CHAPTER VIII

THE REFERENCE LINK AND THE RESPONSE

The study of the interpersonal relationships that exist within any given community is the crux of the study dealing with the response pattern in that community. It is of immense interest to the sociologist to study social, structural and cultural group actions within the ambit of this response pattern and the medical systems. The interpersonal relationships or the interpersonal links may also be called reference links, and are a part of what the sociologists may call social networks. Social networks, as pointed out by McKinlay¹, constitute a facility through which the individual maintains his identity and receives emotional support, material aid and services, information and new social contacts. It is thus suggested here that the chains or networks of ties of interaction largely determine the responses that are made to a system of medicine and its practitioner by members of the community at large. The patient's interacting group affects the actual or anticipated response because to some extent it is affected

by his illness. On the other hand, for the establishment of a clinic and in enlarging his clientele, a practitioner needs the support and contact of his interacting group.

In this chapter an attempt has been made to analyse the network of ties in which a person or social unit is involved while seeking medical help. It is considered both as a major factor in the perception of diagnosis and cure of diseases for the community at large, and as a factor in the establishment of the practice and the clientele for the community of practitioners. In order to analyse the interpersonal links or the reference links (the term which has been used in this analysis) of the social network, the chapter has been divided into two parts. The first part illustrates the pattern of reference links through which a member of the community at large reaches a particular diagnosis and response. The second part mainly examines the pattern of reference links that have helped a practitioner of the community of practitioners in the establishment of his clinic and in widening the circle of his clientele.

Part II: Reference Link Influencing the Response of the Community at Large to Systems of Medicine and Their Practitioners

No patient is merely an organic entity; he is an integral organism, psyche and a social actor.² Patients do not live in

isolation but are related to other members of the community and they interact with them. Roth has rightly called the patient a social person. These members with whom the interaction takes place become their reference links in the health action. Thus, the responses can be considered in terms of both the perception of disease and the resources that are at hand. The resources are the links and form part of social networks which influence the response. Thus, patients are related to other members of the community and these members influence their response by becoming their reference links.

The response is influenced by reference links because in a situation of disease the individual interacts with others in an attempt to seek their help and guidance. The sociological significance of the reference links lies in the way in which these links in a person's response may become channels for transmission of information on the knowledge of the diagnosis of the perceived disease and the response. These reference links thus provide a basis not only for channelising the knowledge of diagnosis of disease but also for motivating a particular response.

The extent and nature of reference links may vary from one community to another, even though as evidence from the works of scholars suggests that the structural and functional aspects of diseases remain similar. In this town, the study indicates that in all cases the reference links had influenced the perception of disease diagnosis and the response; that individuals, when ill, sought help from other members of the community who might be related to them in different ways and with whom they interacted.

The perception of diseases, their diagnosis and the nature of medical care received are thus intricately interwoven with social interaction of individual members within a community. These reference links through which interaction takes place can be classified into permanent links and temporary links. The permanent links are those through which the interaction takes place over and over again of which family members, neighbours, friends, colleagues, members of the same caste, members of the same religious group and members of the community of professionals are among the most important and enduring in mediating and motivating the response pattern. The temporary links, on the other hand, are those in which the interaction has taken place only once e.g. a co-passenger.
All social interaction, for proper understanding, needs to be related suitably to a classification of the participants in such action in terms of their position in a given social structure. The observed reference links in this town can also be classified into 'permanent links' and 'temporary links'. Permanent links for this analysis are further divided on the basis of different types of relationship into 'social group links' and 'practitioners' links'. The social group link includes the relationships through a family member, a neighbour, a friend or colleague, a person of the same caste or a member of the same religious faith. The practitioners' link includes practitioners practising the same system of medicine and practitioners of the other systems of medicine.

Friedson⁴ in his study of 'client control and medical practice' distinguishes between two referral systems, which he calls the 'lay referral' and the 'professional referral'. The 'lay referral' system, according to him, consists of a variable lay culture and a network of personal influence along which the patient travels on his way to the physician. The 'professional referral' system refers to referral behaviour within the system of modern medicine, culture and institution.

In this study the 'social group links' of the 'permanent links' and the 'temporary links' may be compared with the 'lay referral' of Friedson. But in this town the 'professional referral' of Friedson is not really applicable and comparable to the practitioners' link in the permanent links classification. This is so because there are several medical cultures present in this town and not just the modern medical culture. The practitioners' link as stated in this study can be compared to Polgar's professional phase which refers to professionals as any health actors recognised as specialists by members of their community or social group. Practitioners' links thus include all the practitioners irrespective of the system of medicine practiced by them.

