'We always live in fear'

Antidepressant prescriptions by unlicensed doctors in India

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"We Always Live in Fear": Antidepressant prescriptions by unlicensed doctors in India

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"The only crime is that we have such huge stocks of medicines"

Goutam Ghosh, a Rural Medical Practitioner (RMP), welcomed us to the garage of his house in rural West Bengal. The garage doubled up as a consultation room: his Hero Honda motorcycle was flanked by a desk heaped full of drug blister packs and three cupboards stuffed with medications. A soft-spoken Bengali in his late 30s, Mr Ghosh lived in a village 180km northwest of Calcutta. Comparing himself to other RMPs who struggle to stay out of poverty, Mr Ghosh felt he was doing well: "I have a roaring practice." Asked if he prescribed psychopharmaceuticals, Mr Ghosh said that he uses a range of drugs, including tranquilizers and SSRIs such as fluoxetine (Prozac). He estimated that, on average, one patient a day received an antidepressant drug from him. These patients complained of sleeping badly, feeling low, or not wanting to talk to anyone. SSRI antidepressants were effective treatments, but only if taken for at least three months. Unfortunately, few patients were willing to take drugs for such a long time. Previously he dispensed antidepressants "in large quantities," but people were less keen these days. Mr Ghosh also tried to minimize antidepressant prescriptions because patients needed a continuous, long-term supply, yet the illegality of his RMP practice did not allow him to stock drugs in greater quantities. Officially, RMPs have no license to act as medical prescribers, but in practice the government tolerates them because they fill deep gaps left by the state health system. Even more dangerous than prescribing was storing drugs without the required licenses: "We always live in fear. At any point in time, we might get arrested. The only crime is that we have such huge stocks of medicines without a valid drug license."

This article explores how RMPs in rural India are using antidepressant drugs. Next to nothing is known about if and why informal providers, in India and other poorer countries, prescribe psychopharmaceuticals. This gap in the literature is surprising because both "global

mental health" and "informal health providers" have been thoroughly studied over the past decades. These two fields of research and policy should overlap more, not least since "scaling up" mental health provisions in poorer countries by employing people with minimal training has become accepted policy in the World Health Organization.

The dominant view in global mental health is that there is a deep treatment gap for mental illnesses between developed and developing countries. A WHO report from 2008, called *Scaling Up Care For Mental, Neurological, And Substance Use Disorders* (World Health Organization 2008), calculates the magnitude of this treatment gap. It argues that the global psychiatric treatment gap is "more than 75 per cent." Divided by different types of mental disorders, the treatment gap ranges from 32 per cent for schizophrenia to 78 per cent for alcohol use disorders. Depression treatments shows a gap of 56 percent (2008, p. 7). For India, this report argues that various mental and substance use disorders are causing more than 27 million years of DALYs. This stunning figure means that 2625.3 DALYs per 100,000 population are lost. Juxtaposed to this is the scarcity of trained people who can help: there are only 1.87 health providers per 1,000 population and only 0.31 mental health professionals per 100,000 population. What was urgently needed was a a comprehensive strategy to scale up services.

Given that it was impossible – not even in the distant future – to train enough specialized psychiatrists in these countries, the only solution was to tone down the training requirements and to employ low-skilled health workers. This is called "task-shifting," which is not a shift in tasks, but a shift in *who* is performing tasks: "specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications" (Patel, Koschorke and Prince 2011, p. 11). With basic supervision by a psychiatrist or similar specialist, these low skilled health workers were just as good at diagnosing problems, dispensing

psychopharmaceuticals, and offering behavioral therapy. The "mobilization and recognition of nonformal resources in the community – including community members without formal professional training," was the essential element in delivering services for all (ibid.). Part of this overall strategy is the dissemination of quick guides for low-skilled health workers. In 2010, for example, the WHO published the *mhGAP Intervention Guide*, which contains simple treatment algorithms for depression, psychosis, schizophrenia, and a range of other disorders.

In turn, "informal providers" have attracted substantial research, primarily in global public health, not least because of their sheer ubiquity and quantity. As every study on the topic confirms, informal practitioners are a key resource for people in developing countries, especially for the poor. Definitions of "informal providers" vary across the literature, but there is a consensus on core features. According to Sudhinaraset and colleagues (2013, p. 1), informal providers have not received formal training from recognized medical institutions; they are usually paid directly by clients, in cash and without documentation; they are not registered and operate outside of governmental oversight; and they have either no or only loose professional bodies representing them. The public health research is often pointing at irrational practices of informal providers produced by their insufficient expertise. They also generally emphasize that informal providers fill gaps that no one else fills, and that easy access, affordability, and social closeness are the main reasons why they persist or even thrive.

Reviewing the literature on informal health providers in developing countries from an ethnographic position, Cross and MacGregor (2010) call for greater attention to how pharmaceutical supply chains, from manufacturers down to wholesalers and retailers, are shaping unlicensed prescription practices. Health policy interventions are based on rigid boundaries between experts and non-experts, and it is assumed that the dangers of informal prescribers need to

be counterbalanced by more education and tighter surveillance. Instead of placing "a substantial burden of responsibility for the delivery of health commodities and care on actors who occupy marginal or peripheral positions" (Cross and MacGregor 2010, p. 1599), more scrutiny should be given to the "higher levels of the biomedical supply chain" (2010, p. 1598). This paper examines antidepressant prescriptions by Indian Rural Medical Practitioners in this perspective, highlighting how RMPs are embedded in relations with the government, licensed doctors, patients, medical representatives, wholesalers, and retailers. In this paper, we are also particularly interested in how RMPs' antidepressant prescriptions are located in a complicated set of relations with licensed prescribers, pharmaceutical companies, wholesalers, and drug retailers.

