Chapter II

PLACE OF HOSPITALS AND DOCTORS IN PUBLIC HEALTH
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Public health is an organised effort to improve the health of a population, the life span of its individuals and the extent to which people are free from illness. Specifically, it can be seen as a concept concerned with collective efforts by the state and community, aimed at protecting and promoting health of the population. According to Winslow’s classic definition ‘Public Health is the science and art of preventing diseases and prolonging life and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individuals on the principles of personal hygiene, the organisation of the medical and nursing service for the early diagnosis and preventive treatment of the disease, and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health’ (cited from Baggott, 2000, p.1).

As described in the definition, public health is a broad social enterprise, more akin to a movement that seeks to extend the benefits of current knowledge in ways that will have the maximum impact on the health status of a population. It does so by identifying problems that call for collective action to protect, promote and improve health, primarily through preventive strategies. It is unique in its interdisciplinary approach and methods, its emphasis on preventive strategies and its linkages with government and political decision making. Above all, it is also a collective effort to identify and address the unacceptable realities that result in preventable and avoidable health problems and enhance one’s quality of life, and it is a composite of efforts and activities that are carried out by people committed to these ends. These factors make public health a system in itself (Bernard, 2000, p.11).

Modern hospitals form an integral part of public health and are one of the inputs necessary to achieve the goals of public health. Hospitals are important for public health as well as for modern societies because one of the major functions of hospitals is to provide curative care to people. An expert committee of WHO
highlights the necessity of hospitals in today's society as the hospital is an integral part of a social and medical organization, the function of which is to provide for the population complete health care, both curative and preventive, and whose out-patient services reach out to the family and its home environment; the hospital is also a centre for the training of health workers and for bio-social research. (Llewelyn and Macaulay, 1966 p.9).

From the above definitions, it becomes clear that public health is constituted by several inputs for provision of health, including curative and preventive dimensions. Thus medical care provisioning in terms of hospitals and dispensaries is just one of the inputs required to improve the health status of population. Mckeown, Banerji and Qadeer in their work highlight that health is not merely a biological phenomenon. It also depends on social, economic, cultural and environmental factors of the society. These factors play an important role in deciding the health status of the people and society at large. Thus the health problem of the people, their health behaviour, the institutions dealing with these health problems and society, all form an integrated, interdependent and an interacting whole. Health culture of people is in fact a sub-culture of the overall culture of society. This health culture largely depends on the socio-economic, political and environmental factors of the society. Health culture undergoes changes with changes in the overall culture of the society (Banerji, 1982 p.208).

Health of the people is not a domain exclusively of technical and biological inventions of medical sciences; rather health is shaped by biological, social, economic and political factors in society. Health and well-being therefore cannot be a static concept. Health and health system are a function of the balance between socio-economic, political and technological forces. There is no isolated, single, absolute definition of 'health' and, 'health services systems'; they are related to the way a society is structured (Qadeer, 1985, p.199-203).

Hospitals represent the organizational form that provides curative, preventive and rehabilitative services to a population. Taking care of one's health is a fundamental need of all individuals and the modern-day hospital assists in the fulfilment of this need, by alleviating suffering and pain. The hospital has become the centre of modern technology, knowledge and therapeutic facilities to treat all kinds of
illnesses. It has become capable of catering to almost all health needs from serious to routine health problems of the people. Its goal is to curing the health problems of an individual as well as society at large.

**Evolution of Hospitals**

The development of hospital from a place of shelter for the homeless and ill, to the hub of modern medical knowledge, technology, professionals is a recent phenomenon. The transition to this present form took place during the late nineteenth and early twentieth century, when hospitals adopted the biomedical model to cure diseases in the society. The biomedical model of health is a result of conversions of certain ideas regarding living beings, related discoveries and inventions in medical sciences, which are popularly depicted in terms of a series of spectacular breakthroughs. One such discovery was the ‘germ theory’ of Louise Pasteur, who discovered that diseases are caused by microbes called ‘germs’, and that the diseased state of body can be cured by eliminating the causative from the body. Here, health is seen from the perspective of medical knowledge. The bio-medical model espouses an understanding of people’s health, that is based pre-dominantly on the scientific theory of disease causation and hence also recommends effective cure exclusively in biomedical terms. It focuses on three areas- firstly, health is conceptualised merely as absence of biomedical abnormality. Secondly, human body is viewed as a machine, which has to be restored to health, through treatments designed to arrest or reverse the disease process. Thirdly, health of society is seen as largely dependent on the state of medical knowledge and the availability of medical resources. It relies on the hospital as an organization for the delivery of health care to people and society at large; thus, hospitals become the centre of science and technology and for curing diseases. Doctors have assumed importance as providers of curative care; besides this, they are also the ones who exert strongest control over medical technology, which is ever improving and becoming more and more accurate.

Certain social conditions are essential for the existence of hospital. One such condition is the requirement of people to get cured, and hence hospitals become imperative in our society. Although in its current form, the hospital is a cure-oriented, complex organisation, the notion of treating patients and alleviating their suffering, which formed the foundation of the earliest hospitals, still remains the same.
It would be worthwhile to examine some definitions of a hospital, in order to understand it better. Howard Bernum and Joseph Kurzin (1993: p. 259) define a hospital as, 'An image of physical buildings in which services are provided by a skilled staff. Traditionally, hospitals have provided a focus for the delivery of interventions requiring special personnel skills and equipments, monitoring of patients for therapeutic reasons. Most part of health care, however, actually takes place outside the hospitals, in clinics, medical offices, pharmacies, schools and homes. Hospitals, by providing a technical focal point for the referred delivery of skills care, can enhance the effectiveness of non hospital health care' (cited in Heggade, 2000, p.9).

According to William C. Cockerham, hospital is defined as a place providing health services in a centralised manner. He argues that ‘Since many health problems require a level of medical treatment and personal care that extends beyond the range of services normally available in the patient’s home or the physician’s office, modern society has developed formal institutions for patient care, intended to help, meet the more complex health needs of its members. The hospital, the major social institution for the delivery of health care in the modern world, offers considerable advantages to both patients and society. From the stand point of the individuals, the sick or injured person has access to centralised medical knowledge and technology that will render treatment which is thorough and efficient’ (William C. Cockerham, 1978, p. 229). Although, hospitals are meant to provide care and services, they are largely restricted to curative care. In fact, only serious illnesses are given priority for hospitalisation.

According to WHO ‘the hospital is an integral part of a social and medical organisation, the function of which is to provide for the population, complete health care, both curative and preventive, and whose out patient services reach out to the family in its home environment; the hospital is also a centre for the training of health workers and for bio social research’ and 'an institution that provides in patient accommodation for medical and nursing care' (cited in Goel, 1980, p. 165).

According to Rodney M Coe, “A hospital is, first and foremost, a place in which members of the community can obtain services designed to restore them to good health. More recently, it has become a place or setting in which especially older members of the community can obtain services to restore partially the use of enfeebled limbs or vital organs worn from age. The modern hospital is also a place of
learning, a centre for the practical training of physicians and surgeons- to- be, as well as other practitioners. At the same time, advances in scientific knowledge of disease are often made in research conducted in the hospital setting. Yet the modern hospital is also a very large and complex organisation with a recognizable hierarchy of status and roles, rights and obligations, attitudes, values and goals” (Coe, 1978, p. 259).

For our study we consider the definition of Coe, which highlights the hospital as a complex, care providing organisation, along with its training and teaching functions, and has a line of hierarchy which works under a set of values, norms and objectives to achieve it specified goal.

The word ‘hospital’ is closely related to the word ‘hospitality’, and is derived from the word ‘hospice’, which means a place for refuge, a house for rest. The ‘modern’ medical system requires a range of treatment and personal care for health problems, which cannot possibly be made available in the patient’s home or in the physician’s office. That is why concept of hospital as a formal organisation was developed by modern society, so as to meet the complicated health needs of its members. It intended to provide health services to the sick or injured person as an individual who can have access to centralised medical knowledge and technology, while availing of treatment which is more systematic and efficient. It also attempts to protect modern society, through hospitalising the people from many of the ill effects of infections of diseases while caring for the ill in the families. Over all it helps to protect health of the people and society at large.

In fact, the hospital is one of the important institutions in maintaining and restoring the public health care systems i.e. the health of the people. It is responsible for correct diagnosis and appropriate treatment. In general the major functions of the hospitals are 1) care of the sick and injured, 2) education of physicians, nurses paramedical and other personnel, 3) public health – disease prevention and health promotion and 4) research. The primary function of the hospital, the one that has been constant throughout the entire process of its evolution, is care for the sick and injured. While other important functions have developed, they are all subordinate and are recognised as a part of responsibility of a hospital because they contribute indirectly to the care of the sick.
The hospital has evolved through long and continuous struggle of medical development. The hospital ensures the right to good health of human beings and also has a formal recognition by the community for its accountability for restoring good health. This right and responsibility applies to all economic and social strata of society. Though it largely sounds a western idea, to a large extent it also applies in Indian context, especially so after independence, when there has been extensive development in both public as well as private hospitals, which are based on western medicine. The growing consciousness among the people about their health rights, the changes in the morbidity patterns and age composition, the growth of scientific medicine, ecological changes, the greater availability of disposable income and rising standard of living among certain sections of society has increased demand for health care. Ill health arising out of poverty, malnutrition and social disruption has also added to the demand for health care to provide relief. Thus hospital as an organization has gained greater prominence and importance in our societies.

**EVOLUTION OF HOSPITALS: A HISTORICAL OVERVIEW**

The hospital as a social institution is of recent origin and is rooted in the modern medical model. But the history of medicine and surgery dates back to an earlier age, even when hospital as an institution were the sick can be taken for treatment was absent. The existence of hospitals in today's times is a cumulative effect of human fear of death and disease, and humanitarian values, coupled with civic consciousness and religious zeal, which motivates people to establish and run hospitals for the benefit of the population. If society has changed over a period, human qualities such as caring, curing, love and compassion have remained much the same even today, for it was these same fundamental reasons and emotions, that led ancient people to build hospitals for the sick and injured people in those societies.

