



Dr. Zahir's dilemma: money and morals in India's private medical networks

Andrew McDowell¹ 

Accepted: 22 December 2020

© The Author(s), under exclusive licence to Springer Nature Limited part of Springer Nature 2021

Abstract Public health experts often describe care in India's private sector as 'chaotic,' 'substandard,' 'profit-driven,' and 'arbitrary.' Discourse tends to focus on the 'predatory behavior' of doctors who demand consultation fees and kickbacks for everything from medicine, to laboratory tests, to specialist referrals, and even hospital stays. These practices are ethnographically observable. However, this discourse does not take into account the multiple uncertainties, ethical complexity, and personal relationships involved in providing care in exchange for money in a setting of scarce personal and public resources. Situated at the very end of a value chain designed to make money from health, or the lack thereof, private physicians find themselves embroiled in moral peril. In this article, I engage what it means to make a livelihood in a context such as this by considering the economic, moral, and epistemic practices that physicians and their patients use to create and evaluate the value of pharmaceuticals in Mumbai's slums. Based on over a year of clinic ethnography and interviews with family physicians, specialists, pharmacists, and pharmaceutical wholesalers, I trace how physicians manage the effects of a pharmaceutical value chain that produces profit by fulfilling patient's health needs and desires.

Keywords Ethnography · Mumbai · Pharmaceuticals · Care · Treatment · Diagnosis · Value

Dr. Zahir and I watched water slowly fan across the floor. As the 2015 monsoon's brown liquid inundated the clinic in the low-lying, north Mumbai neighborhood where Dr. Zahir practiced as a general physician (GP), he said:

✉ Andrew McDowell
AMcDowell@tulane.edu

¹ Tulane University, 402 Dinwiddie Hall, 6823 St. Charles Ave, New Orleans, LA 70118, USA



Mine is not a cloth shop. It is a clinic. I have to make an income, but I do not wish for people to get sick. Of course, I will profit [*fayada*] from a malaria outbreak [due to the heavy rains], but I do not want a malaria outbreak to occur. I am not simply buying medicines and selling them for a margin. I have to provide help to people who need it. If I was only drawn to income, I'd open a cloth shop. Instead, as a doctor I have people who trust and rely on me when they are in trouble. I have a challenge to think about when I see each patient. I have to make them feel better, because in the end I do not want them to be sick. It is not like I want them to have to see me so many times so I can make a profit. I do well when my patients do well.

The distinction Dr. Zahir Ikrami¹ makes in this moment, between his storefront clinic and his neighbor's cloth shop, is a productive springboard into an analysis of health, pharmaceuticals, and care as objects of value and exchange. This pensive moment reveals that Dr. Zahir, like many privately practicing doctors, is tangled in webs of economic and ethical value spun by the exchange of pharmaceuticals and care for money. He asks the central question of this paper: what does it mean to create a life and a livelihood, in other words value, from suffering and its alleviation.

To consider Dr. Zahir's question, and the possible answers he and his peers offer, I mobilize two interpretive frames, which I will synecdochally refer to as 'money' and 'morals.' In Mumbai's private medical sector, interconnected forms of value—morals and money—animate pharmaceutical action and exchange, as well as the practices that make, add, or distribute pharmaceuticals' economic, moral, and epistemic value (Munn 1992; Graeber 2001). They help interpret the ostensibly chaotic nature of such relations.

Through these bifocal lenses, I examine a number of practices that make value in its multiple forms where sickness and livelihood meet. As a medical anthropologist, I define value, tentatively and with trepidation. For me, value is a social construct that people use to imagine, represent, and negotiate relationships between words, things, and people (Malinowski 1961; Mauss 1990; Guérin 2014; Ramberg 2014). It is a shifting effect of practices that are collectively interpreted—though with contestation—as useful for individual, social, and biological life (Guyer 2004; Elyanchar 2012; Walsh 2012). Value is, therefore, a set of relational practices that imbue objects, actions, and statuses with their desirability and determine what people can and should do to access them (Thompson 1966; Marx and Engels 1967; Munn 1992; Kleinman 1999; Graeber 2001; Paxson 2010). For my purposes value is a shorthand to describe and make comparable those practices that assess or modulate economic, moral, or epistemic use and signification (Lambek 2001, 2008; Graeber 2001; Eiss and Pedersen 2008). I focus on value and medicine in Mumbai's clinics to examine how people create and contest economic, moral, and epistemic value practices around pharmaceuticals, which can broadly be called 'pharmaceutical value.'

¹ All names are pseudonyms. Forthwith, I use physicians' first and last names on first mention. In subsequent mentions, I use either their first name or last name depending on the convention among their patients and themselves.



By and large, anthropologists have theorized pharmaceutical value at global, scientific, and industrial levels (Hayden 2003; Petryna et al. 2006; Sunder Rajan 2006, 2017; Petryna 2009; Dumit 2012; Pordié and Gaudilière 2014; Quet 2018; Chorev 2020). Others have considered pharmaceuticals' situated meanings, movements, and social lives (Appadurai 1986; Geest and Whyte 1988; Whyte et al. 2002; Das and Das 2006; Martin 2006; Seeberg 2012; Peterson 2014; Meier zu Biesen 2018), but the practices that make pharmaceuticals valuable in clinics and households remains largely outside of contemporary ethnographic considerations. Such analyses are crucial for a nuanced understanding of doctor-patient relationships, as value must be situated in its historical, geographical, and social context (Guyer 2004; Narotzky and Besnier 2014).

Dr. Zahir's worry about making *fayada*—benefit, profit, improvement or value—from pharmaceuticals begins to situate the social practice of value between doctors and patients in Mumbai. Though conversant in English, Dr. Zahir often spoke to me, his peers, and his patients in Mumbai's vernacular Hindi sprinkled with Dakhani Urdu. In conversations with Dr. Zahir and others, talk about the value of pharmaceuticals hinged on three polysemic words: *fayada*, *bhav*, and *kaamyav*. Each identifies an important facet of value for physicians and their patients. Though I translate *fayada* as profit above, it could be equally well represented as value, benefit, positive effect, or utility. Objects and actions imbued with utility, profitability, or benefit are described with the adjective *fayadamand*. To be *fayadamand*—profitable, useful, beneficial, valuable—pharmaceuticals must combine health improvements for patients and profits for physicians. Though patients used *fayadamand* to describe treatments and practices, *fayada* is detached from price. At Mumbai's pharmacy counters and clinics, consumers ask the price of a medicine by demanding it *bhav*. *Bhav* can mean price, weight, and emotion and in the context of pharmaceutical value it draws on all three registers operate simultaneously. Patients often spoke of medicines' prices and effects with adjectives “heavy” and “light,” rarely using expensive or inexpensive. The heaviness and lightness of price and bodily effect were both sources of value. Physicians made *fayada* from each through different practices. *Kaamayaab* or *kaam ka* refer to successfulness, appropriateness, and usefulness and its opposite *bekar*—without use or value—represent a situated assessment of use value. Finally, though Hindi's noun and adjective *kimat* and *kimati* might easily stand in for value and valuable, these terms were rarely used to talk about pharmaceuticals or medicine. To summarize this Mumbaikar glossary of value, Mumbai's patients and physicians speak of, assess, and make pharmaceutical value by attending to drugs' ability to provide benefit and profit, their price, weight, and effect, and their utility. Processes that distribute these three forms of value—benefit, effect, and usefulness—between patient and physician are at the center of both Dr. Zahir and his peers' dilemma and their everyday pharmaceutical practice.

Examining value in Mumbai, India's economic capital, and its slum-based clinics, my work is guided by the following questions: How do patients and physicians in Mumbai's private clinics practice pharmaceutical value and the interplay between economic, moral, and epistemic value that comes with it? What are the effects of these practices and what kinds of relations do they rely on and build? What are the pharmaceutical value practices that encourage people to create economic



opportunity from objects and services they think should be exchanged without profit?

Money and morals

Dr. Zahir describes his work, in a clinic not a cloth shop, as having two goals: it is an economic strategy to earn money; and it is a call to address suffering. He lives and works at the confluence of profit, price, suffering, pharmaceuticals, and exchange each day in his clinic. He recognizes that people, many of whom have little money, visit him with their ‘troubles’ in hope that the medicines he provides will solve them.² With this in mind he evaluates the effects of pharmaceuticals and his work through a kind of combined and compartmentalized financial and moral economics. Michael Lambek also writes of such a predicament, describing money and morals as “value” and “virtues,” and argues that anthropologists should examine economic and ethical value together, but in tension (2008). He explains, “First, it does not make sense to talk about value without virtue, or vice versa, especially if one understands value as a function of acts rather than simply of objects. Second, it is dangerous to conflate value and virtue” (2008, pp. 133–134). Following Lambek and Dr. Zahir, I take up the dilemma posed by pharmaceutical use in Mumbai as a dynamic moment when pharmaceuticals’ economic, epistemic, and ethical values interweave, and yet are tugged in different directions.

