CHAPTER VII

FACTORS DETERMINING RESPONSE TO SYSTEMS OF MEDICINE AND PRACTITIONERS

The response to systems of medicine and their practitioners depends upon various factors. The present chapter seeks to attempt an analysis of these factors which determine the response pattern. The chapter has been divided into two parts. Part I analyses the factors that determine the response to systems of medicine while Part II contains an analysis of the factors that determine the selection of and response to the practitioner.

Part I: Factors Determining Response to Systems of Medicine

There are several factors which influence response to the diverse systems of medicine in this town. These factors, which were observed to determine the acceptance of a system of medicine in the town, are: the nature of disease and its perception; the effectiveness of a system of medicine in the cure of a disease; the time spent in the cure of a disease;
the availability of the practitioners of both the sexes within a given system of medicine; the socio-economic background of the community at large. From these factors a series of hypotheses were formulated before and during the course of field work. The first chapter of the thesis carries a reference to all this. The attempt here is to authenticate these hypotheses.

The perception of disease by the members of a community has been observed as an important factor in determining the response to systems of medicine. The diseases as mentioned in the previous chapter have been perceived as a result of various causes. These causes are both natural and supernatural. People believe the mode of treatment and acceptance of a system of medicine are based on the perception of causes of the disease. The diseases perceived to have been brought about by supernatural causes are treated in a way different from those perceived to have been brought about by natural causes or by causes both supernatural and natural. The category of diseases due to natural causes is further divided into three, these being: natural ordinary diseases, natural serious diseases and natural chronic diseases. The diseases in each of these categories are cured in a different way. In order to see the relation between the perception of
diseases and the response-pattern it is necessary to elaborate a few cases of the perception of diseases and the accepted system of medicine for their cure.

In the treatment of smallpox, chicken pox and measles, the diseases perceived by a majority of the people of this place as a consequence of the wrath of Badia Bapji and Sitala Mata, no medicine other than Folk medicine is accepted by the people. Here, it may be worth pointing out that even those members of the community, who believe these diseases to be due to natural reasons, accept the Folk system of medicine. This treatment, it was observed, was accepted by all irrespective of their caste, tribe, religion, occupation, income and education level.

The normal course of treatment prescribed by Folk system and accepted in the cure of these diseases is the following: when there is a patient suffering from any of the diseases mentioned above, the parents of the patient visit the temple of Badia Bapji or Sitala Mata depending upon the deity the disease is an attribute of. In the temple they offer their prayers and make a wish that if the patient in the family is cured they will visit the temple again and offer a horse, ghoda1, to the deity. After the first visit

1. Ghoda is a symbolic horse made of mud and it symbolises strength. It was observed during visits to these temples that a number of such ghodas are found in the temple altar.
to the temple the members of the family in which there is such a patient do not pay any social visits and do not entertain any guests for a period of seven days. In case a guest comes he is not offered any food and when he leaves, they do not wish him avio, (which means 'come again' and is a form normally used to wish goodbye). For these seven days the male members of the family do not shave. On the seventh day no cooking is done in the kitchen of the house and the lady of the house goes begging to five houses and all the members of the family eat the food obtained by begging first and then their own food cooked the previous day. On this day the patient is taken to the temple and prayers are offered. After this the normal course of life is resumed and when the child fully recovers, the qhoda is offered in the temple where earlier the prayers were offered.

Interestingly enough, even though these are obviously Hindu practices or offerings made to Hindu gods, Muslims and members of other religious communities also follow them and accept the same treatment for the cure of these diseases. This is similar to what was found by Hasan\(^2\) in his study. According to him, "Both Muslims and Hindus have affected each other's values although they know that these are 'Hindu

practices' and they avoid a physician."

In relation to the response to these diseases it was observed that the community tries to propitiate the gods and goddesses not only when the disease is present but assumes a perpetual responsibility to propitiate the gods and goddesses with a special ritual performance at least once a year and to make it an obligation to attend these traditional folk ceremonies. For this a special day is set apart, which falls in the month of chomasa, the rainy season, and on this day people do not cook food in their kitchen but eat the food cooked the previous day. A similar finding has been reported by Opler in his study, where he emphasises the significance of protective ritual in these diseases. A point to make here is that folk system is preferred by community not merely in the cure of the disease. Even when a child is vaccinated against these diseases in accordance with Allopathy the set course of ceremonies of the folk system is observed and the deities are worshipped to avoid any contrary effect or reaction from vaccination.

Thus, in the cure of smallpox, chickenpox and measles the response is mainly to folk system in which various kinds of rites are performed.

The importance of cultural and spiritual elements in disease causation and healing are seen clearly in this town. For mental illness the response received indicated preference for the Folk medicine. However, the combination of Folk medicine along with Allopathic medicine was considered to be the best mode of treatment for mental disorders.

Mental disorders have been related mainly to supernatural causes like evil eye and evil spirit. The Folk medicine preferred for the cure includes a course in pleasing the spirits and removing the evil eye, and for this Folk healers, i.e. bhovas are called upon. A respondent narrated an incident where a woman, a postgraduate and a teacher by profession, had suffered from mental disorder due to an evil spirit which, according to the respondent, entered her soon after she had given birth to a child. For the cure of this patient Folk medicine along with Allopathy was preferred and the patient was cured. In another case, narrated by the wife of an Allopathic practitioner, a female relative of hers once became mentally upset because a spirit entered her when she was shopping. As a result she was unable to recognise any one and wanted to commit suicide. She was taken to an Allopathic hospital and given treatment, but without much improvement in her condition. Finally, after about fifteen days, on a
friend's advice, she was taken to a bhova who according to
the informant cured her by exorcising the evil spirit.

