CHAPTER I

SOCIETY AND MEDICINE – INTRODUCTION
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Diseases of one kind or another have always afflicted Man. "Disease is but an expression of man’s dynamic relationship with his environment." Man has always been troubled by sickness, accident, deformity and anxiety; so too, has there been organised response by society to such threats.

In all human groups, no matter how small or technologically primitive, there exists a body of beliefs about the nature of disease, its causation and cure and its relation to other aspects of group life along with treatment and preventive practices.

The significant events like disease of body and mind are explained in both naturalistic and supernaturalistic terms. To explain the hazards in life, there is always some conceptual framework rooted in commonsense empiricism. But often a wound may not heal, a sickness may not respond to treatment and the order of explanation is employed which attempts to come to terms with the metaphysical perspective. In most non-western societies this transcendent explanation for the occurrence of disease tends to figure more pervasively in the total body of medical-lore and practice than does the empirical framework.

The five basic categories of events or situations which in folk belief, are said to cause illness are (1) Sorcery; (2) breach of taboo; (3) intrusion of disease object; (4) Intrusion of

disease-causing spirit; and (5) loss of soul.

All these five categories may be recognized by every society. Many groups are selective in the emphasis laid upon one or a combination of causes. For example, the Eskimos most frequently trace the origin of diseases to the soul-loss and breach of taboo, while the malevolence of sorcerers or witches is particularly emphasized in many African cultures.

The variability of societies and cultural systems make it difficult to generalize about the nature of "primitive" or "folk medicine", but one should not lose sight of its close integration with the other institutions of society. Religion, medicine and morality are often found together in the behavioural act or events, and "Folk medicine" becomes "Social medicine" to an extent not found in industrialized societies.

It is clear that even in "Modern societies" there is a body of beliefs and practices relating to diseases and its treatment based on magical or religious conceptions rather than those of scientific medicine.

The Greeks were not alone in considering disease as a manifestation of disharmony in man's overall relation to the universe. "Health" is rarely, if ever, a narrowly restricted conception having its locus only in the well-being of the individual body. In most African and in certain American-Indian groups, bodily or mental affliction is often viewed as a symptom of moral transgression in thought, or in deed against the norms of society. What happens in the surroundings is believed to affect

1. International Encyclopaedia of Social Sciences, Vol X
the bodily well-being. Apart from his own actions, those of his kinsmen or neighbours can cause sickness. Such an etymological conception calls for treatment involving the members of the patient’s family. A breach of restriction by any of these people will undermine the patient’s health.

A theory of disease implies a theory of normality, yet "normal" is in no way easy to define for all times and places.

1.1. Modern medicine - A brief history.

The modern concept of disease evolved through five successive stages namely, (1) Demonistic theory of the Babylonians and the Chinese (4000 B.C. - 1000 B.C.), (2) Spiritual theory (man alive or dead causing the disease still prevalent among the Barbarians), (3) Diestic theory of Jewish civilization, (4) Diestic and Karma theory of the Hindus, and (5) The theory of naturalism and naturism of Hippocrates, the Greek Physician (460 B.C. - 370 B.C.) known as the father of Modern scientific medicine. During the early stages, the association of health and disease was established through religion and Astronomy which gradually led to the development of early conception of natural causes and preventive methods. Three hundred years before the birth of Christ, the Greek cities appointed physicians whose services were available to every citizen while other doctors set up private practice among the wealthier classes. This practice heralded private practitioners working side by side in all subsequent civilizations. Following the Greeks, the Romans and then every town in the continental Europe had its Municipal Farm Doctors to treat the poor classes free and, others at fixed

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1. International Encyclopaedia of Social Sciences, Vol.X.
The above development was succeeded by the evolution of medicine as a science between the 15th and 18th Century. While on the one hand Anatomy, Physiology, Pathology, Clinical medicine developed in successive stages, on the other, basic sciences like Physics, Chemistry, Zoology, Geology, Astronomy, Meteorology, etc., and many types of physical instruments including microscope upon which the modern science is built developed. Various hypotheses on the spread and transmission of diseases such as contagion, virum and contagion aimatism which actually proved to be the precursor of the Germ theory were propounded. This period was actually epitomized by the discovery of complex vaccination by Edward Jenner in 1795.

The most important and vital event in the evolution of Modern medicine and public health was the establishment of the Germ theory by Louis Pasteur in 1876, bringing in bacteriological era, communicability of diseases and Modern concept of preventive medicine and public health. Simultaneously with the discoveries of causative germ of various diseases, knowledge rapidly advanced on infection and its transmission and prevention by sanitation, prophylactic vaccination, seriotheraphy, chemotherapy. Subsequent to these developments, sanitation on a community basis was adopted as the public health measure, and hygiene was taught to the medical students.

The surgical pathology, traumatism, visible tumours, the development of autopsies and morbid anatomy, the progressive building up of the natural sciences, the taste for objective observation in the field and the introduction of measuring methods - such were the elements of intellectual revolution. The coming
of the new method in medicine, the automatic clinical methods -
can be symbolized by the work of Lennec. He endeavoured to
perfect a certain number of objective techniques of medical
examination making it possible to deduce the existence of
anatomical lesions that were manifesting themselves in discomfort
on the part of the patient. The taking of the temperature with a
thermometer was probably the first of these techniques.

The development of medicine in the 19th Century was due
to the discovery of methods of clinical and paraclinical
exploration. They made it possible to analyse with great
precision on the living subject, anatomical modification and
functional disorder of the principal organs.

Simultaneously, a great effort was made, particularly
under the influence of Ninel, Bretonnean to perfect a
scientifically valid nosology. At that time, the example followed
was the Linnean classification of species and the aim was to bring
order into the observation of pathological facts through the
description of given diseases and morbid entities in the same way
as Botanists and Zoologists described species of plants and
animals. This movement culminated in Bretonnean and Transscan's
doctrine of specificity. Pasteur's discoveries by showing that
microscopic beings were at the root of a large number of diseases
were to ensure the lasting victory of this theory. Those
discoveries are still, today the basis of science.