The analysis of the data collected to evaluate reference links in health action shows that an overwhelming majority of the links fall in the category of 'social group links'. While mentioning the link in their response 84.5 per cent of the respondents emphasised the 'social group links'. Compared to this only 13 per cent referred to the 'practitioners' links' in their response and only 2.5 per cent mentioned the 'temporary links' (See Table IX). A detailed examination

**Table 1**

REFERENCE LINK INFLUENCING THE RESPONSE OF THE COMMUNITY AT LARGE TO SYSTEMS OF MEDICINE AND THEIR PRACTITIONERS

<table>
<thead>
<tr>
<th>Socio-Economic Background</th>
<th>Socio-Group Link</th>
<th>PRACTITIONERS LINK</th>
<th>TEMPORARY LINK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family</td>
<td>Neighbour</td>
<td>Friend/Colleague</td>
</tr>
<tr>
<td><strong>AGE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upto 30 years</td>
<td>24.00(48)</td>
<td>41.66(20)</td>
<td>22.91(11)</td>
</tr>
<tr>
<td>31 to 40 years</td>
<td>27.00(54)</td>
<td>40.74(22)</td>
<td>22.22(12)</td>
</tr>
<tr>
<td>41 to 50 years</td>
<td>29.00(58)</td>
<td>41.37(24)</td>
<td>22.44(13)</td>
</tr>
<tr>
<td>51 years &amp; above</td>
<td>20.00(40)</td>
<td>42.5(17)</td>
<td>22.5(9)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100(200)</td>
<td>41.5(63)</td>
<td>22.5(45)</td>
</tr>
<tr>
<td><strong>SEX</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>72.5(145)</td>
<td>41.37(60)</td>
<td>22.75(33)</td>
</tr>
<tr>
<td>Female</td>
<td>27.5(55)</td>
<td>41.91(23)</td>
<td>21.81(12)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100(200)</td>
<td>41.5(83)</td>
<td>22.5(45)</td>
</tr>
<tr>
<td><strong>RESIDENTIAL STATUS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>65.9(173)</td>
<td>41.61(72)</td>
<td>22.54(39)</td>
</tr>
<tr>
<td>Rural</td>
<td>34.1(87)</td>
<td>40.74(11)</td>
<td>22.22(6)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100(200)</td>
<td>41.5(83)</td>
<td>22.5(45)</td>
</tr>
<tr>
<td><strong>SOCIAL STATUS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caste</td>
<td>56.5(113)</td>
<td>41.59(47)</td>
<td>22.12(25)</td>
</tr>
<tr>
<td>Tribe</td>
<td>19.00(38)</td>
<td>42.10(16)</td>
<td>23.68(9)</td>
</tr>
<tr>
<td>Others</td>
<td>24.5 (43)</td>
<td>40.81(20)</td>
<td>22.44(11)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100(200)</td>
<td>41.5(83)</td>
<td>22.5(45)</td>
</tr>
<tr>
<td><strong>RELIGION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>75.5(151)</td>
<td>41.72(63)</td>
<td>22.51(34)</td>
</tr>
<tr>
<td>Muslim &amp; others</td>
<td>24.5(49)</td>
<td>40.81(20)</td>
<td>22.44(11)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100(200)</td>
<td>41.5(83)</td>
<td>22.5(45)</td>
</tr>
<tr>
<td><strong>EDUCATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>16.00(32)</td>
<td>40.62(13)</td>
<td>21.87(7)</td>
</tr>
<tr>
<td>Literate</td>
<td>40.00(96)</td>
<td>42.70(41)</td>
<td>22.91(22)</td>
</tr>
<tr>
<td>Upto High School</td>
<td>20.00(42)</td>
<td>40.47(17)</td>
<td>21.42(9)</td>
</tr>
<tr>
<td>High School &amp; Above</td>
<td>15.00(30)</td>
<td>40.00(12)</td>
<td>23.33(7)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100(200)</td>
<td>41.5(83)</td>
<td>22.5(45)</td>
</tr>
<tr>
<td><strong>OCCUPATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farming</td>
<td>15.5(31)</td>
<td>41.93(13)</td>
<td>22.59(7)</td>
</tr>
<tr>
<td>Agricultural &amp; manual labour</td>
<td>40.00(56)</td>
<td>41.07(23)</td>
<td>21.42(12)</td>
</tr>
<tr>
<td>Trade &amp; Commerce</td>
<td>30.00(62)</td>
<td>41.93(26)</td>
<td>22.50(14)</td>
</tr>
<tr>
<td>Service</td>
<td>25.5(51)</td>
<td>41.47(27)</td>
<td>22.52(12)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100(200)</td>
<td>41.5(83)</td>
<td>22.5(45)</td>
</tr>
<tr>
<td><strong>INCOME</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upto Rs.500 pm</td>
<td>57.00(114)</td>
<td>41.22(47)</td>
<td>22.80(26)</td>
</tr>
<tr>
<td>Rs.501-1000 pm</td>
<td>29.00(58)</td>
<td>41.37(24)</td>
<td>22.41(13)</td>
</tr>
<tr>
<td>Rs.1001 &amp; above</td>
<td>24.00(49)</td>
<td>42.85(12)</td>
<td>22.42(6)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100(200)</td>
<td>41.5(83)</td>
<td>22.5(45)</td>
</tr>
</tbody>
</table>

