CHAPTER IX

SUMMARY AND CONCLUSIONS

The present research work, one of the first few investigations in India in the context of community studies in the field of sociology of medicine, has focussed its attention on different systems of medicine and their practitioners vis-a-vis the community's response in a town of Gujarat, with the following objectives:

1) to find out the community's perception of etiology and disease causation;

2) to investigate the factors which determine the community's preference for systems of medicine and their practitioners;

3) to study the reference links that are significantly involved in the acceptance pattern of the community at large;

4) to analyse the pattern of reference links that help practitioners in establishing their clinics and enlarging their clientele.
A series of hypotheses emerging from these objectives (Chapter I) have been more or less authenticated in the different chapters of the thesis.

In India, the different systems of medicine in existence can be classified into five: Allopathic, Ayurvedic, Homeopathic, Unani and Folk systems. A study of the theoretical and historical perspectives of these systems of medicine (Chapter II) in India as a whole reveals certain basic differences in their nature and style of practice as well as in the method of training provided by each even though they all share, admittedly, one ultimate end, i.e. the treating and curing of diseases.

In pursuit of the objectives stated in the first paragraph, the study was conducted in an empirical setting with the help of sociological tools of investigation (Chapter III). The tools used for investigation were the interview guide, interview schedule and certain methods of observation. Thirty one private practitioners professing the five systems of medicine in the town of Rajpiple and two hundred respondents selected from that town constituted the interviewees. Besides this, the study has also taken into account the socio-economic and socio-graphic background of the town. The information on this account was collected by staying in the town as well as by
going through the Census, municipal and historical records of the town.

Rajpipla is a small town in the district of Bharuch with both tribal and non-tribal population. It has people from different religions and occupations, belonging to different levels of income and education. (Chapter IV). The study concentrated more on the acquisition of qualitative data than on the collection of merely quantitative survey material.

The five systems of medicine have their private practitioners practising in the town. The analysis of the socio-economic background and the life styles of these practitioners (Chapter V) indicates that the practitioners of different systems of medicine conform to a large extent to the characteristics as prescribed by the systems of medicine they practice. There is a perceptible variation in the socio-economic background of the practitioners of the different systems of medicine. However, this variation has to be understood in the light of the more important fact that a majority of the practitioners belong to the town and by and large share the same cultural milieu and ethos as that of the community at large. This latter fact overshadows to some extent the variation in the socio-economic background referred to earlier.
In their perception of medical profession all of them were of the opinion that medical profession enjoyed a high social status in India. A certain order of preference was evident, interestingly, in the opinions expressed by the practitioners of these systems of medicine. They applied four criteria in order of preference to arrive at this evaluation: acceptability, effectiveness or efficacy, relative costs and the scientific nature and content of the medical systems involved. Applying these criteria, the practitioners ranked Allopathic medicine first followed by Ayurvedic, Homeopathic and Unani medicine in terms of popularity. The Folk medicine, according to them, occupied a unique place, that is, it was perceived to be complimentary to all the other systems of medicine. All the practitioners were well aware of the role of supernaturalism in folk medicine, which is deep-rooted especially in this part of Gujarat. No one liked to argue on the validity of the cures offered by the Folk practitioners but they certainly held it to be of some substitutive value to the other systems of medicine.

While studying the response pattern, the perception of etiology and causation of diseases by the community at large
was investigated (Chapter VI) because the nature of diseases is a major variable involved in such a study. The investigation shows that there existed variations in the perception of diseases by the community at large and by the community of practitioners. Some differences, however, also existed with regard to perception of disease causation by the practitioners of various systems of medicine. It was observed that the perception of etiology of disease by the practitioners could have been the influence to a large extent of the basic diagnostic norms of the system of medicine they practised. This aspect has only been touched upon briefly in Chapter VI as the analysis of the perception of etiology of disease by the community at large is more central to this study.

