CHAPTER I

INTRODUCTION

The present study, "Community Response To Systems of Medicine - A Study of Networks", is empirical, falling in the area of Sociology of Medicine, a field of Medical Sociology. In order to provide a focus to the present study in the sociological perspective, it is essential to discuss briefly the field of Sociology of Medicine before stating the details of the problems that are studied herein.

Field of Sociology of Medicine

The sociologists' interest in the field of medicine is not very old. It was only in the year 1915 that there appeared a journal which bore the name Sociologic Medicine, edited by McInitire.¹ In this journal it was pointed out that medicine had its social aspect dealing with the cause and cure of the pathological state of human beings in relation to society. The study of this aspect grew to be called Medical Sociology.

Robert Strauss in a paper presented on "the Development of a Social Science Teaching and Research Program In a Medical Center", at the 1955 meeting of the American Sociological Society suggested a logical division of Medical Sociology into two branches, the "Sociology of Medicine" and the "Sociology in Medicine." Sociology of Medicine according to Strauss is concerned with studying such factors as the organizational structure, role relationship, value systems, rituals and functions of medicine as a system of behaviour and that this type of activity can best be carried out by persons operating from independent positions outside the formal medical setting. Sociology in Medicine consists of collaborative research or teaching often involving the integration of concepts, techniques and personnel from many disciplines.

While the discussion of the implications of this division of Medical Sociology is ongoing, it may be added here that a sociologist of medicine in this capacity retains a basic standpoint as a social scientist. His adaptation to his environment may depend on an ability to change certain outward manifestations in accordance with his environment. Strauss has asserted that the Sociology of Medicine as a discipline is more

appropriate for sociologists not directly connected with the medical faculty.

The Sociology of Medicine has been described by Friedson as "an area of substance in which generic concepts may be exercised, tested, and possibly even created, but not a field sui generis." Study of the Sociology of Medicine, according to Minocha, in itself and in relation to other areas of social life such as economy, religion, magic and law is now increasingly seen by sociologists to be necessary for obtaining a comprehensive understanding of society as a whole. This is more so because society attaches great importance to health and disease of its members.

Thus, the Sociology of Medicine, a discipline yet in its embryonic stage, is a substantive and theoretical area which has branched off from Sociology. It throws light on health, disease and medical systems in both evolutionary and cross-cultural perspectives. It is an applied field involving the introduction of sociological concepts and methods into the medical system.

Further to this, in the development of knowledge of the social aspect of medicine many areas have received attention


of the sociologists. In the Western countries, mainly in the United States, Sociology of Medicine emerged at the turn of the twentieth century and sociologists have already contributed greatly to the development of this field. Reader\(^7\) has said that for a number of years Sociology of Medicine has had a considerable impact through those social scientists who have 'walked the wards' with physicians and nurses, those who have interviewed patients and those who have taught medical students.

In India, research contact with medical phenomena can easily be said to be only about two decades old, and this can also be marked as the beginning of Sociology of Medicine in India. The works of Western sociologists like Friedman, Parsons, Mechanic, Merton and others have stimulated, to some extent, the studies in this field in India. This was because by this time the model of the Sociology of Medicine laid down by these sociologists had already started having an impact. In India, this discipline has enormous scope for research. The avenues open for research in this field are in the organizational setting as well as in the community. Sociologists, to name a few like Parvatham, Sharadamma, Hasan, Khara, Ahluwalia, who have already conducted research in this field

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in India, have emphasised the point that in the Indian context the study of medical problems should start with a proper understanding of the socio-cultural factors which in the real sense determine the opinion and attitude of the people towards health, disease and treatment. Sociologists and social anthropologists conducting research in this field have also emphasised the significance of culture in such studies. Leslie recommends that there is a need for carrying out large scale holistic studies for the changing relationship between various levels and kinds of health culture in India.

The contributions made by sociologists and social scientists to this field of sociology may be characterised as direct and indirect. Direct contributions result from studies carried out with a view to researching the problems of medicine in a society. These problems may be those of


hospitals or of community. In this category the researcher chooses his field of investigation beforehand. Kendall and Merton\textsuperscript{10} have listed substantive areas of sociological research in medicine, such as social etiology and ecology of disease, social components in therapy and rehabilitation, medicine as a social institution and sociology of medical education.