The data presented here are drawn from the collaborative project "Tracing Pharmaceuticals in South Asia" that studied the production, distribution, regulation, and prescription of pharmaceuticals in India and Nepal. We took biomedicine's "magic bullet" paradigm and turned it upside down: instead of starting with disease symptoms and diagnostics, we started with drugs in order to discover what symptoms they are supposed to treat. The three tracer drugs selected were fluoxetine (an antidepressant), rifampicin (against TB), and oxytocin (a hormone to augment labor). Each of them touches on a distinct field of public health concern: mental health, infectious disease, and maternal health. "Tracing" pharmaceuticals meant that we followed these selected molecules around wherever they went. With each drug, this led us to not only to the obvious actors (such as drug producers or prescribing doctors), but also to actors who have so far been overlooked. The discovery that "quack" doctors in India are also using antidepressants results from a methodology that begins with things in circulation. The main research methods were participant observation and 475 semistructured interviews. Among the people we interviewed in West Bengal were 20 Rural Medical Practitioners. Of them, 18 practiced in rural districts north-west of Kolkata,

two of them practiced in poor areas of the metropolitan area. All of them were men, except one. According to the RMPs, there are so few women in this line because they must be on call during the night, and going out alone in the dark is not safe for them.

Our first point of contact with the RMP interviewees was at an All Bengal Meeting of the Rural Medical Practitioners Association (see Ecks and Basu 2009). Other RMPs were contacted through personal introduction or through sensitization events by development agencies. Our questions ranged from the RMPs' work experience to what drugs they use against depression, tuberculosis, and delayed labor. All the interviews were conducted in Bengali, digitally recorded, and transcribed into English.

Career entry and training

The title "Rural Medical Practitioner," with its capital letters and its deceptive similarity to the label "*Registered* Medical Practitioner" of the colonial period suggests that they hold legitimate degrees and certificate. However, RMPs are strictly *not* licensed to practice biomedicine in any form. "RMP" is the title that the practitioners in West Bengal prefer (see Lakshman and Nichter 2000), but popularly they are called *quack* or *hati daktar* ("elephant doctor").

Mr Ghosh, for example, began his medical career when he was still a boy. Back in the late 1970s, he helped a doctor from a nearby village giving hundreds of injections of streptomycin to TB patients. Later, in the 1990s, Mr Ghosh studied for a Bachelor of Science, but failed to pass. Then one of his neighbors had acute diarrhea and had to be taken to a distant government hospital to get a saline drip. He figured that there was no need for people in his village to travel far for

emergency treatments if only he equipped himself with a working knowledge of medicine and a range of essential drugs. He first attended two training days organized by government doctors, then participated in a course organized by the Council of Paramedical Societies that consisted of four hours every Sunday for one year. Later he completed a similar one-year certificate from the Institute of Alternative Medicines. Mr Ghosh found this basic training helpful, but what mattered more was learning by doing daily practice. By making himself available to all patients at all hours, he felt he had become as experienced as any licensed doctor: "In no way are we less than the [licensed] doctors at Bolpur, regarding the treatments that we do. The doctors attend to patients from eight o'clock in the morning to eight o'clock in the evenings. But *our* duty is for 24 hours" (RMP Ghosh).

In her ethnography of unregulated practitioners in the Indian state of Uttar Pradesh, Sarah Pinto defines them as "persons who work on the margins of legitimacy, practicing medicine and health-education … claiming the authority of development and medical institutions but without their formal sanction" (2004: 337). Not all RMPs are necessarily practitioners without licenses, since many of them may have obtained various certificates (George & Iyer 2013). But these certificates neither amount to an official license to prescribe allopathic drugs, nor to act as a stockist or a seller of drugs. Hence it is more fitting to say that RMPs work *across* the margins of legitimacy. An RMP from Howrah District spoke of his constant fear of illegitimacy: "We treat patients, but we have a fear. There is a social insecurity around us. There is a sword hanging over us, all the time. If this sword was taken off, we would be better able to treat people." The Rural Medical Practitioners' Association (RMPA), their main trade union, has been calling on the government for many years to legalize and train RMPs in the interest of public health (Ecks and Basu 2009).

Mr Ghosh's educational background exemplifies how RMPs work across the margins of legitimacy. He took courses from the Council of Paramedical Societies and from the Institute of Alternative Medicines, which gave him a rudimentary level of expertise. None of these certificates, however, would enable him to treat people on his own. The educational trajectories of the other RMPs we interviewed were similarly patchy. One called himself a "RUMP," a "Registered Unani Medical Practitioner," another referred to himself as a "Practitioner in the Rural Belt of the MBBS," others mentioned certificates in alternative medicine, homeopathy, and Ayurveda. These porous boundaries were also evident within families. As "My grandfather was a doctor, plus I had also learned from other doctors. *(Question: Was your grandfather an MBBS doctor?)* No, he was a *kaviraj* (Ayurvedic doctor) and a homeopath. My father did homeopathy and allopathy. At present I just look at allopathy" (RMP Betai). Sometimes senior family members had inspired them to enter this practice, be it a father who was also an RMP, a homeopath, or an Ayurvedic healer, be it by having an uncle who had graduated with a regular medical degree (the MBBS). These senior relatives had taken them on as apprentices. Informal providers not only work across the margins of legality, they also commonly work with "intermingling" medical streams (Khare 1996; Cross and MacGregor 2010: 1596; Bode, 2006; Frank and Ecks, 2004; Nisula, 2006; Datye *et al.*, 2006).

None of the RMPs we interviewed claimed that they became qualified to practice because they took a regulated program of education. Instead, all of them emphasized how they had become experienced in medicine through years of learning by doing. This may have consisted in changing careers within a broader field of healthcare. For example, some RMPs had worked as orderlies in clinics, hospitals, or nursing homes. Others had initially worked in another medicine-related line, be it as a sales assistant in a medicine shop or as a medical representative (MR) for a

pharmaceutical company.

