Companionable thinking

Veena Das

Abstract

The paper takes up three themes that emerge from the commentaries on the book, *Affliction: Health, Disease, Poverty*: (a) the relevance of neighborhood as the right scale at which to render the relation between health, disease, and poverty; b) the ordinary as an interrogation of the normal; and c) the relation between subjectivation and subjectivity. Knitting together the qualitative and the quantitative as well as advocacy and research, this essay comments on Georges Canguilhem's notions of the normal and the pathological, and of disease as an experiment with life. It also provides a commentary on the default position often assumed in the literature on subjectivity that treats it as the residue, as that which subjectivation cannot encompass. These different themes are joined within an overarching question: how do we learn to see ethnographically what is before our eyes?

Keywords

I am grateful to all the commentators featured in this special section, first and foremost, for recognizing and honoring the ethnographic impulse in my book *Affliction: Health, Disease, Poverty* (Das 2015) and making the book their own by extending its insights and arguments

within the milieu of their own writing, research, and practice.[1] I am particularly grateful for the quality of listening that each of the writers brings to their comments and to Clara Han for her remarkable 'catching' of the moments that appeared in discussions on the book, both here and in the double panel she organized during the American Anthropological Association meetings in 2015. Bhrigupati Singh, too, provides a window into the way that affects such as excitement and curiosity circulated in the seminar room at the All India Institute of Medical Sciences in Delhi where a group of practicing psychiatrists engaged in a discussion of *Affliction*. It is not easy to create the conditions under which scholars absorbed in different ways of pursuing questions that might seem similar can listen to each other; Bhrigupati Singh and Pratap Sharan showed me how conditions can be created for the possibility of such fruitful conversations. Richard Rechtman's essay captures the echoes of a memorable discussion at the Sorbonne in a workshop organized by Sandra Laugier, in which philosophers, anthropologists, and psychiatrists addressed each other. The texts and my response are then fragments of many different experiences of what Andrew Brandel (2016) calls the 'scenes of conviviality'. Within these scenes, I also count some literary characters as my companions.

In Fredrik Backman's (2015) remarkable novel, *my grandmother asked me to tell you she's sorry*,[2] Elsa, the seven-year-old (almost eight) protagonist whose point of view the narrator takes, is having a terrible night. Her grandmother is dead and she is not able to get into the 'Land-of-Almost-Awake'. The most troubling part of Elsa's dream is that she can see this land clearly as if from above, as if she is lying on her stomach on top of a huge glass dome, peering down at it, 'without being able to smell any smells or hear any laughter or feel the rush of wind over her face when the cloud animals take off. It is the most terrifying dream of all the eternities' (Backman 2015, 182).

The ethnographer is sometimes like this child who needs the guiding hand of someone in the land in which they sojourn to be able to smell the same smells and feel the same wind blowing, to let the body absorb the sights and smells and small chatter that is everywhere. Both Michael Fischer and Richard Rechtman seem acutely attuned to this sensory knowing,

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[2]   The title is set in lower case, consonant with the small voice of the child.

but, as Koushik Sinha Deb, Swarndeep Singh, and Shalini Singh,[3] as well as Michael Fischer, observe, there is a quantitative data set that my colleagues from the Institute of Socio-Economic Research on Development and Democracy (ISERDD) and I have worked to produce, and from which *Affliction* draws consequences of some weight. As Bhrigupati Singh astutely argues, there are no sharp boundaries between the qualitative and the quantitative in the text. In fact, I find that the catchall phrases 'qualitative' or 'quantitative' often bear traces of proposal writing rather than acting as serious methodological signposts.

If the ambition of *Affliction* was to make the lives I encountered 'knowable', this involved complicated interaction between first-person, second-person, and third-person perspectives. Listening to stories, observing the unfolding of gestures, catching the murmur of conversations, as well as measuring and counting might all be regarded as part of the form of life we call 'research', affecting everyone who came in contact with it, adding new points of curiosity, attention, and modalities of relating. In Wittgenstein's famous analogy, 'Our language can be seen as an ancient city', he asks us not to be troubled by the fact that some languages (for example, the 'builder's language') seem to be incomplete. 'Ask yourself', he says, 'whether our language is complete; – whether it was so before the symbolism of chemistry and the notation of the infinitesimal calculus were incorporated in it; for these are, so to speak, suburbs of our language' (Wittgenstein [1953] 1968, para 18). Being the careful reader of Wittgenstein that he is, Fischer directs attention to the pedagogic work done by some of these methods for gathering quantitative data, as used by me and my colleagues. He is particularly struck by the way the 'simulated standardized patients', who we trained and used to assess if providers were able to diagnose and treat diseases correctly, and who were drawn from these or similar communities of low-income families, began to carry notions from their training into their lives. They reflected, for instance, on the dividing line between symptoms and diagnosis and on the difference between being given unlabeled medicines and labeled ones, going beyond what they were being trained to do as standardized patients. As anthropologists, we are so accustomed to thinking that our work counts as 'research' only when we write up our findings for anthropological audiences that we often forget how our methods might already secrete dispersed knowledge in the communities we study in ways that we might not have anticipated, provided we are open to explaining what we are doing to our interlocutors or sharing some of our findings with them.

