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A SOCIAL ANTHROPOLOGICAL ENQUIRY INTO PROFESSIONALISM AND DEPENDENCE IN MEDICINE

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CERTIFICATE

Certified that the dissertation entitled: "A Social Anthropological Enquiry into Professionalism and Dependency in Medicine", submitted by Mr. Nabin Kumar Pradhan is in partial fulfilment of six credits for 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.

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The entire responsibility for whatever short-comings that remain in the dissertation is, of course, mine.

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CHAPTER I

INTRODUCTION : PROFESSIONALISM OF DOCTORS AND DEPENDENCE OF PATIENTS

Introduction

Over the past two decades or so an important contribution to the sociology of medicine has come from the cultural critiques of modern medicine. The foremost critic of twentieth century medicine is, of course, Ivan Illich;[1] but he has been followed by several others who have developed his arguments and extended them to cover almost every facet of contemporary 'scientific' medicine and medical care. But in this examination of modern medicine what all members of the school have in common is the uniform and unifying concern with the phenomena of dependence of the patients and the professionalisation of the doctors both of which they contend are consequences of the way medicine is taught and practised in the modern world. Their criticisms of modern medical system are quite plainly pivoted on these two phenomena. Ivan Illich, for instance, points out three significant, and yet little understood, characteristics of

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1 Ivan Illich, Limits to Medicine. Medical Nemesis : The Expropriation of Health (Harmondsworth Penguin Books, 1977).

modern professionally organized medicine.[2] (i) It produces clinical damage that outweighs its potential benefits; (ii) it cannot but enhance even as it observes the political conditions that render society unhealthy, and (iii) it tends to mystify and to expropriate the power of the individual to heal himself and to shape his or her environment.

For cultural critiques the consequences of the phenomena like dependence of the patient and professionalisation of the doctors go in tandem with the mystification by doctors of their powers and prowess leading to super-specialization of modern medicine and professionalism among doctors. All of these they contend are calculated to undermine the interest of the patient.

While some of the earlier scholars like Navarro[3] had seemingly singled out capitalism for the state of affairs, other scholars depending on Illich, hold industrialisation alone to be singularly responsible. Barbara and John Ehrenreich[4] write that the expansion of medical system has been accompanied by a deepening public dependency on that system, and this dependency now extends, in varying degrees, to all strata of society. Marc Renaud, in a

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2 Ibid., p. 16.

3 V. Navarro, Medicine under Capitalism (New York: Prodist, 1976).

4 Barbara and John Ehrenreich, "Medicine and Social Control" in John Ehrenreich, ed., The Cultural Crisis of Modern Medicine (New York: Monthly Review Press, 1978), p. 53.

similar vein, writes that the individual is isolated in the face of his or her sickness with the help of increasingly professionalized 'experts' the physicians. Renaud writes, "This builds an extremely strong tie between the public and the physicians, whose healing powers, precisely because they are more apparent than real, reinforce the belief in the need for ever more expertise, i.e., in ever more consumption of expert services."[5]

One cannot deny that professionalism, super-specialisation and mystification are propagated by doctors; or that the patient indeed is utterly dependent on them and does not participate in the healing process. The question however is: Has the patient only recently, i.e. with the coming of modern medicine, lost his initiative? Could it be that he never had it in the first place and the style of modern medicine, the tremendous expansion in medical technology has highlighted and accentuated this age old fact?

The question becomes important because when cultural critiques of medicine argue against modern medical practice, they usually refer to a 'golden age' in the past where things were qualitatively different. As Illich writes, "All traditional cultures derive their hygienic function

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5 M. Renaud, "On the Structural Constraints to State Intervention in Health", in John Ehrenreich, ed., The Cultural Crisis of Modern Medicine (New York: Monthly Review Press, 1978), p. 109.

from this ability to equip the individual with the means for making pains tolerable, sickness or impairment understandable, and the shadow of death meaningful.....Most healing is a traditional way of consoling, caring and comforting people while they heal, and most-sick-care a form of tolerance extended to the afflicted."[6]

Unfortunately the description of this age both by Illich and others is very hurried and at places patently inaccurate. Not a single contemporary anthropological or historical source can validate such renditions of the 'golden age' and neither do Illich and others provide us with any. This obviously leads us to question the premises of their conclusions. In other words, even without contending the actual conclusions, these conclusions lose their cogency if the premises on which they were based are questionable. To elaborate further, one could say that while professionalism, mystification etc., exist in modern medicine, a statement truthfully representing those facts would find it difficult to rise above the level of reportage if it does not also give us the process through which they occurred. In other words, to put it in the traditional parlance of methodology, these facts would only be tenable but not valid. If antiquity is the relief against which these explanations are worked out, then perhaps a little consideration of history and anthropology would be entirely in order.

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6 Illich, op. cit., pp. 136-7.

Statement of the Problem

The problem that we would like to investigate is not in the nature of hypothesis but more in the nature of an enquiry. The questions that have been raised are actually those suggested, though unintentionally, by the cultural critiques of modern medicine. Though anthropology and history are often invoked by them, this has been done, we believe, rather carelessly, and an enquiry into just these areas alone would significantly aid one to make a critical appreciation of the critiques of modern medicine.

On the problem of dependency, as noted earlier, we find that the cultural critiques emphasize the manner in which medical systems foster and abuse dependency. Structural iatrogenesis, according to Illich, is the loss of autonomy of the patient and his dependency on the doctor.[7] He explains that in this iatrogenesis, the medical bureaucracy destroys the potential of people to deal with their human weakness, vulnerability and uniqueness in a personal and autonomous way. Barbara and John Ehrenreich likewise categorize the relationship between the doctor and the patient as that of dominance and dependency.[8] They maintain that patients are required to submit to the medical management of their problems almost without question.

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7 Ibid.

8 Ehrenreich, op. cit., p. 55.

What, however, has not been clarified is whether this was a result of superiority of modern medicine or because of better organizational skills of the profession whose machinations were far too deep for ordinary people to comprehend. While some cultural critiques are ambigouus of the benefits of modern medicine (many of them see no development at all) yet they are all positive about cultural iatrogenesis and dependency. The question then is why and how were the doctors able to dominate over the people? Or to put it in a different way: Why and when did the people give up their independence? Obviously then the related questions are whether dependency is a new or old phenomenon in doctor-patient relationship? If new, how new? And likewise, if old, how old?

As we unravel these issues we are obliged to look at the question of professionalisation in a similar manner. For a classic illustration of the problem of contemporary professionalism one might take a leaf out of Illich's book again. He writes, "suffering, healing and dying, which are essentially intransitive activities that culture taught each man, are now claimed by technocracy as new areas of policy making and are treated as malfunctions from which populations ought to be institutionally relieved."[9] Renaud substantiates the problem of professionalism in the following way. An

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9 Illich, op. cit., p. 133.

endless consumption process is unleashed because, as Renaud would have it, of the complete way of isolation of the individual from his community, which in turn is carried forward to the isolation of the illness from the entire individual, thus necessitating institutionalized expert solutions to health needs.[10]

It appears, therefore, that professionalization of medicine and the resulting dependence of the patient is a thoroughly post industrial society affair. But what of societies in the third world that cannot yet claim such a status but where we are constantly accosted by medical professionalism and patient dependency? Additionally, is it not also worthwhile to validate arguments regarding contemporary professionalism and its effects in a comparative framework, i.e. by placing them in an anthropological-cum-historical relief. Our major thrust in the following pages would therefore be to do just this kind of a comparative job to see when professionalism among healers arose and how they were able to accomplish this. For if we go by Navarro, Renaud and Ehrenreich : professionalisation and its attendant mystification are fundamentally 'anti-people' in an exploitative sense. If the doctors in the golden halcyon days were with the people, a comparison of the contrasting styles of attaining or disseminating medical

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10 Renaud, _op. cit._

knowledge would be extremely fecund. But a word of caution. We are not, to be in tune with our purpose, prejudging at this stage that professionalism did not exist among ancient medicine men, or in pre-literate "primitive" societies. In the chapters to follow we shall attempt to glean from anthropological and historical works on this subject and try to regroup existing knowledge on and around these themes. We hope that by doing so the assemblage will have a qualitative character of its own.

If we are able to do so, then it should help, not simply in validating or correcting the cultural critiques in matter of detail, but in matter of substance too. Additionally it might also provide us with some clues towards understanding the persistence of the phenomena of dependence, professionalism and mystification in the field of health.

The Perspective

Anthropology has traditionally been strongest when dealing with tradition, and when dealing with the study of the universal man. The study of tradition *per se* often conflicts with the concept of *man*. This results in the vaunted distinction between disease and illness and their correspondence between the two with the intellectual make-up of man in different types of societies. Disease is most commonly associated with the arena of professional practitioners in modern society, where it relates to special theories of

disease causation that are stated in an abstract, highly technical and usually impersonal idiom. Illness is principally associated with the popular culture arena of health care in primitive and traditional societies, where it is believed that sickness is most frequently articulated in a highly personal, non-technical and concrete idioms. It is as if anthropological subjects never suffered from any diseases at all and were forever plagued by psychological induced dysfunctional outbursts like "susto" or "Lulu".

But without going against the grain of most anthropological works, we can from the received texts attempt an examination of the genesis of dependency and professionalisation that we know so well to characterize /and modern medicine/which have been forcefully brought out by the critiques of modern medicine. But our enquiry demands that we investigate whether these phenomena existed prior to contemporary times either in their essential form, or in their incipient form, or whether they did not exist at all. The outcome of such an enquiry should yield significant findings which ought to be amenable to cross-cultural generalization. It may be possible to discern from such a cross-cultural perspective of health institutions, the common drives of man in the health context and how they have been expressed in or layered over by different social situations.

The above would yield, what might be called, an ahistorical cross-cultural perspective reflecting the

essence of man through the perspective of illness and health institutions. But it is equally important to observe the 'historical' dimensions, to evaluate how social pressures and social structures shape institutions, efface certain sharp edges of the past and sharpen new postures for the present.

At this point we must mention that though our method seems to resemble Durkheim's, it is not essentially so. Emile Durkheim held that the simplest form of religion must be found in the simplest form of society. Therefore if one is to understand complex contemporary religious life, one should first understand religion where it is least complex, i.e., in primitive societies. The elementary form will be revealed there to illumine our comprehension of modern religious behaviour. Such a position inspired Durkheim to comment on primitive classifications as the 'first philosophy of nature'. Durkheim and Mauss concluded, "Primitive classifications ... seem to be connected with no break in continuity to the first scientific classifications".[11]

We are, however, not yet ready to grant that primitive health behaviour comprising at least of health technology and health care, were elementary forms from which modern medicine developed into complexity. We share with

11 E. Durkheim and M. Mauss, Primitive Classification (London: Cohen and West, 1963), p. 81.

Sigerist,[12] Rosen,[13] Foucault[14] and Kuhn[15] that modern science (including medicine) is a sharp break from the past. When we are tracing the presence or absence of phenomena like dependence and professionalisation in anthropological and historical works, it is not so much to "reveal" the present but to understand the social setting against which medicine is practiced and solicited, and whether some factors in this setting are relatively unvarying down history or not. Too, it might tell us how men through different periods and cultures coped with the unsettling problem of illness and disease. To say more at this stage would be to anticipate our subsequent chapters.

Outline

In the following pages we shall undertake an examination of the phenomena of dependence and professionalisation in the field of health with respect to three areas which we are deliberately studying. The first is from

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12 H.E. Sigerist, A History of Medicine (New York: Oxford University Press, 1967).