Becoming an RMP was motivated by both "supply" and "demand." Most RMPs said that their initial motivation to join this line was a lack of other employment options. They would have loved to take a regular degree in medicine, but had failed to achieve the course entry requirements. Others had gained a college degree in science or in commerce but could not find adequate employment: "I was worried about economic insecurity. I was educated but unemployed. This is a respectable profession" (RMP Sasumal). They had seen how doctors were much revered, and they hoped that they could win as much respect from the locals.

As Cross and MacGregor (2010: 1594) point out, scholarship on informal prescribers generally assumes that those engaged in unlicensed practice do so for purely economic reasons. However, all the RMPs we interviewed emphasized that they giving selfless service to society. Comparing themselves to MBBS doctors, RMPs stress that they are working at all hours, that they are always on call, that they travel far and wide to help, and that they can better understand what bothers villagers than any other practitioner. If patients did not understand a prescription from a licensed doctor, they would turn to the RMP to explain it.

The RMPs acknowledged that they had less knowledge in medicine than the licensed doctors, but they felt that they could make up for this lack through better rapport: "The Rural Medical Practitioners are the friends, philosophers, and guides of the villagers" (RMP Mitra). They saw themselves as the "mums and dads" (*ma-baba*) of the poor: "The RMPs are practically the villagers' only hope" (RMP Chakraborty). A Branch Secretary of the Rural Medical Practitioners Association (RMPA) said that RMPs were seen as "gods":

> "Anytime and anywhere they see us, they show us respect by calling us *daktarbabu* (revered doctor). If they are given a choice between MBBS and us, they will choose

> us, thinking: 'Because at two o'clock at night I don't get the registered doctor, even if I knock at his door ... They are our close one, they are our god!' They call us god." (RMP Mitra)

The RMPs felt they deserved respect for putting patients' benefit above their own: "I am so popular and have such a good practice. There is a social bond. These big doctors don't have it. Their bond is not such" (RMP Alam). One RMP was proud to say that "sym-pathy" was the highest form of healing: "There are many kinds of -pathy -- homeo-pathy, allo-pathy -- but we need sym-pathy above all. We think these village people don't get sympathy. Sympathy is the first thing we give and that is why they love us so much" (RMP Nimdegi). Styling themselves as champions of "the people," many RMPs subscribed to a peculiar type of Maoism. Bringing health to those in need, with or without a proper license to do so, was portrayed as part of a revolutionary struggle for social justice (Ecks and Basu 2009).

RMPs rarely mentioned conflicts with patients. They generally said that they tried to minimize risks to the patients, and by extension, risks to themselves. They would always refer difficult cases to licensed providers. They acknowledged the limits of their own expertise and only wanted to apply treatments they were confident of. Several RMPs mentioned how they used to put the title "Dr." in front of their names, but do not dare to do so anymore, because it heightened the risk of getting into trouble with patients and the police. The RMPs' position on the margins of legitimacy made them *more* risk-averse than legitimate doctors. When asked about the most pressing challenges he was facing in his everyday practice, an RMP replied that they were trying to avoid "challenges": "We don't have degrees. We don't *want* challenges. We want that the people who love us should benefit from us. What we can't do, we should not take it up as a challenge" (RMP Nimdegi).

If local people turned against an RMP, the police would not be there to protect him. The formation of the RMPA was partly motivated by a sense of threat of attacks from patients and their relatives. Without protection, RMPs could be lynched: "Suppose I make a mistake and the patient dies, I will be blamed for it. The patient's relatives will pin me down and do whatever they feel with me. But if there is a union, they will lodge a case against me" (RMP Subhendu). Unionization does not make the RMPs impervious to patient protests, but at least it could channel it toward non-violent forms. On the other hand, support from the local people protects them against onslaughts from "above": "The villagers will protest if anybody does anything to me. Because, if they call at two o'clock in the morning, it is I who will go. Who else would they get?" (RMP Pal).

Relations with licensed doctors

Many of the RMPs said they had "trained under an MBBS doctor." This training consisted of receiving patients, managing waiting rooms, ordering drug samples received from medical representatives, running errands, or clarifying the details of prescriptions. Several reported that they had attended training events that MBBS doctors had organized in their own spare time, usually on Sundays. Some of them mentioned qualifications that might allow them to prescribe biomedical drugs even though the primary training was in other stream.

Many regular doctors respected them. When we asked an RMP if the doctors in a nearby government hospital might sometimes criticize his prescriptions, he said that this never happened: "No, I have never seen that. My prescription is attached to theirs" (RMP Shubodh). As some of them also said, errors are common in medicine, and just as the RMPs are making errors in diagnosis and treatment, so do the licensed doctors.

All RMPs are happy if they can establish good relations with licensed doctors. "Good relations" were explicitly linked to the RMPs' insecure legal position. Moreover, as mentioned above, many RMPs receive their initial medical training as assistants to MBBS doctors, hence many prefer to fashion this relation as one between *guru* (teacher) and disciple: "We have a lot to learn from them. They are our *gurus*. We see and learn from them. We have our main *gurus* ... We need to learn as long as we live" (RMP Nimdegi). RMPs spoke about how happy they were when a licensed doctor praised them for a treatment they had given. An RMP told us how he once treated an acute case of stroke before bringing the patient to a cardiologist. As he later learned from the patient, the cardiologist asked for the RMP's name and commended him for handling the situation well: "My heart filled with pride on his praise" (RMP Shubodh). Since many RMPs receive basic training from MBBS doctors, it could be argued that licensed practitioners are also working across the boundaries of legitimacy.

