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Operating at the Edge of Il/legality:

Systemic Corruption in Mexican Health Care

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Abstract:

Through a series of ethnographic vignettes, this article examines how providers contribute to corruption in Mexican health care, how providers are themselves subjected to logics of corruption, and the relationship between patients' and providers' vulnerability within contexts of resource scarcity. Doctors, faced with insecure salaries due to nonpayment of wages by the government, collude with hospital staff to sell state drugs on the black market. Meanwhile, vulnerable patients are used as teaching opportunities for private school students—with horrifying, and fatal, effects. *Palancas* ("favors" granted by colleagues and higher-ups to individuals with less authority) and exclusive treatment of *recomendados* (patients given preferential treatment based on the "recommendation" of personnel with greater authority) signal the importance of hierarchical power in determining how corrupt acts are interpreted. What counts as corruption varies from one context to another; therefore, our method seeks to understand how the actors themselves evaluate the "corrupt" social practices in question. Through transnational collaboration (between two coauthors positioned in the United States and Mexico), we aim to contribute to decolonization of anthropology as a discipline by situating

Mexico not only as a repository of ethnographic data but also a site for emerging theoretical intervention.

Keywords: corruption, medical care, healthcare system, intersectionality, Mexico

Resumen:

A través de una serie de viñetas etnográficas, este artículo examina cómo los profesionales médicos contribuyen a la corrupción sistémica en el sistema de salud mexicano, cómo estos mismos profesionales están sujetos a lógicas de corrupción y la relación de vulnerabilidad tanto de pacientes como de proveedores de la salud en contextos de escasez de recursos. Los médicos, quienes enfrentan salarios inseguros debido a la falta de pago por parte del gobierno, se confabulan con el personal de los hospitales para vender medicamentos estatales en el mercado negro. Mientras tanto, los pacientes vulnerables son utilizados como oportunidades para la enseñanza de estudiantes de escuelas privadas —con efectos horribles y fatales. Las “palancas” ("favores" otorgados por colegas y superiores a personas con menos autoridad) y el tratamiento exclusivo de recomendados (pacientes que reciben un trato preferencial basado en la "recomendación" del personal con mayor autoridad), señalan la importancia del poder jerárquico para determinar cómo son interpretados los actos de corrupción. Lo que cuenta como corrupción varía de un contexto a otro; por tanto, nuestro método busca comprender cómo los propios actores evalúan las prácticas sociales “corruptas” en cuestión. A través de la colaboración transnacional (entre dos coautores ubicados en Estados Unidos y México), aspiramos a contribuir a la descolonización de la antropología como disciplina, al situar a México no solo como un repositorio de datos etnográficos sino también como un sitio para la intervención teórica emergente.

Palabras clave: corrupción, asistencia médica, sistema de salud, interseccionalidad, México

Introduction

"They can call the hospital director and . . . they make you responsible for the care of 'recomendados' *[patients with important connections]. Obviously, with so many 'special' patients . . . many times they take up all of the hospital's space and resources, just to treat a cold! . . . The fact that they are admitted and then treated by specialists is a defect of the system."*

—Chief of staff in a Oaxacan hospital, commenting on diverting resources

"One day, the friend who helped me with my little sister's treatment asked me for help getting one of her family members vaccinated in a health center. With the goal of helping her and returning the favor that she had given me, I started searching for ways to facilitate getting her family member vaccinated."

—Nurse in the State of Mexico

Through ethnographic vignettes, we explore corruption in the Mexican health care system. Specifically, we discuss the common use of *palancas* ("favors" granted by colleagues and higher-ups to individuals with less authority) and exclusive treatment of *recomendados* (patients given preferential treatment based on the "recommendation" of personnel with greater authority) in Mexican hospitals. These distinct categories signal the importance of hierarchical power in determining how corrupt acts are interpreted. Simultaneously, this work builds upon rich methodologies for ethnographic inquiry into corruption through its decolonial efforts and transnational authorship.

While corruption in Mexico has been studied from the perspective of human rights, philosophy, and political science (see Estévez and Vazquez 2013; Loeza Reyes and Richard 2018), ethnographic studies are notably absent from the existing literature. In this article, we use

health care as an ethnographic lens for examining systemic corruption in Mexico. Our work builds upon medical anthropological perspectives of Mexican health care. Medical anthropologists have observed how Mexican medical students and residents practice on the bodies of "less agentive populations (including female, racialized, and impoverished)," thus reproducing social difference (Smith-Oka and Marshalla 2019; see also Smith-Oka 2015). What is missing from analyses of (micro)aggressive person-to-person interactions is how corruption is a systemic (not just individual) problem in the Mexican health care system.

