11-25-2020

Operating at the Edge of Il/legality: Systemic Corruption in Mexican Health Care

Rosalynn A. Vega
The University of Texas Rio Grande Valley, rosalynn.vega@utrgv.edu

A. Paulo Maya

Recommended Citation

Vega, R.A. and Maya, A.P. (2021), Operating at the Edge of Il/legality: Systemic Corruption in Mexican Health Care. The Journal of Latin American and Caribbean Anthropology, 26: 46-64. https://doi.org/10.1111/jlca.12513

OPERATING AT THE EDGE OF LEGALITY/ILLEGALITY: SYSTEMIC CORRUPTION IN MEXICAN HEALTH CARE

Abstract

Systemic corruption disables the ability of patients to realize their citizenship-based rights to health, at times with fatal consequences. Shifting the scale of analysis from microaggressions via person-to-person encounters to systemic corruption allows for a complex evaluation of the roles providers play. Health care professionals both contribute and are subjected to systemic corruption, leading to feelings of entrapment and culpability. Their actions both maintain and expose the "public secret" of widespread corruption in the Mexican health care system. In essence, health care providers operate at the edge of legality/illegality within a context of routinized professional-economic insecurity. Based on eleven months of multi-sited research, our binational, collaborative perspective points to how rule breaking and corruption rely on social networks structured by power inequality. The vulnerability of health care providers, including violations of their labor rights, result in dire consequences for the health outcomes of patients living under conditions of precarity.

Keywords

systemic corruption; health care; intersectionality; Mexico

Introduction

In recent years, international financial institutions and supranational political bodies such as the World Bank and the International Monetary Fund have published policy statements

identifying corruption as the primary obstacle to social and economic growth worldwide. Yet, while the pernicious effects of corruption have increasingly captured the attention of policymakers and individuals, anthropologists have been reticent to engage with corruption as an analytic. This reticence is at least twofold. First, by calling cultures in the Global South "corrupt," some scholars in the Global North fear they may inadvertently reproduce existing global structures of inequality that are rooted in a colonial past. Second, many anthropologists are wary that the concept of "corruption" is, in itself, ethnocentric and misleading (Smith 2018).

Nonetheless, "corruption" is a valuable analytic, and must be taken into account when it is being explicitly called out and critiqued by our study participants. Since what counts as corruption varies from one context to another, it is essential to understand how the actors themselves evaluate the "corrupt" social practices in question (Sissener 2001). Research on corruption can avoid many of the pitfalls anthropologists fear by emphasizing the importance of contextualization and the complexity of social experience. Furthermore, ethnographic methods are uniquely positioned to produce contextualized, multi-layered, decolonial analyses of corruption.

Turning to health care corruption, anthropologists in both U.S. and Mexican academies have conducted a plethora of ethnographic studies on the Mexican health care system, but they generally have not included corruption as an analytic. In the Mexican academy the word "corruption" is omitted from academic discourse, even while this term is frequently used by patient and clinician study participants when critiquing the health care sector. What accounts for this disconnect between study participants' critiques and academic analysis? At first glance, this may be because Mexican anthropologists have tended to focus their ethnographic analysis on "traditional medicinal practices" of the indigenous poor (Menéndez 2017), and, more recently,

on women's health, instead of casting a critical gaze upon those in positions of power (Nader 1972). Further examination indicates that academics, like the rest of Mexican society, are also subjected to the constricting and determining logics of pervasive corruption. They are silenced by fear. The silencing of "corruption" within the Mexican academy evidences the ways in which pervasive corruption in society also constrains academic debates, effectively undermining the power of ethnography as political critique (Biehl and McKay 2012).

Instead, failures in health care administration and the poor ethics of individual providers are objects of debate between both U.S. and Mexican medical anthropologists. Harm caused by providers includes a range of microaggressions and can sometimes extend into the realm of tactile encounters—for example, 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 2015; Smith-Oka and Marshalla 2019). 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 healthcare system. Harm caused by pervasive corruption acutely affects the same marginalized patient population that are on the receiving end of (micro)aggressions—impoverished and indigenous women, children, and the elderly—since these are the people for whom public health funds are most often intended. Shifting the scale of analysis from person-to-person encounters to systemic corruption allows for a more complex evaluation of the roles providers play. While they may be perpetrators of (micro)aggressions, they are also captives of a corrupt system that leaves many with feelings of culpability.

Health care professionals both contribute and are subjected to systemic corruption, at times with noxious personal effects. During ethnographic interviews, health professionals

expressed pointed critiques of corruption in the biomedical institutions they supposedly serve and described their individual struggles when attempting to provide quality care to their patients. While attention has been paid to the role of patient citizens in Mexican health care (Gálvez 2011), these ethnographic interviews prompt the question: what of provider citizens? How might their citizenship-based rights be threatened by pervasive systemic corruption in healthcare? The corrupt system unleashes its greatest violence on *pacientes desprotegidos* (vulnerable patients) and is fueled by total impunity of authorities at the top (Le Clercq 2018). This system constrains the potential for compassionate health care by providers—in disparate and telling ways. While these themes emerged during interviews, potential outcries regarding the harm caused to health care providers has been silenced by fear, thus (re)producing the conditions for corruption (Goldstein 2017; Ofrias 2017).

