Chapter Four
PROFESSIONAL ETHICS: COMPARATIVE PERCEPTIONS

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This chapter attempts to understand the very ethos behind the Medical Profession. The twentieth century events such as negligence on the part of the doctors, doctors strike, false medical reporting, drug abuse, sex selective abortions, euthanasia, human organ’s trade, human experimentation etc. have indeed forced us to review the ethical aspect of the medical profession.

Functionalists like Durkheim, Tawney, Carr Saunders and Wilson were of the view that the profession was rooted in its own culture i.e. its codes and ethics. Functionalists, for instance like Parsons believe in any ‘institutionalised’ means to make sure that professional competence would be put to a socially responsible use. The Marxist on the other hand, treated professional skill as a commodity with market value to be exchanged for money. The attributional theorists, for instance Greenwood, Maclver and others always include professional culture comprising of ethical codes as an essential attribute of professions. It could be deduced that professional culture encompassed within its fold, the values, norms, codes, symbols ethics, identities, knowledge, attitudes and such. However the ethics play a crucial role which comprises of a set of

3 S.M. Dubey, in Sheo Kumar Lal ed., op. cit., 1988, p. 34.
prescribed and proscribed norms and codes. It would also serve fit here to dabble with a little bit of history—both oriental and occidental, to perceive the evolution of professional ethics.

Social Genesis Of Medical Ethics

Medical ethics refers to the implications of the professional codes governing the social outlook of the profession. It is a particular discipline which analyses the specific way in which moral decisions are to be made within the medical field. Yet these codes could not be written down like the present day legal codes, thus the bare contours are sketched and the medical professional is expected not to transgress these.

The four basic tenets on which medical ethics are founded include firstly the 'principle of non-malfeasance': the doctor should never use his skills to injure a patient. Secondly, 'the principle of Beneficence': doctors should involve themselves in those actions which would prevent the patient from any harm and only provide for their benefit. Thirdly, 'the principle of autonomy': the autonomous decisions of the patient should be respected by the doctor. Fourthly, 'the principle of justice': the doctors should be just when they dispense their duties.

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8 Ibid., p.367.
The earliest available code of ethics was King 'Hammurabi's' code (2000 B.C) which declared "An eye for an eye and tooth for a tooth". This code of ethics hardly survived the flow of time. Another dominant trend was the 'Hippocratic tradition' in this field.

The modern western system of medicine was derived from the classical Greek physician 'Hippocrates', who belonged to the fifth century B.C. He combined in his rational method the observations of earlier day philosopher-scientists. He correlated the presence of disease with diet, race and environmental influences. His approach was a patient centered and doctor directed one. His method included the rational use of observation and study in the evaluation of disease. Hippocrates tradition negates the earlier belief that super-natural forces cause disease. Thereby his school of thought is often hailed as a victory of rationalism over superstition.

The 'Hippocratic' principle is clearly depicted in the Hippocratic oath which serves as an ethical guide to doctors even today. The oath is

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9 Ibid., p.366.
12 Jacob, op.cit., 1988, p.43.
13 Adler, op.cit., p.610.
sworn upon in all medical colleges after graduation even till date. It is a pledge on the Greek Gods, *Apollo* (the physician), *Aesculpices* (the Greek doctor), *Hygeia* (the Goddess of cleanliness) and *Panacea* (the Goddess of alternative medicine). The oath could be divided into two sections. The first is devoted to continuing the tradition of imparting knowledge to future generations with no stipulation. The next part of the oath is a collection of obligations and prohibitions. The first part of the oath expects the physician to consider those who taught him the art of medicine (his teachers) as his parents, the teacher’s children as his own brothers and sisters when they in turn come to learn this art from him, he is to teach demanding absolutely no fee.

The next part is made up of four types of obligations or prohibitions. Firstly, that the physician is bound to keep his patients safe from anything harmful or unjust. Secondly he is not to prescribe any dangerous drug and is not to take part in a women’s abortion process. Thirdly, physician may visit the sick at their homes, but is not to commit any injustice against women, men, slaves or freemen and is also strictly prohibited from any physical relationship with women. Finally, the physician is not to discuss the patient’s ill-health openly lest his enemies would make use of the information adversely. Yet, the oath has its own contradictions for instance, it prohibits abortions or any use of

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14 Refer Appendix No. 1 for the Hippocratic Oath.
contraception. However, abortion was a much practiced method of terminating pregnancy during the Hippocratic period.\textsuperscript{15} Nevertheless the \textit{Hippocratic} tradition was a rationalistic one.

However, in the middle ages (1100-1400 AD), the church was the supreme authority. The theologists and medical men were the only educated lot, during that period and there seemed to have existed a strong bond between the two. The disease was then considered as an outcome of divine displeasure. So much so, that they had in their times diseases named after their saints. These factors kept a check on the spread of the rational \textit{Hippocratic tradition}.\textsuperscript{16} Thus the Hippocratic tradition took almost a millennium to be accepted both in Rome and in Christiandom.

The \textit{Renaissance period} (1300-1700 AD) which followed the middle ages made room for the '\textit{nouveau riche}' and the self made gentleman. This period gave enough emphasis on scientific and technological innovations and expanded thinking. This by itself proved a pre-condition for the re-establishment of the '\textit{Hippocratic Physician}'.\textsuperscript{17} In the West, during this period the Hippocratic texts were expanded and used by the physicians. These Rules of Conduct were established in all medical schools by the fifteenth century. Benjamin Rush, Samuel Bard, John Gregory and

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\textsuperscript{17} Ibid., p.90.
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Thomas Percival emphasised on framing the moral codes for the medical profession in the eighteenth century. Thomas Percival’s writings served as an ample background for the American Medical Association’s Code of Ethics formulated in 1847. Worthington Hooker, Austin Flint and William Osler of the Nineteenth century dabbled to a great extent with medical ethics. Osler, suggested a brief course on liberal arts for physicians to enable them to efficiently enact their duties as doctors.

The twentieth century is known for its enthusiasm in medical research and technology. This led to a remarkable advancement in health care services. Yet it also raises some touching ethical issues. The Nuremberg trial of Nazi war was one such. These criminals were subjected to human experimentation. Thus, in 1949 The Nuremberg Code was established, as a direct outcome of the above trial. This code was expanded and took shape as the ‘Declaration of Helsinki’ (1964) of the world Medical Association. In the 1950s several non-physicians began to contribute to this field. The nineteen sixties and seventies threw more light on the autonomy of the patients. The nineteen eighties and nineties brought in, the obligations of social justice to the individual.

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19 Ibid., p.533.
20 Ibid., p.539.
The code of ethics is today expected to perform multiple functions for the medical profession. It is to keep competition between doctors under check, to insist that doctors practice within their accepted technical standards, to ensure that the patients gain more trust if the doctors are ethic bound, to add to the respectable status of the doctors, to provide professional power with which the medical profession could rationalise to, keep monopoly over practice and also toward off competitions from outside the profession especially from quacks. The supervisory process regarding the medical education and codes implementation is in the hands of the Medical Councils. In India, the Medical Council of India is the apex body of medical profession which was constituted to regulate medical practice and to uphold medical ethics in our country.

Medical Ethics in India

Medical knowledge in India was encouraged by two factors. Firstly, the interest in human physiology through Yoga and the mystical experience. Secondly, the growing Buddhist tradition between 600 B.C. and 200 A.D. also encouraged it. The Buddhist monk served as a doctor among the folk masses from whom he also begged his food. The monk based his practice on rationalism and negated the magico-medicine which was prevalent in the traditional Indian Society.

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22 A.L. Basham, The wonder that was India (New Delhi) p.501.
The Indian medical system is also bound by its own ethical codes. The ancient rules on professional behaviour were also laid down with great precision. These ethical codes in no way fall short of the ‘Hippocratic rationalism’.

Caraka, who belonged to the first and second centuries after Christ also refers to the discourse to be given to the pupils on completion of their apprenticeship, an excerpt of it follows...

...You must not betray your patients, even at the cost of your own life... you must not get drunk, or commit evil, or have evil companions... you must be pleasant of speech.... and thoughtful always striving to improve your knowledge. When you go to the home of a patient you should direct your words, mind, intellect and senses nowhere but to your patient and his treatment.... Nothing that happens in the house of the sick man must be told outside, nor must the patients’ condition be told to anyone who might do harm by that knowledge to the patient or to another.