The RMPs were motivated by an unmet demand for primary healthcare. The lack of medical services in the villages left a large gap for the RMPs to fill. The RMPs estimated that in the rural areas there are ten times more RMPs than licensed providers (see Ashtekar and Mankad 2001). The government services were also deficient. One of the RMPs said that he wanted to become a medical practitioner after seeing his father die in the government's Primary Healthcare Centre (PHC) because they did not treat him: "There are lots of examples that close relatives died without any medical treatment … There was a PHC within one kilometer from my house but there was no treatment there. Absolutely nothing!" (RMP Sasumal). Given this weak medical infrastructure, the RMPs saw no competition between themselves and licensed providers.

RMPs were proud to say that some of their patients traveled from several kilometers away to see them even though a PHC was much closer to where they lived, simply because they had

more "faith" in the RMPs. Staff in government facilities was perceived to be particularly callous. The doctors there were frequently absent and negligent. Staff in government hospitals was often suspected to be involved in corrupt practices. For example, one RMP described how hospital staff tried to get kickbacks from private diagnostic laboratories. When a patient needed a diagnostic test, hospital staff would tell them that the free in-house facilities were currently not available, and that tests had to be done in a private lab. Often these private labs would not carry out proper tests, but simply print a fake report to save costs. The spoils from this corrupt nexus were shared between hospital staff and laboratory staff. Despite deep distrust in government facilities, RMPs referred cases they could not handle themselves to them, for lack of better alternatives.

Despite the RMPs' emphasis on "good relations," they also reported that MBBS doctors scorned them as "quacks." Disdain might be expressed by an individual doctor who receives a patient previously treated by an RMP and then "rubbishes" whatever they have done: "They insult us. They throw our prescriptions away." A few RMPs felt that the licensed doctors were applying standards to them that were unfairly high. A doctor should not complain about RMPs if he got them through the night and into a hospital alive, even if the RMPs could not do all that would have been best practice to do. Licensed derision of RMPs also came in an organized form through the professional associations of the licensed doctors, such as the Indian Medical Association (IMA): "The IMA makes comments against us. And they try to tell patients that we don't know anything. They try to insult us like that" (RMP Nimdegi).

In turn, the RMPs criticized college-trained doctors for being unwilling to make themselves available to all the people in need. The MBBS doctors were too haughty to reach out rural patients. MBBS doctors put financial gain above the good of society. They assessed how much a patient would be able to pay, then prescribed the most expensive drugs possible: "The

doctors ask patients how many mango trees they have. They want to gage how much the patient earns" (RMP Chakraborty).

The pharmaceutical gift cycle

Wherever pharmaceuticals circulate, commodity transactions are interspersed with gifts and favors. For the US setting, Michael Oldani (2004) analyzed this as a "pharmaceutical gift cycle," a three-way exchange between medical representatives, doctors, and patients. Indian Rural Medical Practitioners are also embedded in multi-sided gift cycles, which are even more complex than in developed countries because they are regularly occurring across the boundaries of legitimacy. Informal prescribers are ensnared in a competitive market that requires those without licenses to offer goods and services that set them apart from their legitimate counterparts.

Fees are the main source of income for licensed doctors. Many RMPs also charge fixed consultation fees, but it is more common to give a "free" consultation and charge a marked-up price for the medicine dispensed. The RMPs had different opinions about the ethics of prescriptions for fee payments, as opposed to dispensing medicines with implicit fees. Some felt that charging only for the medicines seemed fairer; others thought that writing prescriptions for a service fee was more professional and less fixated on money.

Deferred payments by patients are common. Indeed, this type of credit relation between patients and unlicensed prescribers has been documented in other developing markets (e.g., Bierlich 1999; Hughes 2012). Many RMPs estimated that in about 70% of all consultations, patients would either pay nothing right away, or only pay a part of their dues. Only in 30% of consultations, patients would pay up in full right away. Often patients received diagnoses and

drugs on credit for up to six months. It happened that patients never paid their dues, but RMPs said that they try to give their services for free to the poorest. Cash-strapped clients might offer to pay with household items, yet such barter should always be declined because it only deepened poverty: "At times they try to give us our fees by selling cooking utensils. We don't take that. We tell them to give us our fees the day they can without selling anything. That is why we are so close to the village, the people" (RMP Nimdegi).

Free drug samples handed out by medical representatives are vital ingredients in the pharmaceutical gift cycle. Just as there is a hierarchy among licensed doctors in regard to how popular they are with pharmaceutical companies, there is also a hierarchy among RMPs. Those at the bottom are never visited by medical representatives and never receive samples. Being ignored by MRs was not necessarily down to low prescription volumes. One RMP mentioned that he prescribed drugs from Sun Pharmaceuticals worth 250,000 rupees ($4,560) per year, but that this was still not enough to make their MRs come to visit him: "Their representatives never pay me a visit. But because their products are effective and low-priced, I use them" (RMP Ghosh). On the next rung up are RMPs who receive representatives from small manufacturers, but not from the bigger companies. Visits from those manufacturers did not mean that an RMP would always be swayed by their sales pitch. Some said that they received visits and samples from regional companies but that they still preferred to prescribe bigger brands, mainly for concerns about safety and efficacy. On the third rung of this hierarchy are RMPs who get visited by the entire range of manufacturers, regional, all-India, and multinational companies. This group of RMPs still has not reached the top yet because to them the big manufacturers only pitch products that are becoming obsolete among the licensed prescribers. This includes drugs that are becoming less fashionable among trained doctors, as well as substances that are banned: "They mainly promote old products

and a number of unnecessary medicines. For example, Nimesulide [an anti-inflammatory drug], it is a banned drug, but we have seen that a number of representatives come to us with this drug" (RMP Chakraborty). Finally, at the top of the hierarchy are RMPs who receive MRs from all companies, with all products, including newly launched molecules: "All of them come here: Cipla, Ranbaxy ... all those who come to visit the hospital turn up at my place" (RMP Pal).

