Chapter Two
THEORETICAL ANALYSIS

2.1 Social Genesis of the Professions

2.2 Social genesis of the Medical Profession in India.
   a) Indigenous Systems of Medicine
   b) Modern Medicine in India: Attempts at Professionalisation

2.3 Theoretical Issues - An Analysis

2.4 A Brief Review of Literature on the Medical Profession

2.5 A Review of Studies on the Scheduled Castes

2.6 A Brief Sum Up
This chapter presents the social genesis of the Professions in general and with particular reference to the Indian context. Further a detailed analysis of theoretical issues in the field of professions, a brief review of the studies on Medical Profession and also the studies on Scheduled Castes is presented. This particular study is the first of its kind in this field, and the context of the research problem is evolved in this chapter.

Social Genesis of the Professions

The emergence of Professions, can be traced to the middle ages (1100-1400 A.D.), when the practitioners of all practical arts were organised into professions. Alongwith the other socio-economic changes during the Renaissance period (1300-1700 A.D.), the professions developed into a distinct occupational group. The professionals on the other hand evolved into a social group. In the fields of medicine and law the process of professionalisation emerged during the fifteenth century.¹

The strengthening of knowledge and the total acknowledgement of medical professions took place in the nineteenth century. The development of scientific investigation, empirical significance, discovery of vaccination, bacteria and others took shape by then. All these events convinced the medical profession of the importance of scientific knowledge. All major medical schools of the late nineteenth century in

Europe trained their students in biological and biochemical sciences to comprehend the medical therapy and treatment. These specialisations further spread to the United States of America.\(^2\)

In Britain the roots of professionalisation can be traced from the pre-industrial era when professions were seen in association with high status clientele. The medical professionals were patronised by the ruling nobility, the royal court and aristocracy. A gradual transformation of the structure began in the sixteenth century, when some occupations linked to guilds began claiming the status of professions. The modern professional models stemmed directly from the pre-industrial milieu. The professional "status, ideals, codes and norms" were associated with the guild system, like for instance, the attributes of "specialised training, recruitment, autonomy, self governing nature, quality of production and craft ethic". These attributes formed the necessary foundation for the formation of the "ideology of professionism", which developed during most part of the nineteenth century.\(^3\)

In the Indian context medical profession as such developed to a great extent as an outcome of the British rule.\(^4\) Though the Indian

\(^2\) ibid., pp.430-33.

\(^3\) S.M. Dubey, Social Mobility Among the Professions Study of The Professions in a Transitional Indian City (Bombay, 1975), pp.30-42.

The medical system has had its rich heritage, the modern professions were the result of educational, judicial and administrative development which was a logical outcome of the British rule, rather than a technological and industrial progress, as it was with the western countries.\(^5\)

**Social Genesis of the Medical Profession in India**

It was the Westerners who brought with them, their own system of Allopathic Medicine after the downfall of the Mughals. This was later adopted as the official system of medicine initially by the ruling British Kingdom and later by independent India. However, one should not at this juncture overlook the immense heterogeneity of traditional medical beliefs and practices which existed and are still existing all over the country. In India, besides the well known systems of Ayurveda, Unani, Homeopathy and Allopathy, we have a range of localised folk and tribal medical beliefs and practices based on myth, magic and sorcery. Since the study is to deal with the medical profession, it is imperative to understand the Indian systems of medicine which would build an effective social context. We shall now take a quick look at these systems of medicine before which a brief description of the Indian medical scenario is made.

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In India, medicine as an occupation began with the *shamans* who were a combination of a physician, priest, sorcerer, poet and story teller. When the mesolithic culture flourished, men with imaginative powers turned out to be shamans. The society was always ready to support and hold in awe these ‘shamans’ who functioned as intermediaries between man and the spiritual world. In the pre-historic period, causes of diseases were attributed to supernatural powers or to the wrath of gods and spirits. These were treated and prevented by resorting to amulets, charms, magical rites, sacrifices and talisman.\(^6\)

Indigenous medicine as such, in India dated back to the third millennium - the Mohenjodaro and Harrappan civilisation which was characterised by a high level of social sanitation, hygiene and other therapeutic practices. The history of Indian Medicine is often categorised into two phases viz., the vedic period from 1500 BC and the post vedic period from 600 B.C.\(^7\) The Historical evidence of this is documented in the four Vedas - *Rigveda, Samaveda, Yajurveda* and *Atharvaveda*. The *Rig Veda* and *Samaveda* are the important religious books and *Yajurveda* has documented the sacrificial procedures to be followed during a ritual. These vedas talk about pleasing the angry deity as a

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means to treat the sick. The *Atharvaveda*, on the other hand, has documented the beginnings of rational medicine.\(^8\) The Atharvavedic period (1200 - 1000 B.C.) was characterised by two healing systems, the first was based on ceremonial recital of magical verses and sacrificial practices as a treatment to the prevalent diseases. The other healing practices of the period also used magical formulae, yet majorly depended on the empirical rational use of herbal and other medicaments. Inspite of the fact that the two dominant systems of healing existed simultaneously, the magico-religious medicine, reigned supreme during this period. Yet, the demarcation between the two systems existed and became more characteristic when the herbal doctor metamorphosised into the Ayurvedic practitioner. These practitioners commonly practiced among the urban populace in the cities and towns. The magico religious practitioners on the other hand catered to the needs of the tribal and village population.\(^9\) Moreover, this two fold system of medical practice could probably be understood with great and little tradition phenomena.

The Atharvavedic period was characterised by the belief that disease was caused due to commitment of sin in the present or past life, transgressions of the prescribed course of life, disrespect of Gods, witchcraft of enemies, evil spirits etc... Thus diseases have had a

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supernatural origin and amulets were prevalently used as a prevention during this period. This system of treating a disease is referred to as folk medicine. This system of medicine was gradually handed over to the priestly class the Brahmans. The Brahmans further codified and documented the medical knowledge in the post vedic period from when Ayurveda emerged as a distinct medical system. Yet, to begin with, the brahmans had a strong distaste for medical practice in ancient India.10

The Ayurvedic System of Medicine

The medical contents of Ayurveda took root from the writings of Vrddha-trayi's - the 'three elder ones', which comprises of Caraka’s Samhita (a classified and systematised nomenclature of disease), Susruta’s Samhita (on surgery) and Astanga Samgraha (a medical manual based on the former two treatises).11 The Ayurveda is believed to have been initially handed down from Brahma to Prajapati or Daksa. Later, prajapati passed it on to Asvins, who in turn taught Indra. Dhanvantri - the professor of surgery (523 - 583 A.D.) who was embodied as King Divodasa of Benaras imbibed it from Indra. He in turn handed down the knowledge of Ayurveda to the wisemen who

11 ibid., p.19.
approached him as pupils. He also taught Ayurveda to Susrata along with six of his other companions.\textsuperscript{12} Caraka on the other hand believed that Bhardvaja was Indra's first student. Punarvasu was Bhardvaja's student who in turn passed on the knowledge to his six disciples: Angivesa, Bhela, Jatukarna, Parasera, Harita and Ksarapnai all of them compiled books with the assent of other wisemen.\textsuperscript{13}

The term Ayurveda is derived from two words 'Ayur' and 'veda' which meant "\textbf{Science of Life}". Life, here refers to a combination of body, perceptory organs, mind and soul. Ayurveda is a well systematised science which prescribes a particular way of life. It prescribes certain principles of daily routine, night, seasonal and ethical routines. It also laid down rules of regulated diet, sleep and avoidance of mental and sexual intercourse without purpose. These rules were formulated for the promotion of a prolonged maintenance of good health.\textsuperscript{14} These prescribed ways of living were also stated in other religious works such as \textit{Smritis} and \textit{Grhyasutras}.