Physicians like Dr. Zahir are roundly criticized both in the Indian press and by public health experts. Researchers characterize the city’s private sector as a chaotic, irresponsible, and predatory maelstrom in which physicians and others aim to extract as much economic value from patients as possible without regard for patients’ suffering or overall public health (Kamat 2001; Lönnroth et al. 2004; Deshpande and Thorson 2006; Das and Hammer 2007a, b; Cross and MacGregor 2010; Pinto and Uplekar 2010; Bhargava et al. 2011; Duggal 2012; Achanta et al. 2013; Fochsen et al. 2013). For scholars, the presence of money adulterates the moral value of addressing suffering, and reduces sick patients to reservoirs from which to extract money for drugs, care, and knowledge (Nandraj 2015). India’s press also runs countless stories about physicians duping patients, for instance into unnecessary surgeries or expensive diagnostic tests. Both groups view the exchange of money for care as a source of corruption, and Dr. Zahir as well as his peers are not ignorant to this paradox, or to the way in which their practices are viewed by others.

Initially I assumed that Dr. Zahir’s rejection of a commercial role in the cloth shop analogy was an attempt to respond to press and public health criticism, and assert a certain moral superiority vis à vis the shopkeeper. However, in the context of other research his attempt to redefine his business as not entirely within the realm of economics suggests something about the moral nature of his vocation (Weber

² Most Mumbai and Delhi-based general physicians provide pharmaceuticals to patients as part of their fees. The law prohibits the sale of medicines by anyone but licensed pharmacists, so Dr. Zahir describes these pharmaceuticals as “gifts.”



1930). Jonathan Parry, in a seminal study of ritual gifts and secular commerce in North India, calls the ambivalence and risk experienced by those taking money for a vocational service, “a sense of moral peril” (1989, p. 70). He finds this moral peril in the lives of priests accepting gifts and fees for religious services, but not traders who buy and sell goods. Parry suggests that exchange in a cloth shop is purely commercial. As traders engage in open games of negotiation about value with their buyers, value practices like profit-taking, margin, or even deception have less ‘moral peril’ than practices of value making engaged by priests. Those engaged in commercial transactions are not expected to have motives other than profit, nor create relationships beyond that of buyer and seller.

In this light, Dr. Zahir's comparison may suggest that a cloth shop, as a purely commercial endeavor, is less morally risky than Dr. Zahir's clinical use of pharmaceuticals.

Physicians practicing in for-profit clinics, like priests, are charged with doing good because it is their social role. They are expected to have the more primary motivation of alleviating suffering, and foster relationships of care with their clients. Unfortunately, this social role is inseparable from their most frequently used tool, pharmaceuticals, and pharmaceuticals cost money.

In Mumbai pharmaceuticals and their effects are a locus of physicians' moral, economic, and intellectual authority. Yet, because the economic value practices—like taking profit, availing of margins, or selling advice—that physicians use to earn a livelihood from pharmaceuticals present a moral peril, these forms of authority are called into question in a number of ways. The first a moral peril accrued by doctors' need to buy most pharmaceuticals from pharmaceutical companies. Though they often receive free samples from visiting medical representatives, physicians must purchase their basic pharmacopeia. To increase the potential value of these purchased pharmaceuticals, physicians strive to maintain beneficial relationships of patronage, discount, and credit with pharmaceutical producers and distributors. Physicians simultaneously foster relations of trust, care, and vocation with pharmaceutical producers and patients. These relations create value as well as moral peril because though alliance between physician and both groups center on loyalty and mutual aid they seem conflicting. Second, moral peril endangers doctors' social role as members of an esteemed vocational group. Physicians were victims of moral suspicion by civil society similar to that which scrutinized the Banarasi priests Parry studied and the wonder cultivating Bengalurean temple priests Tulasi Srinivas observed (Srinivas 2016). Patients, like devotees, think that physicians ought to act in their patients' best interests, but the need to make a living calls into question what role money plays in this relationships of care. Third, physicians' morally ambiguous aims when prescribing a pharmaceutical affects the perceived utility and desirability of the medicine. Patients often wonder if a drug was really necessary or simply prescribed as a source of income for their physician. In each case pharmaceutical value practices necessary for economic gain imperil the ability for physicians to practice at all, by calling into question their integrity. They continue, nonetheless.

Physicians like the ones discussed in this paper are keenly aware of the tensions created by the need to make a profit on pharmaceuticals, generate a livelihood, and enact a vocation. Their practices, often viewed as illogical or irresponsible by



others, are ways of managing the moral peril that comes with pharmaceutical value wherever it may be found. They present one starting point from which to understand how pharmaceutical value on every level—from drug discovery, to production, to sales, to distribution and use—is enwrapped in the moral peril associated with taking money for a substance that is often necessary for the life and wellbeing of the person who finally acquires it. Observing these physicians shows that the moral perils of pharmaceutical value remain unresolved. They also allow us to view the practices people employ to manage this paradox. These practices both sustain and subvert the economic, moral, and epistemic value of pharmaceuticals for human flourishing, and show us the social dramas that unfold in the realm of medical morals and money.

Methods and sites

To find an empirically-informed path between physicians self-ascribed moral action and the condemnation of the private sector by public health scholars and activists, I conducted a nearly fifteen-month-long ethnographic study of private sector health care in two large slums³ in the northern reaches of Mumbai. In Mumbai, the private sector includes publicly employed physicians who practice outside government-run clinics in their spare time, and those who have no affiliation with the state (Deshpande et al. 2004; De Costa and Diwan 2007; De Costa et al. 2008; Mackintosh et al. 2016).⁴ The private sector ranges from some of India's leading hospitals, to one room clinics like Dr. Zahir's, to a man selling Ayurvedic medicines under an overpass. Though most clinics in the private sector are for-profit, trusts and charitable organizations also offer reduced-price or free medical services (Yesudian 1994; Bhat 1999). The private sector also includes pharmacies, laboratories, pharmaceutical manufacturing, drug retailers, and pharmaceutical suppliers called stockists (Kamat and Nichter 1998; Brhlikova et al. 2011; Seeberg 2012).

Though patients, physicians, and other service providers move in and out of the public sector, my research focused on sources of care available outside the state's health care system. I interviewed more than 175 general practitioners trained in Ayurveda, homeopathy, or Unani, but practicing biomedicine.⁵ I also interviewed six

³ Slum is a contested category in Mumbai. In general slum refers to an unplanned settlement but also expands to planned settlements characterized by a lack in services and disorganized settlement patterns, encroachments, and crowding (Bjorkman 2014).

⁴ Public health scholars describe the private medical sector as an aggregation of those medical services not located in a center run by local, state, or central government. Though these physicians are often accused of asking patients who visit their public sector practices to attend their private clinic, I saw only one instance of this action. On the contrary I observed several instances of these physicians referring patients from their private clinics to their public sector practices.

⁵ Bachelor of Ayurveda, Medicine and Surgery, Bachelor of Homeopathy, Medicine and Surgery, and Bachelor of Unani, Medicine and Surgery are all government recognized degrees in alternative medicine. Though trained in alternative systems these practitioners in Mumbai commonly practice a combination of alternative and biomedicine or biomedicine exclusively (McDowell and Pai 2016a, b). They make up the majority of physicians in the city's 12 high burden wards.



jhola chhap or informally trained doctors⁶; six generalists trained in biomedicine; and fifteen chest physicians. All of these practitioners held clinics in or around the two slums in which I worked. Finally, I interviewed ten chemists, fifteen pharmaceutical distributors, and one drug manufacturer,⁷ all of whom sell and occasionally prescribe medicines in these slums (Kamat and Nichter 1998; Satyanarayana et al. 2016). These interviews were predominantly in Hindi and occasionally in English. I spent hundreds of hours in clinical observation, observing more than 2000 clinical encounters. Physicians conducted these consultations in Hindi and Marathi, occasionally shifting to Urdu or Gujarati. I am able to speak and understand Hindi and Urdu and can effectively understand Marathi and Gujarati. I interviewed just over 200 patients in waiting rooms, living rooms, and tea stalls, predominately in Hindi.⁸

The two slums that comprise the heart of my fieldwork are each about 1.5 square kilometers. Together, they are home to an estimated 550,000 people⁹ and hold 301 private physicians' clinics. That is 190 physicians per square kilometer and about 1 doctor for each 1825 residents. 'Slums,' a controversial catch-all term for urban spaces parallel to or outside organized public services, are frequent targets of global health intervention (Björkman 2014). Global health and development literatures often view these spaces through the lenses of hygiene, poverty, violence, exposure and exclusion, but they are also dense sites of social and commercial action (Garau et al. 2005; Health 2008). Understanding the lives that are lived here requires approaching these spaces not as zones of abandonment or contagion, but as places in which people live, work, and aspire to fulfilling lives.

