II - REVIEW OF LITERATURE

CHAPTER II

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Review of literature is a significant part of any research. The investigator acquires information about what has been done in the field of study, gather up-to-date information about previous researches in the area and obtain information on the topic of investigation. A familiarity with available literature in the area of research is required for making new grounds and the proper designing of the study. Review of related studies further avoids duplication of the work that has already been done in that area. It also helps the investigator to study the various aspects of the concept in its multi-dimensional perspective. The scholar has reviewed some of the literatures on systems of medicine under the headings literatures relating to medicine and Ayurveda siddha, homeopathy, Allopathy, home medicine, doctor and patient relationship, general epidemiology and health, health and family planning, and preventive medicine . The literatures that have been reviewed in the above headings by the researcher are provided in the following pages:

Health is an important aspect in society. According to Anderson it is interwoven with other aspects of life such as government, education, religion and science. According to Parsons illness or ill—health is a deviance from the normal social role. When people fall ill they are expected to behave in a manner behaving the ill. Freidson also holds the same opinion regarding illness. It has been considered as a deviance from a of set norms representing health or normality.

Since time immemorial people have tried to tackle the problem of health or let us say ill health in a rational manner. The primitive people accorded supernatural causes to disease and hence their treatment was also based on beliefs, rituals and supernaturalism. Their method of dealing with the magico-religious beliefs. According to Coe hese early

unscientific efforts paved the way for the later development of scientific systems. The Allopathic systems of medicine is known as the modern system of medicine. This system was the result of several concerted efforts all over the world. Hippocrates is regarded TMs the father of this system of medicine

This system of Medicine was introduced by British in India. in the lath Century The East India Company recruited medical men to e the European population in India. The medical men were assisted by Indians for dressing and other allied work, At that time the allopathic system was not well organised to Meet the requirements of the entire society. This position remained upto the year 1921.

With the government of India act of 1919 public Health and Medical Administration was passed into the hands of provincial governments. Owing to improper organisation of this system, the health, problems were not being adequately solved. Preventive medicine was not being adequately distributed. Other public health problems like housing, sanitation, water apply and environmental pollution were not getting sufficient attention. Therefore separate autonomous medical and Public Health Departments were established civil Surgeons in each district were charged with preventive and health duties, in addition to their medical practice. Besides these Medical practitioners after a short period of training were sent to the rural areas to meet public health functions and ensure community health.

According to Tiwari and others after the advent of India's independence, the organisation of the health departments changed. It was organised on the lines laid down by the Directive Principles of State Policy in India's constitution. Health care was the responsibility of the State Government, The Central Government only laid down the broad policy. There is a Central Council of Health constituting the State Ministers of Health, the Chairman being the Union Minister of Health. The first change that was implemented was that the medical and Public Health Services were under One Director General. In the states there was the State Level Director of Medical and Health Services. Primary Health Centres were introduced in India in the year 1952 as part of the Community Development Programmes. In India the western System of Medicine is practiced by the Government employed doctors as well as by private practitioners. The

present position in Government service is that certain categories of officers are debarred from private practice. Others in government service are allowed consultation service in most of the States. Consultation practice means the medical practitioner may have a private set-up for clientele, may also go to a licence private hospital and may visit the suffering at any appointed place.

The system of Ayurveda is yet another system with which we are concerned in this study. A brief history of this system may also be traced. The origin of Ayurveda is shrouded in mystical explanation as any other Indian phenomenon. "Ayuh" means life and Veda means to know or attain". This science of medicine in India is known to have drived from the Vedas or strictly speaking from the Atharva Veda. The two main sources of ancient Hindu Medicine are the Ahatarva and the Rig Veda. The Atharva Veda is invaluable. It holds the loeical interpretations of the common primitive man. These are vastly magico—religions and empirical rational interpretations.

A collection of facts regarding Ayurveda and the existing medical practices are considered by Filliozat. The origin of this ancient Hindu Medicine has been attributed to super human beings. Records state that it had existed earlier to the Arab Medicine System.

The system of Ayurveda holds the belief that the human body is a mixture of five elements. The well being of a person depends upon the proper functioning of these elements. In the Ayurvedic system diet and medicines are given to promote proper balance of these elements. It gives guidelines to follow a well regulated life which has control over boey and mind and even has measures to bring these dhatus to a stage of equilibrium.

Ayurveda reveals close observation of disease and throws light on causation and diagnosis. Indian surgery be &peaks of remarkable advancement from which even European surgeons may gain a 'vast fund of knowledge as in the case of rhinoplasty. This system of medicine has discovered for its use medicinal properties of plants, minerals, animal substance their chemical analysis and decomposition.

The advancement of Meteria Medica is noteworthy and atee the lack of development of natural sciences, In the early days printing was absent. Healers prepared small compilations for their pupils' use. Medicine was practised in the shrines and research was done there only. Hindu surgeons had knowledge of dealing with fractures. Massage was another therapeutic measure for medical and surgical purpose. They also knew the art of hypnotiam and these are accounted in the Jatakas. Much importance given to Yoga and exercise. Massages and exercises, it was felt, quickened the circulation of blood, expelled sluggishness of blood and cleared air passages.