By engaging the situated knowledge (Haraway 1988) of health care providers with respect to corruption (Gupta 1995), anthropologists can resist lapsing into a binary portrayal of authority and its relationship to corruption. Stated differently, incorporating the perspectives of health care providers in Mexico can help move ethnographic analyses beyond one-dimensional understandings of health care providers as the perpetrators of biopolitical control over patients' bodies, and instead facilitate reflection on how health care providers are themselves drawn to pervasive logics of corruption.

The questions emerge: what factors cause health care providers to operate at the edge of legality/illegality? How are health care providers' quotidian practice of medicine shaped by routinized (in)security at both the professional-economic and physical levels (Penglase 2009)? Furthermore, how do health care providers maintain or expose the "public secret" of widespread corruption in the Mexican health care system (Taussig 1992)?

Methods

This article is based on eleven months of multi-cited fieldwork in Mexican clinics. Initially, the ethnography was focused on approximately 120 medical students in Mexico City. During this phase, the goal of the research was to identify how medical students are adversely effected by negative experiences during their training. Methods included both participant observation and in-depth interviews. Specifically, medical students were also observed as they carried out their internship duties in five public hospitals. These medical students were also interviewed on a one-on-one basis in a classroom setting.

Recordings of the interviews were subsequently transcribed, allowing for the researchers to analyze their narratives and identify recurring themes (Adame and Knudson 2007; Hamui 2018). While multiple themes emerged from the ethnographic data, the predominant theme was the involuntary entanglement of medical school students in the breaking of hospital rules. Students identified a conflict between what they learned about medical ethics and what they were being told to do as subordinates undergoing clinical training.

The second phase of the research took place in a civil hospital in the city of Oaxaca. Researchers observed two residents carry out their day-to-day duties in the hospital. Furthermore, four residents were interviewed in their work spaces (closed- door cubicles) and in nearby coffee shops. During these interviews, the residents explicitly pointed to the common use of palancas and the exclusive treatment of “recomendados.”

This second research phase illuminated the role of social networks and differential authority in the breaking of hospital rules. Interviewees emphasized the importance of *la palanca*, which literally translates to “the lever.” Using “the lever,” doctors in a position of less authority requested favors from colleagues in order to facilitate patient care and help specific

patients. On the other hand, the residents described the preferential treatment of "*recomendados"* (recommended [patients]) by doctors possessing greater authority. Specifically, medical services, instruments, and medicines are redirected away from the general patient population and exclusively towards "recomendados," thus placing many other Mexican citizen-patients at risk.

In the final phase of our data collection, we expanded our research focus to include auxiliary health personnel and patients' perspectives. Specifically, we conducted in-depth interviews with five nurses. These interviews underscored the significant negative effects breaking hospital rules has on health personnel while also adding an additional critique regarding the "arrogance of recomendados." To better understand patients' experiences, we examined patients' written complaints regarding hospital staff and the medical care they received. Furthermore, participant observation was conducted in the Emergency Medicine department, leading to an in-depth interview with a key informant.

After the data collection period concluded, we recognized that by describing how the common use of palancas and preferential treatment of "recomendados" results in personal distress for medical personnel and patients, our informants were signaling and critiquing systemic corruption in different Mexican clinics. It is important to note that researchers never explicitly referred to corruption when interviewing informants. Instead, the research used an inductive approach, followed by open coding to identify emergent themes.

Ethnography is uniquely positioned to uncover the nuances of corruption as it unfolds in contemporary Mexico. Interviews with medical students revealed their desire to provide quality medical treatment to patients. At the same time, they expressed feelings of disappointment—as they were increasingly incorporated into corrupt health care systems, it became ever more difficult to uphold a moral commitment to compassionate care. Given these

contradictions, our approach is designed to resist lapsing into "universal" notions of "good" and "bad." Instead, our project is to engage in descriptive work and rely on study participants' interpretations of the meanings of corruption and its effects. At the same time, it would be disingenuous to claim total impartiality; anthropology is never non-biased. Recognizing that our project will always be incomplete, we have worked as best we could to ensure that wherever normative claims are made, they are representative of those expressed by our study participants.

Anthropology of Corruption: The Importance of Collaborative Ethnography

Our comments on method pertain not only to how our data were obtained, but also how data are assembled and disseminated, since these processes also reveal the uneven and intertwining effects of power and corruption. Co-authored by medical anthropologists at the Institution 1 (Author 1) and Institution 2 (Author 2), we seek to show that collaborations such as ours contribute to the decolonization of anthropology as a discipline by situating Mexico not only as a repository of ethnographic data, but also the site for emergent theoretical intervention. Our transnational partnership helps us to resist the tendency many anthropologists fear when studying corruption—a critical gaze originating in the Global North that characterizes 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 that Southward-facing allegations of corruption can create an us/them framework in which Northern neighbors are implicitly assumed to be free of corruption.

