CHAPTER IV
REVIEW OF LITERATURE

A meaningful analysis of any scientific discipline depends on how we build our theoretical formulations revolving round theory, method and data. The analysis of health status of people residing in urban and rural communities, therefore, has to be within the mainstream of researches done in the field of Medical Sociology. The review of literature pertaining to the field has direct bearing on the present inquiry. Theoretically the prevalent system of medicine had different variants: indigenous, Folk medicine, Homeopathy, Ayurvedic and Allopathic. At the care level the diverse medical systems have one common concern, namely, to provide prevention of illness and cure to the patients. But it must be stressed at the same time that prevention or cure of illness is not only a chemical and physical process. It involves a variety of other factors. Medicine besides being a process of cure is also concerned with the patient's culture, his personality, his norms and values. The societal belief in a certain therapy, may it be indigenous, traditional or cosmic contributes substantially in his recovery.

Any theory of social medicine is complex. It involves not only the pathology with which the person is confronted, it also involves parts of the theoretical formulations of mythology, legends, culture, and above all considerations of economic capability to spend for medicine. It is found that at a broader
plane all over India not withstanding rural or urban community, caste and class, the Allopathic medicine is preferred by the people for its effectiveness. But despite this "effective" quality the acceptance of Allopathy is also determined by the factors of economic well being and cultural and value permissiveness. We argue, therefore, that the data which we have generated from the field constitute part of the general formulations of the mainstream of medical sociology and at the same time enhance our logic further by providing certain new hypotheses and propositions.

Medical sociology or to be precise the health delivery system can be, methodologically interpreted in terms of the (1) popular and general preference of people for diverse systems of the medicine. We then (2) move to the reciprocity between the structural inequalities of society and the acceptance or rejection or the class analysis of the systems of medicine provides us data to examine the basic aspects of social medicine. We argue that there is (3) culture in medicine. Any medicine which has "potential" or "effectiveness" for curing the patient is not accepted by the people on consideration of merit. In normal situations a medicine is accepted when it is supported by culture, when it is part of tradition. The fourth important aspect is the societal one which includes the broader sociological approach of interaction. There is a fundamental
nexus between the three: the patient, the medicine, and the physician. The nature of interaction between the three would determine to a great extent the acceptance or rejection of any one of the three. A recent trend in medical sociology has emerged which establishes it as a profession on par with other sophisticated disciplines such as engineering, computer science, and medicine. It is just a beginning in the process of making medical sociology a well-founded profession. The profession consists of the sub-systems of doctor-patient relationship, doctor-nurse relationship, doctor-technician relationship and other minor webs of relationships which constitute the hospital as a system. In fact, hospital illustrates a complex organisation in the modern society. The professionalism in medical sociology thus is a link between the physician, technology and the hospital as a system on one hand and the patients, their attendants and even the physicians having their specific social background on the other hand. It is this link or bridge function which contributes substantially to the making of medical sociology a profession. It stands on the valid ground that any medicine whatever be its effectiveness or potency can not be acceptable to the patient if it overlooks or neglects the social and cultural configuration to which the patients belong. There are a few researches which fall in this realm of medical professionalism.

Lastly, the physician, the healer or the tribal magic men are part of the wider societal processes. They are the creations
of the wider existential conditions of the containing society. The skills of healing or curing the patients which a physician possesses is in part an outcome of the existential situation of society. There are some studies which have been made on the pattern of physicians' biography — a social profile which shows the nexus between the physician and the patient. Some of these conceptual formulations in terms of theory, methods and data have been applied in the review of literature in the realm of medical sociology.

Popular Preference to Medicine System:

Bhardwaj analyses the type of medical practitioners and the systems of medicine preferred by one hundred and four rural heads of households in four selected villages in Ropar district of Punjab.¹ The results of the survey indicated, contrary to the views of many social scientists, that angrezi (English) medicine and Allopathic physicians were generally preferred over the desi (indigenous) medicine and its practitioners. All the caste-groups (e.g. untouchables i.e., scheduled caste, the landowing caste i.e., jats etc.) showed a substantial preference for the angrezi system of medicine. Less than four per cent of the sampled head of household showed a clear preference for desi medicine. In none of the four villages was the indigenous physician preferred solely on the basis of either its ayurvedic or unani system of

treatment. About a third of the sample households indicated their preferences for either angrezi or desi medicine would depend upon the particular malady. This suggests that the expectancy of cure is more consequential than a traditional commitment to a system of medicine. Madan also reports similar results of a preliminary inquiry carried out in Ghaziabad town near Delhi. The study revealed that a four-fifths majority of the interviewees had a first preferences for Allopathy. The most important reason for "effectiveness" of Allopathy. It was also revealed that in this choice making neither age, nor type of disease was of any significance. It was also revealed that respondents with higher income and occupation showed a clear and unequivocal concern for effectiveness of a system of medicine than reflecting any other concerns.