To elaborate further, the direct contributions are studies of cultural and social responses to illness; the study of how people perceive, define and respond to symptoms or illness; the Personian concept of the 'sick role' and the doctor-patient interaction. The study of referral system in the medical behaviour of medication and treatment is no doubt a new but interesting field of direct investigation in Sociology of Medicine. Friedson\textsuperscript{11} and Polgar\textsuperscript{12} have analysed the referral behaviour in the acceptance pattern of medical


treatment. The investigations of Hall\textsuperscript{13} and Friedson\textsuperscript{14} dealing with the pattern of interaction among the practitioners for the colleague-solidarity and colleague-dependent practice are important direct contributions.

In India, the direct contributions, to list a few of them, are the studies made by the following: Hasan,\textsuperscript{15} has studied a village called Chinhaura (pseudonym) in the district of Lucknow in Uttar Pradesh and has emphasised the cultural perspective to health; Madan\textsuperscript{16} who has found that private practitioners of the modern system of medicine look at their profession basically in terms of making a living rather than in terms of any notion of social responsibility and has thrown light on the commercialization of medical

\begin{itemize}
\item \textbf{15. K.A. Hasan :} The Cultural Frontier of Health in Village India, Manaktaer, Bombay, 1963.
\end{itemize}
practice; Kakar,\textsuperscript{17} has studied the importance of relationship between people's beliefs concerning etiology of illnesses and their attempts to seek relief from it; Oommen\textsuperscript{18}, has made an important contribution to direct studies in the sociology of medical profession from the point of view of role structure aspect; Minocha's\textsuperscript{19} study of a New Delhi hospital is also a direct study in the organizational setting in the field of sociology of medicine; Venkataratnam\textsuperscript{20} has studied the concepts of 'role and status' with the focus on role perception, role expectation and role performance of doctors and nurses in two hospitals of Tamil Nadu.

The indirect contributions, on the other hand, as Reader\textsuperscript{21} has pointed out, result from a study or an investi-

\begin{itemize}
\item \textbf{17.} D.N. Kakkar : \textit{Folk and Modern Medicine.} New Asia Pub., 1977.
\item \textbf{20.} R. Venkataratnam : \textit{Medical Sociology in an Indian Setting,} The Macmillan Company of India Ltd., 1979.
\end{itemize}
gation in a field other than medicine, the findings of
which are later discovered to be applicable to medical
setting. Gouldner's study of industrial bureaucracy,
for example, can be usefully applied to the bureaucracy
of the hospital. Moreover, in India indirect contributions
also include studies in which the researchers have collected
material on medicine mostly in the course of their investi-
gation on other aspects in village and tribal communities.
The works of Carstairs, Marriott, Gould, Lewis, Khare and Opler are some such studies.

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The Focus and Problems of the Present Study

Coming back to the focus and the problems that are being dealt with here, it may be pointed out that this study is an attempt at a direct investigation in the field of sociology of medicine. The study is also influenced at the same time by several other direct and indirect contributions dealing with the various aspects of medicine and society. These works have been listed in the bibliography and some of them have also been referred to at appropriate places in the thesis.

The survival and prosperity of human society depend primarily on the health and well being of its members. The basic urge to survive and enjoy good health has given rise to a constant social endeavour to devise ways and means of curing illnesses. Thus, there exists no society, irrespective of its simplicity or complexity of functions, without a broad spectrum of medical knowledge and beliefs. The different ways of curing illnesses range from superstitions, mythical beliefs and resort to magic, to indigenous and other methods of treatment. These methods are normally termed as systems of medicine, for they do not function in a chaotic or haphazard manner.

According to Srivastava\(^{29}\), each system of medicine represents

a more or less distinct stage in the development of healing art in the progress of human civilization.

