CHAPTER-III

REVIEW OF LITERATURE

Many sections of society have failed to take advantage of the medical discoveries, technological developments, therapeutic and diagnostic knowledge gained from speciality education and to communicate fully and reliably symptoms and problems to the providers of health care. This has not only been a source of frustration to the practitioners but also the basis for a wide range of research studies undertaken by medical sociologists. These sociologists offered recommendations about how health providers could effectively alter patients receptivity to advances in medical technology and therapeutic know-how. Their findings often questioned assumptions made by health providers about the motivation of patients, identified cultural and social structural impediments to effective use of the available technology of medicine and clinical acumen of physicians, and drew attention to the discrepancies between the interests of health care providers and the organisations with which they are associated and those of the patients they treat. (Levine, Scotch and Vlasak 1969). 1

Over a period of time medical sociologists emphasized that health care systems are not confined to scientific

calculations but involve people playing social roles guided by social values and interacting in a social setting. Sociologists have been interested in etiology and ecology of diseases and health, (both physical and mental), organization of medical facilities, responses to illness and maintenance of health and professional education and training as a social process (Kendall and Merton).\(^2\)

Studies concerning mental hospitals (Stanton and Schwartz, 1954), role behaviour of staff and patients (Goffman, 1961), follow up studies of discharged patients (Freeman and Simmons, 1977)\(^3\) and other such related studies added to the body of knowledge regarding deviant behaviour, organizational set up and interpersonal relationships.

The 60's and 70's witnessed growing interest of sociologists in assessing the role and effectiveness of government programmes in providing health care to the underprivileged section of societies. This led to the emergence of "social programme evaluation" (Rossi and Freeman, 1985).\(^4\) The

---


effort to review the health status of the economically poor and socially deprived groups as well as their access to health care facilities led sociologists to move in area of policy research, planning and development.

In the 1980's focus shifted to the cost and quality of medical care systems. Contemporary studies in the field relate to alternative medical care systems available and their effectiveness, changing pattern of doctor-patient interaction, the problems of aged, migrants, minority groups, women and psycho-social aspects related to AIDS to name a few. Sociologists like Simmons and Berkanovic\(^5\) and Kendall and Merton\(^6\) have categorised sociological studies in various areas which include sociology of health and illness, medical education, social epidemiology and sociology of professions. The study of medicine, health and illness has attracted scientists of various disciplines. However, their work differs on conceptual and methodological tools employed for investigation.

Though it is sometimes difficult to distinguish the work of medical anthropologists and sociologists\(^7\) because of


their common interest in socio-cultural phenomenon. Yet one finds that medical anthropologists have a more holistic view in comparison to the more particularistic view of social investigator.8

The present study has drawn from the work of both medical anthropologists and sociologists due to their interdependence on each other. However, it is not possible to cover all the studies undertaken in the field of sociology of health and illness. Therefore, studies related to our research area are included in the present review of literature.

SOCIAL EPIDEMIOLOGY

Social epidemiologists are interested in understanding the etiological chain of events that produce disease. Once the causes of the disease have been identified techniques can be developed for breaking the etiological chain of events and controlling the impact of the disease on a population.9

Epidemiologists at first concerned themselves with effect of demographic factors in mental illness. Later they


not only demonstrated the influence of socio-biological factors on disease (Glazier, 1973) but also concerned themselves with the influence of socio-economic and socio-psychological forces in the prevention of death, disease, illness and disablement. There is a considerable literature examining cultural differences in response to illness, patterns of providing care, and beliefs about illness, medical practice and medicine.

Saunders reported that cultural background influenced medical beliefs and practices of Spanish Americans in the South-Western United States.

Mechanic in a study of "medical student disease" found that upto 70 per cent of medical students coped with stress by adopting the patient role.

Gordon (1966) in a study conducted in New York city noted a tendency to ascribe illness to functionally incapacitating symptoms, among the people of lower social class.

Beecher\(^{14}\) found that wounded soldiers reported less pain than did civilians, thus showing that the reference group plays a major role in definition of symptoms and illness.

Twaddle (1969) in a study of middle aged married couples in Rhode Island found that sick role (as defined by Parsons) was much more applicable to Jews who cooperated most with physicians in comparison with Protestants and Catholics. He also found other important ethno-cultural differences: Protestants regarded functional incapacity (usually an inability to work) as the first sign of illness, Catholics emphasized changes in feeling such as pain, while Jews emphasized fear of eventual outcomes.\(^{15}\)

Mark Zborowski (1952)\(^{16}\) in his well-known study demonstrated that though pain is a biological phenomenon, responses to pain are determined by ethno-cultural factors. In his sample consisting of Jews, Italians and "Old Americans", he found significant variations in response to pain. Jews and Italians tended to be more sensitive to pain than old Americans who never expressed pain in public. Irving Zola in

\(^{14}\) Cited in David Mechanic's "Social Psychologic Factors affecting the Presentation of Bodily complaints" New England Journal of Medicine, CCL XXXVI, May'1972, p.1133.