13 G. Rosen, A History of Public Health (New York: MD Publications, 1958).

14 M. Foucault, The Birth of the Clinic : An Archaeology of Medical Perception (London: Tavistock, 1973).

15 T.S. Kuhn, The Structure of Scientific Revolutions (Chicago: University of Chicago Press, 1963).

anthropological sources. Here we shall concentrate primarily on preliterate societies and use such materials as we have been able to peruse for the purpose of illuminating our fundamental quest. Following this, we shall examine the situation in ancient history and concentrate on highly literate civilizations, those from which the modern world often traces its geneology. Finally, we shall examine our modern societies and see how much of history and prehistory lingers on.

But as we dwell on each of these areas, our probe is perforce to attune itself to the specific problems of these areas. Though we are interested primarily in the phenomenon of dependence and professionalisation we are not simply examining the presence and absence of these phenomena in the following three chapters. When we are examining primitive societies, we have to keep in mind the specificities of that field of study, as we must in the other two cases as well.

The added dimensions in our exercise on anthropological literature is to sort out the supernatural from natural theories and treatment for medicine. How are the two inter-related, or perhaps, inter-twined? Which in turn leads us to enquire how dependence and professionalisation could possibly arise, and, if so, how would that be manifested. In the chapters following this, i.e. where we are dealing with

ancient literate civilisations and with contemporary society, the relative role of the supernatural and the natural in the field of medicine and health have to be evaluated too. Through this paper we are thus trying to make up our minds on another issue, viz., the role of 'rationality' in the health practices of different societies.

This is not, as it might seem, peripheral to our main interest. For, as we shall find, medical pluralism, i.e., opting for alternative system of health care, is linked in different ways to dependency and professionalisation and it has not ceased to become a thing of the past. We hope to be able to take some tentative first steps in understanding the phenomenon when we come to our penultimate chapter on contemporary societies. In this manner, each chapter will ask sometimes the same question differently, or ask different questions to light up areas contiguous to our primary thrust.

Definitions of Terms

Finally it is perhaps necessary to quickly state what we mean by a dependence and professionalisation which are bound to appear and reappear in the pages to follow. These definitions are as we see them but we are not presuming that they are either entirely original or infallible.

(a) Dependence: As the cultural critiques of modern medicine have pointed out the patient is incapable of treating his

ill-ness by himself or with the help of his family and neighbours. In modern medicine, the critics allege, the patient has to depend upon the specialist, the professional doctor.

Now it has been fairly well documented by sociologists, for example, Talcott Parsons[16] that a patient enters the sick role when he is incapable of treating his illness and when his illness is beginning to tell on his normal role performance. In other words, not every instance of illness or malaise makes the doctor's presence unavoidable. Over and above personal medication, there is also the possibility of the lay referral stage. The doctor comes in at a later point. It is here that the patient becomes dependent upon the doctor. Dependence of the patient would thus refer to a situation when the patient is unable to cure himself and is dependent on a professional to restore him back to health.

(b) Professionalisation

Professionalisation of the doctor has the following characteristics. First, he is recognized by the society rightly or wrongly, to be qualified either by training or by super natural endowment, to cure a patient. Secondly, the professional's knowledge is privileged knowledge and not people's knowledge. There are institutionalized ways by which

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16 T. Parsons, The Social System (New Delhi: Amerind Publication, 1972).

the professional acquires, transmits, disseminates and uses this knowledge. The third character follows closely on the heels of this. The professional healer protects professional knowledge by creating a boundary, or a wall, through which the uninitiated lay person cannot enter. Finally, he may also wear or possess symbols or badges which signify his status as a professional healer.

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CHAPTER II

DEPENDENCE AND PROFESSIONALISATION IN PRIMITIVE SOCIETIES : REGROUPING ON THE BASIS OF ANTHROPOLOGICAL LITERATURE

In our previous chapter we had mentioned that anthropologists studying ethnomedicine have by and large concentrated on exotic phenomena like "susto", "lulu", etc., and have paid little attention to what primitive people do when they are stricken by disease. For these anthropologists it is as if diseases never strike the members of primitive societies, and that they have no awareness of natural therapy at all. This state of affairs is, _prima facie_, unacceptable if we pause for a while to think of the vast knowledge the primitives have on nature and their precise knowledge of the properties of different botanical specimen. Lévi-Strauss in the opening chapter of 'The Savage Mind'[1] considers the bewildering corpus of knowledge that the tribal possesses on natural objects, flora and fauna, to be the ingredients of the science of the concrete. Lévi-Strauss is not alone in commenting upon this, and yet this fact is hardly recognized by studies on ethnomedicine.

But neither can we ignore the dominating presence of the supernatural, of magic and witchcraft, in the health

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1 C. Lévi Strauss, _The Savage Mind_ (Chicago: University of Chicago Press, 1966).

institutions and behaviour of primitive people. What is the relative salience of dependency and professionalism in such a situation?

In the first half of this chapter with the help of anthropologists, like Evans-Pritchard[2] and Lévi-Strauss, we hope to understand the phenomenon of magic, witchcraft and sorcery and with it the agency of supernatural forces in the health behaviour and practices of the pre-literate peoples. Instead of viewing the belief in the supernatural, as pre-logical, as was current with Lévy-Bruhl[3] several decades ago, the more contemporary anthropologists insist that magic, witchcraft and sorcery should be seen in the following two contexts. The first is that the supernatural agencies get precedence when demonstrable means ends technology is either absent or inadequate; and secondly, in the context of how mystical and magical thought operates and what is that which separates such modes of thought from scientific mental operations.

In the second half of the chapter we shall try and demonstrate the extent of status maintenance and professionalisation among doctors in primitive societies. We are quite

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2 E.E. Evans-Pritchard, Witchcraft, Oracles and Magic among the Azande (Oxford: Clarendon Press, 1937).

3 L. Lévy-Bruhl, Primitive Mentality (New York: Beacon Press, 1966).

used to the witch doctors and shamans who deal with the mystical and the supernatural. But what about natural therapy?

Sorcery, Witchcraft and Health

It is a commonplace observation that in the face of actual or threatened disaster to do something is psychologically satisfying. It is also a way of relieving anxiety. The anxiety theory of Malinowski has relevance in this context.[4] He opines that in everyday economic pursuits there is no magic; but when the result of the mission is wrapped in uncertainty, the natives take recourse to magic. It can be observed that the linkage which he posits between anxiety and ritual goes back to psychoanalytic theory enunciated by Freud. Malinowski denies the role played by Mana. He attempts to lay the emphasis in pragmatic functions. He asks; "...without knowledge of what could be called the totemic attitude of mind, primitive religion is seen to be nearer to reality and to the immediate practical life interests of the savage."[5]

Anything is better than just remaining passive in the face of actual or threatened disaster. Magic is not only a way about thinking about things, it is also a way of

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4 B. Malinowski, "Magic, Science and Religion", in B. Malinowski, Magic Science and Religion and other Essays (Glencoe, Ill: Free Press, 1948), pp. 1-71.

5 Ibid., pp. 4-5.

doing things. People usually resort to it in situations of actual or potential damage or misfortune.

Illness which is a source of grave anxiety to the patient and his kin is believed in many societies to be due to the anger of a witch or sorcerer. In some cases the victim or his relative may attempt to conciliate the ghost or spirit by invocation and sacrifice. They may like the Azande of the Southern Sudan, themselves make vengeance magic against the suspected witch. According to Azande theories,[6] "Witches" have inherited special supernatural powers to harm others. They may be totally unconscious of their evil potentialities. They have developed physiological theories to explain just where in the body such powers reside. They also have their own ways of consulting oracles. They generally consult oracles to find out who among them carries the power, the cause of the attack and how the misfortune is to be averted. Among the Azande, sorcerers are men who have learned the specific techniques of manipulating key substances and charms. Thereby they can affect others.

The distinction to be noted is that while the witches' supernatural powers are innate and unconscious, sorcery is an acquired technique and is conscious. It should be further emphasized that this distinction between sorcery

6 Evans Pritchard, op. cit.

and witchcraft lies entirely within the total field of beliefs. In such a situation, while studying both sorcery and witchcraft, the entire concern is with the analysis of supernatural beliefs.[7]

But in all these cases, it should be underlined that magical beliefs and techniques imply not just a theory of causality but also a way of acting. And what is equally important is that where there is no body of empirical knowledge to turn for help, then ritual procedures, whose validity does not rest on proven or demonstrable experience, may provide an acceptable alternative. Any of these alternatives not only adequately explains the illness, it also provides a way of acting. The situation is that one or other of the alternatives is likely to be diagnosed by divination. Evans-Pritchard made an analysis of how Zande beliefs are conditioned by the society's dependence on a traditional technology. This traditional technology is characterized by the cumulative experience of past generations. This simple material base offers no alternative to traditionally acquired practices. So it is in consequence in harmony with a conservative ideology. As Douglas points out, Evans Pritchard's analysis showed how Azande, clever and sceptical as they were, could tolerate discrepancies in their beliefs and could limit the kinds of questions they asked about the universe. The relation between belief and society, instead of appearing as infinitely

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7 N. Yalman, "Magic" in International Encyclopaedia of Social Sciences, vol. 9, p. 523.

complex, subtle and fluid, was presented as a control system with a negative feedback.[8]

Mythical Thought and Scientific Thought

It may be recalled that in his classic study of Zande witchcraft, Evans Pritchard demonstrated how apparently irrational beliefs regarding the aetiology and cure of misfortune made sense in their epistemological context. He argued that the elements of the Zande corpus of knowledge formed a closed theoretical system. And in a closed theoretical system, the logic does not really permit the disproof of its constituent concepts. Douglas, commenting on the above study as a contribution to the sociology of perception, writes, 'the belief is on the same footing as belief in the conspiracy theory of history, in the baneful effect of fluoridation or the curative value of psychoanalysis'.[9]

Polanyie, in a celebrated study, shows that there are close parallels between modern scientists and African tribesmen in the defense of their respective cosmologies. In 1958, he included in his book, Personal Knowledge, a fascinating chapter dealing with "the stability of scientific theories against evidence". In this he showed that there are three attributes of the Zande belief system that ensure its

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8 M. Douglas, ed., Witchcraft Confessions and Accusations (ASA Monograph, London: Tavistock, 1970), p. xiv.

9 Ibid., p. xvi.

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stability. He called these "circularity", "epicyclical elaboration", and "suppressed nucleation".[10] He found that all three are also characteristic of scientific theories. More recently, Barnes[11] has suggested that magical thought and operations resemble the normative prescription of empiricist philosophers. In this he substantiates Polanyis but he goes on to differentiate true scientific thinking whom probably Kuhn would call the "normal" scientists.

From a different perspective Levi-Strauss argues a cognate point. He believes that despite their obvious differences, shamanistic cure and western medicines in general share a common feature.[12] Both provide their patients with a fundamental therapeutic tool. This therapeutic tool is marked by a set of codes for ordering disrupted perceptions. This is also intended for restoring the discontinuity between physical and social states, which is marked by illness. The way in which such codes are controlled may vary in significant respects between cultural contexts. Elaborating a Cuna (Panama) incantation to facilitate difficult childbirth, Lévi-Strauss writes that the Shaman's cure consists, "in

10 M. Polanyis, Personal Knowledge (Chicago: University of Chicago Press, 1958).

11 S.B. Barnes, "Paradigms - Scientific and Social", Man vol. 4, 1969, pp. 94-102.

12 C. Lévi-Strauss, Structural Anthropology (New York: Double Anchor Books, 1967).

making explicit a situation originally existing on the emotional level and in rendering acceptable to the mind pains which the body refuses to tolerate", by provoking an experience "through symbols that is, through meaningful equivalents of things meant which belong to another order of reality".[13] Whereas the pains are unacceptable to the woman, the supernatural monsters thrown by the Shaman in his symbolic description are part of a coherent system on which the native conception of the universe is found. By calling upon the myth, the Shaman reintegrates the pains within a conceptual and meaningful whole.

