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The family doctor: health, kin testing and primary care in Patna, India

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ABSTRACT

Private primary care providers are usually the first site where afflictions come under institutional view. In the context of poverty, the relationship between illness and care is more complex than a simple division of responsibilities between various actors—with care given by kin, and diagnosis and treatment being the purview of providers. Since patients would often visit the provider with family members, providers are attuned to the patients' web of kinship. Providers would take patients' kinship arrangements into account when prescribing diagnostic tests and treatments. This paper terms this aspect of the clinical encounter as 'kin testing' to refer to situations/clinical encounters when providers take into consideration that care provided by kin was conditional. 'Kin testing' allowed providers to manage the episode of illness that had brought the patient to the clinic by relying on clinical judgment rather than confirmed laboratory tests. Furthermore, since complaints of poor health also were an idiom to communicate kin neglect, providers had to also discern how to negotiate diagnoses and treatments. Kinship determined whether the afflicted bodies brought to the clinics were diagnosed, whether medicines reached the body, and adherence maintained. The providers' actions make visible the difference that kinship made in how health is imagined in the clinic and in standardized protocols. Focusing on primary care clinics in Patna, India, we contribute to research that shows that kinship determines care and management of illnesses at home by showing that relatedness of patients gets folded in the clinic by providers as well.

Introduction

Studying primary care shows that the process of diagnosis and treatment protocols are not honed separately for each disease but rather that the milieu in which providers work offers certain affordances and constraints that are perhaps calibrated for the particular circumstances of the specificity of a disease. However, the modes of reasoning deployed by doctors are formulated in the milieu in which doctors work and address the set of circumstances

with which they are confronted. These circumstances are revealed in the interactions between doctors, compounders, patients, their kin, and even those waiting for their turns that unfold in the space of the clinic. To comprehend 'how doctors think' (Groopman 2007; Mol 1998) we must understand the different features of the milieu within which doctors either move systematically towards a diagnosis, eliminating one possibility after another in a progressive fashion; or alternatively, withhold a diagnosis and instead concentrate on treating symptoms. We argue that diagnosis, either confirmed through diagnostic tests, or even when clinically suspected, is dependent on how kinship is enacted and performed in the clinic where providers read patients in a way we call 'kin testing'.

A closer look at primary care is necessary even when studying epidemics or specific diseases because the former is the first site where diagnoses are made or missed or patients referred to specialists. For example, India has the highest number of tuberculosis patients in the world and despite serious investments of material resources, creation of expert committees, and active interventions, the challenges posed by old and new strands of TB continue to be daunting. Yet, one specific issue that has puzzled public health experts is that despite successful attempts toward upgrading existing technologies for diagnosis (such as Rapid Diagnostic Tests like GeneExpert) and making access free, rates of testing for patients presenting with symptoms of TB have revealed missed diagnoses (Pai and Dewan 2015). On an average, patients presenting with TB symptoms have to wait for anything between two weeks to six weeks for a private provider to generate a prescription for both old and the new diagnostic tests (Saria 2020). While it was assumed that untrained or poorly trained providers, especially those from alternative streams of medicine, were causing this delay in diagnosis, sustained work with new instruments of data collection such as the Simulated Standardized Patients (SSP)[1] has decisively shown that the problem is wider and frequently encountered in the practices of doctors, regardless of whether they were trained in biomedicine or on other streams such as ayurveda or unani medicine (Kwan et al. 2018). Thus, studying primary care providers reveal why symptoms of patients were not read or further investigated to reach a diagnosis.

A fundamental insight from medical anthropology that has informed both clinical practice and health policy to some extent, is the incorporation of culture as a mediating term for understanding 'idioms of distress', as well as trajectories of care (Good and Del Vecchio Good 1986, Janzen and Arkinstall 1978, Nichter 1981). The distinction between illness and disease first formulated by Kleinman (1988) made illness narratives a genre of story-telling and became a tool for contesting the power of doctors to define the entire reality of illness experience. Productive as these models were for understanding the variations in expert models of disease and the more popular understandings, as well as correcting the picture of patients as purely passive (as the term patient itself was seen to imply e.g. in Parsons 1951), negotiations by both actors in their respective domains influenced each other. In the world of experts, diagnosis is a result of various kinds of negotiations, such as those between the pathologists and the clinicians assigning different weights to measurements, objective protocols, and clinical judgements. In addition, other features of the health system such as the subtle manipulations of doctors and patients from pharmaceutical companies, availability of insurance, and so on, affect how medical experts arrive at a diagnosis. On the side of patients, the treatment process depends upon the kind of support networks (among them kinship networks, patient support groups, NGOs, formed around particular biological conditions) from which the patient can draw material and affective support. 'Kin testing' draws

on these important insights on how diagnosis and treatment result from interactions between multiple actors across many institutional spaces, to show how diagnoses are negotiated and established vis-à-vis kinship.