In his ethical oath Caraka suggests that the physician ought to place the patient’s health much above the physician’s own life. Secondly it is expected that the physician ought to be a person of pleasant disposition and that he should shun evil company. Thirdly, the physician while visiting the sick at their homes should not divert themselves either by thought or deed but concentrate on their patient and the treatment. Caraka further also made it clear that neither the patients’ condition of

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23 Ibid., p.502.

24 Caraka, Samhita, iii, 8,7.
illhealth nor the state of affairs at his home should be discussed openly by
the physician. This oath runs quite on parallel lines to the hippocratic one.
Both these oaths consider the treatment of patient as the supreme most
important activity of the physician. This apart, in their unique ways, they
prescribe the physicians general conduct. These ethical codes of medical
profession are more or less the guiding principle for the different kinds of
medical treatment available to the masses in India.25

Inspite of India’s past glory in this field, the first medical
practitioners as professionals came to India from the West. Firstly, it was
the Portuguese, in 1648 at Goa where they established the first modern
hospital. The French and British followed next in line to the Portuguese
and carried the western system of medicine to the remote corners in India.
With time the British overtook both the French and the Portuguese to a
large extent.26

The British system of medicine brought the English doctors to serve
the British Personnel in India. The English doctors initially kept away
from the Indian medicinemen whom they referred to as native dressers
and black doctors. The Indian practitioners began as compounders and
dispensers of drugs. Thus they got themselves gradually associated with

25 For a detailed description of the different systems of medicine and the process
of formation of medical profession in India refer to chapter two from pages.

26 D. Banerji, "Class Inequalities and Unequal Access to Health Services in India",
the English doctors. The formal training in Native Medical schools began in 1822 at Calcutta and in Medical Colleges at Madras and Calcutta in 1835. The Professional Medical College for Indians was established in 1845 at Bombay. The Medical Council of India was established in 1933 which has been responsible since then, to maintain the minimum standards level. The council has its representative organs at the state and district levels.  

The Indian health policy which was schemed by the British colonialists was far from the services demanded by the prevalent health condition of the masses. The health services in all the British colonies suffered the fate of being subservient to the imperial policy of promoting economic growth. Thus, the colonies were rushed into the colonial health culture from the pre-industrial one.

Pre-Independence Scenario of the Health Care Facilities

The dominant systems of medicine during the colonial period were the traditional ones. These systems had no preventive characteristics and its effectiveness for controlling diseases was very slow and inadequate that the peoples healthcare was minimal and far from the actual requirement.

To add to the situation two hundred years of colonial rule left almost every walk of India's life subordinated to the commercial, political and

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administrative interests of the ruling power. When India gained independence, its political, economic and social fronts left it festered with a variety of maladies. The medical services on the other hand were scattered and inadequate. Yet, the medical services were essential for the survival of the British army and their civilian personnel. Later, these services reached the natives, but only a tiny elite population could avail of its services. Among the rest of the population which constituted more than 90% of the total population, only a small portion of the population availed medical services from Government dispensaries, missionaries, philanthropic and other private institutions. Public health services were provided only during outbreaks of epidemic diseases like plague, cholera and small pox and not during normal circumstances. Thereby the health services in the country were gravely inadequate, for instance, in the United Provinces, there was just one single institution which served a population of 105,626 inhabiting 202 villages. The number of beds available were 73000 or 0.24 per 1000 population. The ratio of health personnel was also very less, for instance one doctor was available for a population of 6000 and a nurse for every 43000 persons a health visitor for every 4,00,000 persons one midwife to 60,000 one qualified pharmacist for

29 Ibid., p.9.
4,000,000 and one dentist for 3,00,000 persons.\textsuperscript{31} This paltry health service was to a great extent schemed by the personnel of Indian Medical Service (IMS) of the British Indian Army.\textsuperscript{32} Such a system of health service reflects the imperialistic attitude of the ruling British. These services were also far from those demanded by the National Movement. The Health Survey and Development Committee popularly known as the Bhore Committee was constituted in 1943 by the British Colonial authorities. The committees' report which was subsequently submitted in 1946 formed the basis of the comprehensive Health Service system schemed after the country gained independence.

Though the Bhore Committee was set up by the British colonial authorities, it was greatly influenced by the national movement. The committee's impact is clearly evident in post independent India's health services. Independent India thus began to implement its comprehensive rural health services through the Primary Health Centres (PHC). Despite such sincere efforts, had the Indian elites are still ruling over the masses even after independence. In the health services for instance, the rural health services receive lesser attention when compared to the urban health services. The Primary Health Centres in the villages are also inaccessible to the village masses. The Auxillary Nurse cum Midwives

\textsuperscript{31} Ibid., p.5.

(ANM) illegally charge money for their services. Thus these services never touch several Harijan women (the lowliest of the low) in the Indian villages.33

Health Services in the Post Colonial Period

The leaders of the post colonial period are forced to commit themselves to the report submitted by the Bhore Committee (1946) and Sokhey Committee (1946) - a sub-committee on National Health. The post colonial period is earmarked with the setting up of the Primary Health Centres (PHC) in 1952 to provide integrated health service as a part of the wider Community Development Programme (CDP). This programme comprises of a socially oriented medical education, campaign against communicable diseases, population control, provision of potable water supply, improving nutrition, promoting the indigenous system of medicine expansion of the network of rural health service, deployment of multi-purpose workers and such. Thereby, a strong basis for an enormous infrastructure was paved. 725, PHCs were established in the first plan (1951-56) period and several campaigns against communicable diseases such as Malaria, small pox, tuberculosis, leprosy, filariasis and trachoma were carried on.34

The second five year plan (1956-61) further emphasised on a well


defined health plan. The emphasis was to fight against the communicable disease and to raise the health standard of the masses. Thus, the Government involved its personnel in a variety of training programmes, strengthened its public health institutions and improved the sanitation facilities. Training programmes for the ancillary personnel, health education for both the masses and the students and more allocation for research in the field of medical education were also stressed upon here. Family planning programmes were also introduced during this plan period. Several Family Planning centres were established in several parts and around 549 clinics were established in the urban areas.  

The infrastructure for health had definitely improved, for instance 8600 hospital dispensaries with 1,13,000 beds in 1951 were increased to 12,600 hospital dispensaries with 1,85,600 beds in 1960. The Mudaliar Committee was set up in 1959 to review the existing infrastructure and its functioning and to improve the health facilities at the district level. The committee in general suggested consolidation and integration of the health infrastructure. It further recommended that PHCs should be expanded to provide a midwife supported by an auxiliary healthworker for every 5000 to 6000 rural persons.

[36] Ibid., p.652.

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The **third five year plan** (1961-66) broadly aimed at a progressive improvement of the health services, to ensure a minimum physical well being and to provide for greater efficiency and productivity of the work force. Emphasis was on the preventive public health services and family planning. A target was fixed to provide drinking water for villages by the end of the third plan. Other programmes such as Malaria and Small Pox eradication were commissioned along with the control of communicable disease. To start with, the drainage programmes were undertaken in the urban areas.\(^{38}\) As the plan was in progress, the **Chedah Committee 1963** was set up to review the maintenance phase of the National Malaria Eradication Programme. This committee later suggested that the basic health workers were to be appointed to collect vital statistics about Malaria and family planning.\(^{39}\)

The **Mukherjee Committee** was set up to review the family planning programme. The family planning programme was implemented in 1961 as part of the health programmes. This committee suggested an integration of the mother and child health programme with family planning, in consideration of a direct link between the infant mortality and the acceptance of the small family norms. The committee also

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recommended a vertical programme for family planning with separate workers.\textsuperscript{49} The period which followed, that is 1966-69 was worked out with Annual Plans. \textbf{The Jain Committee} (1968) emphasised the integration of the personnel of different health services and organisations on the basis of their work. \textbf{The fourth plan} (1969-74) emphasised on a target oriented family planning programme especially with the use of \textit{intra-uterine device} (IUD). The plan also stressed on water supply and sanitation. The Committee on multipurpose workers was formed to review the co-ordination of all these programmes in 1972. The committee suggested measures to integrate medical, public health and family planning services at the peripheral level and also the feasibility of having multi-purpose or bi-purpose workers for the same.\textsuperscript{41}

