Guests and Hosts in an Athens Public Hospital: Hospitality as Lens for Analyzing Migrants' Health Care

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Abstract Based on six months of ethnographic research in the maternity clinic of a major Athens public hospital in 2017, this chapter employs the conceptual lens of “hospitality” to analyze relationships that formed around the care of pregnant migrants arriving in Greece since 2015. Permanent health-care personnel, mostly midwives, are the hosts; guests include migrant women, NGO workers that accompany them to the hospital, Greek Roma maternity patients, obstetrics residents, and the native ethnographer herself. The focus is on pregnant migrants; the other guests provide comparative fodder to flesh out the subjectivity of the hosts. Through an ethnographic reconstruction of the microcosm of the clinic as a space of care, sovereignty, and everyday life, the chapter takes on two theoretical issues: the problem of scale and the argument

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that the hierarchical character of hospitality is incompatible with a rights-based framework. Critiques to the use of the host-guest trope as a frame for the analysis of relations between migrants and receiving states and societies are well heeded. Yet I demonstrate that guest-host dynamics are very much operative in the interaction between state-employed, permanent health-care personnel and migrants. My analysis highlights the limits and capacities of hospitality's scalar transpositions, as well as the critical potential of hospitality as a lens that elucidates how legally guaranteed migrants' rights are accessed and granted in practice; hospitality and rights thus emerge as complementary rather than opposing structural and explanatory frameworks.

Keywords Hospitality • 2015 “refugee crisis” • Maternity care • Auto-ethnography • Greece

INTRODUCTION: THE HOSPITALITY “ASSEMBLAGE”

I press the doorbell to the public maternity clinic's labor ward, paper cup of coffee at hand and writing materials, the tools of my trade, sticking out of the top of my purse. I am going to work, yet this is a workplace where, much like a guest, I have to be buzzed in. I enter the small antechamber and put on the disposable shoe covers and gown meant to prevent me from transferring any germs I have picked up from the outside world into this secluded space. Rendered safe, I push through the swinging doors into the ward's main area, a wide corridor with a central desk at its far end. Seated around the desk, the ward's permanent tenants, a team of midwives, monitor the labor of women visible through the open doors of the seven, one-bed labor¹ rooms lined around the main space. The pregnant women wear disposable, paper gowns similar to mine, except they are naked underneath, their bodies open to the gaze, hands, and instruments, to the inspection and intervention of obstetricians and midwives. Whether they resent or welcome, normalize, or are troubled by this exposure, I cannot say for certain. This is because the women whose birthing process I am observing are strangers—not only unacquainted with the clinic's permanent occupants but also foreign. They are people who do not speak Greek and therefore cannot communicate through words that I and

health-care professionals can understand whether their nakedness and overall surrender of control over their labor in this strange space makes them feel vulnerable to the health-care personnel or secure in their expert custody.

I am neither a health-care professional nor a pregnant woman who has come to give birth. And I am not foreign either; Greek myself, I am a “native” (Narayan 1993) anthropologist. It is June 2017, almost two years after Greece started receiving large numbers of people fleeing wars in the Middle East and South Asia. I am stationed at the maternity clinic of a major public hospital in Athens to conduct ethnographic fieldwork on the maternity care of migrants without a secure or long-term legal status and particularly on their interactions with health-care personnel. In this chapter, I will analyze these interactions but also the interactions of the clinic’s personnel with other members of the public, such as myself, through the conceptual lens of hospitality. Neither I nor the pregnant migrant women are guests in the clinic—at least not in the strict sense of the word, originating in and referring to domestic settings. Further, we are not here by the “hosts”’ gracious and ostensibly uncalculated generosity (Shryock 2008), but rather through administratively mediated arrangements. My presence has been approved by the hospital’s scientific council, after a formal application and upon the recommendation of the university clinic’s chief medical director. The women’s care in the public clinic is mandated by a clear and specific legal framework. Neither are health-care professionals hosts in the sense of unconditional sovereignty over the entity of reception that the term implies. Rather, they are people whose sovereignty over the physical, social, and professional space of the clinic hinges on contracts—albeit permanent—of employment, administrative rules, and numerous structural and symbolic hierarchies, which shape their subjectivities as “hosts.” Nevertheless, “the most essential elements in the hospitality assemblage are in place” (Shryock 2012: S24): the pregnant women and I have crossed thresholds into a space through specific protocols of entry, and we are received in specific areas of this space, reserved for people whose presence is supposed to be temporary. Further, hospitality’s central dialectic of danger and protection (Candea and Da Col 2012; Pitt-Rivers 2012 [1977]; Shryock 2008, 2012) is operative: not only are the guests at the “mercy” (Candea and Da Col 2012: S5) of the hosts, but the latter deploy all sort of “prophylactic” (Candea and Da Col 2012: S3) defenses to make sure the strangers who have entered their

space can neither introduce dangerous elements nor tell defamatory stories after their departure (Shryock 2008, 2012).

USING “HOSPITALITY” IN NON-DOMESTIC SETTINGS

Through an analysis of encounters in the public maternity clinic, I will demonstrate that hospitality may be used as an analytical lens in non-domestic settings where migrants interact with different segments of host states and societies, such as the public hospital. It may be used, despite the fact that there is no direct scalar correspondence either with the home, where the process of hospitality originates, or with the nation-state, where it has been transposed as a discursive trope to characterize the relationship of immigrants with receiving states and societies, albeit in significantly problematic ways. Major social and political theorists (Derrida 1998, 1999, 2000; Kant 2010 [1795]) have used hospitality to negotiate the problem of “the status of outsiders in political spaces shaped by domestic privilege” (Shryock 2012, S21). Yet more recent social-scientific literature has challenged the concept’s appropriateness for the analysis of relations between migrants and receiving states and societies (Candea and Da Col 2012; Rosello 2001; Shryock 2008, 2012). Critiques to the use of the host-guest trope as a frame for the analysis of relations beyond the household have two main conceptual foci: the issue of scale and the incompatibility between the hierarchical and voluntary character of hospitality and a legally binding framework that institutionalizes access to the physical space of a community and its resources and services as *rights*, rather than graciously voluntary concessions, for certain outsiders.