What emerges from engaging physicians who practice in Mumbai's slums is not simply a story of the neoliberal market conquest of a public health care system (Varman and Vikas 2007) or a set of physicians reproducing 'market logics' (Rajan 2003) as the literature might suggest. Rather, physicians practice in a context of intense competition permeated by partial economic and social shifts. Attending to their everyday work, I sketch the diversity of practices Indian physicians mobilize to navigate these incomplete changes and the moral peril created by imperatives to provide care as earnest assistance and to derive a livelihood from pharmaceutical value. Dr. Sarita Patil made this clear to me.

⁶ *Jhola Chhap*, Hindi for "satchel mark" doctors, are named after their once itinerant lifestyle and clinic-in-a-bag treatment paradigm. This is a common Hindi moniker for those practicing as physicians without formalized training in any system. Pinto calls them "ersatz" (2004) while Das calls them Bengali doctors (2015). I have written of them elsewhere as Bengali doctors (McDowell 2017).

⁷ India is a global leader of pharmaceutical production, and factories producing generic drugs are common in Western India, as well as Himanchal Pradesh. 'Local quality' drugs, which physicians buy in bulk, are often produced in the slums of Mumbai in cottage industries and sold in plastic bags. Ahmedabad and Surat are also hubs of production.

⁸ I present all quotations in my own translation. Though I understand Marathi well and can speak it when necessary, I have asked native speakers to double check any translations from Marathi provided here.

⁹ This makes the two slums nearly five times more densely populated than Manhattan and 16 times more densely populated than Paris.



Dr. Patil and her neighbors: commensurability, diversity, and the portability of money

Dr. Sarita Patil¹⁰ practices in an unplanned neighborhood or ‘slum’ in northeastern Mumbai. A family physician, she sees a diversity of patients. Most are women. Her storefront clinic, squeezed between a barber shop and a dry-goods store, faces a cement-blocked road. It is one of six clinics on this 500-m long lane. Dr. Jain’s clinic is to her left and Dr. Jagtap’s to the right. Patients linger in Dr. Mahamalik’s waiting room across the street and several storefronts to the left. I stepped into her office to introduce myself on a warm day in October 2015.

Like many examination rooms I saw, Dr. Sarita’s was simple. A raised examination table flanked the room’s western side. Her desk and a few low stools cluttered the remaining space. Behind Sarita, four shelves of neatly arranged plastic jars containing colorful tablets lined the wall. At the end of each consultation, scanned the wall to select a combination of pharmaceuticals, put them in a small plastic sachet, and hand them to her patients. On the day of my visit, her sari-clad attendant looked on from the examination table, legs dangling off its edge. The attendant’s expression seemed to ask why I had come, and displayed an evident hope that I would leave before she needed to manage a crowded waiting room.

With a knowing look, Dr. Sarita told me that I had met her husband, Dr. Suresh Patil, a week earlier. His clinic is about a kilometer away. The couple divided their practice so that the women who visited her would feel more comfortable, she explained. I remarked in Hindi that she had a lot of competition, and Sarita replied in Marathi-inflected English:

It’s not so bad, really. I get some patients; Dr. Jain gets some patients. There is no shortage. In fact, it’s easier when you know your neighbors, what they prescribe and the like. They do half the work for me, and from what they have given I can often rule some problems out right away. In fact, it gives me an advantage. Probably I can make the patients well before they leave me. If not, they have many people here they can consult.

I had never been presented with this way of thinking about competition, and, at a loss about how to respond, I launched into my standard set of questions about medical representatives and pharmaceutical use. Soon a critical mass of four patients had formed in the waiting room, and the attendant moved towards the door. Still processing our conversation, I excused myself. I wanted to think more about what Dr. Sarita had said. After months of conversation and reflection, I realized that Dr. Sarita and I understood competition differently. Whereas I viewed a surfeit of physicians as an obstacle to economic value practices, Dr. Sarita saw a dense landscape of peers as a site of possibility for creating her own unique set of moral, economic, and diagnostic value practices to attract patients, as well as a way to distribute the potentiality for cure.

¹⁰ All person and place names have been changed. A diversity of names has been used to reflect the diversity of actors involved.



Dr. Sarita did not aim to attract patients, she said there were enough patients to go around, so much as to treat every patient in a way that built a relationship of care. Her husband, who was active in the neighborhood medical association—an organization that sets a suggested price for consultation in the area, arranges meetings and educational opportunities, and hosts networking events—seemed to agree. Their separate practices, one catering to all genders and the other particularly to women, were oriented towards building trust. As we chatted, Dr. Suresh Patil told me, “My goal is to develop a relationship of trust with my patients. To do that I have to make them feel well and feel like I’ve been able to help them. They will do the marketing for me.” Each spouse built a different community around their care. For Dr. Sarita Patil, shared womanhood was a source of trust, empathy, and expertise among female patients, and she built a community of patients that occasionally overlapped with her neighboring physicians. As patients lived and worked alongside physicians for years, clinics were not necessarily competing for patients—despite the economic logic of saturation—as much as providing a network of care in which some nodes were more central. Doctors called loyal customers, for whom they were key nodes in the medical web, ‘fixed patients.’ Unique practices of pharmaceutical and social value within the community of care, in this case, enabled one to become a central node. Incommensurability, or too much difference, on the other hand, would limit the possibility of accepting other physicians’ patients (Janzen and Arkinstall 1978).

Competition, commensurability, and diversification provide Dr. Patil a way of learning about disease and the body, as well as relieving some of the pressure to correctly identify and treat disease. On a subsequent visit to her clinic, Dr. Patil elaborated her earlier point about cooperation and competition. She suggested that she had a strong sense of what kinds of medicines her neighbors would prescribe. If a patient revealed that she had been to a neighboring physician before, then Dr. Patil already had a sense of which medicines had not cured the patient. Sometimes patients would even come with laboratory results. In each case, Dr. Patil could work on the basis of what other physicians had done and try something new in hopes of curing the patient. If successful, Patil would get the social or moral credit for curing the patient despite the earlier physician’s work.

Dr. Naseem Ansari also practices in a ‘doctor lane’ like Dr. Sarita. One of seven physicians in under 100 m, he taught me about commensurability and pharmaceuticals’ epistemic or diagnostic value in a context of competition:

They all say the same thing, ‘as long as I am taking medicine the problem goes away, but as soon as I stop it returns again.’ This is a classic sign of dexamethazone, and means I need to stop thinking symptomatically and begin thinking diagnostically. Even if they give only a few symptoms and say they have been sick for a short time I have suspicion. I give a stronger antibiotic, especially if they tell me which doctor they have seen. If I know the doctor, I can give something stronger, different than what he usually gives. If the patient comes from [Dr.] Azeebhai, its easy. We all know Azeebhai gives all of his patients ciprofloxacin, so I’ll write that patient Augmentin or cephalexin, but skip the ciprofloxacin.



Again, Dr. Naseem relies on the outcomes of various courses of treatment and his own knowledge of his peers' habits to guide his treatment of patients. Though patients' accounts of their illnesses are essential in Mumbai clinics, physicians often doubt their veracity. Patients may not report previous treatment or remember what medications they were given. Recognizing particular experiences of illness, like the effects of dexamethasone, can help in managing this uncertainty.

Prakash, a pharmacist, once explained to me, "Dexa[methazone] is the guru of GPs. If you take it away from them, they are completely lost." He continued, "If you took it away from them, they would be like drug addicts, doing whatever they can to get a hold of it." Though mixed, the metaphor tells much about this steroid's value as an epistemic tool. Simultaneously teacher and addiction, tool and risk, GPs often suggested that dexamethazone manages symptoms and provides quick relief that makes a skeptical patient a believer. The cheap steroid's subtle side-effects also tell physicians about duration of illness and help identify patients who have already consumed some pharmaceuticals. GPs, like Dr. Patil, working in situations of health care overlap, thus develop strategies to reveal the kinds of 'symptom suppression' steroid exposure produces. This is part of their work to make epistemic value from pharmaceuticals.

One November evening in Dr. Khan's clinic, he turned to me after a patient had left the room and said, "That woman, she told me she had not seen another doctor before. I asked her twice and still she told me she had not, but I know she has." Wondering about his clairvoyance, I asked Dr. Khan how he knew. He responded:

Well it's easy. Did you see her face? Her cheeks in particular? They were quite puffy, no? She doesn't normally look like that, but facial swelling is a very common side effect of steroids. She must have taken two or three days' worth. I could see it and know she has taken medicine from someone else. In her case, I have to ask about changes in her illness, what happened first, etc. Even though we don't get a good sense of the progression of disease in these cases, we know we have to give something a little stronger because she has been sick for several days.

Sylvie Fainzang has productively considered the role and ubiquity of deceptions like this one among patients and physicians (Fainzang 1997, 2002, 2016). She suggests that deception is an intersubjective process that has the potential to be both a therapeutic tool and a stumbling block. In these clinics, dexamethasone—though not advised in most biomedical contexts—is as much treatment as it is harbinger of deception. Just as the woman in this case did not tell Dr. Khan about her earlier treatment, he did not tell her he knew. Dexamethasone did the telling. It helped avoid questions of patient reliability when working to practice and increase pharmaceutical value. For these physicians, pharmaceuticals are epistemological tools that cannot lie. Reading the body for the signs of pharmaceuticals is central way of knowing in these clinics. Dexamethasone is only one example of physicians' processes for discerning the traces of pharmaceuticals and their epistemic value. Practices of value around pharmaceuticals allow physicians to manage the commensurability that money and drugs build between clinics.