Firstly, kinship carries with it the possibility of betrayals and abandonment because of the burden of care and consequently destabilizes how health is delivered by providers. The idea that illness is 'managed' by the formation of a therapeutic group from among kinsmen, some of whom have jural responsibilities, while others act out of kinship solidarity, as argued by Janzen and Arkinstall (1978), came from the observations of patients in Zaire, but was strongly influenced by the picture of kinship as a domain of solidarity best formulated in the concept of 'kinship amity' (Fortes 1949). At the same time anthropological literature on witchcraft accusations in Africa was demonstrating that kinship was equally a domain ridden by conflict, and illness was often attributed to the witchcraft or sorcery done by a close relative (Geschiere 2013). As Davis summarized the issue, illness could not be healed till kinship was healed (Davis 2000, see also Last 2019). A similar understanding of the interpenetration of kinship and the occult informs studies in South Asia (Pinto 2014) and Europe (Favret-Saada 2015).

Secondly, once we build into our picture of kinship the fact that kinship relations are often marked by betrayal, distrust and lack of care (Reece 2022)—how is this aspect of kinship expressed in the context of illness in the doctor-patient interactions in the clinic? We show that the clinic is simultaneously a site where illness is brought to the attention of the provider *and* a site where tensions and accusations against kin are dramatized and brought to public attention. It is this interweaving of narrations of illness with narrations of betrayals and neglect that lead us to think of the patient as bringing their *affliction* rather than just a purely biomedical issue to the attention of the provider (Das et al. 2015). We argue that this scene of affliction has an impact on the way providers diagnose illness and lay out treatment trajectories. Finally, while most studies that have spoken on the character of kinship as it is revealed in the unfolding of a disease and failures of care have dealt with patients whose diseases are already identified rather than afflictions that remain undiagnosed (Van Hollen 2018, Lang 2019). For example, Pinto (2014) shows how the family is already dissolved because of mental health issues, and, similarly, Banerjee (2020) shows how the burden of care resulting from cancer necessitates the need for outside mediation from NGOs because the relations were in crises. The context of primary care which we are describing, diagnoses are yet to happen, and the provider is unsure whether there is a crisis looming in the horizon or not.

There seems to be an implicit agreement that while therapeutic trajectories are influenced by kinship relations, the diagnosis is a domain left exclusively to the negotiation among experts with different specialized knowledges. Our work shows that the way doctors decipher the character of kinship relations in the lives of their patients in private primary care clinics has a decisive impact on the way doctors offer or withhold diagnoses, or communicate treatment options to the kin accompanying the patient. The analytic of 'kin testing' reveals this taking account of domestic and household relationships by providers in their plans to deliver health and relief. The clinical encounters we present show the negotiations that clinicians are forced to make after they determine how dependent the patients are on their family for achieving and maintaining health. Kin testing also helped providers discern whether the patients' expression of different symptoms were in the nature of appeals to the provider to intervene in their kinship world, or if they were manifestations of underlying

clinical conditions. We argue that clinical encounters are both an appeal to heal the symptoms, and to address the broken ties of kinship.

Methods

The ethnography presented here was collected as part of a multiyear interdisciplinary collaborative project to understand provider decisions regarding patient care using multiple methods with the aim to improve the quality of TB care in India (Saria 2020). The ethnographic research conducted over 24 months between 2014 and 2018 consisted shadowing private healthcare providers trained in biomedicine who provided primary care to understand what other aspects of social life inserted themselves into the clinical encounter that prevented testing and treating patients for TB. Earlier studies of health providers in resource poor settings have shown how improvisation and pragmatism characterizes the kind of care provided to patients (Livingston 2012, Street 2011). Kin testing shows up even when some material resources such as diagnostic tests are available in the clinic, because of the strain on intangible resources such as time, effort, and value attached to different members of the household that affect the rhythms of everyday life at homes, and influences what resources outside the home can be accessed by whom. Thus, clinics were not spaces where providers discharged professional responsibilities of diagnosing and designing therapeutic regimens, but where they were often drawn into the management of the dangerous potentials of kinship.