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

*NOTE: Figures in the table are in percentage with absolute numbers given in the brackets.*
of reference links requires a detailed discussion of each category of the links referred to, which is attempted below.

The 'social group links' forming a part of 'permanent links', as already mentioned include the reference links of the members of the community with each other in general, for example, a family member, a neighbour, a friend or a colleague, a member of one's own caste or tribe, a person of the same religious faith etc. It may be pointed out that in the 'social group links' a person may be related to his reference link in more than one way i.e. the linking person may be a neighbour, a member of the same caste or religion or a friend. But the present analysis takes into account only one reference link, and this has been done on the basis of the type of link mentioned and emphasised by the respondent. The data indicates that in the 'social group links' the members of the family have been the link for 41.5 per cent of the total respondents. This is followed by neighbours (22.5 per cent), friends or colleagues (18 per cent), members of the same caste or tribe (20 per cent) and members of the same religious faith (25 per cent). (See Table IX). In order to analyse the co-relation of the kind of link mentioned by the respondents and their socio-economic background, each element of the social group links needs to be analysed at length.
While discussing the 'social group link' in relation to diagnosis of disease and acceptance pattern the most important and essential link to be considered is that of members of the family. The interaction of an individual within his family socialises him into a way of thinking, believing and doing, which influences and conditions his action in general. Whenever he is ill, the members of the family are taken into confidence and their advice is sought. Careful observation and investigation shows that in this town, when an individual falls ill, he turns to his relatives who live with him for advice. These relatives in turn depending upon their perception of the disease either guide him or suggest a particular kind of treatment for him. The relatives, who constitute the link, may include members of a nuclear family or extended family, whichever is applicable. In five cases, it was observed that the link was even through the affinal kin, also considered as the family link. A case of a tribal suffering from asthma, which has already been discussed, reveals the link of a father-in-law, who had brought his son-in-law for a particular treatment.

The socio-economic characteristics and the family link indicated no mutual association. The response pattern provided by respondents giving the family member link is analysed in Table IX. It shows that there was no variation in the response
in relation to age, sex, caste or tribe, religion, occupation, education and the income level. However, a significant observation was that women were always accompanied by their family link: educated women by their husbands and illiterate and just literate women by female members of the family, e.g. a mother-in-law, a sister-in-law, a sister, mother or an aunt. In general, within the family the reference link for males was provided by the senior male members of the family and for females, by female members.

The town had strong neighbourly relations, observed both in the physical proximity of the houses and the social proximity of the individuals or families living in them. 22.5 per cent of the respondents mentioned the link, in the response pattern, through a neighbour. In the course of the interviews they said that they had been guided by their neighbours. Neighbours in this case included persons living in adjacent houses as well as in the same vada (A vada is what has already been described earlier as a mohalla, a locality, e.g. a respondent said that he lived in Sindhi vada and the person who had guided him also lived in the same vada). For a person, the response through a neighbour's link implied that there was no social vacuum, that there was some one to help him in case of need. As a respondent
explained, "Since my neighbours got cured by this treatment even I will get cured." The person who recommended and provided the reference links assumed only a moral responsibility of the neighbourhood and nothing else. The data in Table IX reveals no significant association between the socio-economic characteristics and this kind of response. This, however, illustrates the point that even the migrants in the town tended to believe in strong neighbourly ties and sought help from neighbours. According to the data, 22.54 per cent of the insiders and 22.22 per cent of the migrants have given this response.