Many diseases were treated. Treatment was given for cholera and leprosy. The sanskrit texts describe symptoms diagnosis and cure of diseases. In India Ayurveda uses chaulmougra oil for leprosy and even practitioners practitioners here unflinching faith in its ours. Cholera too was treated to Ancient India. The Ayurvedic system also claims the origin of vaccination against all pox and stipulates its re-discovery by Jenner. In ancient India every year Brahmins went around vaccinating those people who had been preparing for the event by dietic restrictions. Veneral diseases too were present during Vedic times. This was treated through the use of vegetable beverages, hydrotherapeutic dietic and climatic methods of Treatment. It is revealed that Ayurveda was providing treatment for those ailments unknown or uncommon in Europe.

At present there is stagnation in this system of medicine as there is no preservation of materiel medico, in museums and there are no proficient instructors. Ancient Indian medical knowledge was mostly in Sanskrit. This in not accessible to modern Indian men also. Somehow there are no adequate translations of ancient Hindu medicine into English. With the coming of the British into India this system received once again much attention. Effort was made for maximum utilization of Indian pharmacology. Regarding the practice of Ayurveda one may say that there were two training systems the Brahmanical and the monastic. The former was in existence even at the time of the Samhitas, practised by Brahmans and the latter was institutional. Entry into this profession was on a secular basis. All castes were allowed to seek entry and their selection as in the hands of their teacher. An individual qualifies to enter the profession on the basis of physical fitness emotional stability, intelligence, interest and permission.

He would be initiated through a ceremony and given instructions to follow good conduct. This was followed by an intensive course of training drawing out into six years, Suerutha stressed the importance of both medicine and surgery of both sastras and practice application of knowledge.

The physician has always enjoyed a high statue in society right from vedic times. In this period there was a distinction between priest physicians and lay physicians. The former occupied a higher hierarchical position compared to the latter. In post Vedic times Manu makes reference to same change in status positions of the priest physicians and lay physicians. In this period there was influx from all castes into the profession but the ambastha (caste) physician enjoyed higher status because of his descent on matrilineal side from the Brahmans.

It is a commonly held belief that scientific medicine owes much to Greek Medicine. A comparison of Greek and Indian Medicine shows them to be having a common ground. Many scholars believe that there was great interaction between Greek Medicine and Indian Medicine and in a way it explains the similarity between the two systems. The two Greek physicians Ktesias 400 B.C. and Megasthenee 300 B.C. came to Northern India. Further the invasion of India by Alexander exposed the Indians to Greek culture and Greek knowledge. With the defeat of the Greeks at the hands of Chandra Gupta Maurya all traces of Greek influence were washed sway.

Jones and Weber also affirm that the influence of the Greeks was limited to the field of astronomy only. If Indian medicine did borrow it was in the field of anatomy. The influence of the Indian medicine on the Greek system was also seen. Many Indian drugs are mentioned in the works of Hippocrates having close similarity to Sanskrit names.Besides this, the seasonal influence on diseases, seasonal Fluctuation of humours causing diseases also bears resemblance to the views of Susrutha and Charaka.

In India the indigenous systems of medicine suffered a set back owing to the introduction of allopathic by the British. Of them mention must also be made of Homeopathy. Homeopath is regarded both as a science and an art. It sprang up as a result of the Inductive Philosophy and Method of Aristotle and Lord Beacon. It is closely

related in principle and practice to logic, Mathematics, Physics, Chemist, Biology, Psychology and other Sciences. Homeopathy or Homeotherapy is a branch of science in general medicine and is concerned with observation and action of remedial agents in health and disease. It is concerned with the treatment and cure of disease by medication as determined by a general principle. It was founded into a scientific discipline by S. Hahneman. As a science it rests on four principles, "similarity, contrarity, proportionality and infinitesimally reducible to the universal principle of Homoesis or Universal Assimilation". In homeopathy drugs are related to diseases and governed by the fore aid principles.

Homeopathy as science is concerned with the law of disease, the action produced by drugs on healthy persons, "the law of mutual action". The laws governing disease form its pathology, the phenomena of drugs from its materia medica and the use of materia medica is therapeutics. Homeopathy has certain hard and fast rules.

These are that it is against administering physiological medication and physiochemical treatment. It is against administering of drugs for palliative reason and is principally converned with the elimination of disease. It is against 'group treatment' of diseases and "pathological prescribing". It is out to treat that diseased individual and not a group of individuals having the same disease. It is against poly pharmacy. It is dependent upon the action of "single pure potentiated medicines", which are made by a technical process and given in very small doses.

It considers the totality of symptoms and causes of diseases. The administration of a drug is not on the basis of the pathogenic diagnosis but is related to the symptoms of the patient and the same symptom producing drugs. This is closely compared and analyzed. In Homeopathy medicines are never mixed up or compounded. Homeopathy is strictly against vaccination and screen therapy. It believes entirely in administration of "sub-physiological" doses for effective cure.

In Homeopathy successful treatment is dependent upon a correct assessment of the individual patient’s degree of susceptibility to medication and selects the most appropriate potency". In Homeopathy drug administration is an intricate process

dependent upon several factors. Of these are individuality of a patient, age sex, temperament, constitution, climate, occupation, the nature, type and extent of disease. Homeopathy originated in the year 1796 as a scientific way of treating diseases. This was a result of the publication of the works of Samuel Hahneman. The name Homeopathy was arrived at by the statement of Hippocrates that any drug could cure the condition that it could cause. For several years from 1796 to 1810 Hahneman carried on experiments and finally was convinced that he had hit at a lam of medicine. He then started the propagation of Homeopathy. He held the belief that drugs like natural causes produce diseases. Drugs are active and most suitably administered in quantities in-measurable by oridinary methods. In 1810 he brought out his greatest publication "Organon" of rational art of Healing. He received severe criticism thereafter because of his contention of administering all doses of single drugs. Later he took to teaching this system of medicine and as a result we have stalwarts like Stapf, Gross Franz and Ruebert Hartman. The Materia Medica was published in the subsequent years. Homeopathy came to be practised in all parts of Germany it 1819, It spread to Austria, Italy and France. Its impact spread even to England. Dr. Quin mastered Homeopathy at Leipzig and Went to London in 1832. In 1844 he became one of the man founders along with several others to form the British Homeopathie society.