Why TB diagnoses were missed entailed studying primary care clinical interactions, and providers associated with the intervention saw it fit to educate us as how patients were presenting symptoms and their accumulation and interpretation of such knowledge. Given that the patients in this milieu presented symptoms and not diagnosed diseases, we were shown the uncertainty that accompanied diagnosing which the intervention aimed to remedy. One such private provider we shadowed was Dr. S, whose clinic lies on the outskirts of the city of Patna in Bihar, India.[2] The clinic is divided into two rooms: a waiting room and a chamber where the doctor sees patients and any caregivers that may accompany them. Dr. S is a general physician in his late sixties who enjoys a good reputation amongst doctors and patients alike, partly because of his affordability. Dr. S charges Rs. 50 per patient and this affordable price makes him attractive to his patient population—the urban poor and working class who live around the periphery of the city.

After entering the clinic, the receptionist writes the patient's name on a piece of paper and requires them to be received by the doctor in the order they arrived. The assistant lets ten to fifteen patients, along with any caregivers, inside the chamber at a time and hands the list of names to the doctor. As the chamber empties, the assistant lets another batch of patients inside, making sure that a steady stream waits both inside and outside the doctor's chamber. Inside the chamber, Dr. S, works efficiently and in a manner that he has perfected over the years. He glances at the patient and starts checking the vital statistics while listening to the patient recount their complaints. He auscultates, checks the blood pressure, weight, asks for age, and other questions, while listening to the complaints, scribbles on his prescription pad, tears the page and hands it to the patient. This recitation of 'bare facts', however, elides the fact that each component of the actions we have summarized is stretched as conversations move between symptoms, complaints about neglect, or the ability of the patient to comply.

Pathology as kinship, kinship as pathology

Let us go to a day in 2015, when shadowing Dr. S, watching as the routines unfolded, an old woman came to the clinic with her daughter. The daughter did most of the talking in an encounter that lasted about five minutes.[3]

Dr. S [*to the patient*]: Okay, take a deep breath. Are you taking the inhaler as well?

Patient: No.

[…]

Dr. S [*to the daughter*]: How long has it been since she stopped taking the medicines?

Patient: Two days.

[…]

Dr. S: The prescription is for 19 December, it should have gotten over at 19 January. The medicines are for a month, so it's been 15 days. In this cold you are stopping medications for *damma* [breathlessness]? You people can't manage the treatment? Are there money issues?

In many ways this clinical encounter is representative of those recorded when shadowing Dr. S and other doctors in the urban periphery of Patna. From glancing at the papers that Dr. S handed to the first author, they understood that the patient had already been suffering from breathlessness when she was brought to Dr. S by her daughter in December. She had complained about it getting worse, but neither the patient nor her daughter enquired about a diagnosis. When the first author enquired what Dr. S thought was going on with the patient, he replied that he suspected the patient had also developed COPD (Chronic Obstructive Pulmonary Disease), either because of living conditions in addition to asthma, or perhaps even TB- neither of the suspected diagnoses were confirmed based on diagnostic tests. Providers reported that all three, including other respiratory diseases, are very common in India, making it hard to determine which disease was to blame since the patient had not been tested for TB and was still not going to be after this clinical encounter. While it may seem that Dr. S already had a diagnosis, but in fact he, as many other doctors, was using diseases as names for or to name symptoms. This form of deliberation of symptoms along with the lack of diagnostically confirmed tests is precisely what allowed missed and delayed diagnoses and, consequently, infectious diseases to spread. Dr. S in the first visit had suspected asthma and prescribed medication based on his clinical experience rather than a diagnostic test as is usual in India (Das et al. 2015).

The interaction continued:

Patient's daughter: No, money is not an issue, her son and grandson are the issue. She only gets taken care of when her daughter comes. She has two sons and grandsons who have stolen all her money. They've taken all her money. What to do?

Another patient: You should bring her sons here and hit them in the face.

Patient's daughter: What to say, friend, in front of the doctor, she lets them do all this and doesn't leave them because of a mother's tenderness.

Dr. S: Weren't you the one who brought her here when her condition became very serious? I had asked you to get her admitted?

Patient's daughter: Yes, I had gotten her, but I didn't get her admitted. Every time she falls ill, I have to come here and bring her here. Nobody else is there, I have to do everything.