Friends or colleagues figured as a link in the response given by 18 per cent of the respondents. This was a comparatively new link in this town as it would appear from the study and its preponderance was evident in the response from respondents living in the new residential colonies of the town. It was observed that people often sought advice from their colleagues at their work places. To give an instance a certain local factory hand related how a fellow-worker in his factory advised him to take a particular course of treatment when he fell ill. As against the first two types of 'social group links', this category was associated with the socio-economic characteristics of the respondents. (See Table IX). Age, sex, education level and occupation were the elements
composing this significant association. Younger people, mostly below the age of forty years, evinced the strongest tendency to give their friends or colleagues as the link. The response in which this link figured came more from males than from females. 20.68 per cent of the male respondents mentioned the link as against 10.90 per cent of the females. There were variations, as between the level of education and this kind of response. If the illiterate and literate are combined together, 14.92 per cent of respondents falling in this category of education level gave this response. Compared to this, the reference of a friend or colleague increased towards higher levels of educational qualifications. The reference percentage touched 23.33 per cent in the case of the most highly educated respondents. Friends or colleagues link also showed significant variations as between different occupational groups, with the maximum percentage of people giving this category of 'social group link' response falling in the occupational group of 'services' followed by the group of labourers. This indicates that these occupational groups interacted more within their occupational circles.

Only 2.5 per cent of the respondents referred to members of their own caste or tribe and of their own religious faith as the link, receiving 1 per cent and 1.5 per cent
response respectively. Here it may be necessary to point out that members of a *vada* traditionally had members of the same caste and religion. Evidently, in most cases with neighbours as the link the neighbour could be of the same caste or tribe or religion. Yet caste or tribe and religion have been progressively diminishing as link factors in the response pattern in this part of India. This could be due to the urbanisation and the modernisation process occurring here. The socio-economic characteristics of the respondents and this kind of response are correlated. (See Table IX).

All but one of the respondents giving these two links were illiterates, the remaining one too fell only in the category of literate by education level. In the case of respondents giving caste/tribe as the link, all were tribals belonging to the lowest income strata. In the case of a link through a member of the same religious faith, all were Muslims and female respondents. Thus, these two links have figured only in the response of uneducated, tribal and lower income group people. This limited response indicates that the considerations of caste/tribe and religion are no longer important or even valid in the given context.

Thus we see that the general pattern of the 'social group link' shows the links used by most people in therapeutically response to be those of a family member, a neighbour,
and a friend or a colleague, though some, a very small percentage, used links of caste or tribe and religious faith.

'Practitioners' link', the second type of permanent link, refers to the situation where the respondents took help from the practitioners. These people were either those who knew the practitioners or they included those who had come across these practitioners while attempting to adopt a particular course of treatment. These practitioners, being unable to treat the cases themselves, helped the patients by becoming their reference links to obtain treatment from other suitable practitioners. Thus, when a chosen practitioner could not himself handle the problem, it became his function, not that of the patient or his lay consultants, to refer to another practitioner. By not being able to treat a patient for some reason, the practitioner became a reference link for other practitioners. As Friedson has pointed out, "The failure of his initial prescriptions leads him into the lay referral structure, and the failure of other lay prescriptions leads him to the physician".

The town has various systems of medicine. Therefore, the 'practitioners' link' in the town can be either for the practitioners of the same system of medicine as the one

practised by the linking practitioner, or for the practitioners of other systems of medicine different from the one practised by the linking practitioner. This link has been divided, therefore, into two categories. Included in the first category are the responses based on the link with the practitioner of the same system of medicine. The link in this case is called the 'practitioner's link' for the same system of medicine and its practitioner. The second type of link is with the practitioners of systems of medicine other than that of the linking practitioners. As already stated on the basis of Table IX, only 13 per cent of the respondents mentioned 'practitioners' link' in their response for the reference pattern. Out of this, the responses referring to 'practitioners' link' for the same system of medicine and their practitioners constituted 4.5 per cent, a percentage smaller than that received for 'practitioners' link' for other systems of medicine and their practitioners. The response received for the latter constituted 8.5 per cent. The analysis shows that both these links were not as significantly associated with the socio-economic characteristics as they were with the nature of diseases.

The field notes show that these links for the same system of medicine figured only in one system of medicine,
i.e. in the Allopathic system. What is more, of 66.6 per cent of such cases most related to gynaecological disturbances in which male practitioners of Allopathic medicine served as links for patients to consult female practitioners practising the same system of medicine. In the remaining cases the link of Allopathic practitioners was used by the respondents to visit Allopathic practitioners for the purpose of routine tests and for specialised facilities like X-Ray. In no case did an Ayurvedic, Homoeopathic, Unani or Folk practitioner become a link with another practitioner of his own system. This leads to the possible conclusion that within a given system of medicine, except in limited cases of Allopathic system of medicine, the fraternity of its practitioners was not very strong. This conclusion assumes significance later in this chapter while discussing the reference link pattern of the practitioners in the process of establishment of their clinics and clientele.