In 1850. the London Homeopathic Hospital was founded e led to multiple spread of small dispensaries all over. England can boast of several stalwarts in the field of Homeopathy. These are Dudgeon, Dyce, Brown, Hughes, Pope, Burnelt and Clarke.

In India it was originally introduced by Honigberger, Tonnier and Berigny. But in actual fact it came to be imbibed and spread by the practise and conversion of Dr.Mahendra Lal Sircar in 1867. He same under the influence of Dr Rajender Lal Dutta.

By the year 1891 Homeopathy had made significant stridee in India. In this regard the narne of Dr. Majumdar deserves mention for popularising this system by his worked on the subject. Further mention must also be made of Dr. D.N. Loy, Dr. Younan, Dr. A. Kshoy Kumar, Dutta and Dr.C.S.Kali.

By the end oil the 19th Century Sri Mahesh Chandra Bhattacharya went a long way in popularizing this system by his low cost medicines and his publications in Bengali, and English. From Bengal it spread to other regions. The popularity enjoyed, by homeopathy encouraged the rising of many quacks and upstarts. These ill-qualified and unscientific people only marred the fair name of homeopathy. The training imparted was not good and different people acquired bogus certificates and degrees. The public image of this system was destroyed.

The seriousness of the situation led to the efforts of true homeopaths culminating in the first state sponsored Homeopathic council in India. With the advent of India's independence the efforts of All India Institute of Homeopathy doubled. With the help of some members of Parliament a resolution was moved in 1948, a committee was set up and allocations yore made in the 1st Five Year Plan.

As yet we cannot say that the standards of Homeopathy in India are perfect. They are varied. Some practitioners have gained as tendency only by reading literature on it, without undergoing any training. Hence it has been unani-mously agreed upon to have a Five Year Degree Course and Boards of Regulation have been set-up in different states to maintain standards, Even this system just like Ayurveda and Unani has receded into the background owing to the introduction of Allopathy in 1856.

The Unani system of Medicine in another form of indigenous medicine used in Indian Society. The birth place this system was in Greece. Its founding fathers were Hippocrates end Galen. The term Unani is derived from the Greek word "Ionian". The Arabs learnt the practice of this system from the Greeks and carried it to other countries was they who were responsible for its origin in India.

This system is based on the Pythagorean theory of four proximal qualities of the element; hot, cold, wet and dry. It is also based on the humoral theory of Hippocrates according to which any imbalance in humoral composition of n person brings about a change in the health status. He cited the importance of several factors, physical, psychical and environmental in causation of disease. The Greek system of medicine endeavoured to

increase "self preservation" and resistance of the person. The Unani likewise is based upon these principles.

After the conquest of the Greeks by the Romans there was decay in medical develop §nt for more than a thousand years. Galen (Circa A.1). 130.200) of Greek parenthood collected and compiled medical knowledge which reigned for more than 15 centuries. In addition to this he rejoined medicine with philosophy from which Hippocrates had separated it. It was he who first showed that arteries contain blood and not air. After his death there was stagnation for over a number of years. In the middle ages the profession was confined to the clergy.

The followers of Nestorius of 5th Century B.C. founded schools of medicine in Persia. They translated the Greek writings into Syriae. One of these schools was responsible for the conversion of medicine from Greek to Arabic. This was the school of junde Shapur (descendent of Shapur the Great, in of Persia). During the period of Arabian dynasty of Omayyad Caliphs (1st half of the 8th Century) books in medicine were translated from Greek into Arabic. These works were modified or influenced by medical knowledge of Persians, Chinese and Indians.

Humain, Avensoar, Rhases and Avicenna deserve mention among the Arab contributors to Unani Medicine. "Ten Treatises on the Eye", is a systematic book of ophthalmology, Rhases (A.D. 360 — 925) Treatise on small pox and measles gives an account of these ailments. Avicenna combined the works of Galen and Aristotle. "The Canon of Medicine" is an outstanding encyclopedia of medicine. It served as a medical bible for several Asiatic and European civilisations for more than 6 centuries. It was translated into Latin and used in the 7th Century as a text at the universities of Montepellier and Louvrian.

Unani Medicine came to India along with the Arab traders. It flourished and expanded with the encouragement of the Muslim rulers. The Indian Hakeeme brought far reaching modifications in this system to suit the Indian environment and temperament. The outcome of such modifications was that it became indigenoious. In India this system came under the influence of Susruta, Wagbhat, Sarangdhar and other Ayurvedic veterans.

The relationship between Unani and Ayurveda can be traced from the time of Harun-al-Rashid (A.D. 764-809). An Indian physician Manke was invited by him to Baghdad. The works of Charak, susruta, Ashtanghriday were translated during the Abbasid Caliphate Ibd Dhan descendent of Dhanapati wax also called to Baghdad by Yahya. He was responsible for several works into Persian and Arabia.