Dr. Patil suggests that competition and diversity distribute the moral peril of taking money for pharmaceutical failure among neighborhood physicians. Though she wanted to retain as many patients as possible, Dr. Sarita knew that her patients could visit others and at times did. The portability of money made building and breaking relations of care possible. It also distributed the onus of treatment success and failure across multiple physicians. Where some might view responses to the portability of patients and their money as competition, many saw this as a form of cooperation to distribute the moral responsibility of taking money for failed treatment. In other words, competition and diversity within the slum produces economic value, as well as distributes the possible relations and responsibilities of care. At the same time, if doctor's combination of discernment, advice, and pharmaceuticals does not work, failure is not personal, but distributed across the many physicians available to the patient.

Differentiated practices, differentiated biomedicines: light and heavy

Many GPs play into patients' expectations of medicine (Kamat 2001; Ecks 2013), or what the doctors imagine they expect. Generalists, like Dr. Sarita, strive to present themselves and their clinics as sources of a specific form of biomedicine that fits patients' expectations of pharmaceuticals as tools to manage the fluctuations between normal and pathological (Khare 1996). To state it baldly, patients come to clinics expecting to leave with medicines, and doctors comply. GPs use at least three pharmaceutical strategies—light, heavy, and tonic—to cater to patients and produce pharmaceutical value.

The 'light medicine' strategy became evident to me as patients in waiting areas explained why they chose a particular doctor. In certain clinics, patients explained, the doctor gives *halki dawai*, light medicine. Initially I thought that patients' use of the Hindi word "halki" or "light" suggested a lightness of price, in other words affordability. Patients, however, were quick to correct me. Light medicine's lightness abided in its effect, not its price. These medicines worked in the body subtly, and had less side effects. This preference for light treatment contradicts received knowledge that Indian patients demand the strongest medicines possible in order to return to work fast (Das 2015). Though some patients did request strong medicines or even injections, this was rare in clinics known to provide light medicine. Patients in these clinics often expressed a concern for side-effects: "I chose this doctor because when I take [his] medicines, it is like not having taken them at all. I mean I feel better, but there is no nausea or uneasiness involved."

The ubiquity of clinics providing light medicine indicates that pharmaceutical value, even when understood as a commodity alone, does not necessarily increase as the experience of disease moves further toward the pathological. Instead, 'light medicines' suggest that pharmaceuticals can also be evaluated by their potential to go unexperienced. In this case lack of experience is an experience.

Doctors knew the term when I spoke with them about their patients appreciating light medicines. Dr. Mahul Phadke explained:



See, it's not that I have light medicines; it's that I add a Rantac.¹¹ I give the same as everyone else, a paracetamol and nemuslide, amoxicillin, and maybe diclofenac or even dexamethazone, but I also always give a Rantac so the gas from the medicines does not bother the patient. That way they think I've given something very simple, but their symptoms subside.

Observing his clinic, it became clear that Dr. Phadke cultivated a practice of lightening medicine, and his was among several of the busiest clinics where light medicines could be found. Like other providers of light medicine, he tended to refer more patients to specialists and the public sector. Speaking for his light medicine peers, he explained that they wanted to cure patients in one or two visits. If they could not, they sent the patients to a doctor whom they felt could. Though providers of light medicines referred more, they tended to test less and ran through possible causes of illness on the basis of medicines alone (McDowell and Pai 2016b). They wanted their "fixed patients" to come for triage, or what they called *normal bimari* or normal sickness, like the common cold, a laceration, a cough or a fever.

On a first visit, few patients received prescriptions beyond drugs dispensed from his supply. On a second visit, Dr. Phadke asked a few patients to buy an antibiotic from the chemist. On the fourth or fifth visit it was clear that this patient was not afflicted by a normal sickness and, usually after ordering a blood test, Dr. Phadke often said something like, "Look, I'm not going to give you my medicines. You're still sick and need something stronger. This time I'm writing a prescription. Buy everything from a pharmacy." If these medicines were not successful, Dr. Phadke referred them to a specialist. He cultivated multiple networks of specialist physicians in order to choose a specialist whom patients might like and be able to afford. "I have known many of these patients since I was a child. I need to avoid any mishaps and give them good advice. They know if I cannot manage, I will send them in the right direction. If I find them a good referral then that too is my success in their eyes," Dr. Phadke explained. Because these physicians were specialists rather than generalists, Dr. Phadke could portray referral as care and if the patient was cured by the specialist, he was part of the cooperative effort towards success.

Thus, Dr. Phadke differentiates his clinic as a space of light medicine and imperceptible side effects from the medical world outside with its strong, harsh medicines. In this case "lightness" was part of the health care product. The pharmaceuticals he provided were useful in part because they dealt with treating normal illness. In Dr. Phadke's clinic, pharmaceutical value rests not in pharmaceuticals' ability to manage experienced pathology, but to address normal discomfort and sift normal illness from major pathology. If the drugs could do this, even if they did not catalyze cure, they were money well spent and the moral peril of medicine for money was averted.

A smaller number of general physicians used a heavy medicine strategy. These practitioners represent their practice as a kind of secondary-care clinic, and do less to cultivate a fixed patient community. Although they see fewer patients,

¹¹ Rantac is a trade name for ranitidine a drug used for heartburn and indigestion sold in the US as Zantac®.



because treatment is more intensive, the clinics always seem busy. A source of *bhaari* or heavy medicine, Dr. Anand Shinde's clinic was always full. I once asked a young man in the waiting room why he was willing to wait so long, and he told me:

I live in Andheri near the mosque. I saw a doctor there for a few days for my cough, stomach pain, and chills, but I did not get better. After a few days my father said, 'Come on, tomorrow we will go see Dr. Shinde in Prem Nagar.' You see, my father was rather sick before. He came here and got better. That is why I came here.

Dr. Shinde was known as a GP heavy enough to treat patients for whom light medicine has not worked. As such, he worked to cultivate an aura of practicing powerful medicine. His patients almost never left the clinic without an injection; about half got IV fluids of some kind; and he asked everyone to purchase a rather lengthy list of medicines in addition to the ones he distributed.

As a physician renown for heavy medicines, Dr. Shinde expected that his patients were more likely to have been sick beyond a few days, had been exposed to the interventions of light medicine doctors, and had probably travelled further to reach him. These factors legitimated costly practices, such as intravenous drips, injections, increased dosages, and longer courses of prescribed medications. Prakash, who owns the pharmacy next to Dr. Shinde's clinic, had this to say:

He is the kind of doctor who writes a high dosage over a longer course of time for his patients. He usually uses monopoly brands, but he gets good results from these medicines. He has slowed down now, but before his heart attack I would have to run to keep up with his prescriptions. Even now they are usually a full page long. I still have to make sure to find out when he takes a holiday, because if Dr. Shinde's clinic is open I know there will be a rush.

In fact, Dr. Shinde's pharmacopeia is so extensive that he asks his patients to return for follow-ups with the list of medicines he has previously prescribed, explaining, "I don't always remember them or what they told me on a previous visit. If I have my prescription, I know what questions I need to follow up on." This is another way of parsing which drugs' effects are observable in follow-up consultation and which are not. In other words, Dr. Shinde modulates the moral and physiological risks of maximizing his profit through documentation and strong, fast acting pharmaceuticals. Patients, even if they did not get well, at least experienced the effect of their investment in his care, Dr. Shinde seemed to reason. Heavy describes both his medicines' effects on the body and their economic burden.

A third strategy used by doctors in these slums is to foster health by combining pharmaceuticals and nutritional supplements. I call these doctors *tonicwale*. *Tonicwale* sell vitamins, nutritional tonics, and supplements directly from their clinics with the goal of strengthening the body's systems of immunity. They speak often about anemia and sell multivitamins to patients with almost every illness.



They combine these tonics with other pharmaceuticals, and often opt for pain killers and steroids. These physicians recognize that most patients come to the doctor with concerns about a lack of appetite. Consequently, they earn most of their income from high-margin vitamins that help stimulate appetite. Liv-p-zyme is an example of one such high-margin tonic. Dr. Shamim buys bottles of the tonic for 50 rupees from a stockiest and sell it to patients a few rupees below the 175-rupee maximum retail price marked on the box. His patients are attracted to his discount and a unique strategy, one that is different from light medicine, that helps to build up health through branded and brightly packaged vitamins.

These three strategies work at a symptomatic, experiential-level, and most of the doctors here think of medicines not in terms of the diseases they manage, but in terms of the reduction of symptoms (McDowell 2017). In each strategy, physician use medicines to discern a physiological cause of suffering and return patients' to an embodied experience that both can identify as normal. As such, patients' reported experience is essential. When a patient's symptoms react to a standard course of treatment, such as paracetamol or ciprofloxacin for fever, the illness is assumed to be cured, and no further analysis is necessary. If symptoms do not respond to these pharmaceuticals, the cause is assumed to be pathological, and this is the impetus for referral to a more specialized doctor.