Srinivasan made an attempt to study the perception of rural populations in utilisation of health care services in Tamil Nadu. Two primary health centres, one at Kanchipuram block and the other at Alangajam block, employed for collection of data. In all, 125 respondents were selected randomly from five sample villages. Among the findings of this study, she reports that the attitude of respondents towards modern medicine has changed in recent years and they have now understood the efficacy of

Allopathic medicine and have implicit faith in it, even though, it is interesting to find that the people still preferred the traditional practice of conducting delivery at home. Thirty four out of 47 deliveries were conducted at the health centres. Majority of the respondents had immunized their children against small pox and D.P.T. All the respondents were aware of family planning programme and its methods. It is suggested that the medical officer-in-charge of the health centre has to inspect the field work of the paramedical staff periodically so as to improve the efficiency of his staff, which will go a long way in improving the image and optimum utilisation of services of the health centre.


things, the study reported as also confirmed by Madan¹, Dhillon², and Banerjee³ that Allopathic system was most popular both in terms of the system actually tried and the system of preference.

A study conducted by Takroo⁴ on "Social Patterns of Seeking Medical Care" was confined to understand, analyse and compare the curative behaviour in two rural settings, namely, primary health centre and non-primary health centre villages in Haryana state. The main objective of the study was to find out the rural people's perceptions of health, followed by their responses to sickness and thereby to identify patterns and predominant preferences for seeking medical care. The findings of this study concluded that rural people of Haryana, within the frame of reference of good and normal health, essentially underlined the importance of well-developed physique capable of withstanding physical strains. The self-assessment of health rated through respondents perception, was found to be predominant and

prevailing.

A sociological study by Dhillon and Srivastav attempted to explore as to 'how people perceive illness and what they do when they fall sick'. According to this study people consider illness as an episode only if it is accompanied either with fever or pain or a person is incapacitated from taking care of himself. It also showed that there is a greater concern for health of the earning members and the family heads than for other members in the family. It was further observed that the curative behaviour is influenced by the way people perceive illness. Except for "serious" and "abrupt" illness, there is invariably a time-lag between perceived onset of illness and seeking medical care. It was found that the home medication is almost invariably tried at least during the initial stages of illness which varies between modified food to "taking medical remedies". Singh in his study of tribal people tried to measure health modernity in terms of scientifically correct information, attitudes and behaviour in relation to physical and mental health, family planning and child care, personal hygiene and environmental sanitation. The study was carried out in two rural blocks of Ranchi district in South Bihar. The health status of tribal people was measured in terms of living conditions, food habits, age at marriage of women,

fertility and family size, immunization and malnutrition in infants, deaths and disability. The findings concludes that unhygienic living conditions, over-crowding, inadequate and imbalanced food habits, pervasive malnutrition, early marriage, high fertility, non-adoption of contraception, high prevalence of illness, and wide spread misconceptions and ignorance of physical and mental health, diet and nutrition, and family planning and child care are prevailing in the studied block.

Structural Aspects of the Use of Medicine System:

Kakar et al conducted a study in rural Haryana on 'Differential Utilization of Health Care Services'. It is apparent from the findings of the study that social inequality played an important role in the utilisation of health services. There was little doubt that the members of the lower classes and scheduled castes remained deficient not only in terms of possessing adequate knowledge about disease etiology but also about seeking therapeutic help in time. Thus, they were placed in an exceedingly disadvantageous position. Even their counterparts belonging to higher classes or non-scheduled castes seemed to have drawn greater benefit from the governmental health services. Thus, the lower social class or scheduled caste status itself

acted as a barrier in the proper utilization of health services. They found "dualism" in the health care services. On the one hand, there were hospital-oriented services run by specialists and super-specialists who follow sophisticated western technology, on the other hand, they found the primary health centre network, primarily looked after by ill-trained and ill-equipped paramedical workers who even lack supportive supervision by their equally inadequately trained supervisors. One consequence of this situation was that the poor whose medical needs were the greatest were put to maximum deprivation in terms of provision of health services as well as their utilization. Furthermore, they viewed that the present pattern of medical education, the nature of technology used, the pattern of expenditure and even the nature of research being conducted in the health sector indicates one thing; and that is, that the governmental health service is still top-down, elite-oriented, doctor dependant, urban-biased and centralized with over-emphasis on curative aspects rather than on preventive aspects.

Bhatnagar's study on "Community Response to Health" was conducted in three selected villages of Patiala district in Punjab on the bases of varying medical facilities. The study revealed that a respondents mentioned lack of disease as the essential quality of a healthy person. However, ignorance about causation and prevention of diseases was widespread in the

villages. The level of awareness regarding the availability of health facilities was also found to be significantly related to education, mass-media exposure, attitudes and beliefs of the respondents. They were aware about the immunization facilities for children, but the knowledge of most of the respondents was limited to the small-pox vaccination. The respondents indicated their awareness regarding only two family planning methods, that is, Nirodh (Condom) and operation.