Just as stories can be told in ways that might affirm or deny the specificity of the lives we try to render knowable, so might acts of measuring (say illness duration, or medicines

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[3]   Since there are three commentators with the common surname 'Singh' I have added first names to avoid confusion.

consumed, or time spent with each patient) enhance the life we are seeking to study, or curtail it, as is the case with the many accountability procedures set by health maintenance organizations (HMOs), which place unwavering faith in protocols over and above the experiences of patients or providers. Similarly, mischaracterization of the categories around which statistics are gathered might result in data sets that obscure rather than clarify the issues at stake. But none of these outcomes are given in advance. Remarking on the stakes of advocacy, Fischer observes that citizen scientists everywhere absorb the concepts used by experts and learn to calibrate their practices in ways that can be offered as criticism or as supplement to the knowledge of experts. Rechtman too makes the incisive observation that advocacy and research are not separate activities in my ethnography. I am truly grateful to all the commentators for their affirmation of the methodological stakes in *Affliction*, and their agreement, so to say, about the blurring of boundaries between qualitative and quantitative, concepts and experience, and advocacy and research in my work.

In the following response, I take up three major issues that seem to me to express overlapping concerns in the commentaries.

Neighborhood: Finding the right scale

There is a plethora of studies on neighborhoods that cast the neighborhood as an appropriate unit for policy interventions, whether in the case of disease transmission, such as the transmission of sexually transmitted diseases (Fichtenberg et al. 2010), or for building resilience, as in the case of the resilient neighborhood projects found in many cities around the world.[4] Yet there is something very different in Rechtman's recognition of the specific way in which the neighborhood provides the right scale for the ethnography in *Affliction* and in Shalini Singh's reflections on how her own interactions with patients took on a different quality because her clinic was located in the neighborhood from where those seeking treatment for opioid dependence were drawn, which was different from clinical interactions in an outpatient clinic of a public hospital. In the case of public hospitals like AIIMS, patients come from great distances and must wait for long periods of time to see a provider; in such settings, the sociality created by the proximity of shared spaces is missing. Both Rechtman's and Shalini Singh's observations raise critical issues about the unit and scale of observation and analysis.

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[4]   For important examples of resilient neighborhood projects in Canada, see http://resilientneighbourhoods.ca/ and the Center for Resilient Cities, http://www.resilientcity.org/.

Rechtman describes what a neighborhood is in a way that is remarkable for its clarity and eloquence. He writes:

> The real collective level of lives as lived is not a construction; it is a fact. I should like to say, an indisputable fact. The neighbors, the relatives, the people you live with – no matter if you like them or not, and even if you hate them; no matter if they share the same values, no matter if they share the same explanations of what is happening as you do – they share the same space, breathe the same air, live the same contradictions and so on. They are affected (even if differently) by the same things.