This epistemic use of pharmaceuticals and the centrality of patients' reliance on them raise questions about Veena Das's theory of pharmaceutical value. Das suggests that medicine is a credence good modulated by patients' experience of suffering (2015). As a credence good, pharmaceuticals' value abides in consumers' confidence in them or their vendors because patients themselves cannot discern the use value of a drug without mediation (Nelson 1970; Darby and Karni 1973; Daviron and Ponte 2005; Esquerre and Boltanski 2017). In Das's context, she argues that when patients buy a drug to alleviate symptoms, they are really paying for expert advice about what remedy to use as they cannot know how the drug is actually working in the body. In Mumbai this seems not to be the case. Physicians and patients are aware that medicines become fetishes of faith, interchangeable on some level with the tonic, or even the placebo. They also know that drugs are a stand in for the moral authority of the physician who prescribes and combines them. However, this credence idea misses the ways that pharmaceuticals allow health to be experienced iteratively. Thus, the trust that is purchased may be in the doctor's use of drugs as diagnostic tools on the road to healing, rather than in the drugs' immediate effect to alleviate symptoms. In other words, they are tools rather than magic bullets, and patients and doctors see them as knowable, testable, and mutable.

Fixing patients on the scale of a life

Regardless of which strategy their situated biomedicine instantiates, general physicians operate on a time horizon longer than just one sickness. Though critics suggest that GPs aim to maximize economic value in any given clinic visit by avoiding diagnosis and treating ineffectively, time spent with them contradicts this. GPs assume that patients will come back multiple times a year, with multiple illnesses, over the



course of a lifetime. Thus, they rarely seek maximal value in a singular exchange of money for pharmaceuticals and expertise. Instead, they expand their work's social and economic value by maximizing profits through the course of a life. Extending care through a lifetime necessarily combines more obvious economic considerations with questions of moral peril, social relations, and practices that generate value.

Most of the GPs I met, and certainly the forty or so I came to know well, see more than sixty patients a day. Many see more than seventy patients in their evening sessions alone. Clinical interactions progress at a breakneck speed, generally lasting between four and five minutes, and individual interactions blur in the clinic's frenzied routine. I observed hundreds of interactions in Dr. Kaman Malwankar's clinic, but, though these interactions filled several notebooks, after a few days, individual patients or acts rarely stood out. Nonetheless, a routine became evident. In the few minutes given to each patient, Dr. Malwankar takes a basic history, asking questions like, "*Kai itaraz?*" "*Taap ahe?*"¹² "Have you eaten something out of the ordinary?" "Have you taken medicine anywhere else?". He then conducts a clinical test or two, usually listening to the heart and lungs and taking blood pressure. Finally, he distributes medicines, and collects his fee. During my observation, no patient left without medicine, perhaps because the consultation fee includes three doses of pharmaceuticals. Though Dr. Malwankar is trained in homeopathy, and at times used it, nearly all patients received biomedical pharmaceuticals.

Though brief and hardly exhaustive, clinical narratives present complex portraits of lives lived. Unlike specialists, GPs tend to know, or think they know, much more about their patients than four minutes allow, and they use this knowledge to make decisions about treatment. These deeper connections became evident over several weeks in Dr. Malwankar's clinic, and I began to see his practice as iterative on a long time scale. Here is one story he told me about a patient:

This patient, she is a washerwoman. Her husband has died, but her children are studying. She visits 10 houses daily in Rajkumar Nagar and washes their clothes. The problem is that she seems to have developed an allergy to the soap and as a result had a rheumatoid flare up in her wrists. I told her to buy rubber gloves and take a few days off at least, so the top layer of skin on her hands can come back, but she cannot. So, I'm giving her Cetirizine and a pain killer.

A bit later, Dr. Malwankar commented about a patient who had come to him with stomach trouble:

She lives up the hill a way and has had chronic indigestion for years. I keep telling her not to worry so much, but she lost two young sons in quick succession. For a while, I had her on a mood stabilizer, but it is not sustainable. Still I think, with that kind of loss just moving on would be difficult. So, I give her Rantac and paracetamol and tell her to go for walks and do exercise. It is not so much because I want her to exercise, but because I want her to go out and try to live a bit.

¹² Marathi for "What's the problem?" "Do you have fever?"



Dr. Malwankar was not the only physician to suggest he knew his patients as people. Doctors recounted similar medical histories for many of their patients. These patients were ‘fixed,’ in the sense of not likely to visit other physicians, and they were as likely to visit their regular doctor due to an acute illness as because of a chronic one. Indeed, illness seemed never-ending in the slums where these physicians worked. It was often just a matter of time before a patient returned.

I often wondered how GPs survive the difficult task of using pharmaceuticals to medicate and make livable the grueling circumstances of their patients. The mismatch between patients’ suffering and the tools used to address it seemed another kind of moral peril. I shared this uneasiness with Dr. Malwankar one night as he prepared to close the clinic. That day he had bandaged a rat-bitten big toe, cleaned a young man’s wounds after an assault by a beer-bottle wielding friend, checked the healing on an arm broken by a motorcycle accident, gave a 12-year-old girl her daily injectable medication for multiple-drug-resistant TB, and waited with a young couple and their toddler for the results of a two-minute pregnancy test. He did all of this while also treating aches, pains, high blood pressure, diabetes, fungal infections, and allergic reactions. He replied: “Some days I have to take a Valium. There’s only so much you can do with paracetamol and dexamethasone.”¹³ Unsurprisingly, just as he eased the suffering of others, he seemed to ease his own with pharmaceuticals. Ultimately, his response to the moral peril of solving structural problems with pharmaceuticals for money was also a pharmaceutical practice.

Though physicians occasionally offer credit or discounts to fixed patients in need, they too need to make a living. These long-term patients are important windows into physicians’ management of the moral perils necessitated by their businesses. By providing inexpensive pharmaceuticals, reliable medical advice, occasional discounts, and referrals to these people, Dr. Malwankar, for example, uses solidarity, empathy, and trust to enhance the value of his services over the long term. Like Dr. Malwankar, other GPs in the area have proven themselves and their medicines to patients who have stayed for months or years. Still, they are aware that this authority, generated by their role in the community and the effects of the pharmaceuticals they recommend, can easily crumble. They are willing to treat their neighboring physicians’ fixed patients because they are opportunities to increase their community of patients, but they recognize that these patients will likely return to their competitor the next time they need care. Pharmaceuticals’ monetary, moral, and informational value here is affected by the temporal stretching cause by sickness as a part of everyday life. To fleece a fixed patient by delaying appropriate treatment could yield a short-term monetary gain, but the value of such gains is severely diminished by moral hazard and its long-term effect of losing the patient.

¹³ Dexamethasone is a commonly used steroid.



Culturally intimate cuts and value webs

Clinical interactions are not the only way that Mumbai physicians create monetary value from medicine. Indeed, money flows from specialist, laboratory, and pharmaceutical companies to GPs in parallel to the networks of value facilitated by GP's and their distribution of pharmaceuticals. Portions of the money paid by patients for specialist expertise, laboratory testing, and pharmaceuticals return to the GPs who have ordered them through what is called in Mumbai 'cut practice' or 'cut practices.' GPs often get their 'cut'—essentially a commission or more nefariously a kickback—and this practice redistributes the money that is collected throughout the private medical network in Mumbai. Cuts overlap with the practices of competition and cooperation that physicians use to create pharmaceutical value. 'Cuts' are an open secret that lays bare another facet of the moral peril caused by the interconnections of medicine and money in Mumbai.

Michael Herzfeld suggests that an anthropologist has successfully analyzed a social group when she understands these kinds of open secrets or cultural intimacies. By this, Herzfeld means she can understand implicit claims, come to know what is not being talked about, and be party to the open secrets of a group (Herzfeld, 2005). He writes:

the recognition of those aspects of a cultural identity [sic] that are considered a source of external embarrassment but that nevertheless provide insiders with their assurances of common sociality, the familiarity with the bases of power that may at one moment assure the disenfranchised a degree of creative irreverence and in the next moment reinforce the effectiveness of intimidation. (Herzfeld 2014, p. 3)

The webs of financial connections that distribute the profits of medical testing, referrals, and pharmaceuticals as 'cuts' are just such an open secret, integrating and disciplining members of Mumbai's medical community. They are so ineffective a secret that they are the topic of television. For instance, the May 27th 2012 episode of Aamir Khan's *Satyamev Jayate* shares the stories of patients duped into unnecessary surgeries.¹⁴ Yet these shadowy exchanges run parallel to the normal practices of care among Mumbai GPs. What does this not so clandestine money do to the moral, public health, and economic value of care and pharmaceuticals?