Modern medicine has passed from a subjective definition
of the patient to an objective definition of the illness. For a

1. "Scientific and Social Aspects of Modern Medicine", Impact of
2. Ibid.
long time, a man who thought he was ill was considered to be so. The sick person was a person who complained of some kind of trouble or an anomaly in his biological functioning. This definition sufficed from the earliest times until the middle of the 19th Century. Throughout this period, medical activity consisted in the meeting between a physician and a man who came to consult him because he regarded himself as ill. The essential part of what the physician discovered was the result of his interrogation. Almost the whole of every treatise on medicine was devoted to an analysis of the patient’s complaints.

Besides the subjective definition of the patient, there is an objective definition. A man is considered to be ill when abnormal symptoms are revealed in him by medical examination. A whole field of pathology is now the subject of what are known as systematic-case-finding examinations whereby people showing no signs of ill-health and considering themselves to be well, but in whom the explorative techniques discover anomalies, are regarded and treated as being ill. But there remains a gap between this objective definition and the subjective definition of the patient - the definition of the person who continues to consider that he is ill and in whom nothing is found wrong. This is probably the most difficult of the problems confronting medicine today.

It is true that in the middle of the 19th Century medicine, at least pathology became established in the West as an exact science and evolved a precise method of research. Certain remedies, of mineral or vegetable origin were already known. But inadequate progress in Chemistry and Pharmacology restricted their truly scientific employment. The first discoveries had but a limited influence on therapeutics. The rise of Bacteriology and
the discovery of anaesthesia opened the way to modern surgery. The field of action of Serotherapy was quickly circumscribed. On the other hand, discoveries in the field of infectious disease were to result in technical advance of preventive medicine. Simple measures employing every day antiseptics ensured the disappearance of puerperal, i.e., infection of or due to childbirth.

An epidemic could be stopped by the isolation of the sick and by the disinfection of contaminated premises. Pasteur generalized the empirical discovery of Jenner and to vaccination against smallpox were added numerous other methods for the active prevention of disease. In short, there was a time lag between the progress of preventive medicine and that of therapeutics and it is remarkable that compulsory prophylactic methods were introduced into legislation in Western countries at the end of the 19th Century, while the notion of compulsory treatment was not to be introduced until 50 years later that too in a limited way - applying to infectious diseases, venereal disease and addiction to drugs.

In fact, a long process of development in medicine and chemistry from 1850 to 1920 was necessary before therapeutics could really burst into life. Some examples may be quoted here in order to reveal the rate of progress achieved.

The best known example is that of the treatment of infectious disease. During the first 50 years of the 19th Century, only one medicine was known - quinine. Centuries of discussion and researches had in fact been necessary to isolate from a popular medicament known to certain primitive peoples, the Cinchona bark, a drug used somewhat haphazardly without fixed dosage and with varying results in all the different fevers - an
active compound chemically defined, whose use in prescribed doses was to establish it as a remedy for specific disease, Malaria. After the First World War, progress speeded up. Ehrlich made known the arsenicals and their action against Syphilis. Later Sulpha drugs were introduced. World War-II saw the large scale development of Fleming's brilliant discovery, Pencillin, the starting point for the yearly discovery of new antibiotics whose field of activity now extends to almost all known microbial infectious virus diseases, alone resisting them. The fact that the diseases which have become easily curable in the last ten years include Syphilis, T.B., Leprosy, Typhus and all the major Septicniae, is a striking evidence to the progress achieved.

Other fields - that of synthetic harmones, for example - have exhibited a similar rate of progress. A century of research resulted in the synthesis of adranalin in 1901. In 1922 came the second success with the isolation of insulin. In 1926 Thoroxine appeared and shortly before the last war genital harmones were introduced.

Diagnostic methods have also improved. The discovery of new therapeutic methods is one of the aspects of the general complexity of medical science and practice. The complicated nature of diagnosis and Posology can illustrate the science of quantities of drugs. These factors and linked progress in therapeutics made it possible to distinguish between different diseases which have a similar clinical picture but this progress has been achieved as a result of increased precision in diagnosis. It is certain that the diagnosis of different congenital malformations of the heart was for long a sort of intellectual exploit of specialists yielding no results. But this diagnosis
raised an acute problem in the very first stage of heart surgery. Introduction of catheters into the heart cavities made it possible to measure their pressure, analyse their blood gases and inject into them radio opaque substance, producing an X-ray photography and satisfactory picture of these cavities. Diagnosis has thus become a real small scale operation requiring the presence of at least two specialists - heart specialist and radiologist - as well as complicated equipment quite apart from the chemist.

It is relevant to note that the progress of science can not be distinguished or separated from its social causes. The rise of medical science in the 19th Century was only possible, thanks to a fundamental change in scientific outlook, to the progress made in Physics, Chemistry and Natural Sciences and above all to the creation of new market for medicine.

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A French author, Philippe Aries, has been at pains to point out that at a certain period in France, during the 19th Century - the attitude of the enlightened opinion towards life and death underwent a change. A growing measure of care, comfort and perhaps the decline of a certain religious mentality caused a progressive abandoning of the fatalistic attitude towards life and death, the attitude that even today can be observed among primitive people. A keen desire arose to improve and prolong human life and it is not surprising that the counterpart of this desire was a considerable increase in the curiosity of scientists about medicine.

It is also true that medical needs find expression only after more pressing needs had been satisfied. It was only in the

1. Impact of Science on Society, Ibid
19th Century that the countries of the West were finally delivered from the fear of famine. The constant rise in the living standards and the gradual decrease in every country of the gap between the satisfaction of the primary needs of the poorer classes and that of the richer classes causes an increase in the demand for medicine.

The objective definition of illness has resulted in the appearance of a social or an administrative definition. Society requires physician to provide information concerning the true working capacity of an individual and the said definition of illness coincides more or less with the definition of the individual’s professional or domestic output actual or potential. Furthermore medicine now being more preventive than curative, Governments have been forced to take legislative and financial measures to enable people to secure the benefits of modern medical treatment.

1.2 Social dimensions of medicine.

When a human being becomes aware of the discomfort and inability to perform his normal social roles, he submits to medical care, no matter he is a city dweller or a peasant. But the choice of remedies vary widely according to the social and the individual’s statuses in each social system.

