CHAPTER III

TECHNIQUES AND EXPERIENCES OF FIELD INVESTIGATION

The nature of community response to systems of medicine, the problem of the present study needs to be investigated in a specific empirical situation for properly understanding it. This chapter deals with the selection of the empirical situation, i.e. the universe of study and the tools or techniques of data collection used in the investigation. While studying a problem in an empirical situation, that is, during the process of field investigation a sociologist confronts many experiences. In this chapter after discussing the universe and locale of study and the tools employed for data collection, a brief description of the experiences during field investigation is given.

Selection of the Universe and Locale of Study

The universe selected for this research purpose is a town called Rajpura of Bharuch district in Gujarat. The field work and collection of data was done by staying in the town from 17th April, 1977 to 20th May, 1978 with occasional short breaks. The inter-sessional periods were utilized for consultations with the supervisor. The universe of study was
so selected as to fulfil all the prerequisites of the investigation undertaken.

The selection of a town for the present research was primarily considered necessary because, besides having all the systems of medicine and their practitioners which is the most important prerequisite for such an investigation, it occupies a special place in the Indian context. According to Gupta, small towns are not merely a creation of arbitrary definition by the Census authorities, but also a geo-economic, social and administrative unit linking the urban complex with the rural hinterland. They represent a mixed social structure and milieu embodying characteristics of rural as well as urban areas. Moreover, a study of this nature against the background of a town acquires significance from the point of view both of traditional and non-traditional features. This is not true of a village where there is only a rural population with predominantly traditional features or of a big city in which the non-traditional features usually over-shadow the traditional. Thus, the selection of a town for the present study was considered desirable and necessary.

The selection of Rajpipla in particular was based on various considerations which can be briefly stated as follows:

Being a small town in area and population, it was amenable to examination by a single investigator.

Also, the town has urban as well as rural characteristics. Socially and economically, the town represents all major social groups; significantly enough, the town has both non-tribal and tribal population. It also has a Muslim population, a point of interest in the investigation. A busy marketing town for the surrounding area, it includes people of all economic groups or strata.

It needs to be underscored that the selection of universe was made only after visiting the town and staying there for some time. The first visit to the town was made to collect the basic historical and other details like the census reports on population and the survey of the systems of medicine and their practitioners. During this period visits to various temples were made as they were considered to play a significant role in the folk system of medicine. After obtaining a social perspective of the town, the second visit was made. It was done with a view to starting a pre-test field work in the town. The visit was utilised to have the first round of talks with people of the town and the practitioners. It is called the first round of talks because it involved in no way an interviewing process in the defined sense and was but informal. This informal round of talks helped in checking off the queries of the interview. Only after this visit were the selection of sample and formulations of techniques for data collection, later used in the field work, determined.
The sample for research depends upon the nature of the problem of the research and the selected universe which is studied. The sample for this research was drawn from two levels: the medical practitioners and the community at large. The medical practitioners were selected as they represent the systems of medicine and the community at large was selected because it is their response which is under examination.

Medical practitioners are of two types: those working in government sector and those in private sector. The government medical practitioners are those who work in government-run dispensaries and hospitals. In this category are also included the practitioners who work in municipalities. The practitioners working in private sector are again of two categories: first, the practitioners working in polyclinics, private nursing homes and private hospitals and second, the private practitioners having their own independent practice. In the universe of this study the sample of all private practitioners having solo practice was included. This included practitioners listed in the municipality records and also names which are not included in the records because they have no legal medical practitioners' status, a pointer to their being the folk practitioners. All practitioners having independent solo private practice belonging to various systems of medicine were included in the sample for the investigation. All of them were interviewed both at their
residence and their clinics.

In all, thirty-one practitioners having private practice in different systems of medicine were selected for the study. This includes fourteen Allopathic, five Ayurvedic, one Homeopathic, one Unani and ten Folk practitioners. It may be important to point out here that the hospitals and dispensaries run by government and trust institutions were not included in the study because out of the five systems of medicine studied only two are practised in these organizations. Moreover, they dispense medicines free of cost making a comparative analysis of the cost of treatment difficult.