Participant observation with medical representatives showed that they approached RMPs with the same sales pitch they had prepared for licensed GPs. For example, we once spent a day shadowing Ashok Das, an MR for Shine Pharmaceuticals Ltd., a mid-sized company from Gujarat with a specialization in psychopharmaceuticals. When visiting RMPs, Mr Das waited patiently for his turn. When called, he first presented an antipsychotic, then moved on to Shine's brand of fluoxetine, called Flumod. He showed how Flumod is available in two dosages, 10mg and 20mg. Mr Das kept repeating that Flumod was "very safe," that it had "no side effects," that all the other doctors were using it, and that this product was doing extremely well in the market. Afterward he pulled out information on three more types of drugs produced by his company, one anti-epileptic, one anxiolytic, and one sleeping pill. Before leaving he left samples of Flumod with the RMPs.

When we asked about the legal status of RMPs, Mr Das said that they were "definitely registered with some universities," and that they had to have one form of qualification or another. Reflecting on his interactions with RMPs, Mr Das said that he was often confused about the exact differences between them and regular doctors: "He [RMP] knows so much and comes across as so well qualified that we get confused if he is a GP or an RMP." Be this as it may, visiting RMPs was standard practice for all pharmaceutical companies: "We think visiting them is very important for our sales. They prescribe a lot of medicines and make for a huge part of our sales output" (MR Das).

Free drug samples open a range of possible exchanges between RMPs, their patients, and licensed doctors. Samples can be handed out by RMPs to poor patients free of charge, which allows them to enhance their standing in the community. RMPs can feed samples into their regular stocks of medicines for dispensing. This allows them to gain an additional income. In exchanges between RMPs and licensed doctors, samples can be transformed either into gifts and or into commodities. According to the RMPs, there were a handful of licensed doctors who gave their samples as gifts to RMPs to support their front-line services in poor rural areas. More commonly, however, doctors were selling the samples they had received as gifts to the RMPs. The RMPs resented doctors exploiting their position in this way: "They insult us downright. I feel like telling them that, because *we* exist, *you* are earning by selling us your free samples. You would not be able to sell the medicines in the open market" (RMP Shubodh). Still, the RMPs appreciated that licensed doctors who passed on samples to them also passed on vital drug information: "We mainly observe the work of our *bosses* [i.e., licensed GPs]. Sometimes we see medical representatives visiting them, so we hear about their products" (RMP Shubodh).

Floating prescriptions

By crossing the boundaries between legitimate and illegitimate prescribers, free drug samples are feeding into the phenomenon of "floating prescriptions" (Ecks and Basu 2009). Marketing people in India use this term for drug prescriptions that "float" among patients, shops, licensed and unlicensed prescribers. In South Asia, prescriptions written by a doctor always stay with the patient. When a retailer fills a prescription, he neither keeps the original paper, nor leaves a mark on it to indicate that the drug has been dispensed. This makes it easy for patients to get

drugs as often as they want. Prescriptions contain the patient's name and the date of the consultation, so it would be simple for retailers to deny filling prescriptions that are older than a few weeks. In practice, however, prescriptions stay with the patients and are used repeatedly. Indeed, not even a written prescription is required: patients commonly bring emptied blister packs or bottles to shops and ask for a new one of the same kind. When other prescribers get to see previous prescriptions, they learn about the patient's medication history and about the prescribing styles of other doctors. Floating prescriptions establish certain types of medications as "normal" treatments, and individual brands as "trusted" brands. Playing on the suggestive power of "trusted because widely used," the MR promoting Shine's Flumod emphasized that their brand is "doing very well" in the market.

Given their legal insecurity and deficient training, RMPs rely on floating prescriptions as a major source of drug information. There are instances when patients show other doctors' prescriptions to them deliberately, to ask the RMP to explain it to them. Good rapport with RMPs motivates patients to ask for their advice. For example, patients come to ask for advice on dosage and side effects. RMPs also said that they sometimes encouraged patients to consult a licensed doctor so that *both* could learn what to prescribe: "I send the patient to a medical specialist. And I ask him to bring that prescription back to me: 'I can't figure out the problem. If you show me the prescription, I will know. Even I need to learn'" (RMP Nimdegi).

Upon seeing floating prescriptions, RMPs can check commercial drug reckoners for how the medicine should be used. Drug reckoners such as *CIMS*, *MIMS*, or *Drug Today* are cheaply available books that list molecules, indications, dosages, side effects, available brands and retail prices: "We see that this is a new drug that has come out. Then we look up that drug in the CIMS India book, for what is this drug about and when is it used. Like this we get to know" (RMP

Chakraborty). If an RMP has good relations with a licensed doctor, he might even discuss the case with him: "We can ask: 'Sir, why was that medicine given?' We spend a lot of time with them and try to find out" (RMP Mitra).

Floating prescriptions are only possible because of the lax regulation of drug sales from retailers. In India, drugs are classified by different "schedules." Some of them allow over-the-counter sales without prescription; others demand that a drug must only be dispensed on the prescription of a licensed doctor. Some drugs, notably opioids, not only require a prescription, but also need to be entered into a ledger that the drug controllers can check. As "Schedule H" drugs, antidepressants are by prescription only. In practice, however, prescription-only medicines can be bought from virtually every shop without a prescription (Kamat and Nichter 1998). This is another example of how the unlicensed drugs market is only possible because of the collusion of the licensed sector. Legitimate players are reaching across the margins of legality as frequently as an illegitimate players reach into legality.