In this way, mental ailments in this town were still
believed to be often curable by the folk system in a magical
fashion. Some maladies were checked reportedly through black
magic. On the crossroads of the town one often came across
a figure drawn on the ground with some rice and coconut and
coloured powder placed on it. These figures were drawn by
bhovas often noticeable in the town and people avoided
stepping over them for fear of the spirit exorcised out of
the mentally ill entering them. If the passer-by were
questioned about the reason for drawing these figures they
would at once answer that some one must have had mental
disorder and the spirit must have been already exorcised.
This response was characteristic and indicated that people
fell back upon the folk system in search of a cure for
mental disorders even when a mental patient was put on
Allopathic medicines. A similar situation obtains also in
China, where Chinese traditional medicine can complement
modern psychiatric care. Vogel⁴ says, "Regardless of the
strictly physical benefits that may derive from traditional
Chinese medicine, there is no question but that the conti-

⁴ E. Vogel, "Chinese in Psychiatry," International
    Journal of Psychiatry, No. 12, pp. 229-238,
    April, 1965.
nuance of an indigenous medical practice has had important secondary benefits in treating less serious psychiatric disorders of a functional nature.

The response to Folk medicine and the bhova ceremony accepted in most cases in the cure of mental ailments can certainly be compared to what Kennedy has termed 'Zar'. The Zar refers to both ceremony and a class of spirits. In Egyptian Nubia, the purpose of a Zar ceremony is to cure mental illnesses through contact with possessing spirits which cause such maladies. The evidence indicates that though the Nubians have several methods for dealing with psychological disturbances, the Zar is believed to be a last resort which has powerful therapeutic effects on such ailments.

Because hysteria and epilepsy are considered by a majority of the members of the community to be caused mainly by the intervention of spirits and goblins, bhovas are normally sent for on such occasions to exercise the evil spirit. However, those who make a distinction between hysteria and epilepsy have recourse to Allopathic medicine for epilepsy.

With regard to ailments like headache, bodyache and eye trouble, it has been observed that the community at large distinguishes between those occurring due to supernatural and other related causes and those occurring due to natural causes. The ailments occurring due to supernatural and other related causes are believed to be minor and caused by evil eye or

nazare, and these are normally taken to the Folk System. The Muslim of the town believe that these disorders can be easily cured by a bhova who chants a few lines from the Koran. For this they often use incantations through a Muslim bhova. In cases of recurrent but minor headaches a patient is supposed to be susceptible to the evil eye and is made to wear a tabees. The tabees or talisman is a very small silver box with words from the Koran written in it and tied either on the hand or worn around the neck with a black thread. There is yet another method of curing these ailments also prescribed in the Folk system. In this method of cure a pot of water is taken; over this pot is placed a plate containing salt and red chillies. This is moved around the head of the patient seven times. After the seventh round is finished the salt and chillies are put in fire. It is believed that if there is no smell from the burning salt and chillies, the evil eye or nazare has been removed and the patient would become well. But if there is smell from the burning salt and chillies, it means the headache or eye trouble may not be from nazare but due to some natural cause. In such an event, that is in cases where the causes of these ailments are perceived to be natural and considered serious in nature the response is generally to Allopathic, Ayurvedic or Homeopathic medicine. The data indicates that 86.5 per cent of the total respondents showed their preference for Allopathy for such headaches, bodyaches and eye-troubles, 9.5 per cent
preferred Ayurveda and only 4 per cent preferred Homeopathic medicine. This larger response to Allopathy in these diseases when the cause is perceived as natural factors is also due to the self-prescribed medicines available from chemists or even from small shops, for example, aspirin.

In the cure of jaundice, the response of the community was by far to Allopathic medicine rather than to the Ayurvedic. However, a point that was recorded in a case of jaundice showed that in practically all cases of jaundice, along with Allopathic and Ayurvedic medicines folk medicine was also in demand as a precaution so that the disease might not become kamli. The treatment given by Folk system in all such cases is called kamla iharavana. Kamla as mentioned earlier, is the local term for jaundice and iharavana means to sweep or brush. It is mimetic magic involving recital of mantras. In the treatment process bhova is called in and he asks the patient to keep his feet or arms in a vessel containing lime water. While the patient keeps the feet or arms in the water the bhova recites mantras and simultaneously waves a sheaf of peacock feathers across the patient from his legs to his feet or from his arms to his hands. According to the respondents, after this ceremony the lime water kept in the vessel turns yellow and
this indicates that the disease has been washed away and the patient is sure to get cured and will not become kamli, the serious jaundice. It was observed that this method of treatment was accepted not only by illiterate but even by the educated people. There was an instance where even a practitioner of Allopathic medicine had called in a bhova to perform this ceremony to cure her child of jaundice.

The response to the systems of medicine in the cure of leprosy, a disease believed to be incurable, presented the following pattern: a majority of the people preferred Allopathic medicine. However, as in jaundice, in this case too they desired the patient to be taken to the Anasuya Temple indicating thereby that the cure process should be supplemented with the Folk medicine. The Anasuya Temple is situated on the banks of the Narbada in the Sinor Mahal of the district of Baroda, approximately fifteen kilometers from this town. The respondents said that this area had the reputation of curing lepers by simply rubbing the dust of the soil of this temple on the affected parts. A large number of lepers from the surrounding places congregate here. The 1901 Census reports that to alleviate the suffering of these miserable beings, the government of His Highness the Gaekwad, opened

on the 1st August, 1890 a leprosy hospital on this spot.

For venereal and skin diseases there would seem to be no response to folk medicine. In venereal diseases and scabies, a kind of skin disease, the response to Allopathic medicine was by far much greater than the response to Ayurvedic, Homeopathic and Unani systems of medicine. The overall response in the cure of skin diseases showed that 73.5 per cent of the total preferred Allopathy, 23 per cent Ayurvedic, 3 per cent Homeopathic and only 0.5 per cent Unani. It was also noted that self-prescribed medicines of both Allopathic and Ayurvedic systems were largely advertised on the walls of this town.