The selection of the members of the community at large was based on purposive sampling, and no stratified quota sampling was adopted. The selection of the sample was done by visiting the clinics visited by the respondents. Also, some cases were picked up by paying a visit to their residence. In all cases a visit to their residence was followed after the interview at the clinic was over. In this way a total of two hundred interviewees were selected from the community at large.

Techniques of Data Collection

The techniques employed in data collection primarily vary and depend upon the nature of the problem, the universe of study and the sample of investigation. According to
Oommen there are three techniques employed for collecting sound scientific data. Because this study employs in part or in full, all the three techniques suggested by Oommen, it is necessary to list them here.

1. Eliciting verbal responses from respondents by asking questions through a mailed questionnaire or, an interview schedule or, interviewing informants, in an informal way, with or without the aid of an interview guide.

2. Observing behaviour, either as a participant observer or as a non-participant onlooker.

3. Analysing documents which may be public (e.g. a census report) or private (e.g. personal letters).

The use of questionnaire either structured or unstructured, was not made in view of the nature of the study and the small size of the sample. Since the use of questionnaire was not considered appropriate for the present investigation, the use of interview guide and interview schedule as tools for data collection was made. There were the two reasons for using both the interview guide and the interview schedule as tools for data collection in the present study.

Firstly, like the other sociologists and social anthropologists, who have come to abandon the spurious choice between quantitative and qualitative data and are concerned, instead, with a combination of both which makes use of the most valuable features of each, in this study also both the tools of interview guide and interview schedule were made use of for collecting qualitative as well as quantitative data. In using both the techniques a problem emerges. The problem in using both the tools is one of determining the point at which one tool should be adopted and then the point at which the other tool should be adopted. In this study this problem was solved by using interview guide for the collection of qualitative data and interview schedule for the collection of data on the socio-economic background of the respondents.

Secondly, both the tools (of interview techniques) were used because on the one hand an interview guide containing typical questions on areas for inquiry, and hypotheses was thought to be indispensable as a tool of data collection for this kind of research. This helped in maintaining the comparability of data obtained in different interviews by confirming that they had covered much the same range of items and were pertinent to the same hypotheses. Interview schedule, on the other hand, was useful to keep a systematic and uniform record of the socio-economic background of the respondents for the analysis.
However, it may also be pointed out here that no uniform pattern was adopted in using the interview guide first or the interview schedule first. This was kept very flexible and was determined only on the spot and according to the situation. The flexibility in the use of these tools and the absence of a set procedure were maintained for the following reasons. At times one got into a conversation with the informant and for this the use of interview guide was made first, and at that stage the use of interview schedule, it was felt, would possibly interrupt the chain of thought of the informant. Therefore, in such a situation the use of interview schedule was made as a test note only when the queries from interview guide were over. Also, the use of interview guide was made first in certain conditions when it was observed that the respondents would not appreciate questions on their socio-economic background, the questions covered in the interview schedule. Thus the interview schedule was resorted to on establishing a proper rapport with the informant through a judicious use of the interview guide. On the other hand, there was the situation, recurring often, when it was thought neither possible nor feasible to start off a conversation with the respondents without introducing oneself to them. Then, again, recourse to interview schedule first proved helpful. Once the informant got over the initial inhibition from making a free and frank conversation, the use of interview guide was followed up later. When it was observed
that the respondents would not mind direct inquiry on their socio-economic background the use of interview schedule was kept first with subsequent questions from the interview guide. Thus, no set procedure in the application of these tools was followed during field work. Where the use of interview guide ended, the use of interview schedule was made or vice-versa depending upon the need of the situation.

Two sets each of interview guide and interview schedule were prepared for use in the present research. These two sets of interview guide and interview schedule were prepared because the respondents in the present research, as already mentioned, were of two categories: members of the community at large and medical practitioners. The medical practitioners of all types were given one set of interview guide and interview schedule. The second set of interview guide and interview schedule was designed for members of the community at large.