The community at large attributed both natural and supernatural causes to different diseases. It was observed that socio-economic background of the community at large was not significantly related to the perception of the etiology of diseases. However, knowledge of symptoms of diseases were at times related to the socio-economic background of the people. Perception of diseases was no doubt influenced by the interacting group of individuals.
The investigation makes it possible to list the factors which determine the preference for a system of medicine (Chapter VII). The pattern of response indicates that factors like perception of etiology and causation of diseases, the effectiveness of a system of medicine from the point of view of fast relief and the presence of the practitioners of both sexes within a system of medicine are significant in determining the acceptance of a system of medicine.

The process of analysing the factors determining the acceptance pattern of the community at large involved the overall comparative popularity of a system of medicine and the relationship of such a preference with the socio-economic characteristics of the community at large. The analysis indicates that the overall comparative popularity of Allopathic medicine was not related to the socio-economic background of the community at large. Not only this, the percentage of response from the community at large expressing preference for the remaining four medical systems, in which the Ayurvedic system ranking first was followed by the Folk, Homeopathic and Unani systems respectively in that order, was also not to a great extent related to the socio-economic characteristics of the community at large. These systems of medicine figured in the given order of popularity on the basis of the systems actually tried and the systems preferred,
which also was authenticated through observations made on a number of patients in the clinics.

Though on the overall comparative preference pattern with regard to the popularity of the Allopathic system of medicine the socio-economic characteristics did not have any marked bearing, yet the detailed analysis of the socio-economic characteristics taken individually as a category indicates that age, sex, occupation, education and income level of the respondents had some determining role in the acceptance of the four systems of medicine, i.e. Ayurvedic, Folk, Homeopathic and Unani. Interestingly and in contrast, significant characteristics of the socio-economic background like religion, caste or tribe indicate no relationship with the acceptance pattern. The Allopathic system of medicine has no doubt consistently won a high degree of acceptance without being significantly related to specific socio-economic characteristics.

The preference for a practitioner was found to be based on certain factors like his behaviour, faith of the patients in him, his reputation, and physical proximity with him. In contrast, factors like caste, tribe or religion of the practitioner and the rate of fees charged by the practitioner were least important in the preference for
a practitioner.

The study further indicates that the preference for a practitioner was influenced by the interaction among the members of the community at large (Chapter VIII). It was not an individual's self-oriented action, but an action involving the help of others who might be related to each other in a variety of ways. In this the advice and guidance of family members appeared to be the most critical. Extra-family consultations like those with neighbours, friends or colleagues, fellow members of a caste or tribe, members of the same religious faith were also involved. These constituted the reference links for an individual in his acceptance pattern (Part I, Chapter VIII).

On the other hand, the study highlights that client choices determined the success of a system of medicine and their private practitioners (Part II, Chapter VIII). This bears comparison with Goodie's statement in his study: "Clients' choices are a form of social control. They determine the survival of a profession or a speciality, as well as the career success of a practitioner." In this town too it was observed that the practitioner had more of a

client-dependent practice rather than a colleague-dependent one, a point also comparable to that illustrated by Friedson:

"While the physician may share special knowledge, identity and loyalty with his colleagues rather than with laymen, he is dependent upon laymen for his livelihood."

The study of reference links in establishing clinics and enlarging the circle of clientele for the practitioners leads importantly to what may be termed as 'referral hierarchy' whereby the superiority of the Allopathic medical system was not only assumed by its practitioners but also readily conceded by the practitioners of the other medical systems. Our data indicate that the practitioners of the other systems of medicine were the reference links for the Allopathic system and that the reverse was an occurrence of exceptional rarity. The only qualifying statement in this regard would be this: though Allopathic, Ayurvedic, Homeopathic and Unani practitioners were not the formal reference links for the practitioners of folk medicine, they had no objection to their patients consulting these practitioners.

Thus, from the investigation, it is possible to draw up certain general statements and observations. The popularity

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2. E. Friedson: "Client Control and Medical Practice", 
of the Allopathic medicine was based on the common understanding that it gave faster relief and also on its greater efficacy in the cure of most diseases. Factors like caste, tribe, religion and cost of treatment played no tangible role either in the acceptance of a practitioner or of a system of medicine. The popularity of the Allopathic system of medicine was hardly affected by the supposed condescending attitude of its practitioners vis-à-vis their patients. This is a point generally presumed to be a hindrance in the acceptability of Allopathic medicine. The practitioners of Allopathy like those of other systems were conversant with the local language and customs. They were adept in the use of certain distinctive local phrases. These accomplishments have no doubt enhanced their status and prestige and the efficiency of their role, and helped them win the faith of their patients. The awareness on the part of the local population of matters relating to conceptualisation of diseases and health care have by and large helped in popularising this system of medicine.