The 'native mind' thus attributes causality to the forces which we call magic. But it should not be forgotten that this magic quite often provides a more credible answer to fundamental questions of ontological import. It makes a coherent system because of the fact that such matters of ontological import, and disease is one of them, integrates well within the context of an overall cosmic interpretation. The explanation of disease etiology and therapy are constituents of this conceptual world. This has been narrated by Bartolomé in the following way . "The mechanisms which the Shaman puts into action during the process of healing correspond not only to his own living out of the myth which gives meaning to the practice, but also to the patient's participation in the known

13 Ibid., pp. 193-6.

process. Hence the sickman must be aware not only of the effect of a charismatic personality acting upon him, although this is important, but also of his own conception of the universe which gives meaning to the sickness as well as to the cure."[14] But should we over look the fact that natural objects are also constituents of this conceptual world?

<u>Natural and Supernatural Causation</u>

The basic assumptions associated with primitive medical practice have been summarized by Ackerknecht a foremost ethnomedical anthropologist in the following passage; We believe that the passage more than anything else reveals tellingly the assumptions of such anthropologists instead.

"Disease and death among primitives are in the overwhelming majority of cases not explained by natural causes, but by the action of supernatural forces. In general, the disease mechanisms are either the intrusion of a disease-producing foreign body or spirit, or the loss of one of the souls which may be abducted or devoured. These mechanisms may be put into motion either by a supernatural agency (God, spirit, etc.) who feels offended, or by a fellow man who avenges himself either by hiring a sorcerer of by himself

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14 M.A. Bartolomé, "Shamanism among the Avá-Chiripá", in D.L. Browman and R.A. Schwarz, ed., <u>Spirits, Shamans and Stars : Perspective from South America</u> (Paris: Mouton Publishers, 1979), pp. 95-148.

acting as a sorcer. Supernatural causes must be discovered by supernatural means, and thus primitive 'diagnostics' consist of various types of divination bone throwing, crystal-gazing, trances etc."[15]

Hughes writes about primitive medicine in a similar vein, basing it primarily upon the principles of magic and religion. He writes, "Ackerknecht has said that primitive medicine is 'magic medicine', certainly much of it is, and in so far as supernatural causes are involved, therapeutic regimes are based on countervailing supernatural powers or events. Thus, the powerful shaman or healer attempts to recover the soul lost or stolen by a human or supernatural agent."[16]

The study of ethnomedicine has important theoretical implications for the persistent question of "irrational" versus "rational" orientation among primitive people. Anthropologists like Benjamin Paul,[17] who have documented the variety of factors that impede the successful introduction of modern health programme in primitive societies in the book, basically base their premises on the assumption that the primitive mind is not quite conditioned to take onnon-

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15 E.A. Ackerknecht, Medicine and Ethnology : Selected Essays, eds., H.H. Walser and H.M. Koelbing (Baltimore: John Hopkins Press, 1971).

16 C.C. Hughes Ethnomedicine in International Encyclopaedia of the Social Sciences (New York: Macmillan, 1968), vol. 10, pp. 87-93.

17 B.D. Paul, ed., Health, Culture, and Community : Case Studies of Public Reaction to Health Programs (New York; Russell Sax Foundation, 1955).

supernatural or non-mystical forms of therapy.

Yet on the other hand, we have onvaluable references from others who document that though the primitive man continues to believe in magic and super natural agencies he also takes recourse to very elaborate non-supernatural medical practices to ward off and combat certain diseases. Medical lore among the pre-literate tribals cannot be subsumed entirely by magic and religion. Natural theraphy and natural causation diseases also play a significant role. P.O. Bodding, for instance, extensively document in his study of santals some 'prothylactic' measures that the santals employ against small-pox and cholera. He warns that prophylactic must, however, be taken in a sense different from what is the common meaning of the world with others. These precautionary measures are of a double nature. On the one hand invocation of the spirit and sacrifices, on the other medicines based on natural pharmacopics. It would be worth an attempt to quote Bodding at length on the precautionary measures taken by Santals. He writes: "In the month of Māgh (January-February) the month when the santals change from the old into the new year, some customary remnants show that this months must have been the first of this year....the entire male population of the village, at a day fixed and after the usual preparations and abstinence, at the end of the village street sacrifice a black female kid and a black pullet and bury them there....The sacrifices are followed up

by giving some pills to every person found in the village."[18] He further mentions the peculiar process of manufacture of these pills in the following words: "These pills are made by grinding some 46 different kinds of medical stuff and mixing them with liquor. Where the sacrifices are performed they are divided into as many portions as there are households in the village, whereupon the Ojha prepared some rice-water in a leaf-cup. With the whole in a winnowing fan the entire assembly starts for the village, and entering every courtyard, beginning from the village street end, the Ojha sprinkles the waterpots with rice water, where upon the pills are given."[19] Bodding mentions that this precaution refers to all kinds of diseases, both among men and beasts, also against misfortunes and accidents, but especially also to small-pox and cholera.

Hoffman illustrates how the Mundas treat an ailment called conjunctivitis. He mentions, "[illegible] which means the act of treating conjunctivitis of the eyes, a carbuncle, or itch, in the following way. They burn Koronja (Pongamia glabra) of water. The affected part is held over this, with a cotton hanging over it to confine the vapour and keep in contact with a diseased spot. They say that, after the

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18 P.O. Bodding, "Santal Medicine", in D. Chattopadhyaya, ed., Studies in the History of Science in India (New Delhi: Editorial Enterprise, 1982), vol. 1, p. 305.

19 Ibid.

operation, they find in the water of the bowl tiny bright yellow discs not larger than a dot. These called Jojoko in Has and Kiriko in Nag, are supposed by the Mundas to be the organisms, now killed by the remedy, which are eating the flesh and thus cause disease".[20] Hoffman remarks that probably when they will come to speak of microbes, they will call them kēlelo kiriko.

It is hardly surprising then when, Hoffmann expresses the following view, "In all those elementary operations of the intellect, the mind of the aborigines works with a most astonishing Precision.... Beyond these elementary operations begins that higher sphere of intellectuality, in which the mind tries by personal, i.e. self-willed efforts, to work out and clearly coceive the end, and purposes of his own creation, and to devise means for attaining them."[21] And we might add that it is quite evident that in all those elementary operations of the intellect, the mind of the aborigines does not only encompass the 'supernatural' causation of disease but significantly, "natural causation" as well.

As we shall soon see that though the distinction between natural and supernatural causation of disease is quite clear it is however accompanied by an absence of

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20 J. Hoffmann, Encyclopaedia Mundarica (Patna, 1950), vol. 12, p. 3549.

21 Ibid., p. vi.

overlapping contradiction and conflict. The two causative agencies have demarcated zones of efficiency according to the primitive tribals as is evident from primitive nosology. Conco, for instance, finds that the Bantus make the most rudimentary distinction between diseases in the following manner.[22]

(1) Natural causes or disease or sickness: It is called "common or ordinary sickness" (Mkuhlane = Zulu) (Mukot lone = Sutho)

(2) Supernaturally caused diseases are generally those against which ordinary known empirical methods of treatment and explanation have failed. It is a theoretical construct made to explain the "out-of-the-beaten-track" type of sickness (Sangoma = Zulu).

A similar view is voiced by Roscoe, et. al., who write that in the beginning of the disease no supernatural damage is felt and home remedies are given. Only when these fail is the whole complicated supernatural machinery involving the augurs, exorcists and scape goats put into action.[23]

This is not the full hemisphere of primitive medical practices. No social group is without its simple medical and surgical practices. No social group is without the use of

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22 W.Z. Conco, "The African Bantu Traditional Practice of Medicine : Some Preliminary Observations", Soc. Sci & Med. vol. 6, 1972, pp. 283-322.

23 Ibid., p. 311.

plants for medicinal effect. There are pragmatic empirical practices in each social group. The rational therapeutic is embedded into the magico-religious practices. Many of these practices endure on the grounds of cause and effect linkage. The process of causality may not be understood in detail. If a specific herb is used, then the subjective probability associated with successful result establishes the pattern of treatment.

Conco shows us in detail how in different primitive societies the natural and supernatural elements in medical therapy and aetiology co-exist. The Zulus, the Manos, the Zandes, the Fijians and the Apaches depend primarily on nature based therapy for diseases which they have found through practice are curable and depend on supernatural element for more difficult diseases. Apart from yaws, coughs, boils, scabies, ringworm, etc. natural therapy is used in a significant manner as by the Apache to treat veneral disease, malaria and epilepsy.

Harley,[24] has noted that if we study the medical action of African medicine in toto and not merely the esoteric aspects, we would find that there are indeed many levels of practices which are quite pragmatic and based on

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24 G.W. Harley, Native African Medicine, with special reference to Its Practices in the Mano Tribe of Liberia (Harvard University Press, 1941).

as much practical experience as our daily mediating of our everyday symptoms and complaints. Indeed he claims that there is even a hierarchy of disease causation and that much of the more magical and not natural therapeutic thinking is concerned with the major unexplainable disorders just as it is with us.

The possible implications for a sociology of knowledge are apparent. There will be little elaboration of the conceptual framework regarding disease causation and its cure, so long as any activity produces a high degree of predictive outcome. After all, what are the cognitive frameworks relating to disease? They are instruments in the total process of adaptation and accommodation. They change when their viability, effectiveness and milieu change. When a folk therapy fails to produce any pragmatic outcome, pressure is generated to move to another framework provided another framework exists. Bodding translates the Santal word Rote calakme ar daktor ran jomme[25] to mean that when your own medicine fails go to the dispensary and take a doctor's medicine. When an alternative therapeutic framework does not exist then magic and supernatural divination provide the only alternative course of action.

In an article entitled "Conception, Pregnancy and

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25 P.O. Bodding, A Santal Dictionary (Oslo: I Kommisjon Hos Jacob Dybwad, 1936), vol. 5, p. 26.

birth among the Tribesmen of the Maikal Hills",[26] Elwin has dealt with the ultimate issues of birth and life in the way that the tribesmen themselves treat such things. A study of the tribesman's attitude to the mystery of birth reveals first the domination of the ideas of sympathetic magic over their lives, then the fears and dangers that seem to threaten them at every turn. Elwin mentions the general precautions during pregnancy observed by the tribesmen of the Maikal Hills. They include the Gonds, Baigas, and a few others. Majumdar[27] gives a similar list for the Hos. Hutton[28] writes that Sema Nagas' treatment of illness, magical and religious proceedings, apart, involves the use of many curious factors. The use of some of the treatments, e.g., that for wounds caused by 'ekra' are based on an obviously erroneous process of reasoning. However, he mentions that in other cases like in the treatments for snakebite, they are undoubtedly sound in many respects.