Dr. S: Okay, stop all this. Tell me properly—after 15 days of taking the medicines how were you feeling?

Patient: After the injections, I felt okay.

Dr. S: So, why did you stop taking the medications?

Patient's daughter: What else will she do, she left me and went back to live with her son. […] The son is saying go to PMCH [Patna Medical College and Hospital] to get treated. […] The son and daughter-in-law have taken all the money, the land. So they want us to go to PMCH, so that money is saved.

Another patient: So the son never says, 'look you're not feeling well, let's go take you to the doctor'?

Patient's daughter: No, he never says all that. She can die for all he cares, whether she takes the medicine or not.

Patient: No, no, he never says that. [*Answering the question of the other patient.*]

The lack of relief and comfort made Dr. S puzzled because he was not sure whether it was because the patient had some other ailment, or nonadherence to the treatment was the issue, or perhaps the poor bioavailability of the particular formulation prescribed. Accompanying these probable causes was the problem of the patient's uncaring sons and grandsons, since care for vulnerable people was always dependent on a web of kinship that in the context of poverty was strained (Mattes 2012). Yet, as we see in the clinical encounter above, kinship, care, and illness connect in many subtler ways than just material constraints. The patient's health had not improved and, as deduced by Dr. S, there had been poor compliance with the treatment. When Dr. S tried to test whether the patient had the means to stick to treatment by asking, 'Are there money issues?' the daughter of the patient shifts the blame from conditions of scarce resources to the family's moral failings by saying, 'No, money is not an issue, her son and grandson are the issue'. PMCH is a public hospital where patients can avail free treatment, but because of overcrowding, overwhelming demand, and scarce resources it is perceived to be of sub-par quality. Dr. S tried to correct the perception by saying that PMCH is good, but the patient and her daughter were looking for evidence of commitment from kin rather than just good quality care.

Dr. S continued:

Dr. S: See, if I give her this machine [inhaler], she will need somebody to push the medicine in her mouth.

Patient's daughter: So, who will do that? Her sons and grandchildren don't care.

Dr. S: Okay, look at this other machine. This she can do on her own. Look at how this works.

Dr. S: [*after demonstrating*]: So, do you want this?

Patient's daughter: Leave it. Just give us some medicines. She will do it as long as she is here. But who will take care of all this when she goes back to her sons?

Dr. S: Look at this, if you just put the capsule in this machine, it breaks the capsule and you can breathe in the medicine. We will have to do something about her condition, there is no other better treatment than this. How can we just not do anything?

Patient's daughter: Leave all this. Just give us the medicines.

The commitment from kin in India is articulated through idioms of *seva* –when referencing intergenerational care (Lamb 2013), or *sneham* – love and compassion (Lang 2019), which does not preclude a dramatized performance of care. The lack of *seva* and *sneham* explained why prescribed plans of treatment and adherence were ineffective but were also somaticized in illness narratives, as in the notion of *sahan shakti*—the capacity to bear pain—which kin saw as lacking in patients who complained too much. In other words, both kinship and illness provided idioms for affliction caused by each other: the illness could be caused by uncaring kin, or the burden of illness would make kin uncaring. The clinic also allowed for grievances against kin to be articulated as illness caused by uncaringness. By offering a more expensive machine, Dr. S was implementing what is a common screening tool, and in welfare economics is called 'means testing', which refers to trying to figure out whether the patient has the means to adhere to adequate treatment (Willis and Leighton 1995). But this 'means testing' was inextricable with 'kin testing' since the question was not just of affordability or even effort, but one of how kinship distributed or excused the lack of the previous two resources. The patient's daughter refused more expensive treatment because her mother's kin was not there to administer it, but she also refused cheaper treatment at PMCH because it evidenced abandonment.[4] Dr. S was forced to negotiate what kind of treatment could be prescribed given the way the reality of the affliction was being made multiple depending on who was taking care of the patient: sons and grandsons or daughter. Kinship compelled Dr. S to ask the patient's daughter, 'Tell me what to do', rather than the other way round, his telling her.

The patient's complaints about her son, voiced through her daughter, provoked other patients to make comments of moral opprobrium—like a Greek chorus. The ailment and the care of the patient by kin is always under the scrutiny of the people who coinhabit their social world for signs of disorder, abandonment, and failure, an always present possibility embedded within kinship. The recognition of disorder implied in Dr. S's statement in addressing the family, 'You people can't manage the treatment?' also forces Dr. S to say 'stop all this' since there is no escaping kinship, at least for some patients. The dynamic of provoking family members by insinuating neglect of vulnerable patients, as well as dismissing such accusations by patients and kin, was a way Dr. S would test the extent to which disorders of the kinship could be remedied or not.