1966 supported findings of Zborowski that there were indeed distinct differences between cultural groups and the way in which they communicated complaints about their health.\textsuperscript{17}

John Campbell (1978)\textsuperscript{18} in his study on a sample of 264 children and their mothers found that parents as well as the socialization process play an important role in handling emotions and playing roles. He noted that older children with higher socio-economic background rejected the sick role.

Koos, in his study "The Health of Regionville" found that social class hierarchy of a family affects its behaviour and attitude towards health and illness.\textsuperscript{19}

Besides ethnic variation, there may be differences by age and sex in regard to acceptance of the sick role as well.

David Mechanic in another study found that boys and older children had more stoical attitude towards illness than girls and younger children, thus showing importance of

\begin{enumerate}
\item Zola, Irving, K., "Culture and Symptoms - An Analysis of Patients Presenting Complaints", \textit{American Sociological Review}, 31 October, 1966, 615-630
\end{enumerate}
age and sex differences in attitudes towards illness. 20

Emil Berkanovic (1972) in his study on sick role conceptions among Los Angeles city employees found that some people feel they are able to recognise their illness behaviour. He further points out that often the physician is consulted only as a last resort and only after all other sources of health information fail to provide an adequate explanation. 21

A REVIEW OF INDIAN SITUATION

In this section, a brief review has been made regarding the country’s progress on public health and medical care system.

India’s poor performance in health has received remarkably little attention from social scientists and national policy-makers. This is especially surprising in view of the fact that during the past fifty years India has pursued a development strategy with a conscious orientation towards equity. This is evidenced in the social sphere in several ways. For example, India adopted after independence a far-reaching affirmative action programme to break the traditionally low social and economic status of the lower castes.

However, the development policy’s main concern was economic growth in the country and hence the social sectors like health were neglected.

India’s approach to organizing health care services was strongly influenced by the British system, whose major component was making high-quality health services, largely curative in nature, available at little or no cost to every citizen. This model was inappropriate for India, firstly because of lack of resources and secondly, India’s epidemiological profile suggests a greater emphasis on prevention and control of communicable diseases.

India’s health services, in fact, reflect the unjust social relations in the country. This is reflected by the development of curative services in large urban areas, adoption of those recommendations of Bhore Committee which favoured the privileged class, namely the establishment of AIIMS and the abolition of licentiate course in medicine. They also developed a medical education system which was accessible only to the children of the small upper crust of the population. Following this logic, it is not surprising that the medical education system should have been alienated from the real needs of the Indian people, and that it was much more in tune with the requirements of Western industrialized countries.

A concrete shape to health policy was later given with the setting up of Planning Commission in 1950 as a part of
the overall social and economic development of the country. The Committee "Health Survey and Planning Committee" popularly known as Mudaliar Committee appointed by the government of India in 1961 made some recommendations for future planning of health development in India. It recommended that there should be one doctor for every 3500 population (1:3500) and the ideal bed population ratio according to the committee was 1:1000. It also touched upon other items like nurses, pharmacists and other personnel.

A National Health Policy was formulated in 1983 after examining the existing situation of health in the country and with a view to attain the committed goal of "Health for all by the year 2000 A.D." through the universal provision of comprehensive primary health care services. It has identified the need for providing primary health care with special emphasis on the preventive, promotive and rehabilitative aspects. It seeks to provide primary health care services, which are relevant to the actual needs and priorities of the community. Also it attributes higher priority to the promotion of family planning as people's programme on a voluntary basis. The programme also places high emphasis on the supply of drinking water to all villages, improvements in the housing and environments of the weaker sections of society, spread of elementary education, etc.
Kakar\textsuperscript{22} and others conducted a study in rural Haryana on "Differential utilization of Health Care Services". The study revealed that social inequality played an important role in the utilization of health services. Members of the lower caste and class were at a disadvantaged position, as they not only possessed inadequate knowledge about etiology of disease but also could not seek therapeutic help in time. Those belonging to higher classes seemed to have drawn greater benefit from the governmental health services. The lower social class and caste status itself acted as a barrier to the proper utilization of health services. They found "dualism" in the health care services. On the one hand, there were hospitals run by specialists and super-specialists who follow sophisticated western technology, on the other hand, there were primary health centres looked after by ill-trained and ill-equipped paramedical workers and inadequately trained supervisors. The poor were even more deprived as their medical needs were met by these inefficient public health centres.

Bhatnagar's\textsuperscript{23} study revealed that ignorance about

\begin{itemize}
  \item Bhatnagar, G.S., "Community Responses to Health: A Study conducted in Patiala village in Punjab", paper presented at the 14th \textit{All India Sociological Conference}, Jabalpur University, Jabalpur, 1978.
\end{itemize}
causation and prevention of disease was widespread and lack of disease was considered as an essential quality of healthy person. Awareness regarding the availability of health facilities was also found to be significantly related to education, mass-media exposure, attitudes and beliefs of the respondents.