The demand for medical care varies with other broad characteristics of society such as the general levels of organisation, literacy, prosperity and industrialization. Consequently numerous underdeveloped countries of the world have

potentially large number of patients. Illiteracy prevents many citizens from learning where to find medical care and services which are often inaccessible to the rural areas where much of the population lives. However as information spreads about the availability and efficacy of medical institutions, public use increases. As urbanization rises, so does the number of patients. In the cities of underdeveloped countries vast crowds of ill persons can be seen at the out-patient clinics and in-patient wards of public hospitals.

Within each country social class and illiteracy appear to correlate with the use of medical care. The lower and poorer social classes may have the greatest number of physical and mental problems. But the higher classes make greater use of medical service because of their greater understanding of medical services, their social sophistication and their ability to pay. The problem varies by social class. For example, in the developed countries, coronary diseases and ulcers are found more often among the upper class. Infections and T.B. are more often found among the lower classes.

The demand for medical care is also affected in several ways by family structure. In the Muslim countries and in some others religion and customs decree that women are to work and live solely within the family circle. Therefore women hesitate to visit hospital and particularly to become inpatients. More men than women use medical services in the Muslim countries but the opposite is true elsewhere, particularly in the West. Medical specialities involving obstetrics and Gynaecology are developed far more in the West than in the countries with sheltered women.
In pre-industrial and folk societies, the bread winner is indispensable to provide current income, and the mother cannot easily be spared from her family care, particularly if inpatient hospitalisation is likely and medical services are used predominantly by children, the elderly and severely ill, younger adults. However, in some underdeveloped countries babies and young children occupy such a subordinate position in the family that they are brought for medical care much less often than adults. In general, the utilization of medical services is higher in the industrial countries, not only because family nursing is deemed less effective than expert hospital or clinic treatment, but also because urban living conditions make home care difficult. The modernization of underdeveloped countries included the establishment of Western style of medical institutions and the propagation of Western health norms and consequently the cross national differentials in the utilization of medical care will diminish.

At the same time, the structure of the family has changed; the modern family consisting simply of the married couple and their children is more and more replacing the large patriarchal family of former times when three generations lived together, and the bonds between cousins of the same generation were still close. Thus, family solidarity was a certain security for anyone who fell ill, since he could count on financial help and practical assistance from the family unit. This type of security has now to a large extent disappeared.

The importance of social medicine has to be recognized because it can help to investigate the influence of social, genetic, environmental and domestic factors on the incidence,
measures for the protection of the individual and community against such forces as interfere with the development of man's capacity. According to Greenwood, the greatest authority in public health in England, "Social Medicine deals with the study of all factors which have a bearing on health, illness and the application of that study for preventing of illness and for raising the standard of living of the community. Social medicine is the result of the transformation of public health into social science."

The social components of the illness have come to be recognized as the medical knowledge and diagnostic methods and treatment procedures become sophisticated. Modern medicine has become highly specialized in diagnosis and in scientific treatment of diseases. It is true that the idea of treating the patient as an individual has not been given sufficient emphasis in institutional medicine. This could be confirmed, as P. George expresses, in the amount of literature on this aspect of medicine. The interrelation between the medical, social and emotional factors of illness and their importance has been accepted.

In almost all types of illnesses the patient's attitude to his own illness and to that of his environment form an important element in the treatment procedure. The necessity of understanding the emotional disturbances that accompany illness and of having a knowledge of the social factors that influence the bodily and mental reactions of a person to a specific disease cannot be over-estimated. The difficulty experienced by the

2. Ibid.
patient may not be understood by the physician in some cases. It is well known that whatever be the type of treatment, if the patient's cooperation is not obtained, it will not have the desired effect. Sometimes the medical line of treatment may not be suitable to the patient. When the patient finds that the recommendations threaten too seriously his way of life, he finds a way to evade the issue. In quite a number of cases, the specialist's knowledge and the hospital's resource are wasted in this way. A justification may be found by the hospital authorities by classifying the patient as non-cooperative. The non-cooperation is mainly due to the inability of the patient to understand what is expected of him.

The medical practitioner might consider this as viewing the problem from a narrow angle. Nobody questions the fact that expert knows better than the patient or any of his relatives about the line of treatment that suits the patient best. But it may be said that it will not be easy for anybody to grasp quickly the usefulness or otherwise of the recommended line of treatment from the viewpoint of either the patient or his family.

The patient who comes to the hospital wishes to have his medical problem classified and advise given. The doctor uses his skill in diagnosing the patient's illness and accordingly recommend the required treatment. In the meantime, the patient has endured examination, tests and many other procedures which he does not understand at all. Some of the recommendations may be even beyond his ability to carry out. In some instances, he is asked to return to medical care, to submit to operation, to live with a permanent handicap, or to lead the rest of his life with the idea of a chronic disease and to be adjusted to it. To face
situations like this, it does not serve any purpose to find fault with either the doctor or the patient.

The development of medicine in relation to its proper place in social life implies a reoriented medical profession utilizing social workers. Since this is the new contribution to medicine, the size, functions and the training of social workers in a medical setting have not been fully understood. For a proper diagnosis of the patient's illness, a review of the entire life from birth to the time of illness with special reference to the causes contributing to his present illness should be made available to the physician. This would be a wide field which should include facts relating to heredity, personality, manner of life, home environment, financial worries, dependents, character of employment and strains and hazards incidental thereto, recreation and standards of living. It is in this direction that the services of medical social workers are inevitable to the physician. The medical social worker is now recognized as an essential professional colleague of the doctor.

As in the Western countries, the idea of having a separate social service department in a medical institution is gaining ground in our country too. In such a programme of public relations, a lot of tact and skill should be made use of, and hence the medical social worker has a definite contribution to make. In the treatment of diseases like venereal Disease, Tuberculosis and Leprosy, the physician would need certain additional information touching on the source of infection, and the contacts made by the patients, which the patient would not ordinarily divulge even to the physician. The social worker through skilful interviewing gets such information and this in
turn helps the patient as well as the community.