Scaling out from the household to the nation-state is far from a straightforward, unproblematic process (Candea and Da Col 2012; Rosello 2001). Rather than a unitary host, the nation consists of diverse hosts (Rosello 2001), positioned vis-à-vis migrants either as individuals or as representatives of collectives or entities, such as the public maternity clinic. Such entities still do not have a direct scalar correspondence with the home. What is more, they do not “zoom out” (Candea 2012, S42) directly into the nation-state either.

Entities such as the home and the nation-state, then, do not sit on a schema of neat, concentric circles (*cf.* Herzfeld 1987). Yet the metaphor of hospitality represents them as such, muting the complexities in processes of trespass and welcome (Candea 2012) shaped by the specificities of each environment—the moral prerogatives to receive strangers as

guests, the “jural” (Pitt-Rivers 2012 [1977], 503) framework of reception, the “danger” (Shryock 2008; Candea and Da Col 2012) that these strangers-turned-guests represent, the “technolog[ies] of control” (Candea and Da Col 2012, S3) put in place in response, the host’s power over the guest but also the obligation to protect her (Lindholm 1982 in Candea 2012), and the contextually shaped dialectic of “friendship and violence” (Shryock 2012, S30) that characterizes the interaction.

The scalar shift is further “disturbing” (Shryock 2012, S28), because of the inherently hierarchical character of hospitality. Political subjects under a state’s jurisdiction should be able to interact with native people and institutions within a legally mandated framework of justice and equality. Domestic hosts and guests, on the other hand, may not interact as equals, even when their social status renders them such (Shryock 2012); further, guests do not enjoy the clarity and protection of a rights-specifying legal framework (Pitt-Rivers 2012[1977], 512).

Migrants, however, are political subjects, whose rights and obligations within any dealings with the host state, including its health system, are contractually regulated and administratively mediated (Rosello 2001; Shryock 2012). Positing migrants as guests, therefore, deprives them of a protective legal framework and blurs the distinction between discourses and practices of benevolent generosity and contractual obligations (Rosello 2001: 9; also, Candea and Da Col 2012 and Shryock 2008). The scalar shift further generates impossible standards for both states-hosts (or any concrete people or entities represented as metonymic for the state) and migrants-guests to reach (Candea 2012; Shryock 2012). The former are condemned as bad hosts, when they do not observe the ethical code supposedly followed by domestic hosts, abiding by a mandate of total openness, such as unconditional acceptance of guests’ cultural patterns. Guests, on the other hand, are castigated, when their visit and behavior do not abide by the spatiotemporal constraints and behavioral norms of hospitality. For migrants, however, the reticence in claiming access to space and resources and the expression of gratefulness mandated by domestic hospitality are “baffling” (Rosello 2001, 10), when their access to spaces and services is established contractually.

I understand and endorse the epistemological and normative criticism that hospitality has been deployed as “a scale-free abstraction” (Candea 2012, S35), muting the complexities in dynamics and relations and fostering hierarchical politics. In this chapter, however, I will use hospitality in my analysis of the interaction between migrants and one type of host in

Greece: the health-care personnel in the public maternity clinic where I conducted ethnographic fieldwork. I will do so, because, as I demonstrate in the ethnographic sections, hospitality dynamics were *de facto* present alongside the contractual framework of migrant care and reception and shaped the interactions of migrants with the health-care personnel. Using the concept as an analytical frame allows us precisely to approach processes of hospitality as objects of ethnographic inquiry.

Its domestic origins and specificity aside, hospitality is fundamentally about sovereignty, about processes of welcome and trespass in spaces which hosts at once control but to which they are also obligated to grant access (Candea and Da Col 2012; Pitt-Rivers 2012 [1977]; Shryock 2008, 2012). Indeed, scholars who critique the transposition of the concept to non-domestic settings also recognize that the distinction between contractual and social obligations to receive “guests” is morally and politically blurred (Rosello 2001; Shryock 2008). And while hospitality’s idealized moral perfection is inconsistent with the constraints of administratively mediated relations, its ostensible lack of calculation and pragmatic concerns is seldom achieved in domestic settings either (Shryock 2008; Candea and Da Col 2012; Rosello 2001). The Athens public maternity clinic of my research constitutes, unlike domestic settings, a space legally required to receive pregnant women, regardless of financial, legal, or political status.² At the same time, it is a highly regulated space, with numerous rules and directives, not always fully clear, determining physical access and access to the different procedures and types of care. The application of these rules and *how* access and care are granted depend, to a degree, on the discretion of the personnel and on their subjective and morally inflected ideas regarding who deserves to benefit from the public good which they have been charged with dispensing (e.g., Willen and Cook 2016). Rather than uncritically transposing hospitality as it has been conceived in its domestic form, I will deploy the concept’s building blocks—sovereignty, the dialectic of trespass and welcome, spatiotemporal constraints of sojourn, the tension between danger and protection and violence and friendship, corresponding mechanisms of control, and the very “distinct materialities” (Candea and Da Col 2012, S14) of the hospital setting—to analyze interpersonal interactions in the microcosm of the maternity clinic. This approach allows an exploration of the limits but also the potentialities of the concept’s cross-scalar application in spaces, such as the public maternity clinic, which incorporate elements of the domestic and the national, without directly corresponding to either.

The analytical tools listed above correspond to site-specific processes that will form the objects of ethnographic inquiry. Apart from elements of the domestic and the national, the clinic further encompasses structural features and cultural norms of bureaucracy, biomedicine, and gendered processes of care. Bureaucracy, biomedicine, and care are all inherently hierarchical domains, entailing entry in physical and social spaces whose cultural codes often evade those who visit them temporarily to conduct business or receive a service. This inherently temporary character of visits to an entity such as a public maternity clinic partly solves the problem of what to do with a guest when the length of her stay ushers her into the category of either local who must be made so or invader who must be expelled (Pitt-Rivers 2012 [1977], 503), a problem inherent in domestic hospitality as much as in the relation between migrants and receiving states. At the same time, the visit of migrants to a public facility of care easily becomes metonymic for their group's "visit" to the nation-state at large, particularly when the public facility's personnel belong to the dominant ethno-national group and see themselves at once as gatekeepers and rightfully privileged partakers of the national state's resources.

This latter element foregrounds the issue of sharing, highlighted in scholarship that denounces hospitality's uncritical transposition. In a world of states, "hospitality" is mediated administratively rather than interpersonally, precisely in order to "insulate all parties from the risks and inconveniences of sharing" (Shryock 2012, S31). Yet the administrative and the interpersonal are hard to disentangle in most settings, not least in the intimate arena of maternity care. As I will demonstrate, concerns regarding the sharing of public resources underlie the process of care and are reflected in but also constitutive of interpersonal interactions in administrative settings and transactions.