Khare\textsuperscript{24} in one of his studies conducted in a village of U.P., revealed a gradual sanskritization and elaboration of ideas regarding disease, as one moves from lower to higher castes. The higher castes think of a disease more with the help of ideas in Great Tradition, whereas the lower castes seek explanations in tribal gods, spirits and magic which are localized. His study is supported by the study of and Thoral.\textsuperscript{25} Thoral in his study observed that higher the caste and class status of the respondent greater was the level of adoption of health practices.

Yesudian\textsuperscript{26} studied the health behaviour of four social classes-High, Middle, Low and Very Low in utilization of health services in Bombay City. He observed that the knowledge level about the disease, availability of health serv-

\textsuperscript{24} Khare, R.S., "Folk Medicine in a North Indian Village", Human Organization, 1963, 22: No.1.


ices and seeking of health care are found to be lower for Low and Very Low social classes because of their educational backwardness. Since all the four social classes differ in their life-styles, in terms of income, housing and environment, etc their health status also differs. While the High and Middle classes mostly suffer from chronic diseases, the Low and very Low classes suffer from communicable diseases, and use mostly the government health services because of their poverty. Here also they are not aware of all the services available in General Hospitals and as a result their use is mostly restricted to out-patient department.

Rao\(^{27}\) in a study of some villages of North Arcot district (TamilNadu) observed that for common ailments at initial stages, larger proportion of respondents with low income preferred home treatment than the respondents with higher income, who preferred a qualified physician. The decision-making regarding choice and treatment is done by the head of the household in greater proportion in low income groups than in higher income groups. A higher proportion of those in higher occupation chose a place of treatment from where they could get quick relief, while a greater proportion of those in lower occupation groups preferred a source from which they could get treatment free of cost.

\(^{27}\) Rao, P.S.S., "Study on Socio-economic and Demographic Correlates of Medical care utilization and Health Behaviour", Research Report, ICSSR, New Delhi, 1981.
Djurfeldt and Lundberg\textsuperscript{28} in their study of a village in Tamil Nadu, found that the high caste Hindus were reluctant to use the medical services provided by a voluntary organisation because they felt humiliated in being treated at par with Harijans.

The social-epidemiological approach to the health problems calls for the identification of the whole process of causation for understanding the etiology of disease so that the events leading to the disease can be traced. For centuries, now it has been established that life style, customs and traditions, beliefs and practices, vocation and profession have serious consequences on the health of an individual and his choice of health care system.

STUDIES DONE IN RURAL, URBAN AND TRIBAL AREAS

There are many factors apart from socio-economic status, ethnicity and religion which affect the prevalence of disease and related factors. Several diseases are correlated to modernization, industrialization and urbanization. These factors also affect the seeking of medical and health care services as well as the type of healer visited by the patients. This section deals with studies done in Rural, Urban and Tribal Areas.

(A) The sick and the family

Illness in all cultures is a psychological crisis for the individual and a social crisis for his family. The attitude and support of the family determines to a large extent the therapeutic aspect of medicine. Social scientists have studied the role of Kin in Sickness some of these studies are referred below :

Gerlach\textsuperscript{29} in a paper on the DIGO people of Kenya, brings out the responsibility of the Kin group in two types of situation when a traditional practitioner is being consulted about a sick person, his kin group assumes responsibility for paying the practitioner. If the Kin group decides to take the patient to hospital, it decides who goes with the patient, who stays with the patient, who pays for his transport and boarding and lodging of the attendants.

Adair\textsuperscript{30} studied the role of Kin in sickness among the Navaho Indians of the US. He stated that "the individual who is sick does not act on his own. " The family members are likely to take matters into their own hands once they learn about the illness. After the root of illness is diagnosed, what song should be performed is suggested; then the family


goes for a singer who knows the required ceremony, and arranges with him what the fee for the song shall be. No ceremony is performed free of charge, as payment is essential for the efficacy of treatment."

Early studies on village life briefly described aspects related to health and covered issues like dietary habits, sanitation, mortality and maternal and child care etc. The next section reviews studies pertaining to these aspects of health and medical care.

Majumdar (1958)\textsuperscript{31}, Madan (1959)\textsuperscript{32}, and Chattopadhyaya (1963)\textsuperscript{33} described sanitation, food habits, medical care, maternal and child health, morbidity and related issues in their studies conducted in villages of U.P. and West Bengal.

Desai (1966)\textsuperscript{34} discussed health and medical facilities, consumption patterns and levels of living in village, Hasteda, in Rajasthan. He observed that there was a significant relationship between economic well being and the type of food consumed; not only did the consumption of superior cereals increase but also the tendency to turn to protective

\begin{itemize}
\item Madan, G.R., \textit{Changing Pattern of Indian Villages}, S. Chand & Co., Delhi, 1959.
\end{itemize}
foods became more marked with the increase in income. He, however, added that apart from income factors such as degree of enlightenment and social status influenced the quality of food consumed.