Ayurveda is based on the notion that there exists no essential difference between the outside world and human body. It thus takes into account the \textbf{Panchamahabhuta} or the theory of creation, the

\textsuperscript{12} ibid., pp.24-25.

\textsuperscript{13} Caraka \textit{Samhita}, vol.1, (Jamnagar, 1949).

account the *Panchamahabhuta* or the theory of creation, the physiopathological theory of *Tridosha*, that is the elementary forms of nature: air bile and phlegm (*the vata, pitta and kapha*) and also the evolution of universe. Thus, any derangement in the body humours such as *Satwa, Rajas* and *Tamas* is believed to lead one to sickness. Though Ayurveda accepts the three basic entities: body, mind and soul, it confines itself to the treatment of body and mind. In the treatment of diseases, drugs prepared from vegetables, metals and minerals are used. The physician is primarily directed to regulate the digestion in all diseases and then take to the treatment of the disease. Food items, both in solid and liquid form were listed out along with their medical properties, effects, taste and natural temperature. Consumption of animal flesh was not prohibited then, though the flesh of pigs, cattle and most fish were not to be consumed regularly. Fermented drugs from grapes, dates syrup, rice, barley and other plants were classified according to their traits and effects. It further prescribed that rain water is the best and the autumn rains are to be collected and used for the rest of the year. The quantity of food to be consumed is believed to be adjusted according to the individuals digestive capacity.\(^{15}\)

The Ayurvedic system of medicine has always been more a way of life than merely a form of healing system. It is said to have originated

\(^{15}\) Caraka *Samhita*, (1949) op.cit., Volumes 1,5,8.
in Tamil Nadu and as mentioned earlier existed in the form of a tradition and was later documented by the priestly class - the Brahmans. Even till date Ayurveda is widely practiced in our country. Another system of medicine which also originated in Tamil Nadu is the Siddha medicine.

**The Siddha Medicine**

This system of medicine emerged from the teachings of the Sittars. While Ayurveda was the characteristic system of medicine in the Ancient Indian period, siddha belonged to the medieval period. The Ayurvedic system of medicine came under the influence of Arabs and inculcated the features of pulse, alchemy and medicinal chemistry. This part of Ayurveda which imbibed these features was later referred to as the siddha system of medicine.

The system of medicine was believed to have had a divine origin from Lord Shiv. Thus it is based on the *Saiva Sampradayam*. Lord Shiv passed on this medical knowledge to Parvati, she to nandideva from whom Agasthya learnt the art. He was believed to inhabit the mythical hill 'Pudya Malai' near Madurai. The available literature on Siddha is in Tamil and even till date is one of the popular native

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medicines of Tamil Nadu. Nagarjuna, who authored *Rasaratnakara* and *Bogar* were the two prominent sittars who practiced this system of medicine. This system of medicine mostly used drugs of mineral origin.\(^\text{18}\)

The siddha system is used to cure diseases with these drugs. This apart they also believe in transcendentalism and often preach the immortality of the soul and strived to achieve, 'Siddhi' - perfection. To attain this salvation the Hindu philosophy prescribes two methods. Firstly, the *Videha Mukthi* which is attained by leaving behind the mortal body. The other is *Jeevan Mukthi*, which is to attain salvation during this life and within the human body. The siddhas aim at attaining *Jeeva Mukthi* with the help of *Yoga* and *Aushada*, which meant meditation and medicine. It is believed that each of these would complement the other. The medicines are referred to as *Kalpas*. Thus siddha system of medicine has a higher aim of attaining immortality of the soul.\(^\text{19}\) The other system of medicine which reigned supreme during the medieval period was the *Unani* system.

**The Unani System of Medicine**

*Unani* is a classical greek system of medicine which underwent a lot of modification in the hands of the Arabian Scholars. The system

\(^{18}\) ibid., pp.129-33.

\(^{19}\) ibid., pp.135-36.
with its Greco-Arabian lineage was developed to a great extent in Arabia and Persia under the aegis of the Khalifas of Baghdad. It further imbibed the features of every native system of medicine from the society where it prevailed for instance from Persia, India, China and other regions of Central and Southern Asia. The name 'Unani' is a distorted form of 'Ionian' meaning, the Greek. It originated way back in the fifth century B.C. It came to India alongwith the Muhammadans when they conquered India.\(^{20}\)

The Unani practitioners are referred to as Hakims. There existed no systematic Unani medical school, each Hakim had a group of students training under him. The practice was usually a family occupation and passed on from father to son.\(^{21}\) They use a set of unique drugs especially very different from the prevalent Ayurvedic and other systems of medicine. Their concept of disease and diagnosis is however similar to the ones adopted by the earlier day allopaths. The method of noting down the medical history of the patient also originated within the Unani system. Their diagnosis relies heavily on the method of testing the pulse.\(^{22}\)

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The Unani system is based on the thesis that disease is a natural process and the Hakim is bound to aid the natural process. It also emphasises the humoral theory like the Ayurvedic system. The four humours include blood, phlegm, yellow bile and black bile. Each of these humours are assigned a temperament, such as blood is hot and moist, phlegm is cold and moist, yellow bile is hot and dry, black bile is cold any dry. It is further believed that each person has a humoral constitution unique to oneself. A disruption in this, brings about a change in the person's health. Every person has the power within him to restore his constitution from the disruption and this system of medicine places a great reliance on this power. The Unani system treats the person not only against the given disruption of the humoral constitution but also facilitates the acquisition of additional power of resistance against further disturbances.\textsuperscript{23}

The first piece of literature on the Unani medicine was a Persian translation of Al-biruni's book \textit{Kitab-ul-Saidana} (Materia, medical and Pharmacology). The stages of the development of the medical knowledge in medieval India can be categorised into four distinct ones, firstly into translation and compilation of Unani medicine between 1221 and 1352 A.D. These include simple translations and compilations initiated by Altamish (1210-1236 A.D.), Allauddin Khilji (1296-1316 A.D.) and

\textsuperscript{23} ibid., pp.61-65.
Mohammad Tughlaq (1325-1352). These were further institutionalised by Firoz Tughlaq (1352-1358). The next stage was the period of integration of the Unani and Ayurvedic Systems during Babur's reign between 1526 and 1530 A.D. The process of compilation was further institutionalised during Akbar's reign (1556-1604 A.D.) it was characterised by the establishment of the Bureau of Translation and compilation and by the symbolic support in terms of a special payment from the royal treasury *Purshigan* to the Vaids and Hakims. They also received special grants *auqaf* to benefit the medical institution and their staff. The third stage in the developmental process of medical knowledge indicated great advancement in the medical practices and techniques. Jehangir's reign between 1605 and 1627 A.D. emphasised on the medical knowledge in integrated medicine. Several new forms of the therapeutic measures were focussed upon such as importance of mercury in therapeutics and inclusion of opium in the Indian pharmacopoeia. They also included new forms of preventive aspects and diagnosis based on pulse examination. By the eighteenth century, efforts were made to popularise the new form of codified medicine. Besides these systems of traditional medicine, there also exists Homeopathy,


25 ibid., pp.33-35.

naturopathy, folk medical beliefs, home medicines, Yogic and Tantric medical systems.