**Early Civilizations**

The two major, ancient civilisations in India and Egypt respectively had prototypes of modern day hospitals. One finds stories available in ancient literature about physicians and their medical practices, which were made available to village people by Buddha and his son Upatiso. It is believed that Upatiso built shelters for pregnant women and diseased people. These examples were quoted very often to inspire the
followers of Buddha to furnish such shelter houses in each and every corner. However, records pertaining to health practice are scarce. The best known example is that of eighteen institutions built by king Ashoka (273-232 B.C.). The historical significance of these institutions is that it reveals the importance attached to the (principles it fostered) services rendered to people suffering from various diseases. This reminds us of the nature of modern hospital, which also considers these principles as the fundamentals. The hospital would provide eatables and other medicines to the needy. These ethical and moral practices relating to health care were not simply the characteristics of hospitals, but were part of the moral and ethical principles of the earlier society (Rosengren, 1980, p.2).

It is extremely difficult to know how early humans reacted to diseases and how they were treated. Fossil remains such as teeth and bones extracted from mummies, throw some light on diseases like arthritis, parasitic diseases, tumours etc. Early humans used religious rituals, prayers, magic spells, exorcism, etc., to understand the reason behind pathological problems (Weiss and Lonnquist, 1996, p.14).

**Egyptian, Greek, Roman Hospitals**

In early Egyptian, Greek and Roman civilizations the temples of God functioned as hospitals. Egyptian physicians used drugs like peppermint, castor oil, opium etc., to treat patients. Greeks used salt, honey and water from the sacred spring. Some of these civilisations had planned cities with the objective of restricting the spread of contagious diseases like malaria (Rosengren, 1980, p.2). During the Christian era hospitals of the Christian people replaced the old temples. Church buildings and other building were also used for treatment purpose.

Medical practice in pre-industrial Europe was more of an empirical art aimed at comforting and consoling the ill persons rather than curing them. Early medical practitioners were apothecaries, barbers, surgeons and lay practitioners whose remedies comprised of various flora and fauna. But the healing was limited to certain known diseases and the rest remained as incurable diseases.
Medieval Hospitals

The influence of religion in the establishment of hospitals continued even in this period. Initially, hospitals emerged as shelters for the poor, the sick, the orphans and homeless people. Surgery was sacrilegious, due to the influence of the Christian belief that the human body was created in the image of god and it could not be experimented upon. To provide relief for the sick people, the priests and attendants were asked to show love and faith, as a method of curing. These institutions were associated with the monasteries and were funded by religious groups (Rosengren, 1980, p.6). The hospital systems in those days were influenced by the Christian values of charity and humanitarianism. But trained physicians practiced in their home and rendered their service to rich people in their homes. The poor people had to depend on hospitals, which were not in liveable conditions. They were crowded places where filth and dirt accumulated, causing high mortality rate among the inhabitants. Until nineteenth century most of the hospitals were more like shelters rather than places where one could expect to be cured of illness. As already mentioned earlier, they were established largely out of altruistic motives of providing some shelter for the poor and the destitute and at times with the intention of isolating those who had contracted some contagious diseases like leprosy or those who were believed to have been possessed by the devil. For many, getting admitted in one of such ‘early hospitals’ represented the last frontier where they stopped, on their way to certain death. These hospitals first gave shelter to the poor, homeless and destitute and later provided medical attention to the sheltered that had become sick. These hospitals were therefore, the feared and shunned by many (Enderle et al, 2000, p.6).

Right from mid-nineteenth century onwards, England and other European countries had discovered the importance of hygiene and sanitary measures for good health, and this became a milestone in the history of public health. It played a major role in modifying the behaviour pattern of people, as well as in transforming the nature of public and other hospitals services. Apart from this evolution of modern medical technology had improved the conditions of the hospitals. Chadwick’s work on sanitary condition of the labour had contributed to the enactment of Public Health Act of 1848 in England. According to Rosengren, this had helped to improve the health condition of industrial workers in England (Rosengren, 1980, pp. 12-25).
It was only during the mid-nineteenth century that discoveries which shed light on the causation of disease were made. Before this, the theories ranged from those supernatural explanations, to ones based on miasma and contagion the humours. It was the French bacteriologist Louis Pasteur (1822-1895), who made the first breakthrough, when he demonstrated the presence of bacteria in the air and identified them as the real cause of disease. This laid the basis for the Germ Theory, which had a tremendous impact on medicine as well as public health. Spurred on by the Germ Theory and the subsequent developments in the field of medicine, a new image of the hospital evolved, wherein it was now considered as an institution where people from all the strata of the society could be treated with the highest possible quality of medical care and be cured of their ailments. It was claimed that Germ Theory now made it possible to locate the specific cause of the disease within the human body itself and restore the body back to its normal functioning by eliminating this cause with the help of a specific course of treatment. This gave rise to specialisation of medical treatment in medicine and surgery in hospital. It was now possible to treat patients of malaria, tuberculosis, rabies, cholera, and diphtheria etc., in a 'scientific manner'. The hospital became a place of observation of such communicable diseases. This was a turning point in the history of hospitals, and there were radical transformations in the function and form of hospitals. The earlier hospital, which was essentially a halt for the dying and the destitute, was now replaced by one where the very best scientific care could be expected. These were major changes in the organisational structure, rules and composition of the hospital, gradually giving the hospital its current, modern form. Since diagnostic and other kinds of equipment were located in hospitals, the doctors were also required to function from the hospitals, as against the earlier times, when they functioned largely from their homes. The use of steamed sterilisation also became a common practice in the hospital. Roentgen’s discovery of the X-rays in 1885 was a major scientific achievement for diagnosis and treatment. It increased confidence in medical diagnosis, and brought hundreds of patients to hospital for treatment (Rosengren, 1980, P. 20).

The period between 1850 and 1900 saw not just growth of the hospital as an institution, but also developments in various biomedical sciences like biology, cellular pathology, clinical microscopy, bacteriology, physiology etc. This increasing knowledge in the physical and biological sciences was a necessary forerunner of the
modern clinical laboratory, the X-ray department, and the operating room and physical therapy department, all of which have contributed to the development of the modern hospital. Although the medical and nursing profession in the later half of the nineteenth century did not reap the full reward of these discoveries, they provided the present century with a firm foundation upon which to build (Rosengren, 1980, p. 21).

Thus with this continuing growth and advancement, the hospital today plays a vital role in curing and trying to prevent diseases, prolonging life and promoting health and efficiency. It attempts to create better sanitary and environmental conditions in the communities for controlling communicable diseases and also tries to ensure improvement in the standard of living and a better life for all. These are the objectives of public health that the hospital intends to achieve.

**Growth of Technology and Rise of Hospitals**

The image that one gets of a twentieth century hospital is one of a centre of sophisticated medical technology. The first half of the nineteenth century is known mostly for the growing importance of physicians and medical researches based largely on clinical observations. Ackernecht points out that in the middle ages medicine was centred in libraries; in the following three centuries (as in antiquity) it centred on the sick individual and in the nineteenth century, for the first time it centred on the hospital (as quoted in Weiss and Lonnquist, 1996, p. 23).

Hospitals had existed for centuries but increased rapidly in number during the 1800s in response to the massive migration into the newly developing cities of the west. Communicable diseases were taking a heavy toll of people’s lives; many among the urban migrants contracted typhoid and TB. Admission in the hospital was only resort that was available. These patients provided unprecedented opportunity for clinicians and the researchers to observe the sick and to search for the patterns in their symptomology, disease progression, and response to medication.

In the beginning of the era of various diagnostic and therapeutic aids, a notable development in the hospitals was Einthoven’s invention of the electrocardiograph in 1903. This was followed by the first basal metabolism apparatus and then the Wassermann test in 1906, and test for pancreatic function and urinary
sugar in 1908. Concurrent with this progress in the field of internal medicine was the introduction of radium for treatment of malignant growths, increasing use of clinical laboratories for microscopic examinations of the pathological tissue and developments in antibiotics. The result of these varied new diagnostic and therapeutic aids was the conquest of diseases formerly regarded as incurable, which in turn resulted in a notable increase in public confidence and in hospital occupancy. A social service department also became part of the hospital as a natural corollary to the outpatient clinic (Enderle et al, 2000, p.9).

The late nineteenth-early twentieth century was marked by advances in the basic sciences such as chemistry, physiology, pharmacology etc.; it was a period of intense interdisciplinary cross-fertilization. Discoveries in the physical sciences enabled medical researchers to take a giant step forward. The impact of medical technology and knowledge on the hospital and specifically on health care delivery was profound. The health care system that consisted primarily of the “horse and buggy” physician, was replaced by the doctor, backed by and centred around the hospital, as medicine began to change to accommodate the new technology. This has been the defining factor for the current hospital, in its modern day form (Enderle et al, 2000, p.10). Technological advancements such as artificial heart valves and artificial blood vessels, and other innovations have further revolutionised the health profession and the institution of the hospital. Through such evolutionary processes the hospital has now became the central institution that provides medical care. Because of the complex, specialised and expensive technology and equally complex procedures that could be only based in hospitals and the technological orientation of medical education, both patients and doctors have been pushed even closer to this centre of medical technology and technological methods of cure. The steady expansion of scientific and technological innovations has not only necessitated specialisation among all health professionals (physicians, nurses, and technicians) but has also required the housing of advanced technology within the four walls of the modern hospital (Enderle et al., 2000, p.15). Increasingly, the hospital became a more curative oriented and individual patient-centric institution, where all the medical knowledge and technology are focused on the individual patient for providing better curative treatment. Hospitals and the personnel within these organisations now started
evaluating their work in terms of the quality of service provided to the patient, effective care and patients’ satisfaction.