An approach that at once deploys the analytical toolkit of hospitality and treats its site-specific manifestation as an object of ethnographic inquiry stands to highlight the complexities in processes of reception blurred by the concept's unproblematic transposition and to lay bare the politics and hierarchies enabled either by the normalized, explicit use by the metaphor (Candea 2012; Rosello 2001) or by guest-host dynamics, even when they are not overtly called that by the people involved. It further reveals that, rather than mutually exclusive, hospitality and rights constitute complementary sets of dynamics shaping the interaction of migrants and members of the host nation in entities and spaces such as a public health-care facility.

GUESTS AND HOSTS IN THE PUBLIC MATERNITY CLINIC

Launching forward from the foundational premise that the problem of hospitality is “the problem of how to deal with strangers” (Pitt-Rivers 2012 [1977], 501) necessitates defining the stranger—even more so if we wish to pay attention to scalar specificities. Equating “stranger” with “foreigner,” particularly in everyday interactions, amounts to methodological nationalism (Wimmer and Glick-Schiller 2002), in the sense that it assumes that ethnic or national belonging forms the primary dimension of people’s social identification and axis along which they form social connections. In this chapter, I lay out the interactions of the clinic’s hosts with an assortment of strangers, separated from the hosts in some cases indeed by ethnicity or nationality, but just as much by gender, class, religion, professional hierarchies or exigencies, and ideological approaches to maternity care. As hosts, I conceptualize those members of the clinic’s medical personnel with permanent positions there, in their status as permanently employed public servants in the Greek National Health System (NHS). Given the scope of my ethnographic observation, this cohort consists overwhelmingly of midwives working in the clinic’s outpatient department, triage department, and labor room, whose interactions with migrants I witnessed when I spent time in those areas, from March to September 2017. To a lesser degree, it also includes two senior obstetricians that participated in my research via informal conversations and semi-structured interviews. People occupying the continuum between (hostile) strangers and potential community members (Pitt-Rivers 2012 [1977], 504), on the other hand, are myself, the native ethnographer; the migrant patients whose care I was there to study; Roma women and their families, who, unlike the majority of middle-class Greeks increasingly opting to give birth in private facilities (Mosialos et al. 2005), overwhelmingly prefer this public clinic for maternity care and childbirth; obstetrics residents, whose presence there is temporary, unlike the permanently employed midwives-hosts; and a male, Middle-Eastern,³ NGO-employed interpreter who had lived in Greece for several years and was accompanying pregnant migrants to the hospital.

Unlike Pitt-River’s (2012 [1997], 503) stranger, all of us listed above do have a “jural” place within the system. I have formal permission to be there; pregnant women are legally entitled to public maternity care; obstetrics residents are contractually employed; and the NGO interpreter’s presence also abides by the hospital’s formal rules, since he is escorting

women seeking care. Further, we are not guests in someone's home. Yet our interactions with our "hosts" are mediated just as much through the "law of hospitality" (Pitt-Rivers 2012 [1977]) as through the administrative framework that regulates our presence in the hospital.

FOREIGN STRANGERS, VOICELESS GUESTS

If the drama of hospitality plays out across thresholds and on specific stages, then setting this chapter's opening scene in the clinic's labor room means that the narrative started out in *medias res*; it plunged into a crucial point toward the climax of a chain of events, rather than telling the story from the beginning. The story of hospitality in the maternity clinic begins in the outpatient department, in whose large reception area anyone can enter freely from the hospital's concrete courtyard. The "tests" (Candea and Da Col 2012; Pitt-Rivers 2012 [1977]; Shryock 2008, 2012) of hospitality, for hosts and guests alike, start here, where guarded thresholds are waiting to be crossed and rituals of intelligibility, which transform strangers into guests (Pitt-Rivers 2012 [1977]), to be performed.

At the outpatient department's reception area, midwives on duty take turns staffing the cubicle where the public conducts administrative matters through the glass window. On my first day of fieldwork at the hospital, on March 16, 2017, I am invited to set up shop inside the cubicle. There, a midwife in her 50s, Martha,⁴ who has most likely worked in the Greek NHS for at least two decades, is processing the paperwork of a Syrian pregnant woman. "Foreigners are a big problem," she tells me, mostly because there is no linguistic interpretation. The hospital does not employ people who could interpret between Arabic or Farsi (or other languages spoken by refugee cohorts, such as the Pakistanis' Urdu or the Kurdish dialects of Kurmanji or Sorani) and Greek. On their part, refugees speak no Greek, and their English is also limited. Furthermore, "all," according to Martha, pregnant migrants come to the hospital when they are close to term. They come without any results of prenatal examinations, a fact that puts pressure on the doctors. Until two months before, she tells me, they used to come in mass numbers without appointments, but the hospital has since coordinated with the NGOs providing social care to refugees, and the appointment system is now observed.

Unpacking these complaints lays out the interpersonal dynamics of hospitality operative in the clinic but also the broader socio-structural context of migrants' social care in Greece at that moment, which played a crucial

role in shaping the subjectivities of the hosts. The fact that the health-care personnel and migrant women under their care were unable to communicate verbally anchors my analysis in this section. The linguistic gap posed an additional challenge to already overworked and frustrated personnel, but more significantly this gap spawned or exacerbated the hierarchies within the inherently vertical relationalities of medicalized reproductive care (e.g., Cosminsky 2016; Davis-Floyd and Sargent 1997), and these factors decisively tilted hospitality's scales of "friendship and violence" (Shryock 2012, S30) toward the latter.

After a few days hanging around the cubicle, I enter an inner space, the outpatient department's examination room. There, women's files are opened or assessed by midwives and obstetrics residents on duty, emergency cases are examined, and fetuses close to term monitored. A few yards away from the open reception area, the examination room has no access-control keypad or doorbell; people just open the door and walk in. The personnel either encourage entry or ask people to walk back out and wait; there is an order in their system I do not quite understand. I push the door open gingerly, expecting to be questioned, but nobody pays me any attention. Pregnant women are waiting to be seen; others are lying in beds behind a cloth partition; trainee midwives are attending to the women behind the partition or hovering around the obstetrics resident on duty seated at a desk facing the entrance.