During the reign of cutb-al-Din and his followers at Delhi 13th to 15th Century, Greco-Arab Medicine flourished and reached its Zenith, Delhi became an important centre, a rival of Baghdad, as far as Unani Medicine was concerned. The Muslim rulers were keenly interested in the progress of the Unani system. The Moghul emperors showed interest in this system of medicine. It was during the period of Babur and Humayun that Hakim Yozufi combined the Arabian, Persian and Ayurvedic medicine systems. This resulted in an indigenous system.

In the 18^{th} century several contributions were made to Unani Arabic Medical books. They were translated into Persian and even into Urdu. Cruised efforts were made to teach this system. Pioneering efforts were made by Maichul Mulk Hakeem Ajmal Khan, freedom fighter and physician. He was the founder of Tibbi College, Delhi. It had reached its Zenith in 1927 at the time of his death. Thousands of graduates of this college are now spread out all over the country services as Unani physicians.

The important feature of this system of medicine is its stress on diet and digestion. Correct diet and digestion produce correct balance of humours. As stated earlier this system of medicine is based on the humoral theory. The four humours blood, phelgm, yellow bile and black bile are used in explaining the personality traits sanguine, phlegmatic, choleric and melancholy.

Another important feature of this system is the ten distinctive features of pulse reading. This was developed by Avicenna. States of the body wore studied by pulse taking without any modern aids. Prevention of disease was considered as important. Unani has special medicines for stomach and liver diseases. Jawarish Jalinoos is used for stomach and liver ailments. Khamira Abresham Hakim Arhadwala is supposed to be good for heart diseases. It is in much demand in the West and South Asian countries. The

drugs of this system are mostly of vegetable origin. Their therapeutic qualities are undisputed all over the world. The medicine is to work on the whole system or body. The treatment is prolonged, harmless and having negligible reactions.

Surgery is also practiced in the Unani system. AL Zhrawits encyclopedias served several Unani Physicians for a long period. Later on there was no improvement and surgery was left in the hands of Jarrahs. Distinguished physicians also did not practice surgery. With the introduction of formal education surgery was bestowed a proper place in the academic curricula. In present day India, this system is on par with the other indigenous systems in serving the sick on scientific lines. Urine, stool and pulse examination are called upon. Drugs are prepared with the aid of latest techniques of pharmacy and modern machinery. They are scientifically prepared and packed. Research is fast growing. Renwolfia Sepentina (Chhota Chand) an Indian medical herb discovered by Hakim Ajmal Khan is a known treatment for blood pressure.

The traditional systems of medicine enjoy a secondary place in society. Therefore, the Department of Indian Medicine is concerned with these systems of medicine like Ayurvedic, Homeopathic, Unani and Siddha

In this study the researcher concerned with the use of the different systems of medicine in society. Therefore the researcher attempted to discuss these systems in this study in detail.

Both Kasl and Cobb's and Rosenstock's models of illness are open to criticism. They explain only one of the reasons for which an individual may consult a doctor, but, they are not exhaustive explanations of illness behaviour. The research of Zola and Balint emphasize the reasons other than reduction of symptoms and physical pain. They have seen factors such as discussing of social, emotional and mental problems as one of the main avenues leading to consultation of a doctor. The studies of Dunwell and Cartwright showed that 72% of the patients consult a doctor when depressed. A study in 1975 by Camberwell and Brown also pointed the same. Their study revealed that only 50% of those suffering from serious depression were not receiving any form of aid for their symptoms. Silver also mentioned that the people were more willing to discuss their

emotional problems in a medical context than in a nonmedical context. An individual may adopt the patient role in order to legitimise his position for financial or other benefits.

Tudor Hart made a study on consultation rates of different classes of patients. The major conclusions drawn from his study were that “middle class consultations had a higher clinical content at all ages, that working class; consultations below retirement age had a higher administrative content, and that middle class was indeed able to make more effective use of primary care”.

Folta and Deck define health and illness to be “relative concepts, determined in part by culture and historical periods and in part by health professionals”. Miner has also summed up his concepts on the same as being determined by social values and rituals of a said cultural group. Health and illness, the concepts and rituals related to then differ not only in different societies but within one society also. The concepts relating to health and illness are constantly changing and need frequent redefinition. Research brings change in ideas of health practices and alters notions of illness symptoms by reducing their occurrence.

Illness behaviour has been studied by several sociologists. Mechanic has analysed the importance of social and cultural factors, the tolerance level of pain, health education, the perceived seriousness of symptoms as all affecting the sick individual.

Apple and Twaddle have noted the subsequent incapacity of the individual to perform normal social role as leading to perception of illness. Zola has analyzed the value orientations of the different social classes in calling some symptoms as normal and some as illness. Mechanic has further observed that persons in stress are likely to perceive certain symptom depending upon the reference group to which one is oriented.

Zborowski has noted cultural differences in relation to illness symptoms among four different ethnic groups. East European Jews, Italians, Irish and old Americans. Zola came to the same conclusion that reactions to pain varied in different ethnic groups.

Twaddle also reported to the same effect. Gordon further disclosed that awareness of symptoms was also governed by social class belonging, for instance the lower the social class the greater the tendency to connote in capacitating symptoms as illness. zoos found in his study of Regionville that lower class people, reported very few symptoms as illness even though they were experiencing them. Freidson has very aptly defined the concept of illness and also wrote the concept of illness propounded by many other writers like Becker, Sigerist, Parsons, Kind and the National Health Survey, “Illness is a type of deviation, from a set of norms representing health or normality”.