Quintanilla[29] cites a similar state of affairs from

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26 V. Elwin, "Conception, Pregnancy and Birth among the Tribesmen of the Maikal Hills", Journal of the Royal Asiatic Society on Bengal, Letters vol. 9, 1943, pp. 94-148.

27 D.N. Majumdar, A Tribe in Transition (Calcutta: Longmans Green & Co. Ltd., 1937), p. 69.

28 J.H. Hutton, The Sema Nagas (London: Oxford University Press, 1968), pp. 100-01.

29 A. Quintanilla, "Effect of Rural-Urban Migration on beliefs and attitudes towards Disease and Medicine in Southern Peru", in D.L. Browman and R.A. Schwarz, eds, Spirits, Shamans and Stars : Perspective from South America (Paris: Mouton Publishers, 1979), pp. 149-56.

Southern Peru. Here diseases are defined in accordance with a certain primitive nosology. In this nosological classification, some diseases are classified as a cluster of symptoms and signs with more or less defined causes, treatment and prognosis. Another group of diseases is identified not by a set of symptoms but rather by a common etiology, usually magic.

Dependence won through highly esoteric practices: How status and professionalization are maintained

Freidson mentions that the lay and professional worlds in interaction can never be wholly synonymous. If only latently, they are always in conflict. These conflicts in perspective and interest are built into the interaction. They are likely to be present to some degree in every situation. He writes, "... just as the doctor struggles to find ways at withholding some kinds of information, so will the patient be struggling to find ways of gaining access to or inferring such information. Similarly, just as the doctor has no alternative but to handle his cases conventionally, so the patient will be struggling to determine whether or not he is the exception to conventional rules. And finally, professional healing being an organized practice, the therapist will be struggling to adjust or fit any single case to the convenience of practice, while the patient will be struggling to gain a mode of management more specifically fitted to him as an

individual irrespective of the demands of the system as a whole."[30]

These conflicts are at the centre of interaction, and they reflect the general structural characteristics of illness. These perceptions are important in understanding what happens in respect to illness. It helps in understanding what happens within the treatment process. Because there is a general tendency to assume that proper education could eliminate the tensions frequently met in the interactions between the clients and professional doctors, we produce below a few case studies to understand some of the persistent features relating to medical professionalism and doctor-patient interaction.

Case Studies:

(i) Bodding's Work on Santals

One important hurdle to lay access to esoteric knowledge is the professionalisation of knowledge. It occurs when the custodians of esoteric knowledge set their own conditions for training new specialists. They also fix their own standards of conduct for aspiring specialists. It all boils down to the fact that the layman's acceptance to seek the help of specialist is possible only in societies where a significant amount of medical knowledge is the privileged understanding of a special category of people. Bodding

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30 E. Freidson, Profession of Medicine (New York: Dodd and Co., 1970), pp. 321-72.

mentions that all santals are interested in medicine, most of them profess to know the medicines for one or a few diseases. He writes that some regular practitioners, especially so the Ojhas, are in high demand because of the fact that they base their work on their ability to find out and treat the spiritual influences behind disease, and because of their ability to offer therapy in a manner which would be most efficacious and in offensive to super natural powers and spirit.[31]

(ii) Langdon on South America and Furer-Haimendorf on Nepal

Langdon narrates the training of Shamans among the Siona of South America. The Shaman has the knowledge to influence the spirits. This knowledge is gained through prolonged training with an experienced or 'master' Shaman. He writes, "Throughout these sessions, the apprentice attempts to pass through a set of 'culturally influenced' visions. It is recognized that all men must pass through the same experiences and visions if they are to accumulate knowledge."[32]

Furer-Haimendorf mentions that a lama know for his gift of clairvoyance is consulted about the care of sickness

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31 Dodding, op. cit., p. 26.

32 E.J. Langdon, Yage among the Siona; Cultural Patterns of Vision, in D.L. Browman and R.A. Schwarz, eds, Spirits, Shamans and Stars : Perspective from South America (Paris: Mouton Publishers, 1979), pp. 63-80.

among the sherpas of Nepal. He writes, "For such consultations people pay, according to their means, fees ranging from Rs 2 to Rs 5 and there are lamas who derive an appreciable income from such consultations. The art of Sundak-Sho (gift of Clairvoyance) cannot be learnt, but Lamas of great spiritual power acquire it spontaneously".[33]

(iii) MacDonald on South African Tribes
Evans-Pritchard on Zande Practitioners

Park sees society's toleration of divination as a kind of licensing. He writes, "As a legitimating procedure, divination in the folk world has much in common with that we may call the 'licensing and certifying complex' in the contemporary urban world".[34] Of course, it varies from culture to culture, MacDonald[35] thinks that just as societies of the European type possess hierarchical professional structures, so also do many folk societies. The professional associations may be established in the case of Shamanistic practitioners. These associations have their own norms and

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33 C.V. Furer-Haimendorf, The Sherpas of Nepal, Buddhist Highlanders (University of California Press, 1964), pp. 202-3.

34 G.K. Park, 'Divination and its Social Contexts", in J. Middleton, ed., Magic, Witchcraft and Curing (New York: Natural History Press, 1967), pp. 233-4.

35 J. MacDonald, "Manners, Customs, Superstitions and Religions of South African Tribes", Royal Anthropological Institute of Great Britain and Ireland, vol. 19, 1890, pp. 264-96.

they enforce it strictly. Evans-Pritchard[36] mentions the importance and significance of the secret societies of Zande practitioners. Nash[37] notes the case of a healer who was done to death by the rest of the healers for what significantly was a violation of association rules.

(iv) Redmayne on Tanganyika

Redmayne describes in detail the divination, sorcery and medicine among the Hehe of Tanganyika, Africa.[38] He writes that common complaints are usually treated with herbal remedies and other curative and protective medicines known only to professional medicine men or women. There are common complaints such as tape worms, scabies, and ordinary wounds which are treated at their face values. But there are also diseases about which many Hehe will consult a professional diviner. Because they believe that they must be told the cause of the complaint before the diviner will be able to advise them

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36 E.E. Evanspritchard, "The Morphology and Function of Magic : A Comprehensive Study of Trobriand and Zande Ritual and Spells", in J. Middleton, ed., Magic, Witchcraft and Curing (New York; Natural History Press, 1967), pp. 1-22.

37 M. Nash, "Witchcraft as Social Process in a Tzeltal Community", in J. Middleton, ed., Magic, Witchcraft and Curing (New York; Natural History Press, 1967), pp. 127-33.

38 A. Redmayne, "Chikanga : An African Diviner with an International Reputation", in M. Douglas, ed., Witchcraft Confessions and Accusations (London; Tavi stock, 1970), pp. 103-28.

about the correct treatment. However, the matters of most serious concern about which Hehe consult diviners are likely to be severe illness and death.

The institutionalization of divination occurs in the following way among the Hehe. Among them there are a considerable number of people who practise divination in a small way by shaking bottles containing foam, or putting the palms of their hands on boiling water. They attract clients who have minor concerns. However, the matters of most serious concern about which they consult diviners are likely to be severe illness and death. The symbol of professionalism is generated in this context. It is generally acknowledged that the most effective diviners are those possessed by a spirit and they often deliver a verdict by calling out, making odd noises, or speaking during the dreams. It is assumed that the supreme being has looked kindly upon them and allowed them to be possessed by a spirit which seeks responsibility in divination. It also enables them to become rich.

The dependence of the Hehe patient to the professional healer/diviner takes many forms. When a diviner has discovered the sickness, infertility or death to be the source of his client's inquiry there are a number of forms of advice he may give. He may tell the client on one occasion that his misfortune has been caused by the supreme being. More often,

he may tell him that he himself will make medicine from different sources for him or he may ask him to go to some particular medicine man. Again he may decide that the client has offended some particular ancestral spirit and the best solution is to make an offering to the spirit that has been offended. Another alternative is that he may decide that Muhoyi (sorcery) is the cause of misfortune and name the sorcerer.[39]

(v) Lewis' Work on Korekore Possession Cult

Lewis documents that in the highly institutionalized Korekore possession cult, recruitment to the post of authorized Shaman for a particular guardian spirit is strictly controlled by the Shamanistic hierarchy. He writes, "The aspiring Shaman who becomes possessed may at first be regarded as troubled by an evil spirit (a shave) of foreign origin. If, however, the curative rituals which are then applied to bring out this noxious demon fail, further divination may suggest that the invading agency is a guardian spirit. The patient is then sent to an accredited shaman for observation, if he

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39 Shirokogoroff, the eminent Russian authority on Tungus mentions that the shaman's profession/vocation is normally initiated by an initially untridled state of possession. The features of professionalism are evident from the fact that those who persist in the shamanistic calling can bridle possession.

See S.M. Shirokogoroff, Psychomental Complex of the Tungus (London, 1935).

evinces the true symptoms, these suggest that his call is genuine. He is then referred to a senior shaman of the hierarchy for further scrutiny."[40]

After achieving the status of an apprentice shaman, the aspirant is required to furnish final proof of the authenticity of his inspiration. Lewis writes that it is established when his possessing spirit reveals the correct historical details of its origin, the location of its shrine, and its precise genealogical links with other spirits of the official spirit hierarchy. As a final proof, the new recruit has to pick the ritual stuff used by the spirit's previous human incarnation from among a bundle presented to him by the senior examining shaman.

Thus, admission to the profession is strictly controlled by the hierarchy of established mediums. The position is generally one reached by achievement rather than ascription by birth. Here a distinction is being made between guardian spirits and _shave_ demons. Many of those who wish to become shamans, but are not considered suitable, are rejected on the grounds that they are possessed not by guardian spirits, but by _shave_ demons. Within this tribal cult, the shamans are ranked in a rigid hierarchy corresponding to seniority. It is in fact essential for the aspirants to be sponsored by an already well-known and powerful shamans if he is to succeed.

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40 I.M. Lewis, _Ecstatic Religion_ (Harmondsworth: Penguin Books, 1971), p. 135.

Another important qualification, though not indispensible, is that the aspirant should be a stranger to the locality and people whose guardian spirit he claims to incarnate. Lewis points out that this doctrine is clearly in keeping with the shaman's role as an impartial arbitrator, inspired by the spirit of a distant and long-departed ancestor, in the affairs of a particular local community.

(vi) Hoffmann's Encyclopaedia Mundarica

The persistence of the phenomena of professionalism, mystification and its corollary dependence of the patient is illustrated in Hoffmann's 'Encyclopaedia Mundarica'. He describes the significance of the Mundari word sirni in the following way:

"A condition superstitiously believed to exist in a patient, necessitating the offering of money instead of a sacrifice in order to ensure the efficacy of the remedy. The buidi (native doctor) pretends to see in the patient's urine how much money is needed (generally a few pice or annas but always in odd numbers). The buidi either takes the money saying that he is going to throw it away or he would tell the people to do it themselves. Then he would pronounce some incantations, or if he is a christian, say some prayer'. Hoffmann then compares this practice by buidi among the Mundas with the sort of practice done by Lutheran native

doctors and establishes close similarity among them.[41]

The illustration by Hoffmann explains professional treatment as a relation between two distinct worlds, the world of the healer (doctor) and the world of the patient, hedged and ordered by professional norms.