Modern medical practice cannot rest satisfied with a cure of the disease which is nothing but the relief of the urgent symptoms. When the rehabilitation has almost become a profession in itself, the medical social worker can play a vital role in preparing both the patient and other people in his environment to enable the patients to take his place in society after discharge from a treatment centre. In institutions like T.B. Sanatorium, Leprosy Asylums, Cancer Clinics, Social workers have become inevitable. Social workers are playing their part in community organization programme too. Some other duties which may be undertaken by them are in the establishment of the social agencies and in the interpretation of social needs in the community planning.

1.3 Contribution of sociology to medicine - medical sociology.

The establishment of sociology as a scientific discipline has taken place within the last century, but it has intellectual roots that reach far back into the antiquity. They range from classical Greek philosophy to 20th century pragmatism, from the search for knowledge for its own sake to schemes to reshape the world. Out of all this, Sociology has developed as a scientific discipline and has seen the emergence of several sociological specialities such as sociology of law, sociology of religion, educational sociology, urban sociology, rural sociology, industrial sociology and so on. It was this quest to become a science that led sociologists to treat medicine in their study of human culture.

Social Science contributions by their nature deal with human relationship: interpersonal or intergroup relationships,
individual personality difference, the perceptions and reactions of people to their internal as well as to their external milieu; it concerns itself with people, who are well or ill, not with the disease process itself; on the other hand, it specifically has to do with society, with people living in groups and with the structure, function and change or action of such groups.

Medicine is essentially the practice of knowledge and skills and attitudes in the cure of the sick. There is a certain body of knowledge unique to this activity which might be termed as science of medicine and which grows by accretion from applications of the physical, natural and social sciences.

Sociological contributions in medicine may be descriptive, predictive or modifying of practice. They deal with the sociological dimensions of the prevention of illness, diagnosis, prognosis or treatment. Medical sociology is still young but it is rapidly growing. The developed countries have recognized the role of social scientists in understanding the significance of socio-economic causes of diseases.

The information we have about the practice of medicine in non-literate cultures indicates that there is a general recognition of social factors in the etiology of illness, and of importance of interpersonal relationships in therapy. Primitive medical practice is oriented usually towards a religio-moral ideology and deals explicitly with anxiety and of guilt associated with social living.

The classical Greek writings too provide an orientation towards the sociology of medicine which is still relevant. During the past century and a half, while medicine has become scientific
in the modern sense of the term, it has never really lost the special insight of previous generations. The converging of medicine and sociology has been gradual and systematic. Medical sociology as a specialized field was first proposed by a physician, Charles McIntire in 1894. There are over 800 sociologists in addition to Anthropologists and Social Psychologists at work in major research projects in the medical field. But there seems to be difference of opinion with regard to whether medical sociology should have an integrated theory and whether it should be grouped under policy sciences.

Eminent sociologists and physicians of the West have attempted to bring out the theoretical framework into which the medical practice and theory can be fitted. Talcott Parsons, Robert K.Merton treat medical system as a part of total social system. The Sociological theory of structure - function provides the framework to interpret the medical system as a major system with its own sub-divisions. The analysis of roles of doctor-patient, organization, deviation from the role-expectations, dynamics of roles, etc., constitute the medical system. This system finally contributes to maintain and perpetuate the total social structure by restoring the patient to his normalcy and enables him to perform his role. In this sense, medical system functions as an agent of social control. Both curative and preventive measures of diseases contribute to the preservation of social order from decaying. In this process of curing illness, the medical system is obliged to understand the social etiology of illness.
Patricia Kendell and Merton. R.K. classify medical sociology into four distinct connected sub-specialities - social etiology and ecology of diseases, components in therapy and rehabilitation, medicine as a social institution and sociology of medical education.

Social etiology and ecology of disease was the first to become established. Demonstration of causes is central to the concept of etiology. Problems studied under this speciality come nearer to epidemiology which focus on sex, economic class, ethnic groups and other factors of status-differences and their role in promoting or not promoting good health.

Therapy and rehabilitation focus on the treatment of illness. The therapeutic situation becomes central showing the effects of illness on interpersonal relations, the influence of the setting on patient's recovery and his return to normalcy.

The third sub-speciality is medicine with its various structure and interlocking statuses and roles. This focuses on social structure and functioning of general hospitals, clinics, health departments and health units and the like. The relation between the physician and patient, the crux of medicine, is of immense interest to the students of medicine as a social institution.

The fourth sub-division - recognition of medical educators of social processes involved in medical education led to the emergence of this sub-division. The sociology of medical education becomes a sub-speciality of sociology of medicine and

the sociology of education. It contributes to the growth of knowledge. Though a specialized and technical aspect of the general milieu of society, medical education develops its own milieu and contributes to the body of medical culture.

It is evident that the structural pattern of society has a bearing on the process of professional socialization. Values and beliefs built into the personality system by the sub-culture may help or deter the internalization of norms, values, skills basic to medical culture. The form and contents of medical culture that is to be transmitted depends upon the values, felt needs and the level of technological development of particular society.

1.4 Background of the present study.

An important area of Medical Sociology is the study of the Doctor-Patient relationship. Doctor-patient relationship is a crucial aspect of the medical settings. The medical system is built around the role-complex of doctor-patient. Admittedly, curing of illness and treating the patients is the concern of the doctor-patient interaction. Sociological studies however have revealed that the curative process is influenced not only by medical but many non-medical factors.

Some of the non-medical issues that are relevant to a proper understanding of this process are the social background of the doctors and patients, the role conceptions of the patient regarding his own role and his conceptions and expectations from the Doctor, the role images of the Doctor regarding his own role and that of the patients, the contents of a particular interactional situation such as the nature of illness, the formal/informal nature of the context of interaction, etc.
1.5 Review of available literature in the area of medical sociology in India.

Medical Sociology is in its early stages of development in India. Contributions coming from sociologists, social workers and physicians however seem to enrich the subject and do cover a wide range of sociological issues. The articles, books and research works have been published by those interested to understand the correlation between medicine and society.