The \textbf{Kartar Singh Committee} 1973, suggested that the ANMs should be replaced by newly designated ‘female health workers’. The committee also prescribed that the basic health workers, malaria eradication assistants and family planning health assistants should be replaced by the new male health workers. Thereby during the fourth plan period, there emerged a major reorganisation and redesignation of health

\textsuperscript{40} Government of India, (1965), \textit{Report of the Health Survey and Planning Committee, Mukherjee Committee}, New Delhi, Ministry of Health.

personnels without increase in the allocation of fund for the health sector.\textsuperscript{42}

The fifth five year plan 1974-79 was launched when the planners realised the failure of a coercive method of family planning and health programmes. Thus family planning and health programmes were made a part of the 'Minimum Needs Programme'. With the declaration of emergency these measures were neglected, this thereby led to the resurgence of communicable diseases.\textsuperscript{43} The Srivastava Committee (1975), suggested improvisation in the health services and medical education. It further emphasised the creation of para-professional and semi-professionals. It also envisaged that in the sixth plan, a male and female worker should cater to every 5000 population. It was felt that the preventive health care services did not reach the masses. Since the larger section of the rural populace could not receive modern medicine, it was taken under consideration to improve the local-indigenous medicine as an alternative. It was with this intention that a 40 crore allocation was made by the centre during the seventh plan for the expansion of the traditional medical systems. An allocation of 60 crore was made for the traditional system of medicine including Homeopathy for the plan period of

\textsuperscript{42} Government of India, (1973) \textit{Reports in the Committee on Multipurpose Workers, (Kartar Singh Committee)}, New Delhi, Ministry of Health.

Thus the allocation here encouraged the practice of traditional system of medicine, yet, there were hardly any measures to integrate both the existing system.

In an attempt to redeem the rural poor from their paltry system of health services, the Government of India in 1978, decided on a 'People's Health in People's Hands' programme. This emerged just before the 'Alma Ata Conference' of the 'World Health Organisation' in 1978. This programme included, integrated services, basic minimum package of interactions, deployment of appropriate technology and also the utilisation of traditional system of medicine. The programme also subscribed for a 'Community Health Guide' and a trained dai for every thousand persons, a sub-centre assisted with a female and male 'Multipurpose Health Worker' for five thousand people, a Primary Health Centre for every 30,000 people and a 25 bed hospital for 1,00,000 people called a Block Health Centre. The committee however made a sincere attempt at vivid planning of health services at all levels such as central, state, district and other rural areas.\(^4\)

Such acts though improved the existing health care services, was found to be inadequate in several ways. It was further felt that a

\(^{44}\) Government of India, (1975), *Health Services and Medical Education: A Programme for Immediate Actions Report*, Shri Vastava Committee, New Delhi, Ministry of Health.

comprehensive approach was the need of the hour that would integrate medical education, research and health services. The National Health Policy 1981 was thus formulated by the Government of India, the major aim of which was to take the health care service nearest to every door. The policy suggested the restructuring of health services on preventive, promotive and rehabilitative aspects of health care and the need of a comprehensive approach. It also suggested the involvement of the community in its programmes and specified well determined goals to be achieved. The seventh plan (1985-90) thus took note of the goal of health for all by the year 2000 A.D. It was proposed herein, that PHC would continue to be the basic foundation to attain this goal. The preventive and promotive aspect of health care service was to receive special attention in this plan. It is to be observed here that these aspects were suggested well in advance by the Bhore Committee (1946). It was proposed in the plan that the Minimum Needs Programme would try to effectively co-ordinate the health and health related services to ensure a comprehensive approach.46

The eighth plan (1992-97) aimed at a package programme that is to deliver the health care service through a package of different programmes that comprised of other social service programmes, secondly

to provide special support for the control of leprosy, malaria and kala-azar,thirdly to decentralise planning and implementation process to the state and local levels and keep the process of training, research and information collection at the Central Government level, fourthly to structurally modify the medical education and finally to incorporate simple inexpensive methods and remedies from traditional system of healing.\textsuperscript{47}

The eighth plan has had its own limitations as pointed out by Ritupriya (1990) that, for the last forty years in the health service plans special programmes for dis-interventions were followed with integration into packages. This integration process was only a superficially formulated one and the packaging of health service with other social services as suggested here is also in the same direction. The plan lacked a skillful means of tackling common clinical problems of the mass in general.\textsuperscript{48} To have a more detailed picture of these health plans, certain major programmes are focussed upon individually.

**Vertical Programmes**

Communicable diseases formed a major part of India's health problems and each of these are tackled with separate mass camps. As a result there are a separate programmes against malaria, smallpox, tuberculosis, leprosy, filariasis, trachoma, and cholera. These


programmes are called so because they all had a single purpose and are carried over throughout the country, with a single command from the national to the village level. These campaigns also have high technical support with DDT, BCG and smallpox vaccines, x-ray units, chemotherapeutic drugs etc... 49

**Primary Health Centre**

The Primary Health Centres were established in October 1952 as part of the Community Development Programme (CDP). The CDP is based on the objective of reaching multifaceted development schemes to the rural populace in the fields of agriculture, rural industry, education, social organisation, communication, transport, nutrition, sanitation, water supply and other such services. These are set to action with firstly, an extended education programme, secondly, community self-help and thirdly Government action. The PHC's inter-sectoral approach with the help of community participation was in fact visualised way back in the pre-independence period by the Sokhey Committee (1942) and Bhore Committee (1946). The PHC was to integrate the health services of curative, preventive and promotive care services. The major functions of the PHCs are firstly medical care, secondly control of communicable diseases thirdly promotion of maternal and child health, fourthly collection of vital statistics, fifthly protection of water supply and promotion of

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environmental sanitation, sixthly conducting school health programmes and later the family planning services.\textsuperscript{50}

Currently, the country has 21693 PHCs 131900 subcentres and 2289 community Health Centres.\textsuperscript{51} The rural area is further catered to by 11080 dispensaries with 13000 beds, 4310 hospitals with 122109 beds.\textsuperscript{52} The PHCs were formulated as the backbone of the State's health service programme. In a later section, the actual working of these centres will be analysed.

\textbf{Social Orientation of Medical Education}

An effort to introduce social orientation in medical education was initiated in 1952. This was initiated alongwith imparting training to the health workers regarding the prevailing conditions of illhealth in our country. In this regard the Government of India upgraded the existing departments of preventive and social medicine throughout the country. This was done to provide a wider academic base than the conventional courses taught on public health and hygiene. The Medical Council of India also reschmed the entire course of medical education with a social orientation.\textsuperscript{53}

\textsuperscript{50} Ibid., p.25.


Indigenous Systems of Medicine

The British policy vigorously withdrew all support to the existing traditional systems of medicine after 1835. Thus there was a gradual decline in the existing systems of traditional medicine. After independence though the Indian medical system was based on the British model, our leaders showed concern to develop these systems of medicine. There has been a spate of grants for supporting their educational institutions and providing service to the people at large. As a result of all these efforts, Medical care facilities have improved to a considerable extent under the Indian system of medicines. Today there are, 2054 Ayurvedic hospitals and 13183 dispensaries, 170 Unani hospitals and 947 dispensaries, 108 Siddha hospitals and 310 dispensaries, 18 Naturopathy hospitals and 7 dispensaries, 275 homeopathy hospitals and 900 dispensaries which serve the country.

Family Planning Programme

The National Family Planning programme was initiated in 1951 with a clinical approach and its extension approach was adopted in mid sixties. This programme gradually extended into a community oriented service network by late seventies. It was made a part of the health


package scheme particularly the maternal, child health and nutrition activities. Since the plan has been implemented, the birth rate declined from 41.2 per thousand in 1971 to 28.9 in 1991-92 and is also projected to decline to 25.72 (1996-97). The fertility rate dropped from 5.2 per thousand in 1971 to 3.5 in 1993. The infant mortality rate declined from 129 per thousand live births to 73 in 1994. The annual population growth rate worked out to 2.14% during 1981-91 which is marginally lesser than the 2.22% of 1971-81. The central plan out lay for the programme has been raised up from Rs.1000 crore in 1992-93 to 1581 crore in 1995. There has also been a rapid increase in the allocation of funds for the programme. The programme emphasises voluntary involvement of people and aims to take the programme to every doorstep. It also stresses to integrate the programme with other medical and public health services, such as the Universal Immunization Programme (UIP), Child Survival and Safe Motherhood (CSSM) and Pulse Polio Immunization (PPI).