In cases where the 'practitioners' links for other systems of medicine and their practitioners' have been referred to as links for the response to accepted treatment, the reference links have been provided mostly by Folk practitioners specially bhoyas. Only in one case a dhai, belonging to the Folk system, provided the reference link for a woman practitioner of the Allopathic system of medicine. It was when the
dhai found herself unable to handle a case of abortion in which 
which sepsis had set in. Thus, out of a total of 8.5 per cent 
cases of this kind, 6.5 per cent cases have been those where 
Folk practitioners served as the reference links. This to 
some extent justifies the statement made earlier in the thesis 
that folk practitioners helped to serve as a guide for other 
systems of medicine. In 1.5 per cent cases, the reference 
link was provided by practitioners of Ayurvedic, Homeopathic 
and Unani systems. In all these 9 per cent cases, practitioners 
of folk, Ayurvedic, Homeopathic and Unani systems serving as 
the reference links, had guided their patients to the Allopa-
thetic system of medicine. In only 0.5 per cent case, an 
Allopathic practitioner had been the linking point for a 
system of medicine other than his own. This was a case of 
acute kidney stone and by common knowledge in India no cure 
is better for this ailment than the one offered by the 
Ayurvedic system of medicine.

It may now be inferred that in a majority of such 
cases the reference links for the members of the community 
in general were the practitioners of systems of medicine 
other than Allopathic and these practitioners provided 
reference links for Allopathic medicine.
The 'temporary links' which amounted to only 2.5 per cent of the respondents, emerged while people were travelling. To have the right perspective we might say that people generally have no hesitation in either seeking or giving advice on health problems even when this involves strangers. There is no element of shame or privacy attached to it.

Thus we might conclude from the study of reference links that these links of human beings within a community help them to form an opinion and mould the health care action. The general pattern of reference links in therapeutic response follows the order of family, neighbour, friend/colleague, medical practitioner, religious, caste and temporary links. These dimensions of differences that exist in the interacting link relationships are only differences of emphasis rather than absolute. In the above cases these links have been particularly valued as advisers because they have had direct experience of the disease or they know a person with such direct experience or a practitioner skilled according to them in treating the disease.

Now, then, this leads us to the problem of understanding the relationship between the reference links and the practitioners whose treatment has been recommended. The question
put to the respondents in this context was: "Are you aware of the relationship between your informant and the practitioner?" The answer that this question elicited in a majority of cases was 'yes'. In only 2.5 per cent cases the respondents did not know the relationship between their reference links and the practitioners. Also, these were the cases where respondents indicated temporary links.

The practitioners and the respondents are tied together through the reference link. The relationship mentioned by the respondents as having existed between their reference links and practitioners may be classified into various categories in their order of preference:

a) the reference link is the relative of the practitioner;
b) the reference link is the neighbour of the practitioner;
c) the reference link is a friend/colleague of the practitioner;
d) the practitioner is the reference link's 'family practitioner';
e) the reference link belongs to the same caste group as that of the practitioner;
f) the reference link belongs to the same religious faith as that of the practitioner.
While discussing the relationship between the patient and his reference link, we have taken just one relationship even though they may be related in multiple ways. Similarly, in this situation it is not necessary that there should only be one kind of relationship between the practitioner and the reference link, specially in a small town like Rajpipla. A practitioner may be related to the reference link through multiple relations i.e., a practitioner may be a relative, a member of the same caste, a person belonging to the same religious faith, a friend and a family practitioner, all at the same time. However, this analysis has taken only one connotation of the relationship on the basis of the emphasis placed on it by the respondents. This is important in view of the light it may shed on the new relationship pattern taking shape in Indian towns, thanks to the impact of westernization, urbanization and industrialization. In a traditional Indian town for example, a casteman was normally referred to as a casteman alone even though he might also have been a good friend which today, as the study shows, has almost disappeared and the element of friendship is emphasised or has become predominant in reference connotation.

The concept of the 'family practitioners' relationship is not new to India where khandani vaide were prevalent.  

9, 'Khandani vaid' means a family practitioner.
These *khandanī veīda* had been linked to families for generations. In this town also 26 per cent of the total respondents mentioned that the relationship which existed between their informants and the practitioner was that of family practitioner. A respondent would often illustrate this relationship saying that his informant and his whole family when in need of a cure visited only the family practitioner of that system of medicine. In Rajpipla some relationships of this nature have passed down from the time of the princely State. The practitioners of that time were serving one set of families. These practitioners and in some cases the sons of the practitioners who are practising now are serving the next generation of these families. On the other hand, if the parents have been visiting one practitioner, the children too tend to visit the same practitioner.