Mention may be made of an article by C. Parvathamma, on "Changing needs in undergraduate teaching: The need for the Physician to understand Human Behaviour for the Diagnosis and Therapy". The article points out the urgent need to include teaching of social sciences in Medical courses. The doctor cannot afford to ignore the social milieu of which he as well as the patient are parts. The medical men should have a comprehensive knowledge of disease and cure or else they will not be in a position to diagnose and treat the disease promptly.

The concept of single-cause disease has given place to multi-cause illness. The social, emotional and cultural aspects of the patients' background need to be understood by the physician. The socio-economic factors determine the cause of some type of diseases and they also influence the responses of the patients towards treatment. Customs, food habits, stigma attached to certain diseases also help the physicians understand the condition of patients and treat them accordingly. The author feels that the behavioural sciences must be taught to medical man. This will help them understand the society which they serve as

1. UGC Institute for Teaching Social Sciences in Medical College, Conference held at Delhi, September 1969.
professionals. Just as acknowledgement of Psychology has increasingly helped to diagnose the mental illness, the knowledge of other social sciences such as sociology, social anthropology are beneficial to physicians because they handle persons and not material objects.

1 "Social Aspects of Disease " is an article with a highly professional and practical approach by B.N. Balakrishna Rao, Retired Professor and Surgeon at All India Institute of Medical Sciences, New Delhi.

The article is the product of experience and expertise. The professional physician has attempted to make the medical man understand the inevitable mutuality of social factors and medical factors. He has brought out how industrialization and urbanization have changed the patterns of living and created fresh problems of disease and sickness.

The author seems to have given a serious thought to the role of non-medical factors in the medical world. He states, "In a country like our’s with so much to develop with meagre resources and the rapidly changing social structure and religious outlook, the problems of the social aspects of diseases are collosal and all pervading in its impact. Each country has to develop its own Independent solution, as the problems are closely interlinked with our culture, philosophy, religion, etc."

The author also speaks of diseases becoming a social problem like old age care, the inability of small families to face health-crises due to non-availability of health attendants,

increasing responsibility of the welfare state, etc.

"The Social Components in Medical Care": Published in the Indian Journal of Social Work, is an analytical article contributed by P.I. George.

The author systematically discusses the social aspects of illness, the contribution of social medicine, the role of medical social worker. He indicates that the interrelationship between the medical, social and emotional factors of illness should be recognized. He explains that the importance of knowledge of social factors in the treatment of a specific disease cannot be over-estimated. The medical social worker's services should be made use of, and with his help the treatment programme of social diseases like venereal Diseases, Leprosy, Tuberculosis will be made easy. The physician would need certain additional information touching on the source of infection and the contacts made by the patients, because the patient would not divulge it even to the physician. The rehabilitation of patients requires the assistance of more and more social workers. The latter can also help in medical social research, being familiar with the medical and social factors, which affect each other initially.

Thus the author explores the wider scope of collaboration between Medical Man and Social Scientists in the diagnosis and treatment of diseases of body and mind.

"Socio-economic context of health and medical care" is a study made by A.L. Srivastava. The article establishes the fact

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that economic conditions, education and occupation influence the responses of people to problems of health and hygiene. Sanitation, health are more cared for by the upper strata than the lower. The author quotes a number of empirical studies undertaken in support of his hypothesis that health and medical care is influenced by socio-economic contexts.

"Occupational attitudes of Physicians" has been studied by A. Ramanamma and Usha Bombawala. It is an empirical study of doctors. The study examines the degree of interconnection between the physician and the patient in order to perform the role-obligations of physician. Inquiry is also made into the question whether the physicians are able to attain effective neutrality in their interactions with the patients.

A.K. Yesuddin has made a study of "Different utilization of health services in a Metropolitan City". This article is based on his Ph.D. thesis. It is an empirical study of 165 patients. The class background, and educational status of patients have been studied. The author has highlighted the role of social inequality in the utilization of health services and the differential socio-economic status among different social classes. Further their differential educational achievements produce differential knowledge of health and disease, health services and perceptions of health service needs. All these factors, the author points out, mould the utilization pattern of health services of different social classes.

"Health, Man-Power and Doctor Migration: " Cole P. Dodge has made a thorough analysis of the condition of health services in developing countries. He points out that the doctors migrate to cities. In his own words, in contrast to the rural area, the largest Indian cities are crowded with doctors. Already, Bombay, Calcutta and New Delhi have a doctor-patient ratio of 1,500. The number of doctors serving 450 million rural population of India in 1971 was less than the number of doctors working abroad, 10,000 to 15,000 respectively. The author feels that in all developing countries doctors prefer a city to the rural or the countryside.

The article is highly informative and compares the health manpower of developing and developed countries. The author has also reflected on the causes, conditions of migration of doctors to urban areas in the Indian context. He quotes, B.K. Mahajan, that "Medical graduates whether qualified in the U.S., U.K., or Indian are urban-biased, hospital-dependent and disease conscious."

"A Sociological Study of the Student Community in Mysore City Undergraduate Students of Medical Courses " is a consolidated report of an empirical study by Sharadamma. This study belongs to the field of sociology of Medical Education. The doctors in the making, the student-physicians are studied with a view to understand their socio-economic background and how the latter influences their choice of profession. The student-physician is a part and parcel of society. He perpetuates the medical culture which is again influenced by the total social milieu of which it

is a part. The present study focuses on the study of his educational process, the mechanisms nurturing his ambition to become a physician, as well as factors presenting obstacles in his doing so. In the same way, the impact of the medical setting on his outlook, activities and habits is also studied. Five hundred and fifty students of medicine have been studied. It is almost two decades since the study was made. Changes have taken place since then in the scheme of medical education, pre-professional course has been abolished and the intake has been increased, but the pattern persists. The castewise breakup of the student-physicians more or less remains the same when compared with my findings. The study therefore, helps us to look at the medical professionals from their angle.

"Women, Culture and Professional Socialization" is a cross-sectional study of women medical and nursing students in Madurai by Venkatarathnam, R. and Annapoorani, M.R. The authors have conducted a field study of 215 medical students and 160 nursing students. After exploring the social and economic background of the respondents, the authors set out to find out how culture influences the professional socialization. Customs, traditional values, morals have roles to play in enhancing or retarding the process of professional socialization among women medical and nursing students. The study tries to find out how women students encounter the restraints of culture in the process of becoming professionals such as doctors and nurses.