In his foundational piece on the "law of hospitality," Pitt-Rivers distinguishes between strangers, who are unknown, and guests, who attain this status through "rites of passage" that make them known to their hosts and situate them along the local "hierarchy of prestige" (2012 [1977], 503). In the context of reproductive care, these processes encompass embodied, social, and cultural elements. At least in the highly medicalized setting that I observed, knowing pregnant women meant knowing the physical particularities of their reproductive systems, their medical histories, but also the social relations and cultural patterns that may have been factors in their childbearing.

At the examination room's desk, an obstetrics resident, Voula, is checking the file of a Syrian woman a month away from giving birth, who has come to the clinic for the first time, accompanied by an NGO-employed social worker and an interpreter. Voula leafs through the assortment of papers in the woman's file⁵ and finds an ultrasound scan with a different name on it. Confusion and irritation ensue, as Voula and Martha, the midwife we met earlier, look through the woman's papers for an ultrasound

with the correct name on it. I want to interfere and tell them to ask the woman herself when and whether she had her last ultrasound. I hesitate, but, prompted by months of ethnographic research on the other side of the “maternity encounter” (Malakasis and Grotti 2016),⁶ I address my suggestion to the social worker, who responds in a friendly but resigned manner:

Even if she remembers, since she doesn’t have it with her... You can’t imagine; they lose half their papers.

A few days later, the same obstetrics resident, Voula, grumbles as she sorts through another Syrian woman’s sparse file. It is a very young woman in her first pregnancy, and she has just arrived in Athens from an Aegean island of first reception.⁷ She does not have an ultrasound or any other examination results with her.

“They don’t know anything; the man knows everything,” Voula scoffs, referring to refugee women in general. “When they have their period; when they are giving birth.”⁸

Martha attempts to give an explanation—“Since it’s the man who’s dominant...”—but Voula persists: “Okay, but the man was dominant here too, but our women knew when they were on their period, and when they were supposed to give birth, and how many children they had.”⁹

For Pitt-Rivers, each community has its own standards, which find no direct equivalent in other settings. But in a colonialism-scarred world, the ostensibly local “hierarchy of prestige” (Pitt-Rivers 2012 [1977], 503) is usually inflected by and reflects imported and imposed “criteria of cultural excellence” (Herzfeld 2002, 905). Historically, in order to secure its own precarious position within the hegemonic space of “*Europeanness*” (Hesse 2007, 646, emphasis in the original), Greece¹⁰ has erected strong boundaries of “civilization” against ethnic, national, racial, or religious categories farther away than itself from the ideal of whiteness and western Christianity (Herzfeld 2002; Tsoukalas 2000). The resulting evaluation mechanism, therefore, situates migrant women, Muslims from Syria and Afghanistan in their vast majority, toward the bottom rungs of a spatiotemporal civilizational ladder.

Unlike Pitt-Rivers’ ideal-typical stranger, then, who has “no place within the system, no status save that of stranger” (2012 [1977], 503), these strangers have a place within the global distribution of “symbolic capital” (Bourdieu 1994), in which hosts are also embedded. Rather than being unknown, therefore, these potential guests are known through

pre-existing prejudices that compel their hosts to privilege culturalist explanations for phenomena largely grounded in these pregnant women's recent structural circumstances. Messy medical files reflect the discontinuity of maternity care over protracted, unpredictable refugee journeys with multiple stops at places where care was either inaccessible or provided in "emergency" (Grotti et al. 2019) rather than regular form. Further, the gendered lack of agency over their reproductive processes attributed to Syrian and Afghan women by Greek health-care personnel (see also Malakasis and Sahraoui 2020) often reflects the linguistic gap or the fact that the women consider it futile to communicate their thoughts and wishes, given the haphazard and indifferent treatment they have faced in structures of reception and care since their arrival in Greece (Malakasis *Forthcoming*) (Fig. 3.1).

The desk where Voula is seated faces the room's entrance. To her right, along the wall, pregnant women close to term lie on reclining beds

Fig. 3.1 The living space of a Syrian family of five placed by the UNHCR in a NGO-administered hotel in downtown Athens. Their suitcases, covered yet ready to use, evince the unpredictability of their journey and overall circumstances, which impacted the maternity care pregnant refugees received

separated from each other and from the main space with cloth partitions. They are hooked up to NST machines monitoring their fetuses' heart rates.¹¹ Behind the partition, I can see stocking feet, but not much else.

Much like in the labor ward upstairs, the social geography of the examination room corresponds to voiceless strangers hosted at the room's physical margins, in "stages" (Shryock 2012: S24) designated specifically for them and the procedures they must undergo. The "hospitality" encounter in this setting does not breed the affinity it would in a home's living room or even in a village square. Hosts are not compelled to entertain their guests at all times or cloak their rational concerns under ostensibly spontaneous warmth. Rather, health-care personnel check in on their pregnant "guests" at intervals designated by conventions known only to them, unlike the "shared language" (Shryock 2012, S22) of hospitality. In the labor ward, these depersonalized hierarchies are accentuated, rather than weakened, by the physicality of the encounter.

On a morning in mid-June 2017, about a month after I have transitioned from the outpatient department to the labor ward, I walk in to find a 20-year-old Syrian in an advanced stage of labor. She is in one of the seven labor rooms surrounding the central desk at the far end of the ward's main area. The door is open, and I can see her standing next to the bed, leaning on it with her arms. She is wearing a hospital gown that bares most of her front when it often comes undone. A young trainee midwife, Artemis, is helping her breathe during the contractions and the pain. At the central desk, three senior midwives are discussing the issue of summer leave; their voices are raised and angry.

As I hover by the room's entrance, a male obstetrician walks in, checks the woman's NST, pronounces it "good," asks about her dilation, and leaves. The woman's body stiffens; she is in pain, but she is making an effort to not yell too loudly. Artemis tells her in English to "relax." A little later, she inserts her finger in the woman's vagina to check her dilation. For Artemis, this is the third time she has assisted a woman through labor, and she is still feeling unconfident. She inserts her finger again to make sure. A female obstetrics resident walks in and speaks to the woman in English, in a raised voice and harsh tone: "relax, not like this, okay?"