Licensed medicine retailers in India fill the prescriptions by RMPs although they are illegal. Given that the retailers can earn from the RMPs, they usually do not mind their custom: "It is very cordial. There is no problem … if I had not been there, how would he have sales? He gets the prescriptions from me" (RMP Pal). The retailers also act as drug suppliers to unlicensed practitioners. According to the RMPs, they procure many of their medicines from these shops. Their advantage of going to a retailer is that shops can be found far and wide even in the rural areas, and that specific drugs can be bought in small quantities. The disadvantage of procurement through retailers is that the RMPs' profit margins are lower. All the RMPs we interviewed said that the retailers did not reward bulk purchasing. Instead, the RMPs had to pay the recommended retail price that patients also have to pay. Moreover, the RMPs said that they had to pay the retailers in

cash and did not get supplies on credit. In this way, the RMPs have to invest in drugs that they might have to dispense on credit.

Hence the RMPs have a financial incentive to bypass the retailers and to procure drugs directly from wholesalers. It is just as illegal for wholesalers to sell to RMPs as it is for the retailers, but as elsewhere, they facilitate illegal practices (see Bloom 2011). Wholesalers' supplies to RMPs also fuel conflicts between RMPs and retail shops. Wholesalers sit in the market towns and supply villages in a radius of up to one hundred kilometers. Depending on an RMP's turnover and on his distance from the market towns, he may either travel to the wholesalers himself or place orders through a middleman, usually once a week. The main advantage of these supplies is that the RMPs get wholesale prices. Wholesalers also offer various incentives. For example, they give extra for bulk orders ("buy 10, get 2 free"). For established RMPs, the wholesalers also give supplies on credit: "If you deal in medicines for the whole year, you get it on credit, which you have to clear in March" (RMP Ghosh). Wholesalers give receipts for what they sell and allow RMPs to return products that have come near the expiry date. However, some wholesalers do not give receipts for certain drugs, because there might be "problems" with them and the wholesalers do not want to be made responsible in case of adverse effects. Whenever receipts are denied, it is likely that the drugs in question are fake or of substandard quality.

Keeping an array of essential medicines is a hallmark of the RMPs. One compared keeping drugs in his chamber with keeping tools in his car for a road trip: "If you go somewhere in a car and it stops working, and you don't have any other transportation in that remote place, how will you feel? If I don't have to medicine for treating my patient, I will also feel like that: equally uncomfortable" (RMP Shubodh). Heaps of drugs around a chamber is a common sight. Where GPs rely more on prescriptions and do not keep many medicines, RMPs tend to stock up. In

consultations with patients, RMPs would sift through piles of pills and tables on their tables and pull out whatever packet they were looking for. Keeping medicines at the ready gave them a competitive edge over regular licensed doctors.

Yet stockpiles of drugs are a source of anxiety. To write prescriptions and to send patients to medicine shops was seen as less risky than stocking drugs. RMPs encroach on the territory of licensed doctors, but the police usually intervene only when an RMP is accused of serious malpractice. That RMPs encroach on the territory of licensed retailers causes them more trouble. For example, Mr Ghosh said that near his village were six medicine shops. All of them had spent money on obtaining a license, but all of them had a lower turnover than he: "My sale of the day exceeds their total sale of the day … so they have a grudge against me." His supplies were worth 100,000 rupees ($1,825). Up to now, he had not been threatened directly, but he feared that it might happen in the future. The Bengal Chemists and Druggists Association (BCDA), a powerful trade union of licensed distributors, wholesalers, and retailers, had stepped up their campaign against rural quack doctors that double up as dispensing pharmacists: "We did not face this in the past. Now we sometimes get threats." By cutting down the use of drugs that need to be taken continuously, such as antidepressants, in favor of essential medicines for acute diseases, Mr Ghosh hoped to minimize the risk of getting attacked by retailers.

There is an ongoing tension between the retailers and the RMPs. In the mid-2000s, the BCDA advised the wholesalers to stop all drug supplies to RMPs. Against their business interests, the wholesalers heeded the BCDA's directive. Soon, however, an effective opposition to this new policy was formed. The RMPA lobbied the BCDA to return to its former stance toward unlicensed prescribers. The West Bengal *panchayats* (village assemblies with executive powers), also turned against the BCDA and demanded that RMPs should be supplied with medicines as before: "They

put pressure on the BCDA by stating that when a villager requires medicines at night, who do they call? You cannot stop the supply of medicines just like that" (RMP Ghosh). Then Somnath Chatterjee, a politician who was Speaker of the Lok Sabha (the lower house of the Indian Parliament), a leading member of the Communist Party of India (Marxist), and Chairman of the Santiniketan Sriniketan Development Authority (near Bolpur), demanded that the wholesalers should continue supplying the RMPs. Faced with so much political support for the RMPs, the BCDA rescinded its ban. Despite this temporary victory, the RMP's legal standing remains shaky.

In theory, any RMP can legalize his position by obtaining a government license for stocking medicines. Yet in practice, the RMPs do not have the resources to do so. For a license, one needs to take many trips to the Drug Control Office in the relevant district town, which can be a long journey. One needs to wait up to three years until a license comes through. One also needed to hire someone with a degree in pharmacy. And finally, one needed to be inspected yearly by an official from the Drug Control Office. Mr Ghosh reported that one of his acquaintances had obtained a wholesale license. The total cost for this license was 55,000 rupees ($1,000), including all the expenses necessary along the way. At some point Mr Ghosh had also started the application process, but then decided that it was too expensive and too much hassle. So far, the Drug Inspector had not interfered with his practice, but the fear of the future remained: "In case he catches me, we'll see what he does" (RMP Ghosh). Reducing medical stocks helped in reducing one's exposure to government officials and retailers.

Antidepressant prescriptions

Floating prescriptions are the primary source of knowledge about antidepressants for the

RMPs. The most common path of learning is that patients bring prescriptions from licensed doctors that contain an antidepressant, then the RMPs look up the drug information in a manual and perhaps ask a GP or retailer for advice, then they gradually build up the confidence to prescribe antidepressants themselves. The RMPs were also influenced by pharmaceutical marketing through MRs, yet none of the RMPs reported this as their initial exposure to antidepressants. If MRs are mentioned, then only after the floating prescriptions: "[We learn from] books. And later we learn about it from the representatives. And we also know doctors who write it, we take their advice" (RMP Betai).