Our differential positionalities—and distinct intersectional identities; i.e. racialization, 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/U.S. citizen, Author 1 has maintained active involvement (through workshops, conference presentations, and publications) in both Mexican and U.S. academies. Her relatively unhindered observation in Mexican clinics and participation in the Mexican academy can be contrasted with the experience of a Mexican academic if she or he were to attempt to conduct ethnographic research in U.S. hospitals and disseminate research findings in the U.S. academy. United States jurisprudence, especially the Health Insurance Portability and Accountability Act (HIPAA), combined with the challenges of publishing in academic journals as a non-native English speaker, make it difficult 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 unequal relationship between the two countries, and how colonial legacies unfold through present-day political economic realities.

Author 2, on the other hand, a Mexican national, writes from a position of everyday embeddedness in social structures penetrated and shaped by pervasive corruption. As a medical school faculty member, his research endeavors into corruption within the health care system have been met with outright dismissal by other medical anthropologists—he has been silenced or cautioned to desist since he is not trained as a physician. His experience points to how mechanisms are not only in place in clinical and governmental settings to maintain the "public secret" of health care corruption, but also predetermine what can or cannot be said within Mexican academia (Taussig 1992).

Defining Rule Breaking vs. Corruption in the Mexican Healthcare System

Seen from a distance, corruption in Mexico can be defined as the breaking of a law or regulation for personal benefit. While this is technically a crime, it is often not perceived as such from a cultural perspective. Examples include the notorious *mordida* (bribes) woven into the fabric of everyday life. Mordidas are a tactic requirement during traffic stops and serve as a lubricant for bureaucratic processes. It can be argued that corruption has penetrated the Mexican sociopolitical structure; however, this argument extends beyond the scope of this article.

Our research uses ethnographic data to examine the specific unfolding of corruption within the Mexican healthcare system. By pointing to two distinct phenomena—*la palanca* and *el recomendado*—our ethnography uncovers how rule breaking and corruption rely on social networks and are structured by power inequality.

La palanca (which literally translates to "the lever") refers to how health personnel with less authority seek the help of superiors when breaking hospital rules. The agents of this "bottom up" form of rule breaking make use of palancas to facilitate patient care; thus, palancas are considered "favors" among colleagues to help patients. Palancas emphasizes the role of social etiquette in everyday forms of healthcare corruption.

On the other hand, "*el recomendado"* (the "recommended" [patient]) refers to how health personnel in positions of power abuse their authority to redirect limited public resources towards their personal acquaintances and away from average patient-citizens. Due to their higher station, other medical personnel are obligated to participate. This "top down" corruption in hospital settings is carried out in total impunity, despite feelings of guilt among subordinate personnel for involvement in what they perceive to be unethical.

While palancas are perceived as a form of social etiquette, recomendados were overtly labeled and critiqued by our informants as corruption. This rhetorical distinction underscores the

importance power inequality plays in how “bottom up” rule breaking is considered altruistic while “top down” corruption is judged as unethical.

Lifeboat Ethics: Scarcity in Mexican Public Hospitals

It is a June Sunday morning and we are headed to a public hospital which is notorious for overcrowding. Potential patients are clamoring at the entrance for access to medical services. As we approach the hospital, a lady is loudly arguing with the police officer who is guarding the entrance. The police officer tells her that an ID is required to enter the hospital, but the lady just keeps showing him a card with the date and time of her doctor’s appointment. When we walked up, we quickly flashed our observer’s badge and were granted entrance. This provoked the woman and her family members to anger. She complained, “Then why is he allowed to pass?”

We walk down the hospital corridors towards the pharmacy, where patients and their families are gathered. The patients are demanding their prescriptions, but the pharmacy manager is yelling back at them through the window, “We no longer have medicine, they did not supply us enough." The patients are clearly dissatisfied and upset. Among them a patient exclaims, “Again with the same old bullshit.”

We continue on to Pediatrics where attending physicians and residents are having a heated discussion about what type procedure to perform. The argument revolves around the high economic cost of the surgical procedure being recommended. Cost is at the forefront of everyone’s mind. A few months ago, faced with a budget cut, doctors and nurses decided to boil used catheters for reuse. In another instance, pediatricians debated whether or not to perform a costly surgery on a newborn, as this would consume scarce resources that could otherwise be

used to treat multiple children. This conundrum led one of the pediatricians to comment that ethics can only be applied where sufficient resources exist.

This 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. At the same time, health professionals are murmuring that the 2015 murder of a health sector official was related to political crimes. [Exerpt from fieldnotes]

We selected this fieldnote as the first piece of raw ethnographic data for this article because it sets the stage for other ethnographic anecdotes to follow. Specifically, this fieldnote points to the problem of resource scarcity in many public Mexican hospitals. At the beginning of the fieldnote, a woman is denied entrance to the hospital based on her not having any form of identification. This can easily be explained as the consequence of the woman's own negligence. However, subsequent fieldnotes and an interview excerpt will clarify how specific patients are privileged to the detriment of "disposable" patient populations.