Providers were also aware that patients like the old woman were indexing neglect by their uncaring family through their complaints, as Lawrence Cohen has shown (1998). But if it is impossible to discern the site from whence the complaints are arising—kinship or pathology—as Cohen shows, it is equally impossible to discern if the relief that patients experience arises from the quality of care or the performance of kinship. As Van Hollen (2018) has documented with cancer patients, kin would uphold norms of care with the collusion of doctors to hide diagnoses from patients. Dr. S, like many other providers, had perfected several strategies to discern whether the kin were invested in the wellbeing of the patient, and one was through offering the patients a choice about which treatment they

would prefer by letting them know the price. In the case study above, the doctor introduces a new therapeutic device that is more effective at delivering medicines to the body; instead of using an inhaler, Dr. S shows the patient a machine that breaks the capsule of medicine, thus making the uptake of medicine easier.

This was one of his tests: if the kin accompanying his patients showed interest, he knew that he could depend on the family to provide care; if not, he would try his best to provide immediate comfort and try to broker health with the existing pathology of kinship. The patient's daughter reads the offer of the new machine doubtfully, and says 'leave all this', because she was not sure who at the old woman's house would help her with the machine. Care from married daughters also reached its limit since daughters had to negotiate between their obligations towards affinal and conjugal homes. This indication from the patient's daughter prevented Dr. S was prescribing other tests which he would have liked.

The clinical encounters that take place pre-diagnosis cannot be pressed into studies of specific diseases since a diagnosis is yet to be confirmed through tests. Since these encounters take place with providers who offer primary care, they are also undetermined by the pressures of a specific protocol. In these moments, expert knowledge is expected to perform its expertise and offer diagnosis and treatment, which Dr. S does—not in a manner established by medical protocols but by offering and responding to triggers that would retain the patient as well as move the case forward. Daughter's mode of speech on behalf of the patient, sometimes to other patients waiting in the room, complaining about kinship when the provider asks about the discomfort in the body, results in a nonlinear conversation marked by patient's silences. This expression of affliction not only illustrates the point that Veena Das has argued that one's pain can 'live in the speech' of the other (1996, 78), but these transactions in the 'construction of pain' between the patient and the kin enfolded the clinic and the family within each other.

Kinship and norms

Kinship itself determined whether medicines would reach the patient; the time of kinship intersected with the time of affliction. One of the possibilities of a clinical encounter is that of offering stability over the affliction, but that stabilization itself can either push patients towards disease (if it remains undiagnosed) or health (if diagnosed and a regimen prescribed and managed). Over multiple clinical encounters, new norms of the patient were constantly being generated as disease progressed, relief offered, knowledge gathered, and triggers or indications presented by patients to highlight the limits of the care they received. Consider, for example, the next clinical encounter, one showing how triggers are presented regarding moral obligations and the ailing body, making the expert take kinship into account in the clinic so as to generate new norms for the patient.

Patient's son: Sir, my father has a headache again that will not go away.

Dr. S: Have you stopped taking the medicines?

Patient's son: Yes, it [ran out].

Dr. S: When did it [run out]?

Patient: Today.

Dr. S: When did the pain start?

Patient: From yesterday. A lot of pain, brother.

Dr. S: The pain is in your stomach?

Patient: Yes.

Dr. S: You did get an ultrasound the last time, didn't you?

Patient's son: Yes, sir.

Dr. S: Where is the pain—in your stomach?

Patient: Here.

Dr. S: The last time you said your head was aching.

Patient: My head is aching beyond limits.

Dr. S: The head is aching, the stomach is aching.

Patient: The stomach is aching, my eyes are aching.

Dr. S: Tell me properly: stomach-ache is one thing, headache is something else. Where is the pain in your stomach?

Patient: Here.

Dr. S: Okay, fine, we will get another ultrasound done, show me which medicines are you taking? [starts measuring blood pressure] The blood pressure is a bit high. [turns to another patient who has returned to ask for some clarification] You should take this medicine for your stomach today. Tell me properly: it's very important, don't take this medicine, your blood pressure is high. Your blood pressure is very high. The tablet I put under your tongue right now—did it provide any relief? Blood pressure is very high. [Dr. looks a bit concerned]

Dr. S [turning to me]: WBC is high. Infection. If there is an infection in the stomach, let's get an ultrasound done, I think. Look, there were two medicines for blood pressure that he is not taking properly, probably, who knows. There is no fever. He hasn't been taking the medicines properly. Something is wrong (*kuch garbari hai*).