We join anthropologists currently engaged in "rethinking" corruption (see Goldstein and Drybread 2018; Muir and Gupta 2018). Anthropologists are aware of how the "Global South" has become shorthand for nations fraught with corruption (Comaroff and Comaroff 2012), and many question whether the concept of "corruption" is, in itself, ethnocentric and misleading (Smith 2018). We resist this tendency and agree with Nancy Scheper-Hughes (2000) and Carolyn Nordstrom (2007) that corruption is sustained through transnational mechanisms, and extralegal activities represent a significant part of the global economy. Thus, our first aim is to make theoretical headway by accounting for anthropology's continuing colonial legacies. Coauthored by medical anthropologists at University of Texas Rio Grande Valley (Rosalynn A. Vega) and National Autonomous University of Mexico (Alfredo Paulo Maya), our work seeks to contribute to the decolonization of anthropology as a discipline by situating Mexico as both our ethnographic field site and the source of our theoretical intervention. Our transnational partnership helps us resist the tendency many anthropologists fear when studying corruption—a critical gaze originating in the Global North characterizing corruption as somehow inherent to the cultures of the Global South, thus blaming the victim and lapsing into racializing logics. Far from reproducing this unwanted gaze, we argue Global Southward–facing allegations of

corruption can create an us/them framework that implicitly assumes neighbors in the Global North to be free of corruption.

Our differential positionalities and distinct intersectional identities—that is, by race, class, gender, country of origin, and citizenship (Crenshaw 2014)—have led to unique constraints when conducting research and publishing findings on corruption at local, national, and global levels. As a bilingual, binational Mexico/US citizen, Vega has maintained active involvement (through workshops, conference presentations, and publications) in both Mexican and US academies. Her relatively unhindered observation in Mexican clinics and participation in the Mexican academe can be contrasted with the experience of a Mexican academic if they were to attempt to conduct ethnographic research in US hospitals and disseminate research findings in the US academe. United States jurisprudence, especially the Health Insurance Portability and Accountability Act (HIPAA), combined with challenges of publishing in academic journals as a nonnative English speaker, create difficulty for researchers from the Global South to equitably engage in ethnographic critique of biomedical structures unfolding in the Global North. Sustained lack of bilateral accessibility and dialogue signals an unequal relationship between the two countries, and how colonial legacies unfold through present-day political economic realities.

Paulo Maya, a Mexican national, writes from a position of everyday embeddedness in social structures penetrated and shaped by pervasive corruption. His research endeavors into corruption within the health care system have been met with outright dismissal by some Mexican scholars. Others have acknowledged its presence, but have suggested he omit the word "corruption" and instead refer to observed phenomena as "lack of ethics" and "poor administration." These colleagues have cautioned him to desist: "Do you know what you are getting yourself into? Aren't you afraid?" His experience of being silenced is strikingly similar to

Michael Taussig's (1992) description of "public secrets." His inability to publish on the topic highlights structures effectively undermining the power of ethnography as political critique (Biehl and McKay 2012). Thus, we not only focus on how data is obtained, but also how it is assembled and disseminated, since these processes reveal the uneven and intertwining effects of power and corruption.

Through our commitment to contextualization and the complexity of social experience, our method is designed to support decolonial analyses of corruption. Our method recognizes that what counts as corruption varies from one context to another, and, therefore, seeks to understand how the actors themselves evaluate the "corrupt" social practices in question (Sissener 2001). We resist lapsing into "universal" notions of "good" and "bad"; instead, we aim to ethically and reflexively describe study participants' interpretations of the meanings of corruption and its effects (see Scheper-Hughes 1995). We recognize our project will always be incomplete; however, we have worked to ensure that wherever normative claims are made, they are representative of those expressed by our study participants.

Our second aim is to provide an ethnographic account of systemic corruption that differs from accounts in other settings by seeking to understand the perspectives of health care personnel with less authority. We primarily focus on medical school students, interns, and residents, although our ethnography also includes data gleaned from patients and nurses. Due to their recent introduction into the medical system, these students and trainees readily and critically reflect on how experiences of corruption in clinical settings conflict with their reasons for going into the medical profession.

By engaging the situated knowledge (Haraway 1988) of medical personnel operating in a middle space between corrupt authority figures and vulnerable patients, our ethnography affords

a unique perspective on how corruption works, and resists lapsing into a binary portrayal of authority and its relationship to corruption (see Gupta 1995). Incorporating the perspectives of health care providers in Mexico can help move ethnographic analyses beyond one-dimensional understandings of them as the perpetrators of biopolitical control over patients' bodies and instead facilitate reflection on how they are themselves drawn into pervasive logics of corruption.

We explore the underlying structures prompting providers to operate at the edge of il/legality, while emphasizing the need for all Mexicans to have access to quality care. This article explores three interlacing issues: how providers contribute to corruption in Mexican health care, how providers are themselves subjected to logics of corruption, and the relationship between patients' and providers' vulnerability within contexts of resource scarcity. While attention has been paid to the role of patient-citizens in Mexican health care (Gálvez 2011), our research simultaneously examines the role of provider-citizens. What are the consequences for patient care when providers' labor rights are violated by routinized (in)security (Penglase 2009),?