As the research evidence shows, even in areas where indigenous medicine system is prevalent, it is more the way of default of the non-availability of institutionalised Allopathic facilities. As Kakari found out, the non-institutionally qualified indigenous medicine practitioners dominate the scene, by virtue of their ability to capitalize on such factors as paucity of qualified practitioners; making themselves readily available; providing medicine in accordance with the local customs; beliefs and demands; and freely imitating the qualified Allopath in the use of medicine.

Culture Oriented Aspects of Health and Medicine:

Matthews conducted a study on "Health and culture in a South Indian Village". The objective of the study was to find out

course and treatment of different diseases, the different types of healers, maternal and child health and family planning. The study revealed that villagers had their own beliefs about causes of diseases which were not just arbitrary superstitions, but part of a system. Villagers had a strong belief in indigenous system (Ayurvedic, Siddha, Unani) of medicine. They had very little knowledge of the Allopathic treatment. Although many villagers used Allopathic treatment they also had great faith in a variety of traditional and spiritual healers. Type of treatment preferred depends on the disease. Traditional healers were preferred for several children's diseases, and for some adult diseases for which there was no rapid certain Allopathic cure.

There is reported to be a vast gap between the availability of medicine facilities in the rural and urban areas. Van Deer Veen's study\(^1\) showed that there is a vast discrepancy between the medical facilities of private practitioners in the urban centres and the state-paid rural primary health centre in Valsad district. Though the majority of the rural population and the tribal communities are dependent on the services of the PHCs, the State Health Centres are still under-utilised. Structural factors can explain the ill-functioning of the PHCs. Yet there are reasons to take into account socio-cultural factors. The efforts

to introduce modern (western) medicine have too often neglected the fact that the average Indian villager interprets the relationship with a doctor in terms of diffused, many stranded and mutually obligatory relationship. The people tend to believe that they "invest in people" and status accentuation is the main mechanism to control their relationships. Through some cases it has been illustrated that there socio-cultural aspects influence the effectivity of medical care.

In his study, Sahu tried to investigate the health culture of Oraons of Rourkela and its hinterland in the state of Orissa. This is a comparative study of Oraons living in a remote village Kokerma which had no health institution and the other Oraons living in Rourkela Steel Plant having free access to very extensive network of health services. The Oraons actively seek health services outside their culturally determined health institutions to get relief from their various health problems. Apart from the availability of such health institutions within the village/city, this study showed that the different ecological, social, economic and occupational contexts determine the nature of health culture of the society.

Gandhi analysed an interactionist approach to the Sociology of illness and medicine and rejected the typological tradition of western sociology as it exhibits ideological as well as theoretical bias. Rather than dichotomizing tradition and modernity, he emphasized the interaction between the contrasting types as obtained in the Indian empirical situation. He has further expanded the meaning of interactionist approach to characterize the meaningful interaction between those who are culturally defined as "ill" or "sick" and the modern, western scientific medical practices and their practitioners. Illness is viewed as a socialization to the indigenous social and cultural institutions of the community. Both, the ill and the medical practitioner are considered to be the active agents initiating new social activities and defining, redefining and modifying the situation together. Since illness is viewed as a part of the interactive process of socialization, it is always conditioned by culture in which it is taking place. Thus, the medico-religious ideas and super-natural beliefs as explanation of diseases among the simple people of India reflect the cultural definition of illness given by the people in village communities. With the change in the type of community, its institutions of socialization also undergo change and the definition of illness

also changes. Similarly, medicine also is emancipated from magico-religious interpretation.

While conducting a medical clinic incidental to pursuing research on Indian culture and personality, Carstairs\(^1\) collected some valuable data on "Medicine and Faith in Rural Rajasthan". He has pointed out that the difference between the points of view of the physician and the village folk with regard to theories of etiology, techniques of curing and conceptions of the role of the physician resulted in misunderstanding between himself, a physician, and his clients. According to him the acceptability of modern scientific system of medicine is possible in three ways: "By the slow diffusion of information about sepsis and infection; by a better understanding of the expectations with which the people approach the doctor; and by preventing new techniques in a way which will link them up with what they are expected to supersede". For his observation in 1950 and 1951, Carstairs spent a number of months in two different villages in Rajasthan, namely, Sujarupa and Delwara. He described that sickness is as much a moral as a physical crisis to the people of rural India. In people's conception the roots of illness extend into the realm of human conduct and cosmic purpose. As a consequence they look for relief to ritual and reassurance, as well as to mundane medicines. "No matter how mere a medicine you give patient",

Carstairs was informed, "unless you and we have faith in it, he never will be cured". To set the patient right morally, as well as medically, the healer must serve as a link between moral man and the purposeful cosmos. He can gain no grace for the affected nor can the sufferer receive it unless both are joined to each other and to the universe by a bond of faith. The vivid episodes in this document dramatize the difficulties of achieving mutual understanding when doctor and patient behold each other through different kinds of cultural glasses. They also indicated, that culture is a connected system and not a mere summation of separate parts. To the western doctor complaints of physical weakness signified malnutrition and anaemia and called for the prescription of iron tonics and vitamins concentrates.