Illness has been considered to be of biological origin and independent of human culture. This analogy of illness has however been considered as taking a one sided view of illness. It has been found that social norms influence the reactions of individuals and society to illness. Treatment is an affair conditioned by society. So also is the idea of illnees. The focus of interest of the sociologist is not on the scientific or medical aspects of illness but on the social and cultural factors surrounding illness.

Illness has been considered as a social deviance. Howard S Becker has given a substantial explanation of deviance as an act defined by society, its laws and social norms. The definition of deviance is therefore dependent not upon the individual or his acts but upon the societal reaction to it and on the process of “labelling certain acts as deviant and ascertaining their treatment”. Becker has given room for fitting illness within the concept of deviance by iving importance to social aspects of deviance and differentiating it from physical etiology. Edwin hemert carried this concept further by distinguishing the types of deviance.

National Health Survey when studying the relationship of family, income and health, selected for measurement, three types of health characteristics. These were disability, hospitalization and injury. It subdivided each characteristic and classified disability into four sub-categories: restricted activities, bed rest, inability to work and inability to attend school. Such a treatment of the topic suggests that health is a multidimensional variable.

Sociology may be considered as a useful discipline to deal with the many facets of health because it places illness and health in a social context. In this way it is not only the sick person but his whole environment and particularly those significant persons who try to heal him find their place.

Henry E. Sigerist presented the concept of the special position of the sick and manifested a systematic concern with healing and welfare of the sick people.

Talcott Parsons placed it in a framework of a theory of social systems. In this connection he said a person's illness has to be legitimated by the authority of the medical profession, his intimates or other people. Legitimization of illness leads to a special sick role, replacing or modifying his usual family or occupational role. This theory had gained popularity. Bet it had been empirically found to be less useful. It was found that this role playing of sick was seldom likely to be desired or prolonged. It was seen that people did not like to give up occupation and family roles.

King emphasised the perceptual component of disease. It was the way in which mon sees the disease, evaluates and acts or does not act upon by different persons. According to Such man illness behaviour may be explained in five stages. He lie demarcated critical transition and decision making points in medical care and behaviour. The five stages that he stated were symptom experience, assumption of the sick role, medical care contact, dependent patient role and recovery or rehabilitation.

It has been noted that pain is one of the cues for consultation of a doctor. Pain is conditioned by the cultural complex and groups in which the individual lives and is socialised. He has stated that Mr.Petre and Zborowski have made ouch studies. In the latter's study were 87 male patients suffering from neurological ailments. They were Italian, Jewish and 'old American' in origin. Based on the fact that they were having the same nature of biological complaints, they were expected to experience the same level of pain. The Jews and Italians showed a marked degree of pain, whereas the "old American" patients conformed to the role of an ideal patient. They did not express pain by groaning and moaning and merely supplied it as information to the doctor to aid in diagnosis and treatment. The former had no restrain on themselves and sought as much attention as

possible from the medical staff. The Jews were more expressive and skeptical as compared to the Italian background patients.

He has mentioned in 'Olio regard Zola's study of Irish and Italian patient . The latter were prone to be much concerned with their pain, in turn disrupting their social life.

Pain cannot be taken as an all encompassing variable leading to medical consultation. There are very many cases where the individual experiences no pain at all, lie may be bothered by a lesion, by cough or by discharge. Many such signs and symptoms of illness may not be in capacitating to the individual. Freidson referred in this regard to Apple. He ascertained that any “attribute” which is of recent origin. or a new experience and the extent to which it disrupts normal life way be considered as illness. Several other studies such as those of Bauman also have been seen. Tie has said health is a feeling of well being, non-experience of symptoms and the individual's performance of his functions well. If as in some cases the individual has become accustomed to some physical incapacity, cough or any other symptom, it ceases to draw the attention of the individual and he learns to accommodate to this primary deviation. The individual manages to propel a certain level of symptoms as illness, irrespective of whether he comes from an advanced society such as America or any other developing country. In feet much that the layman considers aa illness is only a deviation from the normal standards established by culture and practice. To this effect too much may be considered as primary deviation and an individual may get accommodated to his illness. That which he brings for treatment is not determined by biological conditions but is a social variable.

There is a lot of variation in the laymen's concept of illness necessitating treatment and physician's concept of illness. Kooe's study reveals information to the effect that the lower class do not consider many symptoms for treatment.

According to Koos no single definition of illness behaviour may be given. In general it was seen from this study that fear of the outcome of illness, the cost factor and age factor were important in Influencing seeking of medical care. Young age and illness symptoms showed in a mediate attention whereas old age and ill symptoms were not that alarming. The role of the individual in the family was also important. The bread winner

appeared to ignore the Symptoms. Another important factor was the social and cultural factor or the norms prevalent in society. Response to illness was also dependent upon the values held in the family. Disabling illness in this study was defined as one which prevented, the individual from conducting his normal activities and non-disabling as one in which symptoms were there but did not necessitate prevention of normal work. Disabling illness and its incidence increased as one climbed up the social ladder. In a discussion on illness the focus should be on illness rather than on individuals; it was so stated.

According to Louden becoming sick is a social process. It is not merely physical unwellness, but the recognition that all is not well and readjustment of patterns and behaviour. The let stage is communication of sickness to others. Verbally, nonverbally, formally and nonformula. The symptoms and sickness become social property and disturb social relations in some way. Hence the people act to show their concern by rallying round the sufferer or rejecting him. He has Peen that Coffman analyzes the deliberate ignoring of chronic symptoms to avoid the disturbance of social relations that their recognition would cause.