Water Supply and Sanitation

To improve the health status of the community it was realised that along with the health care services and programmes it was necessary to have a protected water supply, environmental sanitation and hygiene.

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Since contaminated water is a source of water borne diseases like typhoid, jaundice, diarrhoea, dysentery, cholera and other such ailments, special national programmes for water supply had been launched as part of the CDP. Yet the budget allocation for this programme is a modest one, often spent on the urban areas. It is only in 1974 that the allocation was beefed up especially during the fifth and sixth plans.60 24000 new villages and 1.17 lakh habitations have been identified as those with "No Source" of water and 1.98 lakh villages as "Acute Quality Problem" villages by a recent survey of 1991-94.61 By 1994-95 the 24000 "No Source" and 47000 partially covered villages are reported to have been covered by the water supply facilities. The drinking water supply for the population has increased from 56.3% in 1985 to 73.9% in 1990 to 82.8% in 1995 in the rural sector. In the urban areas also the supply for the population has improved from 72.9% in 1985, 83.8% in 1990 to 84.9% in 1995. Further, it has been envisioned that about 55.9 thousand "No Source" and 31000 "partially covered" villages apart from the 146 problem villages in the 1985 list, were covered. Thus making the total target as 86.7 thousand villages would be covered during 1995-96. The sanitation facilities also improved for the population from 0.7% in 1985 to 2.4% in 1990 and to 3.59% in 1995 in the rural areas. In the urban areas the facilities increased from 28.4%
in 1985 to 45.9% in 1990 and finally to 47.9% in 1995.62

Nutrition

The major highlights in the field of nutrition are the mid-day meal programme for children, a supplementary nutrition programme and an extensive integrated child development programme. These have been in operation since 1975. These programmes are meant to benefit pregnant women, lactating mothers and pre-school children. These programmes are meant not only for nutritional supplements but also serve to render education to the pre-school children, non-formal education to the mothers and also make available, the provision of preventive and curative health services.63

Minimum Needs Programme

This is a package programme of Minimum Needs. covering areas such as health, nutrition, environment, water supply, elementary and adult education, roads and electrification in rural areas and housing for landless labourers.64 This package programme is schemed because the planned development did not have an adequate impact on the needs of the poorer section.65

62 Ibid., p.181.
The Multipurpose Workers Scheme

The Multipurpose Workers Scheme was established in 1971. It was initially meant to function as an *Unipurpose Scheme*. The unipurpose workers were engaged in a single, specialised health condition services. They were later trained to function as 'multipurpose' workers in 1971. This scheme had a female and male worker for every 5000 persons. It provides an integrated package of service of medical care such as maternal and child health services, family planning service, Malaria eradication, control of communicable diseases, environmental sanitation, collection of vital statistics and health education. This scheme helps in the merger of the several vertical mass campaigns into an integrated health care delivery system, this has in turn strengthened the existing PHCs.\(^{65}\)

The Community Health Volunteers Scheme

The main idea behind this scheme is to entrust people's health in people's hand. A volunteer is encouraged to represent a 1000 people and is entrusted with the responsibility of improving their health condition.\(^{67}\) In its true spirits this programme encourages self-reliance among the community by training one among them as a volunteer. This scheme was recommended way back in 1942 by the Sokhey Committee. When India was herself involved as a signatory in the Alma Ata declaration (1978) it

\(^{65}\) D. Banerji, op.cit., 1985, p.28.

further helped in processing the programme. Further, India's declaration to attain Health for all by 2000\textsuperscript{68} and her subsequent plan of action, fall within the gambit of this programme.

These are some of the major landmark programmes alongwith the different health policies of the Government. The other programmes are Immunisation, Leprosy Eradication, Malaria Eradication etc., Apart from landmark programmes, we shall in the next succeeding section take a brief view on the nature of diseases, causes of death and the pattern of change in the recent years. This will help to analyse the policy and its influence on the medical professionals. The diseases are discussed in the following major grouping such as (i) water borne diseases, (ii) communicable diseases and (iii) vector borne diseases.

**Water borne diseases** include dysentry, gastroenteritis, cholera, guinea-worm and such. The cholera cases increased from 5813 in 1985 to 9437 cases in 1993. The deaths due to cholera however reduced from 154 in 1985 to 53 in 1993. The Acute diarrheal cases including gastroenteritis stood at 9528087 and 6499 deaths in 1992. The guinea worm cases have come down from 39790 in 1983-84 to 20,000 in 1990-91. The other diseases are thyroid hormonal deficiency and such.\textsuperscript{69}

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\textsuperscript{69} Government of India, op.cit., (1993), pp. 135-149.
The **communicable diseases** such as diphtheria cases stood at 6810 cases and 458 deaths, for Polio, the cases were 9390 and 230 deaths, Tetanus-neonatal, the cases were 6687 and 815 deaths, Tetanus-others, the cases were 12023 and 1765 deaths, whooping cough stood at 61848 cases and 47 deaths. Measles at 92297 cases and 838 deaths, ARI at 11058759 cases and 2979 deaths, Pneumonia cases were 434439 and 3192 deaths, Enteric fever, cases were at 352980 and 735 deaths, Viral Hepatitis cases were 98047 and 1268 deaths syphilis recorded 53330 cases and 24 deaths Dogbites / Rabies stood at 12291 cases and 640 deaths in 1992.\(^7\)

The vector borne diseases:- Malaria has been on the increase since 1961 when it recorded 49000 cases to 6.5 million in 1976 to about 1.89 million cases in 1990. The rise is a characteristic phenomena inspite of the National Malaria Eradication Programme since 1960. The plan of operation of this eradication programme was further modified in 1976. 30% of the Malarial cases and 60% of the dangerous P. falciparum infections are found to be prevalent in the tribal areas, which calls for a more intensified approach to be carried out in these areas.\(^7\)

Kalaazar and Japanese Encephalitis emerged as two major health problems. Kalaazar recorded about 57742 cases and 606 deaths in 1990

\(^7\) Ibid, pp. 159-164.

\(^7\) Government of India, op.cit., 1993, p.326.
which increased to 77,102 cases and 1,419 deaths in 1992. This is inspite of the twin approach followed by the Government firstly, vector control by insecticide spraying and secondly, by case detection and treatment rendered at PHCs and referral hospitals. Japanese Encephalitis on the other hand, declined from 2,916 cases and 1,291 deaths in 1990 to 1,420 cases and 481 deaths in 1992. This decline is mostly due to the indigenously produced vaccine. AIDS, emerged as yet another recent public health problem, the reported cases of seropositives have increased from 137 in 1987 to 7,272 in 1992. This apart the STDs have a recorded case of 11,417,40 in 1990. Thus these have posed a severe public health problem to be solved.

The morbidity indicators such as the infant mortality rate went down from 129 to 74 per thousand live births in 1993. The neo-natal mortality rate dwindled from 67.2 in 1983 to 52.5 in 1990. The post-natal mortality rate also reduced from 37.7 to 27.2, and so was the case with the peri-natal mortality which shifted from 53.6 to 48.4, from 1983 to 1990. The still birth rate increased from 9.3 to 11.8 from 1983 to 1990. The crude birth rate stood at 36.9 per thousand population per annum, in 1971

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72 Government of India, op.cit., 1993, pp.141-142.
73 Ibid., p.142.
and at 28.5 in 1993. The crude death rate decreased from 14.9 per thousand population per annum to 9.2 in 1993.76

The Health policy and programmes stand now to be analysed against the existing scenario of deaths and diseases. Inspite of the increased medical facilities we are still placed with a high rate of mortality especially among the women and infants. Communicable diseases are yet to be brought under effective control before total eradication. Non-communicable diseases still have a high incidence. The potable water supply and basic sanitation though improved is not to be overlooked. The illiterate mothers and a large number of malnourished families also add on to the dismal health situation. This apart, a core of medical services are concentrated in the urban areas and the system provides lesser access to the poor and rural populace.

