Chapter One
INTRODUCTION

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This study is conducted to comprehend the **professional culture** of the medical profession. Professional culture refers more specifically to the ideas, attitudes, values, norms, codes, identities, knowledge, ethics and behaviour patterns of the professionals. Three important sub-themes are segregated for the purpose of the study. These include firstly the medical professionals' adherence to the **professional ethics**, secondly the effects of the **primordial identity** of the medical professionals' on their ideas and attitudes and finally the concepts of **equality and merit** in the context of the State's protective discrimination policy within the medical profession.

**Professional ethics** comprises of the norms and codes which underlie the very existence of the profession. The codes of medical ethics propounded by Hippocrates and the Indian Samhita's is an effective point of departure for the study. The professional commitment and orientation of the doctors are to be analysed in the context of the traditional continuities such as caste centered attitudes of the medical professionals. The cases from the field study help to perceive the professionals' adherence to ethics.

The impact of the **primordial identity** on the medical professionals' ideas and attitudes aids to understand the empirical reality. Further, the study attempts to underscore the effects of the existing structural and cultural continuities within the professional setting. These continuities are particularly significant since they seem to play an important role in a
technically advanced profession. The professional skills, knowledge and calibre ought to define the professional power structure and professional ideology. However, the present study ventures to redefine the professional power structure and the professional ideology vis-a-vis the structural and cultural continuities of the Indian society.

The study also seeks to understand the concepts of equality and merit in the context of the State's protective discrimination policy. Merit contributes to the scientific and technological advancement in all professions. Profession is by itself in pursuit of excellence in terms of both performance and discovery. Profession often emphasises on the aspect of merit and excellence. The professional's thereby, tend to overlook the necessity of social justice. The policies of social justice help to bring about a healthy balance in the society and one such is the State's protective discrimination policy which aims to integrate the weaker sections.

As part of its broader objective, this policy provides reservation for the Backward Castes (comprising of the Scheduled Castes, Scheduled Tribes and the Other Backward Castes) in both educational institutions and Government jobs. Medical educational institutions and hospitals also provide reservation. Since doctors handle human lives it is generally argued that such reservations are detrimental in the medical profession. Further, it is often believed that merit and excellence will deteriorate with such policies. The study thereby analyses the characteristics of merit. It
also seeks to perceive how the professional knowledge is put to a "socially responsible use". The professional culture will thus be perceived in a holistic sense with its many particularistic features which contents its much publicised homogeneity and universality.

The theoretical framework of the study uses both the structural-functional model of Parsons and the Processual model of Anselm Strauss to understand the professional culture. The Parsonian pattern variable relates to understand the attributes of the profession. He attempts to build concepts that reflect the properties of all action systems. In the process, he succeeded in formulating five sets of variable properties which he refers to as pattern variables. These variables help in categorising the modes of normative requirements in the social system. These are presented in five polar dichotomies which could classify the decisions of actors, value orientations of culture and the normative demands on status roles. These pattern variables include Affectivity-Vs-Affective neutrality, Diffusiveness-Vs-Specificity, Universalism-Vs-Particularism, Achievement-Vs-Aspiration and Self-Vs-Collectivity oriented. These pattern variables provide an effective framework to understand the present day attributes of the professions as such. The vivid demarcation of the existing attributes of the profession prove as effective grounds for the comprehension of professional culture.

Anselm Strauss in his particularly significant processual approach attempts to perceive professions in its totality. As Strauss and Bucher
make it very clear they attempt to part ways from the functionalist approach. They are vehemently against the functionalist assumption of professions as a 'homogenous' entity with its individual associates possessing similar identity, values, interests and such. They rather present professions as a loose 'amalgamation' of groupings which they termed segments. These segments are as the authors present, more in coalition and conflict rather than in harmony. This is specifically because each of these segments pursue different objectives, have different goals, differ in their definitions of roles and do not necessarily possess similar identity, values, interest etc. The segments according to them, possess the following characteristics: (i) sense of mission, (ii) work activity, (iii) methodology and technique, (iv) clients, (v) colleagueship, (vi) interests and associations, (vii) spurious unity and public relations. In short, they believe that professions exists in a continuous 'process' and are thus in constant movement. This processual approach is far different from the others, since most of the other approaches highlight the attributes and hardly consider the possibility of the processual nature of profession.