The standardisation process was an inevitable outcome of technological applications in the hospitals. Though hospital’s main objective was to provide the best professional, scientific and humanitarian care to the patients, it has often been violated very the professional themselves. This has contributed to the acute specialisation as well as the loss of voluntary health care ethics from the staff.

Another development, with far reaching implications for the practice of medicine has been corporatisation of medicine. Hospitals have become highly specialised territory requiring heavy investment of capital, as well as infrastructure. Large private firms engaged in diverse activities not only dominate medical manufacturing, they have also started playing a major role in ownership and financing of hospitals and budgetary allocations for hospitals.

However, there have been periods of set backs as well as progress in the early period of medical history and in the development of the hospital. It has not been a smooth and easy advance. Many decades of experiments, scientific discoveries and public enlightenment have been necessary to break down the barriers of ignorance and prejudice. The evolution has been accomplished in stages. The hospital today represents high quality of scientific medical care for its patients and never before has its influence been so extensive and widespread; never before has it played so important a part in people’s lives.

THE RISE OF HOSPITALS IN INDIA-THE COLONIAL LEGACY

Like western countries India also has a long history of providing health care. The Indus Valley civilisation had its own specific health care facilities. Even the pharmacology, which was developed by Ayurvedic medicine, is colossal and is significant for giving directions even to current pharmacological research. Medical details were a part of the Buddhist metaphysical text, the Milindapanha (1st century AD). The famous decree of Emperor Ashoka (274-236 BC) in his 2nd Rock Edict (257-256 BC) praises the organization of social medicine shaped by the Emperor along the lines of Buddhist thought and ethics (Banerji, 1985, p.7)
According to Udwadia, in this period most of, ‘the ill patients were looked after in their own homes. Those who had no one to look after them were admitted to hospitals. These hospitals were built and financed by the state’. Edict number 11 of King Ashoka (274 – 236 BC) demonstrates the importance of the hospitals in the kingdom of the King Piyadasi. The hospitals that existed were of two kinds; hospitals for people and hospitals for animals. Pataliputra, Kingdom of Suddhodhana, father of Gautama the Buddha also had excellent hospitals for poor in those days. A description of charitable dispensaries in Pataliputra has also been given by Fa-hian (AD 404 – 411), a contemporary of Chandragupta Vikramaditya (Udwadia, 2000, p.50).

The nobles of the country founded hospitals within the city to which the poor, the destitute, the crippled and diseased came for treatment. Here they received every kind of help free. Physicians examined them for the possible cause of the disease and then prescribed an appropriate diet and decoctions, and everything else that would contribute in easing the suffering. When cured they departed at their own convenience. A Chinese traveller Hiuen Tsang (AD 629 – 645) who visited India during the period of Harsh Vardhana says about the hospitals in India... “In all villages, the highways of the towns, and villages throughout India, the Emperor erected hospices (Punyasalas) provided with food and drink, and stationed physicians with medicines for the travellers and poor persons to be given without stint” (Ibid, 2000, p.50).

During the Pallava period (between 6th and 9th century) in Deccan and the south, health care centres were found near the temple complex. The dispensaries were termed as vaidyasalai – Vaidya meaning medicine man and salai meaning charitable institution during the period of Chola (AD 900 – 1200). These were many such dispensaries manned by local physicians, whose post was often of hereditary nature. These physicians were generally paid in kind, but many attended to the physical needs of the patients without any expectations. (Ibid, 2000, p.50)

The practice of the medicine in India before the intrusion of western nations into this subcontinent in the sixteenth century was limited to the practice of Ayurveda by the Vaidyas and Yunani medicine by hakeems. There is nothing to suggest that western medicine at this point in history was superior to Ayurvedic medicine established by Charaka and Susruta, which was handed down by the gurus to their
pupils and continued for centuries latter. During the subsequent centuries, a series of political, social and economic developments disturbed the ecological balance in the society. Much damage was done to the already stagnant indigenous system by the colonial policy, which patronised western medicine (Ibid, 2000, p.351).

The imperial power, after gaining entry into India built hospitals in quick succession. It is hard to believe, but it is a fact that almost for more than two centuries after these hospitals were established they catered solely to the Europeans, with no access for the natives. The first European hospital was built by the Portuguese, in 1510 by Albuquerque in Goa, on the western coast of India. In 1591 the administration of the hospital was given over to the Jesuits who made it one of the best managed hospitals of the world. Observations regarding this hospital were made by a Frenchman, Pyrard De Laval. He found this hospital superior to the hospital of the Holy Ghost in Rome and the Infirmary of the knights of Malta, two of the best known hospitals in Europe. He wrote, "viewing it from outside we could hardly believe it was a hospital- it seemed to us a great palace, serving the inscription above the gate 'Hospital die Ray Nortro Seignora'. The beds are beautifully shaped and lacquered with red varnish; the sacking is of cotton; the mattresses and coverlets are of silk or cotton; adorned with different patterns, pillows of white calico. There are physicians, surgeons and apothecaries, barbers and bleeders who do nothing else and are required to visit each of the sick twice a day. The sick are sometimes numerous, as many as 1500, all of them either Christian races of Europe, of every profession and quality. Indians are not taken in there." (Ibid, 2000, pp.375-380)

Growth Hospital and Medical Services in the Colonial Period

The East India Company had instituted the Indian Medical Service (IMS) in 1764 and a medical officer was required to be attached to every company, ship and to the permanent trading outposts (factories) with their small standing garrisons. The army, the main instrument of East India Company's political consolidation, was primarily composed of Indian soldiers, the European component being outnumbered by roughly eight to one (Imperial Gazetteer of India, vol. IV, 1909, cited in Kakade, 1998). Mortality and sickness in the European army were mainly due to four major diseases: fevers, dysentery, and diarrhoea, liver diseases and epidemic cholera, which assumed a virulent form when the troops were on march. And the troops were
constantly on the march due to the unsettled conditions of the country (K Ballhatchet, 1980, ibid., 1998).

The frequent outbreaks of fevers and cholera in various stations, districts and cantonments affected seriously the British troops. This led Sir James Martin, who was a member in the Council of India to propose a scheme, in which every medical officer was required to send reports on the medical as well as health conditions of the people.

A better understanding of the various regions occupied by the army, their climate and environment and disease pattern, would provide a basis for a more scientific selection of sites for camps and cantonments, while regular reports on the sanitary condition of barracks, hospitals and transportation would help in the formulation of guidelines for sanitary improvements in the camps and cantonments under Indian conditions. As Martin argued, unsuitable sites and unsanitary conditions “could destroy armies and render courage useless” (J R Martin, cited in Kakade, 1998): The sanitary perspective of J.R. Martin, the main force behind these moves, was influenced by the growing recognition in England of the importance of sanitation and a clean environment.

The European civil population was concentrated in the three Presidency Towns of Calcutta, Bombay and Madras which were centres of British administration as well as the major ports. Here, European residential areas were secluded from Indian areas and along with the cantonments in these towns, were fully self-contained. By the mid-19th century, these areas were relatively well planned and drained and vaccination against small pox (the only effective prophylactic known) among the European civilian residents and residents of the cantonments was almost universal (Bengal Small Pox Commission Report, Calcutta, 1850, cited in Kakade, 1998).

The events of 1857 highlighted the importance of British soldiers’ health and efficiency. The health of the soldiers, which became the primary concern of colonial health policy, remained an abiding concern with the expansion of the British Empire; the army in India increased in importance as the largest single force in the empire, and as a key instrument in the security of Britain’s Eastern possessions. “The main enemy of the British soldier in India was not the Indian enemy but disease” (Royal Sanitary Commission Report, cited in Kakade, 1998).
The mid-19\textsuperscript{th} century marked a watershed in colonial health policy. Most parts of the country were now under direct British administration and a more systematic plan of urbanization and army stationing could take place.

The Royal Commission on Colonisation and Settlement in India, appointed in 1857 to go into the question 'of the desirableness of applying European capital to India through colonisation, as in other countries such as Australia and Canada'. The Commission concluded that the pattern of colonisation in India would be different. It would be through the settlement of 'upper ranks', namely capitalists, who would employ Indian labour, rather than through the settlement of labourers from England. Those settlers in the 19\textsuperscript{th} century were mainly (apart from missionaries) merchants working largely in the seaports and indigo trade (and later tea planters), and who were a 'morally and socially' inferior group in the eyes of the officials, did not figure directly in the colonial health policy. The application of medical ideas for the control of disease currently prevailing in the metropolis was for a long time directed exclusively to the European civil servants and army establishments in India (Ramasubban, 1985, p.15).

The keynote of metropolitan sanitary science, which grew out of the compulsions of urbanization in England in the eighteenth and nineteenth centuries, was environmental control. This was accomplished mainly through town planning, housing and sanitary engineering. These measures required administrative and government institutions embodied in 'local governments', which were responsible for investigation of local unsanitary conditions and their control, and gave the force of legal sanction to these public health measures (Ibid, 1985).

The physical placement of the European population in India was, as far as possible, based on the principles of this sanitary science. Using the criterion of land, the Commission on the army in India laid down elaborate norms for the creation and development of distinct areas of European residence like 'cantonment', 'civil lines', 'civil station' and 'hill station', which were regulated by legislations. These developed into a colonial model of public health and sanitation based on the principle of social and physical segregation. From the time of the Royal Commission Report of 1863, the location and layout of European civil and military areas were decided by criteria of health, laid down by the prevailing medical scientific theories of miasma.
and environmental control rather than by political and strategic criteria. According to
the Cantonments Manual of 1909, it should be carefully borne in mind that the
cardinal principle underlying the administration of cantonments in India is that
cantonments exist primarily for the health of British troops. The prime consideration
was the well-being and efficiency of the garrisons, all other matters must be given a
secondary place (King AD, 1976, p, 118, cited in Kakade, 1998). Earlier, the 'native
lines', the residential areas of Indian soldiers, had been left outside the pale of
colonial planning and construction activity for troops. European fears of miasma
emanating from them had even led to the construction of walls between Indian and
European troop locations to keep the miasma out. The Royal Sanitary Commission
voiced concern for the health of the Indian troops and recommended that cantonment
planning should also be extended to the 'native lives'.