(vii) Karim on Traditional Malay Midwives

Karim in an interesting paper analyses professional rivalry amongst traditional Malay midwives in the Northwest areas of peninsular Malaysia.[42] These midwives manipulate symbolic communication to develop regular clientele. It is a medicine to develop professional superiority over time. But an important element of Malay midwifery is protection from evil spirits harboured by witches. For that reason a midwife is an exorcist with skills. The difference between traditional Malay midwife and traditional medical practitioner, usually male lies in the fact that the former's boundary of knowledge is confined to diagnostic and curative rituals of spirit-possession, in infants and children, young unmarried women and pregnant mothers. Karim writes, "Within a restricted population area, professional rivalries and competition amongst medicines regularly surface in oblique attacks of

41 Hoffmann, op. cit., vol. 13, p. 4003.

42 W. Karim, "Malay Midwives and Witches", Soc. Sci. & Med. vol. 18, no. 2, 1984, pp. 159-66.

witchcraft accusations where the accused strives to maintain her credibility while her accuser gradually wins over her clientele. Significantly codes of professionalism in traditional Malay midwifery are not only determined by skill and experience, but also religiousness (faith in Islam), benevolence, virtue, diligence and a sense of equality and fair-play in the practice of the trade."[43]

The above qualities i.e. skill, experience, benevolence, virtue, diligence etc. are absent in witches who are thought to be anti-Islamic, uncompromising and destructive. Surprisingly enough, when the government midwives attempt to liquidate the popularity of traditional midwifes by controlling midwives in an authoritarian way, they are also tagged as witches.

To sum up, midwifery and witchcraft reflect symbolically polar opposites of the human condition; human versus supernatural order, states of health and illness. Malay midwifery practices are integrative and witchcraft practices are disintegrative. As Karim writes, "the combination of both in the same symbolic ritual order has the effect of creating regular long-term states of dissonance on the structural level, which are from time to time personally and situationally resolved. Generally, in the context of traditional medicine, witchcraft has the catalytic effect of perpetuating social

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43 Ibid., p. 159.

tensions, establishing conflict as a regular feature of social system, but it also introduces venues of interaction and communication that made these social tensions easier to understand and deal with."[44]

(viii) McCauley on Balinese Healers

McCauley writes that in Bali individuals who are able to communicate with the supernatural are said to have *sakti*.[45] Healing is a sign of *sakti*. It is a concept which underscores the ideology of inequality in Bali. People who have *sakti* are higher in status. Because *sakti* is undifferentiated power, they are legitimate leaders in all realms of activity. He has mentioned case histories of two successful Balinese healers to show how the healing role can legimize high status. McCauley writes, "In the case of Gus Aji, Sakti was claimed for his entire caste and his healing ability reaffirmed the sanctity and rightful superiority of the entire group. Mangkar Nered, however, came from a family which had no other signs of *sakti* and his healing skill validated sanctity for himself alone.... Their *sakti* led to high status and wealth rather than their wealth leading to power and status."[46]

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44 Ibid., p. 166.

45 A.P. McCauley, "Healing as a Sign of Power and Status in Bali", Soc. Sci. & Med., vol. 18, no. 2, 1984, pp. 167-72.

46 Ibid., p. 172.

This study of Balinese healers revolves around the two main deliberations in culture - the importance of status and the nature of power.

Professionalism and Medical Pluralism

In the preceding pages we gave several instances of how professionalisation is institutionalised in tribal societies. It also shows that the demand that healers be professionals and above the ordinary man is persistently favoured by these societies. What is also interesting, as we noted in the earlier section of this chapter, is that these healers or medicinemen do not only indulge in magic and rituals but also patiently tend to natural therapy as well. As a matter of fact, in some cases doctors on the basis of their expertise in either natural or supernatural therapy, are also distinguished, just as diseases are distinguished between those that are supernaturally caused and those that are naturally caused.

Medical pluralism exists at two levels. When there is a lack of competition between the natural and supernatural therapeutics, or between variants within each, then the doctors and healers move from one system of medical care to another with relative ease and often as a matter of course. And at the level of the patient this mobility is thus rendered non-problematic. This is evident from Conco's study of the

Bantus as also from Bodding's work on Santals.

The term medical pluralism refers to a situation where individual practitioners have incorporated elements from several medical traditions and a system incorporating an institutionalized health care section and irregular popular health care. What might be the reason for the maintenance of medical pluralism in such cases? Jones points out that less systematically in a world-view, i.e., less coherence among its various parts, is conducive to greater flexibility.[47]

Contrary to Jones who believes that flexibility and medical pluralism arise out of less systematicity in world-view, i.e., less coherence among its various parts,[48] we feel that medical pluralism among healer in primitive societies aided by the lack of tension between natural and supernatural theories causation and that the two are reconciled in a coherent cosmogony. As a matter of fact it may be incorrect to call the movement from supernatural to natural theories and practices of medicine in tribal societies to be illustrative of medical pluralism, for very often, as we noted earlier, one element shades off into another; or for certain diseases these are either only natural or supernatural therapy. This is why we believe that the natural and supernatural elements of tribal

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47 W.T. Jones, "World-Views and Asian Medical Systems : Suggestions for further Study", in C. Leslie, ed., <u>Asian Medical System - A Comparative Study</u> (University of Chicago Press, 1976), pp. 383-404.

48 Jones, <u>op. cit.</u>, pp. 383-404.

medicine are reconciled in a coherent cosmogony. Medical pluralism from the point of view of the practitioners gets impeded as we move on to diverse world views and cosmogonies to such a point that medical paradigms become competitive, as in contemporary times. But more of that later.

In the preceding pages one attempt was to understand the interrelationship between magic, sorcery (in short, of the supernatural) and the natural therapeutic systems and beliefs. We have tried to demonstrate the presence of natural therapy and medical practices in primitive societies to underline the fact that it would be wrong to emphasize the supernatural realm alone. But alongside this we also found that there are professionals who in a highly professional way operate between these planes _sans_ contradiction. Professionalization thus exists both at the supernatural and natural therapeutic levels in primitive medicine. The fact that this has not always been recognized is because of the ethnomedicologists' overemphasis on supernatural therapy. This, however, does not mean that to stress the other extreme would give an accurate picture. It is because the natural and supernatural levels at times merge and at other times remain seggregated that it is important to appreciate that the belief in supernatural causation and therapy does not preempt the people from observing and adhering to nature

based pharmacoepia. And no matter which therapy is being applied, there are professionals on whom the sick in primitive societies depend.

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CHAPTER III

ANCIENT AND MEDIEVAL PHASES

We now turn our attention to the ancient and medieval periods and quickly review, with broad strokes, the extent of professionalism and its concomitant, patients' dependence during these years.

We are, for our very limited purpose, combining the ancient and the medieval periods together for it is our belief that medieval technology only grew quantitatively during these several centuries without any fundamental qualitative departure. Whether we start from the ancient Hindu medical tradition, or the Hippocratic, or the Chinese, we find a certain continuity over centuries - a seeming reluctance on the part of the professionals and men of medical science to forsake the humoral paradigm, or the principle of harmony of constituent elements, which found different expressions in different regions. Even William Harvey who first demonstrated the circulation of blood adhered to the humoral theory.[1]

We should also point out that in this chapter we are dealing with historical and literate societies. Unlike the

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1 Dipankar Gupta, "State and Knowledge : A Critique of Practical Science", Journal of Higher Education, Spring 1983.

previous chapter where we depended primarily on anthropological sources to understand preliterate societies this chapter deals with societies that are literate civilizations where divisions between men and the distinctions between class, rank (or status) is noticeably pronounced. Obviously there are bound to be some very definite differences in the way professionalism, dependence and participation are manifested in such societies from the way they are expressed in the preliterate tribal ones. We shall, however, try to draw these out only towards the concluding pages of this chapter. The major part of the chapter is devoted to an examination of the presence or absence of the phenomena under primary consideration during the ancient and medieval phases. We should begin with Ayurveda and India and go on to examine the Chinese situation and then the Hippocratic and then finally the medieval Salernic tradition.

Ancient Conception of Diseases

(i) Amoral Theory of Indians and Greeks

The golden age of Indian medicine may be said to have occurred from 800 B.C. until about A.D. 1000. It is marked especially by production of the medical treaties known as the Caraka-Samhitā and Sus-ruta-Samhitā. These are attributed respectively to the physician Caraka and Sus ruta. Both these works are regarded as being of great antiquity.

The Indian materia medica was extensive and consisted mainly of vegetable drugs, all of which were from indigenous plants. It is well documented that Caraka knew 500 medical plants, and Sus-ruta knew 700. In surgery ancient Indian medicine also distinguished itself. Detailed instructions about the choice of surgical instrument are given in the classical texts. It has been said that the Indians knew all ancient operations except the arrest of haemorrhage by the ligature. Their operations were grouped broadly as follows: excision of tumours, incision of abscesses, punctured of collections of fluid in the abdomen, extraction of foreign bodies, pressing out the contents of abscesses, probing of vistulas, and stitching of wounds.[2]

The ancient conception of disease was based more or less on humoral pathology. Humoral pathology implies disease originating from the derangement of the humors. It was the function of diet and medicine to bring them back to equilibrium. According to the ancient Hindu schools of medicine, there are three fundamental humors (vayu, pitta, and kapha). According to the Greek there are four fundamental humors (blood, phelgm, bile and water by some yellow and black bile by others).

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2 Encyclopaedia Britannica, Medicine, History of the University of Chicago, vol. 11, pp. 823-40.

To a modern man all this may appear incoherent. But it is not really so when it is visualized with clear perspective. As Chakraberty writes, "It is true that concrete facts and statements appeal more to reason than vague generalization and abstract philosophy. But by close observation it will be easily observed that their '_vayu, pitta, kapha_' correspond to what is expressed in vulgar terminology, as 'nervous, sanguine and phelgmatic temperament' and which can be translated into medical nomenclature as 'hypermetabolism, normal metabolism, and hypometabolism'.[3]

(ii) _Ying and Yang of Chinese Medicine_

Acupuncture is the most well-known Chinese treatment in the west. It was first mentioned in the _Nei Ching_, the locus classicus on the theory and techniques of traditional Chinese medicine. Acupuncture was a way of maintaining a dynamic equilibrium between the _Yin_ and the _Yang_. As Lampton quotes from Veith, "It was believed that the cosmic forces of the _yin_ and _yang_ flowed through the body's twelve "meridians" and that disease frequently was a result of the obstraction of these channels. By inserting needles at specified points such obstructions could supposedly be removed and the normal circulation of forces restored".[4]

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3 C. Chakraberty, _An Interpretation of Ancient Hindu Medicine_ (Delhi; Neeraj Publishing House, 1983), p. 102.

4 D.M. Lampton, _The Politics of Medicine in China : The Policy Process, 1949-77_ (England; Dawson & Sons Ltd., 1977), p. 4.

It constitutes the basic concepts of health, physiology, diagnosis and treatment. These concepts are the bedrock upon which later traditional medical practices was erected. Lampton writes that using the concepts of the Nei Ching, obsterics and gynaecology became identifiable specialities as early as 85 B.C.

But the underlying notion of traditional Chinese medicine was that it was an integrated world-view in which everyday activities had to be constructed in such a way as to maintain health. Moreover, it was widely accepted by the people.

Maintenance of Status and Professionalism

Professionalism is visible in each phase of history. It would be more cogent to see to what extent institutionalisation of the doctor (healer), and institutionalized dependence of the patient existed in ancient societies and medieval ones. The various manifestations of professionalism that we find in ancient India are the system of licensing of medical professionals, the fact that certain medical men were considered as quacks and charlatans, the existence of a system of graduation and finally professional rivalry regarding status and power among the healers.