The relationship arising from friends or colleagues though a recent reference connotation, was cited in the town by 24 per cent of the respondents. These people referred to the relationship between their link and the practitioner as that between one friend and another or one colleague and another. An observation made showed that this kind of relationship was mentioned by most of the respondents who had cited the 'practitioners link' as their reference. In this
case respondents related that the practitioners in the course of their medical practice developed friendly relations with other practitioners. One of the respondents explained further saying that his practitioner and his reference link had studied together up to school level and they were good friends even today.

Twenty four per cent of the total respondents described the relationship between their reference link and the practitioner as that between one relative and another. As already mentioned in the chapter dealing with the socio-economic background of the practitioners the majority of the practitioners in the town belonged to this town and obviously they had their relatives in the town. These relatives have been the link between the practitioners and the respondents. This category also includes a case through a 'practitioner's link' where a male medical practitioner recommended a patient of his to a female practitioner who happened to be his wife.

Neighbourly relations between the reference link and the practitioner figured in the response of 17.5 per cent of the respondents. This bears out the point made in Chapter VII that though a practitioner from a neighbourhood was welcome he was given up in preference for another with
better experience and more popularity. While neighbourhood considerations did matter in recommending a practitioner, they were not found to be commonly prevalent in the response.

Caste/tribe and religious relationships were mentioned only by 6 per cent of the total respondents. 2.5 per cent of these respondents said that their reference link and the practitioner belonged to the same caste/tribe group. As against this, 3.5 per cent of the respondents said that their reference link and the practitioner were of the same religion. The point to be underscored here is that in all these cases the reference link provided only information about the practitioners of folk medicine.

The conclusion that follows from the above investigation is that relationships do play an important part in the diagnosis and cure of a disease. Being a small town where people know each other, the response like any other social action involves human interaction and this interaction influences and helps in forming an opinion and moulds the response in a particular direction. The reference link often helps in the case of a disease and its cure and is thus effective in health action. This is so mainly due to the continuous and intensive social relations existing in the town.
Part II: Reference Link Aiding the Practitioners in the Establishment of Their Clinics and in Enlargement of the Clientele

The socio-economic compulsions and the family wish were the major factors that influenced most of the practitioners of this town in the choice of their profession. A point that emerges from this is to examine how these practitioners have established their private practice in the town. This question of 'how' leads to another related question as to who helped in the establishment of their practice. These questions are interrelated because the process of establishing private practice involves people who may be termed as links. The 'links' as used here form part of the social networks which are perceived here as the field of social relations working in this context. However, before discussing the links involved in the establishment of private practice and the clientele, we might make a brief reference to the opinion of the practitioners about private practice in medicine.

The concept of private medical practice has been universally associated with a stable life. This was also the response received from all the practitioners of this town irrespective of the systems of medicine practised by them. The practitioners included those who started their career in private practice and also those who were at first employed by private or governmental agencies.
The second related reason given in favour of private practice was that it gave them more professional autonomy. The practitioner in private practice, according to this view, was not bound by limitations of formal connection with his colleagues. Only a few practitioners spoke of enhanced pecuniary gains as an incentive and attraction for private practice. But even they would not accord this priority over other considerations. Thus, the concept of private practice was associated mainly with a stable life and professional autonomy by the practitioners in this town.

Kinship, neighbourhood, friendship, past experience links and links through colleagues/other practitioners in order of their preference are some of the reference links which evidently played a role in the establishment of clinics and enlarging the circle of clientele in this town.

In the response of all practitioners the kinship link, or the family link, received the maximum weightage in the establishment of the clinic and clientele. Members of the family and the kinsfolk have occupied key positions in being the link and primary source of help to the practitioners. Twenty nine practitioners stated that the initial cost of the clinic was met or shared by their immediate
family members like father, brother or uncle. In the case of female practitioners, it was their husbands who played this role. The three practitioners who did not give this response included two Allopathic and one Ayurvedic practitioner. However, even out of these three, the two Allopathic practitioners admitted that they had received some help from a distant kinsman living in this town. The Ayurvedic practitioner admitted having received some monetary help from members of his family living in another state of India.

Besides helping with funds, family members and kinsfolk functioned as links in popularising the practice of these practitioners. We might quote from the field notes the response of a few practitioners on the role of the family link in the establishment of their practice and clientele.

1. An Allopathic practitioner, "I was introduced to my clients by my father, who made me sit in his clinic during the summer holidays when I was studying for a degree in medicine. And, later, when I passed out from the medical college I joined him in his clinic."

2. An Ayurvedic practitioner, "I had the training in this medicine from my father who used to take me to his clients."
3. A practitioner of the Folk medicine, "The temple, where we are sitting right now, was built by my father who used to practise here. Ever since his death I have been practising here. His clients come to me because they know me and have faith in me".