Allopathic system of medicine in this town received very high response in the cure of tuberculosis. The data indicated that 88 per cent of the total preferred Allopathic medicine and only 12 per cent of the total preferred Ayurvedic or Homeopathic medicine. Six per cent of the total respondents were those who made the point that to cure the disease radically so that there was no relapse, Ayurvedic medicine should be taken. As in skin diseases, in this disease too there was no response to folk medicine. Typhoid cases were normally taken to Allopathic practitioners with only 4 per cent of the cases going to Ayurvedic medicine and none to Homeopathic,
Unani or Folk medicine.

In the cure of diseases like rheumatism and asthma, the response was greater to Ayurvedic medicine than to the Allopathic. Both these diseases have been categorised as chronic disorders and hence some of the members of the community were of the opinion that Ayurvedic medicine should be supplemented with Allopathic medicine if the attack of these diseases was of a serious nature.

In order to cure stomach disorders the response of the community showed that Allopathic medicines were preferred most, which was followed by Ayurvedic and Homeopathic systems. Fractures, burns and such injuries were thought to be cured by Allopathic medicine. However, for minor sprains and dislocation of discs the respondents did show a preference for the Unani medicine.

In cases of pregnancy and childbirth the response observed showed a higher preference for Allopathy followed by Folk medicine. No one really showed any preference for Ayurvedic, Homeopathic or Unani system of medicine. This point has relevance in the context of the absence of female practitioners in these systems of medicine. Thus, the response pattern depends to a great extent also upon the practitioners of both the sexes obtaining in a system of medicine.
Further, cases of sterility too had shown a preference for Allopathic medicine. However, in all cases of sterility in which Allopathic medicine was preferred the use of such medicine was supplemented by Folk medicine. Sterile women observed fast and worshipped goddess Harisidhi Mata whose temple is near the railway station and is one of the biggest in the town. The sterile woman would visit the temple and offer her prayers and wish that if she had a child she would offer a cradle to the goddess. This is a symbolic toy cradle made of wood and symbolises the child. Such cradles are seen at the temple altar. Some women also observed a fast on Fridays in devotion to goddess Santoshi Mata whose temple is also in this town.

The response to systems of medicine in the cure of diseases of children and infants, it was observed, followed more or less this order of preference: Allopathy, Ayurveda, Homeopathy and Folk medicine. It may also be pointed out here that one of the Allopathic practitioners dispensed Homeopathic medicine in such cases.

From the analysis of a few diseases and the cure sought for them, as given above, we might sum up that the community preference for any given system of medicine depends upon their
perception of the nature and kind of disease and also on their view of disease causation. This leads to the following inference: where diseases have been categorised as being due to natural causes Allopathic medicine receives the highest response; and where diseases have been recognised as due to natural causes but of a chronic nature, a majority of the people prefer Ayurvedic medicine followed by Homeopathy. Where supernatural causes have been ascribed to diseases the Folk system receives the maximum response. Also, depending upon the complexity of the disease and its causes people prefer a plurality of treatment or a combination of medical systems. Significantly enough, except for two respondents no one else seemed to give an exclusive patronage to one system of medicine alone.

It may be suggested that people are becoming increasingly pragmatic in selecting the systems of medicine based on tradition or modern medical care. Nevertheless, the hypothesis that the effectiveness of a system of medicine in the cure of a disease determines the community's response to systems of medicine needs careful scrutiny and evaluation. The community at large has its own evaluation of the comparative effectiveness of different systems of medicine. The effectiveness of a given system of medicine is also related to the nature of the disease.
To examine this aspect with some measure of objectivity, a set of three choices, viz. tradition, comparative expensiveness and effectiveness was provided. The data collected to examine the view on the effectiveness of a system of medicine in the cure of a disease showed that the preference for a particular system of medicine related mainly to its effectiveness. Of the three choices, effectiveness received the maximum response. Interestingly, though two respondents regarded comparative expensiveness as a criterion none mentioned tradition in the choice of a system of medicine. Madan has found a similar response in his study in which he showed that though the decision to choose a given system was dependent upon many variables, effectiveness was the principal among them.

Related to the effectiveness of a system of medicine is the factor of faster relief obtained. People adopt or take to a particular system of medicine because of its proven ability to afford relief in a relatively shorter period. This time relationship in the cure of a disease by a given system of medicine may not be superficially obvious or palpably evident in the response pattern, but it is worth spelling out. In this town it was observed that in the cure

of diseases due to natural causes people often showed a preference for Allopathic medicine because the time taken to achieve a cure under Allopathic dispensation was by far shorter than under Ayurvedic, Homeopathic or Unani dispensation. Not only this, the observations made while sitting in the clinics of practitioners showed that patients were keener on injections for faster relief than on medicines orally administered. The community's definite preference for fast relief was again attested by the fact that the medical practitioners of the town made the maximum possible use of injections in their treatment.

Among the favourable factors in people's response to systems of medicine was the indication that the absence of response to Ayurvedic, Homeopathic and Unani medicine in cases of pregnancy and other gynaecological disorders was accounted for largely by the absence of any female practitioners in these systems of medicine. Women were still found very shy of going to the male practitioner complaining of these disorders. This point may also bear a certain relationship with the fact that India has more women gynaecologists (Allopathic system of medicine) than any other country. Thus, another major hypothesis of the study that was postulated shows a positive relation between
the presence of practitioners of both sexes and the response pattern.