The study on "Western Medicine in a village of Northern India" conducted by Marriot highlighted the responsibility, charity, power, respect, which are important for interpersonal relation in the medical sphere. He observes that it is not so much his technical skill which gives prestige to a healer but his spiritual power gained through diety. The study of medical practice and practitioners in the Indian village of Kishan Garhi has attempted an analysis of the social and cultural problems involved in introducing more effective medical techniques to a conservative Indian village.

Others who have given brief description of the traditional medicine practices include Gould,1 Minturn and Hitchcock,2 and Hasan3. Hasan carried out a study in his book "Medical Sociology of Rural India". He analysed the effects of the introduction of modern scientific medicine in the village and the behavioural factors involved in the failure or success of the physician in the village. Leslie4 also mentioned that in the Centres of British Administration, some Vaidas and Hakims claimed superior status to other indigenous practitioners by virtue of their acquaintance with European medicine. The medical practitioner, since he belongs to a higher cultural and intellectual level can reduce the fear, suspicion and confusion considerably if he tried to understand the rural life and culture, the needs of the villagers and how they can best be help their fight against disease and disability. The physician, who does not try to understand the cultural and intellectual level of the village folk and does not develop respect for cultural differences proves


to be less practitioner in the village dispensaries.

Nichter's study entitled "Toward a Culturally Responsive Rural Health Care Delivery System in India" suggested that the practice of medicine is culturally responsive and that physician be trained to communicate with their patients within their conceptual framework. Cooperation between modern and indigenous medical practitioners is encouraged. In this regard, it is emphasized that cooperation will depend upon a sharing of basic medical resources and knowledge, an understanding of basic cultural concepts of health and healing, and mutual respect is a prerequisite to the establishing of a workable rural referral network. It will require an appreciation by practitioners of each other roles and responsibilities. Mathur's study which is based on the doctoral dissertation on the "Human organisation of a Hospital" is an analysis of the inter-personal relations between the various categories of medical staff and patients themselves. The major conclusion derived from the study is that the socio-cultural factors play an important role in its goal. Behaviour of conformity and non-conformity influenced both by the internal organisation and the organisation of the larger system


of which the sub-system is a part. Thus, socio-cultural values in the main system are reflected in the functioning of hospital. The physical and social environment provided to a patient has a therapeutic significance and can accelerate or impair his recovery. Sachidananda viewed tribal health as a cultural complex of material objects, tools, techniques, knowledge, ideas and values. He opined that if scientific medicine is to be carried in Rural areas, it is necessary that practitioners acquire adequate knowledge of the culture and social organisation of the tribal community. Chaudhri while analysing the factors that why rural people do not utilise the medical facilities available to them. The issues considered important for the non-usability of medical facilities include traditional health and culture, physical environment affecting health and food habits, traditional and modern health and the community fertility and mortality, interaction of traditional and modern systems of medicine and use and application of indigenous medicine.

Traditional Medical System:

Expanding a previous (1963) discussion of folk


medicine in a village[^1] in North India, Khare[^2] offered three interconnected cultural formulations, which seem to characterize the traditional Indian medical system, and which help to introduce considerations of indigenous cultural constructs and interpretations in medical anthropology. The village therapeutic system, it is claimed continues to be predominantly based on such cultural markers as body and being, dava (medicine) and dua (blessings), and dharma (religion), karma (deed), and daiva (God) and it exploits in practice ethical overlaps and differences between the indigenous and modern western medical systems. Khare found in his study that the villager classifies the sick (in body and being) along a set of social factors (age, sex, social status, etc.) and cultural values (e.g. worldly existence versus the renunciation) for treating him under a set of culturally meaningful priorities. There is thus an internal ethical patterning of access to treatment, which grows out of certain basic values of the Indian socio-cultural system and which guides the contemporary villager as he approaches the "doctor dispensary" as a scarce service. The villager not only discovers the differences in the approaches and the ethics of the two—the indigenous and the modern western medical systems, but he is

1. Khare revisited his North Indian Village (Gopalpur near Lucknow in Uttar Pradesh) studied Previously (1958-60).

also actively involved in his own way in adopting himself and the new system to his needs. Consistent with the emphasis in the above two features, however, the villager does this by firmly locating himself in the ethics of his own system (an its cultural values). This stance works because he approaches the western medicine mostly for its results. He goes to their new system with a limited understanding and for purely "getting cured", while also attempting to subsume it under his cultural schemes (and their explanation) "to make sense of what goes on in such places".