Despite subtle differences in the ten neighborhoods I studied, in terms of their residents' political affects and ability to organize, or other more quantifiable measures like whether houses had windows, there were also important similarities. For instance, there was a fluidity between the house and the street, with domestic activities (cooking, peeling vegetables), domestic production (stitching buttons on shirts brought from nearby factories on piece-rate basis, gluing envelopes, etc.), or leisure activities (card playing or gambling) spilling from the house into the street. In several stories in *Affliction*, we see the neighbors emerge as they intervene or not when children are beaten, or moments of crisis that are 'caught' so that neighbors can offer help (see also Han 2012, 2013). At the same time, some of the most vicious conflicts, including incidences of violence, unfolded in the neighborhood, and disputes could go up and down in intensity over long periods of time. I think there are possibilities of developing a new set of concepts, in the nature of experiential concepts, that might help us go beyond the clichés of 'resilience' or 'degrees of pathology'. Rechtman cites Clara Han's (2015) delicate 'echoes of death' as an example. There are not only micro-histories but also micro-geographies – and the ethnographies of neighborhoods might call for different forms of attention from the ethnographer than say studying 'stranger sociality' in the city. I am not suggesting that the neighborhood is a closed entity; indeed, the subtle differences among neighborhoods are not unrelated to the way a particular neighborhood is anchored to the city. One point that Rechtman makes that is of great conceptual significance is that collective life reveals itself at the level of a neighborhood in a different manner than, say, when we choose to take race, class, or ethnicity as the unit of description; the analytical purchase of the neighborhood comes from the force of its empirical character and not from it as an abstraction. I have found it hard, though, to find a handle with which to ask how subtle differences in the milieu of the neighborhood might morph into larger 'events' or produce difference in the texture of lives in these places, but this remains an important issue for me.

The second point with regard to illness narratives that Shalini Singh makes raises a new set of issues. Most accounts of illness narratives have been generated from the site of the clinic.

It was, therefore, extremely interesting for me to see how practicing psychiatrists see the overlap in the boundaries of the clinic and the boundaries of the disease. Drs. Shalini Singh, Mamta Sood, and Prashant Gupta are struck by the individual stories in *Affliction* of patients who end up in the psychiatrist's clinic or hospital intermittently (Swapan, Vidya, Prakash), and who either go on receiving medicines like lithium without ever seeing the psychiatrist again or are unable to sustain treatment because the family has its own hierarchies of deserving and undeserving members. The protocols of psychiatric interventions in a public hospital do not permit providers to contact patients who have failed to turn up for appointments or who give up on therapy, yet these doctors' clinical sense, as shown in their respective comments, is that the pathology that these patients display requires much closer interactions with caregivers as well as with the healers from their neighborhoods, such as Hafiz Mian, the reluctant Islamic healer I portray in *Affliction*. Here is where the strategies of intervention in the neighborhood clinic diverge as multiple connections are made between the psychiatrist and the patient through the intermediaries of the social worker, the NGOs operating in the area, as well as local healers who begin to participate in the life of the neighborhood clinic. The chapter on medicines and markets in *Affliction* begins to unravel the complexities of the networks that operate in clinics located within neighborhoods, but it is only now in collaboration with Vaibhav Saria that I am beginning to be in a position to delineate the complex web of relations between different kind of providers, laboratories, pharmacists, and patients through which the medical environment is actualized in local milieus. Even as I was completing the book, I realized with some trepidation that I could not locate a single study of medical markets and their heterogeneity in an urban neighborhood in India. One of my current projects with Saria is to show how local markets attach the neighborhood to specific features in the city, such as the presence or absence of associational politics, or the networks through which manufacturers of pharmaceutical products are linked to different types of providers such as informal providers, those trained in biomedicine, providers employed in the government hospitals but with private practices, and so on.

Finally, on the topic of neighborhood there is an interesting relation between location and locution. Drs. Deb and Swarndeep Singh talk of the 'local lingo' around disease and cure 'evolving through complex jumbled transactions among social, medical, indigenous, mystical and faith-based systems'. This is a very important observation because it shows that, instead of any sharp lines between a religious or occult vocabulary and biomedical terms for disease, in fact these vocabularies penetrate each other. Further, not only the patients but also the providers in these localities used terms like 'low BP' or 'mild TB' along with other notions such as *haath ka hunar* – the combination of art, attainment, and skill residing in the hand of the healer – showing the circulation of terms and concepts between patients and providers. Yet this is not a division in which the patient has experience and the provider has expert knowledge – both provide nodal points for the co-constitution of 'expertise'.