Analysis

The health service system as seen in the above plans and programmes is riddled with inequalities. It is characterised with an unequal distribution of resources, with an unequal access to the health services, thirdly of unequal participation and finally of unequal health status.77 An unequal resource distribution refers to the unequal distribution between the rural and urban areas for instance, we have only

76 Ibid., p.37.

77 Imrana Qadeer, Health Services System in India: An Expression of Socio-Economic Inequalities, Social Action Volume 35 July-September 1985, p.204.
31.5% hospitals catering to the rural populace of 74% as against a 68.5% catering the urban populace of 26%.\textsuperscript{78} Inspite of a constantly enlarging health service scheme, it is still not found accessible to a large poor rural populace, for instance in D. Banerji's study it was observed that the village upper classes were in good terms with the Auxillary Nurse cum Midwives (ANM). Thus the later attended to their needs personally and ignored her duties toward the majority of the rural populace.\textsuperscript{79} Their inequal participation is dealt with in two ways, firstly by involving the recipients of these services, that is the community at large in the process of planning and evaluation of the health service schemes, secondly by involving the peripheral staff in this process.\textsuperscript{80} Inequality in health status refers to the class based differences in the context of health status. A study in Punjab villages reflected that the Harijan children have higher morbidity rates and also ranked higher in the prevalence of malnutrition than the children in Jat families.\textsuperscript{81}

It could be further deduced that the health system lacks an epidemiological approcah, It is rather based on inappropriate technology,
with an organisation which worked from above and its hierarchical structure matched with the existing social hierarchy.\textsuperscript{82} Thus the health services requires, an epidemiological approach which should be community based medicine with emphasis on a socially oriented technology and finally revamp the organisation and management of the health services.

An epidemiological approach refers to a scientific study of spread and control of a disease. In the Indian context it implies a curative and preventive approach. It also means an effective allocation of funds, in the sense there should be more allocation for public health expenditure which covers water supply, sewerage, sanitation facilities, control of diseases, health education, research and statistics. It has also been noted that emphasis on prevention and cure has been distorted, for instance, malnutrition, diarrhoea, pneumonia and other communicable diseases have received lesser allocation than other neurological and immunological cases.\textsuperscript{83}

The health services is required to be community based since it is often believed that the health behaviour of the people is a part of their overall socio-cultural milieu. The health situation, hygiene conditions, medical facilities, the interaction between doctor and patient, values and ethics of medicine, personal and collective health all go to influence the

\textsuperscript{82} I. Qadeer, op.cit., 1985, p.209.

\textsuperscript{83} Ibid., p.211.
socio-cultural milieu. Thus a community based health service is needed since it formed the necessary matrix for the health services to be launched.

Technology in the field of health services is inevitable but it should be borne in mind that it should be used both at the curative and preventive levels and that the limits of such a technology should be remembered against the social roots of the diseases in the Indian context. At both the curative and preventive levels the Indian health services have undue reliance on technology. At the curative level we opted for scanners, heart-lung machine and other expensive technologies especially in urban institutes. On the other hand, the other peripheral institutions both in the urban and rural areas are left bare with almost no elementary equipments. In the preventive field also, India often opts for more technical ways of handling the diseases like, for instance DDT, IUD, Vaccines, drugs such as Hetrazan, Tetracycline etc... instead of resorting to medical services relevant to the existing socio-economic conditions. The indiscriminate use of technology has a telling effect on manpower development and organisational forms within the health system. India needs more paramedical staff, instead, the system has produced more doctors and specialists. Thereby, only a few professionals could go to the field and meet the majority of the populace who are inflicted more with parasitical

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diseases.\textsuperscript{85} A socially oriented technology would mean an effective juxtaposition of technology according to the socio-economic needs and conditions of the community.

The organisation and management of health services are found to be effective at the top level while the peripheral organs remained rather weak and illequiped. This makes the organisational set up rather insensitive to the health needs of the majority.\textsuperscript{86} Thus for an effective dispersal of the health services, there ought to be a strong district level organisational set up with a well equipped PHC, CHC and SC array of organs.

The promulgation of \textbf{Structural Adjustment Policy} (SAP) in the early nineties has had its own effect on the health services. The main effects are, a cut in the welfare investment which led to stagnation and dismantling of public health services, introduction of fees in public institutions which makes the services inaccessible to the poor, thirdly it handed over the responsibility of health service to the private and voluntary sectors and thereby undermined the rationality of public health. The voluntary sectors concentrate only on those areas where international aid is made available and the private sector focussed only on the curative care. Fourthly, the basic services suffered, yet the family planning programme receives funds from both home and abroad, thus it emerged

\textsuperscript{85} I. Qadeer, op.cit., 1985, pp. 211-212.

\textsuperscript{86} Ibid., p.213.
as a single most domineering health programme. The approach also shifted from an intersectoral one to a technocentric strategy to control the fertility of women. Finally the secondary and tertiary level of public medicare had declined in its services with an inequipped array of PHCs.  

**An Overview**

There are a few points worthy of note at this juncture:-

(i) The same type of health policy is pursued throughout the country thereby overlooking the local needs, socio-economic background and in short the socio-cultural milieu of different regions. This has emerged as a serious impediment against the health services.

(ii) The inaccessibility to the health services is due to the rural-urban bifurcation. This could be tackled with, by improving the health service system at the grass roots level with particular emphasis on the PHCs. (iii) The poor have had less access to the health services in comparison to the rich.

(iv) The perspective of our health plans should focus on the health status rather than merely to tackle the disease which stands badly in need of a wider perspective.

(v) Social Orientation of medical education should be made a definite goal rather than tacitly mentioned in the planning process. Thus there should be more focus on public health and medical research.

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Health services also need to have an intersectoral perspective to have a holistic approach to the problems afflicting the society. This would serve to protect the society against the surging epidemics and several such disasters.

The health services schemes should also use appropriate socially oriented technology: avoid unessential expensive technological gadgets, use effective methods and also substantiate with the available indigenous methods and medicines.

The medical services thus turned out to be an exclusive service. In this social context, the current venture attempts to perceive, the very ethos behind the medical profession. Thus the kind of medical professional the health services has created needs to be looked into. The study therefore tries to understand the ethical systems of the medical professionals. To understand this problem, the following three variables are considered:-(i) 'the commitment aspect', (ii) 'the service orientedness' and (iii) 'the belief of the medical professionals in a patient redressal system'.

**Professional Commitment of the Respondents**

The empirical data generated by the study reflects a general trend of less professional commitment among the medical professionals. The majority of the respondents (44%)

\[88\]

Refer table No. 4.1 for a detailed presentation of the quantified data.
committed to their profession. To analyse further, the difference between the two categories of medical professionals is also presented that is, the Scheduled Caste and the non-Scheduled Caste respondents. The majority of the non-Scheduled Caste respondents (65%) believe that doctors consider the profession as a business, whereas only 23% of the Scheduled Caste respondents felt so. One of the Non-Scheduled Caste respondents opined....

Case C1

Doctors are mostly a money minded lot. Most of them had absolutely no interest to serve the nation. They detested serving in rural areas. The younger doctors are mostly obsessed with entrance exams for a post graduation programme in American and other European Universities. They feel that it would help them earn more.

In the above case the degeneration of the medical profession is depicted. The doctors never seem to have taken interest in serving the rural population. The younger doctors on the other hand, as observed during the field study they are immensely impatient to leave the country. This is their prime concern which they believed would ultimately help them earn more money. Thus their ultimate goal is to earn money as a doctor and not to administer Health care to the society. Another senior non Scheduled Caste respondent comments about the current status of the medical profession...