The study indicates that factors like cost of treatment is not a determining factor in the response pattern to systems of medicine. In order to check up the validity of this hypothesis in this town, the respondents were asked to rate the systems of medicine with reference to the cost of treatment involved. The response showed that Allopathic system was rated as the most expensive. In relation to cost of treatment involved Ayurvedic and Homeopathic systems were placed almost on a par by the respondents. Unani and Folk systems in this town were rated as the cheapest. Thus, even though Allopathic medicine has been rated as the most expensive, the higher rate of response expressed for it clearly eliminates the cost of treatment as a significant factor in the response pattern. Also, it has been mentioned earlier in this chapter that the selection of a system of medicine depends on its effectiveness and not on whether the treatment involved under its dispensation is cheap or not. The field investigation revealed also that cost of treatment was no factor of decisive influence in the response pattern. Every respondent considered health too vital an issue to be made a matter for bargaining at the risk of one's health.
The validity of the socio-economic background of the community at large as a factor in determining the response pattern was made on the basis of the overall comparative popularity of the medical systems in this town. This was examined on the basis of the observations made on the clinics of all the private practitioners as well as on the basis of the analysis of responses received from the respondents. It may be pointed out here that only the first preference of a system of medicine has been kept in mind while analysing the relative quantum of response in the acceptance pattern. The analysis highlights that among the five systems practised in the town, the Allopathic system of medicine (77.5 per cent) received the largest response followed respectively by Ayurvedic (13.5 per cent), Folk (5 per cent), Homeopathic (3 per cent) and Unani (1 per cent) systems of medicine (Table VII).

From the analysis of data, (see Table VII), it can easily be derived that there is no significant relationship between the socio-economic background of the community at large and the overall comparative popularity of a system of medicine. However, an in-depth analysis of each of the essential characteristics of the socio-economic background vis-a-vis the different systems of medicine does point to a certain link-up in the response pattern. This link-up or relationship can
<table>
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<th>Socio-Economic Feature</th>
<th>Allopathic system of medicine</th>
<th>Ayurvedic system of medicine</th>
<th>Folk system of medicine</th>
<th>Homoeopathic system of medicine</th>
<th>Unani system of medicine</th>
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<td><strong>AGE</strong></td>
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<td>Upto 30 years</td>
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<td>77.66(57)</td>
<td>16.60(5)</td>
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<td>31 to 40 years</td>
<td>27.00(54)</td>
<td>77.77(42)</td>
<td>14.81(6)</td>
<td>3.70(2)</td>
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<td>41 to 50 years</td>
<td>29.00(58)</td>
<td>77.77(42)</td>
<td>12.08(7)</td>
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<td>51 and above</td>
<td>20.00(40)</td>
<td>77.5(31)</td>
<td>10.00(4)</td>
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<td><strong>TOTAL</strong></td>
<td>100(200)</td>
<td>77.5(155)</td>
<td>13.5(27)</td>
<td>5.00(10)</td>
<td>3.00(6)</td>
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<td>2.06(3)</td>
<td>3.44(5)</td>
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<td>12.77(7)</td>
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<td><strong>TOTAL</strong></td>
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<td>77.5(155)</td>
<td>13.5(27)</td>
<td>5.00(10)</td>
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<td>5.20(9)</td>
<td>2.89(5)</td>
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<td><strong>TOTAL</strong></td>
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<td><strong>TOTAL</strong></td>
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<td>Rs. 501 - Rs. 1000 p.m.</td>
<td>29.00(58)</td>
<td>77.58(45)</td>
<td>13.70(6)</td>
<td>5.17(3)</td>
<td>3.44(2)</td>
</tr>
<tr>
<td>Rs. 1001 &amp; above</td>
<td>14.00(28)</td>
<td>78.51(22)</td>
<td>13.72(7)</td>
<td>5.00(10)</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100(200)</td>
<td>77.5(155)</td>
<td>13.5(27)</td>
<td>5.00(10)</td>
<td>3.00(6)</td>
</tr>
</tbody>
</table>

8. Table prepared on the basis of data collected during field work.

*NOTE* Figures in the table are in percentage with absolute numbers given in brackets.
be illustrated through a detailed consideration of the essential characteristics of the socio-economic background like age, sex, caste/tribe, religion, education, occupation and income.

The association between the respondents' age and the preference pattern indicated that a majority of the people belonging to different age groups gave their first preference to Allopathic medicine. The preference for Allopathic medicine was almost constant while for the other four systems of medicine there was a slight variation between one age group and another. The percentage of respondents decreased for Ayurvedic and Homeopathic systems as the age of the respondent increased. On the contrary, the percentage of respondents increased with the age of respondents in the Folk and Unani systems. Significantly, no one in the age group of under thirty years gave first preference to Folk or Unani systems and except for this age category, in the other three age groups the preference percentage decreased in the following order: Allopathic, Ayurvedic, Folk, Homeopathic and Unani systems of medicine (Table VII).

According to the data the sex of the respondents had no marked bearing on the preference for a system of medicine; it had virtually not affected the acceptance pattern for
Allopathic system of medicine. Both the male and the female in the town responded similarly as to their preference for Allopathic system of medicine, i.e. a majority of male and female respondents ranked Allopathic medicine first and foremost. In the acceptance of the remaining systems of medicine, sex was found to cause a variation in the response pattern. The order of preference in the case of women respondents was Folk, Ayurvedic, Homeopathic and Unani systems of medicine. Opposed to this, a higher percentage of response from men showed a preference for Ayurvedic and Homeopathic medicine in that order over the Folk system of medicine. Here it may be of use to remember that this variation on the basis of sex was probably related to the absence of female practitioners in the Ayurvedic, Homeopathic and Unani systems of medicine, a point already dealt with earlier.