4. A dhei of Folk medicine, "My links with my clients were made by my mother-in-law who in turn was helped by her mother-in-law. I faced no problem in establishing the practice because my mother-in-law, who was well established in the practice, had introduced me to the clients".

The cases quoted above are those where the profession of the parent had been the same. But even in cases where the profession of the parent was different, family members helped in facilitating the practice by either introducing the practitioners to the clients or by becoming the reference links. A point made earlier in Part I of this Chapter showed that 24 per cent of the patients had mentioned the link between their informant and the practitioner as that of a relative. This clearly proves that relatives and kinsfolk have certainly played an important role in establishing practice.
All practitioners made a reference to good neighbourly relations. The neighbours, according to the practitioners, normally preferred to visit a practitioner of the neighbourhood. According to them, even when the neighbours consulted other practitioners, they would generally do so after seeking their advice.

Links through friends have apparently helped in the establishment of practice. Friends included both the friends of individual practitioners and their family members. There is no doubt that strong friendship ties exist in this town. The friendship ties have been of much help in particular to the migrant-practitioners of this town. One such practitioner of the Ayurvedic system of medicine, for example, related how he had started his practice with his friend, when he came to the town. He had even stayed with him until he had his own house.

Past experience in private or government jobs have also helped some practitioners in the establishment of practice. Past experience helped them in getting their clientèle and the practitioners were of the opinion that to some extent links through their previous jobs proved helpful to them in the establishment process. This was
the view held mainly by the practitioners of Allopathic system of medicine as only they had worked in private or government jobs in this town. A few of these practitioners having private practice are even today associated with government and private institutions in an honorary capacity and the links so continued and maintained do help them, they assert, in their private practice as they come in contact with more and more people.

For the practitioners, links through their colleagues i.e. other practitioners were of very little importance in establishing their practice and clientele. This shows that most practice in this town was client-dependent and very little colleague-dependent. As already analysed, only 13 per cent of the total respondents of the community at large mentioned 'practitioners' link' as their reference link in the response pattern. According to Friedson, client-dependent practice is that practice where clients come directly to the practitioner and the colleague-dependent practice is that practice where practitioners do not attract lay clientele on their own but rather obtain clients through the referrals of colleagues. The practitioners in the town did not lay any pronounced

emphasis, however, on the colleague-link in establishing their clinics and clientele.

The "colleague network" of Hall\textsuperscript{11} is also not apparent in this town. Hall describes colleague network as practice involving a loose network of interdependent practitioners who refer cases to one another. In the present investigation, the colleague links in the town were observed from two angles. One, 'intra-colleague link' i.e. colleague link within the same system of medicine in which the practitioner of one system of medicine is a reference link for another practitioner of the same system of medicine; two, 'inter-colleague link', i.e. colleague link with the other systems of medicine in which a practitioner of one system of medicine is a reference link for a practitioner of another system of medicine.

The observations of the present investigation indicate that colleague link within the same system of medicine was found to be very rare. In fact, the colleague link within the same system of medicine was only evident in the Allopathic system of medicine and that too in some specialized and gynaecological cases. In such cases only the informally qualified practitioners of Allopathic system of medicine

would refer their patients to a formally qualified practitioner of Allopathy or the male practitioners of Allopathy would refer their female patients to female practitioners of Allopathy, specially for gynaecological help. Not even a single case was observed where a formally qualified practitioner of Allopathic system of medicine had referred his patient to an informally qualified Allopathic practitioner; Apart from one instance which is discussed later in this chapter, in no other case a formally qualified practitioner of Allopathy referred his patient to another formally qualified practitioner of Allopathic system of medicine except as noted above. It was further observed that colleague link was not apparent also within the Ayurvedic and the Folk systems of medicine. Of course the possibility of examining colleague links within a system of medicine for Homeopathic and Unani systems of medicine is ruled out as there was only one practitioner in each of these systems of medicine (See Diagram 1). Thus intra-colleague link benefitted only the formally qualified practitioners of the Allopathic system of medicine and not the practitioners of any other system of medicine.

It was observed that the colleague link, albeit weak within the same system of medicine was relatively more
Diagram 1 showing 'Colleague-link'

1. The dotted line indicates the 'intra-colleague link' and it is functional only in the Allopathic system of medicine in which the flow is from the informally qualified practitioners of the Allopathic system of medicine towards the formally qualified practitioners of the Allopathic system of medicine.

2. The solid lines in the above diagram signify the 'inter-colleague link' in which the flow is indicated towards the Allopathic system of medicine from the Ayurvedic, Homeopathic, Unani and Folk system.