India also has different systems of medicine. These systems of medicine, popularly known as Allopathic, Ayurvedic, Homeopathic, Unani and Folk systems, differ in application, theoretically and otherwise. However, in practice, the ultimate aim of all systems of medicine being identical, there may at times be a larger measure of common acceptance of proven theories and remedies. The study of these varied systems of medicine for analysing their acceptance constitutes an important field of investigation. This is so because an understanding of human behaviour in illness and acceptance of systems of medicine are of equal interest to social scientists and those responsible for the delivery of medical care. To name a few of the studies already done in this area, we may refer to the works of Marriott, Madan, Bhardwaj, and Kaker. All these studies deal with comparative analysis of the acceptance

30. Folk system in this thesis includes home remedies, magico-religious and others not falling under any of the four systems.


of the modern scientific medicine i.e. Allopathic system of medicine, in relation to different systems of medicine.

The subject of response and acceptance of diverse systems of medicine has of late gained considerable importance. The present study in the realm of this subject pertains to the presence of different systems of medicine, viz. Allopathic, Ayurvedic, Homeopathic, Unani and Folk systems and their practitioners vis-a-vis the response of the people to these systems of medicine and their practitioners. In addition to identifying the various factors, that are mainly involved in directing the response pattern, an attempt has also been made to analyse the inter-personal links or the reference links involved in the acceptance pattern of the community; and the inter-personal links or the reference links that help a practitioner in the establishment of his practice.

On the basis of the objectives stated above the investigation is focussed on certain pertinent queries:

(a) What is the community's perception of etiology of disease;

(b) What are the factors that are likely to affect the response to systems of medicine;

(c) What are the factors that determine the response
to practitioners of these systems of medicine;

d) Do people adopt a combination of systems of medicine
or prefer just one system of medicine;

e) What are the reference links or the inter-personal
links involved in the response pattern of the
community at large;

f) What are the inter-personal links or the reference
links that help a practitioner to establish his
practice.

Indian society has a great cultural heritage. Culture
as commonly understood is a set of learned beliefs, values and
behavioural expectations which individuals derive from those
with whom they interact. These existing beliefs and values
influence and guide the ways in which people perceive illness.
The values regarding illness may vary from society to society
because of the differences in the cultural milieu which
influence the action of individuals in a society. In his
study of a tribe called Saora, Elwin35 points out that diseases
bear a relation to the form of worship. The various reasons
which villagers attribute to the cause of a disease are related
to their belief in God. Opler36 says that villagers regard
faulty diet, malfunctioning of three dosha (humours in the body),

35. V. Elwin : Religion of an Indian Tribe, Oxford

lack of harmony with the supernatural world, including spirits and ghosts, displeasure of deities and imbalance of elements which control health as the causes for a state of illness. In the Indian context, an investigation into the perception of illness by the people becomes significant because of its cultural diversity. People in every part of India have their own rationales in defining a disease. In the present study a whole chapter has been devoted to this theme because it is the first query that suggests itself to a researcher conducting study of this nature. Also, a knowledge of the perception of diseases by the community lends significance to the study of the response pattern.

Besides dealing in detail with the perception of diseases, a number of hypotheses emerging from the queries i.e. (b) what are the factors that are likely to affect the response to systems of medicine; (c) what are the factors that determine the response to practitioner, put forward earlier in this chapter have been submitted to testing for authenticity. It may be mentioned here that some of these hypotheses were formulated before entering the field of investigation and some in the course of the field work. The hypotheses that were ultimately used to examine the response pattern for systems of medicine and their practitioners are:

1. The nature of diseases and their perception by the community determine the selection of a system of medicine.
2. Depending upon the complexity of diseases people prefer a combination of systems of medicine.

3. The effectiveness of treatment afforded by a system of medicine is an important determinant in the preference for a system of medicine.

4. Time spent in the cure of a disease is a significant factor in selecting a particular medical system.

5. Availability of practitioners of both sexes within a system of medicine determines the acceptance of a system of medicine.

6. Cost of treatment is not an important variable in the preference for a system of medicine.

7. The socio-economic background of the community at large need not in all cases be related to the preference pattern.

8. Behaviour of the practitioner is an important factor in selecting a practitioner.

9. Faith in a practitioner can determine the acceptance of a practitioner.

10. His being in the neighbourhood may be one of the factors in the choice of a practitioner.
11. Being a competent or a well-known practitioner of a locality is a significant factor in the acceptance pattern.

12. Caste/tribe and religion of the practitioner in a town need not necessarily be important determinants in the selection of a practitioner.