Yogic Medicine

Yoga originated from the sanskrit word *Yuj*, meaning to join or to yoke. The term initially occurred in the *Taittirya Upanishad* and *Katha Upanishad*. Yogis a very ancient system of practice. The Mohenjo-daro seals had a characteristic figure of a divinity in a yogic posture. *Rigveda* had also a mention of a seer in a yogic posture. The earlier Upanishads also mentioned different yogic asanas and procedures. Yet, sage Patanjali is acknowledged for a systematic collection and publication of his writings into *Yoga Sutras*. He provided his writing with a theoretical framework and metaphysical foundation with the existing *Samkhya philosophy*.

There were several Yogic practices which existed, yet sage Patanjali’s Integrated Yoga is the most important and comprised of *Yama, niyama, asana pratyahara, pranayama, dharana, dhyana* and *samadhi*. The first five yogas dealt with the body and the following three with the mind. *Yama* refers to improvement of social behaviour. This could be achieved by five noble practices such as physical and

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psychological non-violence, secondly truthfulness, thirdly non-stealing and fourthly self restraint and finally non-hoarding. Niyama is improvement in personal behaviour which is achieved by maintaining purity of body and mind, secondly by being content, thirdly leading an austere life, fourthly study of relevant literature and fifthly dedication to God.\(^29\)

Asana or physical postures have been described by several authors to be practiced on a daily basis. Pratyahara or the restrain of sense organs, though a difficult task, when practiced makes the person much happier. Pranayama or breathing exercise when practiced on a daily basis refreshes and relaxes the person through a better circulation of oxygenated blood in the body. Dharana or concentration, Dhyana or meditation and Samadhi or attainment of superconsciousness deal more with the mind.\(^30\)

A regular prescription of Patanjali’s Integrated Yoga is made for psychosomatic disorders. Moreover it is known to improve the patients resistance and their capability to overcome the illness. It also helps cure stress oriented disorders such as hypertension, anxiety, neurosis, mucous colitis, bronchial asthma, diabetes mellitus, thyrotoxicosis, migraine and rheumatic disorders of the spine. The other

\(^29\) ibid., pp.135-36.

\(^30\) ibid., p.136.
method used in the treatment of mental illness is the practice of *Kudalini Yoga*. This method is believed to have improved the psychic activity of the patient with a feeling of enlightenment.\(^{31}\) Yoga is also used as a rehabilitative measure such as *Shakti Yoga* or praying through devotional music. *Karmayoga* or indulging in missionary activities for the poor and *jnana yoga* or educating people at large through philosophical discourses.\(^{32}\) Yoga is thus a traditional practice which helped in co-ordinating both the body and mind. It also believed to enable the individual to maintain tranquility of mind and a calm composure.

**Tantric System of Medicine**

The term *tantra* refers to an ‘extended knowledge’ which when applied to a religion and philosophy is called *tantrism*. It is believed to have originated as a systematic form of traditional medicine at the beginning of the Christian era. Further, it was assimilated, though a little uneasily into the existing major religious systems such as Hinduism, Buddhism and Jainism. Tantra thus gradually emerged as a pan Indian phenomenon by the sixth century.\(^{33}\)

\(^{31}\) ibid., p. 135.

\(^{32}\) ibid. p. 138.

\(^{33}\) ibid., p. 138.
Tantra, in several ways influenced the Indian way of life, yet could remain only in the periphery of Indian Culture. Geographically also it seemed to have flourished in the bordering states of Bengal, Assam, Kerala and Kashmir. Tantra shared a very disapproved or a barely tolerated relationship, with these major religions. Yet, it has had popular practitioners such as Yogeswari who was Sri Ramakrishna Paramahamsa’s guru, Bhagwan Rajneesh and Agchan Bharati of the contemporary period.\footnote{ibid., p.138.}

The Tantra system believed that the human body could be made an undecaying and immortal entity with the Mercury (rasa) preparations, Yogic practices etc... It is also believed that tantrism is the prescribed veda of the \textit{Kali Yuga}. This is in continuation of the belief that the four vedas were the prescribed scriptures of the \textit{sata-yuga}, \textit{smirtis} for the \textit{Treta Yuga} and \textit{Puranas} for \textit{Duapara Yuga}.\footnote{ibid., p.139.} The tantras contain several \textit{sadhana}s or methods of religious endeavour. It comprises of firstly, \textit{Mantras} or a sequence of sound units, secondly \textit{mudras} or a set of patterned gestures and a range of tantric ichnography comprising of visual imagery.\footnote{ibid., pp.138-39.} Thus the tantric system of healing used mantras, mudras and visual imagery in its treatment process.
Homeopathy

The word 'homeo' is derived from the Greek word 'homoios' meaning similar to and 'pathos' means to suffer. As a system of medicine it primarily emphasises the therapeutics that is well known for its low-cost system and employing non-toxic drugs. Its greatest contribution is the successful treatment of chronic illness. It is also known for the cure of diseases passed on through the genetic line.37

Homeopathy was introduced by the German doctor, Samuel Hahnemann to the world at large. He put down the principles and methods of the system of medicine in his scholarly work Organon of the Art of Healing published in 1810. He presented four basic homeopathic laws. The law of Similars, the law of Direction of Cure, the law of Single Remedy and the law of Minimum dose.38

The dictum that, balancing mechanism kept human beings in perfect health is the basis of homeopathy. Yet this balance could be disturbed by the stresses of life which are psychological, physical or atmospheric in nature. This sick person could be restored rapidly to a healthy state of disposition with the help of the above mentioned principles. The first law, that is, the law of similars - *Similia Simililus curantur* stands for the like cures like, the law of direction of cure

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38 ibid., p.113.
refers to the fact that the return of the sick body to health goes through a particular pattern and is aided to follow the said pattern during the process of cure practiced by homeopathy. The next law which talks of a Single Remedy is that the physician is to use only one particular remedy during treatment. The law of minimum dosage is that the more minute the doses the more potent the effect and thus cure is a certainty.39

India is one of the major countries where homeopathy has flourished to a great extent. There are around 275 state run hospitals and 9000 dispensaries in our country.40 We also have 72 colleges which offer a degree in Homeopathy and 36 institutions which offer a diploma course in homeopathy.41

Naturopathy

As the name suggests, naturopathy relied on the principle that nature brings about cures and the most important dictum on which this system rests is that disease produces bacteria and not the other way round. Though naturopathy could not be traced to a particular founder, Mary Baker Eddy could be noted as the person who institutionalised this system.42

41 Hand Book of Medical Education, (New Delhi, 1994), pp.250-54.
Naturopathy believes in an equilibrium model: \textbf{Yin} and \textbf{Yang} - the elements of heat, cold, the humours or \textit{dosha} are to be found in an appropriate balance to the age and constitution of the individual, within his natural and social environment. It is further believed that illness disturbs this equilibrium. To bring back this appropriate balance, naturopathy prescribes a drugless treatment which essentially involves in the elimination of the undesirable toxics, any metal or spiritual factors that could cause ill health. The cure of any bodily disease according to this system should be sought through the realm of spirits, self discipline and self mastery.\textsuperscript{43}

Some naturopathy practitioners have adopted many techniques of modern physiotherapy for cure. They also use for their diagnostic purposes, X-rays, urine test, palpation, observation etc..\textsuperscript{44} Naturopathy is practiced in India even till date. We have in our country 18 Naturopathy hospitals and 11 dispensaries.\textsuperscript{45}

\textbf{Folk Medicine}

Disease is an inevitable phenomena to be tackled by both primitive and advanced societies. Every society adopts its own treatment to cure the given diseases. The therapeutic process which thus ensued

\textsuperscript{43} ibid., pp.116-117.

