MEDICAL SOCIOLOGY IN INDIA: IN SEARCH OF AN ALTERNATIVE PARADIGM

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CERTIFICATE

This is to certify that the dissertation entitled - '**Medical Sociology in India : In search of an Alternative Paradigm;**' submitted by Sanjay Awasthi is in partial fulfilment of the requirements for the award of the Degree of Master of Philosophy of this University. The dissertation has not been submitted for any other degree of this university or any other university, and is his own work.

We recommend that this dissertation be placed before the examiners for evaluation.

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CONTENTS

CHAPTER 1

EMERGENCE, GROWTH AND DEVELOPMENT OF MEDICAL SOCIOLOGY IN THE WEST

As far back in time as one can ascertain, men have lived in the organized groups that we call communities and have had to deal in one way or another with health problems arising from their biological, social, cultural, or political attributes and needs and from their corresponding circumstances.

Evidence of activity related to community health has been found in the very earliest civilizations. One of the earliest attempts in the Western Word to formulate principles of health care based upon rational thought and the rejection of supernatural performance is found in the work of the Greek physician Hippocrates. The writings attributed to him have provided a number
of principles underlying modern medical system and its interaction with the bigger social system. In his classic treatise, on 'Airs, Waters, and Places', Hippocrates pointed out that human well being is influenced by the totality of environmental factors: living habits or lifestyle, climate, topography of the land, and the quality of air, water and food. Interestingly enough, concerns about our health and the quality

of airs, waters and places are still very much with us in the twentieth century.

Besides his other contributions, Hippocrates maintained that both the mind and the body profoundly affect each other and cannot be considered as independent entities. Thus, a basic precept of the Hippocratic orientation was the recognition that the social environment was an important factor in understanding illness.

A few physicians, such as Paracelsus, a famous Swiss Doctor who lived in the early sixteenth century, did continue to show concern with health and social conditions. Paracelsus demonstrated that diseases common to certain occupations (such as mining) were related to the work environment. He also argued that mentally ill persons were neither criminals nor sinners but sick persons in need of medical assistance. However, the middle ages and the renaissance saw few systematic measures undertaken to explain the relationship between the mind and the body and the effect of adverse social conditions upon health.

It is because of this that Coe feels both medicine and sociology developed more or less separately from about 1890 until after World War II (Coe, 1970). And, as Cockerham has felt, it might be because of the fact that most members of the medical

profession in the 1800s were primarily interested in improving the state of medical technology. They were not necessarily concerned with social reform. The success during this century of Louis Pasteur, Robert Koch, and others in bacteriological research that led to the conceptualization of the germ theory of disease, alongwith tremendous progress in the development of internal medicine, anesthesiology, pathology, immunology, and surgical techniques, convinced physicians to focus exclusively upon a clinical medicine grounded in exact scientific laboratory procedures. The practice of medicine in the twentieth century thus rested solidly upon the premise that every disease has a specific pathogenic cause where treatment could best be conceptualized by removing or controlling that cause within a biomedical framework. According to Sahu, "In this view treatment readjusted the body until its physiological norm was restored, a mechanistic approach that reduced the body to a machine whose organs could be discretely examined and regulated".(Sahu, 1990, pp 53.54). Dubos has pointed out that modern medicine's thinking has been dominated by the search for drugs as 'magic bullets' that can be shot into the body to kill or control all health disorders. (Dubos, 1969).

According to Hepburn, this shift of emphasis from social medicine to biomedicine had a very adverse effect on the proper understanding of the health problems in a totalistic perspective

and, in subsequent years, has dominated the formulation of health policies to such an extent that it haunts the health planners even today. It has further been argued by Hepburn that the effectiveness of health development project is lessened if they are planned on the basis of this orthodox biomedical orientation (Hepburn, 1988).

While the development of modern medicine emphasized the biological and neglected the behavioural sciences, the sociology, in turn, originally spurned the influence of biological elements upon human social behaviour. (Cockerham, 1978). For that matter, a case can be made that modern sociology developed largely in opposition to biological theories that explained differences in human behaviour on the basis of innate biological characteristics. One of the most significant factors in the thought of the French sociologist Emile Durkheim _ whose theories have dominated a large portion of sociology's approach to human behaviour, was his strong rejection of biology (Nisbet, 1974). Although recognizing that biological explanations of human behaviour contribute to our understanding of human interaction, Durkheim argued that they can never be totally sufficient explanations. Instead, the base for sound explanations of social behaviour were to be found in the "social processes of culture, environment, and human thought". Thus social behaviour must be explained from the standpoint of such social elements as norms,

values and statuses that comprise the basis of human group life. The persuasiveness of Durkheim's argument and its support by other sociologists led to the nearly total disregard of biology by social theorists.

Only within the past few years have the contributions of biology once again been given serious sociological consideration.

The Industrial Revolution in Europe and the Development of the Foundations of Medical Sociology

The industrial revolution in Europe brought with it the large - scale migration of the population from the rural to the urban; on the one hand because of the enclosure movement, there was no means of livelihood left and on the other hand the newly emerging industries needed the human work force on a mass scale. Consequently this phenomena of mass migration to the urban areas also led to the creation of various health problems, which were never witnessed before - crowded residential areas with filthy and unhygienic living conditions as well as working conditions. This forced various scholars to find out the root-cause of such health problems which could be done only by taking into consideration the various socioeconomic factors into account. Thus, it was in the year 1837 that M'Cready (M'Cready, 1837) reported the results of a prototype of the sampling survey, in

which he had used the records and collective memory of trade unions as one of his sources of information. This was also one of the earliest accounts of the occupational differences in mortality rates. But perhaps the most interesting point was his discussion of the deleterious effect upon health of the worry and strain, disruption of family life, and spiritual insecurity of the milling herd of rootless workers.

The historical background indicated that the welfare motive, though present, has made little contribution to recent and current developments, but it cannot be dismissed (Hawkins, 1958). There have been many instances of merging the sense of medical sociology and social medicine (Anderson, 1955) - a characteristic typical to the period of the industrial revolution in Europe. As such the latter term is European in origin. To the extent that the word "Sociology" is used at all in the literature on the subject, it carries the condition current in Britain prior to World War II of welfare philosophy, comprising a nucleus of philanthropic social work and ground substance of descriptive statistics enclosed in a membrane of Fabian Socialism.

As an extension of his views on the relations of medicine to society, Virchow developed a theory of epidemic disease as a manifestation of social and cultural maladjustment (in Freeman

et.al, 1963). He differentiated between natural and artificial epidemics as"attributes of society, products of a false culture, or of a culture which is not available to all classes...". Furthermore, these artificial "epidemics occur not only as a result of social contradiction, but also as significant manifestations of the historical process".

Although industrialization began later in Germany than in England and France, and proceeded at a slower pace during the first half of the nineteenth century, by 1848 the existence of a wage-earning class-an industrial proletariat-could no longer be overlooked. As in England and France, industrialization was ushered in by a slaughter of the innocents. Those that survived the cradle were given over to the tender mercies of the factory, and the mine. It was plain, said Virchow, that "the proletariat in ever increasing degree became the victim of disease and epidemics, its children either died prematurely or developed into cripples" (in Freeman et.al, 1963).

Though there were a few studies done amongst the industrial workers' these pointed out the poor health status of the working population but failed to establish any relationship between health and socio-economic status. While on the other hand various researchers, most commonly physicians did recognize that social and economic institutions--especially industrialism--had significant and necessary connections with the problems of the

factory workers. During the 1830s and into the 1840s a gradual but definite shift in thought and attitude on the social aspects of health and disease became evident. Remarkable in this orientation was Chadwick. In the same way Greenhow, based on his empirical data inferred that various environmental factors cause disease, and that "some of these causes of preventable sickness and premature death arise necessarily from the circumstances of our social system...". Similar was the study by John Simon. Again, in 1874 Nikolas Alois Geigel tried to establish a relationship between the rise of capitalism, growth of an industrial proletariat, fast pace of organization and the resultant unhygienic conditions; and changing socio-economic situation, health and illness. (in Freeman et.al, 1963)

Erismann in the Russian context highlighted the artificial environment imposed upon the human being by his social conditions in which he has no control. (Semashko, 1946) In France, Alexandre Layet published a socio-medical study of rural populations in 1882. (Layet, 1882)

At the same time, despite the then dominant forces of capitalism and capitalist modes of production and ideology, it is interesting to note that at the very peak of the bacteriological triumph, various physicians reacted against this dominant trend, probably because of the significance of social conditions in the

causation of disease. Among these were Max Rubner in Germany, Ferdinand Hueppe in Austria and Emile Duclaux in France. Duclaux felt that apart from infections agents the various communicable diseases can be attributed to factors such as nutrition, working and living conditions, education and income. (Freeman et.al., 1963)

Emergence of the Term 'Medical Sociology'

A careful and protracted search reveals no pronouncement on the subject prior to that of McIntire, and it is very unlikely that the term could have occurred much earlier, for American sociology stemmed from the works of Harbet Spencer, particularly his 'Principles of Sociology' which appeared in three volumes, beginning in 1876.

In view of the social and medical climate then existing it is not surprising that McIntire's paper should have been written, nor that it should have been written by a physician. What is truly striking is the clear vision which suggested a future framework of action (McIntire, 1894).

(1) The study of medical practice:

(a) Medicine as a profession, an institution, and a segment of social history,

(b) Medical status, roles and social interactions in relation to diagnosis, care, management and business activities,

(2) Public Health:

(a) Social epidemiology and etiology,

(b) The investigation and modification of attitudes,

(c) Supplementing narrow specialties with general knowledge.

As we have seen, even sociologists, anthropologists, and physicians who have given considerable thought to the subject of medical sociology with benefit of hindsight, have not improved greatly upon this outline. Nor is it possible to argue with his definition of sociology as "the science of social phenomena, the science which investigates the laws regulating human society: The science which treats of the general structures of society, the laws of its development, the progress of civilization, and all that relates to society". (McIntire, 1894, p.425)

A few years later a special domain of physicians with added training was envisaged by Kime. (Kime, 1906) Included under this specialty, he believed, would be population analysis in the epidemiology of disease, legal and professional aspects of medical practice, and the study of ethnic and cultural factors related to health, crime and poverty. This was not too far from McIntire's proposal, but the scientific element was somewhat submerged in the zeal of a crusader.

The book by Warbasse (Warbasse, 1910) was somewhat flat after so promising a start, for it dealt entirely with the broad social aspects of medicine: the relationship between medical service and the public, the social factors in training and professionalism, and the effects of disease upon society. Moreover, it contained no materials from the social sciences, which even that early had made some recognizable contributions to knowledge. Even more anticlimactic was Arrington's theme that the individual and society have mutual obligations and it is upto physicians to harmonize these obligations. (Arrington, 1929)

These two examples have presented just to show that how difficult it had been for medical sociology to establish itself as a separate and important area of study, due to the then prevailing dominant trends in the field of health research.

The identical term seems not to have been used again in the philosophical sense until the appearance of the truly historic discussion by Mangus. (Mangus, 1955) This work was distinguished by its professional tone and by its invitation to social psychologists and anthropologists to integrate in a new specialty. What makes it remarkable, however, is that it was the only publication upto that tune which attempted a theoretical foundation for a behavioural study of health.

Role of the Social Scientists

A number of important contributions have been made---- largely by social scientists, but sometimes by physicians---about the place of the social scientist in medicine.

There was a single cryptic remark concerning exceptional research opportunities in an early book by Davis, (Davis, 1927) the study of professionalism as it related to society and sociological principles was touched upon by Vincent, (Vincent, 1929) and there were other scattered hints, but nothing definitive until the discussion by Lindermann. (Lindermann, 1949) His remarks on social and personal equilibrium, crisis, (defined as 'marked change in interaction'), role (both actual and ideal), and their relation to the emergence of tensions and metabolic disturbance, anticipated in same measure the thoughts of Mangus. Some of the situations in which he thought marked changes or discontinuities might occur were bereavement, loss of customary activity pattern, and shifting family roles and expectations.

Anderson, (Anderson, 1952) wrote in the entirely different vein. His concern was how the sociologist could best accommodate himself to the requirements and interests of the physician and medical student. The field of endeavour was described as concern for the sick and well in groups, but he obviously took "group" to mean "aggregate". He suggested demographic work, both the type usually called ecological (specific rates by occupation,

nativity, and so on, from area to area) and the analysis of historical patterns. There would also be considerable place, he thought, for the study of the relations between social movements and medical development. Some attention was given to mental disease and chronic illness.

The following year brought a paper of much richer detail for the social scientist but with less concern for what physicians were prepared to accept, from Blackwell (Blackwell,1953). His outlook was emphatically scientific and professional. Behavioural sciences were distinguished from other social sciences by their aspirations towards rigorous testing and prediction; and he insisted that science be divorced from "social aspects", which he thought a good journalist could handle as well, from social service, and from exclusively pathological study. Public health administration and community relations were considered important areas of endeavour and specific mention was made of heart diseases, geriatrics and mental disorder.

Leavell (Leavell, 1952) argued for what Strauss thought to be incompatible, the analysis of medical social control by scientists participating in policy decisions, in the 'sociology 'of' medicine' and 'sociology in medicine' combined. Leavell's contribution is especially important for two reasons: it presents the only extensive critique of professional, as contrasted with

personal relations, and is the earliest source containing a lengthy bibliography.