Patient's son: No, he doesn't pay any attention to whether he has taken the medicines or not; he ends up being left alone, so he also doesn't understand. We are working men (*kaam dhandhe waale*), so we leave the house for work.

This dialogue underlines the costs of following through with the obligations of kinship. The patient's son is a butcher who brings to the attention of Dr. S that getting the ailing, afflicted body to the clinic is a problem. He says that the younger members of the family are working throughout the day and the cost of taking the day off will have an impact on the budget of the family. The doctor has to not only take into consideration the messy illness narrative, but must also prescribe medicines in such a manner that prevented the patient from becoming a burden for the family and result in neglect. It would be inaccurate to pinpoint the risk of neglect as the only picture of kinship that emerges, though that certainly becomes salient with aging patients—as becomes evident in the commentary provided by

other patients watching the interaction unfold. A more accurate way of describing the picture of kinship that emerges here is offered by the patient's son, the butcher, who told his father and the doctor, 'we will get all the required tests done at the same time, we cannot come here everyday.' This statement reveals kinship in the clinic allowing for the giving as well as the thieving of care, the illness at times thickening the moral obligation and at other times thinning (Carsten 2013). The clinic in the encounter above emerges as a moral space with the provider being asked to take into consideration the constraints faced by working-class families when providing care to aging bodies. Poverty intersects with kinship in ways that unequally distributes vulnerability even within a household along lines of gender and age amongst others, thus making the impact of poverty difficult to measure solely in terms of material scarcity (Das and Randeria 2015, Vallianatos 2017).

The thickening and thinning of kinship obligation, especially within the constraints of poverty, determined how the body speaks and is heard. Das and Das (2007), through a correlation of health-seeking behavior and household income, have shown that when the family's budget is strained, the ailing body's complaints end up being dismissed as the usual complaints of aging which the person does not have the capacity to tolerate. The clinical encounter above shows that the patient has a chronic condition of high blood pressure, but it had not been managed, whether this acute episode was caused by this chronic condition or an infection worried Dr. S. The other complaints about stomach-ache, headache, and eyes aching were left undiagnosed since the acute episode took the attention of the provider. The patient's son offered several hints or indications such as the rationing of time, effort, and resources that are necessary for working people—at the expense of care and adherence: 'We leave the house for work' and 'he ends up being left alone'. These hints allow Dr. S to fashion a 'cure' by stabilizing the acute episode of high blood pressure and informing that another ultrasound would be needed to generate new norms whenever the family can invest time and effort. Letting the patient's kin know that an ultrasound would be needed in the future enacts the reality of the affliction in the immediate but unscheduled future—when perhaps the affliction might be diagnosed. Such information also lets the patient's family know that the health concern might be serious even while recognizing the burden it might pose on the family.

The suturing of kinship with affliction enacted the reality of the affliction in the household because, as Sarah Pinto writes, pharmaceuticals render 'new ways of being a family, new kinds of bonds, and new forms of intimacy' (2014, 20). Similarly, carving out the time to bring patients to providers, sitting in crowded waiting rooms, getting diagnostic tests done, enacted ways of doing kinship in the clinic. Regardless of whether there is a diagnosable illness, being brought to the clinic by family was seen as performing kinship—just like giving expensive medicines, supplements, or placebos that become therapeutic not because of drug efficacy, but because of the act of giving it to the patient (Nichter and Thompson 2006). But if these care arrangements are dependent on the thickening of kinship, they are also vulnerable to its thinning. As we see in the encounter above, this aspect of kinship emerges or becomes apparent through the pressures of affliction—a son's decision whether to close his shop is isomorphic with the question whether his father's illness is serious enough.

When told that patients might not be brought back to the clinic on schedule, or that medications might not be given, providers were encountering conditions of kinship. Dr. S's clinic was not a neighbourhood clinic; bringing patients to Dr. S required time and effort

from the family since a patient could not just walk in off the street. Afflictions that are made chronic by being dismissed by kin as merely the symptoms of aging and are not remedied at the clinic as such but are accommodated in such a manner that de-stabilizes the clinic as a site of (and medicine a power of) normalization. Kin testing allowed providers to see aspects of relatedness that is naturalized or normalized, such as dismissing complaints of aging family members.