\textsuperscript{44} ibid., p.118.

in a primitive society has its roots in the culture of the given society. In primitive societies, there existed a ritualistic process based on supernatural belief. This kind of therapeutic process rooted within the given society's culture and based on super-natural belief is referred to as folk medicine. Since this folk system of medicine has deep roots in the local culture, its practitioners understood the local peoples' way of life and treated their patients personally. Folk medicine was practiced from the Atharvavedic period (1200-1000 B.C.) till date. It could be traced in the ancient manuscripts of Atharvaveda, Kautilya's Arthasastra, Ayurvedic Samhitas of Caraka and Susruta, in the writings of Alberuni and also in the writings of some Muslim and European writers. This system of medicine attributes both the causation and cure of disease to Gods, goddesses and spirits.46

It also believes that one's own Karma is a source of health and illhealth. The Folk System is often, for the sake of better understanding, bifurcated into the sacred and secular. The sacred sub-sector is said to be rooted in religious belief for instance shamanism. The secular sub-sector is the empirical practice based on herbalism, bone setting, massage and material exercise.47


These folk practitioners are non-registered but part-time practitioners, who often function within the context of village organisations. They perform their functions within the community’s conventions - the caste and village leadership. Thus kinship and caste group have an effective impact in such a regulation. These practitioners have a regular body of patients. They are paid in cash or kind but the major rewards as they believe are social recognition and prestige.

This brief presentation of the different systems of medicine within the given socio-historical context facilitates to understand the development of allopathy or the modern western system of medicine into a profession. India was in the process of transformation from the monarchical form of government into the colonial phase which in turn gave way to the democratic form of Government. As suggested earlier, it was the Westerners mainly, the Portuguese, the French and the British who brought with them the allopathic form of medicine. However the British overtook the other Western powers in no time. Thereby the allopathic system of medicine, gained grounds in India.

The Allopathic System of Medicine

"Allopathy" refers to "The curing of a diseased action by inducing

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48 ibid., p.16
49 ibid., p.16
an action of a different kind" as defined by Hahnemann,\textsuperscript{50} who coined the term and is also the father of Homeopathy. In India the term denotes the modern, scientific or western system of medicine, brought into the country by the westerners.

This system of medicine believes that the human body in its normal state is free of being afflicted by any disease. Disease is rather treated as a foreign intrusion into an otherwise healthy body. Its cure is sought by the application of some form of "opposites". Surgery is practiced to remove any affected organ or part. The indigestion of chemically compounded substances help to "reverse" the course of disease. The application of various physical manipulation and exercise are prescribed to help restrain misused, unused, or atrophied parts. Wherever it is found essential, the temporary reversal of the ill persons social behaviour is suggested.\textsuperscript{51}

This modern system of medicine is characterised by certain assumptions; firstly, that the diseases are generated by certain etiological agents such as bacteria, virus, parasites, genetic malformations or internal chemical imbalances, secondly it demands of a passive patient's role and thirdly the use of invasive manipulation to


restore the human body to its equilibrium point of health. The scientific medicine developed to a great extent in the late nineteenth century mostly from the French and German laboratories.52

Modern Medicine in India: Attempts at Professionalisation

In India, the allopathic doctors first came from the west during the sixteenth century. The Portuguese took the lead and established a hospital at Goa in 1648. They also founded a medical school in 1687. The East India Company from Britain which also came during the seventeenth century to India, had initially employed British surgeons to serve them. But with time, the company’s servants also employed indigenous practitioners to serve them.53

Although the Portuguese were the first to establish medical schools, the British systematised it to a great extent. In Calcutta, the western system of medical education was combined with classes in Ayurvedic and Unani medicine in 1822. The first medical college was opened in 1835 called the Calcutta Medical College. The period between 1822 to 1835 saw a sea change in the attitude of the British and the indigenous systems of medicine were completely discouraged and sidelined. The course consisted of only the modern western system of medicine and the medium of instruction was English throughout.

Madras Medical College was also founded in 1835, the Bombay Grant Medical College was established after a decade and the Lahore Medical College in 1860. Much later, in 1906 Lucknow’s King George’s College was founded and in the following two decades there were colleges established at Delhi, Belgachia, Vizagapatnam, Patna and Bombay. In total there were ten colleges of which six were controlled by the Provincial Governments, two by private bodies, one was under a university and one under the Bombay Municipality.\textsuperscript{54}

The British Government also established Medical schools to produce subordinate staff for doctors and were referred to as Licentiates. There were around 27 medical schools by 1938, of which nine were under private control. This course had lower admission requirements. The duration of the course was also much shorter. These licentiates were recruited into the lower level of the administrative hierarchy. These students received stipends from public fund unlike their medical college counterparts. They also executed bonds to serve both in the Civil and Military services after the licenses were granted.\textsuperscript{55}

The term allopathic doctor in India, specifically referred to the medical practitioner trained in one of the British medical Colleges who were mostly graduates. The licentiates were also referred to as

\textsuperscript{54} R. Jeffery, Recognising India’s The Institutionalisation of Medical Dependency, 1918-39, \textit{Modern Asian Studies}, (1979), 13,2, p.303.

\textsuperscript{55} P.Bala, op.cit., p.69.
allopathic doctors. These doctors were clearly distinguished from those who practiced any indigenous systems. These doctors were all absorbed into serving the Government until 1900. They could not until then venture as private practitioners, if at all they did, they could not cross the borders of the metropolitan cities such as Calcutta or Madras.\textsuperscript{56}

These doctors mostly served the Indian Medical Service (IMS), thereby they dominated all the senior Government posts and also had rights for private practice. By 1855 entry to IMS was made only through competitive exams. These exams were held in London and were said to have had a prescribed age limit. These factors restricted the Indians from entering into the IMS. In the 1913 batch only 55 Indian members were recruited into the IMS.\textsuperscript{57}

The \textbf{British General Medical Council} (GMC) had the overall supervisory power of all the hospitals and colleges. They also set up an Indian counterpart - Medical Council of India in 1933. (MCI). The GMC found much discrepancy of medical standards between the British and Indian Medical Colleges, with time. In 1909 the GMC felt the need to develop their skills in midwifery training and this did not work out in the Indian Hospitals and Colleges for lack of cases. The GMC thus commissioned Sir Norman Walker to tour all the Colleges and Hospitals

\textsuperscript{56} ibid., p.70.