A number of others have included these subjects as subsidiary or tangential matters and two of these are worthy of comment. Social epidemiology, reactions to illness, hospital, social structure, and public attitudes were mentioned as subjects of study by Clausen (Clausen, 1956). He saw nothing inconsistent in occasional consultative functions or the direction of special projects by sociologists. While the chief point made by Rohrer was that few people have the capacity to master theoretical concepts in both kinds of science; a unique but important and remarkable view point. (Rohrer, 1953)

Sociological Theories and Medical Sociology

The relationship of the field of medical sociology with sociological theory can be traced back to the times of Emile Durkheim (1358-1917), the famous French sociologist and widely acknowledged as a 'founding father' of modern sociology who helped to define the subject matter and establish the autonomy of sociology as a discipline. In the context of medical sociology, a major sociological tradition derives from his theory that suicide rates and different types of social context are related, in particular that suicide is related to the level of social

integration so that increased disintegration leads to increased numbers of suicides. Three other characteristics of Durkheim's works have also been adopted: (1) a concern with aggregate rates of suicide rather than individual acts and motives; (2) a positivistic approach that relates suicide rates to 'objective' external variables; (3) the use of government statistics as the data source. (Lukes, 1972; Giddens, 1978)

M.Halbwachs (Atkinson, 1978) concluded that Durkheim's analysis could be simplified to an inverse relationship between social complexity and suicide rates, demonstrated by the fact that suicides were lower in rural areas where life-styles were simpler than in towns. Modern theories usually assume that rapid changes of socio-economic status are the cause of suicide, though unlike Durkheim they include various psychological factors to explain why only certain individuals commit suicide in these circumstances.

Outside the Durkheimian tradition, 'ecological' accounts such as R.Cavan's also focus on social disorganization, which is conceptualized in terms of population variables such as high rates of social mobility and social complexity that weaken the influence of social values on individuals. (Cavan, 1928)

Another important contribution has been made by Talcott Parsons through his two concepts - "sick role" and "pattern variables". Though the concept of sick role was first outlined by Henderson (1935), it was elaborated by Parsons (1951). From a sociological perspective illness can be regarded as a form of social deviance, in which an individual adopts a specific role. Parsons argued that the stability and cohesion of any social system was threatened by ill-health, because those who experienced it were unable to fulfil their normal social obligations in their family and work settings. It was in the general interest of society, therefore, to ensure that those who become ill should feel obliged to seek expert help to enable then to recover as quickly as possible and resume their usual social roles. In modern, industrial societies, seeking expert help implied consulting the qualified medical doctor or physician. While they remained ill, they occupied a new role - that of a sick person.

Parsons implied that, although in most instances individuals seeking to rid themselves of the pain or discomfort of their illness would willingly obey their doctor's orders, some might see advantage in prolonging the sick role if they could avoid onerous social obligations. In this he drew upon psychoanalytic theories which purported to explain hypochondria as a state in

which individuals claim to be ill when expert can find no abnormality to explain the pain or the behaviour.

Although Parson's concept of the "sick role" has demonstrated research utility as a framework for explaining illness-related behaviour and has become a basic concept in medical sociology, the model has some serious defects which led a few sociologists to suggest that it should be abandoned altogether (Kosa and Robertson, 1969; Berkanovic, 1972). Gerald Gordon (1966) has pointed out that, although widely accepted, Parson's sick role concept is not based upon systematic observation and has not been empirically validated. Gordon states that the sick-role concept has been accepted primarily because of its prima facie reasonableness and logical construction.

Once again Parsons was a pioneer in the field of "Doctor-patient interaction", having an important place in medical sociology (Rocher, 1974). He suggested a theoretical model of the doctor-patient relationship based on structural-functionalist assumptions. Given the social importance of restoring sick individuals to health, he argued, doctors and patients were expected to enter into a pact. For the duration of the illness, patients agreed to surrender some of their normal autonomy to the doctor, while the doctors, for their

part, agreed not to use their authority to exploit the dependency of the patients. Thus, for instance, patients had to permit doctors to examine them physically and ask detailed questions about their intimate daily habits. Patients would only do so, Parsons postulated, if they were confident not only of the doctor's technical knowledge and skills, but also of his discretion and objectivity and his personal disinterestedness and commitment to their well-being. In this way, Parsons drew up a profile, or patterning of the requirements of the doctor's role in the relationship which could be compared and contrasted with the patterning of other so-called professional roles and with that of a businessman.

No sooner was this model of the doctor-patient relationship expounded than its limitations as a reflection of real relationships began to be demonstrated. Szasz and Hollender (1956) argued that the extent of asymmetry in the relationship was not always as it had been depicted by Parsons. Two other kinds of doctor-patient relationship were common. In one, there could be no patient cooperation in getting well, i.e., when the patient was anesthetized or suffering from delusions. In the other, the patient might be as knowledgeable about the condition as the doctor, as in the case of diabetes, a chromic condition where there is much more mutual participation and less asymmetry in the doctor-patient relationship.

Szasz and Hollender in essence did no more than modify Parson's model; they did not challenge it. A more fundamental criticism of the model, however, came from Friedson (1970). He argued that the underlying assumption of mutual consensus and cooperation in the relationship could not be sustained. The relationship was so often characterized by conflict as it was by consensus: conflicts about objectives and conflicts about different beliefs about cure and cause. Tension could also arise because doctors could not always fulfil patient's expectations of cure or pain relief.

Sociology of Medicine and Sociology in Medicine

It was as late as in 1956 that Robert Strauss distinguished between Sociology of Medicine and Sociology in Medicine (Strauss, 1957). Sociology of medicine encompasses the use of medical settings and health and illness to study such sociological phenomena as organizational role relationships, attitudes and values of persons involved in medicine. "The institutional setting in which professional socialization of the young recruits to the profession takes place, is also covered under the field sociology of medicine" (Venkataratnam, 1979) While sociology in medicine refers to studies that help to solve problems in medical science or to provide knowledge about a practical problem in medical practice, the allocation of health resources, operation

of health facilities and services. In other words, the sociology of medicine has been more concerned with issues, of power between doctors and patients, and between medicine and the state.

Venkataratnam feels that the sociologist in medicine often has to take the role of an applied scientist to solve certain problems of the medical scientists. For example, he may be asked to help in finding out the social causes for an epidemic spread of a disease in a locality or to find out why people of a community resist taking immunizations. His help may also be sought to explain why patients refuse certain treatment procedures in the hospital or run away from the hospital during the course of the treatment. In these contexts the social scientist has to commit himself to the medical goals of his customer. In this goal identification, his sociological interest is relegated to the background. In these circumstances, objective data collection and freedom of reporting may be jeopardized. His role in medical settings will make him relinquish his main identification as a sociologist. Thereby the feedback to the main body of sociology through his new identification may decrease. Therefore, it is clear that studies in "sociology of medicine" have relatively more theoretical and practical import to the main body of sociology than studies in sociology in medicine.

However, this does not mean that a study in sociology of medicine has no practical use to medical customers and conversely a study in sociology in medicine has no consequence of importance to sociology.

"However, a man who maintains his primary identity with his discipline, in our case "sociology", can continue to contribute to his own field. This professional identity with one's own profession is possible more in the area of sociology of medicine than in the other". (Venkataratnam, 1979, pp.3-4)

Recent Trends

Cockerham feels that what prompted sociologists to organize medical sociology as an area of sociological enquiry in its own right was neither medicine not biology, but the realization that medical practice represented a distinct segment of society with its own unique social institutions, social processes, occupations, problems, and behavioural settings (Cockerham, 1978). The development of medical sociology was greatly influenced by the expansion of the National Institutes of Health in the United States during the late 1940s, which provided the funding and encouraged the interaction of researchers from both the social and the medical sciences. According to August Hollingshead, one of the early participants, a major result of

this interaction was the stimulus to both social and medical scientists to formulate and implement joint projects. (Hollingshead, 1973)

After the II World War, the growth of medical sociology proceeded at such a rate that since 1960 it had become one of the largest sections of the American Sociological Association. Its position was further strengthened when in 1966 the Journal of Health and Social Behaviour became an official American Sociological Association publication. Its position was also strengthened with the journals like "Millbank Memorial Fund Quarterly", "Social Science and Medicine" and "Sociology of Health and Illness".

Seeing the fast growth of medical sociology, John Mckinlay (1971) suggests that the time may come when the research contributions of medical sociology will stand in the same relation to medicine as do those of physiology, endocrinology, and biology as a body of knowledge explaining human functioning in the medical sphere.

However, despite the fast pace of growth and development, upto the present there has been little inclination for either behavioural or medical scientists to look upon cultural and social principles operative in etiology, treatment and the

organization of health services, as a separate specialized area not belonging to any one discipline, yet there is general recognition that the field of interest is not wholly manageable by any one of them. Every discipline tends to conceive of it as one of their many possessions which is shared, for the sake of enlarging the enjoyment of science, with the others.

In one of the most searching and complete examinations of the situation presently available there are discussions of inter-disciplinary, cross-disciplinary, and multi-disciplinary programmes, but no suggestions that the subject matter is truly non-disciplinary or that theory must be distinctively brought to bear with reference to the content and context (Sheps and Taylor, 1954). Medico-behavioural science is an excellent example of the axiom that what is everybody's business in nobody's business. (Hawkins, 1958) In the words of Suchman, "... The trend today is toward weakening rather than strengthening the lines of separation between the behavioural science disciplines and the health fields. Thus we tend to speak of the behavioural sciences as dealing with all aspects of human behaviour regardless of academic discipline and of social medicine as involving not only the patient but the social group and society to which he belongs. There is little doubt that each social science discipline and health field is partner to the other - and progress will be made in the direction of an increasing integration of disciplinary

fields and health services. Future developments will make it more difficult and less profitable to maintain rigid boundary lines or to debate where one aspect of social science or public health ends and another begins". (Suchman, 1963,p.26)

However, it is too early to surmise whether or not Mckinlay's prediction will prove true, because medical sociology is a relatively new field and a considerable amount of research still needs to be compiled and precisely formulated. Nevertheless, John Knowles is correct when he states that medicine is a social science as well as a biological science and that it needs the social sciences as never before. (Knowles, 1972)

Today medical sociology covers a variety of topics (Abercrombie, Hill, and Turner, 1984):

(1) The sociology of illness, illness behaviour and help-seeking behaviour;
(2) The sociology of the healing professions;
(3) Medical institutions and health service organizations;
(4) Social factors in the aetiology of illness and disease;
(5) Social factors in fertility and mortality;
(6) Social factors influencing the demand for and use of medical facilities;
(7) The sociology of doctor-patient integration;

(8) The social effects of different medicine system, such as between private and public provisions of health care;

(9) International patterns of illness and health services.

Sociology of Medical Sociology

Since its emergence and then subsequent growth and development, the field of medical sociology has been predominantly influenced by functionalism and symbolic interactionism, which utterly neglected the politics of medicine. Instead, these schools of thought in sociology, of which medical sociology has been considered to be an integral part, tend to be status-quoist in their approach.

The functionalist school of thought which of late has come to be known as the structural-functionlist school of thought, was evolved initially by the nineteenth - century sociologists who were greatly influenced by the way in which the various elements of a society were interdependent, and they often explained this interdependence in terms of of evolutionary theory or the organic analogy. Just as the heart has the function of circulating the blood, so also do social institutions have functions for society as a whole. Precisely because of this, functionalism could not account for social conflict or other forms of instability, because it saw all social activities as smoothly interacting to

stabilize societies. Furthermore, functionalism cannot account for change, in that there appears to be no mechanism which will disturb existing functional relationship.

It was probably because of these inherently predominant characteristics of this school of thought that the medical socialists never pointed towards the not so positive direction in which the discipline was moving. At the time of the Industrial Revolution, hardly any scholar came forward and highlighted the inhuman living and working conditions of the workers. Due to the enclosure-movements on the one-hand and the steep-rise in demand of the manual work force by the fast-emerging industries, on the other, there was a mass exodus of workers to the urban areas, where they got work in the factories, no doubt., but the cost they had to pay for it was really pathetic. It was only after a few years of the start of the Industrial Revolution that the capitalists woke up to this problem and too because of the decresing productivity of the workers as a result of their constantly deteriorating health status. It was only due to this that the sanitary reform movement started and various laws were passed for the so could improvement of the health condition of the urban masses. Still, there were hardly any steps taken for the rural masses because their ill-health did not affect the smooth functioning of the factories in the urban centres. "While the plight of the rural poor could be conveniently ignored, the

conditions of the urban proletariat could not. First, the rise of working class consciousness was reflected in the formation of trade unions, in demands for better living conditions, and in strike action to force through reforms. Second, mortality and morbidity were becoming so extensive that the capitalists attempt to extract maximum profit through lower real and social wages, were coming into conflict with their need for a productive and reproductive labour force... Third, sanitary conditions became so serious that the epidemics formerly confined to the east ends of large cities, where the poor lived, were spreading to the rich west ends and beginning to kill members of the ruling class". (Turshen, 1981, p.21)

Most of the medical sociologists during that period, functionalist as they were, hardly ever turned their attention towards these problems, and even if they got acquainted to it, always tried to keep it at low key. Even such miserable living conditions were probably perceived by them as "contributing" to the overall 'well-being' of the society, because according to the organic anology, every part in the society just like in a biological organism, has a positive function to perform. Scholars such as Emile Durkheim who propounded the theory of "Suicide" were some of the prominent functionalist theorists.