When asked how they diagnose "depression" among their patients, RMPs mentioned a range of symptoms. Many somatic complaints could be read as symptoms of depression, such as insomnia, weakness, stomach pain, "gas" in the belly, burning and pressure sensations in the head, dizziness, lack of libido, talking too much, or talking too little. None of the RMPs used terms like "somatization," but most of them connected physical symptoms to mental problems: "Many patients complain about other things and then we find that it is [depression]. They complain of insomnia, get irritable while talking to others, their thinking changes, they show symptoms of other diseases, but on investigation, we find that this disease is not really there" (RMP Kotal). Not all depression had "mental" origins, however: chronically low moods could be a symptom of deficient nutrition and anemia (see Kohrt and Harper 2008). Anemia could also result from a worm infestation, hence some of the RMPs' first-line approach to symptoms of "depression" was to prescribe deworming medicines and iron tablets.

The boundaries between "depression" and other forms of suffering were not well defined, however. Depression was commonly linked to "tension" (*cinta*). Depression could be found side-by-side with tension, or chronic tension could slide into depression. Perhaps mislead by the

similar-sounding labels, many RMPs also associated "tension" with *hypertension*, and identified high blood pressure as a form of psychosomatic suffering. In turn, *hypertension* appeared related to *hyperacidity,* so that digestive problems were typical symptoms of mental anxiety. On the whole, familiarity with mainstream biomedical terms was unevenly spread among the RMPs, with some of them giving the same answers that an average Bengali GP would give, and with others who knew next to nothing about it.

The RMPs had various opinions about the epidemiology of depression. Some RMPs estimated that they get one depressed patients per week only. Others said that "20-25%" (RMP Sasumal) came with depression. "30%" were prone to anxiety and tension (RMP Nimdegi). One RMP, Mr Alam, even held that "80%" of his patients were suffering from depression. Estimates of the rates of depression in the population varied widely among RMPs.

There was a clear consensus that depression was increasing. Not one RMP suggested that people were more often depressed in the past, or that anyone was feeling happier in the present era than earlier. Today's life was unequivocally perceived as more depressing and stressful than earlier days. Depression was identified as a side effect of modernization and socioeconomic change: "A recent addition to the list of diseases has been depression. It has reached frightening proportions" (RMP Malla). People were depressed about their economic situation: "Anxiety, depression is increasing. It is mainly because of the economic situation. This is our analysis and we are sure of this conclusion. In my 15 years experience, I have seen the number of patients coming with such problems has increased" (RMP Sasumal). Several RMPs saw a correlation between poverty and depression, with depression hitting the poorest the hardest.

In contrast to the strong consensus on the socioeconomic roots of depression, the RMPs had mixed feelings about treating low moods with drugs. They generally thought that depression is

an illness that needs treatment, but many of them were not certain what treatment might be successful: "One cannot do much about depression patients" (RMP Alam). Nevertheless, RMPs who used antidepressants said that these drugs could alleviate depression caused by socioeconomic strains at least over a short period: "I don't think this problem [depression] can be solved with medicines. The cause is socio-economic. But we use medicines to take care of the symptoms" (RMP Ghosh).

Faced with uncertainty, the RMPs reflected on whether they should treat depression themselves or refer patients to trained doctors. More than half of the RMPs preferred to treat initially: "If anyone wants to come, they should come. I can give basic treatment" (RMP Chakraborty). The others thought it better to refer immediately. RMPs preferring initial treatment identified depression as a minor mental illness and the available drugs as safe to prescribe. "Serious" cases of madness, including schizophrenia, always needed to be referred: "We don't try to treat proper psychiatric cases, like schizophrenia. We just see primary cases like mild depression" (RMP Amta). Many RMPs expressed how they were careful not to stray into to medical territory that they did not know. Their Association, the RMPA, had also advised them only to use drugs that they were confident of, and if they treated mental illness, they should only use drugs at "safe" dosage levels. In line with popular Bengali notions of how to deal with low moods (Ecks 2013), several RMPs talked about how they first applied non-pharmacological approaches: a bit of counseling ("don't worry too much"), a bit of advice on how to solve the underlying problem, and a bit of religious instruction ("try praying").

Surprisingly, the RMPs rarely mentioned using tricyclic antidepressants (TCAs), such as amitriptyline. TCAs are an extremely common first-line drug for depression treatments in rural India. But among the RMPs of West Bengal, amitriptyline seems to play a relatively minor role.

Instead, the RMPs' first-line drugs for symptoms of depression are benzodiazepines, especially diazepam (Valium), alprazolam (Xanax), and lorazepam (Ativan). The chief idea is that worries lead to insomnia, and ongoing insomnia leads to depression. In this way, benzodiazepines are primarily used to avoid that a patient develops chronic problems. Benzodiazepines were regarded as appropriate for all kinds of patients. Tranquilizers were best at "keeping the brain cool" (RMP Shubendhu), which made them suitable for a range of mental problems. Most RMPs knew the habit-forming risks of benzodiazepines: "Once the patient is on medication, it cannot be stopped" (RMP Kotal). Because of their sedative effects, benzodiazepines worked best when given in the evening. Since the RMPs could hand out benzodiazepines from their stocks in the evenings, they preferred dispensing to prescribing.

RMPs found SSRIs "safer" than either benzodiazepines or TCAs. In fact they were safe enough to be prescribed chronically: "You can give lifelong" (RMP Alam). SSRIs could have side effects, however, including migraine and impotence. For safety and efficacy, it made a difference what brand was prescribed, with "generics" being less effective than big brands. Fluoxetine was a "good" drug for patients who did not have trouble sleeping.