The study entitled "Pills Against Poverty" was conducted by Djurfeldt and Lindberg1 in a Tamil village. The main aim of this study is to find out the reasons for the survival of indigenous medicine. The study depicted that the health problems can not be solved by means of medical technology. They intend to demonstrate the impotency of western (or "Allopathic") technological by comparing it with the already existing ("Indigenous") health services in the village. Indigenous medicine is definitely capable of improving the medical care available to the Indian people. But it can not do very much to improve their health situation.

Recent studies in various disciplines indicate that many illnesses have an emotional component and that curing can take place through effective treatment of this aspect of illness.

Henry’s study of an eclectic magico-religious medical practitioner of Eastern Uttar Pradesh in Northern India is a symbolic explanation of the setting in which the curing takes place, the roles of the curer, his public image, and the items and actions of the curing ritual. It showed how this assemblage of symbols establishes expectations of help based on perceptions of the healer and his therapy as powerful, names what is wrong with the patient, suggests the alleviation of sickness-causing agents and thereby contributes to the cure of illness. Impressed by the miraculous reputation of the curer, a patient (generally a woman) comes to the ashram, the residence of holy men and the site of temples, which is suspiciously located where two streams converge. The curer is both a holy man — a person with ascetically acquired superhuman powers and a pujari (priest) — a temple keeper and steadfast worshipper of the deities represented therein. In this curing the divines the cause of the illness, usually a malevolent spirit, and expels it with magical chants and diagrams, and a symbolically potent wand. Finally, he tells the patient how to compound the herbal medicine or how to alter her diet, assures her that she will get well. This mode of healing, in which natural remedies are combined with exorcism, is an expression of a world view which comprehends both natural and supernatural causes of illness.

Societal Perspectives on Health Delivery Systems:

The study "Resources not the Constraints on Health: A Case Study of Kerala" conducted by Panikar tried to find out the factors which contributed to the comparatively better achievements of Kerala in the health sector. And second, what are the factors which inhibited similar progress elsewhere in India. The analysis of the data suggests the reason for the better health status in Kerala as it lays much or equal importance to preventive and promotive measures like sanitation, hygiene, immunization programmes, infant and antenatal care, health education, etc. as curative medicine. Moreover, the spread of education, especially among women in the rural parts of Kerala was probably a crucial factor contributing to the high degree of awareness of health problems and fuller utilisation of the available health care facilities. The conclusion to which this case study leads is that given proper policies and priorities, lack of resources need not be an impediment to the improvement of health status even in low income countries.

Srinivasan in his paper "Management of Rural Health Care" reviews the efforts of government in the delivery of health care services to the rural population since the beginning of the

planned era. It was found that the people living in interior and remote rural areas did not have access to the primary health care. The problem of health care services in rural areas has peculiar characteristics like their concept of health and disease is traditional, apathy towards Allopathic medical practitioners, limited capacity to pay the cost of treatment, transport and communication difficulties, unqualified medical practitioners, and these centres are under-staffed. Doctors and other para-medical workers do not want to work in rural areas because of professional, personal and social reasons. Therefore, to remove this problem enhancing the number of primary health centres and the sub-centres is not only the solution, rather to develop the philosophy of providing integrated health care delivery system. For making health services more meaningful to the population of the country, it is necessary to bring about fundamental changes in focus and approach to the entire health care delivery system in general and above all rural health services in particular so that 'Health For All' by 2000 A.D., becomes a reality.

In her study of "Rural Medical Care in a Changed Setting" Indu Mathur1 made an attempt to observe the functioning of mobile hospitals and health units in rural Rajasthan. These mobile hospitals provide for all diagnostic facilities and services of

highly qualified specialists in surgery, gynecology, medicine, ophthalmology, orthopaedics, E.N.T. (Eye, Nose, Throat), pediatrics, radiology, anesthesia, pathology and dentistry. A close observation revealed certain specific features of the social structure and organisations of the camps, which were not present in other treatment situations of that level. These were mainly as follows:

"The situation is temporary. All the staff works as a team. It is dependent on patient for the success. The treatment process does not involve any financial consideration. Private practice is not allowed to the staff. Humanistic value is central around which all activities enrolls are organised". A comparison of two treatment situations — a hospital and a camp — confirms the observation that people accordingly to the demand of the situation that are constrained by the actions of their co-participants.