In later years the structual-functionalism gave way to 'symbolic-interactionism', which then became the most popular ideology in sociology and consequently medical sociology. In the 1970s, this was seen to be a major alternative to functionalism and social systems theory as developed by Talcott Parsons, which then formed the dominant trend in American Sociology (Rock, 1979). It had its intellectual roots in the concept of the self as developed by George Herbert Mead who argued that life depends on our ability to imagine ourselves in other social roles, and this taking the role of the other depends on our capacity for an internal conversation with ourselves. Society was conceived by Mead as an exchange of gesture which involved the use of symbols. Symbolic interactionism was thus the study of the self-society relationship as a process of symbolic communications between social actors. This perspective was particularly influential in medical sociology for the study of doctor-patient interaction and the sick role.

Thus we find that the majority of the scholars right from the emergence of medical sociology till the present day, in order to tow the lines of the dominant trends in sociology in general and consequently in medical sociology in particular, have tended to utterly neglect the basic issues of the health problems of the masses-the inhuman living and working conditions of the industrial workers during the Industrial Revolution, and in

subsequent years also rather than becoming the spokesmen for the cause of these oppressed classes,they became the spokesmen for the very class which had been oppressing the former.

In this context it is essential to note the contribution made by the 'conflict' theorists, a trend which was primarily started by Karl Marx and Frederick Engels (Rex, 1981). Marx had presented a dichotomous model of social conflict, in which the whole of society was divided into two basic classes representing the interests of capital and labour. According to Marx, in every society there can be distinguished the economic base, or infrastructure and the superstructure. The infrastructure consists essentially of the forces and the relations of production, while within the superstucture figure the legal and political institutions as well as ways of thinking, ideologies and philosophies. And there is a constant contradiction between the forces and the relations of production. The bourgeoisie in constantly creating more powerful means of production. But the relations of production, i.e., both the relations of ownership and the distribution of income, are not transformed at the same rate. The capitalist system is able to produce more and more, but in spite of this increase in wealth, poverty remains a lot of the majority (Aron, 1982). In fact, this is precisely what was happening as a result of the Industrial Revolution, when at the cost of the cheap labour of the helpless masses, the capitalists

were generating and increasing profit, day by day. That is to say, on the one hand the capitalists were thriving on the labour of the workers, on the other hand the workers themselves were living a miserable life under inhuman conditions.

In this context, according to Turshen, Engels was the first to deal with the working class as a whole and not only with particular sectors or industries. "He did not simply survey working class conditions, but made 'a general analysis of the evolution of industrial capitalism, of the social impact of industrialization and its political and social consequences - including the rise of the labour movement '" (Turshen, 1981). In this perspective, at times, the government in collusion with the capitalists did take certain steps to improve the health of the helpless workers, but these were only in case of extreme public pressure. But even when various laws regarding the improvement of the health status of the workers were passed, there was hardly any step taken by the ruling classes to ensure the implementation of these laws. This clearly showed the lack of willingness on the part of the ruling classes to improve the health of the working lot, lest they acquire a position so as to threaten the very existence of that group of people which had provided them jobs. And in this context the majority of the social scientists also colluded with these elites.

From around 1886 to 1912-16 various steps were taken to train and appoint public health personnel to look after the health of the workers and their families but its sole purpose was to maintain productivity by keeping workers in good physical condition and by making it difficult for maligners to 'choose' to be ill (Turshen, 1981). Similarly, the function of the material and child welfare officers was to ensure the reproduction of the work force. (Turshen, 1981). And as far as the question of political will is concerned it is clear by the fact that of all the regulations concerning public health, the ones that were potentially the most costly to industrialists were the Factory Acts. Five labour laws had been passed between 1802-1833, but parliament voted no money for their implementation.(Turshen, 1981, p.25) And in 1856, the industrialists succeeded in pressurizing the government to divest the labourers of any special protection; instead the cases of compensation against industrial accidents were brought under the jurisdiction of the common courts. Marx termed this as "sheer mockery" because the costs of a law suit were so prohibitory that were beyond the means of any worker.

In later years too, various Marxist sociologists have thus argued that the social classes which control the organs of the state- by dominating the executive offices of the government, the mass media and the commanding rights of the economy, the banks,

the city, the insurance companies and the big corporations- have an interest in maintaining the class structure from which they benefit and therefore the health of employed workers. (Elling,1970).

Another landmark in the field of health was the nationalization of the health service in England soon after the II World War. But this sudden change in the policy also had various factors behind it. In the event, the labour government which brought in the legislation feared that, if its socialist proposals for the National Health Service were too revolutionary, it would lose the support of the organized medical profession, whose willingness to work within the proposed service was necessary. Hence, whereas the government did not need to consult the nurses or other occupational groups about the shape which the NHS should take- since those groups did not posses the power to undermine any government plan- it had to make many concessions to secure the cooperation of the organized medical profession. Hospital consultants, for example, were permitted to practise privately (and lucratively) in NHS hospitals; and teaching hospitals, where the elite of the profession had posts, obtained direct access to the Minister of Health, and were not subject to the authority of the new Regional Boards, which administered all the other hospitals. General practitioners, too, won some important concessions. They were able to maintain the status of

independent contractor, which they felt was necessary to ensure their freedom from government control over their clinical practices, and plans for a salaried general practitioner service were abandoned. (Worsley, 1987). In other cases too whenever the state has tried to directly own the health services has been able to secure the support of the organized medical profession despite initial reluctance, and in order to do so has usually had to make substantial concessions to it, despite the fact that such concessions were often necessarily not in the interests of the masses at large.

Moreover, the power that organized medicine exercises over patients and other health occupations has led some sociologists to argue that it has become a major institution of social control in modern society. (Zola, 1972) The boundaries of its work, according to Zola, have been steadily expanding as it claims competence in dealing with more and more aspects of human behaviour. Conduct or states of mind which used to be considered the province of the priest, the lawyer, the policeman or the teacher are now regarded as medical matters.

There is little doubt that the number and variety of tasks of social significance assigned to the medical profession have increased during this century. But there is controversy as to why this has happened. Some scholars write as though the impetus

to aggrandisement has come from the profession itself. The prime motive, according to them, is the profession's self interest, not the health of the population (Illich, 1977) Illich, for instance, claims that increasing medical hegemony has decreased the capacity of ordinary and common man to look after himself and made him more and more dependent on medicine. He feels that it is the evil force of industrial technology, controlled in this instance by the doctors, which has enabled them to usurp so much of the freedom and autonomy which individuals once possessed. He argues that what is needed is to return to less complex health procedures and to revive self-help in place of reliance on doctors.

Other social scientists, most notably the Marxist analyst of health, Navarro (Navarro, 1979), have not altogether dismissed the contention of Illich but have transformed it to some extent. They argue that in so far as doctors do undermine the autonomy of their patients, they do so, not for their own benefit but as agents of the ruling class. Since the doctors themselves are part of a wider ruling class, it is wrong to stop the blame at the doctors only. For that matter the entire ruling class and the elites are to be held responsible. That is to say, in providing health services in the way they do, doctors help to persuade workers that the state has their interests at heart and thus reconcile them to their own unsatisfactory lives and

subordinate position in capitalist society. Yet, given the increasing contradiction of the society, the professional status, the aspirations and the independence of the doctors themselves are also undermined. They, too, are increasingly subject to bureaucratic rules and to the business interests of drug and medical equipment companies rather than acting in accordance with the scientific and humanitarian values they formally espoused. Their interests, he argues, therefore become increasingly parallel to those of the working class. Furthermore, the development of specialists in their ranks, representing different and sometimes conflicting interests, jeopardize their unity as 'professionals' and hence their bargaining power in their relationship with the state. It is not only Marxists, however, who have suggested that the role of commercial interests and especially of drug companies, is as often marked by self-interest as it is by humanitarian objectives. Paradoxically, many of their products can be dangerous as well as effective (but most often dangerous), and some of their sales-promotion techniques and experimental work during the developmental stage of new drug production, above all in poor Third World countries, have been strongly criticized (Lichtman, 1971)

However, in recent years there has been such a fast pace of industrialization in the west and the society has reached to such a stage that now increasingly there is a talk on the concept of

Post-Industrial Society. (Bell, 1974) As a result of the fast pace of economic development and the increasing affluence the concept of the health and its problems and the corresponding perspective of perceiving the same has undergone a sea-change. The traditional basic health problems have already been dealt with and thus there has developed a wide gap in the health status and the health problems of the masses of the poor Third World countries like India on the one hand, and the Western industrialized nations on the other. But the problem arises when the West expects the Third World to follow the same path which it had followed in order to cope with their health problems, and surprisingly the ruling classes of the Third World exactly do the same without knowing and understanding the health related problems peculiar to their own societies and the respective health culture and felt needs which are equally important to understand these. Furthermore, the majority of the medical sociologists working in this area hardly ever raise their voices against such an irresponsible approach of the elites towards finding the solutions to such problems. Rather than becoming the spokesmen for the masses, the downtrodden, and the poorest of the poor, they tend to become the spokesmen for the 'oppressors' and in this way encourage the worst form of international imperialism of keeping the Third World at the mercy of the industrialized West.

CHAPTER-II

EMERGENCE, GROWTH AND DEVELOPMENT OF MEDICAL SOCIOLOGY IN INDIA

Conceived as a distinct scientific discipline, sociology in India, as in most countries of the World, is a 20th century phenomenon (Mukherjee, 1973). However, the sociological investigations in the field of medicine and health came to Indian setting as a by-product of the anthropological studies conducted by Western anthropologists. Their main purpose was to understand the cultural and social attributes of Indian villages rather than the independent understanding of health and medical behaviour (Trackroo and Kapoor, 1981). It is essential to note here that the British interest in understanding the socio-cultural aspects, especially of the tribals, and health being a part of it, generated not because of any academic, social or intellectual commitment towards them but rather due to their own vested interests. By undertaking such studies, the British could tighten their grip of colonial power on the people of the Indian sub-continent, just like other colonies of Asia, Africa and Latin America. Another reason for the initiation of rudimentary sociological studies in the context of health was also due to the British interest to protect their own white population from the various epidemics. This population mainly consisted of army-personnel, senior civil servants and to some extent the

Indian elite. "While the main focus of colonial policy was the health of the army and the European population and the concern for the health of general population crept in only secondarily..." (Ramasubban, 1982). This is also proved by the observation of Doyal, "The vast territorial expansion which occurred during the last decades of the nineteenth century obviously demanded the further deployment of white manpower overseas, with all the attendant risks of death and disease. Government concern was sharpened by the desire to maintain a healthy military capacity in the event of inter-imperialist conflict. Moreover, large-scale white settlement was considered necessary to ensure the security and profitability of the newly annexed African territories. The success of these ventures therefore came to be increasingly dependent on effective medical provision and subsequently a slightly epidemiological approach towards health" (Doyal, 1979, p.240).

Moreover, the sociological studies in the colonial period were very fragmented. Hence, the tendency to conduct studies of tribes as distinct entities, unrelated to the structures of caste, of villages related to urban centres, and of communities independent of the national society became more and more pronounced in Indian sociology. This dominated not only the academic field but deeply influenced also the tribal and other social policies of the government. (Singh, 1973). On the other

hand, in majority of the works pertaining to sociological investigations in the field of health, the method of study was through case studies which delineated on the elements of the total system more than its parts. Health and medicine were studied as a part of total cultural ethos in a given social order and not as an independent enquiry by its own right. Such an approach, according to Trackroo and Kapoor, greatly inhibited the generalization and inferences about health behaviour and health system in India. (Trackroo and Kapoor, 1981)

Soon after independence, the government of free India among other things, also took upon itself the responsibility to improve the health status of the people, especially the downtrodden and the poorest of the poor, and also to improve upon their socio-economic conditions (Sahu, 1987). And in this context the government needed the help of the social scientists in the field of research in health fields, so that proper ways and means could be followed in this direction, systematically taking into account the various socio-economic, political and cultural factors involved in this context. But, unfortunately, the theoretical, conceptual and methodological approaches applied in these contexts were utterly lopsided, because they fitted the Western setting more than the Indian. As Prof. Yogendra Singh observes, "... most of these theoretical formulations have come from the American social Science and conform to a model of society based

on plenty rather than poverty, exchange rather than exploitation, consensus rather than conflict, value rather than power, initiative mobility (reference group) rather than class-conflict or collective mobilization. They focus upon balance rather than breakdown or contradiction in the social system". (Singh, 1973, p.20). Similarly, Banerji also states - "The class bias of the scholars, the lure of becoming dependent on foreign scholars on the 'Western reference frame' and active interest of some foreign scholars in promoting such dependency have been some of the factors which have influenced the formation of knowledge of social science in health fields in India". (Banerji, 1986, p.11-12).