1. Venkatarathnam, R. and Annapoorani, M.R., Department of Sociology, Madurai Kamaraj University, Madurai.
"Who chooses Modern Medicine and Why" is another empirical study conducted by T.N. Madan. This paper reports some of the results of a preliminary inquiry carried out in Gaziabad town near Delhi. "The usefulness of this exploratory study lies in its having led to the questioning or refutation of certain assumptions, regarding the influence of the age, education and upbrining of a person on his acceptance of modern medicine." Five hundred households selected on the basis of stratified random sampling method is adopted to find out who are the people who use allopathic medicine and the reasons for the choice they make.

The study is relevant to my attempt to understand the relationship between doctor and patient. Since I have chosen to study allopathy practitioners and their patients, it is not out of context to refer to the above study made by T.N. Madan regarding the reasons people give for choosing allopathic medicine rather than other medicine. Besides, as the author says, the co-existence in a society, of traditional and modern professional services presents a situation full of interest for sociological inquiry.

He postulates that either the two types of professional services will coexist or they come into conflict with each other leading to displacement of the one by the other, but these postulates become rather questionable in the light of recent interest in reviving the indigenous medicine systems to cure cancer, or leprosy, etc. Indian Journal of Medical Research has recently published an article on "Traditional Medicine System of Global Importance" in which there is a reference to the research.

being conducted in Ayurvedic Medicine system to explore its capacity to cure certain types of diseases. The current status of Ayurvedic medicine system will be referred to in the second chapter of the present study.

The findings of the study are that 4/5th majority of the interviewees have a first preference for allopathy. The most common reason for whatever choice or combinations are made, is the belief that the chosen course of treatment is going to be most efficacious.

The study also reveals that Rural-Urban dichotomy, Age, Education and so forth are not significantly associated with the choices or combinations.

"Socio-Economic Equity and Health Problems of Women" is an empirical study of 372 Tribal Women and 385 Rural Women in Vishakapatnam in Andhra Pradesh. Prabha Ramalingam, has found out in her study that the poorest of the women do not have access to basic health care. She has also brought out that the maternal health care has not reached them while the propaganda of the Family Planning/Welfare Programme have reached.

"Service Orientation of Doctors in India - An application of the concept of relative deprivation to doctors in Madurai University" makes an interesting study of 200 doctors

1. "Socio Economic Equity and Health Problems of Women", Dr. Prabha Ramalingam, XI World Congress of Sociology, Jawaharlal Nehru University, New Delhi, Aug. 18-22, 1986.
2. "Service Orientation of Doctors in India - An Application of the Concept of Relative Deprivation to Doctors in Madurai City", Ms. S. Gokilavani, Department of Sociology, Madurai Kamaraj University, Madurai, XI World Congress of Sociology, Aug. 18-22, 1986 (New Delhi).
of Madurai City. The study points out that the doctors are more oriented towards specialization not helpful to solve common health problems of Indian population. It is evident in the choice expressed by the doctors towards the field of specialization. General Surgery, Paediatrics, General Medicine. Obstetrics and Gynaecology and Neuro-Surgery are more attractive to doctors than other specialities.

1. Medical Sociology in an Indian Setting is a product of research study in the field of Medical Sociology made by Venkatarathnam and published in 1979. It is an attempt to understand an aspect of sociology of health and health behaviour. It is an elaborate clinical study of the role of doctors and nurses in an organizational setting.

While discussing the findings of the study, the author concludes that many of the attributes attached to medical profession as ideal types are yet to become realities in the study of hospitals. The gap between the ideal and actual situation can be reduced only with a thorough change in the philosophic approach to the problems of economic and social life of which doctors and nurses are a part. It is opined by the author that these occupational groups cannot disentangle themselves from the dialectics of social life and remain idealistic. Hence the deviation from the ideals. The author expresses the view that in order to make these groups come nearer to these ideal types, the adult socialization process during the medical/nursing school life has to be different from as it exists now.

Medical Sociology in an Indian Setting is thus helpful to understand the way health and hospital personnel function and what factors either inhibit or facilitate their role performance and how the doctor, nurses and other services are also under the pressure of non-professional factors. The total social set up is responsible for the kind of socialization that the doctors, nurses undergo. The socio-economic background of the doctors and nurses helps us to understand their professional role-performance. After all doctors and nurses are men and women, members of society subject to pressures in their different roles. Hence there is wide scope for sociological understanding of medical professionals.

Doctors are called as fulfledged professionals and nurses as semi-professionals. Are the doctors and nurses committed to their profession? Which factors influence commitment? How do the doctors and nurses perceive their role? What actually are their role-performance? What are the occupational value-orientations of doctors and nurses? These questions have all been analysed by the author. The role-conflicts, role relations, role-behaviour of doctor and nurses have also been studied and analysed. At the end, the author seeks to establish a theory of occupational role structure. The author has made a comparative study of doctors and nurses, by analysing how these professionals function in a milieu of teaching hospital organization.

The socio-economic background of the patients are analysed. The relatives who play the health-attendants, the social structure of the ward hierarchy in the hospital staff, the different roles to be played by the nurses, nurses as perceived by the patients and doctors are also analysed and explained. Though...
the study is not a comprehensive one, as the author puts it, it contributes to the understanding of the mutual behaviour of patients and organisation though in a limited way, thereby implying the wide scope for such studies, structures, inter-relationships, attitudes and values of persons involved in medicine, in a word, to study medicine as a system of behaviour. The latter refers to studies specifically designed either to help solve a problem in medical practice, the allocation of health resources, for the operation of health facilities.

1. *Doctors and Nurses*, by T.K. Oommen makes a significant contribution to Medical Sociology in an Indian setting. It is an empirical study of 1022 doctors and nurses of ten public hospitals in Delhi. The field study was completed between 1966 and 1970. The author has made a detailed and comparative study of doctors and nurses - how these professions function in a milieu of hospital organization. The focal point of attention is "Professionals in Organizations".