While observing the preference for systems of medicine and the association of the socio-economic background, considerations of caste or tribe become relevant in the Indian context and call for examination. Significantly, these considerations failed to receive any support from the data. On the contrary, the evidence collected suggests (see Table VII) that a majority of the respondents belonging to each caste or tribe category preferred Allopathic medicine. The order of
preference shows that tribals seemed no more prone to prefer the folk system of medicine than the non-tribals. The percentage of respondents from both caste and tribe categories in the five systems of medicine followed the same order, i.e. the Allopathic system received the highest response followed by Ayurvedic, Folk, Homeopathic and Unani systems of medicine.

Religion, the second important criterion in the social background, like caste and tribe, had little correlation with the preference pattern. If the respondents belonging to Muslim and other religions were combined together (as in Table VII) as against those belonging to the Hindu religious faith, the response received did not show much variation in terms of religion and the type of the system preferred. Allopathic system of medicine received the highest response from both religious categories. Not only this, the order of preference for the other systems of medicine was also the same for both these religious groups. This, disproves therefore the assumption made by Madan in his study about the association between Hinduism and Ayurvedic medicine. Significantly enough, this study reveals that the percentage of Muslims who preferred Ayurvedic system was more than that of the Hindus. Religion

was in no way an obstacle or a guiding force in the preference for Allopathic system or for that matter for any other systems of medicine.

The analysis of the data collected to study the association between the occupation and the preference pattern indicates that people of different occupational categories preferred Allopathic medicine followed by Ayurvedic, Folk, Homeopathic and Unani systems. However, a detailed analysis of the data as given in TableVII indicates a little difference in the percentage of preference for different systems of medicine in relation to the occupational categories. The association between the occupation and the response revealed the following: a higher percentage of respondents in the categories of agricultural or manual labourers and of services preferred Allopathy as compared to the respondents in the categories of farming, trade and commerce. Presumably, people in these categories opted for the factor of faster relief reputedly offered by Allopathic medicine. This can be appreciated if we remember that a labourer cannot afford to waste a day and lose his meagre wages. He must have quick relief. In contrast, we find there is a higher percentage of respondents in the categories of trade and commerce with their preference for Ayurvedic and Homeopathic systems while the
folk system attracted a higher percentage of respondents from the category of farmers. This is related to the fact that the nature of occupation of the respondents in these categories is such that they were not badly in need of a quick relief.

The level of education as a socio-economic factor showed no association with the pattern of response. The response of people belonging to all types of educational groups was clearly and overwhelmingly for Allopathic and then for Ayurvedic, Folk, Homeopathic and Unani systems of medicine in that order of preference. An important association, however, emerged when the Folk, Ayurvedic and the Homeopathic systems of medicine were examined in depth (see Table VII). The highest percentage of response to Ayurvedic and Homeopathic systems was given by educated people with either professional or higher education. These people have been grouped in the education category of high School and above. Thus, there was an increase in the preference for Ayurvedic medicine as one moved towards higher educational level. Also observed was the fact that this kind of response resulted from the faith of these people in the medicines of those systems which, according to them, afforded a radical cure for diseases. The response to the Folk system showed that it was preferred more by the illiterate and the just literate category of people.
The educated came after these categories in their preference. This pointed to the fact that the superstitious beliefs, though present, had a lesser hold on those with higher educational levels.

It is often assumed that the criterion of economic income must be related to the response pattern, i.e. people belonging to higher income brackets prefer Allopathic medicine while those belonging to the lower income groups do not. This assumption was found to be without much basis in the study of this town where all the income categories evinced maximum preference for Allopathic medicine. What is more, a careful look at the analysed data shows that the highest preference for Allopathic medicine was made by people from the lowest income strata. The percentage of response was on the decline in the higher income brackets. Contrary to this, the percentage of favourable response to Ayurvedic system increased as one moved higher in the income group; and the percentage of such response to folk system decreased in the higher income brackets. The response pattern remained virtually the same for the Homeopathic system of medicine. This response once again

bears out the validity of the hypothesis that the 'cost of treatment is not a significant variant in the response towards system of medicine'.

The residential status of the respondents, i.e. that of their being natives or migrants to the town, did not have a bearing on the preference pattern as a characteristic of socio-economic background. It did have a bearing, however, on the response to folk medicine where the percentage of the native respondents was nearly twice that of the migrant respondents.

From the analysis given above of the socio-economic background and the association of response it can fairly be summed up that certain major factors assumed to be of significance in the Indian context are not actually related to the pattern of response in the present case. Caste or tribe and religion have shown no association in the response factor. Income is not a guiding force in the choice of a system of medicine. The difference in income levels as reflected in receptivity to the Allopathic system of medicine cannot in all instances be ascribed to lack of money. What seems to matter, though, is the relative time taken for healing. Also, the choice of Allopathic medicine is apparently not dependent upon the level of education. It may be added here that the
rating of Homeopathic and Unani systems as the least acceptable has not been done on the basis of the response but merely on the basis of the fact that there were only two practitioners, one in each. Their very small number could be a pointer to a virtual lack of popularity of these medical systems in the town.

It is clear then from the above analysis that there are various factors which determine the response to different systems of medicine.

**Part II: Factors Determining Response to Practitioners**

Once the choice of a system of medicine is made the next question that emerges is how the selection of a practitioner is made by the community. Even though this analysis is not relevant in the case of either Homeopathic or Unani medicine, as in each there is only one practitioner, yet the analysis is attempted since it is likely to throw some light on the factors that can influence the selection of a practitioner if given a choice. There are not one but several factors which the community keeps in mind while exercising their preference for or response to a practitioner.

It was observed during the course of investigation that people were markedly inclined to consult one practitioner of any system in preference to another on the basis of certain
considerations. These were examined and found to be: the
genral behaviour of the practitioner; faith in the practi-
tioner; physical proximity with the practitioner like, for
example, a practitioner in the neighbourhood; reputation of
the practitioner; religion, caste or tribe of the practitioner
and the practitioner who costs or charges less (Table VIII).
These factors tended to prove the hypotheses formulated to
evaluate the response to the practitioners. The hypotheses
have already been stated in the first chapter of the thesis.