The ordinary as an interrogation of the normal

The difficulty of defining the ordinary often results in a slippage between the ordinary and the normal. In his compelling ethnography of a clinic in Delhi, which offers regenerative therapy to severely ill patients, Aditya Bharadwaj (this issue) refers to illness experiences of a different kind than those that figure in *Affliction*. Yet, both of us have an interest in questions about the normal and the critical, health and disease, that arise from our understanding of Canguilhem. Bharadwaj has written earlier on this clinic that operates out of a small facility in Delhi and offers embryonic stem cell cures through procedures that are considered highly unorthodox within global standards or protocols, but which are sought by patients because the therapy restores some of the functions they have lost and allows them to recover some dignity in the remaining years of their lives (Bharadwaj 2013). Instead of countering the accusation often made against this clinic – that it puts patients at risk by its use of unorthodox procedures – Bharadwaj astutely shifts the question to ask, 'what is cure'? He picks up here an issue on which *Affliction* was highly ambivalent. On the one hand, my work has been highly critical of providers in low-income neighborhoods for the delay in diagnosing diseases such as TB and for dispensing unlabeled tablets (antibiotics, steroids) that can harm patients. On the other hand, I am in complete disagreement with such bodies as the Indian Medical Association when they seek to criminalize providers who do not hold degrees in biomedicine and to prohibit their right to practice. There is a complicated history of court judgments in India on these issues that make it clear that the so-called quacks come under periodic attack, and that the needs to which they cater arise because of the failure of policy and inadequate regulation of the pharmaceutical markets. I raise this issue because I think the nuances of Bhardwaj's argument might be lost if we do not pay close attention to context.

It makes sense to me to argue that, in the case of chronic diseases of the worst kind, such as those that Bharadwaj is dealing with, experimental medical procedures might work (at least temporarily) even if there is a lack of clarity about why they work or contradictory claims about the duration of cure and assessment of future risks. Bharadwaj suggests that our very notions of health and disease need to be interrogated if we are to radically reorient our notions of 'cure'. In the case of patients who received embryonic stem cells and recovered some bodily functions, even as they did not discount the risks of severe adverse events later, one might argue, for instance, that patients have the right to define what constitutes 'cure'. For some, a short period of relief enabled by embryonic stem cell therapy might well be worth the risks of future tumors and earlier death. Indeed, Bharadwaj goes further, asking us to do nothing less than to rethink health as carrying within itself the seeds of disease. Thus, for him, the normal contains the pathological much as the pathological generates new norms. While I find this view very inspiring for a philosophy of life, of the kind in which

nirvana (release) is contained within *samsara* (the bondage of the world) as some Buddhist philosophies teach us, I can embrace it only for some conditions or for some phases of life and not for others. The model breaks down for me when I ask myself: what about patients who stop taking medicines for TB mid-course because they think they have been cured? I describe in *Affliction* the conditions under which some patients, who first received temporary relief, later died because protocols of DOTS centers would not allow them to be treated for recurrent episodes of multidrug-resistant TB. According to the protocols, the patient was supposed to have been 'cured' after a single course of medications. (I add that this situation is changing now.) Bharadwaj poses a highly relevant question that asks us to put much more effort into thinking how context might be crucial for thinking of both political and ethical issues in relation to notions of health and disease.

But I think we need to go further. My own inclination, following the sensibilities of J. L. Austin ([1946] 1979) and Sandra Laugier (2015), is to offer the concept of 'ordinary realism' that avoids the dangers of taking sheer neglect and clothing it in philosophical concepts – while also recognizing that an acknowledgment of death, not as a horizon but as an aspect of life here and now, is also a way of affirming one's mode of existence (Han and Das 2015). It seems crucial to me to be able to make much finer distinctions between when it might be appropriate to wage a serious struggle for a reform of practices that are harmful and when it might be important to realize that 'cure' might indeed mean different things to different people.

Bhrigupati Singh picks up on a very interesting comment in the essay by Deb and Swarndeep Singh on the relation between naming and ontology. They write that perhaps 'no ontology exists' that could effectively explain the movement of the disease from its abstraction in the textbook into the reality of the human body, and conclude, 'In the absence of any firm epistemic understandings of why illness happens, new lexicons gradually develop'. Bhrigupati Singh, in a flash of brilliance, adds, 'perhaps no ontology yet exists', and then goes on to suggest that such an ontology emerges only in the concrete conditions under which treatment is sought. The lexical uncertainties regarding such categories as 'low BP' or '*halki phulki* TB' (a light touch of TB) are not a matter of cultural construction, Bhrigupati Singh argues, as if culture would be able to provide certainty where patients are unable to decipher the meaning of the symptoms and providers are reluctant to give their illness a name. These uncertainties are existential; doubts that lead to swirls of emotions are not put to rest by an evocation of culture. Interestingly, Sood and Gupta give a devastating account of how psychiatrists too take 'culture' to be a concept that resides in textbooks more easily than in the realities with which they have to deal in treating patients. The authors here touch on deep issues. Glib references to 'ontological anthropology' and its ability to give us access to alternate realities, as some have argued, fall far short of the demands of the day. I am unable to do full justice to the questions at hand, but let me pick up one thread of the discussion.