This was seen in one of the first households Saria visited in Patna, which had a 70-year-old male patient. He was diagnosed with TB in April of 2014, and we visited him in January of 2015 to follow up on the treatment course that he had just completed. The patient had been deemed cured of TB in November, but he said: 'If I had been cured would I be feeling this way? Every bone in my body is aching. I don't have any strength. I feel feverish all the time'. The old man's affliction, who had finished his treatment, was no longer taken seriously: protocol had been followed, care provided, medicines given, and a wide range of actors had reached a point where they could dismiss the complaints as the usual complaining and lamenting of older bodies without much moral doubt. Yet, treatments fail, or are ineffective, comorbidities arise, and side effects refuse to subside. Complaints not paid attention to at home can find a place in the clinic—but this patient was not brought to the clinic again. The chronicity of some afflictions is the chronicity of kinship.

Chronic kinship

The clinical encounters discussed till now have shown how kinship and the clinic get folded within each other, thereby making multiple enactments of the affliction in socially dispersed sites such as households and neighbourhoods available at the same time in the primary healthcare clinical encounter. We want to offer an example of one more clinical encounter to emphasize the inextricability of health from kinship. It shows that kinship is not a variable that, once accounted for, would allow for a standardized procedure of healthcare to proceed. Rather, even when social knowledge increases it does not always have an impact on clinical practice.

Patient: Sir, give me some medicine for my stomach.

Dr. S: *Maataji*, I cannot do anything for you. I told you before that you should get someone with you.

Patient: Please check me, use your instruments to check. My stomach is not getting better.

Dr. S: *Maataji*, till you get somebody with you, I won't see you.

Patient: I don't have anybody.

Dr. S [to Saria]: She is schizophrenic, and her family is so bad they don't accompany her when she comes to me.

Patient: My son's father-in-law is very nice.

Dr. S: They tell her, 'Go die,' and she is a mental patient, how will she take any medicines?

Patient: Sometimes my anxiety increases beyond my control and my stomach starts to hurt. It feels like it is going to burst.

Dr. S: Okay, okay, go.

Patient: Please see me.

Dr. S: *Maataji*, your work will not be done here. Please get somebody from your home. What has happened to you?

Patient: My stomach is aching.

[…]

Dr. S [to me]: There is nobody who comes with *Maataji*.

Dr. S: What did they say to you, your family, don't they say go alone?

Patient: I told them that I need an injection and that I have to come here to get it. No, there is nobody to listen to me. They say, 'Go alone, we won't go, we will stay at home.'

Another patient: Don't you have any sons or daughters?

Patient: I have a son. My daughters are married and live in their conjugal homes.

That this patient was suffering from schizophrenia rather than anything else could only have been discerned through social knowledge collected over multiple encounters since the patient did not present her affliction in ways different from other patients. We make this claim on the basis of several patients who were eventually suspected to be in need of psychiatric expertise. Such patients would come with a thick pile of papers that would give an idea to Dr. S of their history. Dr. S would look puzzled after poring through all the papers, then, after a short chat, would send the patient and their kin to a psychiatrist for a diagnosis. For this specific patient, Dr. S, was marshalling evidence from previous encounters and from some investigation conducted by the compounder that made him suspect that this patient was suffering from schizophrenia. The lack of accompanying kin makes Dr. S refuse to examine the patient since he says there would be nobody to make sure that the treatment regimen is followed. He repeatedly asks the patient to bring her family members, which the patient counters by saying that she couldn't because they refused to accompany her. Dr. S then prescribes a cheap, generic antibiotic to be delivered through an intramuscular injection to satisfy her demands for treatment—in order to get rid of the patient.

The clinic appears not so much a place where disputes of kinship are resolved as much as an extended site which gave another opportunity for kinship as well as afflictions to be enacted and performed in front of a moralizing audience (Chua 2012). In this context, kin testing emerged as a crucial tool for determining treatment for providers. Furthermore, this mereological relationship between kinship and affliction made it difficult to discern a successful clinical encounter from a failed one. In other words, more clinical knowledge did not always have an impact on better kin relations; this was seen most clearly in the way health crises were handled. The ethnography presented here entailed many hours of waiting for interviews with providers when the comings and goings at hospitals and clinics could be observed. Huge cars that doubled as ambulances rented by families in nearby villages and towns would drive up constantly with sons and grandsons, carrying their elderly parents on their shoulders to the emergency rooms. Whether these health crises emerged out of chronic conditions and illnesses poorly managed by kin, thus resulting in an acute episode,

or whether they emerged out of the pathologically normal episodes associated with aging was inextricable from the doing of kinship.