These hypotheses have been analysed on the basis of a number of selected variables. The variables taken into account include the etiology of diseases as perceived by members of the community; availability of practitioners of both sexes within a system of medicine; socio-economic background like sex, casta, tribe or religion; economic indices like occupation and income and the level of education. The socio-economic background of the practitioner, their specialization and location of practice have also been taken into account. It is true that these variables need not in all cases have a theoretical importance. They have been selected to provide an objective basis for collecting the data for analysing the hypotheses and also for the reason that they are causally related to each other.

No community is a mere collection of individuals who accept or reject medical care. It also comprises interaction of these individuals among themselves who may be
related to each other in different ways. Thus, we can study the various factors which determine the response pattern. We can also study the response pattern as an influence of this interaction which no doubt is an important but hitherto little explored area. In the present study an attempt is also made to study the interpersonal links or the reference links which influence the response pattern. The interpersonal links or the reference links in the thesis have been investigated from two angles. One the interpersonal links or the reference links within the community at large involved in advising and guiding a person in the situation of diagnosis of a disease and its cure, i.e. in the choice of a system of medicine and a practitioner; two the interpersonal links or the reference links within the community of practitioners in the establishment of their clinics and practice.

There are various approaches adopted by sociologists in studying various problems in the field of sociology of medicine. Studying the factors that determine the response and the interpersonal links by way of network analysis within the community is one such approach. Barnes\textsuperscript{37} has argued that the basic idea behind network analysis is that configuration

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  \item \textsuperscript{37} J.A. Barnes \textsuperscript{37} "Class and Committees in a Norwegian Island Parish", Human Relations, Vol.7, pp.39-56, 1954.
\end{itemize}
of cross-cutting interpersonal bonds in some specified way are causally connected with the actions of the members and with the social institutions of society. Bott has used network analyses as more or less an extension of interaction theory, which says that the frequency of interaction is directly related to the degree of liking, i.e., greater the interaction between two persons the greater in general, the sentiments of affection they feel for one another. Thus, Bott has placed the idea of networks firmly in the language of social inquiry. In this study network has been mainly used as an approach to study the systems of medicine and the response of the community. Besides studying the factors that determine the response to the systems of medicine, the attempt here is also to trace the interpersonal links through which a person is to reach a particular response and through which practitioners establish their clinics and further their practice.

It may be added here that the problems and the related hypotheses, under investigation in this study, have been empirically examined in a small town called Rajpipla in Bharuch district of Gujarat. Further, the study is thus

aimed to be mainly qualitative and not quantitative-oriented. It attempts to explore the perception of etiology of diseases of the members of this town, also termed in this thesis as 'community at large', the factors responsible in the response to the systems of medicine and their private practitioners, and the interpersonal links involved in the response pattern against the background of the town referred to above. The findings are presented in different chapters.

The first chapter is introductory and outlines in brief the field of sociology of medicine as well as the areas that have been (and can be) fruitfully explored in this field. It highlights the aims and problems of the study. The queries and the hypotheses, which emerged out of these queries and which have been authenticated in the thesis, find mention in this chapter.

Chapter II of the thesis deals with the emergence and growth of the various systems of medicine in India as a whole. A theoretical description of these systems of medicine in India is necessary as this helps in crystallising an idea about the basic structure and nature of practice of the different systems of medicine.

Chapter III deals with the selection of the universe of study and techniques of data collection applied in this
research. The chapter also has a brief note on the experience of the field investigation.

Chapter IV contains a sociological and demographic description of the town in which the response pattern is under study.

Chapter V analyses the sociographic data on practitioners of different systems of medicine. It gives, in addition, a brief analysis of the perception of medical profession by the practitioners of this town.

Community's perception of etiology of diseases has been discussed in Chapter VI.

Chapter VII deals with the factors which are important in determining the response to systems of medicine and their practitioners.

The study of the interpersonal links or the reference links that guide and influence the response pattern on the one hand and of the interpersonal links that are involved in the establishment of the practice of the practitioners on the other, is analysed in chapter VIII.

This is followed by the concluding chapter which gives the summary and conclusion of the thesis with a few suggestions
in this field of sociology.

In the thesis, Sanskrit, Hindi and Gujarati words have been italicized. Also, meaning of the occupational, educational and other classifications used for analysis in the study have been given in the Appendix.