In my book, I briefly refer to the debates within theoretical medicine about whether one can attribute existence to 'disease' or only to 'particular diseases'. How does this issue relate to the kinds of names that evolve in the thick of lives in the neighborhoods I study, but do not (cannot?) find any place in textbooks of medicine? Let us recall the classic definition of 'semantics' as the study that relates language to ontology (Davidson 2001). While the identity and continuity of an object can be ascertained through truth conditions applied to a proposition in which the object is named, matters become much more complicated when it comes to the identity and boundaries of events. In the case of a disease event, as many of the commentaries note, the meaning of symptoms is hard to gauge, and, as I argued in *Affliction,* even the question as to whether the occurrence of an episode is a new occurrence or a recurring one (Is this a new cough and a new infection, or the same cough I've had for two weeks?) is anchored to many different domains of life. Using the language of economists, one could say that the combination of health as both a credence good (my physician knows more about it than I do) as well an experience good (but I know that I don't feel better regardless of what my blood reports say) make the determination of what is the real, what is a fact, what is it that I am experiencing, hard to determine. This is what I meant about the 'incoherence' created by disease. In subsequent work that I have been doing with Saria, we find that the interpretation of a disease event is never secure since the skepticism regarding institutions (is this laboratory reliable? Do I need this test or is it being prescribed because the doctor gets a cut from the laboratory? Is this medicine genuine or spurious?) marks everyday life. As Sood and Gupta confirm, the patients they treat have little interest in diagnosis as they negotiate these kinds of questions. The philosophical thought experiments in which the relation between language and ontology is muscled down through propositional logic melt down when we move from, say, propositions expressing belief to the swirl of emotions in the context of a disease spinning out of control. It is hard for me, then, to understand the certainty with which so many anthropologists speak of 'the real'; of ontology, as if it were simply cosmology; or of alternate realities. It was very reassuring to me that the psychiatrists participating in this special section share these uncertainties regarding the patients they see in the clinics while also recognizing that patients have other caregivers, and other concerns than those of becoming compliant patients alone.

Subjectivity and subjectivation

In a blinding insight on what is at stake for me in rendering lives I encountered knowable, Rechtman states: 'In recent years, experience as subjectivation has been made into an anthropological object, while, the first, the subjective experience, has been left to clinicians and psychologists, and to the philosopher, but not from the point of view of an empirical analysis'.

Rechtman critiques Michel Foucault for assuming a complete identity between subjectivation and subjectivity, and suggests different routes through which we could overcome the narrowing of these concepts in the Foucauldian model. Though I think the cadences and rhythms of power – especially the hinges and junctions that connect normalizing power, disciplinary power, biopower, and sovereign power in Foucault's texts – are often mischaracterized in much anthropological writing as if these were distinct types of power, I agree with Rechtman's fundamental criticism of how the issue of subjectivity is narrowed in anthropology due to the influence yielded by Foucault's writing. Elsewhere, I have taken the example of the accused Jouy – discussed in *Abnormal* (Foucault 2004), and later in the *History of Sexuality*, Vol. 1 (Foucault 1979) – a youth marginal to the village, who was caught after sexually violating a little girl called Sophie (Das 2016). Foucault argued the case reflected new sensibilities generated by the normalizing power of psychiatry, as evidenced in the anxiety created in the village when this episode came to light. As far as the little girl was concerned, Foucault says she was not particularly bothered, as she went off to buy some roasted almonds immediately after with the small money the man gave her. In my comments on this episode, I noted that Foucault's evocation of a lost innocence and the pastoral quality of life gives him the license to 'read' Sophie's subjectivity, a result of the identity he assumes between subjectivity and subjectivation. I went on to write, 'That sexual abuse leaves children bewildered or frightened about what the nature of the experience was is not something one can read from single acts like that of going off to buy roasted almonds. Acting normally to cover up a devastating confusion is not easily discernable in the texts of the archive' (Das 2016). Rechtman's comments amplify better than I could what is at stake in being able to overcome the narrowing of our understanding of experience by reducing it to 'subject positions'.