An enquiry into these areas in ancient and medieval phases of history would indicate whether professionalism

exists in its essential form, or in incipient form or not at all.

(i) Medical Profession in Ancient India

Chattopadhyaya mentions that in the Ayurvedic view a successful medical treatment depends on four factors.[5] These are: the physician, substances (drugs or diets), nurse and patient. Caraka-Samhita mentions in this connection four such qualities of each of these four factors:

a) The four essential qualifications of the physician are:
   1. Clear grasp of the theoretical content of the science.
   2. A wide range of experience
   3. Practical Skill, and
   4. Cleanliness.

b) The four essential qualities of the substances are:
   1. abundance
   2. applicability
   3. multiple use, and
   4. richness in efficacy.

c) The four essential qualifications of the nursing attendant are:
   1. knowledge of nursing technique

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5 D. Chattopadhyaya, "Case for a Critical Analysis of the Caraka-Samhita", in D. Chattopadhyaya, ed., Studies in the History of Science in India (New Delhi: Editorial Enterprises, 1982), pp. 209-38.

2. practical skill
3. attachment of the patient, and
4. cleanliness.

d) The four essential qualifications of the patients are:
1. good memory
2. obedience to the instructions (of the doctor)
3. courage, and
4. ability to describe the symptoms.

The essential qualifications/qualities of each of these four, the combined operation of which leads to therapeutic success.

A system of licensing prevailed in medical profession in ancient India. The future physician had to seek the permission of the king after his studies and practical training. It was because of the fact that otherwise, quacks and charlatans would force their way and might jeopardize the medical profession.[6] Jolly writes, "Caraka speaks very strongly of such cheats who wander about in the streets boasting in the garb of physicians. As soon as they hear of a patient, they hurry and praise loudly their medical capacities so that they reach his ears. They try to win over the friends of the patient by all sorts of attention and emphasize that they

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6 J. Jolly, "Physicians and Therapy", in D. Chattopadhyaya, ed., op. cit., pp. 275-208.

should be satisfied with small remunerations. When they treat a patient and are not able to allay his pains, they assert that the patient does not get the necessary remedies, he disobeys the directions given and that he cannot control his desire. When the case is hopeless they run away.... Nobody knows their teacher, pupil or fellow-pupil. Such quacks are particularly responsible for the bad reputation of physicians."[7]

The significant role played by professional doctor/healer is evident from Atharva Veda. From it, the crucial position occupied by healder in ancient times would be delineated. Most of the hymns of Atharva Veda are in fact spelt, which among other things are intended at curing of diseases. There was a transition in the role of bhisaj at this epoch in ancient Indian medicine. This transition was from a magician and witch-doctor to a physician in the real sense of the term.[8] What was the root of such a transition? The hymns of Atharva Veda allude that the people in those times followed a combination of utterance of the exact formula by qualified practitioners with the administration of herbal remedies and other treatments for alleviating illness. Basham mentions, "The bhisaj was already a professional man of

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7 Ibid., pp. 176-7.

8 A.L. Basham, "The Practice of Medicine in Ancient and Medieval India", in C. Leslie, ed., Asian Medical Systems : A Comparative Study (University of California Press, 1976), pp. 18-43.

considerable repute in his society, and gained a competent living from his services to the sick and injured".[9]

Zimmer writes that the Vaidya expected adequate rewards for his treatment. He was assisted by trained nurses, normally referred to in the masculine (paricaraka). Basham mentions that nursing appears to have been a definite profession or trade and not merely a task performed by any domestic servant.

Basham describes the vaidya in practice in ancient India. He writes: "The qualified medical practitioner, as depicted by Susruta, must have been an impressive sight as he went on his rounds in the ancient Indian city. Attended by an assistant, who no doubt carried his bag of surgical instruments....The ideal vaidya was able to instill such confidence in his patients that they trusted him as fully as they trusted their parents and kinsfolk, and he cared for them as he would care for his own sons."[10]

The extent of the pharmacopoeia of the vaidya was a very large one. He was not prohibited to advertise his therapeutic skills. The preponderance of quacks and charlatans is also evident from Caraka. Basham quotes from

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9 Ibid., p. 19.

10 Ibid., p. 29.

Caraka-Samhita: "Immediately on hearing that someone is ill, they swoop down on him from all quarters and in his hearing speak loudly of their medical attainments. If a doctor is already in attendance...they make mention of his failings... when they realize that the patient is at death's door, they make themselves scarce and seek another neighbourhood."[11]

There is evidence too to suggest that many were considered to be quacks and charlatans in ancient India. It is not only a feature of present day societies, and it reveals the emphasis that was placed in ancient days on professional qualification and professional recognition.

A system of licensing was known to have existed in the practice of medicine in ancient India. It has high relevance, when taking into account medicine as a public service. It is mentioned in *Susruta Samhita* that the *vaidya* should be sanctioned by the king. Jolly interprets it as a measure to prevent quackery. Susruta also envisaged some form of government control of the medical profession. Basham cites such an illustration from *Susruta Samhita*. He writes: "The quack doctor (*kavaidya*) kills people out of greed, because of the fault of the king (*nrpadosatah*) suggesting that the government has been negligent or corrupt in licensing poorly qualified practitioners...the same text suggests that

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11 Ibid., p. 30.

positively draconian measures were taken against the incompetent doctor, who was liable to put to death by the king."[12]

Zimmermann[13] observes a slight degradation of the status of Brahmin physicians within the caste system. He mentions that Astavaidyas in Kerala, are said to be Nambudiri Brahmins slightly degraded by the necessity of shedding blood, as surgeons. It involves two major problems: (i) the position of surgery within the Ayurvedic system, (ii) the status of the learned practitioner within the Brahmin physicians of Kerala and the Kurup bone-setters, attached to the Nayars.[14] Such a polarity was once exhibited in classic texts. It expresses itself, he says, in the opposition between scholarly and popular practices. The classic texts exhibit the two opposite aspects; they develop surgery, blood-letting on the one hand and on the other hand emphasise the equilibrium of the humors in the human body. Zimmermann names the former operative processes and the latter expectant theories. They are intermingled with each other. He writes, "Furthermore, certain chapters describe the tasks of the physician attached to the person of the king - medicine is connected with

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12 Ibid., p. 33.

13 F. Zimmermann, "From Classical Texts to Learned Practice : Methodological remarks on the Study of Indian Medicine", Soc. Sci. & Med., vol. 12, 1978, pp. 97-103.

14 Ibid., p. 100.

political management and the art of war - while other chapters stress the Brahminic ideas of purity, compassion for all living beings and non-violence. One and the same logical design applies to the methods and to the position of the physician."[15]

(ii) Streams of Institutionalization in Chinese Medical Practice

The Chinese became involved in the institutionalization of ethical and professional standards in medical practice quite early. As Lampton mentions: "As Croizier notes, the Rites of the Chou Dynasty (Chou-li) acknowledged the state's responsibility for controlling medicine practice by administering qualifying examinations on prospective practitioners.... Subsequently, both the Sung Dynasty (907-1279 A.D.) and the Yuan Dynasty (1234-1368 A.D.) placed controls on medical practitioners. Departments of medical education were established in all provinces for the purpose of examining physicians and medical personnel holding official posts, censoring published medical books, identifying medicinal herbs, training medical students and directing medical works generally."[16]

The introduction of qualifying examinations in medicine is remarkable in the sense that it implies the differentiation of the skilled practitioners from the unskilled ones. There was a very early growth of state medical service

15 Ibid.

16 Lampton, op. cit., pp. 5-6.

in China. Needham writes of such development in the chin dynasty (265 A.D. to 420 A.D.) "on the one hand the title of Po-Shih (doctor or professor) had appeared as early as the Chin dynasty (-3rd century), and on the other hand the principle of examinations for scholarly competence had been brilliantly inaugurated by the emperor Han Wen Ti, who himself set the questions in 165 B.C., probably the earliest occasion of the kind in any culture."[17]

Needham mentions that an imperial decree of 1188 A.D. ordered that unqualified medical practitioners must pass the provincial examinations, and these included the several classical writings as well as sphygmology and other medical techniques. Any one who did really well could gain an opportunity of raising to the ranks of the Han-Lin "Medical Academicians". Such men were called _Jui_ (literally confucian physicians) as opposed to _yung i_ (common practitioners) and _chhuan i_ or _ling i_ (wandering medical pedlars, who went about jingling their special kind of bell on a staff and handing out herbal remedies for the smallest fees.)[18]

Needham summarizes his article entitled "China and the Origin of Qualifying Examination in Medicine" in the foolowing way: "(E)xaminations of proficiency were held in

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17 J. Needham, _Clerks and Craftsmen in China and the West_ (Cambridge: Cambridge University Press, 1970), p. 382.

18 Ibid., pp. 265-6.

China from 165 B.C. onwards; the Imperial university was founded in 124 B.C., Regius professorships and lectureships in medicine implying examinations for qualifications, date from 493 A.D.[19]

The social status of the Chinese healer in traditional Chinese medicine is highly relevant in this context.[20] Medical men were considered to be technicians (Shu-Shih). They were given a middle rank in the society. Porkert writes that throughout Chinese history, the social status and influence of the physician were essentially determined by the rank assigned him in the Confucian social pyramid and by the degree of social and psychological independence he succeeded in attaining through affiliation to Taoist philosophy and method.[21] The crux of Confucian philosophy was social ethics, the relation of the individual to society. On the other hand, Taoism emphasized the private needs of the Chinese mind. It represented the complementary philosophy to Confucianism.

Here two streams of institutionalizations are seen i.e. (1) institutionalization and integration into Confucian administration, (2) institutionalization and integration into Taoist administration.

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19 Ibid., p. 395.

20 M. Pokert, "The Intellectual and Social Impulses behind the Evolution of Traditional Chinese Medicine", in C. Leslie, ed., op. cit.

21 Ibid., pp. 68-69.

The institutionalization and integration of Chinese medical science into the Confucian administration was a mixed blessing. Initially it re-analysed the accumulated data. It had the driving force to systematise the theories. But in the long-run it was jeopardized by the attitude of the Confucian administration. The Confucianists disparaged observation of nature. It crippled further empirical research in the sphere of medicine. The qualitative decline in Chinese medical science started under the Yuan in the 14th century. With it, the social downgrading of physicians began. It continued under the Ming, and become rife by the middle of the Ch'ing era - i.e. since the end of the 18th century.

The institutionalization and integration of Chinese medical science into Taoist administration follow a different path. There exists complementarity of style between Taoist ethics and medical texts. Taoism, as pointed out earlier, takes care of individual salvation and control over the forces of nature. Porkert writes: "The reputation of being a Master of the Tao (tao-Shih), at least up to the T'ang (9th century) and perhaps well into the Sung era close to 13th centuries), carried with it a strong flavour of other worldliness and a reminiscence of priestly or shamanistic functions. Consequently, a medical man who was a tao shih, or at least succeeded in giving himself the air of a tao-shih, could transcend the barriers of the Confucian society.[22]

22 Ibid., pp. 69-70.

(iii) Doctor Medicinae : Hippocratic and Salernic Traditions

The term Doctor Medicinae was coined in Salerno, the citadel of western European medicine in 9th century A.D. It implies obtaining a licence and graduating. To obtain a license and graduate, medical students at the institute of Salerno had to pass through a series of stages. First, they had to read the logical treaties of Aristotle for three years. Then, they had to learn medicine from the books of Hippocrates, and Galen for five years. Finally, they had to carry on clinical practice for one year under an experienced physician. Eventually, the candidates had to undergo an examination, in which the questions were set from the works of the Greeks and the Arabs. Needham writes, "The pattern of general education without vocational trend, followed by a course of theoretical medical study, and a year or two of practices under supervision, was foreshadowed in Europe as far back as 1224 A.D. in an edict of the Emperor Frederick II. The edict of Frederick II was apparently not quite the first of this kind, for in 1140 A.D. Roger of Sicily had decreed laws concerning state examinations for physicians."[23]

Ancient medical science in Greece formulated a fixed pattern through which discovery will be made. The inquirer

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23 Needham, op. cit., p. 393.

was considered competent if he conducted his researches with the knowledge of the discoveries already made and made them his starting point. But anyone, who rejected this and attempted to conduct research in any way or after another fashion, and claimed that he had found out something, was considered to be a victim of deception if not a wilful deceiver.