While segregation was an effective tool, at least in the three Presidency towns
contact with the native population was unavoidable. Native servants often lived in the
native areas and native dealers and tradesmen serviced cantonments and civilians.
Grossly unsanitary conditions prevailed in these large and unplanned urban centres
and the native population could well serve as secondary sources of infection. In a his
despatch to the Government of India the Secretary of State for India recognised this
threat and pointed out, "The determination of the effects of local causes on the
mentality of the native population, besides its intrinsic value in connection with the
welfare of the people of India, cannot fail to have an important bearing on the health
of the European residents among them" (Military Dispatch, No. 297, 1863).

The health service system at the time of independence projected the political,
economic and social values of the colonial rulers. Medical services were needed to
support the British army and the British civilian personnel living in India. Later on,
medical services were made available to the native gentry who constituted a tiny
fraction of the total population. Among the rest, which was more than 90 percent of
the population, only very few could get some form of medical care from the
extremely limited number of hospitals and dispensaries run by government agencies,
missionaries, philanthropic institutions and private practitioners. Similarly, public
health services were provided only when there were massive outbreaks of epidemic
diseases such as plague, cholera and smallpox (Government of India, 1946b, p. 35-
Personnel of the Indian Medical Science (IMS) and of the British Indian Army played a key role in framing this colonial pattern of health services of India.

The IMS embodied all the shortcomings of the colonial medical services (Roy 1982, pp.31-33). Firstly, its backbone was the Army Medical Corps which, in any case, did not attract the cream of the profession. The army, being a colonial one, it probably inducted even more mediocre personnel than were recruited for the home army. Secondly, and more important, this set of second rank professionals effectively held complete sway over the Indian medical and health services. Within their ambit of influence were the native professionals too, many of whom they patronized and groomed on their own selves, to carry forward the tradition of the colonial medical services (Banerji, 1975b,)

Soon after, the East India Company also required hospitals to take care of the white settlers working in trade or living in the settlements around trading ports and factories. The company had set-up hospitals in the three centres of British power, trade and commerce in the seventeenth and the eighteenth centuries Bombay, Madras and Calcutta.

The first British hospital in Madras Presidency was established at Fort St. George in 1664, which was meant exclusively for the British population. In Madras, the second hospital was constructed with public subscription, at a cost of 838 pagodas (about Rs. 3000). The company acquired this hospital and built their hospital in 1690. It was founded at James Street in the fort with a beautiful building costing about 2500 pagodas in the Tuscan style. A century later in 1772, Britishers constructed another big hospital called Madras General Hospital. The reconstruction of the hospital’s entire building was completed in 1859 (Jaggi, 1979, pp 75-78).

It was for the first time in history that the native Indians could have access to these western hospital services, with the possible efforts of Assistant Surgeon John Underwood. The hospital for the care of the native poor was built at Purasawakkam, a southern suburb of Madras in 1799. The hospital was named as ‘Native Infirmary’ and brought under the authority of the medical board. In the early part of the 20th century, the government took over the management of the ‘native infirmary’ hospital. A new hospital with 266 beds and an auditorium was constructed. The native
infirmary was later named as Stanley Hospital in 1940. It had a bed strength of 1000 and catered chiefly to the poor population of Madras and its suburbs (Ibid, 1979, p. 78)

Pondicherry was the headquarters of the French on the eastern coast of India, where the French established a hospital in 1701 for French troops and civilians. The hospital continued serving the people till the twentieth century, when the French left India; the Indian government took over and upgraded this hospital, changing its name into Jawaharlal Nehru Institute of Post Graduate Medical Education and Research (JIPMER) (Ibid, 1979, p75).

Meanwhile, the British had consolidated their power strongly during 18th century, especially in the province of Bengal. In 1707-8, the first hospital was started by the British government at Fort William of Calcutta, under the authority of Governor General Robert Clive. A second hospital was started in a temporary building inside the old fort in Calcutta. The old Fort was later converted into a custom-house, making it imperative to construct a new hospital inside. Subsequently a third hospital was built in 1769, known as the Presidency General Hospital. These hospitals primarily served army men and sailors and also admitted Europeans of all class and callings.

It was almost 300 years after the consolidation of their rule that the Britishers built a hospital which was actually meant for the care of the native people. This hospital was established in Calcutta during 1792 and 1793 and was later called as Medical College Hospital. It was inaugurated on 1st April 1838, as a small hospital with thirty beds and an OPD, to provide clinical instruction to students of the new college. By 1853, the hospital had expanded to 500 beds, accommodated within twenty-four wards. The hospital also contained a ward for women and children, an obstetric ward and an ophthalmic ward too. It was the first hospital that admitted both European and native Indian patients (ibid, 1979, pp. 85-89).

British control over Calcutta got diverted as Bombay developed on western coast, making it the stronghold of British rule in the late seventeenth century. In 1676, British constructed the first hospital in Bombay. By 1784 three more large hospitals were erected in Bombay- one for Europeans within the gates of the Fort, another on
the Esplanade for sepoys and the third for convalescents on the adjacent island. By mid nineteenth century, the number of hospitals grew in Bombay. The foremost among them was JJ Hospital at Byculla, established with donation form Jamshedjee Jeejeebhoy and East India Company in 1843. The hospital actually opened in 1845 to the people. To commemorate Sir Robert Grant who concentrated his efforts to uplift the native poor in his Presidency, a foundation stone was laid on 30th March’ 1843. The hospital was completed in October 1845. Just five months after the JJ Hospital opened to the poor patients of Bombay, Grant Medical College was affiliated to it. Thereafter, both Grant Medical College and JJ Hospital functioned as one of the great institutes, combining the pursuit of science with service and care of the sick (ibid, 1979, pp 82-85).

After the foundation of JJ Hospital, numerous other hospitals were established by philanthropist in consultation with the government in Bombay. The foundation stone of the building of St. George’s Hospital was laid on 22nd February 1889 at Old Fort George and the Bai Motilal Obstetric Hospital was founded on 9th March 1889 (Ibid, 1979, p.82-85). Though hospitals services were made available to the native people, monopoly over dispensing the medical services still lay with the British. They had monopoly over recruitment in the government medical institutions, especially as teaching faculty. The Indian doctors were largely in private practice, as their entry in the government hospitals was restricted. The GS Medical College and KEM hospital come up in defiance against the British-managed and staffed Grant Medical College and JJ Hospital. The most important condition for the endowment for KEM was that all members of teaching faculties should be well qualified Indians not in government service. The college opened in June 1925 and was affiliated to Bombay University in 1926 for the MBBS degree. In the beginning of the twentieth century, hospitals were built in large numbers in various places in central India, like Hyderabad, and in north India as in Delhi, Agra and Indore. By 1912 there were as many as 2670 medical institutions in India, which treated about 2,78,89,469 people as OPD patients and about 4,53,900 as indoor patients (ibid, 1979, pp.93-94)

Role of Christian Missionaries During the Colonial Period

Alongside the British government Christian missionaries also played a crucial role in provisioning of medical relief to Indian civilians, who were denied the medical
facilities offered by the British army. The missionaries’ activities of providing medical help were more prevalent in the areas under the greater influence or concentration of British rule, like Madras Presidency, Bombay Presidency, Calcutta and Orissa. Some of the major groups were the English Baptist Missionary Society, London Missionary Society and Arcot Mission, which founded Christian Medical College in Vellore. In mid 1800s these and other missions like the American Presbyterian, United Presbyterian etc. extended their work in the areas like Jaipur and Nainital in UP. During the early twentieth century there were as many as 244 hospitals run by these missionaries, largely concentrated in the regions of Bombay Presidency, Madras Presidency, Bengal, and Punjab (Baru, 1996).

During late the nineteenth century these missionaries established hospitals at various places as part of their missionary work. As studied by Baru, a hospital was established by Clara Swain in 1870 in Bareilley and Dufferin hospital opened in 1889 in Bareilley. In Baheri, Kesar Sugar Mills started a hospital in 1944, while in Banda, a hospital was started by a local private institute during the mid 1800s. In 1854 the Thomson hospital was founded by the British government, which replaced the old Dufferin hospital established in 1855 in Agra. Balrampur hospital was founded in 1869, and was built by a trust set up by the Maharaja of Balrampur; Lady Kinniard Hospital for Women was started in 1891 by Zenana Bible Medical Trust in Lucknow. Harriet Benson Memorial hospital at Lalitpur was established in 1930 by the American Episcopal Mission for women and children and Dufferin Women’s Hospital was established in 1933 in Jhansi. In Faizabad, Dufferin Hospital was founded in 1891, Lal Balbhadr Prasad Women’s Hospital was 1946 and Sri Guru Charitable hospital, Ayodhya, founded in 1939 by Swami Snakananda Giri. Mayawati Charitable Hospital was established in 1899 by Advaita Ashram of the Ramakrishna Math in Almora. Creighton Freeman Hospitals, Vrindaban, was established in 1910 in Mathura. Indore Charitable Hospital was established in Indore in 1848 with funds contributed by the ruler Turkoji Rao II; while a leprosy hospital was founded in 1874 with funds donated by the ruler of Dhar, The Canadian mission opened a women’s hospital in 1891 and Prince Yeshwant Rao Ayurvedic Hospital in early 1900s in Indore. In Jabalpur, Elgin Hospital for Women was established in 1873 under the Dufferin fund, while the Victoria Hospital came up in 1876 with donations from Raja Gokuldas. In the 1700s, allopathic dispensaries were established with partial funds
from private and state subscription and later Jackman Memorial Hospital was founded by United Christians Missionary Society in 1885 in Bilaspur (Baru, 1996).