The resident thinks the woman's dilation is at eight centimeters; she thinks her cervix is also effacing but holding up on the upper left. She asks the woman to open up and inserts her finger in her vagina. After this, the woman falls on her knees again in pain, and the resident yells at her, "not like this." At the central desk just outside, the senior midwives'

conversation has turned to what they will cook for lunch once they make it home after their shift. One of them says she will make sautéed wild greens and fried potatoes to serve alongside grilled fish. It's a down-home, wholesome meal, and I register a general sense of approval.

I turn my attention back to the Syrian woman in labor. She is now standing up and leaning toward the bed in rhythmic movements; she's crying, but more quietly. The senior midwives are now talking about the hassle and intricacies of dying the roots of the hair.

While I join the midwives' conversation on hair coloring, I maintain eye contact with the pregnant woman through the labor room's open door. I want to be encouraging and friendly, but I don't know how. I am also thinking that, if she were one of the five Syrian women with whom I have been conducting long-term, ethnographic interviews on their maternity care in Greece for the past eight months, she would describe to me this scene in detail, probably mentioning that there was another "doctor" there (given the paper gown I am wearing, similar in color and cut to the gowns worn by health-care staff) taking notes in her hot-pink notebook. The woman sees and observes everything quite keenly; she just has no words to express her thoughts.

Either solicited and put into words or unspoken and merely assumed, the thoughts of refugee women were interpreted to health-care staff by a set of people occupying a distinct position in the structure of care formed around refugee women, interpreters employed by NGOs to accompany them to public health-care facilities. Through interpretation that exceeded the linguistic, these actors shaped potential guests—the humanitarian sector's broader involvement, however, also shaped the subjectivities of the hosts.

MAKING STRANGERS KNOWN: THE GUEST-INTERMEDIARY

Most days that I arrive for fieldwork, I find Qassem at the hospital's concrete yard, chatting to a pregnant, usually Syrian, refugee and her partner, explaining or urging them toward secular and "modern" ways of thought and practice centered on gender equality and faith in biomedicine.

"In the end, I have my way of convincing them," he tells me, confident in all the ways in which he straddles the world of the clinic and that of refugees. "This is not Syria, where she will give birth at home or by the well."

A political refugee from the Middle East himself, albeit one who did not receive asylum but rather “amnesty” via a large 2001 program for undocumented migrants (Fakiolas 2003), Qassem has been in Greece for 21 years. After working an assortment of jobs, he was hired, in the summer of 2016, as an interpreter for a major NGO that provided, at the time of this research, housing as well as medical and social services to refugees. His job is to interpret for all the women aided by his organization who come to the hospital.

In Pitt-Rivers’ account (2012 [1977]), in small, face-to-face communities, strangers become guests via their relationship with an established community member. Qassem himself occupies an intermediate spot between guest and community member in the hospital; he is neither medically trained nor employed in the Greek NHS, yet the treatment he receives positions him at a middle ground between professional insider and member of the public. At the outpatient department’s reception cubicle, he explains the data on the asylum-seeker’s card to the midwife preparing a woman’s file; “what would we do without him?!” the midwife coos to me. Unlike the rest of the public, and indeed unlike most other NGO-employed interpreters and social workers I observed in the clinic, Qassem is inside the cubicle, not in front of the window. Like me, he is invited to store his belonging in the staff cabinets at the back of the cubicle. In an office, he confers with an obstetrician on the problem of a woman’s missed prenatal examinations; the two commiserate over the messy cases they are called to handle. Qassem tells the doctor that he and other NGO workers are “going crazy.” “I’ll go crazy one of these days too,” the doctor replies. At the examination room, he engages in familiar, cordial banter with residents on duty. “I only have one Elisa, I do not have ten,” he tells one of them, trying to cajole her into skipping a bureaucratic formality. “And you’re paining me.” The refugee woman he is accompanying is at her eighth pregnancy, and she is also recovering from surgically removed thyroid cancer. Four pregnancies ended in miscarriage, and she has borne three girls via C-section. The current fetus is also female. “She won’t stop until she has a boy,” Qassem tells the resident, “you mark my words.”

“No, I will perform a tubal ligation after this C-section,” the resident, Elisa, retorts. “No more.”

The woman’s medical file further reveals a serious car accident; her abdomen is scarred by a sizeable burn.

“With this burn and a fourth C-section, we are doing a tubal ligation,” the resident insists.

“I am telling you, they don’t stop until they have a boy,” Qassem also stands his ground. “It’s law.”

Health-care staff relies on Qassem to make refugee strangers known, yet he does more than that, and this is perhaps why he has transitioned from stranger to guest to halfway community member, unlike most NGO workers, who are treated with professional distance by the clinic staff. Qassem does not only interpret refugees to the health-care staff; he also strives to enculturate them into the gender and medical norms that prevail in Greek hospitals.

“These people are not used to maternity care,” he tells me when I interview him after months of observing him at the clinic. “They don’t know anything. When you tell them they must undergo exams, it seems strange to them; ‘I’m pregnant, I’m not sick.’”

Much like most members of the health-care staff, Qassem identified culturally backward, oppressive gender norms as the main obstacle refugee women’s care. “Peasant” Syrian men, unlike other Middle-Eastern national groups, such as Iraqis or Kurds, object to male doctors seeing their wives’ bodies, he said. “The typical ones we see with the headscarf,” he tells me, reiterating the hegemonic, racially profiling stereotype. “She has married a man, and he is the only one who has the right to see her.”

In his self-appointed position as intermediary, he gets drawn into interpreting the Koran for them, to explain that there is no shame in a man seeing a woman’s body for medical reasons. “I am forced to become one of them,” in appealing to the Koran’s authority, he tells me; a task that, as an atheist, he resents (Fig. 3.2).

Months of effort, he said, have paid off; most refugees have stopped demanding female doctors. Refugees listen to him, he said, because he facilitates their path to care. “So, they don’t say anything. Whatever I say, that’s what’s done.”