\textsuperscript{57} Crawford, op.cit., 1914, p.505.
for a report. The GMC in fact wanted a permanent officer to be appointed in India for the above task. The Government of India preferred a timely stop-gap arrangement. This tussel led the GMC to declare the derecognition of Indian degrees from 1930. In this context the Act to establish the Medical Council of India (MCI) was passed in 1933.\textsuperscript{58}

The task set before the MCI was to regulate the standard of medical colleges. To start with, the Council implemented the policy formulated by the GMC in the 1920s. This was firstly, to document the number of students in proportion to the facilities, provided in the Colleges and Hospitals. Secondly, to supervise the rules and regulations which ought to be followed and thirdly, to document the conduct of examinations. The GMC was thus working through this counterpart organ to keep the medical standards within its fold. The GMC as is reported was fairly successful in its attempt, for instance it checked the growth of student numbers especially in Bengal and Bombay. They effectively changed college regulations and tightened the examinations and thereby the pass rate of LMS and MBBS students went down from 65\% in 1916-17 to 37\% in 1926-27 and to 27\% in 1927-28. However, in the 1930s, the pass rate was constant between 30 and 40\%. The position of MCI constitutionally was not strong enough in the years to come and

especially after independence was declared in 1947. It could not prevent State Governments from opening new medical colleges with inadequate facilities and prevent the claws of a rigged examination system. This was the reason for GMC to derecognise the degrees of MCI in 1975. It thereby declared that no doctor with an Indian degree is recognised to be sufficiently qualified to practice in Britain.\(^{59}\) The Indian Medical Association formed in 1928 vehemently opposed this legislation along with the nationalists. The Association contended that India would continue to be subservient to the ruling imperial power with absolutely no devolution of power to the provinces.

The constitutional reforms of the twentieth century had also affected the process of professionalisation of the Indian medical system. The **Morley-Minto** reforms of 1909 emphasised on including Indians in the provincial councils. **Montague-Chelmsford** reforms 1919 stated that the British aimed to bestow upon India, Self-Governance but only as a compatible proposition to the superior British rule. They further improved this to say they were ironing out the creases caused by the racial, regional and religious differences in India. The western educated Indians raised their voices against these propositions and so did the congress party which formulated a set of its own reforms. Yet the 1919 set of reforms included in its ambit, Indianisation, transfer of

\(^{59}\) ibid., p.323.
administrative services to the elected Ministers and devolution of powers to the provinces.\textsuperscript{60}

Indianisation of the Medical system took place in two spheres, firstly it reduced the number of services reserved for the members of the IMS and secondly the entry for Indians into IMS was made easier. The process of Indianisation was rather slow before the first world war (1914-1919). All the recruits were to serve with the Military and their service here was for a minimum of five years. The number of doctors transferred to the civil work depended on the needs of the Military service, for instance when war was declared most of those in the civil service were also called in. Thus they left a bare skeletal staff for the needs of the public. This apart, the British officers and others in the service refused to serve in the Indian Army, for the fear of being made to serve under the Indian officers. Medical education which was so far an imperial policy was transferred but the maintenance of medical standards was still a reserved subject. The process of Indianisation was in a great way the result of the 1919 Montague-Chelmsford reform. Yet, with the years to come the IMS lost its character. In the provinces there was a great deal of hostility for many reasons and after independence in 1947 the IMS lost its all India character.\textsuperscript{61}

\textsuperscript{60} Refer the Constitutional Reforms of 1909 and 1919 for further details.

\textsuperscript{61} For more details refer Jeffery, op.cit., 1979, pp.309-315.
In the meanwhile, the double system of medical education: graduates and licentiates caused much embarrassment for the Indian doctors both in India and abroad. It was in 1939 that this embarrassment gained grounds in the Indian context. There were a variety of ways through which India could have trained her medical professionals but she chose the British Model, which resulted in the dual system of graduates and licentiates. (The IMS was in fact worried about the politicisation of medicine in the public sector and commercialism of medicine in the private sector). The licentiates were themselves in favour of abolishing their system of education through medical schools which was known for its inferior training. They were against this ‘casteism’ within their profession. The GMC was also not prepared to recognise the Indian doctors and demanded the removal of licentiate since 1927. Further the provincial ministers’ conference in 1938 discussed the issue and settled for a uniform standard of medical education. This point was also emphasised by the Bhore Committee report (1946) and thus the licentiate education was abolished in 1956.\textsuperscript{62}

The system now presents a graduate course for five and a half years called MBBS, Post graduation courses in different specialties for a period of three years and diplomas for a period of two years. Thus, this was the developmental process of the Medical Profession in India.

\textsuperscript{62} ibid., p.319.
The colonial legacy to the Indian Medical system was the discouragement of the practices of Indigenous systems of medicine. This has today a detrimental effect on the country's health services and the people's attitude towards the available medical services. The most frequently quoted is the injection fixation among the villagers and tribals in the remote pockets of our country. This has further diminished the importance of the indigenous practices. The state is now endowed with the responsibility of imbibing the necessary medications from the systems of indigenous medicines. The recently introduced Structural Adjustment Policy (SAP) has also created conditions for an exclusive health service system catering to the urban upper classes rather than a mass oriented health service to reach the common man.

Secondly, the subservient role the Indian Medical System was made to play by the British GMC has had its effect through the ages. It has not only derecognised Indian degrees since 1975 but also belittled the Indian Medical Education. This has today created much embarrassment for the Indian doctors abroad.

The impact of colonialism is reflected even today in the country's health policy making and planning procedures. While the British delivered their reforms toward the Indian Self-Government with their velvet gloved iron hands, the Indian health plans and programmes have time and again only promised "to make medical care and medical education relevant to India's needs", this has only remained a promise.
The process of development of allopathic medicine into a profession in the Indian context is traced. This process is considered as the most important change in the modern society. The growth of these professions crystalised in the late nineteenth century and early twentieth century.\textsuperscript{63} They have with the passage of time increasingly gained importance in the modern industrial society.\textsuperscript{64} They act both as an indicctor and as an initiator of the process of modernisation.\textsuperscript{65} A systematic study of professions began with the eighteenth century political economists in Europe. In due course, an ocean of literature emerged in this field. For paucity of space we shall attempt to present a brief review of the theoretical issues.

**Theoretical Issues - Analysis**

The \textit{structural-functional} approach was well represented in Durkheims Division of Labour. He analyses the increased demographic complexities: material and moral density. He also stresses the fact that social volume leads to division of labour which eventually would lead to specialisation. He stresses on the increasing roles of occupational


\textsuperscript{64} A.M. Carr Saunders and P.A. Wilson, \textit{The Professions} (London, 1933), p.22.

groups, professional groups and syndicates. Professions are rooted in moral codes and ethics unlike business, which according to him are related to commercial and profit oriented values. Other sociologists like Tawney, Carr Saunders and Wilson stress on similar issues. Parsons on the other hand, identifies similarities such as rationality, functional specificity and universality between professions and business.