The Structural Functional School

During the period that followed soon after independence, the structural-functional theories of the scholars like Talcott Parsons and Robert Merton, were in full bloom in sociology. In fact, the structural-functional approach ruled the roost all over the World including India, especially in the context of the work done in sociology during that period. As Mukherjee has appositely put it "... Following the dominant (or rather the monopolizing) trend in British social anthropology and US rural sociology in those days, these modernizers of Indian sociology (the then Indian sociologists) denounced the historical approach

as pseudo-scientific and adopted a 'structural-functional' approach, guided by a positivistic orientation ..." (Mukherjee, 1979, p.48) At that time Parsons was propagating his social systems theory and the concepts of sick-role, doctor-patient interaction and the pattern-variables. While Merton was busy explaining his ideas regarding the functions performed by various institutions in a society. Though Merton's work was, to certain extent, a slight departure from the approach of his predecessors, still he was very well a structural-functionalist.

Like Durkheim, Parsons begins with the question of how social order is possible. He observes that social life is characterized by 'mutual advantage' and peaceful cooperation rather than 'mutual hostility and destruction'. A large part of Parson's work is concerned with explaining how this state of affairs is accomplished. Moreover, Parsons perceived society as a system. He argues that any social system has four basic functional prerequisites - AGIL, i.e., adaptation, goal attainment, integration and pattern maintenance. These can be seen as problems which society must solve if it is to survive. The function of any part of the social system is understood as its contribution to meeting the functional prerequisites. Solutions to the four survival problems must be institutionalized if society is to continue its existence. That is to say, solutions must be organized in the form of ordered, stable social

institutions which persist through time. Further, the concept that bridges social action and social system is that of 'pattern-variables'. He defines these as the fundamental dilemmas that face actors in any situation (Rocher, 1974). Social systems may be characterized by the combinations of solutions offered to these dilemmas. There are five sets of dilemmas--

(1) Particularism versus universalism. Actors have to decide whether to judge a person by general criteria (universalism) or criteria unique to that person (particularism).

(2) Achievement vs. Ascriptions. This refers to the choice between modalities of the social object.

(3) Affective neutrality versus affectivity. Actors can either engage in a relationship for instrumental reasons without the involvement of feelings (affective neutrality) or for emotional reasons (affectivity).

(4) Specificity versus diffuseness. Actors have to choose, in any situation, between engaging with others totally across a wide range of activity (diffuseness) or only for specific restricted purposes (specificity).

(5) Self orientation versus collective orientation.

Parsons thus attributed universalism, achievement, affective neutrality and functional specificity to modern Western

societies, and particularism, ascription, affectivity, and functional diffuseness to traditional societies.

Similarly, David McClelland in 'Achieving Society' maintained that achievement motivation is an important plank of development and which existed only in the developed societies and not in the developing ones. Moreover, if the developing societies wish to develop they shall have to follow the same path and stages of development that were followed by the West. (McClelland, 1961)

It is in this context that we shall have do look into the various studies conducted in the field of medical sociology in India both by the Western and the Indian scholars as well.

Community Based Studies

One of the first institutional studies carried out in the field of medical sociology in India, soon after independence, was the Research Cum Action (RCA) project on environment sanitation in a few areas in India covering 95 villages in Najafgarh (Delhi), Poonamallee (Madras) and Singur (Calcutta), with the objectives of popularizing the use and maintenance of sanitary latrines amongst the rural folk and also to 'inculcate' in them the 'sense of cleanliness' (GOI, 1957; Program evaluation

Org.,1960). It was carried on by the Harvard school of public health under the sponsorship of the Ford Foundation. Another remarkable aspect about this project was that it followed an interdisciplinary approach with the involvement of specialists from three areas - public health engineering, health education and social sciences. It was, in fact, the first major litmus test for the social scientists to prove their worth and indispensability in any such study which would come up in future, and it was also a challenge to the competence of the social scientists involved in the project to"(i) have the interdisciplinary capability to understand the entire process of 'research-cum-action' envisaged in the project and identify the areas where they could make the needed contributions, and (ii) have the conceptual and methodological base to mobilize the already existing knowledge available in this field and also to undertake research programmes to generate the critically needed inputs in the research-action-evaluation process". (Banerji, 1986, p.35)

The RCA project utterly failed and this can be inferred by the simple fact that the sanitary latrines were never accepted by the rural masses. And this aspect of non-acceptance was not without reasons. The scholars associated with RCA failed to look into the wider health needs and other socio-economic aspects of the rural masses. (Banerji, 1986) The unsuitableness of such

sanitary latrines has been explained by Paul Harrison on the basis of his personal observation and perfectly summed up in the following words -- "Part of the problem here is the choice of appropriate technology. The porcelain four-gallon flush of the rich, rainy temperate regions is totally unsuited to the tropics. It is too expensive and wastes too much water. It also wastes one of the biggest potential sources of organic fertilizer in the Third World". (Harrison, 1986, p.293) The failure of the RCA project basically depicts the failure of the social scientists, because the responsibility lay in them to find out the various socio-economic factors which could prove to be a hindrance in the acceptance of such latrines.

The other major institutional project of that period was the Narangwal Project, which in turn had various other studies within it. Out of these the Rural Internship Study was the most important and the most long-lasting and involving as sizeable number of social scientists (Taylor et.al., 1967, 1968). This entire series of studies were carried out by the economic assistance of the US government, the main scholar behind it being Carl Taylor who in turn was serving in the Johns Hopkins school of Hygiene and Public Health. It was in this context that various prominent American psychologists including David McClelland had specially devised a Rural Thematic Apperception Test (RTAT). However, the major drawback of this study was that

despite the involvement of such a large number of social-scientists a proper articulation could not be brought about between the actual health problems and practices and the related social sciences data collected.

Another area of medical sociology where the large institutional studies especially the foreign aided ones have played a prominent role, has been population control and family planning. The bogey of population explosion was first raised in the 1950s in the USA, a phase which lasted till the late 1970s and streaks of which can still be observed even today . And it was later learnt and also pointed out by various scholars by providing convincing evidences that this issue was deliberately raised so as to secure the American vested interests at the global level. As Doyal has rightly said - "Indeed policies of this kind became a central pivot in US foreign policy since it was considered important to control the size of the Third World populations both for political reasons--to stave off the threat of revolution among the 'starving millions' - and also to provide an economic climate as conducive as possible to American investment". (Doyal, 1979, p.280). The economic vested interests can be clearly gauged by the fact that such population control campaigns were initiated by private American organizations like Rockefeller Foundation, the International Planned Parenthood Federation (IPPF) and the Ford Foundation. And by the 1960s very

considerable political support was engendered, resulting in the active involvement of the United States government. (Demerath, 1976)

The majority of the family planning projects were based upon the Knowledge, Attitude, Practice (KAP) model, which owed its emergence to the American studies related to agriculture. The sociologists propagating the KAP model felt that health education spread amongst the masses had to the knowledge regarding the ill-effects of large family, which in turn led to 'attitude' and attitude finally led to the 'practice'. The scholars employing upon this approach as a consequence of the influence of their Western counterparts also felt that if this process was properly followed in the right manner there was no chance of failure at all. (Dhillon, 1968) Again, the very fact that despite so much efforts by the sociologists and other social scientists, the government could not persuade in convincing the masses regarding the small-family norm, shows that such an approach was an utter failure. In this context also, the blame mainly goes to the social scientists, who in their enthusiasm to graft the Western model in the Indian context without going into the details of the socio-cultural, political and economic aspects of the masses, led to the failure of these projects. It was later empirically demonstrated by certain scholars that the success or failure of the KAP approach had a strong correlation with the socio-cultural

factor. (Brown and Margo, 1978) Moreover, the sociologists advocating a rigorous family planning programme failed to understand the simple reason of non-acceptance of these programme by the people. Their socio-economic condition is such that an additional child in a poor family means two additional hands to work. Since most of the peasants live only on a subsistence level these children prove to be of great help (Mamdani, 1972)

McKim Marriott was one of the first scholars to work in the field of medical sociology in India. His observations are mainly based on his experience in the village Kishangarhi in district Aligarh in Uttar Pradesh in the early fifties. This case-study revolves around a purposive medical intervention in the form of a clinic setup in the area and manned by a 'gora' doctor. Marriott has tried to compare and contrast the Western and the indigeneous medicine and the factors affecting the non-acceptance of the Western medicine especially in the context of the local culture and the local social structure. The world of villagers, according to Marriott, consists of three great social realms - kinship and family, village and caste, and the outside world. (Marriott, 1955) However, this study also suffers from various flaws. For instance, the sudden opening of a dispensary of Western medicine and then the study of the health behaviour clearly must have obstructed the scholar in learning the real situation; the scholar suffers with an inherent preconceived

notion about the superiority of the Western medicine; he attaches so much importance to the local social structure that he advocates to mould the accessibility of the health services in such a way that they blend with the local social structure; and finally he is so much influenced by the preconceived bias in favour of the Western medicine that in a case of tuberculosis where the patient was previously prescribing to gold-oxide and honey, he criticises the indigenous medicine while, on the other hand, he praises the Western medicine when the same patent is prescribed shark-liver oil for the same disease. Shark-liver oil, as we all know, is not a cure for tuberculosis.

G.M.Carstairs' work refers to the recording of a number of lessons that he learned in the course of his attempts to practice medicine in two country villages of Rajasthan, i.e., Sujapura and Delwara. According to him misunderstandings are found to arise by false expectations on both sides (the doctor and the patient) based on different theories of etiology, different techniques of cure, and different conceptions of the role of the physician. Carstairs finally emphasizes upon the importance of faith between the two. "No matter how rare a medicine you give a patient", feels Carstairs "unless you and he have faith in it, he never will be cured". In this context, Carstairs also maintains that the villagers should essentially be convinced about the efficiency of the Western medicine, whether 'rationally' or

'irrationally' (Carstairs, 1955). This study is open to criticism on the ground that like Marriott, Carstairs started his case-study by opening a dispensary in the area; he fails to talk of the specific health problems minor or major; he does not describe about the diseases prevailing in the area in the context of the social structure and the locally available medical system and also does not effort to find out as to why the people did not turn up for treatment. That is to say he avoids looking into the root causes of the health behaviour of the people.

The study by Lewis, (Lewis, 1958) though did not entirely pertain to the health status of the population, but an important chapter of the book highlights this aspect in a sizeable manner, especially in the context of the concepts of disease causation and cure. This chapter is based on the intensive interviews of eight Rampur villages giving a very detailed and deep information on the notions of etiology of certain common but serious diseases, which included malaria, cholera, dysentery, smallpox, typhoid, puerperal fever, eye inflammation and hysteria. He attempts to analyze the indigeneous beliefs and practices of the community in relation to these physical hazards. Further, he also tries to correlate the notions of etiology with that of the methods of treatment adopted by the villages. And finally, analyzing the overall medical and health conditions of the village he observes that a knowledge of local beliefs should be

of help both in treating particular ailments and in learning to understand the basic concepts of the village people. (Lewis, 1958, p.301) However it should be kept in mind that this analysis seems to be based upon an arbitrarily selected sample and hence cannot claim to represent the real situation in North India.

Similarly, Opler (1962) has tried to explore the prevailing Hindu view of health and illness in Rural India. According to him the notion of harmony and balance is the central theme in the Hindu concept of disease and disorder. He observes that this idea is "a basic cultural conviction of the Hindus. Just as the equilibrium among the 'doshas' may not be altered with impunity, so must a harmonious organization or relation be maintained in regard to many other matters in Indian culture". Some of these according to him are the 'varna' 'caste' and 'jajimani' system (Opler, 1962, p.35). However, the author using various terms and expressions which no longer describe and analyze the changing aspects of the contemporary social structure, tends to oversimplify the prevailing situation. He does not take into consideration the inter-caste and inter-class contradictions existing in the villages and also other such socio-economic factors which influence the health behaviour of the people; rather he seems to be preoccupied in emphasizing upon the 'harmonious' coexistence of the various sub-groups in the

community on the basis of the 'well-knit' traditional social structure.

Like Lewis, Ishwaran (1968) though has not done a full-fledged study on the health status of the community, he has devoted a whole chapter on the discussion and analysis of health and illness in his study of a South Indian village Shivapur. It attempts to provide a detailed description of health notions of the villagers. Apart from classifying the various diseases on the basis of their source of origin and extent of seriousness, he also tries to depict the doctor-patient relationship by highlighting the type of medical specialists consulted alongwith the image of the physicians. Another prominent feature of this work is the emphasis upon the close interaction between the medical system and the social system. - "... There is a close connection between the 'medical system' and the 'social system' of Shivapur. The social system norms and circumstances affect the medical system - the doctors, the patients and the community. The family, kinship and the caste contexts shape their attitudes. Much misunderstanding of the behaviour of villagers with regard to their health and illness problems can be avoided if there social structure and belief system are clearly grasped". (Ishwaran, 1969, p.126). Ishwaran certainly needs praise since he can claim to be one of the first Indian scholars to emphasize upon the strong bond between the social system and the medical

system. Nevertheless, by resorting to sweeping generalizations and subjectivity in observation the scholar has made it empirically less sound and analytically less attractive.