This article contains four ethnographic vignettes regarding corruption in Mexican health care. The first describes the penetration of "lifeboat ethics" (Scheper-Hughes 1997) into clinical care, demonstrating how scarcity both frames and justifies corruption in Mexican health care. The second reveals how doctors, faced with insecure salaries due to nonpayment of wages by the government, collude through *palancas* with hospital staff to sell state drugs on the black market. This vignette demonstrates that while it is difficult to distinguish between law enforcement and criminals in narco corruption, it can be equally difficult to distinguish between victims and perpetrators in health care corruption. The third illuminates how power and inequality facilitate

preferential treatment of *recomendados* in public hospitals, to the detriment of other patients who are supposedly guaranteed access to care as a citizenship-based right. The final vignette reveals how medical professionals are interpellated as subjects of a corrupt regime, with fatal consequences for intersectionally vulnerable patients. This vignette links the vulnerability of health professionals with less authority to the vulnerability of certain patients. It adds a final layer to the unequal power dynamics explored as it demonstrates how health care delivery unfolds at the intersection of race and class.

Methods

This research was inspired by responses to a course assignment at National Autonomous University of Mexico Medical School, where Vega was once faculty and Paulo Maya is current faculty, and where medical anthropology is part of the core curriculum. As a course assignment, 120 students wrote about an impactful experience—either positive or negative—while on clinical rotations. Many of their responses described events clashing with their moral values, such as witnessing interrelational conflicts between hospital personnel and being inculcated to break treatment protocols.

The data was collected over eleven months and three distinct phases.[1] Phase one began once the course had ended and final grades were issued. To pinpoint how medical students are adversely affected by negative experiences during their training, Paulo Maya identified essay responses describing negative experiences in elaborate detail. He invited these students to participate in in-depth interviews, explaining their anonymity would be maintained during dissemination of research findings. Twelve students accepted, and interviews were conducted in

a classroom setting, away from clinics where they were assigned their rotations, and were recorded with the students' consent.

Interviews lasted forty-five to ninety minutes. Students were asked open-ended questions regarding how treatment protocols were broken, interactions between different hospital personnel, and the emotions these experiences produced in them. Interview recordings were transcribed, allowing us to analyze their narratives and identify recurring themes (Adame and Knudson 2007; Hamui 2019). While multiple themes emerged, the predominant theme was the involuntary entanglement of medical students in breaking hospital rules because of their lesser authority within the hospital's social hierarchy. Students identified a conflict between what they learned about medical ethics and what they were told to do as subordinates undergoing clinical training. During this phase, five medical students were also observed for eight weeks while performing internship duties in five public hospitals.

Phase two, which lasted four weeks, occurred in a Oaxacan public hospital where we, along with two research assistants, were granted access as observers. While our observations initially centered on the routine activities of two residents, these observations naturally included their interactions with other hospital personnel. Using notebooks with basic blueprint sketches of the clinic, we noted the time and spaces of different interactions, and wherever possible we noted specific phrases used. After each event, we reconstructed observed interaction in detail in our field notes. We subsequently interviewed four residents and two chiefs of staff, recorded with their consent, in their work spaces and nearby coffee shops. Interviewees offered their perspectives on events we observed and explained how the common presence of both *palancas* and *recomendados* affects their work. Interviews with residents lasted between thirty and forty-five minutes, while interviews with chiefs of staff lasted up to two hours.

In the final phase, we spent eight months focusing on nurses' and patients' perspectives. In-depth interviews with five nurses, lasting between sixty and ninety minutes, underscored the significant negative effects of breaking hospital rules experienced by health personnel; these interviews also added an additional critique regarding the "arrogance of *recomendados*." To better understand patients' experiences, we examined patients' anonymized written complaints regarding hospital staff and the medical care they received. Patients dissatisfied with treatment received in public hospitals in the State of Mexico can submit complaints to the Oficina de Calidad y Seguridad del Paciente (Office of Quality and Patient Safety), with the goal of helping public hospitals improve patient care. In exchange for access to these records, we conducted qualitative data analysis of these complaints for the Office.

It is important to note we never explicitly referred to corruption when interviewing informants. Instead, the research used an inductive approach, leading us to engage in descriptive work based on informant interviews. Initial data analysis was conducted by Paulo Maya, who hand coded every piece of textual data using open coding to identify emergent themes. Instead of searching textual data for predetermined themes, analysis was conducted in a manner that allowed themes to emerge. The goal of open coding was to uncover themes not made obvious through the process of data collection. These novel themes included "*el aguante*" (having to endure hardship) as part of medical training, "*formas de guardar silencio*" (techniques for maintaining silence) in order to avoid potential repercussions from hospital authorities, and shame regarding low exam scores or needing to repeat a year.[2]

Paulo Maya selected ethnographic data focused on corruption in the Mexican health care system. Recognizing the importance of power differentials and social hierarchies in determining how corruption is interpreted by informants, Vega conducted focused coding around *palancas*

and *recomendados* and identified data with the most explanatory power. Subsequently, Vega constructed the ethnographic vignettes presented by translating data from field notes and interview transcripts.