The hospital lacks 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 that we have encountered across multiple Mexican states and dozens of individual clinics. The next fieldnote will add complexity to this phenomenon by indicating that while the lack of medications is partially due to insufficient funding, there is also a second, more nefarious, cause as well.

This opening fieldnote also identifies medical personnel as troubled agents. Given extreme scarcity in the public sector, health care personnel are forced to make difficult decisions.

Health care personnel are fully aware that boiling used catheters for reuse in patient care is risky; however, it is considered the lesser of evils when compared to other medical equipment that might be sacrificed in a budget cut. Deciding which medical equipment to purchase and which to sacrifice is a relatively easy task compared to the decision of which child to treat and which to let die (Foucault 2003:239–264). Given a context of extreme scarcity, Mexican doctors are often faced with choices for which there is no ethical alternative. This context had rendered the hospital a "gray zone" where "lifeboat ethics" predominate (Scheper-Hughes 1997).

Health care personnel have been proactive about denouncing the troubling conditions in which they work. Labor unions representing different types of health care personnel were frequently on strike during our research period. During our research, health care personnel linked resource scarcity to embezzlement by politicians. While rumor is an important form of social critique, in this paper, we focus on the lived experiences of informants as described to us in in-depth interviews and observed through participant observation.

Drug Dealer, M.D.

One day we were rotating in the Family Medicine unit, very carefree, when we realized that one of the doctors always prescribed the same medications. When we asked him why, he answered us, "[The coordinator and director] prohibit me from giving all kinds of medicines. When I need the medicines, they are scarce. To avoid problems with the coordinator or the director, I always give patients the cheapest medicines. Certain types of medications need authorization in order to be prescribed at the pharmacy; that is, the seal and signature of one of the two mentioned authorities." At that moment, I was satisfied with this answer. But later, I

noticed that the doctor wrote down the social security numbers of some patients—especially the elderly. He folded them and kept them in his desk drawer.

On one occasion the head coordinator entered the office 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. At the same time, the doctor continued writing up other prescription orders from his computer, ordering three or four boxes of each medication. By the time the shift was over, he had written orders for ten more prescriptions, but he never gave them to the patients in question. For the last two, he recorded the patients' social security numbers while leaving blank the name of the medication.

He turned to the medical assistant and said, "I'm going to the bathroom. I'll be gone 15-20 minutes" and he ordered me to accompany him. After we left, he turned to me and smiled. "I'll show you how to deal with people. This is how it is done everywhere! You just follow me." He stopped at the restaurant to buy a Coke before taking me to the pharmacy. When we arrived, the pharmacy manager opened the door and said, "Let's head to the kitchen." The doctor gave the pharmacist the Coca Cola and said with a wry grin, "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 with a joking tone, "You already know that I always do. You can fill them out with whatever you want." The pharmacy manager went to look for the prescriptions the doctor was ordering, while the doctor explained, "We have to leave the pharmacists with a few blank prescriptions so that when they complete their inventory forms they

won't say that any of our orders were unjustified. An investigation into the pharmacy inventory would screw us all!"

Just then, I remembered that the prescriptions require authorization from the coordinator. As if he were reading my thoughts, the doctor continued on, "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 a reason to suspect, 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 arrived with approximately thirty boxes of medicines the physician had ordered. 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 $300-350 USD). There were multiple boxes of each medication. The doctor proceeded to put the medications in a black bag that he hid in his white coat.

After leaving the pharmacy, we went to the coordinator's office to give him some of the medications. Then, as we were returning to the doctor's office, he said to me with an annoyed tone, "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—or 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 all the patient consultations for the day had concluded and we were alone, I asked him, "Why do you keep the social security numbers of some patients?" In a faint voice he answered, "Old people do not come back for

future visits—loss 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."

To be honest, I did go to him once and asked him to help me with a prescription. He just took a page from his pad and said, "Write in 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. Just as I walked in, the pharmacy manager greeted me and said: "That's my Doc! How's it going? Let him through!" He opened the door and gave me the medication and I left. Now that I'm telling this to you, I feel remorseful about that. Honestly, I feel really bad.

--Medical Student

The second cause for insufficient medications is revealed in this one-on-one interview excerpt: some physicians commit social security fraud in order to obtain drugs to sell on the black market. Instead of sensationalizing this ethnographic finding, we hope to situate it within the context of resource scarcity. The scarcity described in the prior fieldnote does not only extend to medical equipment—another reason for recurrent strikes is the government's failure to pay medical personnel's salaries. The vulnerability of health care providers is not only demonstrated through the illicit sale of prescription drugs, but is also reflected in doctor's 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 that patients go to the private clinics where they work a second shift after their regular hours in the government hospital. These doctors promote their moonlight clinics by explaining that the services and medicines provided can be paid out of pocket by the patient and patient's family

members at "low prices". Given chronic overcrowding and inaccessibility problems in public hospitals, some patients desperately pursue invitations to private clinics, even when this increases *their* financial precarity.