In the same sequence one of the most prominent and full-fledged medical-sociological study has been conducted by Kwaja Arif Hasan (1964) in Chinaura village near Lucknow city. Taking into account the 'direct factors' like sanitation, cleanliness, malnutrition, skin infections habits of eating out of common utensils, sleeping in the poorly ventilated innermost rooms and 'indirect factors' like the various socio-cultural beliefs, customs and practices, Hasan tries to study and analyze the health status of the population. This study, too, faces certain conceptual and methodological shortcomings. Chinaura, rather than being a typical village, is, in fact, an atypical village since it is situated very close to the city and the highway and thus has a constant and close interaction with the urban area. Moreover, though Hasan refers to the aspect of culture as the crux of the study, he fails in this effort when he does not take into account the socio-economic and political aspects of the health behaviour of the villagers. This is clearly understood by the fact that he blames the villagers for expecting from the PHC Doctor to give medicines free of cost. He never tries to understand why the villagers do so? Aagain, without going into the root-cause of the problem he blames the

village folks for the skin diseases simply because they do not use soap. At another place he accepts that the doctor manning the PHC does not reside in the village, but he fails to consider this as a factor of the absence of proper and close interaction, between the local people and the doctor. And lastly, like his contemporary scholars, he seems to be suffering from a preconceived bias regarding the superiority of the Western medicine while his case-study gives the impression that he has neither properly understood the Western medicine nor the indigeneous and folk medicine.

Another significant community-based study has been by C.M.E.Mathews (Mathews, 1979) carried out in the rural areas of North Arcot District of Tamil Nadu. Observation and structured interviews being the main tools of study, the scholar focuses on the understanding of the health beliefs of the local people before initiating any health-education drive. She has also made efforts to throw some light on the aspect of poverty in this context and also on understanding the causes of the non-acceptance of the family-planning programmes, which she later attributed to socio-economic factors.

Studies of Hospitals and the Medical Profession

One of the first studies in the Indian context taking into consideration the health services provided by the hospital, has been conducted by T.N.Madan (Madan,1969). In this perspective the universe was Ghaziabad which was a small town in the vicinity of Delhi and one of the main objectives was the study of the preference for the Western and indigenous system of medicine and its correlation with the socio-economic background of the patients. One of the significant conclusions was that there is an established superiority of the Western medicine as far as the acceptability is concerned. Moreover, a direct relationship was also found to exist between the choice of medicine and the income of the patients. Besides being weak on the methodological count the study cannot also claim to be representative due to the atypical situation of the universe. Another study pertaining to the profession of doctors by the same scholar was published in 1980 (Madan, 1980). Questionnaires being the main tool, the sample was the doctors of the All India Institute of Medical Sciences, New Delhi. Taking into account the social background of the doctors and also conceptualization by the doctors regarding their role within the institution and in the wider societal context, he had inferred that while the doctors perform modern roles it cannot be said for sure that they perform an extra-professional modernising role in society.

Indu Mathur's 'Interrelations in an Organization (Mathur, 1975) concerns itself with the study conducted in Sawai Man Singh (SMS) hospital in Jaipur. Understanding of formal and informal relationships existing in the hospital and also its impact upon the health services provided to the patients, can be termed as the prominent aspects of the study.

Though the title of Venkataratnam's book is 'Medical Sociology in an Indian Setting' it only concerns itself with the various aspects of the roles of Doctors and nurses in two hospitals in Madras. Apart from having a misleading caption, the study is also weak from the methodological point of view since it is based only upon the observations made by the scholar and there has been no effort to get across the point of view of the health personnel.(Ventakataratnam, 1979)

In the same series of hospital studies, 'Doctors and Nurses', a study conducted by Oommen (Oommen, 1978) also holds a prominent place in Indian medical sociology. Oommen concerns himself with the occupational structures of doctors and nurses in a public hospital in Delhi, differentiating between 'full-professionals' and 'semi-professionals'. Apart from the basic drawback that the study was conducted by post-graduate students, "Oommen's generalization that the social background of doctors contributes to high prestige of their profession and conversely the humble

origins of nurses depressing the prestige of nursing profession, cannot be treated as a causal explanation since prestige to an occupation is determined more by the societal value attached to that profession than by the social background factors". (Mehta, 1987)

Advani conducted his study on doctor-patient interaction in general hospitals (Advani, 1980) and in this context he found the applicability of Parsons 'pattern variable' 'affective neutrality' on the doctors who avoid any kind of emotional attachment with patients. However, this inference is yet to be firmly established especially in the Indian context.

Of late, Ambika Chandani carried out a survey regarding the doctors of Jodhpur city, most of whom were government employees and attempted to find out their social background, career-pattern, role perception, and role-performance, role-set and medical ideology (Chandani, 1987). Though the objectives are full of sociological terminological jargon, since the sample size is too small it is almost impossible to generalise it and make use of it in a wider social context.

However, one drawback common to almost all of the above-mentioned studies is that none of these has taken into account the patients' perception about the hospital and its

personnel, an aspect which should occupy the most prominent place in any hospital-based study, because after all, it is the poor patient for whom this entire monolithic organization is primarily built and if one fails to take him into consideratioin the study cannot at all be termed as sound with a strong methodological and conceptual base. Moreover, leaving aside the aspect of the patients, in the majority of the works, the scholars have preferred to confine themselves only to the doctor's, and nurses, in some cases. Paramedical staff and other hospital personnel who are no less important in the hospital and its functioning have hardly ever been taken into cognizance.

Conflict School

One of the first studies in medical sociology in India which, taking into consideration the various socio-economic, political factors behind the existing health status of the population, had vehemently attacked the current socio-political set-up by raising certain fundamental questions concerning the cause of ill-health of the masses, is that by Goran Djurfeldt and Staffan Lindberg, two Swedish scholars who worked in the areas of Thaiyur Panchayat near Madras city. (Djurfeldt and Lindberg, 1976) The entire study concerns itself with the establishment of three basic premises - (1) The health situation in the village is a consequence of the prevailing economic and political order;

(2) The health problems cannot be solved by means of medical technology. The study intends to demonstrate the inefficiency of Western medicine in comparison with the indigeneous medicine and it concludes that none of them have been successful in dealing with the health problems of the village; (3) Only a drastic transformation of the economic and political structure can give the people of Thaiyur the means to improve their own health. The scholars conclude that "The health policies pursued in India today are an outgrowth of its class structure, which is extremely rigid. There is a deep cultural and social segregation between the different classes". (Djurfeldt and Lindberg, 1976) The study definitely needs credit not only for being one of the pioneering contributions from the progressive school of thought, but also because of its approach looking at the health problems of the poor and analyzing it from an altogether different perspective, a perspective hardly ever followed in the Indian context. But, at the same time the study could have become a distinguishable landmark had it been methodologically and conceptually much more sound. Apart from other shortcomings, the very criteria of the selection of the village seems to be arbitrary; its an atypical village due to its proximity to the city and a salt factory where many of the villagers are employed. Moreover when coming up with an altogether different approach of study which is contradictory to the dominant trends of study in the area and which also opposes the basic government policies, the scholars should have

taken special care to take a sufficiently large sample size so as to be in a firm position to substantiate their arguments. And last but not the least, the scholars rather than verifying their arguments through empirical findings, seem to be more obsessed with the Marxist frame of reference and its superimposition on the real-life situation. As such, the study and the conclusions do not seem to be smooth and blended with the empirical findings but rather a deliberate attempt to graft a particular ideological viewpoint in a particular situation, irrespective of its suitability.

The work by B.D.Mishra et.al., (Mishra et.al., 1982) is another significant study conducted to review the family planning programme and to evaluate its shortcomings. Rather than perceiving conflict as emerging from direct coercion, they see in the systems context, as Lockwood (1964) had done. He developed a distinction implicit in Marxism, between 'system' and 'social' conflict. System conflict occurs when institutions are not in harmony: for example, when the political sub-system pursues policies which conflict with the needs of the economic sub-system (Rex, 1981). In a somewhat, similar manner, Mishra et.al., have followed a systems approach in studying the family planning programme in the then Allahabad division of Uttar Pradesh. This has helped them to take into consideration the manifold governmental activities that are comprised under the family

planning programme; the interrelatedness of the various programme levels and activities as well as their relationship to the environment; and portray the range of family planning activities rather than to provide a segmental view. The study takes into account the behaviour and activities of the people involved in the programme, at three levels -- (a) the villager, whose behaviour is the object of policy; (b) the staff of the rural PHC, who are responsible for persuading the rural population to limit family size, and; (c) the administrators under whose control and policy guidance the PHC functions. Apart from finding fault with the implementation process, the scholars also maintain that one of the main reasons of the failure of the programme has been its secludedness. According to them, the family planning programme should be a part of the wider developmental programme; only then it can be expected to be successful. The scholars have undoubtedly done a novel job by applying the system approach in studying the implementation of the family planning programme. But, the actual field study does not prove to be as thorough and convincing in its approach as compared to its conceptual framework. The authors fail to properly utilize the systems approach in their study and hence do not come out with the real reasons for the failure of the programme. Their main emphasis has been on the structural inadequacies of the implementing agencies, rather than the more fundamental causes like socio-economic deprivation. In other

words, the authors fail to properly articulate the family planning programme in the light of the various socio-economic, political and cultural factors. Precisely because of their unclear approach, the study, sometimes gives the impression of being influenced by the structural-functional Parsonian idea of the social system and sometimes by the system-conflict approach of Lockwood (1964).

Apart from these there have been a few other studies also which though very well find a place in the conflict school itself but are different from the above studies in the sense that they are more holistic in their approach, are neither unidimensional by being obsessed with and influenced by just one or two factors in the purely Marxian sense nor tilted towards the structural-functional consensus approach. In other words, rather than making the applicability and superimposition of a particular school of thought as their main objective, they have tried to make the understanding of the poor health status of the people, as the objective. Such an approach have made them more realistic and problem-oriented rather than utopian and discipline-oriented.

One of the first studies of this kind was carried out by Banerji, who in his 'Poverty, Class and Health Culture' (Banerji, 1982) attempts to raise certain basic issues of health problems in the context of the contradictions between the interests of the

ruling classes on the one hand, and the well-being of the depressed sections of the society, on the other. This work puts forth a fresh methodological and conceptual perspective to social sciences in India. It is based on a nine-year study of nineteen villages, spanning from 1972-1981, spread over eight states of Gujarat, Haryana, Karnataka, Kerala, Rajasthan, Tamil Nadu, Uttar Pradesh and West Bengal. Due to the careful selection of villages, the study tends to cover six major linguistic zones of the country, which in turn, cover around 85 per cent of the population of the country. By following a holistic approach, taking into account the various socio-economic and political factors which constantly influence the health status of the rural population, especially the downtrodden, Prof.Banerji also attacks the conventional methodological and conceptual approaches to the study of rural life in India, which are usually based upon Western reference models and often lead to presentation of a fragmented and materially distorted account of social reality. He attempts to present the social reality as the stepping stone to develop an alternative approach. The most remarkable methodological and conceptual aspect of this study is the definition of poverty. According to Banerji," those who do not get two square 'wholesome' meals all the year round and those who do not have very elementary facilities of housing, potable water supply and sanitation, underlines degree of poverty and deprivation among populations in rural India" (p.210). Since the

spans a long period of nine years, it has successfully been able to closely observe, understand and analyze the changing health status all these years (if at all) of the population and also the period when the government resorted to forced family planning operations, the overthrow of the same government, and the various concessions made in the health services by the government due to democratic forces operating at that time. Another most significant aspect of this work is its concept of "health culture" around which is built the entire methodological edifice. "Perception of a health problem, meaning of the state of health and disease, response to various institutions that exist for dealing with these health problems, all form an integrated, interdependent and interacting whole, which can be termed as the health culture of the community" (p.208)

However, the most important implication of this study is that it makes it possible to relate health problems of a community and its health culture with the aspect of poverty and that the various social, economic and political forces in the community which influence the degree and the nature of poverty, and the health status of the people can be improved only when drastic changes are brought about in the wider socio-economic and political structure.

Unfortunately this approach, though very rational problem-oriented and even empirically verified, has been followed by few scholars, simply because of its rebellious nature and inherent antagonism with the dominant trend prevalent in the social sciences, and its attack on the very socio-economic and political fabric, which tends to perpetuate the poor health conditions.

In the same sequence of studies, Sahu has done a remarkable work on Oraons making 'health culture' as the crux of his study and the Rourkela Steel Plant as the centre for comparison and contrast of the availability, accessibility and utilization of the health services at various levels. (Sahu, 1980) In this way the study has highlighted the health culture of Oraons in different ecological, social, economic and occupational context. The Oraons living in and around the Rourkela Steel Plant constitute one extreme of the health status, while those living in a remote village which does not enjoy the services of any health institution forms the other extreme of the health status. In between these two there are two other villages, one of them has a sub-health centre and the other a primary health centre (PHC). In this way the scholar has observed and analyzed the health behaviour of Oraons at four major levels. On the basis of qualitative as well as quantitative data, Sahu concludes that apart from the Oraons living in the Rourkela Steel Township who

have the best health services available, even those living in the remotest villages do have felt-needs regarding their health problems but they remain unmet either because of non-availability of non-accessibility of the health services. Even within the township no difference was found between the health behaviour of the Oraons and the non-Oraons, which proves the fact that the felt needs and the health proves the fact that the felt needs and the health problems, and not the cultural differences are the most significant factors behind the acceptability of a particular kind of health service system. "Access to health institutions was found to form the pivot which determined the health behaviour of Oraons". (Sahu, 1987, p.307) It was also found that in most of the cases the availability or accessibility was influenced by socio-economic, political, and even religious factors. In the case of a dispensary run by christian missionaries, its services were denied to the non-christian Oraons. In the conclusion Sahu feels that only a radical change in the socio-economic and political setup can bring about some real improvement in the health status of the poor Oraons, and no piecemeal approach would be helpful in this context. "The study provides data to assert that improvement in the access of tribal population to culturally and socially oriented health services, rather than promotion of purposive intervention to make Oraons to accept a pre-determined health programme is the prime need in the field of health in

tribal areas as a part of national development" (Sahu, 1987, p.308).