Numerous other medical schools attached to hospitals sprung into existence in different parts of India. Christian Medical College Vellore (CMC) is one among them. It is a centre renowned for learning and good patient care. It was founded through the vision and missionary zeal of Ida Scudder, who started with a one bedded clinic at Vellore in 1900. Two years later, she built a forty-bedded hospital, which grew over the years to the present 1700 bedded medical centre. In 1909, she started the School of Nursing and in 1918 she opened a medical school for women.

William James Wanles of Canada came to India as a Canadian Medical Missionary doctor in 1889 and started his work with a clinic in a single room in the small township of Miraj. Gradually, he introduced the latest technology and equipment in India and established a medical school, a leprosy hospital, and the Mary Wanles Memorial Hospital and TB sanatorium, named after his young wife who died of cholera.

The work of missionaries continued even after India got independence. Today the missionary work is organised under two associations, viz., Christian Medical Association of India (New Delhi) and Catholic Hospital Association of India (New Delhi). Under Christian Medical Association of India alone in 1996 there are 250 hospitals and dispensaries with total bed strength of 7642. A large number of these hospitals are located in Kerala, Uttar Pradesh, Tamil Nadu, Bihar, Maharashtra and Andhra Pradesh.

INDIA AFTER INDEPENDENCE

During the time of independence some of India's most eminent medical professionals like Dr. B.C. Roy, Dr. A.R. Ansari, Dr. Khan Saheb, Hakim Ajmal Khan, Dr. Jivraj Mehta, and Dr. N.M. Jaisoorya, played an important role in shaping the health service system and made the demand for an efficient health service system an important plank in the anti-colonial struggle (Roy 1980a, National Planning Committee, 1948 cited in Banerji, 1985, p.14).
The National Planning Committee also endorsed the findings and recommendations of the Bhore Committee (Government of India, 1946a), which had submitted its report in 1946. Many of its proposals and recommendations continue to be pertinent and valid to this day.

The guiding principles adopted by the Bhore Committee were: (1) No individual should be denied adequate medical care because of inability to pay for it. (2) The health services should provide, when fully developed, all the consultant, laboratory and institutional facilities necessary for proper diagnosis and treatment. (3) The health programme must, from the beginning, lay special emphasis on preventive treatment. (4) Medical relief and preventive health care must be urgently provided as soon as possible to the vast rural population of the country. (5) The health services should be located as close as possible as to the people to ensure maximum benefit to the communities served. The active cooperation of the people must be secured in the development of the health programme. The idea must be inculcated that ultimately the health of the individual is his own responsibility. (7) Health development must be entrusted to ministers of health who enjoy the confidence of the people and are able to secure their cooperation (Government of India, 1946a, v-vi).

In the long term perspective, the smallest service unit was to be a Primary Health Unit serving a population of 10,000 to 20,000. Some 15 to 25 of the primary units were to be assisted and supervised by the Secondary Health Unit and 3 to 5 of these would be placed under the District Health Organization, serving a population of three million and a Health Centre was to be established at each district headquarters (Government of India 1946c, pp.17-34). To achieve the active participation of the people, the plan recommended setting up of Village Health Committees of 5 to 7 voluntary workers who, after training would help promote specific lines of health activity (Government of India 1946c, p.14).

On the question of training physicians, the Bhore Committee was of the view that 'on the whole, having regard to the limited resources available for the training of doctors, it would be to the greatest ultimate benefit of the country if these resources were concentrated on the production of only one, and that the most highly trained type of doctor, which we have termed as a basic doctor' (Government of India 1946c, p.340).
The Bhore Committee also recommended the setting up by the Central Government of at least a few high quality, advanced institutions to: (1) bring together all educational facilities of high order for training of the more important type of health personnel. (2) Promote the highest type of research in all branches. (3) Coordinate training and research, (4) Provide advanced post-graduate training in an atmosphere fostering the true scientific outlook and spirit of initiative. (5) Inspire high ideals of the profession, and (6) Promote a community outlook. The setting up of the All India Institute of Medical Sciences was a response to this recommendation (Government of India 1946c, pp.431-37).

Types of Hospitals in Independent India

There are many kinds of hospitals in India, ranging from small government-run health centres, privately owned polyclinics and small nursing homes to very big teaching hospitals, general hospitals and public and private specialty hospitals. For sake of convenience and understanding, hospitals can be classified into various types based upon their objectives, the nature of care they provide and their ownership.

Objectives

According to their objectives, hospitals can be classified into three categories. Teaching – non research hospitals- the main objectives of these hospitals are teaching based on research and the provision of health care is secondary. Such as: All India Institute of Medical Sciences, Delhi.

General hospitals – the main objective of these hospitals is to provide medical care to the people while teaching and research is the secondary objective e.g. district or taluk hospitals, Primary Health Centres (PHCs) etc.

Special hospitals – These hospitals concentrate on a particular aspect or organ of the body and provide medical care in that field, such as- cancer, dental, psychiatric and TB hospitals. According to systems of medicine one can delineate the following categories:

1. Allopathic hospitals
2. Ayurvedic hospitals
3. Homeopathic hospitals

4. Unani hospitals

5. Hospitals of other systems of medicine

Ownership

In India, the hospital sector has three segments viz. public sector, voluntary non-profit sector, and the for-profit private sector. This classification of hospitals and other forms of health institutions is based on two norms a) type of ownership and b) the profit or non-profit nature. The hospitals in each of these categories are distinct in their characteristics as they differ in structure, functions, performance and the community they serve. Thus the hospitals can be classified into different types depending upon different criteria. The most commonly used classification is based on the financing and ownership patterns. Based on these criteria the hospitals can be classified into government, namely publicly supported and run for the public, and private ‘for profit’ ones, where the profits are shared between the investors, and thirdly, the hospitals run with ‘non-profit’ motive where the profit incurred through nominal fee gets reinvested for the service of the people.

Government Hospitals

The public hospital is an establishment or a group of establishments created and managed by a public authority. In some cases this may be local authority, such as the municipality. These hospitals are administered, maintained, and controlled by either state government or directly by a ministry. It is the responsibility of the state to take care of the health of its citizens, especially of those who are poor, and those who are unable to avail of the health services provided privately. It is people’s property which is run and maintained by the state/government for people. This falls within the welfare model of the state, wherein getting health care from the state is looked upon as a basic right of the citizens. These hospitals run with no profit motive, except with the motive of providing service. These hospitals are accountable to the state and public at large. Public hospitals are financed from the overall budget for public services.
Private Hospitals

Though private hospitals existed in India for over centuries, the concept of corporatisation of health services has emerged as a recent phenomenon in early 80s. Apollo Hospital Enterprise was the first company to introduce this concept. It started its hospital in Madras, a metropolitan city in India. These hospitals are, generally, owned by individual doctors, groups of doctors or commercial groups. Such hospitals are set up with the purpose of making profit on investment and serving the people at the same time. Some of these for-profit corporate hospitals are large, specialised public limited hospitals, which are run as a commercial enterprise. Such private institutions operate with the sole motive to earn profit. For them health care becomes a commodity which can be sold in market for profit. These organizations are accountable to the investing body.

Non Profit Hospitals (Charity):

These are philanthropic institutions created and managed by religious communities or other groups or individuals, primarily to serve the sick on humanitarian ground as a moral and social responsibility. The functions of these hospitals are to provide care for the sick and the poor, and promote health of the community. The profit generated in these hospitals is expected to be ploughed back for the furthering of the objectives of the hospitals. It is not shared by the members or trustees of the hospital. These hospitals spend more on patients than they receive from them. The deficit is covered through donations and grants from donors and the government. The charitable hospitals are answerable to their trust and management authority. The motive behind providing such services is to get satisfaction and enhance their influence in society, but not to get direct material gain.

Structure of Hospitals

There are great diversities within and between the hospitals in terms of their structures. Hospitals can be categorised into three types as per their structures, as primary, secondary and tertiary hospitals. Structure also with the goal of hospital, the controlling authority and the nature of care provided.
Primary Hospitals

These are the places that an individual or people first approach or have initial contact with to seek medical help in case of ill-health or disease. A majority of the prevailing health complaints and problems of the people requiring medical attention can be satisfactorily dealt with at this level. In India primary health the government runs primary health centres and each PHC serves a population about 30,000.

Secondary Hospitals

These are the district level hospitals in which more complex problems of the patients that cannot be taken care of at the PHC level are dealt with. These hospitals thus serve as the first referral level in the health system and provide various types of curative services.

Tertiary Hospitals

Tertiary hospitals offer highly specialised/ complex kind of care or treatment. These institutions not only provide highly specialised care, they also undertake teaching and training of specialised staff. In addition, the tertiary level hospital supports and complements the actions carried out at the earlier level.

Work Culture of Hospital

The work culture of any organisation is inter alia dependent on the society, which actually shapes the organisation and its employees. Before discussing the nature of work culture let us see how culture has been understood by various sociologists. Culture, according to some sociologists, determines everything that people do, feel and think. Therefore, 'Human Behaviour' is determined by culture; (White, 1948) culture is the man made part of the environment (Herskovits, 1955). It reflects the way of life of a people, their traditions, heritage, etc. It is the totality of beliefs, norms and values, which is related to the patterned regularity in people's behaviour (Cited from Sinha, 1990 p.13).

Organizational culture can possibly be a microcosm of the encompassing culture. It is like a mirror image of the dominant values, norms, beliefs that exist in
the society. Organizational culture generally overlaps with or is synonymous to the concept of work culture; but the two are conceptually different. Work culture means work related activities and the meanings attached to such activities in the framework of norms and values regarding work. These activities, norms and values are generally contextualized in an organization. An organization has its own orbits, goal, objectives, technology, managerial practices, material and human resources as well as its limitations. Its employees have skills, knowledge, needs and expectations. These two main factors, namely organizational and organismic interact, and over time establish roles, norms, and values pertaining to work. It is this totality of the various levels of interacting factors around the focal concern for work, which is labelled as work culture.