3. The chain lines indicate the 'invisible-colleague link', in which the flow is towards the practitioners of the Folk system of medicine from the practitioners of Allopathic, Ayurvedic, Homeopathic and Unani systems of medicine.
evident as inter-colleague link and a reference of inter-
colleague link in detail is significant. The pattern of
inter-colleague link i.e. colleague link in which a practi-
tioner of one system of medicine is the reference link
for another system of medicine, in this respect is as follows:
a known practitioner of Ayurvedic, Homeopathic, Unani
medicine and also a practitioner of Folk medicine would be
the link for a practitioner of Allopathic system of medicine.
The link here definitely tended to move towards Allopathic
system of medicine; the reverse being an occurrence of
rarity (See Diagram 1). Thus even in the inter-colleague
link the practitioners of Allopathic system of medicine
have benefitted more than the practitioners of any other
system of medicine.

Moreover, before discussing the possible reasons
for the existence of negligible and weak colleague links
both in 'intra-colleague link' and 'inter-colleague link',
a reference to an interaction or a reference pattern, which
though not manifest, is pertinent. This interaction may be
termed as 'invisible colleague link', evidence of which
could be traced and perceived in the process of analysing
'colleague link' in this town. In this 'invisible colleague
link' it was observed that the flow was from the practitioners of other systems of medicine towards those of the folk system of medicine. Though the practitioners of other systems of medicine did not formally recommend their clients to the practitioners of folk system, yet this phenomenon was observable from the fact that the practitioners of other systems of medicine did not object to their clients receiving treatment from the folk system of medicine along with their own. Also the existence of the 'invisible colleague link' is confirmed by the fact that the practitioners of Allopathic, Ayurvedic, Homeopathic and Unani systems of medicine in their perception have described folk system of medicine as complementary system of medicine to their own, (See Diagram 1).

The lack of colleague link within the same system of medicine, it was observed, was due mainly to professional frustrations and jealousy among the practitioners. Though the practitioners did speak of friendly relations among themselves, the observations made highlighted the sensitive and tenuous nature of the colleague link resulting from jealousy and competition among practitioners of the same system of medicine and from a feeling of superiority or
inferiority among practitioners of different systems of medicine. These conflicts, implicit in the practitioner-to-practitioner relationship and observable through their behaviour with each other, were found to be the major reason for the virtual lack of colleague link in the establishment of practice and clientele. Besides this, a feeling of competition appeared to be another reason for the lack of colleague link in practice. However, these factors remained latent as there was only very little face-to-face interaction among these practitioners in their daily life. The situation of the colleague link as found in this town is not comparable to what Hacker\textsuperscript{12} has observed among the practitioners in the United States of America. Practitioners in the United States, according to Hacker, collaborate more than compete with each other.

Informal or formal organizations and associations of practitioners are a help in enhancing and reinforcing the colleague link in private practice as it gives an opportunity to the practitioners to come into contact with each other. But in this town such associations were absent with the

result that the colleague link has not been very helpful in establishing and promoting practice and clientele. Moreover, this also illustrates Hall's\textsuperscript{13} point of 'inner fraternity' which no doubt Hall has used in a particular context. The practitioners in this town were found to be lacking in a sense of any marked inner fraternity.

Network of caste and religion has played almost no role in the establishment or furthering of the practice of the practitioners in this town. No one stressed or mentioned, unless pointedly asked, about the reference link through caste. Caste or religion played no role, according to the practitioners, in getting clients. Not only this, it was observed that even in the colleague link considerations caste or religion did not play any role in this town. We might cite an example of a colleague link in which caste had no role. "A practitioner of Allopathy belonging to the Vaishya caste goes on a holiday every year and during this period he asks another practitioner to sit in his clinic so that he does not lose his clients by completely closing the clinic. The practitioner who sits in his clinic is not a Vaishya by caste but a Brahman by caste. However, while asking the other practitioner to sit in his clinic, only

the comparable qualifications of the substitute practitioner are kept in view and not his caste or religion\textsuperscript{a}. The practitioners did not bring caste or religion into their links and in no way did this criterion help in the establishment or furthering of their clientele.

To sum up, links through family members, (including nuclear and joint family) friends, neighbours and past experience have helped more in the establishment of practice and in the enlargement of clientele than the links through colleagues, caste and religion. The links that have been stressed here provide necessary help in the practice of the practitioners. This clearly indicates that like in the response to perception of diseases and systems of medicine, it is not an individual decision but a collective decision in which the network of interaction within groups plays an important role. Similarly, the establishment of practice and clientele is not the result of an individual action but the result of an action in which the interacting ties have played an important part. Thus, the reference links have a significant place in the health action of both the community at large and the community of practitioners.

\footnote{14. From the personal field notes.}