It needs to be emphasized, however, that RMPs did not distinguish very clearly between different groups of psychopharmaceuticals. We were often told, for example, that SSRIs were a kind of "sleep medicine." Hence it is difficult to determine from our interviews with RMPs if they saw SSRIs as addictive as benzodiazepines. Yet one problem that was only mentioned in relation to SSRIs, but not to benzodiazepines, was that patients stopped taking them before the course is over. Benzodiazepines do not have a "course," whereas SSRIs — similar to antibiotics — should be taken for a certain minimum period. Asked for how long he usually prescribed fluoxetine, RMP Ghosh said that it was hard to convince patients to adhere:

"As soon as I say that the medicine has to be taken for three months to cure, at once they say: 'It is such a bother to take the same medicine for three months. How can we continue for so long?' They will take it for ten, fifteen days, up to a month, and as soon as they start feeling a little better, they discontinue … their reaction is: 'Who will take so many medicines?' This is their mentality" (RMP Ghosh).

Poorer patients were always eager to see quick results. Medicines that took too long to work made patients criticize the RMPs for selecting the wrong drug. Licensed doctors had more authority to convince patients that it might take a few weeks until symptoms alleviated. This pressure from patients made SSRIs less attractive compared to fast-acting benzodiazepines. The cost of long-term treatments had to be considered as well, before a prescription was made: "We see the patient's condition before prescribing. We give it to those in jobs, government employees, businessman- those who can continue" (RMP Sasumal).

Conclusion

Public health research on informal providers tries to assess therapeutic competency and to formulate policy recommendations on how to improve quality of service (Sudhinaraset *et al.* 2013). It would be fairly straightforward, by way of conclusion, to do the same here. As we have shown, Indian RMPs are informal providers who are already using a range of antidepressants in their daily prescription practices. They have easy access to all forms of psychopharmaceuticals and, unless there were fundamental changes in the supply chain, unlicensed doctors will continue to use these drugs. The Indian government pursues a policy of keeping RMPs outside the margins of legality, but at the same time tolerates them working across those margins as long as there are no

complaints brought against them. The more serious obstacles that the RMPs face do not come from the government, but from rivals within the wider private sector. Licensed allopathic doctors maintain a range of different links to the unlicensed RMPs which can change from friendly to hostile according to different people and to different situations. As crucial as relations to doctors in the formal sector are the RMPs' relations to drug wholesalers and retailers. On the one hand, no RMP could practice without the collusion of the wholesale sector, which supplies the RMPs with all the drugs that they request without questions asked. On the other hand, RMPs often assume a rival position to licensed drug retailers, making the RMPs constantly threatened by trade organizations that represent both the retailers and the wholesalers. Mr Ghosh, for example, has reduced is use of antidepressants primarily because he is living in fear of stocking these drugs in his garage without a wholesale or retail license. Hence a policy recommendations could suggest that the distribution of psychopharmaceuticals should be more strongly controlled by the government, and that private sector groups such as the wholesaler and retailer lobbies are helped in their campaigns against unlicensed providers.

Another set of policy recommendations could emphasize the need for "more education" of unlicensed providers to minimize irrational prescriptions. Currently, RMPs receive no proper training. Their knowledge is derived from an eclectic mix of learning by doing, occasional contact with licensed doctors, "floating prescriptions" patients bring to them, and short courses in paramedical or nonbiomedical subjects. Many RMPs are prescribing on the same level of competency as licensed GPs. They seem to have a good notion of how to diagnose depression, including somatized depression, and they know the basic medicines recommended in biomedicine. They know that SSRIs are supposed to be taken for a minimum duration and try to encourage their patients to adhere to the regimen.

Obviously, they also make mistakes, such as equating anxiety with hypertension, or believing that tranquilizers "keep the brain cool" and are the best first-line treatment for symptoms of depression. The RMPs already have ties to licensed doctors, they take to read drug reckoners when they see a floating prescription for a drug they do not know yet, and they are very willing to refer cases to licensed doctors that they are not sure of. Above all, all the RMPs we have met are eager to receive approved medical training. Their perilous legal position makes them circumspect and weary of retributions from patients if they make mistakes. RMPs are illegal practitioners, but they would much rather be legal practitioners, and they jump on any opportunity to make their work legitimate. If the WHO offered training in mental health treatments, the RMPs of rural West Bengal would probably embrace this with open arms.

However, in this paper we do not want to make any such policy recommendations. Firstly, we are approaching antidepressants from a position of doubt about their efficacy, and the last thing we want to do is to advocate the further dissemination of drugs that potentially do more harm then good. We do not want to advocate "rational" uses of antidepressants if the entire class of drugs might well be proven to be irrational (Tyrer 2012). Secondly, medical anthropologists are in the privileged position to avoid the pressure to justify research only through its uses in health interventions.

Thirdly, hasty policy recommendations might obscure other, more profound questions arising from the position of RMPs in WHO strategies. One of these questions is why there seems to be a culture of "strategic ignorance" (McGoey 2012) among policymakers about informal providers. In all its calculations of the so-called treatment gap, the WHO does not only exclude informal providers from its statistics, but it also excludes the entirety of the formal private sector. For India, treatment gaps are calculated as if no private doctor ever prescribed

psychopharmaceuticals, when in reality at least 90% or more of all psychopharmaceuticals are prescribed by private practitioners, both licensed and unlicensed. We suspect that there is no thorough engagement with informal providers in view of including them into strategies of "scaling up" mental health services because these strategies sound more compelling if the people who are supposed to carry out diagnoses and therapies are innocuously called "non-formal resources in the community," decontextualized and without any agenda of their own. Policymakers want to co-opt informal providers such as the RMPs without having to acknowledge their illegality, and without having to take on any responsibility for a campaign gone wrong.

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