To elaborate further, it may be pointed out that there are two types of interview schedule i.e. the structured interview schedule and the non-structured interview schedule. For the purpose of this research the non-structured interview was made in the first set, because, admittedly, the non-structured interviews are used for a more intensive study of the social acceptance pattern. It is, besides, a more flexible tool. The interview schedule in the first set contained questions on the
socio-economic background of the medical practitioners. It also included queries on identification data. The questions included here related to the medical practitioners' age, sex, caste/tribe, religion, income level, type of family, type of house and information on the parental education and occupation. The interview guide used in the first set had questions pertaining to the choice of profession, perception of the systems of medicine and the network involved in the establishment of the clinic and the clientele. The interview guide and interview schedule of the first set were drafted in English. They were, however, translated into Hindi or Gujarati if a given situation so demanded.

The second set of interview guide and interview schedule made for members of the community at large was also drafted in English keeping in view all previous visits and experience in mind. They were translated into Gujarati or Hindi as and when required. Interview schedule made for the community at large was also unstructured containing questions worded in a manner congruent with the Rajpipla idiom. It was also more or less on the same pattern as that of the practitioners, mainly containing questions on the socio-economic background and identification data. Interview guide in the second set for the community at large had questions pertaining to their view of disease causation and cure, their evaluation of the systems of medicine and the reasons for such evaluation and the network
involved in the acceptance behaviour.

The interviews during the field work were conducted at the clinics of the practitioners in two shifts i.e. in the morning between 9.30 a.m. and 12.30 noon and in the evening between 4 p.m. and 7.30 p.m. Interviews were also held at the residence of the practitioners to achieve a better assessment of their socio-economic background. The folk practitioners had no set clinic hours; they were interviewed at different hours of the day, but mainly between 12.30 noon and 5.30 p.m. This was done in this manner because they were easily available around this time. The interview schedule was filled in the presence of the respondents whereas the interview guide was filled up mainly after returning from the interview. In all cases, however, some notes were made on the spot. It was observed that the respondents never disliked this. In fact, they wanted their responses to be written down.

The members of the community were interviewed in the clinics of practitioners as well as at their residence. In both types of interviews extensive notes and general observations on each interview were made in a separate sheet of paper. The dress, appearance and gestures of the interviewees were quietly taken note of at the time of interview, which helped later in analysing the results. Throughout the interview, all efforts were made to maintain a normal and informal
atmosphere to help the respondents feel free and be at ease while responding. Here, a point worth mentioning and agreeing to unhesitatingly is the one made by Minocha. An interviewer should not give an explanation to the interviewee about his presence and his enquiry along with an assurance that the information obtained would be kept confidential. The point is well made and sound, for such statements tend to arouse suspicions in the minds of the respondents. However, it is mentioned here as the first procedure of the interviewing technique.

When the field work was started, no hard and fast rules were formulated on the use of the tools for data collection. It was left open to the requirement of the field. For this reason, it may be noted here that while the interviews were in progress the use of observation technique was also made. The observation was in the form of a non-participant onlooker. This technique yielded, in many ways, the most reliable and adequate information. It helped a great deal in assessing the interaction of individuals with each other and in recording its characteristics. The observation was not formal or systematic. It was so due to the fact that the present study


situation considerably limited the scope of watching the persons involved all the time. The use of this technique was no doubt time-consuming in the data collection; nevertheless, it led to a better understanding of the functioning of the systems of medicine and the networks involved. It also helped in evaluating the relationships between the practitioners and his clients, and vice-versa.

The observation as mentioned earlier was made as an onlooker-observer, hence the practitioners were in no way disturbed in their clinics. As a matter of fact, the observations were made by sitting in the clinics without interrupting the practitioners in their work. As no specific questions were put either in the interview guide or in the interview schedule regarding the nature of clinic, the technique of observation came as a necessary tool for assessment of the clinic. And as to the folk practitioners' situation, it required a proper observation.

Thus, the use of observation technique, which was made during field work, helped in observing some of the significant aspects of the situation and in blending qualitative and quantitative data to arrive at more meaningful generalisations. Also, the use of both the tools of interview and the observation technique combined together helped in yielding the best results by supplementing one with the other. Through direct observation
all the relevant aspects, not fully capable of being covered in the interview, were recorded and systematised.