Rationale

The current venture attempts to depart from the very ethos of the medical profession and explain the processual nature of such a profession in the context of structural and cultural continuities of the traditional society. In the context of such continuities the States protective discrimination policy is framed to integrate the weaker sections, who were
relegated as unclean Castes within the Hindu system of social categorisation.

The provisions granted thereby attempt to check atrocities against the weaker sections. These are also specifically designed to enhance the ability of the Scheduled Castes to successfully compete with other castes. Thus, the Central and State Governments provided reservations for these category of castes in both educational institutions and in Government jobs.

The State’s policy of protective discrimination thus attempted to improve their educational and employment vistas to a considerable extent and opened up different avenues like administrative, clerical, technical, medical etc. Yet only 6.8% of the scheduled castes were in undergraduation level and 3.5% in postgraduation level in all the professional courses. (refer table 1.1).

Table 1.1

<table>
<thead>
<tr>
<th>Enrollment of Scheduled Caste Students in Professional Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduate Level</td>
</tr>
<tr>
<td>Scheduled Caste</td>
</tr>
<tr>
<td>29748 (6.8)</td>
</tr>
</tbody>
</table>

Source: Data supplied by the colleges and universities to the UGC, for the year 1977-78. Note: Figures within brackets indicate percentage to total.

The emphasis on the scheduled castes in medical profession in this study is not to overlook the significance of the Scheduled Castes in other
professions. There are many studies on scheduled castes in other professions, particularly engineering. On the other hand, there are no studies on the scheduled castes in medical profession. There is also a less representation of the Scheduled Castes in the medical profession (refer table 1.2 below).

Table 1.2.

<table>
<thead>
<tr>
<th>Enrollment of Scheduled Caste Students in Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Graduate Level</strong></td>
</tr>
<tr>
<td>Scheduled Caste</td>
</tr>
<tr>
<td>7763 (8.4)</td>
</tr>
</tbody>
</table>

Source: Data supplied by the colleges and universities to the UGC, for the year 1977-78
Note: Figures within brackets indicate percentage to total.

The Objectives of the Study

The major objective of the study is to understand the Professional Culture. The related sub-themes to understand the same are, firstly, to perceive the respondents adherence to the professional ethics. Secondly to understand the effects of the 'primordial identity' on the medical professionals' ideas and attitudes. Thirdly, to understand the State's protective discrimination Policy in the medical profession with the help of the concepts of merit and equality. The study follows a methodical pursuit for the collection of data. A brief account of the methodological issues.
Methods and Techniques

The present study deals with the medical professionals in Delhi. Medical professions here refer to doctors, mainly drawn from five major hospitals in the capital. These hospitals are All India Institute of Medical Sciences, Safdarjung Hospital, Lok Nayak Jaiprakash Narayan Hospital, G.B. Pant Hospital and Maulana Azad Medical College. The doctors in the sample include Junior Residents, Senior Residents, Associate Professors, Consultants and Professors. The sample is a purposively schemed one and includes the clinical and non-clinical professionals at one end and the postgraduate students and teachers at the other. The sample thereby paves way to sense the problem dimension of the professionals from many angles. An effort is made to perceive their adherence to their professional ethics, the impact of their primordial identity and the aspect of the reservation policy in the medical profession.

Different types of data are available for this study. They include primary sources, secondary sources and self generated sources. The primary sources included data from Governmental documents regarding the Scheduled Castes and the health policies and programmes. This comprised of several legislations, archival documents, Government reports etc.

Secondary sources include the published materials. These are in the form of published books and articles. The self generated sources
refers to the data collected during the field study. An intensive field work was carried out with the help of an interview schedule. A case study of fifteen typical respondents also formed a part of the study of which five life histories are presented in chapter seven.