Parsons is considered the pioneer of the structural-functional approach. He defines professions as a "cluster of occupational roles" and those who enact these roles involve in functions valued by the society. Such functions gave these professional men a career, which meant not just doing but living a full time job. He distinguishes three core criteria for a profession: (i) the necessity of a formal technical training alongwith an institutionalised means of judging both the adequacy of the training and the competence of the trained individuals, (ii) that the cultural tradition must be mastered and its skills put to use in some form or the other, (iii) a full-fledged profession must have institutionalised means to make sure that the professional competence will be put to socially responsible uses. The important attributes of a profession according

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68 ibid., p.38.
to him are rationality, authority based on ‘technical competence’ and universality. He further attempts to link these important attributes of profession with the normative pattern of social structure.\footnote{69} Parsons as pointed out earlier distinguishes the similarities between the profession and business. Yet he did not overlook the self-interest of business vis-a-vis the disinterest of the professions.\footnote{70} The structural-functional approach is criticised for its dubious premise. It is also criticised for the fact that representativeness of the sample studied is not considered and has failed to acknowledge the power structure of the professions.\footnote{71}

The modern society on the other hand has in the process of transition metamorphesised, into a predominantly profit oriented and materialistic one. This is largely due to the changing social values. The structuralist approach thus looks at profession as a highly abstracted and theoretical functional package, which fulfills a specific need of the society, according to the existing social values and goals.\footnote{72} Contrary to this approach, the interactionists’ view social structure as a determinant characteristic of the degree of professionalisation.\footnote{73}.

\footnote{69}{ibid., p.38.}
\footnote{70}{ibid., pp.39-43.}
\footnote{71}{E. Greenwood, in Attributes of A Profession: Revisted, in Readings in the Sociology of the Professions, ed, Sheo K.Lal et.al., (Delhi, 1988), p.5.}
\footnote{72}{Y. Singh, op.cit., 1988, p.11.}
\footnote{73}{S. Singh, in ibid., p.125.}
The Interactionists' view professions as a set of role relationships between the professional and his client. Profession is considered a social role which is defined by the relationship between the professional and the client according to E. Hughes. He also emphasises on the autonomy and authority of the profession. The professional is known to mystify his practice by maintaining secrecy of his knowledge. An Interactionist perspective pictures the profession to be free from an objective control system.\(^{74}\)

Hughes tradition of presenting the first hand experience of the social world concentrates on detailed studies. Parsons on the other hand, hardly gives guidelines for an empirical study and the vacuum which emerged is said to be filled by Lazerfield's empiricist methodology. Empiricism avoids untested theoretical speculation. It aims at providing a quantitative and empirical evidence.\(^{75}\)

Marxists, on the other hand, view professional knowledge and skill as a commodity with a market value to be exchanged for money. These aspects of profit oriented commercialism are not dealt with in the above mentioned approaches. The bourgeois ideology in the capitalist society is blamed for encouraging the development of professions in the interests of the capitalists. The capitalists are blamed for using the

\(^{74}\) ibid., p.124.

professionals as their tools. The Marxist approach is preoccupied with the capitalistic society and never sketched the contours of profession. This gap is filled in by the attributional approach which always worked towards a universal definition of profession.

Traces of the attributional approach were evident from the beginning of the twentieth century. Sociologists to a great extent were preoccupied with the definition of profession. They were found most of the time deliberating on its different attributes. This preoccupation could be traced from the days of Flexner (1915), from when a wide variety of characteristics were suggested. Yet, there was a consensus regarding the aspects of prolonged specialised training in a body of abstract knowledge and a collectivity or service orientation. There have been other characteristics also pointed out by different social scientists, apart from those presented by the sociologists.

The economists stress upon the closed monopolistic aspect of the professional labour market like Cainnes and Friedmen did. The political scientists refer to profession as a "privileged private

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government". The policy makers viewed professions as 'narrow and insular' in their vision of social weal. The political influence of professionals is also enquired into. The relation of professions to political and economic elites and the state is dealt with by Johnson. The relation of the profession to the market and class system is emphasized by Larson.

To a great extent these essential attributes of a profession, distinguished by the existing literature do overlap. These attributes have been distinguished by many theorists including Greenwood, Millerson, Goode, Barber, Parsons and several others.

The attributional approach, thus deals with the characteristics and did not in its parlance, give much scope to study the process of development of the profession. In contrast to this approach, the processual approach traces the process by which an occupation or a non-profession transforms itself into a profession. The, processual theorists (Caplow, Wilensky, Bucher,A Strauss) focuss upon the process of formulation of the profession and the issues of class and power

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80 Glibb, 1966, in Dingwal, ibid., p.20.
dimensions of the profession. In the process, the processual theorists also fall into the same fallacy of sketching the characteristics as the attributional theorists did. The attributional theorists characterised the 'ideological attributes' of the professions, while the processual theorists switched over to the 'organizational traits'. The processual theorists did move away from the homogeneous community, identity, values, role interests, paradigm of the attributional theory. The processual theorists emphasize more on the conflicting interests and change. They acknowledge the presence of "segments" within the profession. These segments could appear to exist in opposition to the others and it could create coalition and opposition also within the profession. These 'segments' are used to explain the shared interests of professionals within the same specialisation.85

This processual approach mainly distinguish the developmental sequence of the occupation as suggested by Caplow and Wilensky.86 The process of professionalisation is identified through four main areas of analysis which include the degree of substantive theory and technique, the degree of monopoly, the degree of external recognition and the degree of organization of a profession or a semi profession. This


approach gives a wider perspective to the study of professions.\textsuperscript{87} This approach to a great extent overlooks the day-to-day development and interaction pattern within the professional setting. This vacuum was bridged to an extent by the ethno-methodologists, for instance Erving Goffman.

Goffman studies face-to-face interaction in a naturalistic setting. He was critical of organizations in his essays on total institutions, and particularly laid bare the 'underlife' aspect of the organization. In his study the inmates of the mental hospital did maintain an organizational identity and simultaneously involved themselves in those activities which violate the organizational norms. Thus in his attempt to develop a "sociological version of the structure of self", Goffman highlights the "inmates situation in a mental hospital".\textsuperscript{88} Goffman also employs his \textbf{dramaturgical model} in analysing the actors in their daily lives as they present themselves and indulge in \textit{Impression Management}.\textsuperscript{89} This approach to study the profession from its clients (patients) situation has in many ways challenged in many ways the existing frames of study. The other theoretical models approach the study of professions from the establishment's point of view like the above

\begin{itemize}
\item \textsuperscript{87} ibid., p.26.
\item \textsuperscript{88} Erving Goffman, Assylums - Essays on the Social Situation of Mental Patents and Other Inmates (Chicago, 1961).
\item \textsuperscript{89} Erving Goffman, Presentation of Self in Every Day Life, (Chicago, 1959).
\end{itemize}
mentioned structural-functional approach, structural and Marxists approaches.

**Ivan Illich**, in his approach to study the medical establishment, questions its very basic functions. He insists that the medical establishment is in itself a threat to health. He deals with the new epidemic which arose as a result of this medical establishment which he refers to as *iatrogenesis*: threat let loose by the physician (symbolising the medical establishment) on his patients.\(^\text{90}\)

**An Overview of the Theoretical Issues**

The theoretical issues which are dealt with so far, can be categorised into the Attributional school of thought and the Processual school of thought. The Attributional theorists were preoccupied with the process of sketching the characteristics such as values, identity, definite roles, interest, power, autonomy, authority etc. The processual theorists on the other hand, questioned the very unity of interests among the professionals. They do agree with the core ideas of the profession. They present within the ambit of profession, a constant movement or change and that professionals are divided among themselves. Each of these divisions are referred to as *segments*, these segments tend to change and are found in constant motion. The processual theorist do not assume the homogeneity of the professionals as the other theorists have

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done. The criteria for the segment formation could range from work activities, colleagueship, interests, specialties etc... Thus in their view these segments are in constant motion and the professions are a loose amalgamation of these segments.