Defining Rulebreaking vs. Corruption in the Mexican Health Care System

Outsiders to Mexican corruption may view those breaking laws or regulations for personal benefit as criminal, yet many engaging in such corruption do not ascribe criminality to their actions. The notoriety of *mordidas* (bribes) is an example of corruption woven into the fabric of everyday life. *Mordidas* are a tacit requirement during traffic stops and serve as a lubricant for bureaucratic processes. Here, we use health care as a lens for examining particular ways corruption has penetrated the Mexican sociopolitical structure. We argue that whether actions are viewed as criminal—or, indeed, corrupt—depends on who is breaking the rules and to what end.

In the ethnographic vignettes in subsequent sections, we point to two distinct phenomena—*la palanca* and *el recomendado. La palanca* (literally, "the lever") refers to health personnel with less authority who exploit social etiquette to seek the help of superiors when breaking hospital rules. Since agents of this "bottom-up" rulebreaking use *palancas* to facilitate patient care, *palancas* are considered "favors" among colleagues. *El recomendado* refers to health personnel in positions of power who abuse their authority to redirect limited public resources toward personal acquaintances and away from average patient-citizens, with subordinate medical personnel obligated to participate. This "top-down" corruption occurs with total impunity, despite feelings of guilt among subordinate personnel for involvement in what they perceive as unethical.

Our ethnography uncovers how both "bottom-up" rulebreaking and "top-down" corruption rely on social networks and are structured by power inequality. While *palancas* were perceived as a form of social etiquette, *recomendados* were overtly critiqued by our informants as corruption. This rhetorical distinction underscores the importance power inequality plays in how "bottom-up" rulebreaking is considered altruistic, while "top-down" corruption is judged as unethical.

Lifeboat Ethics: Scarcity in Mexican Public Hospitals

"Lifeboat ethics" is a concept developed by Nancy Scheper-Hughes (1997) to describe how moral principles governing a person's behavior may dramatically shift in contexts of extreme scarcity and social inequality. The following vignette, gleaned from our field notes and written from our perspective, describes "lifeboat ethics" in a Mexican clinic, and illustrates how scarcity both frames and justifies corruption in Mexican health care.

As we approach a public hospital notorious for overcrowding, potential patients are clamoring at the entrance for access to medical services. A woman is arguing with the police officer who tells her a government-issued ID is required to enter, but she just keeps showing him a card with her doctor's appointment. We walk up, flash our hospital-issued observer's badge, and are granted entrance. This provokes the woman to complain, "Why are they allowed to pass?" This causes us to reflect on how our unhindered access evinces our relative privilege in comparison to patients who are barred from entering.

We arrive at the pharmacy, where patients are demanding their prescriptions. The manager is yelling through the window, "We no longer have medicine, they did not supply us

enough." The patients are clearly dissatisfied and upset. One exclaims, "Again with the same old bullshit."

We continue to Pediatrics, where attending physicians and residents are having a heated discussion about what type of procedure to perform—specifically, the high economic cost of the recommended surgical procedure. Cost is at the forefront of everyone's mind. Recently, faced with budget cuts, doctors and nurses decided to boil catheters for reuse. In another instance, pediatricians debated whether to perform a costly surgery on a newborn, consuming scarce resources that could otherwise be used to treat multiple children. This conundrum led one pediatrician to comment that "ethics" can only be applied where sufficient resources exist.[3]

These providers' overt critique of scarce resources is not unique to this hospital. In March, multiple health-sector labor unions were on strike to denounce the shortages of medications and resources in government hospitals. The strikes intensified in June after the former head of health services in Oaxaca was accused of embezzlement. Experiences of corruption have led health professionals to whisper that the 2015 murder of a health-sector official was also related to embezzlement of public funds.

We selected this field note as our first piece of raw ethnographic data because it sets the stage for other ethnographic anecdotes to follow. Specifically, this field note points to the problem of resource scarcity in many public Mexican hospitals. The field note begins with a woman being denied hospital admittance because she had no form of identification. This can easily be explained as the consequence of her own negligence. Subsequent field notes and an interview excerpt will clarify how specific patients are privileged to the detriment of disposable patient populations.

The hospital lacked sufficient medications to meet patients' needs. Based on our combined eighteen years of experience researching unequal access to health services in Mexico, the problem of bare pharmacy shelves is something we have encountered across multiple Mexican states and dozens of individual clinics. The next field note adds complexity to this phenomenon; while the lack of medications was partially due to insufficient funding, there was also a second, more nefarious, cause.

This opening field note identifies medical personnel as troubled agents. Given extreme scarcity in the public sector, health care personnel were forced to make difficult decisions. They were fully aware that boiling used catheters for reuse is risky; however, it was considered the lesser of evils when compared to other medical equipment that might be sacrificed in budget cuts. Deciding which medical equipment to purchase and which to sacrifice was relatively easy compared to deciding which child to treat and which to let die (Foucault 2003, 239–64). Given a context of extreme scarcity, doctors were faced with choices for which there is no ethical alternative. This context rendered the hospital a "gray zone" where "lifeboat ethics" predominate (Scheper-Hughes 1997).

Health care personnel were reactive in denouncing their troubling working conditions. During our research period, labor unions representing various types of health care personnel were frequently on strike, and health care personnel linked resource scarcity to embezzlement by politicians. While rumor is an important form of social critique (see Briggs 2016; Briggs and Mantini-Briggs 2004), we ground our discussion of corruption in the lived experiences of informants to resist the potential for sensationalizing corruption in the Global South.