The way Qassem is welcomed and allowed to cross thresholds almost as if he worked at the maternity clinic belies the hospital staff’s often acrimonious ambivalence regarding the NGOs’ inroads into Greek public health care. The humanitarian sector’s involvement in Greek social care grew significantly in response to the austerity regime that started in 2010.¹² Its irruption in response to the episode of migration that began in the summer of 2015,¹³ however, hints at supranational processes of entry and reception that affect the hospitality encounter in the public clinic’s microcosm. Refugees crossing into Greece from Turkey on their way to countries of Northern and Western Europe have been, since early 2016, trapped

Fig. 3.2 A Syrian refugee walks the streets of Athens pushing her three-month-old baby in a stroller. After interviewing Qassem, I asked her if she would be embarrassed to have a male obstetrician examine her or assist her with childbirth. “No,” she said emphatically, she understands that he would be looking at her as a doctor, not as a man. And since his examination would be health-related, the Quran would have no problem with it either

in Greece, unless they accept to return to Turkey or to their countries of origin. As part of turning Greece into a “buffer state” for the rest of the European Union (Christopoulos and Spyropoulou 2019), the European Commission has directed significant funds toward the social care of migrants there (Howden and Fotiadis 2017), funds primarily channeled to the humanitarian sector via the United Nations Refugee Agency (UNHCR). Major transnational and Greek NGOs operative in the country have used these funds to offer health care and housing and to employ numerous social workers and interpreters aiding refugees in their dealings with administrative and medical structures.

Although refugees desire to reach countries of “core” Europe (Delanty 1995, 48), they are made to wait indefinitely in the physical and political foyer of the larger edifice. The image of the “foyer” evokes the domestic, but transposing the conceptual metaphor of hospitality to state-level entry

and reception transcends its use as a heuristic for the interpersonal dynamics of the clinic; rather, it risks reproducing its discursive deployment by powerful public actors, who use it to depict migrant reception precisely as an act of benevolence toward uninvited and henceforth indebted guests (Rozakou 2012). Arguably, however, it is precisely the built-in hierarchies and power-based arbitrariness of the official, contractual framework, which disproportionately allocates migrants to first-entry EU states and violates refugee law through “agreements” of dubious legality (Christopoulos and Spyropoulou 2019) that foster hospitality-like dynamics in entities such as the public hospital. Through the mass involvement of the humanitarian sector, protocols of entry had to be adjusted and the hosts’ mastery over the house was challenged.

Referring to the problem of the linguistic gap, a senior obstetrician, Eleni, said that a major medical NGO had offered the hospital to station its interpreters there permanently, provided its logo could be displayed on hospital premises. But this would brand the hospital as a refugee hospital, Eleni said, and the hospital was already serving more refugees than its share, at the expense of the specialized medical services that it was supposed to provide to refugees and the general population alike.

For another senior obstetrician, Angela, the current circumstance of refugees and the humanitarian sector compounds a structural imbalance of Greek health care, the underdevelopment of the primary-care sector. The maternity clinic of the hospital where I conducted research is one of the University of Athens maternity clinics, based and separately administered in various university hospitals in the Athens metropolitan area. These are public hospitals but with a strong research and teaching component; both Eleni and Angela are also faculty members apart from senior doctors. For Angela, taking on the care of dispossessed cohorts, such as refugees, detracted from the clinic’s primary mission. Ordinary maternity care should take up only about 20 percent of the clinic’s activity, she said, and the rest should be research and specialized services (e.g., pathological pregnancies).

If strangers must become known, for hosts the central test of hospitality is that of sovereignty; the challenge of rendering their physical and social space supposedly is wide open, while retaining the power to determine and regulate access (Shryock 2012). My interlocutors are employees in a publicly owned facility, not domestic hosts. Their words, however, reveal a sense of ownership that compels them to speak earnestly in terms of welcome and trespass.

“We deal with everything here, it doesn’t bother us,” Angela told me, during an evening shift at the labor ward. “We would just like some sort of entry control; they are sending us women without their histories and appointments.”

Yet refugees are a “wave,” Angela said; the chronic cause for the hospital’s scientific but also class demotion are “gypsies,” whose presence is, for Angela, a factor that has “forced” middle-class, Greek women to resort to private maternity clinics.

“We end up offering our specialized knowledge to immigrants and gypsies,” the doctor protested.

Syrian refugees have occupied the role of an Other, in Greece and wider Europe, since 2015, yet partially so often also represented as dignified supplicants rendered such by circumstances that in the past affected Europeans as well. Roma however constitutes Europe’s perennially racialized and marginalized cohort (e.g., O’Nions 2014).

THE GUESTS-BEGGARS

Looking at it from this angle, the difference between refugees and Roma is the fundamental difference, in Pitt-Rivers’ analytical terms, between honorable indigents and insolent beggars. The former are people who are not allowed to pay and who, at better times, would be willing and able to reciprocate. The latter, however, are chronically unable or unwilling to pay or to potentially assume the role of hosts at another hospitality “occasion” (2012 [1997], 509). Furthermore, they do not act as guests, but rather as rightful partakers in public health, often defying formal rules of access. At the triage department, many of them have learned the code for the access pad, normally restricted to the public, and buzz themselves in asking for prenatal care, which, as triage midwives also stated, contradicts the character of the hospital as a tertiary-care facility.

Social boundaries, however, are fluid and contextual. Thus, Roma are re-humanized when contrasted to the “inhuman” subjectivities of other cohorts in the clinic’s microcosm, a microcosm embedded in broader Greek social hierarchies. Tellingly, this re-humanization is articulated amidst the labor ward’s head midwife rant against the hierarchies between midwives and obstetricians. She is speaking loudly and aggressively, unconcerned about who may hear her in the buzzing ward. Residents are steps away, and senior obstetricians walk in and out. Midwives assist women through hours of labor, she says, yet obstetricians hog the credit merely by

stepping in the delivery room at the last minute. Greek women are also to blame, she argues, because they are “clueless” of the work that midwives perform.

Another senior midwife, Alkmini, interjects to confirm the contrast between ungrateful mainstream Greeks and Roma women. Once, she tells me, she assisted a Greek woman with fetal arrhythmia through her delivery, yet the woman credited the successful outcome to her doctor, who had had no part in the process. Unlike Greek women, Roma women acknowledge the work of the midwives, expressing their gratitude by saying “auntie, may I eat your shit.”

“There is no doctor who is also a human being,” Alkmini concludes.

To wit, Roma patients suddenly are re-humanized and transition from hostile strangers to guests, when they observe the conventions of hospitality by displaying gratitude toward their hosts. The tilt of the scales from hostility to openness may be temporary, given the abysmal social chasm that separates Roma from mainstream Greeks, but it occurs nonetheless. More than this, however, it is a gratitude that is acknowledged and praised, because it confirms the subjectivity of the hosts as such, through the acknowledgment of their professional mastery.