Let us examine the scientific aspects of Hippocratic medicine. Hippocrates set himself the task of solving medical problems in a rational way. Sarton says, "Hippocrates, like a true scientist, realized that truth matters above anything else, and therefore he recorded his failures as accurately as his successes. A quack salver would have hidden his failure, not necessarily because he was dishonest, but because the whole business of medical charlatanry implies over confidence."[24]

The fifth century Hippocratic corpus points out that just as in all other arts the workers vary much in skill and in knowledge, so also is it in the case of medicine. Sarton writes: "Some practitioners are poor, others very excellent, this would not be the case if an art of medicine did not exist at all, and had not been the subject of any research and discovery, but all would be equally inexperienced

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24 G. Sarton, A History of Science, Ancient Science through the Golden Age of Greece (Oxford University Press, 1959).

and unlearned there in and the treatment of the sick would be in all respects haphazard.[25] So medicine in the golden age of Greece had discovered both a principle and method.

On the other hand, Galen was the lodestar of the medico-philosophical traditon of Hellenistic world. Galen's work showed the enormous influcnces of philosophy. The correlation of structure and function dominated his anatomical investigations. Galen spoke of philosopher-physician treating in aristocratic homes. The common man had little access to the philosopher-physicians.

Scarborough writes, "Doctors' fees became legend in their own time. Manilius Cornatus, ex-praetor and legate of Aquitania, agreed to the sum of 200,000 sesteries to be paid to a physician for treatment of a disease that left nasty scars. Charmis of Massilia gained 200,000 sesterces by 'selling' one of his rich patients to a certain Alcon, the wound specialist. Galen received 400 gold pieces from the consular, Boethus, for curing his wife. Consultation by letter allowed the doctor to take his fee even when he could not visit his patients. Rich patients often gave difficulty to the physician but Galen assures us that they need to be endured."[26]

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25 Ibid., p. 366.

26 J. Scarborough, Roman Medicine (Great Britain: Thames & Hudson, 1969), p. 121.

Furthermore, Galen castigates those physicians who depend upon popular knowledge for their therapeutic procedures. He said: "...if...you should tell me of such things, as are uttered by the man in the street, you would say nothing of man of quality....You would be setting forth the information of the lower and less intelligent class of the inhabitants."[27]

The somewhat tacit assumption that the ideal of treating poor patients without fee is accepted as an established fact in earlier days of that professionalisation is of recent phenomenon is believed by our review in the preceding pages. Even among the practitioners of Medieval Arabic Medicine,[28] a descendant of the Galenic stream the situation does not hold. Burgel mentions: "In the fountain of information by Ibn abi Usaibi'a, a collection of about 400 biographies of famous physicians upto nineteenth century, only a few are expressly reported to have treated patients without fee, and in most of these cases we are incidentally informed of extraordinary riches in the possession of those benefactors."[29]

He further points out that the ideals of treating poor patients without fees was important, but it could only be

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27 Ibid., p. 121.

28 J.C. Burgel, "Secular and Religious Features of Medieval Arabic Medicine", in C. Leslie, ed., Asian Medical Systems : A Comparative Study (University of California, Press, 1976), pp. 44-62.

29 Ibid., p. 51.

realised on the basis of sufficient wealth or a self-denying way of life.

Quackery was also prevalent in medieval Arabic medical practices. Real physicians had to wage a constant struggle against quackery. Burgel writes, "Even during the most prosperous period of Arab medicine, critical voices painted a gloomy picture of the alleged decay in contemporary medicine, and called for severe control by the government and strict adherence to the ancient authorities. These measures were considered the only protection against the otherwise irremediable decline of the Hippocratic art."[30]

Burgel writes that like modern professional practitioners, the physician in medieval Arab would receive his patients either in his home or in a _hanut_ (a special shop in the town). He had apprentices who assisted in the preparation of drugs. If treatments requiring extraordinary knowledge were required, the physician should consult a specialist.

Participation and Professionalisation : Comparison in the Literate and pre-Literate Societies

Without belabouring any further on the existence of professionalism and status in literate societies, let us look back and compare the differences in the manifestation

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30 Ibid.

between literate and preliterate societies with respect to participation and professionalisation.

It can perhaps be maintained that the participation of patient is greater in pre-literate societies to the extent that the healing process often takes a dramaturgical form in such cases.[31] This should not be taken to mean that the patient or his kinsmen are the initiators of the dramaturgical form, but merely that they have to be willing participants in its enactment. In other words, the professional involves the patient and his relatives in an intense healing process, and the patient is not simply required to supinely ingest drugs or be inactive while incantations rend the air. One can, of course, say that a modern doctor also demands participation in so much as the patient should be willing to abide by the doctors' prescribed regimen. But the manifestation is different in primitive societies. It is quite often much more than simple regimen and demands active involvement of the patient under supervision and direction in actually combating at the moment of crisis the Pathogenic spirits or substances. When, as Turner points out that in the sickness episodes in primitive societies there is the expectation that events will proceed to a climax it is quite often the patient that aids in the climaxing.[32]

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31 R. Prince, "Variations in Psychotherapeutic Procedures", in H.C. Triandis and J.G. Draguns, eds., Handbook of Cross-Cultural Psychology (Boston: Allyn & Bacon, 1980), vol. 6, pp. 314-21.

32 V.W. Turner, The Ritual Process (Chicago: Aldine, 1967).

Needless to say this does not mean that the patient either cures himself or is freely without direction and authority the protagonist of the dramaturgical form of healing.

The situation changes when we come to literate societies. This is probably because of the altered form that dissemination of medical knowledge takes place in literate societies viz., through the written word. In non-literate societies, it must be orally delivered. Finnegan,[33] argues convincingly that this is the major factor in the actualisation and transmission of oral literature to the audience. In a non-literate context an audience is in practice essential - there is no written form in which it can be expressed otherwise than in front of those to whom it is directed. As a consequence of it, in all likelihood, the healing process takes a dramaturgical form in non-literate societies.

To what extent the lack of rigid and pervasive status differentiation aids in the patients' participation in the dramaturgical process of healing we are not very certain. In any case, the presence of the distinction between manual and mental labour only arises with the coming of literate societies. So perhaps the last attribute includes the previous one.

On the question of the professionalisation of the

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33 R. Finnegan, "Literacy versus non-Literacy : The Great Divide?" in R. Horton and R. Finnegan, eds., Modes of Thought (London: Faber and Faber, 1973), pp. 112-44.

doctor we find that in ancient and medieval historical societies the emphasis by decrees, by texts and by preceptorial authority, on upholding legitimately trained doctors is very pronounced. Simultaneously we find a constant war being waged in these periods against the quacks, the non-professional doctors and the healers who do not belong to the codified professional body. Such a state of alert against quacks seems to be quite absent in pre-literate societies; or at least so it would seem to us from the literature we have studied. This itself is a further manifestation of both the existence of class and status distinctions in literate societies as it is also another manifestation of the way professionalisation was upheld in the past.

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CHAPTER IV

RECENT PERIOD

We move on now to the recent period, to contemporary times. Times when it is universally agreed that professionalisation and mystification of doctors and the dependence of the patient is deeply entrenched. It would be futile to disprove the existence of these phenomena or even try to prove their existence. But what seems more legitimate is to probe contiguous areas and link them with an argumentative strand we have only hinted at earlier.

When we were talking of primitive societies we voiced our disagreement with the ethnomedicologists when they argued that medical pluralism existed in primitive societies because of lack of coherence. Our point of view was that the belief that medical pluralism existed in a heightened state both at the level of the healer and the patient in primitive societies was because the sharp distinction we tend to draw from our vantage point between natural and supernatural therapeutic systems which may not in fact have existed with such clarity, if at all, in tribal societies. At the same time, in these societies, a distinction is made between natural and supernatural causation of diseases and therapy (a point often missed by ethnomedicologists) the rival systems are

not competitive here and very often one form of therapy merges into another. The two are united in an overall symbolic and meaningful system. By saying so we were able to point out to the existence of professionalisation among healers in primitive societies and not only when the super natural was involved, but also when earthly and natural substance were being tackled and employed for medical purposes. The existence of rival systems of medicine is however more pronounced as we move on to historical societies, but it was never so sharp as it exists in contemporary times. There are various types of healing processes in Indian villages too. For instance, Egnor[1] finds in a Tamil Nadu village, where allopathy has not yet entered, four different healing traditions existing in an overlapping way. Those four systems are i) Ayurveda, ii) Tamil Saiva bhakti, iii) Siddha Medicine, and iv) Trance healing. These four systems appear on the surface to be unordered and diverse. Again these systems appear not to be integrated into a unitary, internally consistent medical system from its outer surface. Yet a study of the mythical and philosophical groundings of these traditions undertaken by Egnor proves them to share some common premises and to communicate to the patient a common message concerning the nature of life. We substantially agree with Egnor on this.

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1 M.T. Egnor, "Death and Nurturance in Indian Systems of Healing", Soc. Sci. & Med., vol. 17, no. 14, 1983, pp. 935-45.

In Indian history we have heard of rivalries between the Ayurvedic and the Unani schools,[2] but these are not as pronounced as the collaboration that existed between them. A large number of Ayurvedic doctors were patronised by the Mughal courts and some of the renowned Unani doctors undertook to translate tomes of Ayurvedic literatrre.

Notwithstanding the pre-germ theory, the 1835 Act of the British in India to derecognise Indian system of medicine, the rivalry between indiggnous and Western system of medicine became all the sharper with the germ theory. Simultaneously we also note that the rivalry between different forms of indigenous medicines also tended to grow following the development of various institutions for the development of different streams of indigenous medicine. To a considerable extent this was fuelled by a species of cultural nationalism. But we shall not go into this here. Instead we shall in this chapter depend upon instances from contemporary India and Srilanka and try to understand how rival systems prevail and how people take recourse to them. What, however, existn; and this is relevant for us, is that depending upon a variety of circumstances, the patient of contemporary times however still retains his option for pluralism. In other words though there may be a sharp break between the natural and supernatural

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2 P.D. Gaitonde, Portuguese Pioneers in India : Spotlight on Medicine (Bombay: Popular Prakashan, 1983).

theories and therapies of medicine and a break between different kinds of non-supernatural theories, the patient may on certain occasions opt for a plural system of medicine. Now comes the rub. If a patient is able to break away at times from the highly professionalised, dependency usurping system of western medicine, does it mean that he can win back his autonomy by doing so? Or does it mean that he is travelling from one form of dependency to another or co-travelling simultaneously with several.