Drug Dealer, MD: Mitigating Insecure Employment Conditions

In the following ethnographic vignette, a medical student's attention was drawn by the repetitiveness of his attending physician's prescriptions, wondering how such a small range of drugs could be appropriate for a number of different ailments. The attending explained that due to resource scarcity, he is limited to the least expensive medications. This satisfied the student's curiosity until he saw the attending physician stealthily record elderly patients' social security numbers. The attending's actions suggest he intended to use the social security numbers for reasons other than patient care.

The vignette, written from the student's perspective, illuminates how doctors sell state drugs on the black market to compensate for insecure salaries and how medical students are inculcated to do likewise. The logic of narco corruption makes it difficult to distinguish between law enforcement and criminals; in the context of health care corruption, it is just as difficult to distinguish between victims and perpetrators. The vignette concludes with the student requesting a *palanca*, thus enacting the lessons he has been taught. We faithfully transcribed portions of the student's interview to accurately represent his own words.

We were rotating in the family medicine unit when we realized a certain doctor always prescribed the same medications. When we asked him why, he answered, "[The coordinator and director] restrict me from giving all kinds of medicines. . . . To avoid problems with the coordinator or the director, I always give patients the cheapest medicines." At that moment, I was satisfied with his answer; later, I noticed he wrote down los números de seguridad social *(social security numbers) of some patients—especially the elderly—and kept them in his desk drawer.*

One day the head coordinator entered unannounced and asked the doctor, "What happened? Are you going to give me that or not? Do you already have them?" The doctor

replied, "Quiet! After a while I will pass it to you. Don't worry." When the coordinator left, the doctor took out his prescription pad and asked me to write the social security number of the patient who was currently in consultation. Meanwhile, he continued writing up other prescription orders from his computer, ordering three or four boxes of each medication. When the shift was over, he had written orders for ten more prescriptions but never gave them to the patients. For the last two, he recorded the patients' social security numbers while leaving blank the name of the medication.

He said to the medical assistant, "I'm going to the bathroom. I'll be gone fifteen or twenty minutes," and ordered me to accompany him. After we left, he turned to me, smiling. "I'll show you how to deal with people. This is how it is done everywhere! You just follow me." He stopped to buy a Coke before heading to the pharmacy. When we arrived, the manager greeted us, "Let's head to the kitchen." The doctor gave the pharmacist the Coke, grinning, "I've brought you more, so you can hook me up." The pharmacist replied, "But I want my share! Did you bring me blank prescriptions?" The doctor replied, jokingly, "You already know I always do. You can fill them out however you want." While the manager went to get the prescriptions, the doctor explained, "We have to leave the pharmacists with a few blank prescriptions so when they complete their inventory forms they won't say any of our orders were unjustified. An investigation into the inventory would screw us all!"

Just then, I remembered the prescriptions require the coordinator's authorization. As if reading my thoughts, the doctor continued, "Actually, the coordinator's signature is also required, because without that, the prescription orders are not valid. But since he and I are friends. . . . In order to not be visiting his office all the time and giving others reason to be

suspicious, he gives me a prescription pad with all the pages already stamped with his seal. It's as if he authorized them!"

The pharmacy manager returned with approximately thirty boxes of medicines. I recognized Clonazepam, third-generation Cephalosporins, and Combivent Respimat (an inhalation spray used to treat chronic obstructive pulmonary disorder that is expensive on the market—around US$300–350). There were multiple boxes of each medication. The doctor proceeded to put the medications in a black bag hidden in his white coat.

After leaving the pharmacy, we went to the coordinator's office to give him some of the medications. As we were returning to the doctor's office, he said to me, clearly annoyed, "That bastard wanted more than his share! He's no idiot, but neither am I! Hey, when you need or want something, tell me and I'll get it for you, no problem. Here, that's how things are handled—at least with me. You know, you have to have friends in the right places! Even the cops come to ask me . . ."

He sat down and asked me to bring in the next patient. After patient consultations had concluded and we were alone, I asked him, "Why do you keep social security numbers of some patients?" He whispered, "Old people do not come back for future visits—lost to follow-up. I keep their social security numbers for emergency cases. . . . I'll note down if the person is a man or a woman. I always choose old people because if something happens, they are the ones who make the least fuss."

Truthfully, I did go to him once and asked him to help me with a prescription. He tore a page from his pad, saying, "Write the name of the medication you need. You already know how to do it! Go to the pharmacy. Don't stand in line because others will start to recognize you." I went to the pharmacy in fear. As I walked in, the manager greeted me: "That's my doc! How's it

going? Let him through!" He opened the door and gave me the medication. Now that I'm telling you this, honestly, I feel really bad.

While this vignette identifies how resource scarcity leads to insufficient medications, a second cause is also revealed: the attending physician is giving patients cheap medications while fraudulently using patients' social security numbers to obtain more expensive drugs to sell on the black market. Instead of sensationalizing this ethnographic finding, we examine the dynamic nature of resource scarcity in Mexican health care. Doctors, including attending physicians, sell drugs on the black market to compensate for income insecurity.