Ishwaran (1967) in his study described how the villagers perceive health and illness, the common diseases and their cure, purity-pollution and health.

Let us now review the studies which deal with traditional healers and modern healers.

(B) The Traditional and Modern Healers

Throughout human history we find individuals who claim to be able to give assistance in certain kinds of illness. The physician, the healer and the tribal medicine man are part of the wider societal processes. The skills of healing or curing the patients which a physician possesses is in part an outcome of the existential situation of society. Even in countries where professional medical care is highly developed, individual "healers", some of them with little scientific training, continue to practice their real or alleged skills and to attract a clientele of people who would describe themselves as well educated. In many developing countries among rural and largely illiterate population, traditional practitioners commend themselves to the local

community and make good their claim to possess special skills in the art of healing, through their knowledge, reputation, personality, relative success and method of approach to people who seek their aid.\textsuperscript{36}

Matthews in his study on "Health and Culture in a South Indian village"\textsuperscript{37} tried to find out the course and treatment of different diseases, the different types of healers, maternal and child health and family planning. His study revealed that villagers had strong beliefs about the causes of disease which were not based on any scientific explanation but were part of the social system. Villagers had great faith in alternative systems (Ayurvedic, Siddha, Unani) of medicine and traditional religious and spiritual healers, but they had very little knowledge of English (Allopathic) system. Though villagers used two or three systems of medicine simultaneously the type of treatment used, depended on disease. Traditional healers were preferred for several children's diseases, and for some adult diseases for which there was no rapid Allopathic cure.

\textsuperscript{36} Read, M., Culture, Health and Disease, Tavistock, London, 1966, p.15.

Bhardwaj\textsuperscript{38} in his study of one hundred and four rural household heads in four villages of Ropar district of Punjab, analysed the type of medical practitioners and the system of medicine preferred by the villagers. Unlike Matthews, Bhardwaj found that English medicine was generally preferred to desi medicine. Most of the households (belonging to different caste groups of the Village) showed a substantial preference for the \textit{angrezi} (Allopathic) system of medicine. Desi (Indigenous) system was preferred by less than four percent of the sample households. About a third of the head of the sample households indicated that the choice of the system depended on the expectancy of cure rather than to any traditional commitment to a system of medicine.

Madan\textsuperscript{39} in his study conducted in Ghaziabad town near Delhi also found similar results. His study revealed that the majority of interviewees preferred Allopathy. The most important reason cited for this preference was the "effectiveness" of Allopathy, Factors like age, sex and kind of disease did not play any role in this choice. It was also revealed that respondents with higher income and occupation showed a clear and unequivocal concern for effectiveness of a system of medicine rather than reflecting any other con-

\begin{itemize}
\end{itemize}
Takroo\textsuperscript{40} conducted a study to find out how rural people perceive illness, followed by their responses to sickness and thereby to identify patterns and predominant preferences for seeking medical care. The findings of the study were that rural people of Haryana laid a great deal of importance on a well developed physique capable of withstanding physical strains.

Srinivasan\textsuperscript{41} made an attempt to study the perception of rural populations in utilisation of health care services in the state of Tamil Nadu. The study reports that the attitude of respondents towards modern medicine has changed in recent years and they have now understood the efficacy of Allopathic medicine and have implicit faith in it. Yet it is interesting to find that the people still preferred the traditional practice of conducting child delivery at home.

A sociological study made by Dhillon and Srivastav\textsuperscript{42} attempted to explore as to 'how people perceive illness and

\begin{itemize}
\item \textsuperscript{40} Takroo, P.L., \textit{Social Patterns of Seeking Medical Care}, Unpublished Ph.D thesis, Punjab University, Chandigarh, 1980.
\item \textsuperscript{41} Srinivasan, S., "Health Care Services in Rural Tamil Nadu", \textit{Social Change}, Vol. 14, No. 3, p. 30-36.
\item \textsuperscript{42} Dhillon, H.S. and Srivastav, V.P., "How People Perceive illness and what they do when they fall sick: A Study of curative behaviour in Urban community", Central Health Education Bureau, \textit{Technical Series 29}, paper 28, Monographed.
\end{itemize}
what they do when they fall sick'. They found that a symptom was considered illness only when there was fever or pain or it was incapacitating for a person. The study also revealed that greater care was taken of the health of the earning member and the head of the family than other members of the family. The treatment process or curative behavior was largely determined by the perception of the people regarding illness. Except for "Serious" and "Abrupt" or "Sudden" illness there was invariably a time-lag between perceived onset of illness and seeking medical care. Home medication was almost invariably tried during the initial stages of illness which varied from modified food to taking medical remedies.