All the factors or considerations stated above were
expected to be relevant in determining the response and were
therefore included in the interview guide.

The response pattern obtained made it possible to
observe that the general behaviour of the practitioner
constituted the consideration or criterion for 31.5 per cent
of the total respondents in response to the query, 'What
is your criterion for selecting a practitioner?' (Table VIII).
The question of behaviour of a practitioner is no doubt a
relative one and is related to the role performance of the
practitioner. Hence, the analysis of this criterion is done
on the basis of the role performance.

Role of a practitioner is part of a social role and
like other social roles it also has a set of expectations and
<table>
<thead>
<tr>
<th>Socio-Economic Background</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upto 30 years</td>
<td>24.00(48)</td>
<td>31.25(15)</td>
<td>29.16(14)</td>
</tr>
<tr>
<td>31 to 40 years</td>
<td>27.00(54)</td>
<td>31.48(17)</td>
<td>29.52(16)</td>
</tr>
<tr>
<td>41 to 50 years</td>
<td>29.00(58)</td>
<td>31.03(10)</td>
<td>27.31(7)</td>
</tr>
<tr>
<td>51 years and above</td>
<td>25.00(49)</td>
<td>32.99(53)</td>
<td>30.00(12)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100(200)</td>
<td>31.5(63)</td>
<td>29.5(59)</td>
</tr>
<tr>
<td>Social Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caste</td>
<td>16.65(13)</td>
<td>31.85(36)</td>
<td>30.08(34)</td>
</tr>
<tr>
<td>Tribe</td>
<td>19.00(38)</td>
<td>31.57(12)</td>
<td>28.94(11)</td>
</tr>
<tr>
<td>Others</td>
<td>24.5(49)</td>
<td>30.61(15)</td>
<td>28.57(14)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100(200)</td>
<td>31.5(63)</td>
<td>29.5(59)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>75.5(151)</td>
<td>31.78(48)</td>
<td>29.80(45)</td>
</tr>
<tr>
<td>Muslim &amp; others</td>
<td>24.5(49)</td>
<td>30.61(15)</td>
<td>28.57(14)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100(200)</td>
<td>31.5(63)</td>
<td>29.5(59)</td>
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<tr>
<td>Education</td>
<td></td>
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<td></td>
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<tr>
<td>Illiterate</td>
<td>16.00(32)</td>
<td>31.25(10)</td>
<td>28.12(9)</td>
</tr>
<tr>
<td>Literate</td>
<td>48.00(96)</td>
<td>32.29(31)</td>
<td>30.51(28)</td>
</tr>
<tr>
<td>Upto High School</td>
<td>21.00(42)</td>
<td>30.95(13)</td>
<td>30.95(13)</td>
</tr>
<tr>
<td>High School &amp; above</td>
<td>15.00(30)</td>
<td>30.00(9)</td>
<td>30.00(9)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100(200)</td>
<td>31.5(63)</td>
<td>29.5(59)</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
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<tr>
<td>Farming</td>
<td>15.5(31)</td>
<td>38.25(10)</td>
<td>29.03(9)</td>
</tr>
<tr>
<td>Agriculture &amp; Manual Labour</td>
<td>28.00(56)</td>
<td>32.14(18)</td>
<td>30.35(17)</td>
</tr>
<tr>
<td>Trade &amp; Commerce</td>
<td>31.00(62)</td>
<td>30.64(19)</td>
<td>29.03(18)</td>
</tr>
<tr>
<td>Service</td>
<td>25.5(51)</td>
<td>31.37(16)</td>
<td>29.41(15)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100(200)</td>
<td>31.5(63)</td>
<td>29.5(59)</td>
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<tr>
<td>Income</td>
<td></td>
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</tr>
<tr>
<td>Upto Rs 500 P.M.</td>
<td>57.00(114)</td>
<td>31.57(36)</td>
<td>29.82(34)</td>
</tr>
<tr>
<td>Rs 501-1000 P.M.</td>
<td>29.00(58)</td>
<td>31.03(18)</td>
<td>29.31(17)</td>
</tr>
<tr>
<td>1001 &amp; above p.m.</td>
<td>14.00(28)</td>
<td>32.14(9)</td>
<td>28.57(8)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100(200)</td>
<td>31.5(63)</td>
<td>29.5(59)</td>
</tr>
</tbody>
</table>

Note: Prepared on the basis of Data collected during Field Work.
expected behaviour pattern in the interaction. Parsons'\textsuperscript{11} analysis of social roles of practitioners is a key influence in the history of this aspect of sociology. However, being a small town with a population of about 25,769 people the practitioners are unable to follow the Personian model of the role performance. The social and professional requirements made on a practitioner in this town often exceed his performance of his role in a set pattern of 'effective neutrality' given by Parsons. This finding can easily be compared with that of Bloor and Horobin\textsuperscript{12} who have also pointed out that, "the ideal type need not be isomorphic with the empirical reality it describes, it selects certain aspects of the phenomenon under the study as important while others are ignored." In this town the range of behaviour observable in a unimodel definition of the social roles given by Parsons falls short of its achievements.

**Practitioners' role performance in relation to members of the community determines the acceptance of a practitioner.**

This is so, "because in the medical care situation, for example, both physician and the client hold expectations of their own

\begin{itemize}
\item \textbf{11. T. Parsons} : \textit{Social System, The Free Press of Glencoe, 1951.}
\end{itemize}
and the others role. The members of the community expect that in their interaction with practitioners, the latter should talk to them politely and must not take them merely as objects but as human beings. Their conversation should not only be about the disease but other things as well. Springer's finding fits in here, for he says that:

"the physician is often a general adviser on problems not related to health alone. He is at hand when required and he may intervene rapidly when his help is needed. On the other hand, he often plays an active role in the prevention of many diseases and he contributes to improving the general health of the community."