The context of resource scarcity places multiple actors at risk. Our research builds upon the existing literature on biopolitics by revealing how physicians and other healthcare personnel are also vulnerable. Nonetheless, we recognize that healthcare corruption in Mexico has unequal consequences based on differential power and authority. In the above interview excerpt, elderly patients are the most vulnerable and the most readily exploited.

Notably, the medical student describes certain mechanisms by which social networks bolster ongoing corruption in Mexican hospitals. The way in which the pharmacist and the attending physician exchange favors is not dissimilar from how police officers purchase well-positioned posts along the narco-trafficking corridor so that they may be on the receiving end of constant kickbacks from drug traffickers needing to successfully move their product along reliable routes (Andreas 1998). Just as the logic of narco corruption makes it difficult to distinguish between law enforcement and criminals, in the context of health care corruption, it is similarly difficult to distinguish victims and perpetrators.

For example, was the medical student in this ethnographic example an accomplice or a victim? The medical student describes feeling guilty for having asked the attending physician for help with a prescription. His use of the word “help” is significant because it underscores how rule breaking is described as a “favor” when it is requested from a person of lesser authority. The next fieldnote illuminates the distinction between a *palanca* and *pacientes recomendados*; thus, it emphasizes the important role of unequal power.

“El Recomendado”

We are walking through the Nursery area within the Pediatrics Department. The area is crammed with the relatives of newborns hoping to catch a glimpse through the nursery window. We are barely able to make our way down the corridor. Body heat fills the air with a thick vapor, making it difficult to breathe. Beyond the crowd, we can make out the attending pediatrician, who is busy performing supervision activities. Nurses are scurrying around throughout the area.

We arrive at the Internal Medicine Department and, initially, everything was quiet. Minutes later, one of the hospital administrators bursts into the area, walks straight up to the attending physician, and orders the physician to attend a recomendado right away. The recomendado is an elderly man with cirrhosis—he is a relative of the administrator’s close friend.

The hospital administrator leaves the area and the attending physician barks at the head nurse, “He is a special patient, so start working on his case now!”
Nurse: “But there are no beds. The hospital is filled to capacity! It’s Sunday and we have limited staff onboard!”
Attending physician: “Did you not understand that he is a recomendado? Do you want us to tell the bosses that we aren’t able to treat him?”

The nurse does not answer. Meanwhile, the residents and medical students are silent. The attending is taking the recomendado to his office and the nurse leaves to another area of the hospital. The residents instruct the medical students to prepare the required medical equipment.

Twenty minutes have passed and the Head Nurse arrives with two stretcher-bearers. She walks into one of the patient rooms and has a female patient from her hospital bed into a

wheel chair, explaining, "Don't worry, ma'am. We are just going to move you temporarily. We had an emergency!" The patient is silent, but has a nervous expression on her face, as the nurse pushes her wheelchair to the Gynecology department.

Having cleared space for the recomendado, the Head Nurse returns and tells the nurses to pause their care and supervision of other patients and, instead, prepare the bed for the new patient. One of the nurses 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 to their department for me as a favor. Luckily it's a palanca, otherwise I'd be toast!"
Nurse (referring to the hospital administrators): "They just give orders here, not caring who they screw over!"

The Head Nurse finishes preparing the bed and walks to the attending physician's office. They return to the room with the recomendado, accompanied by two residents and three students. The internist instructs his team, "He has chronic cirrhosis of the liver. You have to run labs and drain the ascites fluid." One of the residents resists, saying, "But the hospital is packed. What do we do if we are sent more patients from the Emergency Room?"

The attending physician replies in a matter-of-fact tone, "Don't worry. I'll take care of that." He takes a trash can and walks to the elevator, while the residents and students watch him incredulously. The attending jams the trash can between the elevator doors, making sure that no more patients are transferred from the Emergency Department. He yells, "I took care of it. Now get to it! I'm going to my office and I'll be back soon." The residents and students are quickly performing the therapeutic maneuvers….

It is around seven o'clock the next morning and the recomendado has just woken up. The attending asks the elderly man, "How do you feel? Did the doctorcitos[1] *treat you well?"*

Recomendado: "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 fieldnote, the importance of power inequality comes into stark relief. The hospital administrator is the most powerful actor, and is therefore able to exercise his authority over the attending physician, who in turn exercises his authority over the nurses, residents, and medical students.

The *recomendado* receive special treatment, to the detriment of the general patient population. That is, the presence of a *recomendado* has a direct, negative impact on the care other patients receive. He receives specific resources that were intended for other patients. His arrival at the hospital meant that a female patient was literally displaced from her hospital bed. Furthermore, the Internal Medicine Department is rendered physically inaccessible to all incoming Emergency Room patients. Mexico guarantees universal health insurance (*Seguro Popular*); thus, the exclusive treatment of particular patients in public hospitals is not only an act of corruption, it is also a violation of citizenship-based rights.