The literature on utilization of medical care have stated is dependent upon health status and certain situation. Kosa and Zola Mechanic has cited that character of the symptoms is an important determinant of care seeking. A body of data appears to support that symptoms are primary determinants of help seeking behaviour. Such men's study reveals that many symptoms leave the afflicted person with little alternative but to recognize that he or she is ill and that fennel medical care is required.

An alternative view has also been stated, that there are many events and situations intervening between help seeking behaviour and symptoms.

Kosa and Zola have reviewed Peckham's, as well as Koos study demonstrated wide social clew variations in recognition of symptoms requiring medical attention.

A symptom may be a necessary condition for help seeking. Extensive research has shown that other factors precipitate help seeking in the apparent absence of symptom. symptoms may be regarded as sufficient conditions for occurrence of help seeking, if whenever symptoms arise, help seeking results. Such circumstances cited by Mechanic are 105° temperature, fractured lee, broken back, severe heart attack and extreme psychosis.

The question of help seeking becomes an issue to the individual placed in order of importance in relation to other issues of life. It occupies a hierarchical position as Kooss study also reveals. A second mediatory factor is how far these symptoms interfere with meaningful social life. Apple has shown this to be a major reason, Symptoms which cause social disruption and not the symptoms themselves are important as far as lay or professional help is concerned. Certain symptoms are differentially disruptive in different social categories such as psychiatric symptoms in professional people and physical symptoms in low socio-economic groups. The importance of symptoms varies as per life styles, occupations and what is debilitating in one may be only minor and bothersome in another. The other mediatory factor la the accessibility of medical services.

It has been stated that not all the people who are ill go to doctors and many of those going to doctors are not ill at all. This pattern of seeking medical care affects the system, as well as the ill. There is no single explanation of the illness affecting use of medical care services there are other factors to be reckoned with resulting from research of two decades or so. Denton has considered McAinlay who has come out with a set of factors affecting health care utilization. These are the cost of health care utilization. Cost, though it is important, is not the sole factor affecting use. Various socio-demographic variables such as age, sex, education, religion, ethnicity and socio-economic status have been found to affect health care utilization. Males seem to use these services lesser than females, Geographical location o± these services also seems to affect use of these services. Social psychological variables also seem to affect the use of medical services, such as "fears of medical findings, treatment getting worse-beliefs that legitimate health care can help the situation, knowledge of illness, recognition of need, sense of urgency and Alienation from health care organization”.

The influence of socio-cultural variables in utilization has been studied by Zborowski, Zola, Gordon, Koos and Twaddle E.A, Suchman has extensively studied “health, social structure, attitude towards modern medicine end socio-demographic characteristics to health care usage”.

It has been stated that for the sick individual the influence of others such as friends, family members and their reaction to his illness is important. It defines the role he has to play, the course of action he must take and ultimately his recovery. The sick role can be gauged only by examining society, the interaction that takes place between society and the individual. This sort of evaluation is similar to any other role evaluation. The sick role is enacted behaviour The behaviour may expected pattern, the framework for These concepts are in expectation of significant then conform or vary considerably from the Certain concepts may be utilised to form study of any role including the sick role significant others, expectations, focal persona, behaviours, deviance and sanctions.

Every Individual has many roles to play such as student parent, husband etc. and the tick role may be considered as one among these roles. The sick role may be understood to create incapacity leading to inefficient performance of other roles. This may call for mitigation of this incapacity and taking the advice of significant others. The sick role expectations may vary in cases of different types of illnesses. It may vary according to stage of illness, stigma attached to illness and availability of resources.

Hipman and Sterne have stated the importance of socio-demographic factors in their study of aged persons. It was revealed that the aged were compelled to assume the sick role by cultural beliefs. Pertain also came to the same conclusion, as old age legitimizing sick role. The sick role is also influenced by the “variation in the makeup of significant others”. It is dependent on the relation-ships that these significant others have with the ill persons. It is also dependent upon the knowledge and beliefs regarding health that these individuals hold. The evaluation of the 'significant others’ regarding the worth of the focal person is aloe important. The other factor focused upon by Mechanic and Field is that the significant others weigh the benefits of recovery and hence influence sick role “expectations”. Hence in this way they may condition incapacity and resumption of normal role. It has been stated that illness may also be considered as deviance. In this

sense it has been said that it is not merely the physical symptoms of illness but on the other hand the meaning that is imbued to these symptom by society irrespective of whether they are judged rightly or wrongly by the health professionals.

Motivation in giving a, particular meaning to these symptoms lends clarity to the understanding of illness as deviance. It has been started by Parsons that illness is a form of deviance. It has been seen as necessitating social control through medical care. It has been considered as beyond the control of the individual and makes for exemption of normal activities, legitimizes exemption from normal work and makes it inevitable to pursue medical aid and advice.

Parson's sick role analysis was much criticized although it opened vistas of research. One of the reasons for the criticism was that it can fit only into the urban industrial frame work and not all typos of organizations. Also the exemption from work which was specified may not be so in all types of sickness.