Work culture of an organization is influenced by the culture of the society within which the organization is operating. Cultural forces influence an organization either directly by inducing the management to set up culturally required goals and objectives or by concentrating or facilitating the transfer of technology, by providing a network of appropriate or inappropriate suppliers and clients, and also by indirectly transmitting cultural norms and values through the employees. Therefore, all major contradictions within an organisation have roots in the disjunctions within ever changing cultural forces of the surrounding milieu (Clegg, 1977). But Pugh feels work culture has some link to pan national technology advancement. He says the work culture of a particular organization is connected to a range of pan-national technological advancements, which tend to influence the work forms and organizational structures irrespective of the local cultural requirements (Pugh, 1981, cited in Sinha, 1990, p.16)

According to Sinha, work culture means work related activities, the cognition, the effect and the values attached to them in terms of the normative structure. Within a setting there are different levels and types of setting where participants can work and do work related activities. Of them organization is by far the most visible and well-defined entity. Hence, work culture may be examined at four levels within an organization.

1) Organizational goals and objectives and the way they are perceived and reacted to by the employees.
2) Technology of an organization, its structure, work forms, financial positions etc.

3) Social groups, norms, values, power structure, role relations, etc.

4) Work behaviours and other work related activities (Sinha, 1990, p.17).

Management attitudes depend on organizational culture and organizational processes. According to Hofstede, management attitudes also influence the internal culture of an organization. Early managers, whether owner or founders of the organization, have an even more lasting impact. This is because the founders are the only ones that can adapt the organization to themselves; all subsequent managers, to some extent have to adapt (Hofstede, 1985). The culture of an organization always reflects, in part, the complex interaction between a) the values, beliefs and ideals that founders or early managers bring to the organization initially, and b) what the organization learns subsequently from its own experience (Schein, 1983). Negandhi (1973) has argued that difference in the organizational structure; processes and effectiveness among industrial firms are due to their overall management attitude and some of the external environmental conditions - when size, technology, resources, and the location of the firm are held constant. It is safe to infer that culture affects the organizational form, management practices, and organizational performance in different social environments (cited in Evan and Damanpour, 1995, p. 319).

Thus work culture forms an important part of the organisation. It means work related activities, to which values are attached, and it operates under the normative structure, while defining the work environment of the organisation and reflecting the microcosm of the larger culture. The above-mentioned notions of work culture also apply to hospitals, in general, and doctors, in particular. Like other organisations, hospitals also vary in their work culture due to the differences in their goals, organisational structure and management style, which together create a distinct environment of their own. Thus it becomes important to understand the varied work culture existing in the hospitals under study and its influence on the values and perceptions of the doctors working there.
Role of Professionals in Functioning of Hospitals

The major function of the hospitals is that of curing, of healing sick people and managing diseases and other disorders of the human body. It also has a variety of other health-related functions like training health practitioners, providing laboratory and other medical facilities, and executing preventive medical programmes to enhance the health of the community. Within the hospital patient related tasks can be divided into two parts (i) treating/ managing diseases and illnesses, and (ii) administrative or managerial jobs of the hospital. Each of the four major categories of personnel, doctors, nurses, para-professionals and social workers play a crucial role in the functioning of the hospital.

Physician

The physician is a key person in the functioning of a hospital, whose main responsibility is to cure the patient by diagnosing the illness of the patient. In order to carry this job the physician takes assistance from other professionals in the hospital, by co-ordinating, monitoring and supervising the treatment processes along with the other support staff. The physician also looks into administrative functioning of the hospital, where s/he assists in overall management of the hospital. Physicians also play an important role in formulating policy decisions of the hospital.

Nurses

Next to the doctors, the nurses play a significant role in the hospital. Their job is to implement/ execute the course of action prescribed by the doctor, such as dispensing the medicine and monitoring the patient's condition. In the present context they to handle a lot of technologies, like critical life saving and patient monitoring equipment, in intensive care situations. They also provide bedside care, such as making beds cleaning the sick person, etc. Apart from this, they also supervise the work of their sub-ordinates as well as assist in certain kinds of administrative work. Nurses rank second in the hierarchy of professionals in the hospitals.
Paramedical Staff

They are the technical experts in various fields of medical technology, which are used for effective diagnosis and, at times, therapy and management. Their main job is to assist doctors in accurate diagnosis of disease by conducting various technical tests.

Social Workers

The main responsibility of the social workers in the hospital is to locate the patient's disease within the socio-economic and environmental context as against the clinical approach of the hospital. They help the patient to adjust to the socio-psychological conditions of the diseases, and also look into the preventive, promotive and rehabilitative aspects of health care.

Administrators / Management

The administration section forms another important part of a hospital's function. Other than administrative matters this section looks at, the maintenance of the hospital, provision for the non-medical needs of patient care, management of the financial affairs etc. while the medical staff oversees the therapeutic programmes. The administration defines the medical staff's official powers, standardises the hospital administrative procedure and establishes a level of quality for the hospital's medical services. They are responsible for the co-ordinating the work of all hospital personnel.

Influence of Hospital Structure on Functioning of Doctors

In an earlier section we have seen how, over time, with developments in a number of fields including medicine, the hospital has developed into a complex organization, with extensive use of medical technology for patient care. Not only this, its objectives too have changed, from being an organisation providing care, largely due to religious or charitable reasons, to a care providing-agency of the state, to a profit making industry. Based on these three goals of health care delivery hospitals can be categorised into three different types, charitable, government and private hospitals.
The approaches of these three kinds of hospitals towards providing health care are different from each other. The first one provides health care with a humanitarian base (religiously), the second provides healthcare as a responsibility towards people, arising from their right to health, and the third does so, only for monetary returns. The people/patients who utilise the services of these hospitals belong to various socio-economic strata. Only those who can afford to pay can avail of the services offered by private hospitals. Whereas, in case of the other two types of hospitals the care is meant for poor and deprived people. So the approach of the private hospital towards their patients is to provide as good/effective care as possible because they are getting paid for the services that they are offering. This approach of service delivery may not be applicable in the case of other two types of hospitals. Such ideologies of hospitals can have a direct impact on the kind of service that these hospitals provide.

The motive and ideological approaches can also impact upon the personnel working in these hospitals as well as the functioning of the hospital. The perceptions, attitudes, role and overall functioning of hospital staff can be influenced by the ideology of the hospital in which they are working. It may also possibly affect the inter-personal and inter-professional relation/interaction between the professionals in these organizations. For example, the goal of a charitable hospital is to provide health as a religious endeavour or service to society. Influenced by this ideology, the staffs working in this hospital tend to work with a religious and humanitarian approach while providing health care to its users. We assume that they are more likely to be sympathetic, concerned, and devoted towards the patients. Their perceptions, attitudes and behaviour regarding their own profession, patient and health care are likely to be guided by sacred or humanitarian ideas. This will affect the overall performance of the professional and also the functioning of the hospital. Working in a profit-oriented organization, the perception of the professional towards the patient would be that of a customer who is willing to purchase the services that they are providing. Hence, their interest would be to gain profit while providing good quality health care.

Similarly, the structures of the hospital too have an impact on its functioning. As we have seen, hospitals can be divided into three types according to their structures, namely primary, secondary and tertiary. The size and structure of the hospital defines the kind of management required or adopted. Each system of
management has its own set of rules designed to facilitate the smooth functioning of the hospital. It has a typical characteristic of monitoring, maintaining and controlling the overall functioning of hospital. This particular way of functioning of the management becomes a guiding force for its staff. For example, the goal or the objective of the charitable and government hospital is to provide free services to the poor and destitute people. But the management of these hospitals is executed is different. Therefore the rules and regulations operated by this management in these hospitals are different. As a result the overall functioning of the hospital and governance is different. So the outcomes i.e. the services provided or service provisioning /delivering also tend to be different.

Organisational Structure of Hospitals

To accomplish the tasks of a hospital and to co-ordinate its multiple activities the hospital relies on an organised hierarchy of staff and functionaries, and all the tasks are operationalized through formal rules, regulations and administrative procedures. The key to hospital efficiency and overall effectiveness is the coordination between various departments and individuals. They represent a complex and highly specialized division of labour which is inter-locking and interdependent. There are three components in the delivery of care: the patient who seeks medical care in the hospital, competent and qualified personnel to provide the care and the management or administration that works for effective functioning of the hospital of these three factors, the care providers and administrative staff function in the hierarchical order as per their occupations and authority. Among the care providers there are four kinds of personnel working in the hospitals (1) doctors (2) nurses (3) paramedical staff and (4) medical social workers. There are at least 23 different occupational status groups represented in the hierarchy of a hospital.

- Physicians: 1) visiting physician 2) residents 3) Interns
- Nurses: 1) Clinical supervisors 2) Head nurses 3) Staff nurses 4) Student nurses
- Paramedical Professionals and Technicians: 1) Dieticians 2) Laboratory Technicians 3) X-ray Technicians
• Social Workers

• Occupational Therapist and Physical Therapist

• Semi-skilled workers: 1) Trained Attendants 2) Medical Technicians 3) Dieticians aids 4) Ward Receptionist and Clerks

• Un-skilled Workers: 1) Nurses' aides 2) Male aides 3) Ward helpers 4) Cleaning maids

This difference is precisely because of the three important components which determine the overall functioning of the hospitals, i.e. goal, management and staff. A particular kind of structure entails a particular type of goal and management, which requires a set of rules and regulation for the monitoring and maintenance of that organization. These rules and regulations, norms and discipline are then executed by the staff in order to achieve the goals or objectives of that organization. These rules, norms, regulation become a guiding factor to work effectively which further result into effectively/efficiency of the organization.