Besides the use of these two techniques of data collection, the use of already published literature and other written documents was also made. The documents considered were both public and private. The public documents were the census reports and the municipality records. The category of private documents consisted of the records made available by the practitioners. The other written literature included the writings of sociologists, social scientists and a few medical practitioners. References to these are made in the bibliography at the end of the thesis.

Thus data for the present research was collected with the help of the tools and techniques of data collection mentioned above. After collection of data, the next stage was that of data analysis. The process of data analysis was mainly based on the content analysis method of the interview reports and not on coding. As is known, the analysis of data with the help of coding is more frequently made with reference to quantitative materials, while the use of content analysis is frequently resorted to with reference to qualitative materials and where the sample is not too large in number. The data collected from doctors, because of its small number, was not put on the coding book. Similarly, even for patients no coding
books were prepared for the use of computer. However, coding chart for tabulation of data was prepared for the community at large. Besides this, some specific incidents narrated by the respondents taken down during the field investigation were analysed. These were subsequently used as examples in the thesis.

Problems and Experiences During Field Investigation

Before writing about the experiences of the field investigation, a brief note may be written on the use of published and unpublished literature which was consulted for the present work. In the absence of many sociological studies in the Indian context in this field of sociology, for the purpose of this research one had to dig and depend upon both the sociological and non-sociological published and unpublished material in India as well as abroad. Studies conducted in the Middle East, China and other countries, details of which are given in the bibliography, were taken as major guidelines in the present investigation. Prior to the doctoral work, the courses on 'methodology' and 'community and social medicine' taken during the course of Master of Philosophy helped a great deal in obtaining a knowledge of the field work on and in getting familiar with medical terms and concepts. This understanding of medical terms and concepts helped in
communicating with the practitioners and knowing the general terms used in medical sciences.

The literature consulted for the present research produced an impression that sociologists often face difficulties in the course of their field investigation. Also, the difficulties of doing field work in cultures other than that of the field worker can be varied and complex. The problem is often aggravated in terms of language. However, my stay in Gujarat during my school days has enabled me to have some knowledge of their culture and a sufficient knowledge of their language. As such, the research did not encounter many major problems. Instead, in the process of field work for the present research, there were many interesting events.

While conducting the field investigation, I have had different kinds of response to me from different sets of people. Rapport was struck immediately with a few practitioners of Allopathy, Homeopathy and with a couple of Ayurvedic practitioners. Medical practitioners without a formal education in medicine were unaware of my identity as a sociologist and it was only after the discussions were in progress that they were able to correct their initial impression of my being a representative of the Ministry of Health, a social worker, etc., all despite the fact that, at times, I had introduced myself as a researcher in sociology.
The folk practitioners, categorised as medical practitioners falling in the category of Folk system or 'the other system of medicine', had initially a hostile attitude towards me. It would take me the whole of the first sitting of the interview to make them amenable to reason. Then they would express their regrets for having suspected my identity and intentions at the outset. Their hostile attitude stemmed perhaps from the fact of their being basically uneducated or perhaps from the fact of their being unfamiliar with research work or investigative interviews. In one case a folk practitioner was not willing to talk to me fearing I would steal his art of healing. He told me, "If you are not suffering from any disease, then why waste my time?" I could only interview him when his wife came forward to help. She had seen me in the clinic of a practitioner talking to people. She convinced her husband about my bona fides. Only then was he willing to talk to me any further. In another instance, a folk practitioner told me that he had learnt from another person of the town that I had come to the town to 'challenge' the folk practitioners. But when I explained, he changed his opinion and was willing to talk to me. In a third case, two folk practitioners who distinguished themselves as perfume sellers told me at the outset of my interview that they were merely perfume sellers because of the fear of being reported to the authorities for doing
something illegal. It took me nearly two hours to win their faith and then they not only told me how they practised but also showed me samples of the kind of medicines dispensed by them. The point to be appreciated here is that such practitioners are no doubt doing something illegal in the eyes of law but it has some social sanction as they apparently cure people. This is an important feature in the difference between legal sanction and social sanction. The moral and the immoral mean different things to society and law.