Singh\textsuperscript{43} in his study of tribal people in Ranchi district of Bihar concluded that unhygienic living conditions, over-crowding, inadequate and imbalanced food habits, pervasive malnutrition, early marriage, high fertility, non-adoption of contraception, high prevalence of illness, and widespread misconceptions and ignorance about physical & mental health, diet and nutrition, family planning and child care are prevailing in the studied block.

\textbf{CULTURE ORIENTED STUDIES}

Marriot and Carstairs were among the first to carry out social science studies in India. They both lived in villages

for a considerable time to present the contrast between Western and rural Indian medicine in terms of doctor-patient relationship.

Marriott (1955)\textsuperscript{44} noted three concentric realms in the social world of the villagers: The intimate realm of family and kinship; the realm of the village and caste and the remote realm of the outside world. The doctor practicing Western medicine is perceived as a member of an outside world and, therefore, regarded with suspicion and his prescriptions are ignored; whereas indigenous folk medicine - magical, sacred and secular - flouris in the community. Even from the point of view of the number of patients, frequency of visits, expenditure, the patronage of indigenous treatment surpasses that of western medicine. Besides, several ideas and practices have come to be associated with western medicine namely, personal privacy, individual responsibility, reliability of certain techniques and of inter-personal trust, and these are not seen as compatible with the traditional social organisation of the Indian villages.

He attempted to analyze the cultural problems involved in introducing what was considered to be more effective medical technique to a "Conservative" village, Kishangarh in Aligarh district of Uttar Pradesh during 1950-52. He high-

\textsuperscript{44} Mckim Marriott, "Western Medicine in a village of Northern India", in B.D. Paul (ed.), \textit{Health, Culture and Community}, Russell Sage Foundation, New York, 1955, p. 239-269.
lighted the importance of the cultural-valuational aspects of medical role like trust, responsibility, charity, power and respect, which are important for interpersonal relations in the medical sphere. Analysis reveals several strains and conflicts that have existed in the past between the roles assumed by indigenous and western practitioners - conflicts that have acted as barriers to the spread of Western medicine.

Carstairs\textsuperscript{45} conducted his studies in 1951 and 1952 in two villages- Surajpura and Delwara - located in the extreme North of Rajasthan. In these case studies he has pointed out the difference between the points of view of the physician and the villagers with regard to theories of etiology, techniques of curing and conceptions of the role of the physician resulted in misunderstanding between himself, (a physician) and his clients. He outlined the importance of "faith" and "assurance" in the patient which the traditional medicine establishes, while the modern medicine lacking this "aura of conviction" focuses to show the result dramatically and without delay.

He stressed that sickness is as much a moral as a physical crisis to the people of rural India. In people's conception the roots of illness extend into the realm of

human conduct and cosmic purpose. As a consequence they look at rituals for relief and reassurance. To set the patient right morally, as well as medically, the healer must serve as a link between moral man and the purposeful cosmos. He can gain no grace for the affected nor can the sufferer receive it unless both are joined to each other and to the universe by a bond of faith. His study dramatizes the difficulties of achieving mutual understanding when doctor and patient behold each other through different kinds of cultural glasses.

K.A. Hasan\(^46\) in his study has elaborated cultural dimensions of health. His study brought out the fact that the common beliefs, customs and practices connected with health and disease have been found to be intimately related with treatment of the patients. It also highlights that some of the cultural factors play a positive role, while others have negative influence on the health of the village community.

Later in a case study 'Doctor-Patient Relationship' Hasan\(^47\) analysed the effects of the introduction of modern scientific medicine in the village and also described the behavioural factors involved in the failure or success of


the physicians in the village. It was found that when the cause of the disease was not understood and when more elaborate forms of treatment were not available only then modern practitioners were consulted. Hasan, on explaining the relationship of doctor & patient, wrote that the personal equality between the physician & patient could not be maintained in the village life. The patients and their relatives could talk to a folk medical practitioner more freely than to the modern medical practitioner. They met the physician with fear, suspicion and lack of understanding.

In a North Indian situation, a western physician - Gould had considerable difficulty in trying to find out why the village people came to him for certain complaints and not for others. He found that people talked about "country medicine" and "doctor medicine". The villagers distinguish between chronic illness such as rheumatism and acute illness such as typhoid, (malaria being on the border-line between two.) The villagers hold that chronic illness can be treated by "country medicine", whereas the others need "doctor's medicine".

Van Der Veen’s study showed that there is vast dis-


crepancy between the medical facilities of private practitioners in the urban centres and the state-paid rural primary health centre in Valsad district (Gujarat). Though the majority of the rural population and the tribal communities are dependent on the services of the PHCs, the Health Centres are still under-utilised. According to Veen structural factors can explain the malfunctioning of the PHCs. But one cannot ignore socio-cultural factors. The efforts to introduce modern medicine have too often neglected the fact that the average Indian villager interprets the relationship with a doctor in terms of multiple and mutually obligatory relationships. The people tend to believe that they "invest in people" and status accentuation is the main mechanism to control their relationship.