The Sample

The sample is a purposive one with 300 respondents. It comprises of 150 scheduled castes respondents and 150 non-scheduled castes respondents. The sample includes same number of Junior Residents, Senior Residents, Associate Professors, Consultants and Professors from both the categories (refer Table 1.3 below).

<table>
<thead>
<tr>
<th>Category of Doctors</th>
<th>Sample Size</th>
<th>Sample Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior Resident</td>
<td>74</td>
<td>25</td>
</tr>
<tr>
<td>Senior Resident</td>
<td>64</td>
<td>22</td>
</tr>
<tr>
<td>Associate Professor</td>
<td>54</td>
<td>18</td>
</tr>
<tr>
<td>Consultant</td>
<td>48</td>
<td>15</td>
</tr>
<tr>
<td>Professors</td>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>300</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The Field Study

The field work was carried out in New Delhi at five major hospitals. They are, All India Institute of Medical Sciences, Safdarjung Hospital, Lok
Nayak Jaiprakash Narayan Hospital, G.B. Pant Hospital and Maulana Azad Medical College. The field work was carried out for a period of three semesters (a year and a half, between January 1993 and July 1994). The method of data collection was by an informal interview which often extended into an interesting discussion for a couple of hours. The field work was aided with an interview schedule as a guide.

Initially a pilot survey was carried out to sense the pulse of the situation in the field and to check the adequacy of the interview schedule. The pilot survey was carried out on 10% of the total sample. It comprised of 30 respondents fifteen each from the Schedule Caste and Non-Scheduled Caste categories. Since the study is primarily a qualitative one, the research is based on several sessions of prolonged discussions with the respondents. To capture the holistic view of the problem dimension discussions with every respondent was carried out for more than once and at different social settings such as the doctors personal chambers, corridors, near the wards and the operation theaters. The discussions were also held at the homes and hostels, of the respondents. The detailed case studies were also done and among the fifteen cases, five typical cases are presented in chapter seven. All these respondents were met at all possible social settings and several rounds of discussions were carried on with them.
The Problem of Rapport

The problem of rapport was the most time consuming to surmount with. The problem of the study is a very sensitive issue. The issue is most sensitive in medical college campuses. The researcher was turned off several times before she could build a rapport and get the respondent into an informal chat. These at times took a minimum of four to five visits. There were at times several rounds of discussions on other issues before the actual process of generating the relevant data began.

Analysis of the Data

The analysis involved both quantitative and qualitative methods. It includes the statistical representation of the empirical data collected from the field of study to present both the background and the attitudes of the respondents. Since the technique was more of an informal discussion, it is possible to gauge the problem dimension of the respondents in a more detailed manner. Tabulation of certain attitudinal responses, is also presented. Yet, a majority of these were presented in a qualitative form.

The case study method seeks to delve deeper into various dimensions of the problem. It has in many ways, helped to understand the intricacies of the medical profession and the professional culture at large. The data thus analysed was also put through the reliability test.

Reliability of Data

The data collected was cross checked during the course of the field
work, for instance from the responses of both the categories - the Scheduled Castes and Non-Scheduled Castes respondents. This helped to draw deductions and conclusions with least difficulty. The data was also put through the reliability test t-test. It was found significant at the level of 0.001.

A Brief Overview of the Chapters

The essential issues to be discussed in chapter two, include the social genesis of the profession and of medical profession in India, a theoretical analysis of the profession, a review of literature on medical profession and a review of studies on Scheduled Castes. The social genesis of the profession traces the formation of the profession from the medieval era through the renaissance to the modern and contemporary times. A special emphasis is to be given to the specific social context of these times, and the impact it had on the development of the medical profession in particular.

A theoretical analysis of the professions include a brief overview of the different schools of thought in this field. The structural-functional approach is explained with Durkheim's and Parson's paradigm. The interactionists' perspective is analysed through the approaches of Hughes. Empiricism is elucidated with Lazerfield's methodology. The Marxists school of thought is also briefly looked into, in its application to the study of professions. The attributional approach is also examined in this context.
which lays down the characteristics of the profession. The processual approach on the other hand studies the developmental sequence of the profession. The ethnomethodology is also analysed to perceive the professionals’ interaction pattern and the true picture of the profession. A Brief review of literature on the medical profession in India is undertaken to contextualise the current study since it is the first of its kind.