The management and staff of the hospital are also influenced by the size of the hospital. In a small hospital the working staff will be small in number and the form of management is of a certain kind. There is a high possibility for closer interpersonal relationships between the staff or professionals. In case of large hospitals, the size of staff is bigger and the form of management is complex. This is likely to result in strict rules and regulations and set of norms to be followed by the staff for achieving efficiency and better results.

It is important to keep in mind that ultimately the larger socio-economic forces in society shape the hospitals, even if they have different ideological moorings. Within this larger socio-economic context, the study proposes to examine whether different ideological orientation of institutions impact upon its structure and functioning. Hence, we propose to look at hospital as a sub-system of larger social system.
Thus one can safely conclude that the structure and goals of the hospital are likely to influence the functioning of the professionals in that hospital in terms of their perceptions and behaviour towards their colleagues, patient care etc.

HOSPITAL AS A SOCIAL ORGANIZATION

As seen in the early parts, the hospital became a central component of public health, as the major provider of a range of curative and other services relating to treatment, management and control of illness, disease and disorders. It has become the centre of many activities that need simple to complex technology, complex procedures specialised skills and trained staff. All these are organised/centralised in the hospital in a structured manner, bound by norms, and rules and regulations, and directed towards the goal of alleviating pain and sickness.

Cockerham explains the growth to the hospital in modern society from poor houses to hospital as a social organization. He says, 'Since the end of the nineteenth century, a new image of hospital evolved in western capitalist society as an institution where patients of all classes could generally expect to find the highest quality of medical care and could reasonably expect to be cured of their disorders. Three major factors were responsible for this change. First was the fact that, medicine had indeed become a science in terms of employing scientific methods to seek out accurate medical knowledge and to develop successful techniques that could be employed in a consistent manner. Secondly, concomitant with the development of medical technology was the discovery and use of antiseptic measures in the hospitals helping to curtail infections. Thirdly, there was a significant improvement in the quality of hospital personnel; especially important was involvement of trained nurses and lab technicians, whose specialized skills were able to support the physicians in their primary role as diagnosticians and practitioners. In the twentieth century, the hospital has thus become the major institutional resource available to the society for coping with problems of health and illness' (Cockerham, 1978, p. 233).

As mentioned earlier, since many health problems require a level of medical treatment and personal care that extends beyond the range of services normally available in the patients' home and in the physicians office, modern society has developed formal institutions for patient care intended to help to meet the more
complex health needs of the members. The hospital is an important institution in the modern world, which offers considerable advantages to both patients and the society.

Elaborating upon the hospital as an organisation, Rosen says, 'Elaborate equipments, complex procedures and specialized skills have necessarily accompanied the introduction of scientific developments in medicine over the last century. Radiology and radiotherapy have acquired expensive machines and specially trained staff, metabolic investigation has involved the combined efforts of persons skilled in several disciplines such as biochemistry, physiology etc. However, the new technologies and the treatment that they offer cannot be utilized economically in an individual context. They become economical only when organized on large scale. The modern hospital is an institution organized for this purpose, and during this century it has become the dominant institution in medical care, training and research. Nonetheless, this is a considerable enlargement of its previous functions, for until recently the hospital was a place of charity, a refuge for the sick and homeless, or for the dying poor' (cited in Tuckett, 1976, p. 225). Thus the hospital has become a complex organization, needing to organize its activities for the patients.

Like any other typical formal organization, the hospital also has a division of labour such that the organizational tasks are distributed among the various positions as official duties, a hierarchy of authority which distributes/sanctions- both rewards and penalties- to ensure conformity to standards and to coordinate work and an explicit, codified system of rules and regulations to govern decisions and actions (Enos, 1977, p.391).

Every organization has to have a structure, goals, collective human power to carry out the activities, set of activities, definite management style, etc, to function. Reflecting upon the above characteristics of hospital as a social organization, Madan opines that all organizations have a formal structure through which roles are defined, authorities are delegated and responsibility assumed. A large scale hospital also involves the functioning of many groups of people, the structure provides internal hierarchy of authority through which the workers are allocated to different levels and their performance controlled by those at a superior level (Madan, 1980, p.245).
Certainly, not all hospitals are alike in their organization of services. However general hospitals, as the single most common type of hospital, exhibits organizational features similar to most other types of hospitals. As an organization, the general hospital has been described as being formal, highly stratified, quasi-bureaucratic and quasi-authoritarian (see Croog and Steeg, 1972; Georgopoulos and Mann, 1972). General hospitals have also been described as 'multi-purpose institutions' in that they provide a variety of health related functions for society such as (i) treating patients, (ii) conducting medical research, (iii) training health practitioners (iv) providing laboratories and others medical facilities to the community and (v) sponsoring health education and preventive medicine programme for the general public (Coe, 1970; Heydebrand, 1975).

In the view of Robert Wilson (1963), the hospital is a hotel, a school, a laboratory and a place for treatment. However, the primary goal of the hospital, is that of providing medical treatment to its patients within the limits of contemporary medical knowledge and technology and the hospital's available resources. The hospital thus qualifies as a formal organization in that it has developed to co-ordinate scarce resources to achieve a stated goal in as efficient a manner as possible (Becker and Gordon, 1966, cited in Cockerham, 1978, p. 239).

A hospital may be different in some aspects compared to schools, universities, courts etc. due to its distinct goals, and objectives, technology, managerial practice, material and human resources. It has a framework of norms and values regarding work and behaviour expected of its staff. It has an internal hierarchy of authority, interpersonal relations and a line of communication. It has planned and co-ordinated activities of a group of individuals in view of achieving specific goals of the hospital. These characteristics of the hospital make it unique among other social organizations. Even though there are various types of hospitals, such as public, private and charitable hospitals, if one considers all normative structures, then it is not difficult to find concurrence with the assertion that all hospitals are different yet very much alike.

Thus a hospital is more than its buildings and people; it is a system of action, a network of expectations that pull together to form a new social reality. Depending in part in the way actions and expectations have become patterned in a hospital, it takes on a character of its own.
Hospital in its Social Environment

Hospitals are large social organisations catering to the health needs of large sections of people. Hospitals do not exist in isolation but are very much a part of the society. It is people who run hospitals. Hospitals, in turn, serve a definite purpose in society by alleviating the physical suffering of the people. However, a hospital is also a system of its own. A system is a set of inter-related and inter-dependent parts, organised in a specific manner to achieve a set of goals. Hospitals have a definite goal and structure for providing services and alleviating the suffering of the people in the society. Their range of services is divided into various subsections as departments, and its activities organized under a set of hierarchy of authority in order to achieve the goals.

Levey and Loomba mention that, an organization is a system; because the definition of 'organization' fulfils the requirement of what is called a system (it has at least two interrelated elements and a set of goals). It is important bear in mind that organisations are primarily human systems and the role of humans in organizations cannot be ignored (Levey and Loomba, 1973, p.103).

In many respects the hospital contains within its wall a microcosm of the world outside. While the hospital as a social system in itself, is intricately involved with the world, beyond its walls and an understanding of the hospital system must be linked to an examination of its larger connections with the society. In many sociological studies hospitals have been seen and analyzed as social systems, as complex organizations, and as small societies (Croog and Steeg, 1972, p.274).

Being a part of the social system hospitals also undergo change. Society, organizations and individuals all are mutually interdependent. As part of society, hospitals can never operate in isolation from the other units of society. As norms, values, customs and culture undergo change, the hospital organization adopts this change and transfers the same to its members through a definite structure and work culture.

The influence of the external environment upon the internal system of the hospital is pervasive, affecting many aspects of the structure and content of the
interpersonal environment within the institution. The external setting in which hospital exists can be differentiated at a number of levels (Croog and Steeg, 1972, p. 283).

Relating the hospital as an organization to its environment, Madan argues that the hospital is in constant interaction with the community and it would be a mistake to regard the relationship between the people working in hospital and society in which they live as static. He further argues that the environment within which people, hospitals and society live and function is ever changing. The hospital as an organization has been influenced by the society so much so that the norms, values, work culture of the people and institution are shaped by the larger social system (Madan, 1980, p. 99, 253, 289).

Thus from the above views about hospitals and the influence of larger social environment on the same, one gets an understanding that the hospital, as being a part of the larger social system, is influenced by socio-economic, cultural, political and environment factors of the society. Hence, the values, norms and work culture of hospital do not emerge in isolation but are shaped by the larger social forces within which the hospital functions.

Organizational Theories

Organizations have assumed great importance in everyday life. We spend a good amount of time as participants in organizations. Almost each and every work is carried out by some or other kind of organization, be it education, recreation, or livelihood, and such services are available through organizations.

Emphasizing the importance of organization for the individual and the society at large, Aldrich, states that organisations are all around us and thus we tend to take their existence for granted. They are simply a non-problematic element in our everyday lives and as such, we shut them out of our consciousness. They hover around the edges of our life-space as rather vague entities (cited from Chaturvedi, 1995, p.3).

An organization consists of many components. It arises as a result of the planned and co-ordinated activities of a group of individuals with a view to achieve a
specific goal or a set of goals. It is a consequence of the joint efforts, and a system of continuous purposive activity of specified kind. The organization has a definite boundary, which incorporates a distinction between what is inside and what is outside. These boundaries may not always be explicit or stable. They are, nevertheless, there (ibid, 1995, p.11).

These characteristics of the organization reveal that an organization is a goal oriented collective, which suggests that organizations have a structure, definite goal or set of goals and their activities are directed towards the objectives, while retaining their identity as a distinct social entity.

Organizations can be viewed from different perspectives. There are two important streams in sociological thought that of structural and open system theories of organizations. It is important to note that, though these are different perspectives of looking at organizations, they represent two sides of the same coin. Every organization obtains some degree of stability through its structure, systems and methods although none of them are totally constant. Organizations are neither in a state of continuous change and so devoid of an identity or territory, nor are they static. Infact, it is the endeavour of every collectivity to establish a state of dynamic equilibrium, such that not only can the pressures for change be accommodated, but can be also minimized. The difference between the two sets of definitions lies in the fact that while the first set focuses on the state towards which organisation strive, the second set lays emphasis on the process involved in reaching that state (ibid, 1995, p. 12).

