

BETWEEN RECOGNITION AND NEGLECT

Mohamed Farris Masthan M.

Sree Balaji Medical College, Chennai, Tamil Nadu, India

farrismasthan007@gmail.com

KEYWORDS: Continuity of care; Embodiment in medicine; Health inequity; Healthcare systems; Marginalised communities; Whole person care

She sat so still in the crowded Digital *Seva Kendra*, her infant pressed close against her chest, as if the baby might somehow shield her from the noise and indifference swirling around. People rushed past in every direction, forms shuffled under impatient hands, numbers barked out, instructions repeated like a tired script. She hardly shifted. Her face carried no obvious urgency, just a kind of heavy calm that made me pause. I kept wondering whether she truly grasped what was slipping away from her, or whether endless visits to places like this had simply taught her body to wait in silence.

She came from the *Narikkuravar* community, a nomadic group listed as a Scheduled Tribe in India. She had come seeking the maternity benefits that the government promised women in her situation. But her Aadhaar enrolment had been suspended for months. Every time she tried, the answer was the same: come back later, try again, call the helpline—1947. The number itself felt like a quiet mockery, borrowed from the year of our independence. The need was plain to see. Her body, still tender from recent childbirth, deserved that support. Yet the system refused to see her without that single piece of official recognition.

Anger rose in my chest as I watched. As a postgraduate student in Community Medicine, I could not simply stand aside. I stepped forward, spoke directly to the officials, and searched for any loophole or alternative route. Their responses stayed flat, cold, and procedural, as if her life and her child's future were just another file to be processed. I could stand beside her that afternoon, offering what little solidarity I had. But I could not force the paperwork to bend. In the end, we walked away with nothing resolved. Her body, carrying both new life and old exhaustion, remained locked outside the help that was supposed to reach it.

Not long after that day, I visited a home and met a 63-year-old patient who had been diagnosed with tuberculosis six years earlier. He had given up treatment after only six months. He still smoked heavily, the cigarette almost permanent between his fingers, and carried a long habit of drinking that seemed to dull whatever edges life threw at him. When I first saw him, he stood outside with his friends, laughing loudly, talking as though sickness belonged to someone else entirely. Inside the small, poorly ventilated house, the air felt thicker. Several family members, including young children, shared that single cramped room. His wife pulled me aside and described, in a low, tired voice, how she scrubbed the bathroom after every use, trying desperately to keep infection away from the little ones. There was simply no space to isolate him. The daily work of protecting the family had quietly fallen on her shoulders, and on the household as a whole.

He admitted without hesitation that he had tuberculosis. Yet he did not seem to connect his smoking, his movements, his very presence in that crowded room to the danger drifting toward his wife and children. Care for him came only when the cough grew fierce enough to drive him to a nearby clinic. Otherwise, treatment was simply abandoned. He had even torn up his old medical records and the tuberculosis card in some moment of frustration or denial, erasing much of the trail that might have helped. When I examined him, his thin frame told its own story—clear marks of chronic illness written across his body. I spoke to him carefully about the risks of leaving it untreated, about drug resistance, and about the free support available through public programmes. He nodded slowly, took my phone number, and promised he would come. No one ever did.

That visit sat heavily in my chest for days afterward. Care had begun once, years ago, but it had not held. Addiction, gaps in understanding, and the complete absence of steady follow-up had broken everything apart. The illness remained right there in the house. The family learned to live around it, cleaning and breathing the same air with quiet fear. His body carried the disease openly for all to see, while any real care around it quietly slipped away.

Then there was the woman in the marginalised settlement, also from a tribal background. For more than two years, she and her family had moved between private clinics, chasing treatment for infertility caused by polycystic ovarian syndrome. Tests kept piling up, and so did the expenses, until the money simply ran dry. Eventually, the visits stopped. Cost was part of it, of course, but deeper confusion and the lack of any clear direction played their role too. She understood so little about what was happening inside her own body, and no steady path forward ever appeared. Her husband stayed mostly distant from the struggle, lost in his own routines of smoking and drinking. The entire weight of continuing treatment fell on her alone. Government facilities existed not far away, yet they never became the consistent support her life actually needed. Without guidance or someone to help her keep going, her efforts slowly weakened and faded. The body that carried both the illness and the deep longing for a child received care only in broken pieces, then less and less, until it felt almost abandoned.

These three encounters refused to leave my mind during those months of field work. Each one revealed, in its own painful way, how a person's body becomes caught between the pressures of family, the harsh realities of living conditions, and the rigid rules of healthcare systems. In the first, a single piece of paper decided whether a mother could receive the basic support her body needed after giving birth. In the second, a man's stubborn habits kept spreading risk while his family silently bore the daily burden of fear and adjustment. In the third, a woman carried the physical pain and emotional ache of infertility almost entirely on her own, watching care begin and then slowly dissolve.

As a trainee in community medicine, these moments created a sharp, uncomfortable tension inside me. Our training speaks loudly about equity, about reaching the unreached, about making a real difference in people's lives. Yet in practice, my hands often felt small and limited. I could sit and listen, explain the risks as clearly as I knew how, offer whatever advice lay within my power, and walk alongside someone for a single visit. But I could not tear down the walls of documentation, I could not keep motivation alive across long, difficult months, and I could not reshape the way families divided their emotional and practical loads. That limitation pressed on me every time I left a home or an office, knowing the body I had just seen would continue carrying burdens the system only partly understood or addressed.

Power moves in such quiet, stubborn ways through these encounters. Administrative rules that claim to welcome everyone somehow end up pushing certain bodies to the side. Treatment programmes expect patients to return again and again, yet the daily struggle for survival in crowded homes or uncertain incomes pulls people in completely different directions. Families step in to carry what formal care leaves behind—adjusting, cleaning, worrying, sometimes growing exhausted and resentful in the process. The body becomes the exact place where all these forces collide: shaped by distant policies, pressed by immediate environments, and held within relationships that both sustain and constrain.

Across these three stories, one truth felt painfully clear. Care does not simply flow from need alone. It depends on whether the person is truly seen and recognised by the institutions that hold the keys to help, whether that engagement lasts beyond the first hopeful contact, and whether genuine support exists that actually fits the messy realities of their daily life. When any one of those pieces weakens or fails, care turns uncertain, incomplete, sometimes almost illusory.

These experiences have quietly changed how I think about embodiment in medicine. The body is never only the site of disease. It lives entangled inside relationships, inside harsh environments, inside systems that quietly decide what kind of care can actually reach it. To care properly, we must learn to pay attention to these surrounding conditions with the same careful seriousness we give to symptoms, to medicines, to test results. In the daily grind of community medicine and public health work in India, that attention often begins with nothing more dramatic than simply noticing what the system chooses to make invisible, and

what ordinary families carry, day after quiet day, without complaint or fanfare. The real challenge lies in keeping that noticing alive, even when one doctor's actions can reach only so far. ■

Biographical Note

Dr. Mohamed Farris Masthan M. is an MD postgraduate in Community Medicine at Sree Balaji Medical College, Chennai, with a background in medicine, public health, and community research. His interests include healthcare delivery, health equity, epidemiology, and medical education. Through postgraduate training, Dr. Mohamed Farris Masthan M. worked with underserved communities, shaping his understanding of illness beyond clinical aspects. His research focuses on disadvantaged populations, including adverse pregnancy outcomes and substance use. Dr. Mohamed Farris Masthan M. is also interested in strengthening primary healthcare via digital health, AI, and evidence-based practice. He aims to work at the intersection of clinical medicine, public health, and health systems to make care more accessible and responsive.