Case C2

It is today no more a noble profession. Doctors are greedy and selfish.
<table>
<thead>
<tr>
<th>Professional Commitment Group</th>
<th>Committed</th>
<th>Partially Committed</th>
<th>Not Committed</th>
<th>Considered it as a Business</th>
<th>Cannot Say</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled Caste Respondents</td>
<td>41</td>
<td>20</td>
<td>8</td>
<td>34</td>
<td>47</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>(27.3)</td>
<td>(13.3)</td>
<td>(5.3)</td>
<td>(22.7)</td>
<td>(31.3)</td>
<td>(100)</td>
</tr>
<tr>
<td>Non-Scheduled Caste Respondents</td>
<td>5</td>
<td>36</td>
<td>5</td>
<td>98</td>
<td>6</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>(3.3)</td>
<td>(24)</td>
<td>(3)</td>
<td>(65.3)</td>
<td>(4)</td>
<td>(100)</td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
<td>56</td>
<td>13</td>
<td>132</td>
<td>53</td>
<td>300</td>
</tr>
<tr>
<td></td>
<td>(15.3)</td>
<td>(12.6)</td>
<td>(4.33)</td>
<td>(44)</td>
<td>(17.7)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Source: The above data was obtained from the field survey.
Note: Figures within the bracket indicate percentage.
This statement of opinion further clarified the greed for more money and wealth, which was also stated in the earlier case. It also emphasises the fact that doctors are selfish. The earlier case for instance, also depicted the phenomenon of preferring urban based jobs or posting in the health services. It also highlights the fact that doctors selfishly wanted to leave their country to reach other developed nations merely to make money. They are unmindful of the investment of the State in their technical education. This talks volumes not only of their selfishness but also of the loss to a developing nation in its investment in producing a medical professional. Another senior Non Scheduled Caste professional is of the view that.

Case C3

Corruption and Commercialism, are our current national evils, these have also crept into the profession. The younger doctors are relatively more committed. They start off as committed professionals but, the older they grow more the money they want to make. He gradually indulges in malpractices. This is also because corruption and commercialism seem to be the order of the day.

The earlier cases presented younger doctors as those shunning rural postings to urban ones, ignoring the duty of serving the nation, leaving the country for European and American Universities, yet, according to Case C3 young doctors are found to be comparatively more committed. The case also points out that such mal-practices are encouraged by corruption and commercialism which are found to rampantly exist in our society. As the
tabulation shows there are only 23% of the Scheduled Caste respondents who believed that the profession is degenerating into a business. An young Scheduled Caste doctor differs from the above mentioned opinions, he is of the belief that....

**Case C4**

Competency has increased and doctors are more professional in their approach to their patients.

Thus in this case the Scheduled Caste doctor is of the opinion that the professional character of the doctors has increased greatly and so also their competence. This not only counters the argument that the medical profession is degenerating into a business but also qualifies the doctors with high professional calibre and character. In total, 27% of the Scheduled Caste respondents feels that the medical professionals are a committed lot, on the other hand, only 3.3% of the non Scheduled Caste respondents opined the same.

This disparity of opinion between the two categories invite further examination. The majority of the respondents (44%) consented to the degeneration of the medical profession into a mere business. The Scheduled Caste respondents on the other hand, present a highly professional character of the profession as against the over all majority of the sample. This could be due to their varied backgrounds, to analyse this aspect we shall take into consideration a few important variables. They are, firstly
the familial income level, secondly the respondents’ fathers occupation. The familial income level shows a great variance between the two categories. The scheduled caste respondents are equally distributed between the categories of Hand to Mouth existence, just sufficient, moderate and comfortable. The non-Scheduled Caste respondents are on the other hand, concentrated in the moderate and comfortable categories.

The respondents father’s occupation also shows great variance between the two categories. Among the non-Scheduled Caste respondents a majority of their fathers were Government officials and professionals which is not the case with the Schedule Caste respondents. The scheduled caste respondents were mostly first generation doctors. 19% of the non-scheduled caste respondents fathers were professionals and only 4% of the scheduled caste respondents fathers were professionals, among these only 2 respondents were children of doctors against 15 of them from the non-Scheduled Caste category. It could be interpreted here that the Scheduled Caste respondents are still in the socialisation process within the profession. Since they are mostly first generation doctors and are not so well off, the Scheduled Caste respondents are still in the initiation

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89 Refer table no.3.6.
90 Refer table no. 3.7.
stage. Thus, they are more interested in presenting a highly committed picture of the professionals.

The Scheduled Castes are very conscious of the impressions they create. This could also be explained with other instances. One of the non-Scheduled Caste respondents is of the view that...

Case C5

The scheduled caste doctors are mostly bothered about their social status. Being a doctor would definitely bring them more respect in the society.%

The Scheduled Caste respondents are thus creating a status for their profession and inturn for themselves when they present a highly professional characteristic of the medical profession. This apart the varna system of hierarchy placed the Scheduled Castes at the bottommost strata. The Scheduled Caste medical professionals, thereby achieved only an economic upliftment. The Scheduled Caste respondents thus have a strange mix of both ascribed and achieved status. An ascribed status rendered by the varna system helped them to achieve the status of a qualified medical professional with the help of the State’s policy of positive discrimination.%

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91 The Schedule Caste Respondents had more representation from the not-so-well-off categories for more details refer table 3.4 in chapter three.

92 We have dealt with the aspect of positive discrimination in great detail in chapter six.
The Scheduled Caste respondents thus create an impression about the medical profession as a highly professional category. Thereby they strive hard to create a respectable status for doctors in the society, much more than what is in reality, as observed during the field study. They seem to be pre-occupied with their status as medical professionals and found it imperative to present themselves, as much more professional than they came across during the field study.

This could probably be explained more clearly with Erving Goffman's concept of Impression Management. E. Goffman used six dramaturgical principles to understand the social world. In his principles of Impression Management, he stated that individuals indulge in the act of deliberately creating impressions which occurred during the process of interaction. His thesis presents 'two selves' of the 'self-as-performer' and 'self-as-character'. He symbolises the person as a "peg" over which something of collaborative manufacture will be hung for a time. This framework did receive a lot of criticism.

Probably it could be interpreted here that the Scheduled Caste respondents indulge in Impression Management since they credit more

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94 Goffman was primarily criticised since this concept ignored the motivation and goal orientation aspect of the individuals involved in social acting and his dramaturgical method has had no core idea. Most of the important criticisms point out that Goffman's dramaturgical method is inadequate in that it seems to overlook the intentions of the actors and that the notion of two selves rushed itself as a solution over the phenomena of social acting.
professional commitment and high professional calibre to the medical professionals. Thereby they attempt to create a highly respectable position and emphasis a higher status to the medical profession which is observed to be business oriented by the a majority of the non Scheduled Caste respondents and in total by a majority of both the category of respondents.

The prime motivation of the scheduled caste respondents or the 'goal' in presenting such impressions could have been to balance their lesser ritual status accorded by the varna system of hierarchy which does not include the Scheduled Castes. The study looks into the intentions of the Scheduled Caste respondents when they indulge in 'impression management,' thus an attempt is made to overcome the frequent criticism of the Goffmanian dramaturgical method.

To pick out certain nuances within this theme there are less number of Scheduled Caste respondents (22.7%) who believed that the profession is degenerating into a business. To analyse a few of them, a Scheduled Caste Senior Resident is of the belief that...

**Case C6**

The doctors do not execute their duties in the wards or Out Patient Departments (OPD). They are not at all duty conscious. We find them always preparing for entrance exams to American and British Universities for their post graduation courses which would fetch them more money as a doctor.

Thus, here is a case to explain the phenomenon that most doctors are not duty conscious. They spent most of their time to make more money
for themselves by securing admissions in other American and British Universities for their post graduate courses. Yet, another Scheduled Caste respondent, an Associate Professor by designation observes......

**Case C7**

Doctors could never bring themselves to believe that they ought to serve the society. They feel that the society and the Government are to meet with their needs. Only very few doctors today are for serving the society but a majority of them are money minded.

The respondent, in the above case points out that the doctors are not concerned very much about service to the society. This, further explained the loss of the state, since the Government invested in the doctor's medical education. The doctors in turn did not show any interest in serving in the rural areas. This has today left a poor representation of health services in the rural areas. We have only 31.5% of our public hospitals catering to 74% of our population in the rural areas. Whereas we have 68.5% of our public hospitals catering to 26% of our population in the urban areas. There are yet another set of opinions which in a way justify the degeneration of the medical profession for instance......

**Case C8**

The professional standards have definitely gone down. This is because of materialism which has caught up with our society. This is because we have had an unbalanced transformation. This

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leads to relative deprivation. The doctors now look for the shortest means to achieve a better status for which the easiest way is to earn more money.

Though the respondent here agrees with the existing degeneration, he shifts the responsibility to the unbalanced development of the Nation and widespread materialistic values in the society. This according to him has rubbed onto the profession which is by itself fast degenerating. We have another case of an Associate Professor who opines......

Case C9

Doctors might have to serve the society but they also need to survive in this big bad corrupt world.

Further a Scheduled Caste Consultant observes that....