Studies on Tuberculosis

The studies on tuberculosis conducted under the auspices of the National Tuberculosis Institute (NTI) and by individual scholars as well, can be considered as a hallmark in the field of medical sociology, mainly due to their conspicuousness regarding conceptual and methodological clarity. It all started with the National Sample Survey (NSS) carried out in the mid-fifties (ICMR, 1959), whereby it was learnt that 1.8 per cent of the total population suffered from radiologically active tuberculosis, out of whom one fourth were infectious and that the prevalence was similar in rural and urban areas. Soon after that through the studies conducted by the then Tuberculosis Chemotherapy Centre, Madras, it was found that home-treatment was equally effective as compared to sanatorium treatment. (Tuberculosis Chemotherapy Centre, 1959). Based on these findings, the National Tuberculosis Institute (NTI) initiated a series of operational research studies based on an interdisciplinary approach. Apart from the sociologists, a number of other health personnel, statisticians and engineers were actively involved in it, which ultimately led to the formulation of "nationally applicable, socially acceptable and

epidemiologically effective National Tuberculosis Programme for India" (Banerji, 1971) The primary thrust was to evolve a felt-need oriented programme since a fairly large number of patients were conscious and seeking treatment.

In the same series were outstanding findings drawn from the study conducted in the rural areas of Tumkur District in Karnataka, which showed that more than 50 per cent of the tuberculosis patients visited government health institution and most of them were sent back with a 'bottle of cough mixture'; three fourth of these were found to be 'worried' by the problem; and the majority of the rest were 'conscious' of the symptoms of the disease. (Anderson and Banerji, 1963)

Similarly, another study by Raj Narain questioned the very basis of the definition of defaults in the context of tuberculosis patients, given by the health administrators. It was found that in many cases the 'poor' patients were termed as defaulters simply because they 'did not turn up' for a complete treatment, without taking into account the socio-economic reasons for such behaviour. On the contrary, it was found that many of these so called 'defaulters' did turn up for the treatment but failed to get the proper treatment from the health institutions; while others, due to the nature of their occupation, and other factors, migrated to other areas; and finally there were some who

had got cured even before the stipulated period of treatment, but these were also termed as defaulters, (Banerji, 1967; Singh and Banerji, 1968).

The most significant contribution of these tuberculosis studies was that they made possible the subordination of technology to the people, "rather than subordinate people to a predetermined technology, such as use of mass miniature radiography or of highly sophisticated and expensive chemotherapeutic regimes, in sophisticated institutions". (Banerji, 1985, p.141). Moreover, almost all the studies revealed that it were the health administrators and health institutions, which were at fault, rather than the people themselves, as was the belief earlier.

CHAPTER- III

NEO - IMPERIALISM AND MEDICAL SOCIOLOGY IN INDIA

A complete and thorough understanding of the various aspects of medical sociology in India also requires an enquiry into the global perspective of the same problems taking into account those international forces mostly emanating from the industrialized, developed West, which have constantly influenced the growth and development of medical sociology, and which can be comprehended as a part of the larger phenomena of neo-imperialism. Moreover, these international forces in the form of neo-imperialism have not only remained confined to the disciplinary scope of the Indian medical sociology but rather have engulfed the various institutions of the society as a whole. These forces of imperialism can be put into theree categories --

(1) Social and cultural imperialism;

(2) Academic imperialism;

(3) Economic and political imperialism.

(1) Social and Cultural Imperialism

The social and cultural imperialism has been mainly manifested through the predominance of the deliberately created tradition-modern dichotomy by the modernization theorists,

whereby the people of the developing countries like India, were termed as non-rational, inactive and fatalistic, other-worldly and over-religious. As a result of this, claimed the Western scholars, the third-world societies needed to be 'taught' to follow the proper path of development. While certain scholars even maintained that the need for achievement or achievement motivation exists only amongst the people of the developed countries, but absent or negligible amongst the people of the developing societies, and moreover, these developing societies would have to follow the same path of development which the West had followed. (McClelland, 1961) Similarly, Parsons held that the process of development would take place in the society which has the capacity of adaptation and absorption of the external factors. Since the Asian societies are rigid and closed they have less flexibility of adaptation and absorption of the external factors and therefore less chances of development. (Rocher, 1974; Parsons, 1966). Applying the 'pattern-variables' formulated by Parsons (already discussed in Chapter II), to the study of development, theorists like Bert Hoselitz concluded that there was a broad difference in kind as between developed and undeveloped societies; that there were clusters of pattern-variables, not just random mixes, peculiar to this society or that. Undeveloped societies, which they called 'traditional', were typically particualristic, ascriptive and functionally diffuse; developed societies were universalistic,

achievement-oriented and functionally specific. Ascriptive, diffuse roles, therefore, were unsuited to modern situations calling for personal responsibility and clearcut, objective managerial decisions. To bring about development, therefore, 'modern' values needed to be implanted (Hoselitz, 1960; Hoselitz and Moore, 1963). It was with this approach that the Indian sociologists were made to believe about their capability and hence were made dependent upon the West for their each and every solution to the various problems, which, in almost all the cases, were peculiar to the Indian conditions and could have been easily handled by the Indians themselves. It was because of this deliberately created atmosphere that even after independence the Indian scholars, including the medical sociologists, always looked towards their Western counterparts for each and every conceptual, theoretical and methodological framework of their study. This practice of establishing a correlation between the socio-cultural factors and the incapability of the native population is not a recent phenomena. Even in the late nineteenth and early twentieth century Max Weber had maintained that only certain religions helped in the proper growth and development of 'the spirit of capitalism' and, according to him, the credit went to the protestant ethics, which could only prove to be conducive to the proper development of capitalism, while religions like Hinduism had practically no contribution in the

encouragement of the capitalist form of 'entrepreneurial spirit' (Weber, 1930)

(2) Academic Imperialism

Though the structural-functional school of thought had been the dominant school all over the world, including India, most probably because of the conscious attempt of the colonial powers to perpetuate their rule, even after independence of these colonies this school of thought continued to have a prominent role to play, though in a different form, and now a new breed of scholars like Talcott Parsons and Robert Merton carried on the mantle of structural-functionalism, especially in the developing countries. This trend was in full bloom till the 1970s, but it continues to influence the Indian medical sociologists to this day. In this context, the most significant concepts were that of sick-role, doctor-patient interaction, and pattern variables of Parsons. Such concepts, it seems, were rigorously propogated to divert the attention of the medical sociologists from the more fundamental issues like exploitation--social, economic and political of the masses through the health services, which has constantly been used as a tool by the ruling classes in fulfilling their vested interests and oppressing the downtrodden sections of the society. Even at times when the majority of the rural areas were suffering from various dangerous diseases, there

were no proper health services even to meet the basic health needs of the rural population, most of the medical sociologists were busy verifying the applicability of the Parsonian concepts of 'sick-role', 'pattern-variables' and 'doctor-patient interaction', while, one the contrary, it was expected from them to provide solutions to these health problems by guiding the government in giving the right direction to its health policies. Unfortunately, the use, application and testing of these Parsonian concepts have been popular amongst the social scientists even to this day. (Oommen, 1978; Advani, 1980; Gupta, 1985) However, certain scholars, both Indian and foreign, have, of late made some efforts to break this structural-functional academic hegemony of the West, not only by using the concepts and methodology suitable for the Indian context but also by raising certain pertinent and fundamental questions about the existing pro-elite, pro-ruling class bias in the health services and also in the dominant trend in medical sociology (Eg. Banerji, 1982; D-jurfeldt and Lindberg, 1975; Sahu, 1980; Qadeer, 1985)

Not only in the field of medical sociological studies has the West tried to hold sway, but academic imperialism can also be witnessed in the field of medical education. The medical curriculum in India is such that it exposes the doctors only to the health problems faced by the elite, which has little to do with the real health related problems of the poor rural

population, and which, in fact, needs the utmost attention simply because of its poor and neglected health conditions. (Banerji, 1973; Government of India, 1982) Such kinds of medical education and health services are more suitable to the developed than the developing countries. Close adherence to the medical curricula used in Britain, France or the United States prepares the students for patterns of illness and treatment which are often irrelevant to the health problems of the developing countries. In this process, even the socio-economic determinants of these typical third-world problems are ignored. (Doyal, 1979) However, even when the colonial powers had made certain efforts for the understanding of such health problems in a 'holistic perspective', students have generally been forced to study their customs and taboos and other socio-cultural aspects as interpreted by a largely racist anthropological tradition (Raikes, 1975) Therefore, feels Doyal, both poverty and ill-health have tended to be explained in cultural terms, and the causal relationship between them observed (Doyal, 1979). How far the medical students are away from the socio-economic reality of their own society is clear from a study conducted by Ramalingaswami. When asked from the medicos about the causes of poverty, 40.5% blamed the people themselves for their poverty. Expressing their ignorance about the cause of poverty in another question, 40.36% replied in negative about the knowledge of poverty line. Again, the majority of the students thought of

development only in the economic sense. In this way, it was found that young doctors have hazy ideas about some of the most pressing social issues and problems in community health field (Ramalingaswami, 1987). While, in fact, "the doctor has to understand the socio-economic and cultural milieu of his patients if he has to become a successful clinician, leave alone a successful health functionary. This means that in Indian setting a doctor has to know about poverty because fifty per cent of Indian population is living below poverty line and eighty per cent people live in rural area". (Ramalingaswami, 1987, p.183). Furthermore, since most of the doctors are drawn from the upper-class or upper-middle class, hail from the urban areas (Chandani, 1987; Madan, 1980; Qadeer, 1990), the existence of academic imperialism is also proved by the fact that most of the doctors prefer to work only in the urban areas and specialize in those disciplines which correspond more to the disease pattern of the West and more to their own society (Navarro, 1970; Zaidi, 1988). Qadeer has rightly pointed out "... The systems' restricted coverage makes it a prerogatiive of the rich and its urban bias only heightens this. By relegating preventive and public health to a lower position in priorities, the system in effect gives second place to 80 per cent of the population who are living below the poverty line or at subsistence levels and need these services most. Its priorities are of those who have already acquired levels of living where elementary public health

services are assimilated into the living style itself and people need only sophisticated curative services" (Qadeer, 1990; p.103). Such doctors who are already cutoff from the masses socially culturally and economically, and undergo the Western medical socialization can be perfectly termed as "trained incapacity for rural practice which is itself the product of the British system of medical training within large centralized hospitals" (Johnson, 1973, p.297) And, at last, when the doctors find that whatever they have learnt as a part of their curriculum, that is of little use in the rural areas, and at the urban areas too there is not much scope for the utilization of their specialized knowledge, they tend to go abroad, which we term as 'brain-drain'.

Compared to the ties of political and economic dependence, unequal exchange and transfer of technology, the transfer of intellectual technology from the advanced capitalist countries operates in a covert fashion, through the training of third world students, the activities of major research foundations and establishments of research and teaching 'subsidiaries' in the poor countries. It is indeed in the framework of the underlying political and economic interests of neo-colonialism that research on poor countries has developed. In other words, theories, methodologies and explanations of causality are often remedies based upon the implicit interests of the rich Western countries in alliance with the dependent bourgeoisie and ruling elites in

developing countries. Research activity is socially and politically conditioned by the mechanics of economic and political dependence. Moreover, Western models of economic thought and techniques of analysis provide "the rationalisations which are required to evaluate performance and 'measure' 'success' or 'failure' of the development process". (Chossudovsky, 1977). "Third World countries are usually thought of as 'catching up' with the educational systems developed in and for Western countries". (Worsley, 1987, p.195) But radical educationalists such as Ivan Illich and Paolo Freiri have argued forcibly that orthodox Western methods are completely inapplicable; that basic education is what is required for the mass of the population, and that people are best motivated to learn when they can see the connections between what they are being taught, by people who understand their conditions of life; and where they feel that learning is likely to lead to significant, even radical improvement in their lives. (Freiri, 1971; Illich, 1971) Education is, no doubt, important to an all-round development but it must be the kind that is relevant to the needs of the country (George, 1988) and, as Harrison points out, "not the kind of education made up of academic irrelevances, alien concepts and sentiments, the kind that fills children's heads with dreams of the city and unfits them for their role in the village, the kind that brands the many as failures, so that the few can enjoy the excessive rewards of success". (Harrison,

1986, p.327) Similar comments apply to health care and the related sociology of knowledge.