THE GUESTS-DENIZENS

Shortly after she rants against obstetricians, the head midwife rebukes two residents directly, when they perform an episiotomy¹⁴ on a Syrian woman. Episiotomies are a key indicator of the biomedical model of maternity care (Smeenk and ten Have 2003; WHO 2015), dominant in Greece since about the 1980s (Georges 1996). Just after they have incised the woman’s tissue, the head midwife enters the delivery room and takes over, chastising the residents angrily and loudly.

Later, I ask the resident who led the labor process if she is a senior resident. My question aims to understand the way labors are allocated among residents, but she thinks I am asking why she did not stand her ground. “Yes, I am senior, but we don’t speak back to the midwives,” she tells me; “there is a lot of bullying.”

To join the obstetrics community, residents must learn the ways of established obstetricians. The labor ward, however, the site where they are hosted and tested as potential community members, is the domain of midwives, who favor a less medicalized model of care. At the overlapping thresholds of physical spaces, professional categories, and communities

demarcated by their ideologically and scientifically divergent approaches to care, the lens of hospitality highlights the multiple struggles, structural hierarchies, and normative processes of trespass and welcome that occur just below the veneer of contractual arrangements.

Although united with the residents by age and precarity, for most of my fieldwork, I have gravitated toward the permanently employed, mostly middle-aged midwives, who have seemed more central to the processes I am there to observe. I interact closely with residents for the first time when Saleena comes to the hospital to give birth, on a Sunday in June 2017, along with her husband and nine-year-old daughter. Saleena is not wearing a head covering, and her husband dons a white T-shirt and long shorts, a casual summer outfit similar to that of the average Greek. Their smiling, sociable little girl speaks Greek fluently and interprets for her mother at the triage unit. Amira has thick, dark hair in long, carefully woven braids; the image of her face etched in my mind months after the encounter evokes animated drawings of Heidi. She's wearing a red-and-white, polka-dot dress and a white cardigan, and she is carrying a red, child's backpack. The admiring affection the child evokes to the staff conditions her parents' welcome.

Amira is even able to translate my consent protocol to her mother. Yet even before I ask, one of the residents on duty, Effie, has already encouraged me to witness Saleena's delivery. This has been the case since I started at the hospital; nobody has ever asked me if I had a woman's consent to be present in any procedure; on the contrary, they have encouraged me to watch. The joint effect of formal rules and hospitality dynamics is once again at play: the effects of my formal permission are compounded by the growing friendship of my hosts. Effie also encourages me to make my way upstairs to the labor ward, on the hospital's second floor, via the internal elevator, which links the ward to the ground-floor triage unit, rather than the regular route open to the public.

As we wait for Saleena, placed in a labor room, to reach the pushing stage of her labor, I spend time with the residents. During shifts in the labor ward, they hang out in what is formally the head midwife's office: a long and narrow room, crammed with brown and gray, old-fashioned pieces of office furniture. It is 9 p.m., dinnertime in Athens, and they invite me to join them in ordering food. We debate from where to order *souvlakia*, and I recommend my neighborhood grill, some 700 meters away from the hospital. As I praise the place, the familiar pang of fragile attachment hits me, followed by the equally familiar reaction of shutting it

down. “My” neighborhood will be mine for as long as my professional situation allows me to keep a residence in my home country—a length of time that, for a junior academic unsure of her next position, is hard to determine.

As we eat, I chat with Effie. She is 32 years old. Fueled by my own anxieties as much as by the objectives of the research, I ask about her plans after the residency. She tells me she will pursue some sort of specialization abroad, in a subfield of either gynecology or obstetrics. After this, she may stay abroad. Hoping for a spot in the saturated Greek NHS is “absurd,” she says, and the alternative of a private practice would be viable only if she were the younger relative of an established gynecologist, who would bequeath her clientele and equipment.

Just as we finish eating, Saleena is ready to start pushing. Minutes after she is wheeled into the delivery room, she gives birth to a baby boy, assisted by three residents, Effie, Maria, and Nikos, who have asked me how to say “congratulations” (*mabrouk*) in Arabic. They know I have been working with refugees outside the hospital, and, in this moment, I am the (Greek) community member that facilitates the hospitality event. Nikos is excited; he asks me a few times to get the pronunciation straight, and he says it to her. Saleena thanks them, and I teach them how to say, “you are welcome.” The moment’s joyful connectedness occurs in the context of—or, arguably, despite—multiple host-guest relationships between the Syrian family who stepped into the Greek hospital to bring their new member into the world and continue on their way, the Greek anthropologist stationed in her home country on a fixed-term academic contract, and the obstetrics residents, who shall have to look for different employment, quite possibly outside the country, once their training periods at the public hospital end. Our multiple subjectivities as guests or hosts in the nation-state, in the hospital, and, for me and the doctors, as denizens in the country’s labor force generate a plural hospitality event where hostility is “laid in abeyance” (Pitt-Rivers 2012 [1977], 509) through the realization of the contingency of host and guest positions.

Yet, for some of the health-care staff, I am still a “dangerous” guest. Before we started eating, Maria and Nikos broke Saleena’s waters manually, and I asked why. Maria responded that, since Saleena had been admitted to the labor ward, there was no point in letting her wait it out. The necessary conditions were in place; this was her third birth, and she was already dilated. Had they let the labor evolve by itself, she said, it might have taken all night. This way, she gave birth three hours after arriving at the clinic’s triage.

Hearing our exchange, Soula, the midwife on duty that night, intervened to tell me that breaking a woman's waters manually was a natural way of inducing labor, without medication. A little while later, when Saleena was given her newborn boy for skin-to-skin contact,¹⁵ Soula asked me whether I had noted how well, how by the book everything was done. The biomedical model of maternity care, which represents pregnancy and birth as dangerous processes requiring medical management and interventions such as episiotomies and C-sections, prevails in Greece as in most industrialized countries (Rowland et al. 2012; Smeenk and ten Have 2003). Yet the opposing view of reproduction as a natural process that requires little intervention has been gaining increasing scientific and social currency, as evinced by statements, directives, and campaigns of bodies such as the WHO and the UNFPA (Lokugamage and Pathberiya 2017). In her capacity as midwife but also representative of the hospital, Soula tried to ensure that my post-departure stories would confirm the clinic's adherence to this trend. I responded that I was not there to judge them; I was there to understand.