The vulnerability of health care providers is also reflected in doctors' interactions with patients. Doctors sometimes attempt to ameliorate their own financial precarity (or seek personal financial gain, depending on how their actions are interpreted) by suggesting patients go to private clinics, where the doctors work a second shift after their regular hours in the government hospital. They promote their clinics by explaining the services and medicines can be paid out of pocket by the patient at "low prices." Given chronic overcrowding and inaccessibility problems in public hospitals, patients desperately pursue invitations to private clinics, to *their* financial precarity.

The context of resource scarcity places multiple actors at risk. Our research builds upon existing literature on biopolitics by revealing how physicians and other health care personnel are also vulnerable. We recognize health care corruption in Mexico has unequal consequences based on differential power and authority. Health care personnel with less authority, such as medical students, are at risk because they are taught to practice medicine in ways corrupting and detrimental to their moral conscience. Patients are at risk because they receive compromised health care, as evidenced by cheap or missing medications and recycled medical equipment (such

as catheters). Elderly patients are most vulnerable and readily exploited; instead of receiving the life-saving medications they need, expensive medications dispensed in their name are sold by their physicians on the black market.

Notably, the medical student describes certain mechanisms by which social networks bolster ongoing corruption in Mexican hospitals. The way the pharmacist and the attending physician exchange favors is not dissimilar to police officers purchasing well-positioned posts along the narco-trafficking corridors to receive kickbacks from drug traffickers (Andreas 1998). The logic of narco corruption marries the roles of law enforcement and criminals. Similarly, physicians selling state drugs on the black market are both victims of income insecurity and perpetrators of crime.

Was the student in this ethnographic example an accomplice or a victim? He describes feeling guilty for having asked the attending for help with a prescription. His use of the word *help* is significant because it underscores how rulebreaking is described as a "favor" when requested by a person of lesser authority. The next field note illuminates the distinction between a *palanca* and *pacientes recomendados,* thus emphasizing the important role of unequal power.

"*El Recomendado*"

The following vignette describes an incident we observed during the night shift at a Oaxacan hospital.

We arrive at the Internal Medicine Department and, minutes later, a hospital administrator hurries to the attending physician and orders him to attend a recomendado *immediately. The* recomendado *is an elderly man with cirrhosis—a relative of the administrator's friend.*

The attending physician barks at the head nurse, "He is a special patient; start working on his case now!"

Head nurse: "But there are no beds. The hospital is filled to capacity! It's Sunday and we have limited staff on board!"

Attending physician: "Did you not understand he is a recomendado*? Do you want us to tell the bosses we aren't able to treat him?"*

The nurse says nothing; the residents and medical students are silent. The attending takes the recomendado *to his office and the nurse leaves to another hospital area. The residents instruct the medical students to prepare the required medical equipment.*

Twenty minutes pass and the nurse returns, walks into a patient's room, and helps the patient from her bed into a wheelchair, explaining, "Don't worry, ma'am. We are just moving you temporarily. We have an emergency!" The patient is nervously silent as the nurse pushes her wheelchair to the Gynecology Department.

Having cleared space for the recomendado*, the head nurse returns, telling the nurses to pause their care of other patients and prepare the bed for the new patient. One nurse objects, "But we have too much work! We don't have time!"*

Head Nurse: "I don't have time either, but it is an order from the higher-ups. Imagine what I had to do to get Gynecology to transfer a patient for me. Luckily it's a palanca*, otherwise I'd be toast!"*

Nurse (referring to hospital administrators): "They just give orders here, not caring who they screw over!"

The head nurse and the attending return to the prepared room with the recomendado*, accompanied by two residents and three students. The internist instructs his team, "He has*

chronic cirrhosis of the liver. Run labs and drain the ascites fluid." One resident resists, "But the hospital is packed. What if we are sent more patients from the emergency room?"

The attending replies, "Don't worry, I'll take care of that." While the residents and students watch him incredulously, the attending takes a trash can and jams it between the elevator doors, ensuring no more patients are transferred from the emergency department. He yells, "I took care of it. Now get to it!" The residents and students are quickly performing the therapeutic maneuvers . . .

Around seven o'clock the next morning, the recomendado *wakes up and the attending asks him, "How do you feel? Did the* doctorcitos *treat you well?"*[4]

Patient: "Very well! I feel better now! But how will I pay them?"

Attending: "That's what we are here for! To serve people!"