Gandhi50 expanded the meaning of interactionist approach to characterize the meaningful interaction between those who are culturally defined as "sick" and the modern, western scientific medical practices and their practitioners. According to Gandhi, both the patient and the medical practitioner are active agents initiating new social activities and defining, redefining and modifying the situation together. Since illness is viewed as a part of the interactive process of socialization, it is always conditioned by

culture in which it is taking place. Thus, the medico-religious ideas and super-natural beliefs as explanation of diseases among the simple people of India reflect the cultural definition of illness given by the people in village communities. With the change in the type of community, its institutions of socialization also undergo change and the definition of illness also changes. Similarly, medicine is also emancipated from magico-religious interpretations.

Some studies which provide brief description of the medicinal practices include works of Dube\textsuperscript{51}, Opler, Leslie, Nichter and Chaudhari.

In an account of Indian village life in Hyderabad state, Dube relates illness to the ritual structure of Hindu life, emphasizing that the punctilious observance of the ritual cycle of festivals leads to the prosperity and well being of families. Opler\textsuperscript{52} in his study of illness in village India, mentions that the idea of harmony and balance finds a central position in the Hindu view of health and sickness.

Leslie\textsuperscript{53} mentioned that in the centres of British


Administration, some vaids and Hakims claimed superior status to other indigenous practitioners by virtue of their acquaintance with European medicine. The medical practitioner, since he belongs to a higher cultural and intellectual level can reduce the fear, suspicion and confusion considerably if he tried to understand the rural life and culture, the needs of the villagers and enable them to fight disease and disability. The physician, who does not try to understand the cultural and intellectual level of the village folk and does not develop respect for cultural differences, proves to be a less successful practitioner in the village dispensaries.

Nichter's 54 study entitled "Toward a Culturally Responsive Rural Health Care Delivery System in India" suggested that the practice of medicine is culturally responsive and that physician should be trained to communicate with their patients within their conceptual framework. Cooperation between modern and indigenous medical practitioners is encouraged.

Mathur's 55 study provides an analysis of the interpersonal relations between the various categories of medical


staff and patients themselves. The major conclusion derived from the study is that the socio-cultural factors play an important role in its goal. The physical and social environment provided to a patient has a therapeutic significance and can accelerate or delay his recovery.

Chaudhari\(^{56}\) analysed the factors that were considered important by rural people in the utilization\(\text{non-utilization}\) of medical facilities available to them. The factors that were considered important include traditional health beliefs, physical environment affecting health and food habits, traditional and modern health and the community fertility and mortality, interaction of traditional and modern systems of medicine and use and application of indigenous medicine.

**STUDIES DEALING WITH THE CONCEPT OF DISEASE AND SICKNESS**

Some attempts have been made by physicians and social scientists in tropical areas to examine local traditional classification of illness.

Jelliffe and Bennett\(^{57}\) two medical workers with wide experience, have suggested that in African systems there are

---


three types of illness: (i) trivial or everyday complaints treated by home remedies; (ii) European diseases, i.e., diseases that respond to Western scientific therapy, such as malaria; and (iii) African diseases, which are not likely to be understood or treated successfully by Western medicines. The authors also put together a list of traditional treatments in more than one tropical area. They speak of the type of diet based treatment in which "hot" foods are given for "cold" complaints and vice versa. Physiotherapeutic treatment includes massage and poultice. Herbs are also used as medicine in many parts of the world, and surgical techniques cover cataract removal and circumcision, both for male and females.

Adair et. al.58, in their socio-medical study about the cultural concepts of disease of Navaho Indians of the U.S., revealed the general view of the Navaho attitude toward illness: "Illness bears evidence that one has fallen out of delicate balance; it is usually ascribed to the breaking of one of the taboos which guide the behaviour of the Navaho, especially in the case of conservative elders, Illness may also be due to contact with the ghosts of the dead or even to malevolence of another Navaho who has resorted to witchery. The Navaho does not make the distinction between religion and medicine; for him these are aspects of the same

thing. This is an important cultural fact that many workers in the health field have failed to realize; as a result, many doctors and nurses have antagonized their patients.

Hamed Ammar\textsuperscript{59} an Egyptian Sociologist, writes, "In some rural areas of Middle East, disease is believed to be caused either by failure to fulfill some religious ritual or ceremony, such as a well-to-do man not performing his pilgrimage— or his failure to give the promised offering to a Sufi saint. Curiously, tuberculosis is believed to be caused by pretense and social conceit. Thus, the cultural idiom also determines the classification of diseases, the weight of their seriousness and the type of treatment required. There is "cold" illness that could be cured by medicament and there is "hot" illness that requires the placation of hidden forces. There are diseases thought to be curable by modern medicines and others thought not to be so curable, and in the light of such a division one knows what kind of "specialists" he would call.