Case C10

The young doctors begin their careers as a committed lot, later a lot of dissatisfaction creeps in especially, monetarily and the pressures of the materialistic society transform them into a less committed lot.

The above two cases also acknowledged the degenerating character of the medical profession. Yet, as in the previous case they have also reflected upon the degenerating social values.

Another interesting feature is that, a more number of the Scheduled Caste respondents (31.3%) abstained from commenting on the issue of professional commitment on the other hand only 4% of the non-Scheduled Caste respondents abstained from commenting. This could be interpreted
in three ways, firstly that the Scheduled Caste respondents display a general apathy toward the issue of professional commitment, secondly that they are unaware of the phenomena and thirdly that it is a sensitive issue not to be commented about. If it is due to a general apathy then it only depicts the unprofessional characteristic of these medical professionals. The second reason would also amount to be the same and there is hardly a possibility of the third in this case. Apart from the professional commitment, the study also tries to analyse the service orientedness of the medical professionals.

Service Orientedness of the Professionals

The data regarding social orientedness of the respondents proves that the majority (62.3%) of them feel that the medical professionals are interested in their own career betterment. To have a clearer version of the quantified figures, the study looks into the orientations of both the categories. The majority Scheduled Caste respondents (64.7%) and the non-Scheduled Caste respondents (60%) feel that they are interested only in their career betterment. A Scheduled Caste consultant opines thus.....

Case C11

To achieve professional excellence is my only aspiration. This will give me both wealth and status.

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96 The apathy of the scheduled caste respondents' is further contrasted in the following chapter in the context of the reservation policy as against the apathy of the non-scheduled caste respondents.
Yet another Scheduled Caste respondent, an Associate Professor is also of the opinion that....

Case C12

To achieve perfection in my career is my aspiration which will give me enough status.

The above two cases present the medical professionals as being oriented more towards the betterment of their individual careers. 17% of the medical professionals in general, 30% of the non-Scheduled Caste respondents and 3.3% of the Scheduled Caste respondents feel that the medical professionals are interested in making money. The aspiration of a Junior Resident of the Non-Scheduled Caste category runs.....

Case C13

My ambition is to secure a post graduation seat in surgery so that I can make more money.

Yet another Non-Scheduled Caste Junior Resident said

Case C14

I aim at a post graduation degree from any of the American Universities because we could earn much more than what we could with an Indian degree.

A Scheduled Caste Senior Resident says.....

Case C15

I aspire for a Government job since it gives me both status and money.

Another case of a Scheduled Caste Junior Resident says.....
Case C16

I would like to teach and practice. I prefer to teach in a private college because they provide more facilities especially they have no restrictions on private practice so the monetary benefits are better off. I prefer to specialise in surgery because there are more monetary returns."

In the above cases monetary benefit seem as an important criteria. Each of them seem to have different means such as a post graduation course in a well demanded specialisation for instance surgery, postgraduation course at any of the American Universities and for still others a Government job or a private one to achieve the end of making money. Thus making money emerges out as an important criteria. These two factors of being obsessed with their individual career betterment and of making money do appear to be in sharp contrast to the highly committed nature of the contemporary doctors as presented by a majority of the Scheduled Caste respondents in the earlier section where the study analysed the concept of professional commitment (refer Table 4.2).

Only 12.7% of the Scheduled Caste respondents and 3.4% of the Non-Scheduled Caste respondents believe in service to the community and another 10% of the scheduled caste respondents believe in serving their own Castemen. Thus the percentage of those respondents who believed in serving the society or their own Castemen is strikingly low when compared
Table No. 4.2
Service - Orientedness of the Medical Professionals

<table>
<thead>
<tr>
<th>Group</th>
<th>Achieve Excellence in Professional Career</th>
<th>Serve the Society</th>
<th>Serve their own castemen</th>
<th>Make Money</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule Caste Respondents</td>
<td>97 (64.7)</td>
<td>19 (12.7)</td>
<td>15 (10)</td>
<td>5 (3.3)</td>
<td>14 (9.3)</td>
<td>150 (100)</td>
</tr>
<tr>
<td>Non Schedule Caste Respondents</td>
<td>90 (60)</td>
<td>5 (3.3)</td>
<td>-</td>
<td>46 (30.7)</td>
<td>9 (6)</td>
<td>150 (100)</td>
</tr>
<tr>
<td>Total</td>
<td>137 (62.3)</td>
<td>24 (8)</td>
<td>15 (5)</td>
<td>51 (17)</td>
<td>23 (7.6)</td>
<td>300 (100)</td>
</tr>
</tbody>
</table>

Source: The above data was obtained from the field survey.
Note: Figures within the bracket indicate percentage.
to the percentage of those interested in achieving 'betterment in their individual careers'.

Thereby, as in the previous sub-section on professional commitment, it is found that the respondents depict more unprofessional characteristics in comparison to the professional attributes presented by the attributional school of thought. Some of the significant attributes of profession include prolonged specialized training in a body of abstract knowledge and a collectivity or service orientation.97

The respondents, as they have understood themselves seem to be more affected by the current day fads of commercialism and corruption thereby fit their profession into the ever moving process of societal transformation.98 Their professional career as it appeared during the field study, is an on going process toward achieving wealth and status. To reach these well defined goals each respondent has had his or her own means such as securing a post graduation seat in a well demanded specialisation, securing post graduation seat in an American or British University, securing a Government or a private job. The next theme in the analysis of the professional ethics is the patient redressal system.

97 For a detailed analysis of the attributional school of thought refer chapter two.

Patient Redressal System

The patient redressal system raised a good number of arguments ever since the Supreme Court’s ruling. The medical professionals are definitely not for any check over themselves and therefore did not believe that patients should have any legal means of redressal. The **Consumer Protection Act of 1986** (COPRA) drew a similar response from both the categories of respondents. Around 79% of the Scheduled Caste respondents disagreed and so did 78% of the non-Scheduled Caste respondents (refer Table 4.3 below).

Table No. 4.3

**Respondents Attitude Towards Consumer Protection Act**

<table>
<thead>
<tr>
<th>Group</th>
<th>Agreed</th>
<th>Disagreed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled Castes</td>
<td>32</td>
<td>118</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>(21.3)</td>
<td>(78.7)</td>
<td>(100)</td>
</tr>
<tr>
<td>Non-Scheduled Castes</td>
<td>34</td>
<td>116</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>(22.6)</td>
<td>(77.3)</td>
<td>(100)</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
<td>234</td>
<td>300</td>
</tr>
<tr>
<td></td>
<td>(22)</td>
<td>(78)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Source: The above data was obtained from the field survey.
Note: Figures within the bracket indicate percentage.

99 On the thirteenth of November 1995 the Supreme Court’s ruling stated that "service rendered to a patient by a medical practitioner by way of consultation, diagnosis and treatment, both medical and surgical is covered under the meaning of ‘service’ as defined in the Consumer Protection Act 1986." For more details see the relevant AIR.
The COPRA is "an act to provide for the better protection of the interests of consumers and for that purpose to make provision for the establishment of consumer councils and other authorities for the settlement of consumers disputes and for matters connected there with."\(^{100}\) The paltry condition of health services with surging incidence of communicable diseases, epidemics like plague and others have brought before the citizens a basic contradiction of our health policy, which as presented earlier has several limitations. These limitations of the health services could be countered with the COPRA.

The medical professionals raised a serious opposition to the COPRA. Their main contention is that the doctor-patient relationship is not one of manufacture - consumer. Yet another point in their argument is that the definition of the term consumers in COPRA is too wide. According to the act "consumer" refers to any person who -

(i) buys any goods for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any user of such goods other than the person who buys such goods for consideration paid or promised or partly promised, or under any system of deferred payment when such use is made with the approval of such person, but does not include a person who obtains such goods for resale or for any commercial purpose; or

(ii) hires any services for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any beneficiary of such services other than the person who hires the services for consideration paid

or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person;\textsuperscript{101}

As the above Act presents, service under COPRA could include the doctor-patient relationship however there are two exclusive considerations under which the act is inapplicable. They include, firstly any service which is availed free of cost and secondly service of personal nature. The medical professionals are very skeptical about this new introduction within their professional power structure. The professional power which ensues from their professional knowledge could be kept under constant check and supervision with the implementation of this act. Thereby they could not accept it with ease. One of the senior radiologist among the Scheduled Caste respondents believes that

\textbf{Case C 17}

The ultimate sufferer due to this act would be the patient. The physician would take a lot of time in investigating the problem than administering medical aid immediately to the patient.

