The absence of responsible bodies does not permit Arabs to build their houses respectfully. And the worse thing is that we are not even present on the agenda of the state [*medina*]. In the end it will blow up in the government's face, if they don't take care of the Arab towns wisely (Shalan and Malcha 2011).

In Jaffa, an Arab resident discussed the encroachment of Jewish communities pushing Arabs out of the neighborhood. "The Tel Aviv municipality wants to Judaize [*leyahed*] Jaffa and is not taking care of its Arab residents. We won't have a place to live" (ibid). While Jewish protestors discussed the need of equality for all citizens and justice for the people [*ha'am*], Arab participants spoke of their specific needs as *Arab* citizens—tying their status to the historical marginalization of Palestinians in Israel. They accented their demands with their particularity, as for them housing was already a marked, political issue.

The summer of 2011 infused the country with an aura of change I have never experienced in Israel. But what I want to stress is that despite—or maybe because—of this stress on solidarity and unity, the deep chasms that separate communities in Israel

were not addressed. Despite the call for a new Israeli-ness, a new public, and a new government, the exclusionary power of the public remained. After the third protest in early August which brought nearly a half a million Israelis to the streets, the government announced it would create a committee under the leadership of Tel Aviv University's Economics Professor Manuel Trajtenberg to examine the issues raised. Yet the committee, as was quickly noted, "Did not include a religious or Arab representative" (Zarchia and Shtul-Traoring 2011). Thus the boundaries of the new Israeli-ness, of who is allowed to speak and who remains excluded, echoed its existing borders.

In the midst of the summer, the physicians' strike joined the tent strike. People demonstrating against the cost of housing and price of cottage cheese joined doctors to march together in the quest to change the country's national agenda. Doctors in Meir Hospital in Kfar Saba set up a solidarity tent outside of the hospital where residents protested (Even 2011c). One Haifa tent-dweller who participated in a physicians' demonstration told journalists, "If I won't be here for the doctors, it may be that the doctor won't be there for me when I need them…. it's all related. There are so many systems in a problematic state when you understand that everything is collapsing" (Rabad 2011). Parliament Member Tzipi Livnie spoke to the crowd of physicians in a demonstration before the Knesset in July: "This is not a struggle only about wages, and the future of physicians in Israel, or on the future of medicine, it is a struggle about the future of Israel" (Even 2011h). Statements such as Livnie's transformed the physicians' strike into an integral part of the larger social justice movement. And like the massive social demonstration that called for a new Israeli-ness, a new identity for the country, the call for saving the public health became tied to the image of a new Israel. The call of the

physicians became: “Without medicine there is no country” [*bli refua ein medina*] (ibid). From a campaign aimed to save the public health, the physicians’ protest transformed into saving the country. But whose country was now being saved?

In this chapter I have examined how the use of the notion of a public worked in the Israeli context to maintain the existing exclusionary status quo. Publics draw upon the past relations to orient a future; they rely on previous understanding of the public to create (and often re-create) the idea of a public. The public in Israel has largely been exclusionary of the Arab sector, including the Bedouin community. As such, by claiming to speak for the public, to represent the public, and to lead to a new public face of Israel, the social demonstrators of 2011 failed to move their agenda of change forward because they did not, and could not, unpack the divisions of the public. They needed to maintain a unified public to have widespread support, but as such, they could not challenge the exclusionary power of the public in Israel.

But I don’t want to conclude that the use of the notion of a public or the public is simply another mechanism of exclusion. For as Warner writes—and is true of all social categories— “no one actually inhabits the public” (Warner 1992, 396). This comment, I want to posit, provides the possibility of moving the analytic of the public beyond its dominating role. For while Warner rightly highlights the paradoxical role of the public—as both universal and privileged, creating identification and alienation (ibid, 397)—he provides an avenue for considering how the concept of the public might provide a means of maintaining difference.

When one enters into the realm of the public and becomes a mass subject, one also recognizes a piece of one’s particularity. As Warner concedes, “It is at the very

moment of recognizing ourselves as the mass subject, for example, that we also recognize ourselves as minority subjects" (ibid, 387). Thus despite the public's ability to remain universal and not rooted in the specificity of its constituents, the specificity of its subjects—both those who create it and those who are excluded from it—remains present. Warner calls this the "residue of unrecuperated particularity" (ibid, 384). I understand this phrase as noting the markings, the particularities bound to each of us. Like the possibility that the pubic includes each of us, our particularity can never be erased.

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It would be not just, or correct, if one's conclusion from this text is that medical providers in southern Israel do not practice or provide good medicine to their Bedouin patients. That is not my experience in SH, nor the experience of families or of providers. My intention throughout my research and writing has been to understand the difficulties of working in such an environment, of the frustrations of both staff and families, and what takes place when the domains that most influence health—history, politics, and economics—are considered irrelevant to medical care. I have, unfortunately, not always been able to do so, and with that I apologize to the reader and to the individuals who shared with me their time, a scarce item, their experiences, and often their frustrations and wisdom.

What I have wanted to stress in this dissertation is the increasingly difficult process of providing medical care in a climate of discrimination, in a climate that does not permit certain conversations to take place—because of language, because time, because of human resources. But this formulation is not just an issue of economics or politics. It reaches beyond the specificity also of Israel and of the Bedouin. It touches on

how we relate to others, how histories might enter into the public sphere, how the pieces that are so central to patients, to their communities, might be given a space within a medical world that increasingly value standards and protocols. If these histories were allowed in, not only might these families, patients, and communities be healed but how might the scope of medicine and equality change as well?

Image 1:

(Image taken by author).

Image 2:

(Image taken by author).

Image 3:

Source: (Magnazi and Einav 2011).

Image 4:

(Image accessed from Israeli Medical Association Website).

Image 5:

(Image accessed from Israeli Medical Association Website).

Image 6:

(Image taken by author).

Image 7:

(Image taken by author).

Image 8:

(Image accessed from Israeli Medical Association Website).

Image 9:

Source: (Shalan and Malcha 2011).

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