In this field note, the importance of power and inequality comes into stark relief. The *recomendado*—who received special treatment, including resources intended for other patients—had a direct, negative impact on the care other patients received. His arrival literally displaced another patient from her bed. The internal medicine department was rendered physically inaccessible to all incoming emergency room patients. Beginning in 2001 with Seguro Popular, Mexico guaranteed universal health insurance coverage;[5] thus, hierarchical access to treatment in public hospitals is not only corrupt but it is also a violation of citizenship-based rights.[6]

After the recorded event, residents and medical students expressed their overt criticisms of the attending's actions. The hospital administrator was the most powerful actor and, therefore, able to exercise his authority over the attending who, in turn, exercised his authority over the nurses, residents, and medical students. This top-down rulebreaking was considered corrupt. Medical students and residents did not critique the head nurse's actions the same way. She was

forced to request a favor from the Gynecology Department to make space for the *recomendado.* This bottom-up rulebreaking was not deemed corrupt because her actions were constrained by her rank. Health professionals with lesser authority are subjected to a corrupt system, leading them to reluctantly participate in violating patients' citizenship-based rights, and leaving them feeling guilty and helpless.

The Disposable Patient

The following vignette, which details the fatal effects of health care corruption, is assembled from ethnographic observations and interviews with residents and the chief of staff. The residents' experiences illustrate how the weight of repressive subjecthood grinds upon the conscience of well-meaning and relatively-disempowered health professionals. The vignette demonstrates the connection between medical professionals' interpellation as subjects of a corrupt regime and corruption's fatal consequences for patients. It reveals how, in the process of covering up incriminating facts, this connection is silenced and rendered invisible. In this way, the systematization of corruption allows for the daily assault of both medical professionals and patients to play out in near absolute impunity (Le Clercq 2018).

A fourteen-year-old girl was admitted to the hospital during active labor. She was attended by the preceptor (a gynecologist) and fourth-year medical students. The gynecologist allowed private university students to attend the patient, but since they did not know the technique for labor, they required guidance. The gynecologist indicated that, in order to make the procedure a greater learning opportunity, he would put the placenta back into the girl's uterus. He performed a maneuver that subsequently caused uterine atony, and the patient suffered a heavy hemorrhage.

The maneuvers in the Obstetric Medical Standards handbook for hemorrhage were performed, including uterine massage and pharmacological treatment, but produced no result. The case was now an emergency. The patient was transferred to the operating room and an attempt was made to ligate the hypogastric arteries. The same gynecologist accidentally cut the iliac arteries, thus producing greater loss of blood volume. He did not disclose this to the anesthesiologist! The gynecologist tried to use compression to stop the bleeding, and it wasn't until the anesthesiologist noticed a decrease in vital signs and asked, "What is happening?" that the gynecologist admitted what was occurring. "Code blue" was activated and all necessary specialists provided support. Hearing the call, the chief of surgery, one of the hospital's best surgeons, rushed in and did everything possible to preserve the patient's life. However, he did not have the necessary equipment and the situation was out of his control, culminating in the patient's death. The thorax was opened to massage the heart as a final attempt to keep the patient alive. Finally, relatives were informed that everything possible had been done, but they could not save their family member.

A thorough investigation—which included all the doctors involved—was conducted. Documents were adapted so no data of "negligence" would come to light. The anesthesiologist stated in her final note that when surgeons opened the thorax, there was still blood volume; this contradicted the surgeons' notes indicating the patient no longer had blood volume. The investigating doctor spoke with all the doctors to ensure their corrected notes aligned with the version that best suited both the hospital and those involved. He explained to us it was necessary because, if the truth were exposed, the hospital director and the doctors who performed their work correctly would lose their careers—without having had significant involvement. He

explained he doubted the gynecologist's intention was to kill the girl—it was just a procedure that spiraled out of control, and innocent people shouldn't have to pay.

We include this horrifying vignette to call out and condemn systemic corruption in Mexico. We are wary of the optics of voyeurism, and hope this vignette will be read as an incrimination of corruption's fatal effects rather than careless reproduction of dehumanizing "poverty porn" (see Velden 2019).

When reading this excerpt, the gross incompetence of the preceptor is immediately striking. He intentionally provoked an emergency to create a teaching opportunity; he privileged his desire to teach private school medical students over the patient's right to health; and he betrayed his Hippocratic oath by purposefully placing the patient's life at risk. This excerpt also reiterates the issue of resource scarcity in Mexican public hospitals—a common theme among all the excerpts. While the chief of surgery rushes to help upon hearing code blue, he lacked the necessary equipment to save the young woman's life.

This case further highlights the role of intersectional vulnerability of patients, especially when compared to the prior field note regarding the *recomendado*. While the medical professionals were concerned for their careers, the most intersectionally vulnerable individual—the fourteen-year-old patient—died for the sake of a teaching opportunity. Along with intersectional vulnerability based on gender and age, the patient was likely poor and lesser educated.[7] The preceptor's decision placed the patient's life at risk, and the medical team's collusion to cover up the circumstances surrounding her death shed light on how certain individuals are privileged and others are disposable. Given this article's decolonial effort, it is essential we acknowledge that many of the power dynamics that allowed the preceptor to kill the patient also enable us, as authors, to use her death as an example.

The fact the cover-up was successful—effectively erasing the young woman's identity—is indicative of how efficient, effective, and systemic corruption is in Mexican health care. While her death was initiated by one person's heinously unethical decision, multiple others were inadvertently implicated in the tragedy, and the entire medical team was complicit in cover-up efforts. This universal participation in the cover-up is justified as protecting "innocent people" from losing their careers, including the preceptor. This justification again underscores the issue of intersectional vulnerability.