The structural approach to organisation sees them as a set of interdependent elements or as patterns of behaviour among members. It understands organizations as distinct social entities and generally focuses on the constructive features of organizations, that is, the relationship among various elements of organizations and the central tendencies in interaction patterns among the members of the collectivity.

On the other hand, the open system approach to organisations has been derived by a theoretical biologist, Bertalanffy, from the ideas of an organismic view of biology, in order to understand organisations in a better way. The open system model of organization contends that there is a continuous interaction between the
organisation and the environment, where there is a constant flow of inputs from the environment into the organization and vice versa (ibid, 1995, p. 13).

Essentially, this open systems model entails an organization-environment interface. It presumes that the structure, boundary, actions and even survival of organizations depend upon the context in which they operate. Thus the community, the power structures operating outside the organization, the nature and linkages between various organizations existing simultaneously in the environment, the social, economical, cultural, environmental factors of the society, all together influence the organization (ibid, 1995, p. 13).

Similarly, the hospital as an organization can also be looked upon as an open system model. Hospitals do not exist in isolation; rather they are continuously influencing and being influenced by their environment. Hospitals have very weak boundaries through which there is continuous flow of input and output between hospital and its society. This interaction has a strong effect in influencing the hospital, its structure and boundaries. Through this constant interaction values, norms, behaviours of the hospitals are influenced by the larger social environment (Denton, 1978, p.264; Freeman, 1972, p. 275; Levey and Loomba, 1973, p.106)

Through the process of adaptation and learning, hospital as an organization interacts with its environment and at the same time responds to the changing conditions in the environment. In terms of understanding of internal and external environments of hospital we intend to employ the open systems model, as it fits into such a model.

Hierarchy in the Hospital

The technical innovations in medicine have given rise to new specialties such as cardiology, neurology, gynaecology, thoracic surgery and many others. Accordingly, separate departments developed within the hospital, so that responsibility and authority could be properly defined. Therefore, spontaneous response and life saving precision was predicted and also expected from the hospital organization.
Hospitals developed many activities as a part of their function in order to cater to the health needs of the society. They not only increased in size but also in terms of medical staff and ancillary services. It has become a large scale and highly complex organization developed with the aim to provide health services to its patients. In the process of providing care, the hospital has become one of the highly stratified and rigid social organizations.

These complex and varied activities have created a great need for coordination between different medical and non-medical specialties and activities for care delivery of care in hospital. As a result, a complex administrative system is required to allow a hospital to function, especially since facilities have to be available day and night and throughout weekdays, without a single break. In order to accomplish its goals and coordinate its various activities, the hospital relies upon a prescribed hierarchy of authority, which is operationalized through formal rules, regulations, and administrative procedures. This hierarchical order of hospital staff falls under the concept of bureaucracy described by Max Weber. According to Weber, bureaucracy is a rational and impersonal division of labour which is structured in a hierarchical manner, attached to levels of graded authority (lower officers are supervised by the superior ones) and their fixed and official areas of jurisdiction are governed by laws or administrative regulations (Haralambos, 1980, p.279-286). The key to hospital efficiency and overall effectiveness is the coordination of the various departments and individuals. They represent a complex and highly specialized division of labour which is both interlocking and interdependent. The hospital uses complex and hierarchical authority for control of its functions.

It uses dual authority as a basic device for controlling and directing the activities of diverse types of personnel. On one side there is the line of administrative authority, which takes policy and administrative decisions. The other line of control is the professional authority, in which the physicians hold prime authority, who directs specific clinical tasks such as drawing up a treatment plan, prescribing drugs, hospitalization of patients, ordering laboratory procedures etc. S/he plays a key role in the varied activities of hospital. The system of professional authority has permitted physicians to exercise superior power throughout the hospital structure.
The doctor occupies the apex position on the ladder of the hierarchy of hospital authority. S/he supersedes all the other members within the medical division of labour in the hospital, and allocates responsibility to the rest of the staff in hospital. The physician also shares both administrative and clinical responsibilities, and in many cases s/he is at a higher authority in the administrative level. Thus s/he exercises influence on both clinical and policy decisions in the hospital. The physician is the manager, programmer and co-ordinator for allocation of the responsibilities among the rest of the staff in the hospital.

Doctors in Hospitals: The Process of Socialisation

A formal organization such as the hospital relies entirely upon the external environment for the personnel (Freeman, 1972 p. 285). Many of the influences upon interpersonal relations stemming from the external environment are inextricably intermeshed with social structural elements in the community.

Socialisation is a process through which individuals learn the values, norms and culture of the society that they belong to. Since doctors, like other professionals are key actors in a hospital, it is important to understand the process through which they acquire their values and norms. Hence, the role of the primary and secondary socialisation agents needs to be discussed here.

Man is not born social but becomes so through the process of socialisation, which transforms man from a biological being to a social one. Humans are not only social but also cultural beings. Culture plays a vital role in the process of socialisation. It transforms the personality of an individual. Therefore, humans are not only social but also cultural beings. Humans and culture share an intimate relationship. The transformation of an individual into a social and a cultural being is a long process. After birth, s/he is gradually moulded in society as a social being where s/he learns the socially permitted ways of behaviour. This process of moulding and shaping the personality of the humans is called socialisation.

Socialisation is defined by sociologists in many ways. Ogburn defines socialisation as, 'a process by which the individual learns to conform to the norms of the group. According to Ernest Becker, 'Socialisation may be viewed as the training of
a performer, one who can play the roles required by the culture plot.' (Ogburn, 1964, p. 214).

Every human being tries to adjust to the conditions of his/her social environment. This process of adjustment itself is socialisation. The individual thus learns to conform to the norms of the society. This is how society maintains its order. Thus socialisation is a process through which the individual internalizes norms, values, culture of the society. These indoctrinated norms, values, and culture gradually become part of the personality of the individual.

Many theories were developed by sociologists explaining the process of socialisation and its importance in development of the personality of individuals. One can take a brief overview of a few theories of socialisation.

Cooley’s Theory of ‘Looking-Glass Self’, where he argues that the, 'self might be regarded as the internalized object representing one’s own personality'. He believed that the self and social are two sides of the same coin. Our ideas, loyalties, attitudes, and points of view are derived from others. One means of their transmission he calls as ‘Looking glass self’. To him, self-ideas or self-attitudes develop through a process of imagining what others think of us, by a kind of a ‘looking-glass process’ (Cockerham, 1978, p. 251).

In his theory of ‘Self’, – Meads agrees with Cooley that ‘Self’ is social. But he states that the individual becomes aware of himself largely through interaction. It means the individual comes to know about himself by what is known as ‘role playing’. He says that the individual, in order to get a picture of himself, plays the roles of others. In seeing himself as 'other' sees him, the individual is actually putting himself in the place of others and imagining what their response might be. This he calls ‘role playing’. The ‘others' may be parents, close associates and society at large, and they play a significant role in developing his ‘Self’ (Haralambos, 1980, p.544-545).

While taking a view of the process of socialisation in his ‘Theory of Collective Representations’, Durkheim highlights that the individual becomes socialized by adopting the behaviour of his group. By ‘collective representations’ he means the body of experiences, ideas and ideals of a group upon which the individual
unconsciously depends for his ideas, attitudes and behaviour. To the individual the collective representations are objects or factors of social value. These objects are symbol-products and are mutually owned and mutually proclaimed.

Thus collective representations have great significance because they are collectively created and developed. Since collective representations or social values are the product of collective action, therefore, they are imperative and compulsive (ibid, p. 524-526).

Regarding the phases of socialisation Denton opines, "The norms, values and beliefs constitute non-material aspects of culture. People learn the norms, values, and beliefs of any relevant social group or grouping through the process of socialisation. Socialisation can be divided into two phases, primary and secondary socialisation. Primary socialisation refers to the initial learning of the values, norms and beliefs of the family, community and society by the child. Although, the foundation of belief is laid during this phase, it may undergo extensive change during the ensuing socialisation, referred to as secondary socialisation" (Denton, 1978 p. 6).

Primary socialisation takes place during the childhood of a person and is influenced by the family, peer group and school and teachers. Secondary socialisation is a long process and a continuation of the primary socialisation. The values, norms and beliefs are learned at a wider level and the socializing agents are training organization and work organization. David Tuckett argues that certain aspects of attitude and behaviour of individuals cannot be understood without reference to family, schools, university and working organisation as a collective existence. To support his proposition, he refers to Durkheim’s work on socialisation: according to Durkheim, social factors are significant elements of behaviour and belief that are shared by the members of the group (i.e. Collective) and expressed in which the group conceives itself and its relations with the objects which affect it. Two significant factors that are thought to govern social action are value and norms. Values refer to collective beliefs and are conceived at a relatively abstract level (Tuckett, 1976, p.13).

He further argues that the process of secondary socialisation operates throughout the life of a person, 'As a new member of a medical school or a particular medical ‘firm’ (medical team), an individual picks up and adapts to the new
ambiance; he is sensitive to the particular norms and values that exist in the new situation. Again, an individual may be socialised formally (as when a new recruit to an undergraduate society undergoes initiation rituals or when a new patient in hospital is formally admitted to a ward) or informally – by gradually attuning himself to subtleties of meanings and actions in the new situation. The process by which recruits in occupations like medicine, law, army, sociology, or the administrative grades of the civil service are socialised so that they come to think, act as and indeed ‘are’, doctors, barristers, officers, sociologist, is a special form of secondary socialisation termed as professionalisation' (Tuckett, p.15). Here the role of medical education assumes significance because its role on the values of physicians is multifaceted. This influences the physicians both through the selection process into the field and through the actual socialisation process (Denton, p. 173). Thus socialisation plays an important role in shaping the values, perceptions and behaviour of the doctors.