The rationale provided above generally holds good for the Allopathic system of medicine. Field has stated


that illness must be seen as problematic and socially defined, for the ways in which patients and physicians define and act towards illness are only partly determined and shaped by the 'primary' underlying disease processes by which illness is produced. Moreover, if the practitioner is, as Friedson⁵ so cogently argues, "a moral entrepreneur then he must be aware of this fact, and of the social consequences of his practice of medicine."

The response of practitioners of Allopathy, Homeopathy, Ayurveda and Unani to Folk system may not be scientific, but it certainly highlights the coexistence of modernity and tradition. By not overtly objecting to instances of acceptance of the Folk system of medicine by the community at large, by falling in line with people's belief and respecting their values wherever required, the practitioners gained social legitimation. Thus, the perception by the practitioners of the Folk system as being complementary to the other systems of medicine and the third position occupied by Folk system in the order of preference by the community at large.

substantially bear out the points made by Gould and Simmons in their studies to the effect that scientific medicine is not replacing folk medicine but rather supplementing it. Thus, for the diseases which were assigned natural causes the members of the community at large accepted Allopathic system followed by Ayurvedic, Homeopathic and Unani systems. In the case of diseases assigned supernatural causes the folk practitioners and the Folk system were preferred. It is also true that resort was often made to a combination of systems of medicines. This duality of systems of medicine was also an accepted phenomenon by the practitioners. For example, at times Allopathic practitioners also prescribed basic Homeopathic medicines, the knowledge of which they had acquired from the available textbooks on this medicine.

The suggestion that emerges from the study is that when the aim of all systems of medicine is the welfare and upliftment of people from a state of disease, the training required for the medical practitioners should be attuned


to the needs of the community. As Falk\textsuperscript{8} has said, "Practitioners should be trained in such a way that they must be fully conversant with the common health problems and the requisite medical measures. Their training should be more practical than theoretical."

In the social situation obtaining in India, where certain beliefs and practices are deep-rooted in the cultural psyche of the people, the education and training of the practitioners should not be confined to five watertight compartments. The observations in this town have indicated that the preference is mainly disease specific-oriented. Hence, each system should try to enhance its practitioners' capabilities for curing a set of diseases in which that system is perfect or more effective. This sort of situation would in a way lead to a division of labour within these systems of medicine rather than to increasing competition within them.

In conclusion, we might thus mention a point of contention. The inferences drawn from the present study cannot apply to the whole of India for the simple, obvious

and well-known reason that the cultural milieu in India changes from region to region. And the cultural milieu, which is a complex of customs, traditions, beliefs, superstitions and life styles with contemporary connotations, controls public opinion to a great extent. The study may not be fully applicable either to big cosmopolitan cities or to villages. The study can be taken as an index, however, for other small towns which have an important place in the country and where more or less identical characteristics and considerations appear to prevail. The aim of this study, moreover, has not been to make broad generalisations devoid of actual validity or to make suggestions of practical import. However, an important suggestion for further research in this field that emerges is to investigate and analyse the pattern of network both at micro-level as well as macro-level in the big cities of India. These investigations could include the pattern of reference ties in the response pattern; as well as in the establishment of practice and enlarging clientele both within a system of medicine and the pattern of reference ties for the practitioners of different systems of medicine. It is hoped, that the study may prove to be a contribution, albeit of a limited nature, to the speciality or discipline in sociology which, as alluded to earlier, is of recent
origin with most of the students of this new field being barely at the threshold. This work might also give a few insights into this relatively new world for sociologists and social scientists interested in the question of diseases and their cure, of health and health care in the community, hospitals or other organizational settings.

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