The last part of this chapter deals with the review of the studies on Scheduled Castes. These studies are broadly categorised into the ethnographic profiles, studies on social mobility and change, problem oriented studies, studies which deal with the constitutional safeguards and those on dalit movements. These studies help to evaluate and analyse the present research problem in the necessary direction.

Chapter three - Social Background of the Respondents is to deal with both the socio-economic and the socio-cultural background of the respondents. The socio-economic background, includes the region-wise distribution of the respondents, their age profile, rural-urban distribution, educational background, family background and the familial income level of the respondents. The socio-cultural background includes the political involvement of the respondents, their exposure to mass media, their participation in extra-curricular activities and their attitude towards certain issues and value orientations.
This detailed study of the background of the respondents serves two important purposes. They are firstly to understand the problems of the medical professionals in the context of their backgrounds. Secondly to compare the backgrounds of both the categories of respondents - the Scheduled Castes and the Non-Scheduled Castes.

**Professional Ethics: Comparative Perceptions** - Chapter four, is to include social genesis of medical ethics in general, social genesis of medical ethics in India, the State's health policy and programmes, the professional commitment of the respondents, their service orientedness and their views on the patient redressal system.

Social genesis of medical ethics will refer to the specific socio-cultural context in which medical ethics emerged. It is to be traced from the Hammurabi’s code, down to the emergence of the code of the contemporary period. Social genesis of medical ethics in India is traced to analyse its emergence since the vedic period. The Indian system of medicine will also be presented within its specific cultural contexts. The State’s health policies and programmes are to be critically analysed to perceive its relevance meticulously. This would sketch the necessary background to perceive the respondents’ adherence to professional ethics.

Chapter five - **Discrimination and Differentiation: Scheduled Castes in Medical Profession** is to deal with the impact of the professional's primordial identity on the medical professionals' ideas and
attitudes. Discrimination and differentiation did exist in the American, European, Asian and other societies. These have also punctuated history and have also been the cause of many a war. The impact of these in the medical profession was never studied in great detail. The current study will focus on filling this gap. This chapter will categorise discrimination and differentiation into two levels. They include the academic level and the professional level.

The academic level would refer to student-teacher interaction and interaction among students. Herein the focus is on victimisation, if any, by the teachers on the caste basis and the level of interaction among the students. In cases of reported discrimination and differentiation, the degree of discrimination will be analysed and categorised with the help of scales from low to medium to high. At the professional level of discrimination focus will be on the kind of discrimination within the profession. The indicating events would be the interaction among the medical professionals. This will include doctor to doctor interaction, superordinate-subordinate interaction, other related events such as undue transfer, punishment postings and delayed promotions. To fathom the problem to its minute detail, the study will categorise the degree of discrimination from low to medium to high. These indicating events would help us perceive the issues of discrimination and differentiation which mar the apparently noble medical profession.
Chapter six - The Reservation Policy in Medical Profession: An Analysis of Responses will deal with the aspects of equality and merit in the context of the State's policy of protective discrimination. The chapter would deal with the concepts of equality and merit, the constitutional safeguards for the weaker sections of the Indian society with specific reference to the Scheduled Castes. The analysis and interpretation which thus ensues will enable us to perceive in depth, the aspect of equality which is the central theme here.

Chapter seven - A Study of Five Typical Cases will emphasise on the professional culture. The issues of professional ethics, primordial identity and the States protective discrimination are to be analysed. Five indepth life histories of the respondents from the Scheduled Castes category. This will help us to understand in detail the heterogeneity of the medical profession.

Chapter eight - Conclusion also comprises of two parts. The first part presents the finding of the study under four sections. They include the social background of the respondents, the professional ethics of the respondents, the impact of the primordial identity on the professional and the reservation policy in the medical profession. The second part of the study focuses on the analysis and interpretation of the findings. We have herein tried to analyse the data with the help of the Parsonian paradigm and the processual paradigm promulgated by R.Bucher and A. Strauss.