On the whole, during the field investigation the practitioners of all systems of medicine in general gave me time to interview them and had patience to answer all my questions. So much so that at times they would get delayed in closing their clinics. In one instance, an Allopathic practitioner showed me how the screening was done. The practitioners often asked me to listen to the case history of the patients which they thought might be of some help to me in the investigation. At times practitioners even sent for me at my residence when they thought that they had some peculiar case and I could gather some interesting information from it. They often explained some of the diseases and their symptoms to me and also translated the medical jargon into simple language and into local terminology.
The medical practitioners were very receptive in all the cases except when asked in some way or other about their income. Some of the practitioners looked embarrassed probably because of their poor income while others were so perhaps due to their fear of income tax or professional tax. On encountering this attitude initially, I had to make these enquiries in an extremely discrete manner to avoid their suspicion. For this reason the assessment of economic status was based on the observation of the clinic, and the number and kind of patients and on visiting the houses of these practitioners.

The practitioners showed immense hospitality and when I used to visit them in their clinics they felt sorry that they could not offer me tea or coffee. Because the first round of interviews with all the practitioners began at their clinics, they invited me to their houses to meet the members of their families. I accepted these invitations without any hesitation as this alone could help me in observing their socio-economic background in depth. Their warmth and respect for me for having come miles away to do research in this town was evident in their hospitality. It was interesting to note that some of the practitioners, who offered me coffee, had done so because I had gone from Delhi and coffee is perhaps considered a modern drink in this part of India. The tea that the practitioners offered me was in fact a hot sweet syrup,
a thick brew of tea, milk and a special masala (condiments) added to it. The practitioners, who were not able to offer me tea or coffee due to their poor income, avoided the issue in a diplomatic way. However, I could realize that they felt uncomfortable for their inability to offer me a cup of tea. In such cases as I would get up to leave after a long session of interview with them they would come out saying, "Had you stayed longer, we could have had a cup of tea or a cold drink together".

In general, the practitioners of all systems of medicine including the practitioners of Folk medicine were very gentle and helpful. They did not hesitate to talk to me for hours. Those having formal education talked to me both in English and Hindi, but with a few I had to make the conversation in Gujarati. On the whole, the practitioners of Folk medicine, who provided interesting anecdotes, made the work of collecting the data very interesting and the experience rewarding.

The present study deals with the aspects of networks involved in the acceptance pattern of various systems of medicine. A point to be underscored here is that in the process of this field work I had developed a network to meet all the respondents. The practitioners of Folk medicine including dhais who also fall in this category, have no legitimate status among the professionals in the census
and in the municipal records. They had no sign boards to display. I could contact them and interview them only through the network which I had developed. It is needless to say that the practitioners and the members of the community at large i.e. the local people, were part of this network. A lady practitioner of Allopathic medicine had arranged for my introduction to one of the dhaia of this town.

In my experience of field work for the present study the members of the community in general, who may also be termed as clients, were also very cooperative. The informants were not lazy, irritable or suspicious. Those who had these negative traits were given their time to get used to the idea of interview and in due course they ceased to be hostile towards me. Among the informants, it was observed, the elderly people were more eager to have long discussions with me, the younger were curious to talk to me because they thought they were adding to my knowledge. Women informants were interested and had no hesitation in talking to me about their families, sickness and ways of treatment. Elderly people were helpful in giving me historical details of the town. Women had a better knowledge of the cures for certain diseases. In the final analysis the acknowledgement has to be unreservedly and gratefully made that data collection for the present study was completed with a large measure of
success thanks to the generous response from my respondents.
All my meetings with the respondents ended in typical Gujarati
fashion in which they would send me off on a warm avlo
(come again) note.

In conclusion of the present chapter it may be pointed
out that some sociologists conducting research give pseudonyms
of the communities. For example, Hasan⁵ has given a pseudonym
to the village of his study. I do not think it necessary to
do so for the present study. The names of the places and the
town are real as also the individual instances quoted in the
text; however, the identity of the informants has been
disguised.

5. K.A. Hasan : The Cultural Frontier of Health in
Village India, Manaktales, Bombay
1963.