In the present study of Medical Professionals in Delhi an attempt is made to understand the professional culture with the help of the Parsonian frame. The Parsonian frame is the most influential one among those theorists who spoke of the characteristics. In the current venture the focus on several such segments is possible since the professionals belong to different backgrounds, different Caste, Class, Gender, Region etc... Which could be the basis for segment formation. The problem dimension of the Scheduled Caste category is the major focus area since it seems to us as a very sensitive issue within the medical profession and also that there has been no single study on this theme. We shall now pass on to a brief review of literature on the medical profession.

A Brief review of Literature on the Medical Profession

Literature in this field is categorised into those which deal with the medical professionals and those which focus on the professional organisation. The studies on medical profession deal with medical students, doctors and nurses. The studies on professional organisation are again grouped into three categories. They include firstly, the social
context and orientation of medical education secondly, the state’s involvement in medical profession and thirdly, the professions’ contribution to social change and modernisation.\textsuperscript{91}

The studies on medical students mostly deal with their social backgrounds for instance in the studies of Sharadamma and Parvathama 1968, Jayaram 1977. Some of these studies also focussed on their orientations and professional socialisation (Rao T.V. 1976, 1978). The studies on medical Professionals, the allopathic doctors deals with their social profiles and professional roles. These studies on doctors are of different kinds for instance those studies on private practitioners such as Madan in 1972, those studies of doctors in public hospitals for instance Advani 1975, Mathur 1975, Srivastava A.L. 1975, those studies which focus on doctors in elite institutions (Madan 1977), doctors within an organisational set up like Oommen’s study (1978), and the comparative studies of institutional doctors and private practitioners as done by Madan 1972, Chandani 1977, Ramanamma and Bombawale, 1978.\textsuperscript{92}

The studies on professional organisation include those which deal with the social context and orientation of medical education such as Banerji’s (1969, 1973) Kakar’s (1973, 76) and Madan’s (1976). Certain

\textsuperscript{91} S.L. Sharma, Sociology of Professions in India in, \textit{Survey of Research in Sociology and Social Anthropology}, (New Delhi, 1985), p.265.

\textsuperscript{92} ibid., p.265.
studies deal with the State's involvement in the regulation of the medical profession, this issue was dealt with by Banerji (1974, 1975) and Jeffery (1978). There are other studies which deal with the medical professionals' role in social change and modernisation by Banerji (1966) and Madan (1976). 

Since the present study deals with the medical professionals as such, a quick review of the studies grouped under the first category is sketched. Among Madan's studies (1972, 1977, 1980) the first was on Doctors in a North Indian City: Recruitment, Role Perception, the second study on Doctors and society and the third was a comparison of medical professionals in three Asian societies. The former was the study of private practitioners, the second on doctors who were practicing in an institute and the third a comparative one. An attempt was made in these studies to understand doctors - in terms of their social background, their training procedure, how they relate themselves to their work and to the society at large. Madan also points out that medical profession is disconnected from the prevailing socio-cultural conditions. He also suggests that the profession encourages the acquisition of all qualifications by the physicians for their own sake.

93 ibid., p.266.

94 T.N. Madan Doctor in a North Indian City in Beyond the Simla Village, ed., Satish Saberwal (Simla, 1972) and also refer T.N. Madan Doctors and Society (Ghaziabad, 1980).
This, according to him, led many doctors to opt for one of the two equally counter-productive courses of action: either they chose to emigrate to western countries by which they enter into any international market inspite of the second class treatment they receive or else they seek admission into the "little golden ghetto" to cater to the needs of the well-to-do and wealthy. The brain drain of doctors which has affected almost all Asian countries is likely to continue unless dramatic developments take place, for instance, the derecognition in 1975 of Indian medical degrees by the British GMC.

The doctors are excessively preoccupied with their own self-centered ambitions, frustrations and their failure to relate to the people in general in the same manner in which they are able to relate to their own class and explain their growing resentment with the State. Their concern always ran counter to the States' policy, which seeks to promote community medicine and demands that doctors should shoulder their responsibilities towards the rural population. Doctors on their part complain about political interference to reinforce their control over medical institutions. Madan believes that it is imperative for Government professional bodies to form a combined platform which aimed to provide a balanced mix between the official policy on the one hand and personal and professional satisfaction of doctors on the other.
Advani (1980)\textsuperscript{95} studied "Doctor-Patient relationship in General Hospitals" where he identifies the dimension of the existing hospital systems, behavioural components of doctor-patient relationship, perceptions of doctors and patients and their interaction patterns. His study proves that doctors possess high social status in the society and that their professional values greatly influence their practice. Doctor's preferred role relations with patients, subscribes to Parson's affective-neutrality perception, in order to avoid emotional involvement with patients. The patients are greatly influenced by the duration of contact, previous experiences, and the size and image of the hospital. The socio-economic status determined their choice of the hospital, mode of treatment and level of satisfaction. However, the study did not focus upon the interaction between doctors of different social backgrounds.

Oommen's\textsuperscript{96} (1978) study on "Doctors and Nurses", analyses the occupational role structures of doctors and nurses working in public hospitals in Delhi. Oommen's study focuses on the consequences of the transformation of the occupational roles of doctors and nurses from that of private practitioners to public servants and the effect on their working in the Government organisational set up. He identifies three

\textsuperscript{95} Mohan Advani, Doctor-Patient Relationship in Indian Hospitals (Jaipur, 1980).

\textsuperscript{96} T.K.Oommen, Doctors and Nurses. A Study of Occupational Role-Structure (Delhi, 1978).
perspectives so far as the definition of profession is concerned, firstly the objective-evaluative to construct an ideal typical notion of profession, secondly the symbolic-realistic view, as a symbol of ideal and actual, Thirdly class-interest representing a different perspective concerning a reality of profession. He also deals with specific aspects such as the relationship between the profession and social structure: role commitment of the professionals and their role perceptions; role conflicts and relations, occupational value orientations and the role behaviour of doctors and nurses. The data suggests that the social background of doctors contribute to their high prestige in profession whereas, conversely, the origin of nurses, depress the prestige of nursing profession. However the study did not consider the effect of the social background of the SC/ST doctors on their professional prestige.

Srivastav's (1979) study explored the nature of interaction in a hospital setting which exist among three interacting units of the hospital organisation: the doctor, the patients and the para-medical staff. The major hypotheses and the findings of they study are: firstly that patients approach the problem of health and disease according to their cultural norms, and this was partially proved. Secondly that the doctor's behaviour towards patients is not much influenced by the soci-
economic status of the patients. Thirdly the expected behaviour of doctors is not translated into reality. Fourthly that illiteracy and language problems are major barriers to closer interaction among doctors, patients and para-medical staff. Fifthly that the dissatisfaction among the para-medical staff indirectly affect the doctor-patient interaction. Sixthly that the data partially proves that the bureaucratic structure and process in the hospital is often affected by the socio-cultural demands on hospital personnel. Seventhly the analysis proves that one of the major causes of conflict in the hospital is the excessive bureaucratic control and non-recognition of the professional competence of its personnel. The findings of the study support the contention that socio-cultural status of the patients and doctors influenced their interaction pattern. The doctors are the experts in relation to their patients. The patients on the other hand insist on a diffused and intimate relationship with a doctor. This creates a dilemma in this relationship which is further emphasized by the organisational limits and demands upon both.