The occupational role structures defined as interrelationships between the different dimensions of occupational role analysed in this study makes a contribution to an interesting sociological issue relating to professions. The hypothesis is that the manner in which an occupational category carry on their activities is influenced not only by the degree of professionalization but the nature of the milieu in which the activity is pursued. And so, the above study intersects between the areas of role-analysis, organizational behaviour and sociology of professions and professionalization.

"Socio-Economic Injustice and Hospitals: A socio-geographical analysis of the location of hospitals in the city of Madurai" is an article based on the survey of Madurai Corporation. The study reinforces the fact that medical care facilities and services are almost always concentrated in the heart of the city. It is already well-known that the allopathy doctors are urban biased and speciality oriented.

"The Sociology of an Indian Hospital Ward" is an empirical study conducted by Joanna Patrick. The book has been reviewed by Prof. T.K. Oommen published in Religion and Society. This study of female hospital ward of a Christian Mission hospital in a small town in Punjab cannot be a typical Indian Hospital Ward in the opinion of the Reviewer. The central theoretical purpose of the monograph is to unfold the fallacies of Western models with the aim of refining them. The co-existence of the traditional non-rational and modern rational elements in the empirical setting seems to have surprised the investigator. The Reviewer of the study points out that this is due to an erroneous theoretical assumption rather than a refreshing discovery of empirical reality.

1.6 Scope and significance of the present study:

This is an empirical study exploring the doctor-patient relationship from a sociological point of view. It is recognized that in contemporary India, though Allopathy is the most visible form of medical system, traditional systems of medicine such as Ayurveda, Siddha, Yunani and Homoeopathy also continue to meet the

1. "Socio-Economic Injustice and Hospitals", Ms. S. Gokilavani, Lecturer, Department of Sociology, Madurai Kamaraj University, Madurai, XI World Congress of Sociology, New Delhi. Aug. 18-22, 1986.
medical needs of a large number of people. However, the present study is limited to the doctor-patient relationship in the Allopathic system.

The objectives of the present study are the following:
1. Identification of the socio-economic background of the Doctors in Government and Private Medical Settings, the views of the doctors regarding their profession and their expectations from the patients.

2. Identification of the socio-economic background of patients in Government and Private Medical Settings, factors relevant to patients' choice of a particular doctor, their expectations from the Doctor.

3. Examination of the impact if any, of different medical settings, on the nature of Doctor-Patient relationship.

1.7 Methodology:

The data for this study are collected from 400 doctors and an equal number of patients. The doctors selected are M.B.B.S. Graduates or Post-Graduates working either in Government or Private hospitals in Mysore City. As the total number of doctors in the city is limited, data has been collected from available doctors.

The medical settings that are chosen for study include Government hospitals, private hospitals, nursing homes, health centres, family welfare units, etc., where allopathic medical practitioners work.
The Government hospitals approached for study are Krishnarajendra Hospital, Cheluvamba Hospital, P.K. Sanatorium, Railway Hospital, E.S.I. Hospital, Mohandas Tulsidas Hospital, Nursing Homes and Clinics.

Before discussing the methodology in detail, let me describe the major Government Hospital of the City, Krishna Rajendra Hospital, popularly known as K.R. Hospital, is a Government hospital providing medical care to the Mysoreans and surrounding villagers. It is a big complex having a number of units. The Maternity Hospital is known as Cheluvamba Hospital and it is also located in the same premises. A separate hospital for children is functioning in the same compound.

1 A brief history of K.R. Hospital may be considered: Prior to 1886 there were three classes of medical institutions in the State, namely, first class institution with hospital accommodation, second class which were dispensaries with a few beds and third class which were merely dispensaries. Mysore which was the capital, where the Maharaja lived, had the privilege of having a first class hospital. Bangalore City was then a second class station with a town hospital and dispensary.

The nucleus for K.R. Hospital was started at Mysore during the year 1876. It was expanded at an expenditure of Rupees Five lakh.

In 1930, when the Medical College was transferred from Bangalore to Mysore, this institution became the major teaching hospital providing clinical facilities to the college.

The present out-patient block was built in 1927 in commemoration of the Silver Jubilee of His Highness and Maharaja of Mysore, Krishnaraja Wodeyar. It was commissioned with medicine and surgery departments. By 1930 Eye and E.N.T. departments were added. In 1949, Dermatology and Venerology departments were added. This was followed by Dental Department in 1950, Orthopaedic department in 1961, Psychiatry in 1964, Thoracic Surgery Unit in 1978.

The statistics of the early period is not available. In 1967, 5,92,076 out-patients have got themselves treated amounting to a daily average of 1622. The patients continue to come not only from Mysore city and district, but also from the neighbouring districts of Hassan, Chickmagalure, Coorg and Mandya.

The new out-patient department block has come up in the premises of the hospital complex. It has four floors meant for different functions. The new building will be up to date and well planned. Now K.R. Hospital is the largest teaching hospital in the State with a sanctioned bed strength of 1050.

K.R. Hospital has been visited during the working hours for data collection, between 8 a.m. and 12 noon and again between 3.00 p.m. and 5.00 p.m. Service is free of cost for out-patients and ward charges are collected from in patients admitted to special wards. The hospital provides medical care to a large number of patients. In 1979 itself, the average daily out-patient attendance stood at 900. In 1981, 23,765 patients have been treated; 3,775 operations have been conducted. In 1982, 24,665 patients have been treated and 4,757 operations have been conducted. In 1983, 25,613 patients are treated and 5,118 people are operated upon. The bed strength of the hospital in 1981 has
been 1050, out of which 973 are commissioned. There are about 569 staff members forming the hierarchy of positions in the administration of the hospital. On the medical side, there are 26 doctors appointed to work in the hospital. Apart from them, there are post-graduates specializing in different branches of medicine who also work in the hospital. The teaching staff of medical college also come to hospital and, added to them are internees undergoing training after their graduation in medicine. Thus I have been able to collect data from doctors concentrated in the hospital complex.

Cheluvamba hospital, housed in the same premises of K.R. Hospital, is a maternity hospital. Cheluvamba Hospital celebrated centenary this year. A brief history of this hospital may be relevant here.