In her article on "The Delivery of Hospital Service in North India: A Client Institution Interaction Model", Kirkpatrick presented data and analysis from a case study of the gynaecology ward of an Indian mission hospital in Punjab. The aim of this study is to demonstrate not only that conflict in the delivery of modern health services has a cultural basis for that

has been amply elaborated by now — but to suggest a social structural statement of the confrontation of clients and bureaucracies in situations where clients' social lives are still embeded in the primary institutions of kinship in the rural or urban village.¹

Medical Profession:

The urban studies reflect largely structural and processual analysis of medical professionals which emphasize social background and role of professionals. Madan (1972,² 1980)² carried out two studies. First on "Doctors in a Northern Indian City: Recruitment, Role Perception" and the other study on "Doctors and Society". The former is a study of private practitioners and the later is of doctors who are practising at the Institute. An attempt was made in both the studies as who are the doctors — in terms of their social background, how and why they had been trained? And how they related themselves to their work, and implicitly or explicitly to society? Besides, Madan points out in his study, that medical profession is only divorced from


prevailing socio-cultural conditions but it also encourages the acquisition of all qualifications for their own make. This leads more and more doctors to opt for one of the two equally counter-productive courses of action — either they choose to emigrate to western countries where they can participate in any international market, even though as second class citizen, or else they seek admission into "little golden ghettos" to cater to the needs of the well-to-do and wealthy. According to him, the brain drain of doctors which affects almost all Asian countries, is likely to continue unless dramatic developments take place as for instance, the de-recognition in 1975 of Indian medical degrees by British Service in 1975.

The excessive pre-occupation of doctors with their own ambitions and frustrations and their failure to relate to the people in general in the same manner in which they are able to relate to their own class account for their growing conflict with officialdom. Their concern run counter to official policy seeks to promote community medicine and demands that doctors should shoulder their responsibilities towards the rural population. On their part, doctors complain, not without reasons, that politicians interfere regarding their work and training and that they are out to reinforce their control over medical institutions. All this, Madan says make it imperative for government professional bodies to jointly engage in action aimed at providing a balance mix between official policy on the one
hand and personal and professional satisfaction of doctors on the other.

Nagla (1980)\(^1\) carried out a study on "Sociology of Medical Profession: A Study of doctors at Medical College Hospital Rohtak (MCHR)\)", in the state of Haryana. She analysed profession, professionalisation, and professionalism and tried to identify the basic attributes of profession in order to find out how profession differed from an occupation. Attempts have been made to describe the phenomenon of professionals in complex organisation. It also describes the social importance of medical practice that illustrates the wide variety of problems presented to doctors. It is found that medical profession is a predominantly male occupation. The data also reflect a larger representation from higher castes and classes. Most doctors prefered to attend patients whenever they were on call for emergency cases on odd hours in night. Her findings revealed that almost all the doctors were to a large extent satisfied with their profession, though they had some problems, for instance, the unfair terms of service, for the hard work and tedious work, the unsatisfactory financial reward, loss of freedom to move etc. In fact, these problems made them dissatisfied and because of this, some have mentioned frustration in their work.

\(^1\) Nagla, Madhu (1980). *Sociology of Medical Profession: A Study of doctors at Medical College Hospital, Rohtak, M.A. Dissertaiton*, M.D.University, Rohtak.
Advani (1980) studied "Doctor-Patient Relationship in General hospitals" for his doctoral work. He identified the dimensions of existing hospital social systems, behavioural components of doctor-patient relationship, perceptions of doctors and patients and their interaction patterns. He finds that the social status provided to the doctors in the society and their professional values greatly influence their practice. In regard to doctor's preferred role relations with patients, doctors subscribe to Parson's affective-neutrality perception, in order to avoid emotional involvement with patients. The patients are greatly affected by the duration of contact, previous experiences, and the size and image of hospital. The socio-economic status determines their choice of the hospital, mode of treatment and level of satisfaction.

Oommen's (1978) study on "Doctors and Nurses", attempts to analyses the occupational role structures of professional Allopathic doctors and nurses working in public hospitals in Delhi, the capital city of India. Oommen focuses on the consequences of the transformation of the occupational roles of doctors and nurses from that of private practitioners to as public servants, and the effect on their working in the organisational set up that is, in public hospitals. He identified

1. Advani, Mohan (1980), Doctor-Patient Relationship in Indian Hospitals, Jaipur: Sanghi Prakashan.
three perspectives so far as the definition of profession is concerned: (1) Objective-evaluative to construct an ideal typical notion of profession; (2) Symbolic-realistic viewed as a symbol and ideal and actual; (3) Class-Interest representing a different perspective concerning a reality of profession. He then deals with specific areas such as the relationship between the profession and social structure; role commitment of the professionals and their role perceptions; role conflicts and relations, occupational value of orientations and the role behaviour of doctors and nurses. The data suggest that the social background of doctors contributes to their high prestige in profession whereas, conversely, the origin of nurses, depress the prestige of nursing profession.