Venkatratnam's study (1979)\(^9\) on Medical Sociology in an Indian Setting, analyses the Hospitals and their functioning units: doctors and nurses in Tamil Nadu. The study attempts to understand a few propositions such as doctors and nurses role in the hospital in

\(^9\) R. Venkatratnam, Medical Sociology in an Indian Setting, (Madras, 1979).
terms of their perceptions. Secondly, the role expectation and actual role performance of their own roles and of each other. Thirdly, the role satisfaction and dissatisfaction in terms of the difference between role expectation and role performance and their causes. Fourthly, the sociological revelations that emerge from an analysis of the role performance of doctors and nurses in a hospital. He has redefined the concepts of ‘status’ and ‘roles’ as it should be understood in an organisational context. He applies the concept of ‘relative deprivation’ and demonstrates the frustration of the occupational groups as the product of economic or the larger value system of the society. His study also proves that doctors did not perform their roles satisfactorily. This is so because according to him, they were not sufficiently socialised with the professional qualities of affective-neutrality, acquisition of knowledge through research, and teaching and following the rule of bureaucracy. Universalistic criteria against particularistic demands were found to be conspicuously absent in these hospitals. The situation of the nurses is different from the doctors since they were subordinated to doctors by profession and their position within the hospital setting was quasi-independent. The nurses perception of the doctors role generally did not conform to that of doctors and thereby stated that doctors did not fulfill their role tasks as per the expectation of nurses.
Rammanamma and Bambawale (1978) studied the occupational attitudes of physicians. They examined the following aspects—firstly, the amount of time spent per patient by doctors in relation to a patient’s illness or in relation to a doctor’s rewards. Secondly, the degree of interaction between the physician and the patient in order to perform the role obligation of a physician and finally, if the physicians are able to attain affective-neutrality in their interaction with their patients. The major findings of the study are that the general practitioners combine physical cure along with the psychological and emotional cure of the patients. This approach seems to have given the physicians less monetary gains, however it cured patients especially those with abnormal complications. On a normal routine the consultants get patients with a case history from general practitioners or government hospitals.

Chandani (1980) in her study The Medical profession: A Sociological Exploration, attempts to examine the subtle aspects of the profession. The structural origins of the practitioners show that women doctors in the medical profession were fewer in number and profession was highly dominated by the middle castes. Choosing of a

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100 Ambika Chandani, Medical Profession: A Sociological Exploration, (Delhi, 1975).
profession was largely done by the family for their wards and the doctors by and large did not decide on their own to enter into the profession. Altruism and not individual aggrandizement is considered an impending factor to take to medical profession. Courtesy, dedication, expertise and humanism are the special qualities that a doctor should possess as per the prescribed code of ethics. On the other hand, her study proves that the doctors did not possess these qualities in real life situations. Regarding their treatment pattern, as the study suggests, it has improved a lot and the rate of success of doctors in treating the patient is high. Doctors do not involve themselves in a situation which is beyond their competence. The doctors on the other hand experience problems regarding the patients behaviour. Medical ideology includes medical ethics, integrity of doctors, colleague feeling, good behaviour toward patients, service to humanity expertise and service above self. These issues were all analysed and empirically dealt with in her study.

Fatima Abidi's (1993)\textsuperscript{101} study \textit{Women Physicians - A Study in Roles and Role-Conflict} deals with the role-conflict of Women physician and the coping mechanism which they develop. Her study is both a quantitative and a qualitative one, based on one hundred and fifty respondents. The major conclusions of this study include firstly,

\textsuperscript{101} N. Fatima Abidi, \textit{Women Physicians - A Study in Roles and Role-Conflict}, (New Delhi, 1993).
that the visibility of role discharge would lead to role-conflict. The study shows that the social and professional roles would reinforce one another in causal relations yet there is an amount of incompatibility and incongruency since these two roles are not internalised simultaneously in a person's life. Familial role expectations are observed to be higher in the beginning and lesser as life progresses therefore role-conflict is bound to decrease with time. The phenomenon of social role conflict is found to be more among the younger and recently wedded physicians. Familial role-conflict occurs due to varied perceptions of the family members. The study points out that the Professional role-conflicts tends to lessen when the responsibility is shared by a number of people, than merely by an individual. Another important finding of this study is that the Professional role-conflict tends to occur more with the senior physicians than with the younger physicians. Faculty members have more concern for awards. The study suggests that if appropriate coping mechanisms are practiced role-conflicts could be resolved.

This review of literature on Medical Professionals dealt with the studies in this field and emphasized on a few important ones. These studies have all considered several aspects of the Medical Profession yet none of these studies dealt with scheduled castes in professions or in medical profession in particular. We shall also review the literature on scheduled castes to get a clear picture of the studies in this category.
A Review of Studies on Scheduled Castes

There exists an enormous amount of literature focussing on the Scheduled Castes. We have picked out a few for the purpose of this study. The initial studies in this field were travel accounts by other nationals for instance, Hamilton Buchanan, W.W. Hunter (1868). The beginning of the twentieth century was characterised by ethnographic studies such as Crooke (1896), Rose (1911), Russel (1916), Ibbetson (1916), G.W. Briggs (1920), etc. These studies focus on their social life pattern of the Scheduled Castes and their living conditions.¹⁰²

The next set of studies are those which concentrated on the social change aspect. These studies discuss it through the reform movements (Fuchs 1965, Babb 1970), the process of sanskritisation (Hutton 1951, Patwardhan 1966, Beteille 1967, T.R. Singh 1969, Gopal Guru, 1985 etc.), the process of westernisation (Issacs 1965, Beteille 1967, Lynch 1968 and others) and the Role of Ambedkar (Zelliot 1970, Gore 1994 and others). The social change aspect is also reflected upon in the rural-urban studies and census studies. Certain studies like those by Issacs (1965), Parvathamma (1968), Satish Saberwal (1970), and others are problem oriented studies. These studies focus upon the social discrimination of the Scheduled Castes. Another grouping of


There are other studies which deal with the Dalit Movements. These studies tried to emphasise on the Dalit struggles for equality—both political and cultural, within the socio-historic background. Some of the important studies in this categorisation include Omvedt (1976, 1989, 1995), A.K. Roy (1980) Barbara Joshi (1986) Ghanshyam Shah (1990) and others.

Sociologically, there seems to have emerged a fivefold approach from the different studies in this field. They include the ethnographic profile, the aspect of social mobility and change, the problem oriented studies, those which deal with the State’s policy towards the Scheduled Castes and those which deal with the Dalit Movements.

However, there was no focus on the Scheduled Castes in medical profession in the earlier studies. The State’s policy of protective discrimination granted the reservation of seats for the SC/ST in all educational institutions and Government jobs. This policy raised much heat and dust within the medical profession. This was the case in several other professions also. Yet, it should be borne in mind that this issue was a very sensitive one in the medical college campuses and hospitals. The study thus focuses on the problem dimension of the medical profession with special reference to the Scheduled Castes professionals.

^{103} ibid., pp.276-97.

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