Rethinking Systemic Corruption in Mexican Health Care

Our research on corruption in Mexico draws different conclusions than research conducted elsewhere, while also adding complexity to the Mexican context. Donna Goldstein and Kristen Drybread (2018) indicate corrupt practices are complex legal and financial schemes that almost always fall within the category of "white-collar crime." They signal the difficulty of predicting how the public may become aware of corruption as well as motivated to address it. In their individual articles, the authors point to the raced and classed aspects of corruption in Brazil, arguing that white-collar crimes are considered "white" and "innocent" (Goldstein 2018), while lower-class and nonwhite "criminals" are considered "corrupt" (Drybread 2018). In contrast, our research in Mexico reveals corruption is woven into the fabric of everyday health care provisioning. The systemic nature of health care corruption in Mexico interpellates all medical personnel to participate. In stark contrast to the Brazilian context, bottom-up "rulebreaking" is characterized as good social etiquette while top-down "corruption" is condemned as an abuse of authority.

Regarding the Mexican context, Arianda Estévez and Daniel Vazquez (2013) argue it is not enough to have adequate laws regulating political and social processes since institutions and actors tend to exercise their power in legal and illegal ways. Our ethnographic research supports this assertion. While universal health access is guaranteed in Mexico as a citizenship-based right, health care corruption—ranging from physicians siphoning patients' medications from the public health care system into the black market to killing vulnerable patients in the name of medical education—demonstrates that having adequate laws is not enough.

Our attempt to decolonize anthropology has left us wrangling with the process of studying corruption and how to contextualize local interpretations of corruption within histories of inequality. By engaging in collaborative, transnational research, we strive to recognize, expose, critique, and change colonial practice. Thus, while existing research on "the coloniality of power" has tended to emphasize only two social positions (vulnerable or powerful), we demonstrate how medical students are simultaneously vulnerable and powerful (Quijano 2008; see also Galtung 1990; Loeza Reyes 2017). Medical students occupy a "middle space" between health care authorities and patients; and as perpetrators *and* captives of a corrupt system, many are left with feelings of culpability. Focusing on them enables us to provide a more complex rendering of power.

Descriptions of *palancas* and *recomendados* provide fleshy details of how health care providers navigate pervasive corruption in ways that lead them to skirt the edge of legality/illegality, and how their capacity for providing compassionate care is constrained in the process. At the same time, we acknowledge how resource scarcity in the Mexican medical system has meant nonpayment of wages for providers *and* nonrendering of needed health services for poor citizens. The rights of vulnerable patients and their providers are mutually

imbricated—systemic corruption violates providers' labor rights and, simultaneously, disables patients' right to health.

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1. This research was conducted in accordance with rules and regulations for protection of human subjects at the National Autonomous University of Mexico. Hospital-based participant observation during phase two was approved by Research Ethics Committee CONBIOÉTICA 20CEI00920140412. The other phases of our research were deemed "exempt" by the research division at Institution 2 Medical School.

2. Generally, our findings were fairly consistent among demographic subgroups. Our informants were closely grouped in age—medical students were between twenty-two and twenty-three-years old, while residents were between twenty-three and twenty-six-years old. However, we found one striking difference based on gender. Female informants described "*el aguante*" in terms of enduring sexual advances of male authorities. In contrast, male informants described "*formas de guardar silencio*" regarding sexual advances from both female and male authorities. Informants' gendered characterization of sexual harassment merits further inquiry.

3. In so doing, the pediatrician underscored how, in contexts of extreme scarcity, physicians are unable to follow what they are taught in ethics courses. Instead, "lifeboat ethics" apply (discussed further, below; see Scheper-Hughes 1997).

4. The attending refers to residents and medical students as *doctorcitos* (which literally translates to "little doctors") in order to emphasize their lower professional rank.

5. Seguro Popular insured lower-income Mexicans and individuals who did not otherwise have insurance through employment in order to achieve universal health insurance coverage across the Mexican population. (See http://www.salud.gob.mx/unidades/dgpfs/faq.htm.) On January 1, 2020, under President López Obrador, Seguro Popular was replaced by the Instituto de Salud

para el Bienestar (Insabi), which ensures universal access to health care and medications for all citizens. The switch to Insabi was fueled by critiques that Seguro Popular did not actually provide universal *health care access* but instead guaranteed *insurance coverage* (which is not the same thing). These critiques are supported by our ethnographic findings.

6. There are two health care systems in Mexico. Private hospitals and clinics serve the rich—including top hospital administrators, government officials, and medical school professors—who reproduce hierarchies of power in our ethnographic vignettes. Some medical students in our study will go on to work exclusively in the private sector, while others will combine work in the public medical system with "moonlighting" in private clinics.

7. Of the maternal mortalities occurring in the State of Oaxaca in 2013, only 24.4 percent were employed, 43.9 percent never received any education, and 49 percent had a primary school education. Observatorio de Mortalidad Materna en México. Numeralia 2013. México: OMM. Available at:

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