Studies of illness and illness behaviour are important as they enable us to gauge the stage at which an individual consults a doctor. Illness perception does not straight away make a path for consultation. It has been said that it may lead to self-medication or to the use of any other medical or magical systems available. It has been stated that in Western societies, the lay knowledge of illness is in consonance with the medical conceptions of illness, whereas in the other cultures lay knowledge of illness is in variance with the professional knowledge of illness. It has been stated that, therefore, in the non-western societies there are lesser chances of the people accosting the modern system of medicine. But, it has been added that in Western society too, there are class-wise variations in illness concepts as well as in consultation practices. It has been stated that in western societies only pain is recognised as a symptom of illness among the lower class, whereas middle class orientation is more towards use of medical criteria in establishing illness and use of medical care. Some types of lay referral systems have been distinguished by Freidson. One of these is where they would be client participating in an indigenous lay culture and develops firm resistances to modern medicine. They may, as such and then have unscientific beliefs such as belief in gift of touch. In such a class of people the indigenous possess more faith than the modern practitioners, In the second

type that has been discussed by Freidson the lay referral system has been 'truncated'. The sick individual is influenced by interpersonal relation-ships in the family. In this type the individual has a greater chance of using medical aid as compared to his counterpart in the expended lay referral system. In the third type the lay and the professional culture both merge imperceptibly into one another. The lay referral system is considerably 'truncated' and the cues for consultation come from within the individual's knowledge of illness. This knowledge of the medical system may lead to self-medication and then to consultation. Only in extreme cases there is a report of use of indigenous medicine.

Finally in the last type discussed by Freidson, the individual positively utilizes the medical system owing to a "cohesive and extended referral structure and culture similar to that of the professional".

Freidson has quoted Suchman's study in New York city. This bears evidence to the effect that the Puerto Ricans who had minimal modern medical knowledge of illness had an extended lay referral structure. The other two ethic groups namely the Jews and the Protestants did not have the same.

In Raphael study the types of lay were co-related to medical utilization pattern systems. The study revealed that medical utilization was lowest in communities with low education long residence and highest in cases of high education and mobility.

One such study revealed that there are some barriers to seeking of medical aid such as fear of investigations and treatment. Besides this sometimes people draw their own conclusions about their illness that they cannot be helped by consultation. In some cases they become resigned to their illness symptoms especially if it is a common one in their group and they treat it in their own way. It is revealed that it is not only social and physical, factors which influence consultation but also as Morris contended the nature of the medical services. The study also revealed that in some cases complaints were not taken to the doctor because of self-medication. This particular study revealed the necessity of health education.

Freidson, Mechanic and Coe give primacy to self-medication in the course of seeking formal care, but the sequence of events is not specified. The poor people in particular are known to resort to self-medication, owing to lack of knowledge, increasing costs or part of traditional sub-culture of the poor. The poor go in for self-medication at the outset of illness. They are influenced by mass media advertisements and have a conception of the body as a constant plumbing system to be flushed out or cleaned and they use laxatives, liver and kidney tablets etc. They go in for formal care when the disease is more advanced. The organization of medical services also contributes for the practice of self-medication, especially among the poor. In Great British and New Zealand under the nationalized medical care system consumption of patent medicines has decreased. In Great Britain Self-medication is not used as an alternative to consulting a physician.

Kith, Kin and friendship net work decide when professional help should be sought. Suchman found in his study that most of the people discuss their symptoms with others and Zola has included the influence of others as a key trigger in a person's decision to seek-medical care. Evidence suggests that the lay referral system is important among the poor than in any other social category.

Freideon and others have pointed out that it is common among the poor because of poverty, local cohesiveness, and lack of knowledge of external resources. He has systematically analyzed the whole process of seeking help from intimate; informal confines of nuclear family, though distant authoritative laymen to the professional. This network of consultants he called as the lay referral structure or the "Lay referral system". Lay Referral structure is considered as a hierarchical information seeking process, through which one reaches the more informed and experienced and then to formal medical care. Very little empirical work has been conducted in this area.

A study was made in Aberdeen, Scotland in this area. The study was concerned with the organisation of health and welfare services and their use by lower working class families, with reference to role of Kin, family and friendship networks. The findings of the study showed that the underutilizes had extended lay referral system. Several factors operate even within the lay referral system influencing formal consultation. The lay

referral system is more among underutilizes in Aberdeen study. Among the poor lay consultations may be immediate. The sick role may not be claimed for many reasons especially economic and familial. There is the evaluation of the health problem in relation to other problems. Another factor is the person in the lay referral system who is first lay person consulted, who may guide one to a doctor.

It has been noted that the lay referral system deter-mines the stage of formal care. Low socio-economic class have extensive lay referral system and for various reasons do not consult formal help as soon as the upper socio-economic persons who have lesser lay referral system and they reach the professionals faster. Also it has been seen that the lower socio-economic status persons who have lesser lay referral system reach professionals faster. It has been stated from this study that the lower socio-economic persons cannot reach the professionals because of their sub-cultural variation with the professionals.

Freidson shoes that the lay referral system and lay consultation is not uni-directional but may back from the physician, in discussion of diagnosis, prescriptions etc.