Srivastav’s (1979) study explores the nature of interaction in a hospital situation, which exist among the three interacting units of the hospital organisation, viz; the doctor, the patients and the para-medical staff. Some of the major hypothesis and the findings of the study are as follows: (1) The hypothesis, that the patients approach the problem of health and disease according to the cultural norms which they adhere to, is partially proved; (2) the findings of the study very clearly points out that the doctors’ behaviour towards patients is not much influenced by the socio-economic status of the patients; (3)

the expected behaviour of doctors is not translated into reality; (4) illiteracy and language problems are major barriers to closer interaction among doctors, patients, and para-medical staff; (5) the dissatisfaction among the para-medical staff indirectly affect the doctor-patient interaction; (6) the data partially proves that the bureaucratic structure and process in the hospital is often affected by the socio-cultural demands on hospital personnel; (7) the analysis proves the last hypothesis that one of the major causes of conflict in the hospital is excessive bureaucratic control and non-recognition of the professional competence of its personnel. The findings support the contention that socio-cultural status of patients and doctors influences their interaction pattern. The doctors are expert and specific in relation with their patients, whereas patients insist upon a diffused and intimate relationship with a doctor. This constitute the dilemma of human relationship which is further complicated by organisational limits and demands upon both.

In his study on "Medical Sociology in an Indian setting", Venkataratnam1 (1979) analysed the Tamil Nadu hospital and their functioning unit, doctors and nurses. It seeks to find out: (1) doctors and nurses' role in the hospital in terms of their prescriptions; (2) the role expectation and actual role performances of their own roles and of each other; (3) role

1. Venkatratnam, R. (1979), Medical Sociology in an Indian setting, Madras: The Macmillan Co. of India, Ltd.
satisfaction and/or dissatisfaction in terms of the difference between role expectation and role performance, and their causes; and (4) the sociological truths that emerge from an analysis of the role play of doctors and nurses in a hospital. He has redefined the concepts of 'status' and 'roles' as it should be understood in an organisational context. By applying the concept of 'relative deprivation' he has demonstrated the frustration of occupational groups as product of economic or the larger value system of the society. In his analysis of the perception of role performance by doctors of their own and nurses' roles, he showed that doctors did not perform their role tasks satisfactorily because they were not properly socialised to the professional qualities of affective-neutrality, acquirement of knowledge by research, of teaching the medical students and following the role of bureaucracy. Universalistic criteria against particularistic demands, are conspicuously absent in these hospitals. The situation of nurse is quite different from that of doctors. Since by profession, they are subordinated to doctors, their position in the hospital is quasi-independent. Nurses perception of the doctor's role is generally conformed to that of doctors. Thus, nurses said that doctors did not fulfill their role tasks as per the expectations of nurses.

attitudes of physicians”. They have examined the following aspects; (1) Whether the amount of time spent per patient by doctors is in relation to (a) patient’s illness and (b) doctors’ rewards; (2) the degree of interaction between the physician and the patient in order to perform the role obligation of a physician; (3) whether the physicians are able to attain effective-neutrality in their interaction with their patients. Their major findings are as follows: (a) the general practitioners combine physical cure along with the psychological and emotional cure of the patients; (b) the paid physicians even though they have less monetary gains, are compensated by curing patients, who have abnormal complications; (c) usually the consultants get patients with a case history from general practitioners or governmental hospitals. They cannot give much emotional and psychological satisfaction along with the physical cure as the time they can utilize for examining the patient is too little. These authors have also examined the time spent per patient by doctors in relation to the patient’s illness and the doctor’s rewards. They have observed negative relationship between these two occupational hazards as such seem to make or mar the career of a professional and yet none of the three categories (General practitioners, Paid physician, Consultants) of doctors have felt the need to restress this part in their professional life. The maximum degree of interaction between the physician and patient is between the general practitioner and his
patient and to a less extent between the consultants and paid physicians, and their patients. All the three categories of physicians can perform their roles without considerable emotional involvement. Finally, it has been found in their study that, each type of practice has its own silver lining and the rewards are generally much more than in any other.

Chandani (1980) in her exploratory study, "The Medical Profession: A Sociological Exploration" attempts to examine the subtle aspects of profession. Data have been collected on the basis of interview with 152 doctor of (institutions as well as private) of Jodhpur city. The structural origins of the practitioners shows that lady doctors in the medical profession is very low, and this profession is highly dominated by middle castes. Choosing of a profession is largely done by the family for the wards, the doctors by and large decided to enter into the profession of medicine. Altruism and not individual aggrandizement was considered an impelling factor in joining this profession. Courtsey, dedication, expertise and humanism are the special qualities that doctor should possess, but here the doctors do not possess these conditions in real life situation. Regarding their treatment pattern, it has improved a lot as the study suggest that the rate of success of doctors in treating the patient is high, Doctors do not involve themselves in situation which is

beyond their competence. From the patient side the doctors feel that their nature and behaviour also pose some problems. Medical ideology which includes medical ethics, integrity of doctors, colleague feeling, good behaviour towards patients, service to humanity, expertise and service above self are also analysed in this study.