(3) Economic and Political Imperialism

Though, after World War I the firm control of the various European powers on their colonies had weakened as a result of the War, and in later period which was aggravated due to the Great depression and World War II, but once the wars and reconstruction were over, the colonial powers recovered and with renewed force reincorporated all of Asia, Africa and Latin America into ever closer economic ties with the West; and this time, the new ties were much more stronger and more efficient than they had been in the period of classical-imperialism before World War I. These new ties were through the multinational corporations (MNCs), which had been built up in the developing countries like India into the multinational corporate system whose centre was in the United States (Frank, 1970; Sanders and Carver, 1985)

The economic and political imperialism can be better understood in the light of the concepts of 'centre-periphery' and the 'dependency theory'. In the development theory of Marxist sociologists like A.G.Frank (1969), the centre refers to the loci of economic power in the global organization of production and distribution. In this perspective, the global economy is

conceived in terms of a hierarchy of economic centres which, through military, political and trade arrangements, extract an economic surplus from subordinate peripheral economies and regions. The distinction between the industrialized core and underdeveloped periphery is thus part of a more general theory of imperialism. The backwardness of peripheral economies is held to be a consequence of their dependence on various core economies and not the effect of their poor resources, illiteracy, 'traditionalism' or 'political instability', as is generally pointed out by the modernization theorists. The industrial development of the centre is at the cost of the underdevelopment of the periphery.

Closely related to the centre-periphery concept is the dependency theory, which can be understood as a critical response to the 'laissez-faire' model of international trade and economic development. Dependency theory argues that the global economy cannot be conceived in the free manner as a system of 'equal' trading partners precisely because the superior military, economic and political power of the Centre (the industrial societies) imposes conditions of unequal exchange on the Periphery (developing societies depending on the export of raw materials and labour). The dependency theorists trace these conditions to the colonial days when the dependent societies, were forced to specialize in the production of raw materials and

at the same time to import finished products from them. These theorists argue that the system of dependency, while no larger organized under direct colonialism, is still maintained through the power of multinational corporations which dominate international trade by controlling the price of basic materials. (Amin, 1976)

Keeping these theories in mind, we find that the development of medical sociology in India, to a great extent, has been influenced by the dominant economic and political interests. Right from the time after independence when large-scale public health projects were initiated and in which there was also a large-scale involvement of sociologists, we find that most of these were supported by various big business houses of the United States; for instance the RCA project, the aim of which was to 'teach' the local rural population the benefits of the sanitary latrines. A similar involvement can be seen in the Khanna, Narangwal and various family-planning projects. Furthermore, once the projects were over, the Indian sociologists who had 'performed' their job 'well', were given 'placements' at various important institutes here and abroad (Banerji, 1986). In such a situation when the Indian scholars had their personal interests in mind, how could they be expected to emphasize upon the interests of the masses at large, challenging the inapplicable and altogether alien western models ?

Moreover, the involvement of the big business houses in the various health related projects can also be understood in the light of the emphasis placed upon control of malaria by large-scale use of DDT, which was then manufactured by the Rockefeller. In fact, the entire Malaria Control Programme with the help of the US government was considered to be a part of the policy of imperialist expansionism (Cleaver, 1976). This orientation can be understood by putting the following words, "powerful communist forces are at work in this country and throughout the world, taking advantage of sick and impoverished people, exploiting their discontent and helplessness to undermine their political beliefs... Health is one of the safeguards against this propoganda. Health is not charity, it is not missionary work, it is not merely good business - it is sheer self-preservation for us and for the way of life which we regard as decent. Through health we can... prove ourselves and to the World, the wholesomeness and rightness of democracy. Through health we can defeat the evil threat of communism" (Simmons, 1950, p.13). Similarly, the pressure put on the Indian government for the installation of radiography units in large numbers for the detection of tuberculosis, also had the interests of the West involved in it. The United States was keen on this aspect because by that time those machines had become redundant due to the control of the disease, and they were searching for markets in various third world countries like India. (Banerji,

1986) In a similar instance, the undue emphasis put on the use of IUDs in the family planning programme was mainly because of the fact that its production too, enjoyed the monopoly of the West.

Now the question arises - way did the Indian medical sociologists at that time not stand up and challenge such illogical application of the 'Western Reference Model' in the Indian context and also the imperialist expansionist policy of the capitalist countries ? First of all, the initial studies conducted in the area of medical sociology in the Indian setting were by Western scholars themselves, who, in turn, were financially assisted by the various business houses. McKim Marriott was then a fellow for the Ford Foundation in India and Carstairs was a Rockefeller Research Fellow from Cambridge (Banerji, 1986). In such a situation, it would have been utterly fallacious to expect impartial, 'clean' studies from them, conceptually, theoretically and methodologically suited to the local setting. Though, even at that time quite a number of Indian scholars had raised their voices against such studies based on the dominant Western model (Mukerji, 1958; Saran, 1958) but Western impact had penetrated to such an extent that such arguments could not refrain the majority of the scholars from blindly following this path.

CHAPTER - IV

SOCIOLOGY OF KNOWLEDGE OF MEDICAL SOCIOLOGY IN INDIA

Apart from the impact of the neo-imperialist forces on the growth and development of medical sociology in India,especially in the context of the health services development, medical sociology has been facing certain problems - social, economic and political - within the country also which can to a large extent be held responsible for giving a particular direction to medical sociology, a direction which has not proved to be in the proper welfare of the masses and their health problems.

To start with, any meaningful academic activity depends to a large extent upon the political will of the ruling classes of that society. This unprecedented power of the elite or the ruling classes in echoed in the view of Mills (Mills, 1956). He explained the power structure of the United States as an integrated array of elites in different spheres. Mills identifies three key institutions: the major corporations, the military and the federal government. Those who occupy the command posts in these institutions form three elites. In practice, however, the interests and activities of the elites are sufficiently similar and interconnected to form a singly ruling minority which Mills terms "the power elite". He refers to political leaders as 'lieutenants' of the economic elite and

claiming that their decisions systematically favour the interests of the giant corporations. In the Indian context, though the clout of the military elite is almost negligible, mainly because of the fact that the defence industries sector is not in the private hands as is the case in USA, the other two elites are definitely responsible for the major policy decisions including the shaping of health services and its related research activities. Since the ruling classes thrive on the exploitation of the poor masses, their interests are invariably in contradiction with that of the general population. Due to these interests, the ruling classes are always unwilling to take such measures, especially in the context of the improvement of health services, which may lead to more awareness amongst the ignorant masses, ultimately leading to the threat to the very positions, setting on which, they exploit the masses. That is too say, poor health or marginal health of the lower strata of the population, keeps their exploitative rule intact; they are most unwilling to part with, and can go to any extent to perpetuate their hold over power. This fact has been evident in the successive years after independence through the various policy decisions of the government, from time to time. The Bhore Committee way back in 1946 had emphatically recommended preventive health care, creation and maintenance of healthy environment both at the homes and the place of work especially in the rural areas, production of such social doctors who combined in them the abilities of a

doctor as well as a social worker and finally the active cooperation of the people in all the health programmes. A somewhat socialist approach is also reflected in the report by the statement - "No individual should fail to secure adequate medical care because of inability to pay for it" (Government of India, 1946). Unfortunately, the committee failed to clarify the course to be adopted for the fulfillment of these objectives especially in the context of the holistic understanding of the health problems of the society and also an indispensable role of the social sciences in achieving these targets. A similar thinking again echoed in the recommendations put forth by the Sokhey Committee, a few years later, where it was stated - "The organisation (health services) ... should provide each individual in the country with adequate medical care, curative and preventive - irrespective of his ability to pay for such services". (Government of India 1948, p.230). Apart from other aspects the Committee also recognised that since the rural areas have all along been neglected at the cost of the urban areas, they needed much greater attention, and that the root cause of the various health problems in poverty. It also called for an active cooperation of the people in each and every health programme. However, by 1962 the Mudaliar Committee (Government of India, 1962) felt that the objectives envisaged by the Bhore Committee were somewhat utopian and hence there was a need to dilute them so as to make them more practicable. This should

not, nevertheless, be perceived as total inefficiency on the part of the government. Still, this Report also, though talked about the need for improved health facilities for the masses, especially the rural ones, it showed little inclination towards the understanding of the health status in a totalistic perspective. This continued till the late seventies when, due to the pressure of the democratic forces, which was unprecedented in the history of India, the government introduced the Community Health Workers Scheme to ensure "People's Health in People's Hand'. But again, due to improper understanding of the local social structure, the scheme could not succeed as expected. The local caste and class character of the villages made the scheme useful only for a selected few, both from the point of view of employment opportunities and the health services as well (Qadeer, 1985). Writing in this context some scholars even termed the elites as 'mafia' (Jobert, 1985).

Subsequently, after a few years, a Study Group on an Alternative Strategy for Health Services in India was set-up by the joint efforts of ICSSR and ICMR (ICSSR-ICMR, 1981). Though it was dominated by the physicians and under-represented by the social scientists because out of fourteen members only four are social scientists, still it is considered to be "the most comprehensive and the latest of all health policy documents we have in India so far" (Oommen, 1987, p.156). Despite the fact

that it is the first report which has scathingly attacked the existing health service system and its failure because of the inherent class contradictions of the society, it seems to be a confused document and as Oommen has remarked, "This is a curious document: parts of it read like an official report, parts of it like a political pamphlet, and yet other parts like the pronouncements of an oracle, moral exhortations"(Oommen, 1987, p.157). Apart from other shortcomings the most glaring from the medical sociological point of view is the understanding of the term 'community'. The committee seeks for the involvement of the 'community' in all the health programmes initiated by the government especially in the context of its emphasis on an approach starting from below, from the people. But, despite the presence of four social scientists, the committee fails to understanding that the community is not a homogeneous but a heterogeneous structure consisting various kinds of social, economic and political groups, whose interests are generally contradictory. In such a situation talking about the involvement of community as a whole without going into its complexities reflects a clear ambiguous approach on the part of the study group. (Minocha, 1987; Oommen, 1987) "The study group dismisses the social scientist's vision of the village community ... as a heterogeneous, conflict prone, stratified unit. This group continues to subscribe to the outdated conception of the village in its prisitine glory, as a harmonious, virtuous, self-conscious

entity having a will and mind of its own, reflected in some sort of charismatic leadership such a community is not only visualized as the goal of the alternative strategy, but also seen as a precondition for actualizing the proposed model". (Minocha, 1987, p.49). Rather than suggesting measures to first set right the lopsided social economic and political structure of the community, the study group, in an utopian manner, emphasizing upon the change in the values, advocates for the propagation of an attitude of goodwill, tolerance and respect for each other. "They will also have to learn to organize themselves ... on the basis of a community based on principles of mutual respect, tolerance and goodwill, cooperation and sympathy for the underdog. It must be realized that these changes in attitudes and values will be the result of the successful operation of the alternative model just as it is the deliberate cultivation of these attitudes and volues that will itself make a major contribution to the success of the model".(ICSSR-ICMR, 1981, p.203) In this context, the study group appears to be influenced, though unconsciously, by the views of Talcott Parsons and in this way by the structural-functional approach of understanding the society. In Parsonian sociology, social order depends on the existence of general, shared values which are regarded as legitimate and binding, and act as a standard by means of which the ends of action are selected. These shared values, according

to Parsons, arise out of consensus and not conflict (Rocher, 1974).

This predominance of the structural-functional approach in the majority of various other medical sociological studies, has greatly hampered the proper understanding of the health status and health problems of the society, in relation to the inherent caste, class and other contradictions. Emphasis upon consensus rather than conflict, cooperation rather than competition, and utopian harmonious coexistence of the various groups, acted as blinkers for the sociologists, who were thus refrained from getting an objective and real assessment of the health problem of the masses. For such a pathetic state of affairs of medical sociology, the scholars themselves are to be held responsible to a great extent. Firstly, most of the sociologists have not bothered to go to the community itself and then study its health problem. They preferred to confine themselves to the hospital-based studies, which, of course, could not claim to be representative of the entire population's problem, simply because of the fact that almost 75 per cent of the population resides in rural areas, a majority of which does not have access to the proper health services. Secondly, even if a few who undertook community based health studies, did not bother to go into the root causes of the poor health of the masses, and it seems utterly incredible on their part. This clearly shows that such

scholars were never even interested to perceive the health problem in a holistic perspective. Some scholars like Mathews (Mathews, 1979) did recognize the importance of poverty behind the poor health, but failed to correlate at with the macro social structure.