Most physicians activate expert financial exchange networks in the course of diagnosing and treating serious illness. We can use Dr. Bal Tilak, and his patient Raju, as an example. Raju had been unwell for three days when he visited Dr. Tilak, and was given a colorful sachet of pills. After ten days, his fever and cough had not responded to Dr. Tilak's combination of drugs.¹⁵ Dr. Tilak began to wonder if Raju might have TB. He asked Raju to get two simple blood tests and a chest X-ray, at

¹⁴ Available on youtube: <https://www.youtube.com/watch?v=1Lg0kUtS8ic>.

¹⁵ Physicians distributed 4–6 different drugs in small sachets during the first few visits. These often include a pain killer, an antihistamine, a steroid, and bronchodilators among other things (McDowell and Pai 2016a, b; McDowell 2017).



a nearby lab with which Dr. Tilak had a relationship. In return for his referral, Dr. Tilak received a kickback of forty percent of the cost of the X-ray and thirty percent of the cost of the blood tests.

This, however, is not the end of this financial story. During the same visit, Dr. Tilak wrote a prescription for an antibiotic. He generally started with amoxicillin and wrote a prescription for a generic.¹⁶ Dr. Tilak was among the approximately sixty percent of physicians who have given a ‘monopoly’ to a particular pharmaceutical company. Giving a particular company a monopoly on his practice meant that Dr. Tilak agreed to prescribe only this particular brand of medicines. In return for prescribing one brand over its many competitors, he received a retainer from the company along the lines of 30,000 to 40,000 rupees (\$450–\$600). The company then scrutinized their sales figures at nearby pharmacies and Dr. Tilak would direct patients to these particular pharmacies, if he failed to meet a certain quota of prescriptions, he jeopardized his relationship to the company and its reward. As a result, he prescribed that particular brand of antibiotic almost exclusively, and his patients could only fill the prescription at neighborhood chemists, whose stock was monitored by the drug company to be certain Dr. Tilak was meeting his targets.

Two days later, Raju returned to Dr. Tilak with an X-ray indicative of TB. Dr. Tilak had received multiple circulars with subtle threats from the Brihanmumbai Municipal Corporation (BMC) and District TB Officer urging him not to treat TB and to refer patients to the public sector. He was more than happy to do this, as he worried about TB exposure, and did not want to be branded as a TB doctor. So, during his follow up, he told Raju to visit the local public hospital or a chest physician as this illness was beyond his understanding. Raju, unaware of Dr. Tilak’s suspicion, and wary of the long lines at the BMC hospital, opted for a private specialist. Dr. Tilak suggested a chest specialist, Dr. Minar Sarvankar, and handed Raju one of the referral slips that Dr. Sarvankar’s physician relationship officer had asked him to use. Referral slip, X-ray, and lab results in a colorful plastic bag, Raju visited Dr. Sarvankar’s clinic the next morning. He paid Dr. Sarvankar four hundred rupees (\$4.60) for the consultation, one hundred of which went back to Dr. Tilak. Dr. Sarvankar examined the diagnostic results and, seeing a shadow on the X-ray, diagnosed Raju with TB.

Foregoing further examination, Raju started TB treatment. Dr. Sarvankar prescribed AKT4 (an anti-TB chemotherapy), *Triple-A Calcium*, *Livfor Tonic*, and *B Protien Powder*. He chose the last three supplements based on his own monopoly relationship with their producer. He had no such relationship with Lupin, the maker of Mumbai’s most common anti-TB combination pack, AKT4. Lupin’s margin of profit on the drug is limited by a governmentally imposed essential drug price ceiling and the company does not provide a profit share to physicians (Ecks and Harper 2013). Raju purchased the drugs from the pharmacist attached to Dr. Sarvankar’s clinic. Though he bought fifteen days of AKT4 for two hundred rupees (\$3), the

¹⁶ Seeberg (2012), Brhlikova et al. (2011), and Das (2015) have convincingly shown that pharmaceutical sales representatives are an important source of biomedical knowledge for general practitioners and have an effect not just on what physicians prescribe but how they think about disease.



final bill ended up being closer to 1100 rupees (\$16.50). Two hundred of the 1100 rupees Raju paid would eventually return to Dr. Sarvankar as a cut or kickback. Then Raju headed home to confer with Dr. Tilak and start his TB treatment.

Obviously, financial incentives influence physicians' choices about what to do after they have reached a threshold of suspicion, after they have decided to order a test, to write a prescription, or to give a referral. This comes with an ambiguous kind of agency in which taking action can be read in multiple ways with multiple values and unintended consequences. On the one hand, the system by which nearly half of each fee is returned to a GP as his 'cut' doubles the cost of private care for a serious illness such as TB. However, such commissions also allow physicians to charge low fees for patients with 'normal' illnesses, thereby reducing the cost of basic care. We can view this as a failure in the physicians' attempt to manage the moral peril inherent in their jobs, but even in its most sinister interpretation, Raju received care but it was delayed. Thus, it seems that the multiple forms of social and ethical value at play here for GPs are greater than the potential monetary value of Raju as a consumer and his willingness to pay.

In fact, while one would think that the cut system would encourage testing, diagnostic thinking, and referral when needed, many reports suggest that this is not the case (Kapoor et al. 2012; Das et al. 2015; Sreeramareddy et al. 2014; Mistry et al. 2016). My own prior observations confirmed this low rate of diagnosis and referral. Of 1000 patient interactions, doctors only asked for a test thirty-three times and referred to a specialist or government hospital twelve times (McDowell and Pai 2016a). For a doctor who charges thirty rupees (\$0.45) as the fee for a consultation and three doses of medicine, the one hundred rupees (\$1.50) 'cut' for referring a patient—essentially free money—should set the bar for referral rather low. But across the two hundred consultations I observed with a doctor who received only thirty rupees per consultation, he referred only one patient to a specialist and asked one to undergo diagnostic testing. Although diagnostic delays can cause serious problems, they occur because physicians are trying to help patients save money. The contradicts the portrayal of the kickback system as corruption spoiling care.

Thus, after sketching the open secret of financial flows, we have a rather contradictory picture of the private sector and the embrace of market and care. It seems that in this case, despite the presence of the cuts, money does not have coercive power, it is by and large not changing GPs practice of treatment. Instead relations change the meaning of money. GPs seem to be acting against their financial interest by not referring, but rather they view the cut as a bonus compensation, rather than an avenue for increasing profit.

In general, GPs in the slums of Mumbai provide basic care and, if necessary, guide the process of selecting an expert. Low rates of diagnostic testing and expert referral, despite economic incentives to do so, suggest that specialist providers of this knowledge must compete—in a financial, confidence, and expertise market—against both each other and also in a real sense against GPs' existing practice of symptomatic medicine (McDowell 2017). Here money kicked back to the GP is, unsurprisingly, a way to increase longer term value and facilitate pharmaceutical value practices. At the same time, its moral value is highly suspect as the money that passes through these exchanges come from the sick poor. And so, referral, as an



added expense for the patient, is a last resort, which can of course lead to delay, failure of care, and increased moral peril for an everyday GP who has cultivated a fine balance between value practices based on trust and a history of success. In short, financial exchanges among physicians facilitate relations and cause immense uncertainty for GPs. They are not particularly lucrative and physicians aspire to avoid them, but this can imperil long term relations of care nonetheless.

Conclusion: moral and (micro)economics

This romp through morals and money in Mumbai clinics might simply reinforce a basic argument that urges anthropologists and others considering private sector medical care to examine the creation of value as an everyday practice within particular social contexts (Polanyi 1944). This is a key first step, but the ethnographic data in my assemblage suggests more. Here we see pharmaceutical value practices, so often studied from a global and industrial perspective, working at ground level, in relationships between doctors and patients. These practices both augment and attenuate the moral peril physicians experience when exchanging money for pharmaceuticals and care. They reveal the source of the money that flows up the pharmaceutical value chain and the social and embodied results of a highly capitalized market in drugs. In each case, they present the ways in which actors work to simultaneously maximize the economic, moral, and epistemic value of pharmaceuticals, while managing the moral perils associated with taking money for a practice which is necessary for well-being. In these clinics, questions of pharmaceutical value, frequently lived and studied as distal implications of broader processes of capital across the value chain, become those of biological and social life and death. I have considered the ways that these physicians grapple with moral peril: (1) diversification and distribution of responsibility, (2) using pharmaceutical as combination tools of diagnosis and treatment to increase value, (3) providing pharmaceutical care over a lifetime, and (4) delaying costly care when possible. These physicians provide an ethnographic look at the kinds of risks, rewards, and forms of relationality that come with the practices of making and assessing the value of pharmaceuticals at the place where they intersect with suffering and bodies.