A Senior Resident of the non-Scheduled Caste category opines that.....

\textbf{Case C18}

These kind of acts are more applicable in western and other developed countries. In India it would delay medical services to the patient and will also cost them a lot of money."

\textsuperscript{101} Ibid., pp.1325-1326.
These reasons serve more as an excuse not to be questioned on their professional capability. They do not believe that the patient should have a redressal system to counter the monopoly which has ultimately emerged from the phenomenon of professional power. The Medical Professionals appear to be strongly against any kind of shift within the professional power structure.

The study sample also comprises of another group of professionals who suggested certain improvisations in the act. They opine that a medical professional should be involved in the judgement process for instance a Junior Resident says.....

Case C19

The presence of senior and experienced doctors in the team is a must. This would help to represent the doctor's difficulties in administering treatment in that particular case.

Yet another respondent, a Scheduled Caste Senior Resident suggests......

Case C20

If COPRA is to be implemented, then the judging authority should be a group of medical professionals. The bench sitting on judgement should comprise of only one representative from the legal side.

This suggestion further underlines their strong contempt and apprehension for the COPRA. There are other respondents who are totally against such an act. A non-Scheduled Caste consultant has this to say regarding the COPRA.
Case C21

A doctor should not be allowed to go through this. He is not in a business, he serves the society with his knowledge.

Such a statement contradicts the phenomena of the majority respondents attitude that the medical profession has degenerated into a business. There appears to be a deepset crisis in their professional value system. Thus the respondents appear less prone to any major change within their professional power structure. This attitude also reflects upon their less pro-people outlook.\textsuperscript{102}

There have also been several studies in the past which highlights the aspect of ethics within the medical profession, some of the important ones are discussed below. The institutionalised pattern of medical practice especially within the \textit{Parsonian} frame proves to be of great functional significance. Its characteristics being \textit{universalistic achievement}, \textit{functional specificity}, \textit{affective-neutrality} and \textit{collective orientation}. \textit{Universalistic-achievement} refers to the application of scientific knowledge by technically competent and trained doctors. This makes the profession extremely classificatory and not relational. \textit{Functional specificity} restricted or narrowed down the problem to the specific complaints and disabilities. \textit{Affective-neutrality} refers to objectivity and

\textsuperscript{102} Ibid, p.1325-26.
not to an emotionally coloured judgement of the doctor. The functional significance of the above characteristics is that it enabled the physician to delve deep into the problem by collecting certain private matters. It thus minimises the resistances which might at times prove fatal. The last pattern variable called collectivity orientation distinguishes the professional roles within the organizational network. It prescribed a relationship of mutual trust between the doctor and the patient. Among the two, the physician is the one who possesses the technical know-how. He is thereby expected to 'help' the patient within the institutionally patterned situation. However, it left the physician with no chance to advertise his services, to bargain over his fee, to refuse his services to poor patients on 'credit risks' and his prerogative is to charge the patients according to the distinction from the market situation or a business.

T.N. Madan’s study provides empirical evidence for the self centered nature of the doctors, the wide gap between the medical professionals and the people and their lack of involvement in the community affairs. He also infers that doctors look upon each other as competitors much like the shopkeepers. Their relationship with each other

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103 There were other studies also in this field one of the recent ones include Ghanshyam Shah’s (1995) study of the Surat city after the 1994 plague epidemic.

104 Parsons, op.cit., 1951, p.438.

105 ibid., p.439.

106 ibid., p.464.
is one of ‘avoidance’ and their greater fear is that of losing patients.\footnote{107}

Madan further states that in his study of Ghaziabad doctors

There is much mutual criticism, alleging lack of Professional ability and even the resort to corrupt practices such as sale of free small drugs and issuance of false medical certificates......in return for monetary consideration......A doctor always has time to receive a salesman. He receives \textbf{free samples} of old and new drugs from the visitor. The drugs then generally \textbf{sold to patients} in the form of mixtures or powders......\footnote{108}

\textbf{Chandani} conducted an empirical study of doctors in Jodhpur city. The doctors in her study pretend to be committed to their professional duties. Defacto, they were a ‘variety of businessmen’. Thus she infers that the doctor’s doctrine to serve the sick is more a myth than a reality.\footnote{109}

\footnote{107}{T.N. Madan, \textit{Doctors and Society} (Ghaziabad, 1980).}

\footnote{108}{T.N. Madan, \textit{Doctors in a North Indian City Recruitment, Role Perception and Role Performance} in S. Saberwal’s \textit{Beyond the Village: Sociological Explorations}, (Simla, 1972), p.100.}

Oommen's study was conducted in Delhi. His study proves that doctors take conscious decisions to enter the medical profession. This indicates a greater extent of role commitment. Secondly, more investment of resources led to a higher role commitment. Thirdly, the 'self-orientation' of doctors also adds to their role commitment. Fourthly, the longer the period of training (seven years in the case of doctors) the higher the financial investment. This provides for greater occupational role commitment. Thus, Oommen had argued in favour of the role commitment of the doctors, though several other studies have proved otherwise.

Madan's and Chandani's study had outrightly disproved the Parsonian near altruistic description of the medical profession. They have in fact disproved every pattern variable that is, universal achievement, functional specificity, affective neutrality and collectivity orientation. To perceive the professional ethics of the medical professionals the present study has focused on the norms and the value system of the respondents.

Ghanshyam Shah in his recent work on Surat as a follow-up after the Surat Plague states emphatically that

The outbreak of pneumonic plague in Surat......in September-October 1994 created Panic World Wide. Nearly 33 percent of the population ran away from the city. Among those

110 T.K. Oommen, Doctors, and Nurses: A Study in Occupation Role Structure (Delhi, 1978).
who absconded, a majority were medical practitioners, entrepreneurs and other professionals and members of the upper middle class. Tetracycline was used indiscriminately.\textsuperscript{111}

Thus he presents a situation, where the doctors are expected to administer health care to the public during the insurgence of Plague epidemic. The professionals instead fled from the situation. He further adds that.

Profit has become a prime consideration in the Medical Profession. The concepts of "service to the humanity," "professional ethics" are outdated; they wish to earn money as fast as possible. Keeping themselves informed with recent developments in their own disciplines is not their priority. They have no time for that, Pharmaceutical industries and their representatives educate them. Of course, there are exceptions, but they are few and far-between.\textsuperscript{112}

Thus, Shah's study proves that the current day Medical Professionals are hardly altruistic but are rather business like. The present study also infers a similar scenario of doctors in Delhi. There appears very less traces of professional ethics as prescribed in the Hippocratic oath or Caraka's Samhitha, which places service to the patient as the supreme duty of a doctor. On the whole a majority of the medical professionals are found to adhere least with the professional ethics: they are found to be less

\textsuperscript{111} Ghansham Shah, 1995, op.cit, p.115.
\textsuperscript{112} ibid., p.116.
committed, less service oriented and did not encourage any patient redressal system. The data generated during the study has helped as to pin point two important reasons for the above phenomena:

(a) the already existing lacunae in the health plans and programmes.
(b) the general materialistic atmosphere of the society at large.

(i) the health plans and programmes formulated by the state is infested with its many limitations and gaps as pointed out earlier in this chapter. The recent Structural Adjustment Policy also increased these gaps by creating an "exclusive service orientation" of the health plans and programmes.

(ii) the commercialised society where materialistic values replaced the traditional value system could have also eroded the highly esteemed professional ethics. These features constitute the socio-cultural milieu which could inturn have its effects on the professional ethics.

Yet, inspite of the fact that a majority did not adhere to the professional ethics, a few of them agree that they believe in the existence of a core system of values and ethics. The empirical data presented above has given an insight into the current crisis in the profession. At this
juncture one could probably recall an interesting dialogue from one of Bernard shaw's plays.

Ridgeon:- We'er not a profession: we're a conspiracy.
Sir Patrick:- All professions are conspiracies against the laity. And we can't all be geniuses like you. Every fool can get ill, but every fool can't be a good doctor: there are not enough good ones to go round. And for all you know, Bloomfield Bonington Kills less people than you do.113