Moreover, at times, when certain scholars witnessed the failure of the various government health programmes, as a result of the unacceptance by the people concerned, rather than attempting to understand the cause of such unacceptance (behind which the people had their own rationality) they resorted to 'victim-blaming'. i.e., they blamed the people themselves for the failure of such programmes. (for example, the RCA project and the family planning projects). In this context George Foster was one of the first sociologists to have emphasized upon understanding the people themselves and then formulating the suitable health policies (Foster, 1958). According to him, rather than blaming the poor community the social-scientists should try to understand the bureaucracy which is, in fact, responsible for such failures. Setting aside all other research priorities, the most difficult task for medical sociologists, feels Foster, will be the study of health bureaucracies. According to him, it simply does not occur to many health administrators that at least half of the problems encountered in providing health care to poor rural people are bureaucratic in nature. They also think that if any change is

essential to improve health levels, at must take place at the community level and not at the bureaucratic level. While, on the contrary, it is the bureaucracy that needs to be overhauled. (Foster, 1984)

Another important area where medical sociology has not been properly utilized has been medical education. First of all the 'market-requirement' is such that most of the doctors wish to specialize in various fields but not 'social and preventive medicine'. At the same time, whatever exposure they get of the medical sociological contents that is for from the actual health condition of the masses. In fact, these medical students are never able to know about the real causes of poor health of the downtrodden. It seems from their knowledge that they never try to understand whether one's socio-economic status, class and caste, has any thing to do with one's health condition. This has been proved by various studies. (Ramalingaswami, 1987)

This kind of alienation of the doctors due to medical education as well as the medical sociologists due to their faulty conceptual, theoretical and methodological approach, from the actual pathetic health status of the masses, is closely associated with the phenomena of blind following of the Western Reference Frame, whereby the scholars have tended to adhere to the Western conceptual, theoretical and methodological

frameworks, which had little applicability in the Indian context. Here it is important to note that most of the medical sociologists, in their zeal to adhere to these frameworks, often could not get the real picture of the health conditions of the common masses. Drawing together a wealth of information, Sanders and Carver feel what disease and underdevelopment are intricately bounded together. Health services and medical attitudes imported wholesale from the developed world has often seemed as much part of the problem as part of the solution. They maintain that in so far as Western medical attitudes towards the health problems has had an impact on the mass of people in underdeveloped countries, it has largely been a negative one, reinforcing a political and economic system that is the root cause of their ill health (Sanders and Carver, 1985)

And lastly, closely interlinked with the above aspects, is the problem of the improper underutilization of medical sociologists. This is mainly due to the hospital based, cure-oriented approach of the health services followed by the government. This situation, in turn, owes much to the over-professionalization of the medical profession. This phenomena has made the people over-dependent upon the doctors even for the health problem which are basically social, economic and political in nature, and the role of the doctor is extremely limited in such cases. Such a situation has best been described

by Ivan Illich who feels that undoubtedly the number and variety of tasks of social significance assigned to the medical profession have increased during this century, but the impetus to aggrandizement has come from the profession itself. The prime motive, according to him, is the profession's self-interests, not the health of population (Illich, 1977). Illich, for example, claims that increasing medical hegemony (predominance) has decreased the capacity of ordinary people to look after themselves and made them more and more dependent on medicine. So, on the one hand the profession of medicine retains control over traditional illness and technical procedures such as surgery, while on the other hand it expands into areas of everyday life such as what we should eat or drink. This medicalization of life is called by Illich as iatrogenesis, which he described as being of three kinds :

(1) Clinical Iatrogenesis, from the side-effects of diagnosis and treatment. For instance the diagnosis of mild hypertension might label someone and restrict his activities, while at the same time he is subjected to a lifetime's medication, with a much higher chance of side-effects than future benefit;

(2) Social Iatrogenesis, which encourages consumption and dependency. The medical profession and medical care

organization create an artificial need and so generate ill-health;

(3) Cultural iatrogenesis, by which healthy responses to suffering, impairment and death are paralyzed by people's addiction to medical care as a solution to all their problems. This expropriation destroys the healthy autonomy of individuals.

This kind of approach of the doctors of taking upon themselves the entire responsibility of the understanding and subsequently finding solutions to all kinds of health problems of the masses, seems to have severely restricted the role of a medical sociologist in giving a holistic solution to the complex health problems.

CHAPTER -V

ALTERNATIVES

Commenting upon the current status of the affairs of research related to health problems, McKinlay has rightly observed - "much of it is atheoretical, frequently ahistorical, usually apolitical, defensive of the status quo and dominated by managerialism. There have indeed been few broad-ranging structural analyses of the overall health care sector and of the political and economic forces that influence its shape and content ... " (McKinlay, 1984, p.2)

Keeping in mind the various forces, social, economic and political, and certain vested interests that have constantly influenced the growth and development of medical sociology in India, the subject needs a new direction so as to become more meaningful in understanding the health problem of the masses and especially the rural poor and then providing right solutions to these. With respect to the various issues discussed in the preceding chapter, the following alternatives can be spelt out for a proper utilization of medical sociology in the context of contemporary health problems of our country ---

(1) First of all, it is utterly essential for each and every medical sociologist to keep his study people-oriented. The

people for whom the entire health policies are formulated should be the nodal point for any medical sociological study because unless the specific health problems and needs of these are kept in mind, all the health policies are bound to fail. It is also essential to note here that the term 'people' does not indicate a homogeneous group, as has been understood by a large number of scholars; instead it refers to the poorest of the poor and the downtrodden sections of the society, which, by virtue of their pathetic socio-economic condition, always remain the neglected groups. At the same time the 'privileges' of the health services are cornered by a miniscule section of local elites.

(2) The Indian medical sociologists will have to come out of the confinement of the structural-functional approach, which emphasizes upon the existence of consensus for the establishment of order in the society, an approach which is far from reality and the actual conditions existing in the society. On the other hand, the people-oriented conflict approach, much closer to reality, maintains that rather than consensus, the basic condition of social life is dissension, arising through the competition for power and advantage between the different groups. The dominant social process, therefore, is not the steady effort to restore harmony or

equilibrium but the endless struggle between the haves and have-nots, privileged and the downtrodden. The role of the elites in the fulfilment of their vested interests and perpetuation the status quo, has been demonstrated by various scholars (Mills, 1956) and also the importance of power and authority in the establishment of one's superior position in the society which leads to relationship of domination and subordination producing antagonistic interests. (Dahrendorf, 1954) The structural-functional approach," instead of being a lens which sharpens our perspective and puts social reality in focus, it becomes a pair of rose-coloured glasses which distort reality, screening out the harsh facts about conflict of purpose and interest in human affairs". (Inkeles, 1982, p.39)

(3) So as to get a complete understanding of the health problems of the community the scholars will have to adopt a holistic approach in their study. The medical-sociological studies conducted by the National Tuberculosis Institute and the related scholars and also the "felt-need' and 'health-culture' approach adopted by a few scholars (Eg.Banerji, 1982: Sahu, 1980), can act as guidelines for the coming generation of medical sociologists. The most important characteristic of such studies has been that the particular health problem was not perceived in isolation,

but instead as a part of a larger whole, which in turn, consists of a gamut of other social, economic and political factors. Only then will it be possible to come out with the actual health problems of the people.

(4) It can be very helpful in any sociological study related to health, to make concepts of 'health-culture' and 'felt-need' as the pivot of the study. Health culture can be understood as an "integrated, interdependent and interacting whole" consisting of community's perception of the health problem and, response to various institutions that exist for dealing with these health problems (Banerji, 1982, p.208). Such an approach can greatly enhance the authenticity of community based health research, as has been successfully proved by various studies (Eg. Banerji, 1982; Sahu, 1980). Moreover, such studies can greatly help in the formulation of suitable health problems of the community and not simply in accordance to the convenience of the bureaucracy.

(5) There is a dire need for the formulation and utilization of such conceptual, theoretical and methodological framework which suits the local contexts and also takes into account the inter-regional variations, keeping in mind the local traditions, structure - social, economic and political, replacing the dominance of the use of Western reference

frame. This problem was aptly put forward by Saran way back in 1958, "Indian thinkers, with one or two exceptions have been too much dependent on the West for their theory and have been promptly accepting the changing theoretical framework from the West" (Saran, 1958, p.123). So were the views of his teacher Mukerji, " ... It pains me to observe how Indian scholars succumb to the lure of modern, 'scientific' techniques imported from outside as a part of technical 'aid' and 'know-how' without resistance and dignity. In the intellectual transactions that are taking place it seems that we have no terms to offer, no ground to stand upon". (Mukerji, 1958, p.229-33)

(6) Also urgently required is the reversal in the dominant trend of hospital based studies in medical sociology. In our society where 76.89 per cent of the total population lives in rural areas and merely 23.31 per cent in the urban pockets (Government of India, 1987, p.7), it is highly unjustified to carry on most of the studies in the context of hospitals, which cater to a very small proportion. Moreover, since there is a vast difference between the urban and rural areas regarding the availability and accessibility of the health services (Zaidi, 1988) such hospital based studies cannot, at all, claim to be representative of the entire population's health status. Hence, the need of the

hour is to concentrate on the community-based studies, though, not at the cost of the total abandonment of hospital studies.

(7) Even within the category of the hospital studies emphasis should be laid more upon providing solutions to the health problems of the poor patients and less upon the applicability of the Western theoretical models, especially the Parsonian models. Firstly, suitability of such models has not been established yet in the Indian setting and; secondly, it is more essential to help in solving the health problems in a holistic perspective, especially in a developing society like ours. Since the basic health maladies have yet to be removed and various widespread diseases yet to be eradicated, it seems highly unethical on the part of the medical sociologists to concern themselves more with the testing of theoretical models than with searching for ways to alleviate the health status of the population at large. However, within the scope of hospital-based studies itself still there remain various unexplored areas and if proper research are conducted within these areas it can prove to be very valuable in solving the various health-services related problems of the poor masses. One such area is the exploration of the reflection of the socio-economic hierarchies existing in the wider social

structure, upon the hierarchical structure of the hospital. As has been stated by Qadeer "In the Indian setting ... oranizational hierarchies are to a large extent dependent upon the social hierarchies of the larger social systems. Thus the majority of the doctors have a bourgeois or upper-middle class background while the nurses and the technical staff come from the middle class ...". She further writes, "This replication of social patterns brings along with it certain other traits as well, one of which is the upper class (elite) culture that pervades the health care institutions. The patient - specially if he is a common man - becomes the least important element ... If special attention is bestowed on any patient, it is more often due to social rather than disease status". (Qadeer, 1990,p.102)

(8) The medical curriculum in India needs a strong input of sociological contents. Way back in 1946even the Bhore Committee had emphasized upon this aspect, though somewhat in a different manner. "The doctor of the future should be a 'social physician' protecting the people guiding them to healthier and happier life". (Government of India, 1946) This is important because as we perceive today, most of the diseases in our society are an outcome of the impact of wider social, economic, political and cultural forces. In its exploration of social factors modern medicine has

discovered that behavioural sciences have major implications for the future development of medicine. (Coe, 1970). Similarly, Toha and Srivastava have observed, "In formulating the educational goals of medical education the changing milieu and the emerging social demands of health care should be given due importance. The basic philosophy of the re-organization of the medical curricula should be based on the holistic view of man in health and illness". (Toha and Srivastava, 1987, p.178)

(9) There is an increasing emphasis on the collective and integrative effort of the social scientists from various disciplines in understanding and solving health problems from an inter-disciplinary perspective. Suchman is right when he says "... sociology in public health is basically an applied science. This means that behavioural scientists working in the field must be problem-oriented, not discipline-oriented". (Suchman, 1963, p.10) Some scholars have even emphasized upon the use of generalist social scientists who do not consider their disciplines as water-tight compartments. (Boek and Hilleboe, 1955) And since "the health institutions in India cannot yet afford to use a battery of social science specialists for its research and service activities, the need is to have 'general practitioner' of social sciences who are unfettered by

arbitrary disciplinary barriers". (Banerji, 1973; pp.145-147)

(10) Since any medical sociological research (and its findings) cuts across a wide section of the society, and also read by scholars and laymen from various walks of life, the scholar should not resort to, as Andreski has termed, the 'smokescreen of jargon' (Andreski, 1974). Keeping the research, including its conceptual framework, lucid and straightforward, its usefulness can be enhanced manifold. In such a situation the sociologist becomes more acceptable to the scholars of other disciplines.

(11) For a right and proper utilization of medical sociology and giving it its due place in the academic world, deprofessionalization of the medical profession is utterly essential. As long as the understanding of the health problems are dominated by a purely clinical and medical perception, and as long as medicalization of life perpetuates, it will be difficult to comprehend the health status of the masses in the proper wider perspective, and hence, to alleviate the health status of the community.

(11) Gunnar Myrdal, in a brilliant essay on 'The relations between social theory and social policy' argued that the

social sciences are important to a democracy because they encourage the open discussion of important issues by appealing to the people's rationality rather than to superstition and narrowness. The sociologist can make this contribution, however, only if his situation affords him reasonable freedom and security. (Myrdal, 1953) Hence, it should be one of the first prerequisites for the development of an impartial medical sociology, committed only to the cause of the common man.

(13) Last, but not the least - since, over the years, 'medical sociology' has expanded manifold, increasingly becoming concerned with a broader approach to the role of social, economic, political and cultural forces in health and medicare, its designation should be changed to - 'sociology of health'so that the array of the academic and research activities it covers are incorporated in it. (Mehta, 1987; Rosen, 1963; Suchman, 1963).

SUMMARY

Though man had recognized the importance of socio-economic, political and cultural factors in relation to health, since the earliest times, medical sociology as a proper field of study received impetus during the Industrial Revolution in Europe when the pathetic living conditions of the poor and helpless industrial workers motivated a number of scholars to study the relationship between such living conditions and the health of these workers. Unfortunately, the majority of the medical sociological studies were predominated by the structural-functional approach, a trend which continues even to this day. Even in the post-Independence period in India when there was an urgent need for a proper utilization of medical sociology so as to comprehend the various health problems of the poor masses and provide solutions to these, due to the predomination of the structural-functional approach, the discipline did not grow and develop in the right direction, and being under the influence of the various socio-economic and political forces, it has utterly failed to come up to the expectations of the people of Free India. In order to make medical sociology more meaningful in the context of both - the health services and health problems of the people at large, emphasis will have to be laid upon keeping the studies people-oriented, which involves the understanding of the people,

taking into account the gamut of socio-economic, political and cultural factors which constantly influence their health status in some form or the other, which in turn, will facilitate the formulation of such health policies that are 'bottom-up' and not 'top-down' in their approach.

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