In the aftermath of the recorded event, residents and medical students were overtly critical of the attending's actions. However, the Head Nurse's actions was not critiqued in the same way. The hospital administrator exerted his authority over the attending, and the attending, in turn, exerted his authority over the rest of the medical team. This top-down rule breaking was considered corrupt. In contrast, the Head Nurse was forced to request a favor from the Gynecology Department when she needed to transfer a patient and make space for the

recomendado. This bottom-up rule breaking is not deemed corruption because the nurse's actions were constrained by her professional rank.

That is, health professionals with lesser authority are subject to a corrupt system, thus provoking them to *operate* at the edge of legality/illegality (Goldstein 2012). Medical students, residents, and nurses are reluctantly interpellated into structural logics of corruption that leave them feeling helpless and guilty. Not only does the weight of this repressive subjecthood grind upon the consciences of well-meaning and relatively disempowered health professionals, it can also have fatal consequences for patients. As demonstrated in the next ethnographic excerpt, the constant interpellation of medical professionals as subjects of a corrupt regime and the violating and fatal consequences for patients are 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).

The Disposable Patient

[I will tell you about] the case of a 14-year-old girl who went into labor and was attended by the preceptor (a gynecologist) and fourth-year medical students who were on the labor and delivery rotation at the time, myself included. The gynecologist also let students from a private university attend the patient, but these students did not know the technique for labor, so they required guidance. When the gynecologist arrived, he told us he wanted to make the procedure more educational and for everyone to have a greater opportunity to learn. For this reason, he decided to 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.

Then the maneuvers indicated by the Obstetric Medical Standards handbook for obstetric hemorrhage were performed. These included uterine massage and pharmacological treatment, but the treatment produced no results. 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. However, he did not mention this to the anesthesiologist! The gynecologist was attempting 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 had no choice but to say what was occurring. Subsequently, "code blue" was activated and all the necessary specialists came to provide necessary support. Hearing the call, the chief of surgery, one of the best surgeons of the hospital, rushed to the operating room and tried to do 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 with the death of the patient. The last maneuver performed by the surgeons was to open the thorax 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.

Subsequently, the doctor in charge of the intensive care unit conducted a thorough investigation that included all the doctors involved. Documents were adapted so that no data of "negligence" would come to light. For example, the anesthesiologist mentioned in her final note that when surgeons opened thorax to massage the heart, there was still blood volume; however, this contradicted the note of the surgeons who indicated that the patient no longer had blood volume at the time. The doctor spoke with all the doctors and made sure they corrected their notes so that everything was aligned with the version that best suited both the hospital and those

involved. The doctor in charge of the intensive care unit did not hesitate to explain to us that it was necessary to do so for the simple fact that, if the truth were exposed, both the director of the hospital and the doctors who performed their work correctly would lose their careers—without even having had significant involvement in the case. He also explained that he doubted the gynecologist's intention was to kill the girl, it was just a procedure that got out of control for all those involved and that innocent people should not have to pay.

--Resident in hospital

When reading this excerpt from an in-depth interview with a resident, the gross incompetence of the gynecology preceptor is striking. However, a deeper examination reveals the relationship between patients' intersectional vulnerability and systemic corruption in the Mexican healthcare system. The preceptor intentionally provoked an emergency obstetric situation in a vulnerable 14-year-old patient in order to create a teaching opportunity. In so doing, he was privileging his desire to teach private school medical students over the patient's rights to health. He furthermore betrayed the Hippocratic Oath by directly and purposefully placing the patient's life at risk.

This case highlights the role of intersectional vulnerability of patients, especially when compared to the prior fieldnote regarding the recomendado. The young woman was especially vulnerable given her gender, age, and socioeconomic standing, among others. It is likely that the young woman was also indigenous. However, given the coverup that occurred in the aftermath, very little is known about the patient. The fact that the coverup was so successful—effectively erasing the young woman's identity—is indicative of how efficient, effective, and systematic corruption is in Mexican healthcare. The recomendado, on the other hand, was a man whose

social capital stimulated the redirection of limited resources away from more vulnerable patients and towards him exclusively.

This excerpt reiterates the issue of resource scarcity in Mexican public hospitals—a common theme among all of the excerpts. While the chief of surgery rushes to the case upon hearing code blue, he lacked the necessary equipment to save the young woman's life.

Finally, the excerpt also details how corruption becomes systemic. While the young woman's death was initiated by one person's heinously unethical decision, multiple others were inadvertently implicated in the unfolding of the tragedy, and the entire medical team was complicit in coverup efforts. This universal participation in the coverup effort is justified as protecting "innocent people" from losing their careers, including the gynecology preceptor. However, this justification again underscores the issue of intersectional vulnerability. While the medical professionals are concerned for their careers, the most intersectionally vulnerable individual—the 14-year-old patient—was essentially sacrificed and manslaughtered for the sake of a teaching opportunity. The preceptor's intentional decision to place her life at risk and the medical team's collusion to coverup the circumstances surrounding her death shed light on how certain individuals are privileged and others are disposable.