In a related comment, Rechtman picks out a question I raised in a companion paper to *Affliction* that I wrote with two colleagues, in which we interpreted the common finding that women show higher levels of depression and anxiety than men (Das, Das, and Das, 2012.) My two colleagues and I puzzled over the fact that while women who had suffered from cumulative adverse reproductive events showed high levels of depression, our survey showed that this was not the case with their respective husbands. We asked, did the women's suffering over the miscarriages, stillbirths, or child deaths not register in the psyches of their husbands? We concluded that there were no standing languages for men to express grief; Rechtman rightly says in his comments that we cannot know how the men felt and cannot deduce it from either the results of the mental health questionnaires or even from the ethnographic interviews. What we can say is that individual subjectivity is not fully colonized by the processes of subjectivation; how subjectivity expresses itself becomes a question that requires us to go beyond the available languages provided by one's culture. Let me add that the issue is not that there is an inner state called 'grief' that is either expressed or not, as if expression was some kind of translation from the inner to the outer. Rechtman's stunning

descriptions achieve perfect pitch through the relentless prose of mechanical repetition he uses in order to render (non)life during the Pol Pot regime. As he describes the experiences of Cambodian refugees in his own practice as a psychiatrist in Paris (see Rechtman 2005, 2006), we see how the experience of violence led to the disappearance of time as horizon. Rechtman's prose is not simply a representation of the pain of the survivors of this brutal regime; it is as if the body of writing absorbs their pain in itself. (This was a theme central to my 2007 book, *Life and Words: Violence and the Descent into the Ordinary*.) The aspiration of developing further conversations with psychoanalysis and psychiatry that would yield a better understanding of subjectivity – treating it more than simply the leftover from subjectivation – is an important one for anthropology, and I hope the path we have begun to forge here will remain sufficiently open for all these disciplines.

Fischer's understanding of *Affliction* as mirroring the structure of writing in Wittgenstein's *Philosophical Investigations* ([1953] 1968) provides another important way of thinking about subjectivity and subjectivation. Even perceptive accounts of self-knowledge in philosophy continue to argue that the individual in traditional societies simply follows social roles (see Taylor 2008; Moran 2015), so that there is little room left for exploring the nature of the subject beyond these social roles. Anthropologists might have contributed to this restricted picture by presenting experience in the societies they studied through typification rather than capturing the relation between singularity and multiplicity. Fischer takes the singular figures in *Affliction* and their stories as providing scenes of instruction. He shows how each case complicates our understanding of such concepts as responsibility, obligation, self-knowledge, power, and inheritance, to name a few, showing how individuals must learn to establish a relation with the social conditions (including norms) with which they are confronted. I found his way of analyzing this series to be extremely productive because none of these cases are presented as examples to illustrate the working of a social norm. Their importance, instead, lies in the range of possibilities for individual formation and for showing the interweaving of necessity and contingency. Fischer perceptively calls this series a 'demonstration of the fabric of life'. I must admit that after Fischer demonstrated that such a series exists in the stories told in *Affliction*, I realized how singularity and collectivity (and not only singularity and multiplicity) might be seen as two sides of the same coin.

A final comment I want to make is on Rechtman's remarkable use of the first person. I understand him to be saying that the anthropologist's subjectivity, in one mode of doing ethnography, might be comparable to the relation an author establishes with her characters when she might, of necessity, abandon her own voice to that of her characters. In the same way, as one sees an exchange in which the third person becomes the first person or the second person becomes the audience or the spectator in theatre, so the intense relations one establishes in one's fieldwork often lead to new ways of knowing what it is to be in the world

with the other, through the shifting relations that emerge between these perspectives. The interweaving of first, second, and third person in theatre is also a lesson on what it is to possess a voice (even if only temporarily mine) and what is it to abandon it to another. I am glad to say that these exchanges have enabled me to abandon my words, once formed through such intensities of relations and events in the field, to the care and custody of such readers as I am fortunate to count as companions in thought.

About the author

Veena Das is Krieger-Eisenhower Professor of Anthropology at the Johns Hopkins University. Her most recent books are *Affliction: Health, Disease, Poverty* (Fordham University Press, 2015), *Four Lectures in Ethics* (co-authored, University of Chicago Press, 2015), and a co-edited book with Clara Han, entitled *Living and Dying in the Contemporary World*: *A Compendium* (University of California Press, 2015). Das has been honored with honorary doctorates from the universities of Chicago, Edinburgh, and Bern, and most recently was elected by the Senate of Durham University to receive an honorary doctorate in June of 2018. She is a Fellow of the American Academy of Arts and Sciences and of the Academy of Scientists from Developing Countries.

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