Some important studies conducted by social scientists in the area of disease, sickness, control and eradication of communicable diseases in India are also being reviewed. These studies have tried to assess the notion of disease prevalent among the people and theories of disease causation.

\textsuperscript{59} Ammar, h., \textit{The Sociologist Approach to Problems of Community Development}, Sir's el Layyan, U.A.R., Arab States Fundamental Education Centre, 1960.
Khare⁶⁰ offered three interconnected cultural formulations, which seem to characterize the traditional Indian medical system, and which helps to introduce considerations of indigenous cultural constructs and interpretations in Medical Anthropology. The village therapeutic system continues to be predominantly based on such cultural markers as body and being, dāva (medicine) and dua (blessings), dharma (religion) and karma (deed) and dāiva (God) and it exploits in practice ethical overlaps and differences between the indigenous and modern western medical systems. Khare observed that the villager classifies the sick (in body and being) along a set of social factors (age, sex, social status, etc.) and cultural values (e.g. worldly existence versus the renunciation) for treating him under a set of culturally meaningful priorities.

According to Khare, there is thus an internal ethical patterning of access to treatment, which grows out of certain basic values of the Indian socio-cultural system and which guides the contemporary villager as he approaches the "doctor dispensary" as a scarce service. The villager not only discovers the differences in the approaches and the ethics of the two— the indigenous and the modern western medical systems, but he is also actively involved in his own

way in adapting himself and the new system to his needs. Consistent with the emphasis in the above two features, however, the villager does this by firmly locating himself in the ethics of his own system (on its cultural values). This stance works because he approaches the western medicine mostly for its results. He goes to the new system with a limited understanding and for purely "getting cured", while also attempting to subsume it under his cultural schemes (and their explanation) "to make sense of what goes on in such places".

Opler\(^6\) in his study disclosed a variety of beliefs causing the disease. He concluded by emphasizing the significance of protective ritual about smallpox: "Many standard rites are, in fact, precautionary ceremonies in which a deity is regularly honoured, so that he will bear his worshipers goodwill only. For ex, just before the season when smallpox is likely to erupt, a rite in honour of the goddess of smallpox is carried out in each household, in the course of which she is fed, honoured and ceremonially led from the vicinity".

Henry's\(^6\) study of an eclectic magico-religious medical practitioner of Eastern Uttar Pradesh in Northern India is a

---

symbolic explanation of the setting in which the curing takes place, the roles of the curer, his public image, and the items and actions of the curing ritual. The curer is both a holy man - a person with ascetically acquired superhuman powers and a pujari (priest) - a temple keeper and steadfast worshiper of the deities represented therein. In this curing the curer locates the cause of the illness, usually a malevolent spirit, and expels it with magical chants and diagrams, and a symbolically potent wand. Finally, he tells the patient how to compound the herbal medicine or how to alter her diet, assures her that she will get well. This mode of healing in which natural remedies are combined with exorcism, is an expression of a world view which comprehends both natural and supernatural causes of illness.

Carstairs wrote about the Hindu body image, added another factor to these descriptions of beliefs about illness in North India: "While they were sick, patients felt themselves to be invaded by something evil. This might be expressed in physical terms, as bad air, bad blood or phlegm; but still more often it was personified, as the invasion of one's body by a witch or evil spirit". In his study of medicine and faith in Rural Rajasthan, Carstairs concluded that according to the cultural system of the

village patient, symptoms of physical disability were connected to moral weakness by a chain of convictions involving nutrition, blood, semen and transgressions of the ethical code. Ideal remedies therefore included pilgrimages and ritual baths to wash away one's sins-atonements rather than tonics.

Sudhir Kakar\textsuperscript{65} has tried to show how mental illness is given a ritualistic and magical twist in Indian society. Like in most parts of the world, the belief in possession of spirits and demons is an explanation for illness in Hindu religion. Shrines of gods and goddess are considered healing places and religious specialists are believed to cure physical illness by their healing touch.

\textbf{STUDIES ON MEDICAL ORGANIZATIONS}

Social science studies dealing with organizational medical behaviour, medical professionals including medical students, doctors and nurses, medical and nursing education, health administration, hospital administration, roles and relationship in medical organization etc., are highlighted below:

An exploratory study of integrated health services in India at the district health administration level was done

under the auspices of the National Institute of Health Administration and Education (NIHAE), New Delhi by Tewari and Sharma in 1971. A study on "Patient Satisfaction and Ward Social System" was also done at NIHAE. At the conceptual level, the sociological frameworks by Parsons and Loomis were employed but at the data collection level, psychological technique of semantic differential was used and consequently for analysis too. The results showed that the patients of the functional ward showed greater satisfaction than the patients of non-functional ward.