Though an ethnographic account can bring together physicians, patients, and pharmaceuticals to show how the latter take on value in clinics and households, it ultimately raises more questions than answers. More numerous and more thoughtful scholars than me are needed to consider the ways that the public provision of pharmaceuticals in clinics deals with the problem of scarce resources and pharmaceutical value. In addition, I have gestured to the value practices of physicians who treat both communicable and non-communicable diseases. Work remains to be done around the pharmaceutical value practices made possible through the long-term pharmaceutical treatment of chronic conditions like heart disease, asthma, high blood pressure, or even HIV. How does chronic illness's lifelong temporality of care present opportunities and challenges for physicians? What are their implications for care and public health? Finally, what do pharmaceutical value practices look like when patients access care directly from pharmacists? This practice is well documented in India,



but little recent work considers the value practices that occur when pharmaceuticals enter the consumer market by way of physicians owned, for-profit storefront clinics.

These questions abide. Answering them will require grappling with the moral peril caused by pharmaceuticals in the clinical setting, as well as the moral peril posed to anthropologists who might be tempted to lay the negative individual, economic, social, and public health effects of pharmaceutical value creation solely on the shoulders of general physicians. Moving beyond this standard narrative requires three things. First, it necessitates understanding how physicians are conflicted, compromised, and caught in a chain of pharmaceutical value, as I have tried to do here. Second, it will mean advocating for and building public structures that enable the poor to access pharmaceuticals as a human right rather than an economic choice. A third, and critical step, is to use these deep contextual analyses to inform policy-making that replaces doctors' stop-gap, poverty management work with structural changes that will mitigate the inequalities, exposures, and stresses that foster sickness in communities like the ones presented here.

Acknowledgements I owe debts of gratitude to innumerable Mumbaikars who by sharing informal chats in waiting rooms, at bus stops, and across pharmacy counters helped me learn more about medicine. I am deeply indebted to Prashant Kumbhar and M. Afzal Sheikh for introductions to their neighborhoods and the great kindness shown to me by physicians, pharmacists and all other kinds of medical practitioners. Without their insights and engagement, the paper would not have been possible. I am also grateful for Shibhu Vijayan, Ravdeep Gandhi, Rishabh Chopra, Jalpa Thakkar, K. Praveen, Vaishnavi Jondhale, Nilesh Dhotre, Varsha Nagwekar, Vaibhav Saria, Nambi Konar, Eunice Lobo, and Vrushal Walkar's shared fieldwork and friendship. Puneet Diwan, Daksha Shah, Arun Bamne, Nerges Mistry, Madhukar Pai, Ursula Rao, Maya Unnithan, Sarah Pinto, and Jean-Paul Gaudilliere asked challenging questions of earlier iterations of this work and certainly made it stronger. Veena Das shaped this project. Without her subtle tending, it may never have grown. Adeline Masquelier, Allison Truitt, and Tara Dankel provided crucial eleventh-hour insights that helped zero in on value. Finally, I am indebted to the Foundation for Medical Research, Mumbai and Nerges Mistry for innumerable forms of support in Mumbai. Shortcomings are mine alone.

References

- Achanta, S., J. Jaju, A.M. Kumar, S.B. Nagaraja, S.R.M. Shamrao, S.K. Bandi, A. Kumar, S. Satyanarayana, A.D. Harries, and S.A. Nair. 2013. Tuberculosis management practices by private practitioners in Andhra Pradesh, India. *PLoS ONE* 8 (8): e71119.
- Appadurai, A. 1986. Introduction: commodities and the politics of value. In *The social life of things: Commodities in cultural perspective*, ed. A. Appadurai, 3–63. Cambridge: Cambridge University Press.
- Bhargava, A., L. Pinto, and M. Pai. 2011. Mismanagement of tuberculosis in India: Causes, consequences, and the way forward. *Hypothesis* 9 (1): 1–8.
- Bhat, R. 1999. Characteristics of private medical practice in India: a provider perspective. *Health Policy and Planning* 14 (1): 26–37.
- Björkman, L. 2014. Becoming a slum: From municipal colony to illegal settlement in liberalization-era Mumbai. *International Journal of Urban and Regional Research* 38 (1): 36–59.
- Brlhikova, P., I. Harper, R. Jeffery, N. Rawal, M. Subedi, and M. Santhosh. 2011. Trust and the regulation of pharmaceuticals: South Asia in a globalised world. *Globalization and Health* 7 (1): 1.
- Chorev, N. 2020. *Give and take: Developmental foreign aid and the pharmaceutical industry in East Africa. Princeton studies in global and comparative sociology*. Princeton: Princeton University Press.



- Cross, J., and H.N. MacGregor. 2010. Knowledge, legitimacy and economic practice in informal markets for medicine: A critical review of research. *Social Science & Medicine* 71 (9): 1593–1600.
- Darby, M., and E. Karni. 1973. Free competition and the optimal amount of fraud. *Economics* 16 (1): 67–88.
- Das, J., and J. Hammer. 2007a. Location, location, location: residence, wealth, and the quality of medical care in Delhi, India. *Health Affairs* 26 (3): w338–w351.
- Das, J., and J. Hammer. 2007b. Money for nothing: The dire straits of medical practice in Delhi, India. *Journal of Development Economics* 83 (1): 1–36.
- Das, J., A. Kwan, B. Daniels, S. Satyanarayana, R. Subbaraman, S. Bergkvist, R.K. Das, V. Das, and M. Pai. 2015. Use of standardised patients to assess quality of tuberculosis care: A pilot, cross-sectional study. *The Lancet Infectious Diseases* 15 (11): 1305–1313.
- Das, V. 2015. *Affliction: Health, disease, poverty*. New York: Fordham University Press.
- Das, V., and R.K. Das. 2006. Pharmaceuticals in urban ecologies: The register of the local. In *Global pharmaceuticals: Ethics, markets, practices*, ed. A. Petryna, A. Lakoff, and A. Kleinman. Durham: Duke University Press.
- Daviron, B.T., and S. Ponte. 2005. *The coffee paradox: Global markets, commodity trade, and the elusive promise of development*. New York: Zed Books.
- De Costa, A., and V. Diwan. 2007. ‘Where is the public health sector?’: Public and private sector health-care provision in Madhya Pradesh, India. *Health Policy* 84 (2): 269–276.
- De Costa, A., E. Johansson, and V.K. Diwan. 2008. Barriers of mistrust: Public and private health sectors’ perceptions of each other in Madhya Pradesh, India. *Qualitative Health Research* 18 (6): 756–766.
- Deshpande, K., V. Diwan, K. Lönnroth, V.K. Mahadik, and R.K. Chandorkar. 2004. Spatial pattern of private health care provision in Ujjain, India: A provider survey processed and analysed with a Geographical Information System. *Health Policy* 68 (2): 211–222.
- Duggal, R. 2012. The uncharitable trust hospitals. *Economic and Political Weekly* 47 (25): 23–24.
- Dumit, J. 2012. *Drugs for life how pharmaceutical companies define our health. Experimental futures*. Durham, N.C.: Duke University Press.
- Ecks, S. 2013. *Eating drugs: Psychopharmaceutical pluralism in India*. New York: NYU Press.
- Ecks, S. and I. Harper. 2013. Public-private mixes: the market for anti-tuberculosis drugs in India. *When people come first: Critical studies in global health*, pp. 252–275.
- Eiss, P.K., and D. Pedersen. 2008. Introduction: Values of value. *Cultural Anthropology* 17 (3): 283–290.
- Elyanchar, J. 2012. Before (and after) neoliberalism: Tacit knowledge, secrets of the trade, and the public sector. *Cultural Anthropology* 27: 76–96.
- Esquerre, A., and L. Boltanski. 2017. *Enrichissement: Une critique de la marchandise*. Paris: Gallimard.
- Fainzang, S. 1997. Les stratégies paradoxales. Réflexions sur la question de l’incohérence des conduites des malades. *Sciences sociales et santé* 15 (3): 5–23.
- Fainzang, S. 2002. Lying, secrecy and power within the doctor–patient relationship. *Anthropology & Medicine* 9 (2): 117–133.
- Fainzang, S. 2016. *An anthropology of lying: Information in the doctor–patient relationship*. London: Routledge.
- Fochsen, G., K. Deshpande, and A. Thorson. 2006. Power imbalance and consumerism in the doctor–patient relationship: Health care providers’ experiences of patient encounters in a rural district in India. *Qualitative Health Research* 16 (9): 1236–1251.
- Foucault, M. 1966. *Les mots et les choses: une archéologie des sciences humaines: une archéologie des sciences humaines*. New York: Gallimard.
- Foucault, M. 1973. *The birth of the clinic*. New York: Parthenon.
- Garau, P., E.D. Sclar, and G.Y. Carolini. 2005. *A home in the city: Achieving the Millenium Development Goals*. London: Earthscan.
- Geest, S.V.D., and S.R. Whyte. 1988. *The Context of medicines in developing countries: Studies in pharmaceutical anthropology. Culture, illness, and healing*. Dordrecht: Kluwer Academic.
- George, A., and A. Iyer. 2013. Unfree markets: Socially embedded informal health providers in northern Karnataka, India. *Social Science & Medicine* 96: 297–304.
- Graeber, D. 2001. *Toward an anthropological theory of value: The false coin of our own dreams*. New York: Palgrave.
- Guérin, I. 2014. Juggling with debt, social ties, and values: The everyday use of microcredit of microcredit in rural South India. *Current Anthropology* 55: S40–S50.
- Guyer, J.I. 2004. *Marginal gains: Monetary transactions in Atlantic Africa*. The Lewis Henry Morgan lectures Chicago: University of Chicago Press.