Rethinking Systemic Corruption in Mexican Healthcare

The topic of corruption has been recently studied by a few transnational-Mexican scholars in the fields of human rights, philosophy, and political science. An interesting question for future inquiry is whether transnational academic training—and therefore, only partial embeddedness within the pervasive logics of corruption in Mexico—correlates with an increased readiness for "breaking the silence" about structural corruption.

Arianda Estévez (a human rights scholar who received her PhD at the University of Sussex and is currently a researcher at the National Autonomous University of Mexico [UNAM]) and Daniel Vazquez (a philosopher who obtained his PhD at King's College London and his MPhil at UNAM, and is currently based at the Autonomous University of Barcelona) have recently co-edited the Spanish language book, *Nine Reasons to (Dis)trust the Struggle for Human Rights* (our translation), published in Mexico. In it, they argue that it is not enough to have adequate laws to regulate political and social processes since institutions and actors tend to exercise their power in legal and illegal ways.

Laura Loeza Reyes, a University of Paris-trained political scientist who, like Estévez, is also currently a researcher at UNAM, notes the steady increase in impunity and corruption (Le Clercq 2018, Loeza Reyes and Richard 2018). She argues that corruption in Mexico is rooted in long-lasting historical-cultural processes that strongly shape the subjectivities of the population (Loeza Reyes 2017). She critiques the "feudalization" of public institutions—that is, the economic capture of the Mexican state by elites. This racialized framework, characterized by crisis and corruption, reveals in its unfolding what Peruvian sociologist Anibal Quijano calls "the coloniality of power" (Quijano 2008). This framework is reproduced through political-cultural practices: certain aspects of culture that justify, legitimize, reproduce, and normalize corrupt acts like those observed in our fieldwork (Galtung 1990; Loeza Reyes 2017).

In essence, illegal and illegitimate sources of power reproduce inequality and social injustice. Loeza Reyes signals that the main victims are the most disadvantaged sectors of society and professionals who are capable of disclosing how human rights violations are reproduced. We use ethnographic evidence to argue for an acknowledgement of how intersectionally vulnerable patients *and* lower-ranking health care professionals are also among

the victims. The rights of patients and their providers are mutually imbricated—systemic corruption disables patients' right to health and, simultaneously, violates providers' labor rights. Resource scarcity in the Mexican medical system has meant nonpayment of wages for providers *and* non-rendering of needed health services for patients.

Systemic corruption has resulted in crippling consequences for the labor rights of health professionals across the Republic. Health professionals are beginning to betray the "public secret" (Taussig 1992) of corruption in the Mexican health care system, and by doing so they are heightening their own vulnerability. Systemic corruption disables the ability of patients to realize their citizenship-based rights to health. Corruption can have fatal effects for patients, especially those who suffer from "intersectional" inequality (Crenshaw 2014).

At the same time, vulnerability is refracted through a social hierarchy. The vulnerability of health care providers, including violations of their labor rights, results in dire consequences for the health outcomes of patients living under conditions of precarity. This relationship is thrown into stark relief when health care providers go on strike to protest corruption, inadvertently leaving impoverished and/or indigenous patients without *any* form of public health care. At other times, the vulnerability of public health care providers is reflected in their interactions with patients (e.g. suggesting that patients visit a private clinic during their moonlighting hours).

Signaling how health care corruption in Mexico has direct economic *and* health consequences for the impoverished population is analytically useful and should not be interpreted as a normative argument that morally condemns health care providers for their actions. While normative arguments are consonant with other disciplines, anthropological research on corruption is uniquely positioned to examine the social context within which corrupt

actions unfold and to analyze how corruption exacts its worst harm on those who are the most vulnerable.

Anthropology is positioned to become a valuable platform for the voices of disparate victims affected by corruption. Ethnographic research reveals how patients and providers are both affected, albeit in different ways, by health care corruption. Moving forward, ethnography can provide "thick description" (Geertz 1973) of how "the violence of impunity" (Loeza Reyes and Richard 2018; Le Clercq 2018) materializes in the Mexican health care system, to the detriment of patients and providers alike. This approach does not erase differential power within the provider-patient relationship. The problem of corruption has deep roots in historical-cultural processes such as inequality and injustice. Future studies on corruption would benefit from including perspectives from a broader array of situated actors—patients, patients' families, providers of different ranks, hospital administrators, policymakers, etc. This approach holds the potential for revealing how experiences of corruption are refracted through a social hierarchy.

[1] The attending is referring to the residents and medical students as *doctorcitos* (which literally translates to "little doctors") in order to emphasize their lower professional rank.

References

Adame, Alexandra, and Roger Knudson. "Beyond the counter-narrative: Exploring alternative narratives of recovery from the psychiatric survivor movement," *Narrative Inquiry* 17 (2007):157-178.