Community seeks personalised care and attention from the practitioners. Ahluwalia has also said that if the professional services become personal they are better valued.

According to Marshall:

"the professional man does not give only his skill. He gives himself. His whole personality enters into


his work. It is hardly possible to be satisfied with a doctor or a lawyer unless one likes and respects him as a man. He is called upon to form a judgement and an understanding of human nature, as well as a knowledge of medicine or law. The best services can be given only when the practitioner knows his client intimately, his character, his foibles, his background and his family circumstances."

Though, this may be termed easily as an example of a family practitioner, yet the observations made in this respect in this town indicate that the practitioner behaved in an expected manner because the community being very small, it was not very difficult to get to know the clients intimately.

Members of the community do not approve of the practitioners who maintain a socio-economic difference in their outer appearance. In the Indian context it has been observed by Merriot\textsuperscript{17} that the poor response the practitioners of Allopathic medicine get is mainly because these practitioners are thought to represent for much of the population a high standard of living and a high degree of professionalization. However, this feeling was not found to be present in the attitude of the practitioners of this town. They were by and large

'insiders', that is to say, they were well adjusted in the given cultural milieu and as such had no problem in performing the role expected of them in the cultural context. The use of colloquial language was invariably welcomed by the clients and, to a great extent, it narrowed down the gap between the practitioner and the community and helped the practitioner in his role performance which influenced the community's response to him. Furthermore, while referring to a patient's disease, the practitioners often kept cultural and social aspect of the disease in mind. For example, if a patient suffered from leprosy, the practitioners, it was observed, would term the disease only as garmi noo roq and not rakt pitt. This was because they knew that the disease had a social stigma attached to it.

Thus, the practitioners', friendly expression, behaviour and receptivity changed the acceptance pattern. It was observed that the practitioners in their friendly expression would address elders, with a note of respect, as kaka, meaning uncle. The friendly behaviour does influence the response pattern. As Svarstad¹⁸ has pointed out, "The first strategy

the physician might use is to express friendliness and receptivity towards the patient." According to the analysis of the investigation shown in Table VII, the members of the community, irrespective of their socio-economic background, did approve of the practitioner with a friendly behaviour, and this no doubt was an important factor bearing on their response to practitioners in this town.

Virtually nobody willingly goes to an unethical or incompetent practitioner, and clients almost always claim that their own practitioners are excellent and go on to illustrate this with a reference to the consideration of faith in a practitioner. (See Table VIII). This consideration was mentioned in the response to practitioners by 29.5 per cent of the total number of respondents. The subjective stress, if one may call it, was that faith and determination could perform miracles. If one had faith in the practitioner and if one used subjective initiative, one could overcome illness even though circumstances and facilities might not be satisfactory. Faith in the practitioner was stressed by the members of the community as a reason for the selection of a practitioner, and his opinion was not related to the socio-economic background of the members of the community. The analysis
in Table VIII clearly indicates that this factor was noted among 29.5 per cent of the total of the respondents who belonged to varying socio-economic background. It may also be worth mentioning here that even the practitioners mentioned the faith of their clients in them as a reason for their success in practice. An educated bank employee of this town mentioned in his response that faith consideration was very important in the selection of a practitioner. According to him, "If there is faith in the practitioner, even plain water given by him would help like medicine."

Practitioners adopted various means to retain the faith of their clients. Clients developed faith in their practitioners because practitioners tended to value the sentiments and feelings of their clients by hanging up photographs of gods and goddesses on the walls of their clinics and by paying due respect to their religious feelings. They also maintained the faith of their clients by taking care to avoid criticizing or contradicting the validity of some supernatural manifestations in the cure of certain diseases. One of the reasons for having faith in folk practitioners was that they performed their practice in a temple or a mosque. The use of 'Marium flower' by a chai in the delivery of a child helped to maintain the faith of her
clients. The dhai would say that she had brought the flower from Mecca, the holy place of Muslims. She would always take it along when called for a delivery. She would put the flower on the head of the expectant mother and then move it over her head and then keep the flower in a pot containing water. She said the flower which was actually dry, grew bigger and bloomed when kept in water and as the flower bloomed automatically, the vaginal passage of the expectant mother became wider and the child was born without any difficulty. This flower, it was observed, had helped the dhai in developing the faith of her clients. She called this flower mubarak phool, the auspicious flower.

The fact that women practitioners of Allopathic medicine allowed their clients to carry on their cultural practices proves the point that by not offending the cultural sentiments of the members of the community the practitioners tried their best to gain the faith and confidence of their clients. The respect cultivated by practitioners for these practices has helped in gaining the faith of the members of the community not only in this part of the world, but also in other countries. Grangvist has found that in the Middle East the West-trained practitioners try to develop the faith of their clients.

and avoid any conflict by allowing their cultural practices free play. To quote a practice observed by Grangvist, "When she has given birth, a mother steps three times over the threshold and back, with the child, another woman carries the child if she is too weak. This is for fear of harm, or fear that she will not have any more children." On similar lines an example from the field notes can be mentioned here. A certain woman practitioner of Allopathy narrated a practice after child birth which she allowed for the sake of the satisfaction of the community. The practice called meyu consists in making a tampon soaked in fatkari (citric acid) and in a country wine made from mohade tree and inserting it in the vagina after childbirth. This, it is believed, contracts the soft parts of the vagina and they revert to their original position.