- Hayden, C. 2003. *When nature goes public: The making and unmaking of bioprospecting in Mexico*. Princeton: Princeton University Press.
- Health, W. C. o. S. D. o. 2008. *Our cities, our helath, our future: Acting on social determinants for health equity in urban settings*. Kobe: WHO Centre for Helath Development.
- Herzfeld, M. 2005. Political optics and the occlusion of intimate knowledge. *American Anthropologist* 107 (3): 369–376.
- Herzfeld, M. 2014. *Cultural intimacy: Social poetics in the nation-state*. London: Routledge.
- Janzen, J.M., and W. Arkininstall. 1978. *The quest for therapy in Lower Zaire. Comparative studies of health systems and medical care*. Berkeley: University of California Press.
- Kamat, V.R. 2001. Private practitioners and their role in the resurgence of malaria in Mumbai (Bombay) and Navi Mumbai (New Bombay), India: serving the affected or aiding an epidemic? *Social Science & Medicine* 52 (6): 885–909.
- Kamat, V.R., and M. Nichter. 1998. Pharmacies, self-medication and pharmaceutical marketing in Bombay, India. *Social Science & Medicine* 47 (6): 779–794.
- Kapoor, S.K., A.V. Raman, K.S. Sachdeva, and S. Satyanarayana. 2012. How did the TB patients reach DOTS services in Delhi? A study of patient treatment seeking behavior. *PLoS ONE* 7 (8): e42458.
- Khare, R. 1996. Dava, Doktor, and Dua: Anthropology of practiced medicine in India. *Social Science & Medicine* 43 (5): 837–848.
- Kleinman, A. 1999. Experience and its moral modes: Culture, human conditions, and disorder. *Tanner Lectures on Human Values* 20: 355–420.
- Lambek, M. 2001. The value of coins in a Sakalava polity: money, death, and historicity in Mahajanga, Madagascar. *Comparative Studies in Society and History* 43 (4): 735–762.
- Lambek, M. 2008. Value and virtue. *Anthropological Theory* 8 (2): 133–157.
- Lönroth, K., M. Uplekar, V.K. Arora, S. Juvekar, N.T. Lan, D. Mwaniki, and V. Pathania. 2004. Public-private mix for DOTS implementation: What makes it work? *Bulletin of the World Health Organization* 82 (8): 580–586.
- Mackintosh, M., A. Channon, A. Karan, S. Selvaraj, E. Cavagnero, and H. Zhao. 2016. What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. *The Lancet* 388 (10044): 596–605.
- Malinowski, B. 1961. *Argonauts of the western Pacific: An account of native enterprise and adventure in the Archipelagoes of Melanesian New Guinea*. New York: Dutton.
- Martin, E. 2006. The pharmaceutical person. *Biosocieties* 1 (3): 273–287.
- Marx, K., and F. Engels. 1967. *Capital, a critique of political economy*. New World paperbacks. New York: International Publishers.
- Mauss, M. 1990. *The gift: The form and reason for exchange in archaic societies*. London: Routledge.
- McDowell, A. 2017. Mohit's Pharmakon: Symptom, rotational bodies and phramaceuticals in rural Rajasthan. *Medical Anthropology Quarterly* 31 (3): 332–348.
- McDowell, A., and M. Pai. 2016a. Alternative medicine: An ethnographic study of how practitioners of Indian medical systems manage TB in Mumbai. *Transactions of The Royal Society of Tropical Medicine and Hygiene* 110 (3): 192–198.
- McDowell, A., and M. Pai. 2016b. Treatment as diagnosis and diagnosis as treatment: Empirical management of presumptive TB in the Indian private sector. *International Journal of Tuberculosis and Lung Disease* 20 (4): 536–543.
- Meier zu Biesen, C. 2018. From costal to global: The transnational flow of Ayurveda and its relevance for Indo-African linkages. *Global Public Health* 13 (3): 339–354.
- Mistry, N., S. Rangan, Y. Dholakia, E. Lobo, S. Shah, and A. Patil. 2016. Durations and delays in care seeking, diagnosis and treatment initiation in uncomplicated pulmonary tuberculosis patients in Mumbai, India. *PLoS ONE* 11 (3): e0152287.
- Munn, N.D. 1992. *The fame of Gawa: A symbolic study of value transformation in a Massim (Papua New Guinea) society*. Durham: Duke University Press.
- Nandraj, S. 2015. Unregulated and unaccountable: Private health providers. *Economic and Political Weekly* 47 (4): 12.
- Narotzky, S., and N. Besnier. 2014. Crisis, value, and hope: Rethinking the economy. *Current Anthropology* 55 (S9): S4–S16.
- Nelson, P. 1970. Information and consumer behavior. *Journal of Political Economy* 78 (2): 311–329.
- Parry, J. 1989. On the moral perils of exchange. In *Money and the morality of exchange*, ed. J. Parry and M. Bloch, 64–93. Cambridge: Cambridge University Press.



- Paxson, H. 2010. Locating value in artisan cheese: Reverse engineering terroir in New-World Landscapes. *American Anthropologist* 112 (3): 444–457.
- Peterson, K. 2014. *Speculative markets: drug circuits and derivative life in Nigeria. Experimental futures: Technological lives, scientific arts, anthropological voices*. Durham: Duke University Press.
- Petryna, A. 2009. *When experiments travel: Clinical trials and the global search for human subjects*. Princeton: Princeton University Press.
- Petryna, A., A. Lakoff, and A. Kleinman. 2006. *Global pharmaceuticals: Ethics, markets, practices*. Durham: Duke University Press.
- Pinto, S. 2004. Development without institutions: Ersatz medicine and the politics of everyday life in rural north India. *Cultural Anthropology* 19 (3): 337–364.
- Polanyi, K. 1944. *The great transformation*. New York: Farrar & Rinehart.
- Pordié, L., and J.-P. Gaudilière. 2014. The reformulation regime in drug discovery: Revisiting polyherbals and property rights in the ayurvedic industry. *East Asian Science, Technology and Society* 8 (1): 57–79.
- Quet, M. 2018. *Impostures pharmaceutiques: Médicaments illicites et luttes pour l'accès à la santé*. Paris: Éditions La Découverte.
- Rajan, K.S. 2003. Genomic capital: Public cultures and market logics of corporate biotechnology. *Science as Culture* 12 (1): 87–121.
- Ramberg, L. 2014. *Given to the goddesses: South Indian devadasis and the sexuality of religion*. Durham: Duke University Press.
- Satyantarayana, S., A. Kwan, B. Daniels, R. Subbaraman, A. McDowell, S. Bergkvist, R.K. Das, V. Das, J. Das, and M. Pai. 2016. Use of standardised patients to assess antibiotic dispensing for tuberculosis by pharmacies in urban India: A cross-sectional study. *The Lancet Infectious Diseases* 16 (11): 1261–1268.
- Seeberg, J. 2012. Connecting pills and people. *Medical Anthropology Quarterly* 26 (2): 182–200.
- Sreeramareddy, C.T., Z.Z. Qin, S. Satyanarayana, R. Subbaraman, and M. Pai. 2014. Delays in diagnosis and treatment of pulmonary tuberculosis in India: A systematic review. *The International Journal of Tuberculosis and Lung Disease* 18 (3): 255–266.
- Srinivas, T. 2016. *The cow in the elevator: An anthropology of wonder*. Durham: Duke University Press.
- Sunder Rajan, K. 2006. *Biocapital: The constitution of postgenomic life*. Durham: Duke University Press.
- Sunder Rajan, K. 2017. *Pharmocracy value, politics & knowledge in global biomedicine*. Durham: Duke University Press.
- Thompson, E.P. 1966. *The making of the English working class*. New York: Vintage Books.
- Udwadia, Z.F., L.M. Pinto, and M.W. Uplekar. 2010. Tuberculosis management by private practitioners in Mumbai, India: has anything changed in two decades? *PLoS ONE* 5 (8): e12023.
- Varman, R., and R.M. Vikas. 2007. Rising markets and failing health: An inquiry into subaltern health care consumption under neoliberalism. *Journal of Macromarketing* 27 (2): 162–172.
- Walsh, A. 2012. *Made in Madagascar: Sapphires, ecotourism, and the global bazaar*. Toronto: University of Toronto Press.
- Weber, M. 1930. *The Protestant ethic and the spirit of capitalism*. New York: Scribner.
- Whyte, S.R., and S. Geest. 2002. *The social life of medicines*. Cambridge: Cambridge University Press.
- Yesudian, C. 1994. Behaviour of the private sector in the health market of Bombay. *Health Policy and Planning* 9 (1): 72–80.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Andrew McDowell is an assistant professor in the Department of Anthropology at Tulane University. He is a sociocultural and medical anthropologist.