Hence it has been seen that there are several alter-native courses of action than going to a physician, left open for en individual feeling sick. These alternative courses may be going to a chiro-practitioner, a faith healer, or a druggist or self-medication. Theo may be resorted before consulting a doctor or even after consulting a doctor especially in the case of chronic illnesses or psycho-somatic illnesses. It has also been seen that many of these are organized and others are not so well organized. They somehow form a threat to the “mainstream” of medical institutions. They manage to enter into the patterns of health care utilization and affect society as well as scientifically organized systems of medicine. Study of the lay definitions of illness becomes necessary to gauge the stage at which e doctor or medical help is sought. As stated earlier illness does not straightaway lead to consultation of a doctor. It has been stated that in Western countries there are greater chances for immediate consultation of doctor than in non-western countries. This is because of higher level of medical education in those countries. But again class-wise differences have been noted. It has been stated that in non-western countries there is a lesser chance of people accosting the modern western system of medicine even if they

approach medical aid as compared to the western societies. It has been seen that seeking of medical aid is a social process, "defined by (1) the particular culture or knowledge people have about health and health agents and by (2) the inter-relationships of the laymen from whom advise and referral are sought. There is then a cultural content in the system whether of ethnic or socio-economic origin and a network or structure.

It is important to mow the lay construction of illness as this concept influences the use or non-use of medical services, it also accords shape to the medical system and vice-versa. The process of seeking medical aid is dependent upon the organisation of the medical system and the organisation of the lay knowledge about illness. There are certain factors which promote the seeing of medical aid. One of these is pain. Of course it is not the only variable. It has been seen that attribute which disrupts normal life may be considered as illness and some action may be taken. That which the individual brings to the doctor as illness may not be solely determined by biological conditions. It is a socially determined variable.

According to Hasan, it is said that in India the indigenous systems of medicine or Ayurveda was used especially in rural areas. Later with the introduction of Unani, it was seen that it was encouraged by Muslim nobles. This system of medicine was used mostly in the urban areas in India. It was found to be displaced by the modern system of medicine. The allopathic system of medicine flourished in the urban areas. It was seen that because of better prospects of living and earning the allopathic doctors settled to treat the urban people. Hence it was seen that a greater number of doctors are found in the urban areas as compared to the rural areas.

From the immense research that has been conducted on health care utilization, certain conclusions has been drawn. One most important consideration that has been cited is the cost factor. Though it is an important factor it is not the only factor affecting use of medical services. Various socio-demographic variables such as age, sex, education, religion, ethnicity and socio-economic status have been found to affect health care utilization. It has been stated that males use these services, lesser than females. It has also been seen that geographical location of services is important, as it affects the use of services. Then again social-psychological variables such as “fears of medical findings”,

have been noted. The influence of socio-cultural variables in utilization has been studied by several social scientists such as Zborowski Zola, Gordon, Koos, Twaddle and Suchman.

According to Louden people may not resort to the modern system of medicine as soon as they are ill. They may initially resort to some indigenoue system of medicine and in case the disease does not elbside, then they may approach the modern system of medicine.

The people are seen to be visiting hospitals for acute emergencies. They have certain ideas about the cure of certain diseases. They believe that the cure of certain diseases like jaundice epilepsy, small pox and mental illness are not fully cured by modern medicine. Hence such beliefs may withhold the people from approaching modern medicine.

It has been stated that the patient practitioner relationship is an important one in society. It is not an accidental happening but a well rehearsed one in which both the patient and the practitioner have certain expectations. They act in accordance to such expectations. It has been said that this relationship itself is therapeutic. It is a socially and culturally learnt relationships It is a learnt behaviour pattern like other behaviour patterns.

It has been observed that the doctor by virtue of his qualifications holds a higher position as compared to the patient in this relationship. It was noted that in western countries the doctor having high technical qualifications was ranked high with patients. In conclusion of the Parsonian analysis state that in the doctor patient relationship; the patient is in a characteristic "situational dependency" the doctor's attitude to-Nards the patient has been discussed under what Parsons has termed as "affective reutrality".

This is a device which keeps the patient at a sufficient distance from the doctor. It prevents him from getting emotionally involved with his patient, therefore maintaining a professional interest.

The studies of Szasz and Hollender have accepted the Parsonian analysis. They consider the problems in functional terms, Hence any relationship not be fitting the situation becomes dysfunctional.

Freidson has stated that there is an underlying conflict in the doctor patient relationship, as each enters the situation with their own expectations. His study of the attitudes and behaviour patterns in Montefiore Hospital in New York has made several conclusions. It was seen that patients choose their doctors on the basis of competence and interest shown by the doctor in the patient.

From a study conducted by Ann Cartwright on patients and doctors in England and Wales certain conclusions were drawn. It was Peen that patients desired maximum time to be given to them in order to be satisfied.

It was also seen that patients chose their doctor on the basis accessibility rather than on the basis of qualifications or organization of practice. It was also seen that most of the patients had a family doctor and preferred him to a specialist. They felt that he was the beet for a preliminary check-up and he would refer to a specialist if necessary.

Several social scientists namely Freidson, Mechanic, and others have stated that self-medication is practiced before the seeking of formal medical care. It was seen that people resort to this practice because they lack knowledge of Medicare, increasing cost of medicine and the part played by traditional sub-culture of these poor people. They are influenced by mass, media and advertisements; It has been observed that self medication is resorted to by the people in case of persistent disease conditions. It has been observed that one of the reasons for the practice of self-medication is the set-up or the organization of medical care in Britain for example self-medication is not used as an alternative to consulting a physician. This is so because of the nationalized medical care system.

Conclusion

The literatures reviewed on the use of the different systems of medicine in Madurai District. The Central and State Governments in India are spending lot of funds to improve health status of the people and solve the health problems through services and availability of different systems of medicine. A research study on this topic could help the policy makers to evolve and implement the various health care services available to the people properly. Therefore, the scholar thought it appropriate to take up a research study on use of the different systems of medicine in Madurai District.

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