In this way the practitioners know that the response of the members of the community to a great extent also depends upon how much faith they are able to gain. On the other hand, the hypothesis that faith in the practitioner determines the response to practitioners can be regarded as real because the members of the community have cited this factor as a criterion for their response to a practitioner.
The factor of accessibility to a practitioner in terms of physical distance was favoured as a consideration by 17 per cent of the total number of respondents. This factor, which can also be termed as the neighbourhood practitioner factor, is not significantly associated with the socio-economic background of the members of the community at large. However, it has some association with the sex of the respondents. The relatively higher tendency, as noted in Table VIII, to consult a neighbourhood practitioner seems to be characteristic of female respondents. Besides, the physical structure of the town is such that all the practitioners are within walking distance. This could be one of the reasons why a practitioner of neighbourhood, in spite of the strong neighbourly relations, was given as a factor for response only by a limited number of respondents. Moreover, as indicated in Table VIII the factor of a 'well-known practitioner' also received a somewhat better response as compared to this factor - an indication that preference for a practitioner of neighbourhood gave way to preference for a well-known practitioner of the town.

The factor of 'well-known practitioner' or 'the famous practitioner' in the response is related to the popularity of the practitioner both in terms of his experience and background.
The qualifications of the practitioner have a bearing, albeit in a limited way, on the 'well-known practitioner factor'. That is, the well-known practitioners in the town are those who have had either a relatively longer experience in their practice or those whose parents have been in the same profession. For instance, the youngest practitioner of Allopathic medicine in this town, who falls in the category of well-known practitioners, is the son of a practitioner who had been very popular with his clients.

The factor of 'well-known practitioner' as illustrated in Table VIII shows an association with the socio-economic background of the respondent. The age of the respondent giving this factor as the determining factor in his response to a practitioner is also significant. The percentage of response for this factor decreases as the age of the respondent increases. This indicates that younger people are more prone to cite this criterion for response. It is also true that younger people are more educated and hence the data also indicate that the percentage of the respondents giving this response is higher among the educated than among the illiterate and barely literate. The response shows that this factor is stronger among male respondents than among the female. It may be rightly assumed
here, on the basis of the earlier analysis, that the females are more inclined to visit a practitioner of the neighbourhood or a practitioner of their own sex than a well-known practitioner. In brief, the relationship between the socio-economic background and this factor indicates that the younger educated men belonging to higher income groups are more prone to accept a well-known practitioner than those who are older in age, literate but belong to the lower income strata.

The religion, caste or tribe of a practitioner has not received much response as factors determining the response to him. (See Table VIII). In fact the caste, tribe or religion of a practitioner as a factor in the selection was given by only 3 per cent of the total respondents. This too was observed through intensive interviewing. A significant element noticed in this case was that the three per cent of the total respondents who cited this factor did so for the choice only of folk practitioners. This response may be said to have some relation with the socio-economic background of the respondents. All the 1.5 per cent of the total respondents giving the caste or tribe factor belong to the Hindu religion and fall in the category of either illiterate or literate education level and lower income group. As to the religion of the practitioner as a factor, the respondents were all Muslims, and, again, belonged
to the lower income group and education level. A respondent who gave this response for the selection of a practitioner said that he selected a Muslim bhova because he alone could read the Koran. Hence if he had to choose a folk practitioner he would select a Muslim bhova.

Both the above factors, though given only for folk practitioners pose a significant question. Had there been a tribal in Allopathic, Ayurvedic, Homeopathic or Unani system of medicine, would the tribals prefer him? Likewise, had there been a Muslim in Allopathic, Ayurvedic, or Homeopathic medicine, would the Muslims prefer him?

All the factors given above as the determining factors for selecting a practitioner go to prove the hypothesis formulated to examine the factors influencing the community's response to practitioners of various systems of medicine. It is no doubt interesting to note that the factor of 'a cheap practitioner' received only 1 per cent of the total response. Therefore, it may easily be inferred that the hypothesis relating to this factor has been by and large proved. Also, it gives sufficient support to the point already referred to that the economic reason plays no significant role in the choice of either a system of medicine or a practitioner of medicine. One of the major reasons for such a response could
also be that all the practitioners in the town maintained a
uniform pattern of charging fees depending upon their system
of medicine. In fact, no practitioner, except women practi-
tioners of Allopathic medicine charged a consultation fee.
Even these practitioners had kept their fees at a minimum,
i.e. Re.5/- which also they charged in gynaecological cases.
A point to be noted here is that the practitioners of Allo-
pathic medicine were aware of the need for keeping their
charges at the minimum. It was observed that no practitioner
of this system normally dispensed medicine. Also, all the
practitioners were capable of making an assessment of the
socio-economic background of their clients and, at times,
when they felt that their clients were very poor, they
even did not mind dispensing free medicines.

Thus, from a study of the community response to systems
of medicine and their practitioners, it may be concluded that
the response to systems of medicine was mainly based on the
perception of disease causation, effectiveness of a given
system of medicine and the time spent in the cure of a disease.
On the other hand, the response to practitioners was mainly
determined by the behaviour of practitioners, faith in prac-
titioners, practitioners' proximity and their being well-
known. In other words, the response to practitioners was to a
great extent based upon the cultural, social and physical access-
ibility of practitioners. Cultural and social responsibility 
was refera
to whether or not the practitioner was perceived as responding to the patients and their diseases within a certain framework consistent with the community's cultural expectations.

However, before concluding the chapter, it is important to underscore the point that the response to systems of medicine as well as to their practitioners though based on various factors, is also influenced by the interaction of members within the community. As pointed out earlier, the perception of etiology of disease of an individual is influenced consciously or subconsciously by the norms laid down by the community, the opinions held by it and by the interaction with other members of the community. Similarly, the response to a given system of medicine and their practitioners in the cure of diseases is not the result of an individual decision but a decision directly or indirectly influenced and shaped by the interacting group. The study of this interacting group generating relationships that influence is also important in the response pattern. In the following chapter this aspect of the response pattern is studied in detail.