Biehl, João, and Ramah McKay. "Ethnography as Political Critique." *Anthropological Quarterly* 85, no. 4 (2012): 1209-1227. d

Bourdieu, P. "The Forms of Capital." In *Handbook of theory and research for the sociology of education*, edited by J. G. Richardson, 241–58. New York: Greenwood Press, 1986.

Crenshaw, Kimberlé Williams. “The Structural and Political Dimensions of Intersectional Oppression.” In *Intersectionality: A Foundations and Frontiers Reader,* edited by P. R. Granzka, 16-22. Boulder, CO: Westview Press, 2014.

Estévez, Arianda and Daniel Vazquez. *9 razones para desconfiar de las luchas por los derechos humanos.* Mexico City, Mexico: FLACSO, 2013.

Foucault, M. *“Society Must be Defended”: Lectures at the College de France1975–1976.* New York: Picador, 2003.

Galtung, Johan. “Cultural Violence.” *Journal of Peace Research* 27, no. (1990): 291-305.

Galvez, Alyshia. *Patient Citizens, Immigrant Mothers: Mexican Women, Prenatal Care, and the Birth-weight Paradox.* New Brunswick, NJ: Rutgers University Press, 2011.

Geertz, Clifford. "Thick Description: Toward an Interpretative Theory of Culture." In *The Interpretation of Cultures*. New York: Basic Books, 1973.

Goldstein, Donna. “Invisible harm: science, subjectivity and the things we cannot see.” *Culture, Theory and Critique* 58, no. 4 (2017): 321-329.

Gupta, Akhil. “Blurred boundaries: the discourse of corruption, the culture of politics, and the imagined state.” *American Ethnologist* 22, no. 2 (1995): 475-402.

Hamui, Liz. “Experiencia intersubjetividad y sentido: las narrativas en las ciencias sociales y de la salud.” In *Narrativas del padecer. Aproximaciones teórico-metodológicas*, edited by Liz Hamui, Bianca Vargas Escamilla, Lucero Fuentes Barrera, Jessica González Rojas, Tomas Loza Taylor, and Alfredo Paulo Maya, 135-155. Mexico City, Mexico: Manual Moderno, 2019.

Haraway, Donna. “Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective.” *Feminist Studies* 14, no. 3 (1988): 575-599.

Le Clercq, Juan Antonio. “El complejo impunidad.” In *Derechos humanos y violencia en México* [Human rights and violence in Mexico], edited by L. Loeza Reyes and A. Richard, 19-48. Mexico City: Centro de Investigaciones Interdisciplinarias en Ciencias y Humanidades, 2018.

Loeza Reyes, Laura. “Violencia structural, marcos de interpretación y derechos humanos en México” [Structural violence, interpretation frameworks and human rights in Mexico]. *Argumentos* 30, no. 83 (2017): 249-274.

Loeza Reyes, Laura, and Annaliese Richard. 2018. *Derechos humanos y violencia en México* [Human rights and violence in Mexico]. Mexico City: CEIICH-UNAM.

Menéndez, Eduardo L. “Antropología de la Salud en las Américas: Contextualizaciones y sugerencias” [Anthropology of Health in the Americas: Contextualizations and suggestions]. *Salud Colectiva* 13, no. 3 (2017): 353-357.

Nader, Laura. “Up the Anthropologist: Perspectives Gained from Studying Up.” In *Reinventing Anthropology,* edited by D. H. Hymes, 1-28. New York: Pantheon Books, 1972.

Ofrias, Lindsay. “Invisible harms, invisible profits: a theory of the incentive to contaminate.” *Culture, Theory and Critique* 58, no. 4 (2017): 435-356.

Penglase, Ben. “States of Insecurity: Everyday Emergencies, Public Secrets, and Drug Trafficker Power in a Brazilian Favela.” *PoLAR: Political and Legal Anthropology Review* 32, no. 1 (2009): 47-63.

Quijano, Aníbal. “Coloniality of Power, Eurocentrism, and Social Classification.” In *Coloniality at Large: Latin America and the Postcolonial Debate,* edited by M. Moraña, E. Dussel, and C. A. Jáuregui, 181-224. Durham: Duke University Press, 2008.

Scheper-Hughes, Nancy. “Lifeboat Ethics: Mother Love and Child Death in Northeast Brazil.”

In *The Gender/Sexuality Reader: Culture, History, Political Economy*, eds. Roger N. Lancaster and Micaela di Leonardo, 82-88. New York: Routledge, 1997.

Smith-Oka, Vania. "Microagressions and the reproduction of social inequalities in medical encounters in Mexico." *Social Science & Medicine* 143 (2015): 9-16.

Smith-Oka, Vania, and Megan K. Marshalla. "Crossing Bodily, Social, and Intimate Boundaries: How Class, Ethnic, and Gender Differences are Reproduced in Medical Training in Mexico." *American Anthropologist* 121, no. 1 (2019): 131-125.

Taussig, Michael. 1992. *Defacement: Public Secrecy and the Labor of the Negative.* Palo Alto, CA: Stanford University Press.