Kinship in some ways mirrored badly managed chronicities of illness/afflictions, it included ordinary acts of carelessness such as not buying medicines, not cajoling patients to take them, forgetting to bring them for check-ups, as well as intense moments such as carrying dying parents on shoulders to hospitals. Family in the clinic allows us to conceptualize 'kinship as a dependency relationship between actors that facilitates being in the world in liveable fashion', which includes all forms of medical technology (Wolf-Meyer 2020, 232). These dependencies did not always ensure care, and rendered the patient vulnerable to small betrayals and possible crises. The thinning of kinship also explains why multiple visits do not necessarily result in a laboratory-tested confirmed diagnosis or even a better treatment.

Conclusion

The various clinical encounters studied here show how kinship inserts itself in private primary care clinics in ways that influence the status of health for the poor in the peripheries of Patna. The provider is not just treating a possible disease but an affliction whose pain sought acknowledgment in bodies and households. Providers posed the question to patients, 'Where is the pain?' but received answers to the question 'Who is your pain'. The two domains—kinship and health—mirror one another, and also provide a vehicle for explanation, excuse, justification, as well as leverage for each other. Kinship forces the patient and the provider to generate acceptable compromises and, consequently, definitions of health that are commensurate with their social realities and environments. Our ethnography shows the individual presenting a familial or social reality that is at least temporarily incommensurable with medical care, hence the doctor was hard pressed to negotiate what would be acceptable for him as well as the patient and their family.

Private providers had clinical suspicions, and they would often use diseases to describe and name symptoms. Yet, diagnoses were missed precisely not only because they were not confirmed through diagnostic tests, but also because symptoms can be masked or be misleading. The clinical encounter in primary care shows how the potential of crisis that might result from missed diagnoses of serious diseases accompanies the use of therapy for suspected diagnoses. This made primary care a different site for the response and performance of kinship from sites where patients and kin already are negotiating expensive, invasive treatments in the clinics of specialists; in the latter the burden of care from diseases has already been responded to by kinship. This uncertainty in primary care where diagnoses or crises have not yet happened made 'kin testing' a crucial tool. Providers would do 'kin testing' in their clinical encounters to see if patients would be taken to get diagnostic tests so that clinical suspicions could be confirmed; to see which medicines were affordable for kin; whether patients would be brought back if treatments failed - in short, to test and see the limits of care. Technological decisions are closely intertwined with cultural knowledge about kinship and abandonment, the needs of care, and the possibilities for healing and therapeutics in a specific relational web of dependency. When family members were not interested in taking patients to diagnostic and pathological labs, diseases would be treated on the basis of the providers' clinical judgment, or through empirical use of medications rather than confirmed results, with the hope that if the prescribed therapy was ineffective,

then the patient would be brought back to the clinic. Thus, whether care is given or not given to patients by their kin has an impact on how they recover or not, live with a specific disease. Looking at how disease makes a prior appearance as affliction in the clinic, shows how providers try to broker health with the existing arrangements of kinship.

Notes

1. The usefulness of Simulated Standardized Patients as a tool for monitoring and evaluation programmatic interventions for TB and other diseases was first demonstrated by Das et al in 2015, and has subsequently been successfully used in several countries, including China, Kenya, Vietnam. See Das et al. (2022) for a discussion of the epistemological issues of 'simulation' and 'reality' of SSPs in the field.
2. Dr. S was shadowed by the first author though both the first and second author shadowed providers in multiple cities in India. The language spoken at the clinics was Hindi which the authors who conducted the ethnography speak.
3. While the encounter did not last very long, it was quick. We do not reproduce the entire transcript in the interest of brevity and indicate the parts we have taken out by ellipses.
4. Kinship in the absence of poverty interacted with the landscape of healthcare in converse ways. Providers reported that even when affordable treatment was available families would spend money to take their ailing kin to other cities for more expensive care or taking them to the relatively new branch of a private hospital chain- the only one in the state – to perform care. Family members might also be 'doctor shopping' which Bianca Brijnath (2014) has shown is also evidence of care and performing kinship, further illustrating how kinship intersects with care.

Ethical approval

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