T.N. Madan in his study dealt with medical profession, social background of Allopathic doctors, the image of the profession, the role performance of doctors and doctor-patient relationship. Besides, this study, Madan had also carried out a number of studies on private practitioners as


116
well as on the medical profession. His studies have a lacuna in the sense that they lack the patient’s evaluation of the doctor’s role.

T.K. Oommen\textsuperscript{70} studied the occupational role structure of professional Allopathic doctors and nurses working in public hospitals in Delhi. He also attempted to find out the effect of the organizational set up of their work and explained the relationship between profession and social structure, role commitment of the professionals and their role perceptions and role behaviour of doctors and nurses.

Another study on the role analysis of doctors and nurses is done by Venkataratanam.\textsuperscript{71} He tried to find the role of doctors and nurses in hospital in terms of (i) their prescription, (ii) their role expectation and actual role performances, (iii) role satisfaction and/or dissatisfaction in terms of the difference between role expectation, and (iv) the sociological truths that emerge from an analysis of the role play of doctors and nurses in the hospital. This study again has analysed the role performance of doctors and nurses without taking into account the target group of patients.

\begin{itemize}
\item \textsuperscript{70} Oommen, T.K., \textit{Doctors and Nurses - A Study in Occupational Role Structure}, Macmillan, Delhi, 1978.
\item \textsuperscript{71} Venkataratanam, R., \textit{Medical Sociology in an Indian setting}, Macmillan, Madras, 1979.
\end{itemize}
A.L. Srivastava in his study analysed the nature of interaction among the doctors, the patient and the paramedical staff in a hospital. His findings indicated that the doctor-patient interaction is influenced by their socio-cultural status and not their economic status. The doctors are specific about their relations but patients insist upon a diffuse and intimate relationship with a doctor.

Advani carried out a study on "doctor-patient relationship in general hospitals" for his doctoral work and found that the doctor subscribes to Parsons affective-neutrality prescription in order to avoid emotional involvement with patient’s.

Ambika Chandani conducted a study to examine the social background of 152 doctors (institutional and private) in Jodhpur City. She found that the majority of the doctors were from urban areas belonging to middle class families. These doctors also preferred to work in urban areas because of lack of infrastructure in rural areas.

A. Ramanamma and Usha Bambawale assessed Doctor-Nurse-

73. Advani, M., Doctor-Patient Relationship in Indian Hospitals, Sanghi Prakashan, Jaipur, 1980.

- "City Doctors : A Social Profile" : in Chandani & Lal (ed.), Medical Care, Readings in Medical Sociology.
Patient relationship in terms of amount of time spent per patient in relation to patient illness and rewards, the degree of interaction between the patient/physician and nurse and their role obligations, the physician and the nurses ability to maintain affective neutrality without indifference towards the patient. They found that the work/reward relationship in the two professions is poles apart and so is the authority structure. Most of the doctors and nurses are able to maintain affective neutrality while dealing with the patients.  

Aneeta Minocha carried out a study in Lady Harding Medical College, New Delhi in 1966-68. According to her two major factors of modern medicine affect the doctor-patient relationship - Firstly, the growth of specialization has resulted in changing the doctor's role from "know all" & "care all", generalist to a specialist in a narrow field rendering the relationship more impersonal. Secondly, modern medicine is increasingly being practiced in the context of organisation such as hospital in which number of functionaries, as member of team, play a role in the treatment process. She also noted that female patients found it embarrassing and difficult to consult and be examined by male


76. Minocha, Aneeta, Some Aspects of the Social System of an Indian Hospital, Delhi University, Delhi, 1974.
doctors.

Madhu Nagla\textsuperscript{77} in her study analysed professions, professionalization and professionalism and identified the basic attributes of profession which differentiate it from occupation. She found that medical profession is dominated by male doctors and that most of the doctors were satisfied with their profession in spite of unsatisfactory financial rewards, loss of freedom to move, very hard work with the unfair means of service etc.

Nigar Fatima Abidi\textsuperscript{78} carried out her study on "Women Physicians" in five government hospitals of Delhi. In her study she dealt with socio-economic background, role performance by these physicians, conflict perceived if any, and the mechanism of coping with this conflict.

The most important study of "Primary Health Centres on the Functional Analysis of Health Needs and Science" was done by the Narangwal Group at Ludhiana\textsuperscript{79} under the auspices of the John Hopkins University School of Hygiene and Public Health (USA) where attempts have been made to relate health


\textsuperscript{78} Nigar Fatima Abidi, Women Physicians, Manak Pub. Pvt. Ltd., New Delhi.

services to the community health needs.

Kakar\(^{80}\) studied the role of indigenous and multi-purpose health workers in a development block of Haryana and also worked\(^{81}\) on folk concepts of ecology of illness, food beliefs and nutrition education and socio-cultural aspects of malnutrition.

To conclude, one can safely say that the areas of research delineated above would cover the empty canvas of sociology of Health and Medical care to a large extent.

---