Formerly known as Vani Vilas Hospital, located on Yelwal Road behind the present Mararani's College hostel, it was started in 1890. After Maharani Kempananjamanni provided the hospital with 21 beds it came to be known after her. Further expansion in 1939 added two storeys and 175 beds at a cost of Rs.4 lakh to the hospital, which was again renamed as "Cheluvamba Hospital."

There are at present four clinical laboratories with one each for Cheluvamba block, one for the children's hospital attached to the maternity wing in 1964 and two for the out-patient department. There is also an independent bio chemistry laboratory at the children's hospital, which includes the Department of Paediatrics of K.R. Hospital. It has a bed strength of 80. Nearly 10 years later, another ward was constructed with donations

1. Indian Express, 28th December 1988.
from Mrs. Akkal Bai.

Located amidst lush green grass adjacent to the K.R. Hospital on Irwin Road, this Government hospital now has a bed strength of 400. There has been a marked rise in the number of out-patients. In 1980-81, there were 28,174 out-patients in obstetrics and gynaecology. This figure rose to 39,832 in 1984-85.

During the last eight years, there have been 40,995 deliveries at the hospital. On an average 5,000 babies are born per year. The bed occupancy rate is 78 percent.

During the last three years, 3,328 sterilization operations have been conducted. Pregnancy was terminated medically in 1,410 cases. Since 1984-87, 77 staff nurses and 73 group "D" officials have been trained in laproscopic sterilization at the hospital. A total of 114 doctors have been trained in medical termination of pregnancy during the same period.

But this leading hospital is not without problems. The number of out-patients demanding treatment is on the increase though the hospital is not being expanded proportionately. Hospital Superintendent Dr. Anke Gowda laments that the funds received are too meagre to expand the facilities.

Private hospitals are also visited. Hardsworth Memorial Hospital generally known as Mission Hospital, is run by the Christians. More details about this hospital have been given in the Sixth Chapter. In all, there are 18 doctors working in this hospital. The bed strength is 280 and the charges for special ward varies from Rs.15 to Rs.25 per day. Daily attendance of the

1. Please see Page No. 159
patients stands at 150. Out-patients pay fees ranging from Rs. 3 to Rs. 10. Specialists charge Rs. 30.

Railway Hospital has also been visited and data is collected from doctors and patients. Like in other places in our country, here also the services are confined to the Mysore Division Railway employees.

E.S.I. Hospital which is housed in a newly constructed building caters to the medical needs of the employees of the various factories.

P.K. Sanatorium is a Government hospital and it treats patients suffering from Tuberculosis. Both preventive and curative measures are adopted by the hospital. The data is collected from the doctors and patients of this hospital also.

There is one more private hospital increasingly visited by the local people: viz., the Kamakshi Hospital run by a Hindu Trust. It is also observed that experienced medical doctors of both Government and Private Medical settings visit these hospitals and nursing homes.

Recently, one more private hospital called B.M. Hospital (Basappa Memorial Hospital) has been added to city. Though I had no opportunity to collect data from the doctors and patients of this setting, I have met some of them, who have also worked in the Government hospital.

Doctors' clinics, mostly manned by single doctors, are visited for data collection. Every locality in Mysore City has got a number of Doctors' clinics where out-patient treatment is given. More details of these clinics are given in the fifth
Data is collected from the doctors and patients with the aid of a questionnaire. Doctors working in different medical settings have been met and requested to fill in the questionnaire. Doctors who are willing to express their views have been interviewed wherever possible.

Similarly, patients are also contacted under different medical settings. Respondents include in-patients and out-patients. Literate patients filled in the questionnaire themselves. In the case of illiterate patients, the information has been elicited by the investigator. Sometimes the attendants of the patients have provided the information.

Pre-testing of the questionnaire has been done and the suggestions of the doctors wherever feasible are incorporated. The questionnaires which are separately prepared for doctors and patients, have both closed and open-ended questions.

It may be relevant to note some of the problems encountered during data-collection. Though most of the doctors have generally co-operated, sometimes it has not been possible to contact some of the senior doctors who were very busy. So far as the patients are concerned, it is necessary to recognize that the atmosphere of the hospitals is not conducive to a normal interaction and the investigator interested in collecting data from the very persons who are under treatment will face special problems in establishing rapport and eliciting information. The patients may be in no frame of mind to respond to the questions of the investigator as they are preoccupied with their illness, their desire to get relief from their complaints as early as possible,
etc. As a result, considerable effort has been involved in collecting information from the patients.

The data collected are processed in the framework of the objectives of the study. The data collected are statistically analysed, tables are prepared and the major findings have been given a tabular form. These tables are presented in the thesis in suitable contexts.

Apart from primary data, secondary data are also collected from health authorities of the city and state, census data, information published in magazines, periodicals and newspapers, etc.

1.8 Organization of the thesis:

The thesis is divided into seven chapters, each dealing with different aspects of the problem under the title, "A sociological study of Doctor-Patient relationship in hospitals, nursing homes and clinics in Mysore city". The first chapter is a historical study of relation of medicine to society and the social components of illness. In this chapter, I have also tried to give a brief account of medicine as practised in preliterate and literate societies.

In the second chapter, an attempt is made to present the systems of medicine prevalent in India. Here, a brief description of Ayurveda, Siddha, Yunani and Homoeopathy and Allopathy has been given.

In the third chapter, with a brief and general introduction on doctor-patient relationship in sociological context, I have presented the field data collected from the doctors working in a Government hospital medical setting. Data on
doctor-patient interaction in the Government hospital setting is the main focus of this chapter.

Fourth chapter presents the data collected from the patients studied under Government medical setting. Size, composition and the interaction of patients with their doctors have been analysed.

The fifth chapter is concerned with the private medical settings. Field data collected from the doctors working in the private hospitals, nursing homes and clinics have been presented here. The size, composition, and the interaction of private doctors with their patients have been the major concerns of this chapter.

The sixth chapter is about the patients studied under private medical settings. Data collected from these patients cover the size, composition and their interactions and expectations, etc.

In the seventh chapter, the findings of the study are summarized and conclusions are drawn. A few areas of further studies in this field are also indicated.