Perhaps the most striking characteristic of medicine in India today is the great variety of systems which are practised. Keeping in view of this idea Montgomery1 (1981) presented an analysis of the biographies of a group of medical doctors (practising either Ayurveda, Siddha, Unani, Homeopathy or modern medicine) as a way of identifying the features of variability in medical practice in a city in Tamil Nadu. Important changes in legislation, growth of public and private hospitals, expansion of pharmaceutical and chemical manufacturers, development of medical practitioners' associations and changes in disease patterns and population are each reflected in details from the life histories. The overall aim of the study is to outline approach for relating the observed variability in medical practice to those factors and for suggesting which have been of greater importance in contributing to the widest ranges of variation. The sets of biographical excerpts demonstrate that the social and cultural

organisation of the private practitioner's life is multifaceted.

The nature of the practice of medicine in this setting is at once an extremely social, interactions endeavour just as it is also highly individualised beneficiaries of a formal, ascribed, hereditary role tradition an informal achieved, self determined life experiences. Their having taken up medicine seems almost to have been predetermined and yet just as distinctively, their lives are the products of retrospectively identifiable, unpredictable, chance events. In decision terms, their career choices can be traced to parental influences as well as to their own emergent commitments. The skills, they manifest partly have been taught to them by others and partly have derived from their own practical clinical experience. The modifications, they employ in their practices are both genuinely indigenous and foreign by both ancient Indian concepts of duty and legal provisions regarding medical registration and drugs derivative from the colonial context. The livelihood is less a profession than an occupation, an neither term is fully apt. Likewise work is in some ways a business and perhaps is more a charity, but it is not simply either one or a combination of both. Their position in life is respectable and at the same time, some what uncertain. At points each of their lives appears traditional but also, there is no doubt that all are definitely modern.

Concluding Observations - The Emerging Trends:

The review of literature made in the preceeding pages
enable us to bring out the major trends of research available in the field of medical sociology. Admittedly, it must be observed that some valuable research work has been done in different fields of medical systems. Normally the researchers have made an effort to find out the acceptance, rejection or preference of the people varying medicine systems. Methodologically, though at some places not clear, field data have been generated by carrying out field studies through the tool of observation, administration of schedule, case studies, and interviews. The nature of study has been structural historical. The historical approach has been employed widely while inquiring about the practice of folk medicine and other systems of Unani and Ayurvedic medicines. It is the traditional belief in the systems which can not be analysed without employing historical and ethnological methods. Most of the studies thus have used structural-historical approach to the study of medical practices.

The review of literature shows the recent trend in terms of data. The general practice has been to make inquiries into the rural communities including the peasantry and the tribals. The rural community has also been interpreted with the perspective of structural, cultural and traditional approach. One very significant trend of research has been to look into medical practices in terms of social stratification. The acceptance of a particular medicine system is not based on potency or effectiveness only. It is the structural inequality of the society in
terms of high caste which also determine the entry of a particular system. Such an approach helps us to have an insight in the medical practices in terms of inequalities. The studies make it obvious that the lower segments of society are very much willing to accept the Allopathy system; in fact they are aware of the effectiveness of the system but they can not go for it because their "economy" does not permit them to do so. On the other hand there are segments of society which are culturally so much constrained that they would not go for the acceptance of any system because it is denied by their culture. However, in serious illness any system which is assured to be effective is acceptable to any group. In the realm of theoretical formulations it must be observed in categorical terms that we have not been able to find any substantial theoretical constructs in the available researches. However, some broad propositions are available in most of the studies. For instance, it is found that Allopathy as modern system of medicine has become a system of society. Even the rural sector has gained awareness about this system. Provided they have money, they would prefer it. However, at the local level in the village simple folk medicine for cough and cold and other such minor disorders are accepted. All the studies concede to this general observation.

In some situations it is found that the villagers are not faced with the problem of either or in the choice of this-that system. They even prepared to synthesize all the systems. What is
found is that there are some diseases which are preferably cured by one system of medicine and there are a few more which can be dealt by other systems. In the villages by and large the choice is between Ayurvedic and Allopathic systems. The practitioners of Unani and Homeopathic system are less than often.

One very new trend of constructing hypotheses is about the elite nature of Allopathic system. The lower sections in crucial situations tend to accept it but it is widely held that the present Allopathic medical profession including the modern hospital system is predominantly biased towards elitism and capitalism. The flood of clinics and nursing homes which is recently sprouting in towns and cities largely cater to the needs of the middle class and the higher ones. The poorer section are left high and dry because they simply can not afford to get treatment for a simple ailment for it cost them a little less than Rs. 50.

The trend of research in the field of illness and disease has thus both theoretical and practical relevance. The present inquiry plugs some threads from the available hypotheses and data. We have studies both on rural and urban segments. We have a few studies on scheduled castes and scheduled tribes. The nature of these studies is by and large descriptive. What we have taken as our strategy of research is to compare the rural communities with the urban ones. And in doing that we have analysed our field data with the wider development and policy
formulations of the government both at the state and centre level. This has helped us to widen the scope of the currently available data and constructs.