THE GUEST-POET

This is a good line to navigate tricky turns in the ethnographic encounter, but not entirely true. After understanding, I must write. And the balance I must strike between representation and critique (Cabot 2015) is never far from my mind. In the clinic's hospitality "assemblage" (Shryock 2012, S24), I occupy the spot of the "guest-poet" (Shryock 2012, S23), the guest whose post-departure words can make or break the hosts' reputation. The more the doors of the house open to me, the more I become aware of the danger I pose—and also, in a more self-serving way, of the danger of producing shallow scholarship or not being allowed back for future research. On one of my first days in the hospital, a midwife describes to me, guilelessly, the class and ethno-racial hierarchies, rather than formal and equitable rules, which determine in which maternity wards women are placed after giving birth. Or perhaps what I perceived as lack of guile concealed, in fact, an intention to get this information out. Whichever the case, she opened up the house to me in a dangerous way (Shryock 2008, 415), which could create all sorts of trouble, were I to relay this information. I will not do so here, or in any other articles, particularly since I did not corroborate the scheme she described by prolonged and systematic observation in the wards. Yet awareness of the "deception" (Bernard

2011, 256) inherent in ethnographic fieldwork, when research participants have normalized the ethnographer's presence enough to let their guard down and behave as if there were no observer in their midst, crept up on me throughout my sojourn in the clinic.

The only time I do not feel welcome at the clinic, when hostility between hosts and guest is not "laid in abeyance" (Pitt-Rivers 2012 [1977], 509), is when my behavior indicates that I have not learned the local language and that the "poems" I will write after leaving may mar the reputation of my hosts. Flustered by the pain of an Afghan woman in a labor room, I ask her in English if she needs me to call a "nurse," thinking she is likelier to understand "nurse" than the more specialized term "midwife." From a few yards away, the head midwife hears my inaccurate, albeit well-intentioned word choice. The chastising that ensues resembles the ones I have witnessed against obstetrics residents. While I cower at my chair, my head hunched over my notebook, actually documenting the incident and already intending to use it in an article such as this, the head midwife paces around bellowing, her irate remarks shooting forth from accumulated anger.

This is why this country is going to shit; this is why we have such a large percentage of C-sections. You are a guest here. This is what you will call us in your writings, nurses?

CONCLUSION: CONTESTED SOVEREIGNTY, AMBIVALENT HOSTS

This is the first and only time I am called a "guest" during my fieldwork in the clinic. My "hosts," the midwives, are hosts who do not own the house, yet feel proprietary and protective toward the physical space of the hospital, the public-health resources it encompasses, and the norms of reproductive care they espouse and promote. Their subjectivities as hosts emerge through and alongside their plural identifications and exigencies: civil servants, health-care professionals, Greek nationals, women, and people embedded in specific class hierarchies and ideological contestations within the broad community of maternity professionals.

Similarly, in an entity that combines the bureaucratic with the biomedical, rules of access claim unassailability in their supposed basis on rational planning and scientific principles. The lens of hospitality, however, foregrounds the complex interaction of formal rules, sociocultural hierarchies,

and professional and ideological exigencies that determine the content, so to speak, rather than the form of “guests” reception in the clinic.

An indiscriminate transposition of hospitality to settings featuring processes of welcome and trespass risks stretching the concept to a point that would render it slack and meaningless. Its critical deployment, however, illuminates and problematizes *de facto* hospitality dynamics in entities where physical access and access to resources should be available on the basis of an equitable and contractual framework rather than class or ethno-racial hierarchies.

NOTES

1. The term “labor rooms” refers to the rooms where women in labor are placed until they are fully dilated and ready to start pushing, when they are taken to the delivery room.
2. In April 2016, the Greek government passed a law granting free maternity care throughout pregnancy, labor, and the post-partum period to all women without means or insurance, regardless of legal or political status in the country.
3. This identification is not meant to essentialize him, but rather to protect his anonymity per the ethical commitments of my research.
4. All names have been changed to protect the anonymity of research participants.
5. For the significance of the file and what it reveals regarding the trajectories of pregnant migrants along migration and care routes in that specific socio-historical period in Greece, please see Grotti et al. (2019).
6. From November 2016 to July 2017, I conducted ethnographic research with five Syrian pregnant refugees in Athens with the help of a Syrian interpreter. Working closely with them afforded me a grasp on the way pregnant migrants perceived and experienced maternity care in Greece—a perspective I could not acquire through my work in the hospital, because of the linguistic gap and my spatiotemporally limited interaction with migrant women.
7. Refugees entering Greece via Turkey did so via boats that docked at one of five Aegean islands: Chios, Kos, Leros, Lesvos, and Samos. Depending on geopolitical circumstances and administrative rules beyond the scope of this chapter, some refugees were transferred or allowed to make their way to the mainland. For detailed discussions of these processes, particularly as they pertain to pregnant women, please see Grotti et al. (2018) and Malakasis (Forthcoming).

8. The same quotation appears in a forthcoming publication by myself and Nina Sahraoui, on the effects of gender on migrants' health-related deservingness.
9. For evidence that belies claims that migrant women exercise little or no agency within their own maternity care, please see Grotti et al. (2018) and Malakasis (Forthcoming).
10. By "Greece," I refer to the nation-state established in the modern period. Further, the term does not denote a unitary social actor, but rather the hegemonic discourses propagated by the most powerful actors within the collectivity.
11. The "fetal non-stress test" (NST) is performed after the 28th week of gestation to evaluate the health of the fetus by measuring its heart rate in relation to its movements. It is called a non-stress test, because it is not invasive and poses no risk or discomfort to the fetus.
12. In 2011, one year into austerity, the percentage of Greek nationals seeking medical assistance from *Médecins du Monde* more than doubled from the previous year (Chauvin et al. 2012).
13. *Médecins du Monde* reports that consultations in Greece made up 68.7 percent of total consultations performed in 13 European countries in 2016 (Aldridge et al. 2017).
14. An episiotomy is an incision made in the perineum, the tissue between the vaginal opening and the anus, previously considered to prevent and heal better than spontaneous tears during childbirth (Mayo Clinic 2018).
15. Skin-to-skin contact, associated with natural, rather than biomedical, approaches to childbirth, entails laying the naked newborn on the mother's bare chest directly after birth. It fosters bonding, nursing, and the infant's physiological and neurological development (Marín et al. 2010).

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