There is yet another interesting aspect to this question. This is the empirical instance from China where, probably for the first time, the government tried to fight back against professionalism and specialisation and give back, what the cultural critiques call, the 'initiative' to the people. A quick study of the Chinese experiment will also be very elucidating in this case, and we shall attempt this also in the following pages.

The Existence of Medical Pluralism in Contemporaneous Societies and Its Implications

From the point of view of the Western medical paradigm the question of how primitive man can reconcile their assumptions about sickness with instances where their therapies fail to cure is often being asked. By taking resort to the distinction between scientific thinking and

everyday thinking which Schutz[3] made, an explanation of how primitive man can ignore the empirical failure can be constructed. By scientific thinking, Schutz means that it strives for coherence. It is concerned with making consistent what its assumptions and premises say about the real world with what actually happens. Its main preoccupation is to have a firm grip of the entire domain of the phenomena. Scientific thinking may be a necessary condition for gaining technological mastery within the chosen domain. It may also be a cognitive style associated with the kinds of people who are recruited to the profession.

On the other hand, everyday thinking is preoccupied with the pragmatic. It is not marked by a deliberate striving for consistency beyond the point into which the subject's everyday activities take him.

Scientific thinking is not that important in society. It is only a part and constituent or what goes for a bundle of knowledge. Only a selected few engage in this sort of thinking. But everybody in society is engaged in everyday thinking and the sociology of knowledge must touch upon this aspect significantly. As Berger and Luckman write, "...the sociology of knowledge must first of all concern itself with what people know as reality in their everyday, non or pre-

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3 A. Schutz, Collected Papers 1. The Problem of Social Reality (The Hague: Martinus Nijhoff, 1962), pp. 229-34.

theoretical lives. In other words, commonsense knowledge rather than ideas must be the central focus for the sociology of knowledge. It is precisely this knowledge that constitutes the fabric of meanings without which no society could exist.[4]

If such a distinction is kept in mind, then in everyday thinking what the western medical paradigm calls empirical failures are interpreted in a pragmatic context. They are, not interpreted as an acid test of a particular medical system.

Horton remarks that everyday thinking is contaminated by an uncritical attitude to the assumptions of the conceptual system as a way of understanding medical beliefs.[5] An important corollary to this point is that the assumptions are not competitive. But again the absence of competitive medical system does not imply that there is no other medical system. If a medical system is defined according to its unique beliefs and practices, then medical pluralism would be said to have existed in India and elsewhere. As Leslie has argued that 'all medical systems can be conceived as pluralistic structures'.[6]

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4 P.L. Berger and T. Luckman, The Social Construction of Reality (Doubleday: Garden City, 1966), p. 27.

5 R. Horton, "African Traditional Thought and Western Science", Africa, vol. 37, 1967, pp. 50-71, 155-87.

6 C. Leslie, "Medical Pluralism in World Perspective", Soc. Sci. & Med., 14B, 1980, p. 191.

Nichter mentions that the South Kanarese health arena consists of folk herbal specialists, traditional ayurvedic specialists (vaidya) and compounders, traditional-modern ayurvedic specialists trained in the integrated system of ayurveda and biosciences, astrologers, diviners, exorcists, possession medium, allopathic practitioners, chemists and eclectic combinations of the above.[7] He notes the relationship between patient and practitioners in the South Kanarese context. The rural practitioner has to contend with a rising number of cosmopolitan, and traditional modern practitioners. Both cosmopolitan and traditional modern practitioners give forms of medicine which appear identical to the layperson. He writes: "...the rural practitioner must win the trade of the lay population by establishing a reputation for having good medicines, power of the hand, and reasonable costs as discerned by lay cost reckoning. In as much as a practitioner's compensation depends on fees hidden in medicine charges, the practitioner stocks popular medicines and to some extent acquiesces to client's demands for particular medicine forms."[8]

Bhattacharyya analyses the concept of medical pluralism by examining the pluralistic nature of psychiatric

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7 M. Nichter, "Paying for What ails you : Sociocultural Issues Influencing the Ways and Means of Therapy payment in South India", Soc. Sci A Med., vol. 17, no. 14, 1983, pp. 957-65.

8 Ibid., p. 964.

domain in Bengal.[9] Three varieties of pluralism are identified, i.e. (i) the social institutional pluralism of the diverse specialists, (ii) the cultural cognitive pluralism of the clients' conceptual framework, (iii) the pluralism resulting from the divergent perspectives of clients and specialists. The main argument is that all three forms of pluralism can be better understood, if pluralism is conceptualized in terms of actors' structuring activities. To quote, "Clients' behaviour and especially treatment seeking strategies also constitutes the structure of the system. From this point of view, the psychiatric system is one of cognitive pluralism because clients make distinctions between the three conceptual paradigms to organize and justify treatment strategies."[10]

Leslie opines that medical pluralism is a desirable state of affairs as it allows for the existence of multiple modes of healing. Beals, Amerasinghen and others contrast medical pluralism with thoroughly standardized 'scientific' medical system. Beals[11] suggests that, as an Indian villager

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9 D.P. Bhattacharyya, "Psychiatric Pluralism in Bengal, India", Soc. Sci. & Med., vol. 17, no. 14, 1983, pp. 947-56.

10 Ibid., p. 954.

11 A. Beals, "Strategies of resort to Curers in South Asia", in C. Leslie, ed., Asian Medical Systems (Berkeley: University of California Press, 1976), pp. 184-200.

is used to contradiction in multiple modes of cure, so he feels comfortable enough in the presence of mutually contradictory medical systems. Amarasinghem[12] speaks of diagnosis and treatment of Schizophrenia in the context of medical pluralism existing in Sri Lanka. In her opinion, the diagnosis and treatment of Schizophrenia in Sri Lanka is more optimistic than it is in the West, where it is visualized as incurable. Each medical system, from the Welter of plural medical systems, would diagnose it in different way. As a consequence of it the disease would disappear because it would not have any consistent definition. The very lack of orderliness appears paradoxical and queer to the Western medical scientists. Sometimes, such lack of orderliness among these traditions, explain their culturally satisfying quality and also account for the healing of the patient.

It is primarily for the patient and to a lesser extent for the healer, that different healing systems criss-cross on a fundamental way. It may happen in a meaningfully coherent way. As has been pointed out earlier, the existence of multiple world-views in medicine is congenial to more flexibility. The more autocratic medical system aspires to be the less it can absorb the needs of particular patients.

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12 L.R. Amarasinghem, "Movement among Healers in Sri Lanka : A Case Study of a Sinhalese Patient", Cul. Med. Psychiat, vol. 4, 1980, pp. 71-92.

Let us differentiate between a single over-arching world-view and a multiplicity of competing world-views. Where a single over-arching world-view holds sway over people's mind, the main competition to establish theory comes from new patterns of everyday thinking. Such a challenge can be coped with by simple adjustments within the overall framework of the theory. It may be coped with by introducing new auxiliary postulates. Though in the long-run such adjustments may change the framework itself, participants of any one generation in short-run are largely unaware of such changes. They tacitly assume the established body of theory as having absolute validity.

Where a multiplicity of competing world-views reigns, the challenge to any particular body of theory comes from two sources. (i) As usual, it comes from new patterns of everyday thinking, and (ii) it comes also from spokesmen of competitive world-views. To establish the supremacy of a particular world-view, its spokesmen try to eliminate inconsistencies in their own theory. Simultaneously, they try hard to locate inconsistencies in rival world-views. They no longer wait for new situations to occur. They devise new situations to show either the superiority of their theory or inferiority of some rivals' theory. The crucial proposition is that they are faced with a multiple bundle of answers to the same question about the world.

And it is primarily in this multiplicity that the patient can manipulate from his end a plural system of medicine not because he irrationally falls prey to "pre-science", or that he is only momentarily swayed by science, but because the questions of medicine pertain to questions of illness which are contemporaneous with man and precede any known and datable technology. Or, more bluntly, because no medical technology has been able to demonstrate its infallibility not only to lay man but also to doctor.

We shall like at this point to take cognizance of Michel Foucault's work, especially his _The Birth of the Clinic_.[13] It is a slight digression but it is worthwhile because Foucault tries to demonstrate that the break from pre-modern to modern medicine is not so much as a leap from rationality to irrationality and that the pre-modern medical systems were also characterised by a systematicity which modern medicine partakes of. This latter point is similar to Kuhn's[14] which we have mentioned earlier but Foucault arrives at this point via a different route.

Kuhn postulates two tenets: (1) All observations of nature are theory-embedded. They depend on a framework of

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13 M. Foucault, _The Birth of the Clinic : An Archaeology of Medical Perception_ (London: Tavistock, 1973).

14 T.S. Kuhn, _The Structure of Scientific Revolutions_ (Chicago: University of Chicago Press, 1962).

assumptions that colour the way in which the observer approaches the phenomenon. As a consequence of this there is no independent way to know how well scientific ideas represent some underlying reality. Ideas are evaluated by their practical utility in solving problems. (2) Major changes in scientific theory amount to 'revolutionary' changes. Such periods are followed by periods of 'normal' science during which the implications of the changes are worked out as new theories are applied to individual cases. Fundamentally important hypotheses provide alternative vantage points. They do not so much grow from one another as they do replace one another. The conflict between new and old theories is centered around 'anomalies' which arise in the application of the old ones.

In such a framework, Kuhn makes plausible the puzzling (as he points out at first sight) Aristotelian physics. It is in this context that Foucault's _The Birth of the Clinic_ is relevant. He does not try to make plausible the puzzling classical medical structure. For him, once the formal structure of classical medicine is seen the claims of modern medicine can as well be treated as governed by similar arbitrary structure.

Foucault begins by examining the origins of modern clinical medicine. His study converges on the relatively few years at the turn of the 18th century, that was marked

by swift and complete change in epistemology. Foucault sets out to show "...what was fundamentally invisible is suddenly offered to the brightness of the gaze, in a movement of appearance so simple, so immediate that it seems to be the natural consequence of a more highly developed experience. It is as if for the first time for thousand years, doctors, free at least of theories and chimeras, agreed to approach the object of the experience with purity of an unprejudiced gaze. But the analysis must be turned around; It is the forms of visibility that have changed."[15]

To begin with, Foucault acknowledges the medical profession's explanation of this break from classical age to modern age. But he provides it a new reinterpretation. The medical profession's view is that, with Bichat, medicine arrived at objectivity from fantasy. For Foucault it is the forms of visibility that have changed.

Foucault shows that medical discourse can be better understood by showing that it has a different structure. He writes: "For the clinical experience to become possible as a form of knowledge, a reorganization of the hospital field, a new definition of the status of the patient in society, and the establishment of a certain relationship between public assistance and medical experience, between help and knowledge, became necessary; the patient has to be enveloped in a

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15 M. Foucault, op. cit., p. 195.

collective homogeneous space....An absolutely new use of scientific discourse was then defined: a use involving fidelity and unconditional subservience to the coloured content of experience - to say what one sees; but also a use involving the foundation and constitution of experience - showing by saying what one sees".[16]

From the above passage we see that when modern structure of clinical perception replaced the classical structure of medicine, what changed was not the semantic content only. Medical profession's standard official explanation was the change primarily in the semantic content. Foucault in his attempt to reinterpret it showed that what fundamentally transformed medicine was the syntactic form.

The Birth of the Clinic attempts to find the structure which underlies discourse, perceptual experience (gaze) etc. This structure changes discontinuously at certain periods, i.e. at the turn of 19th century. Foucault writes about such a structure: "This structure, in which space, language and death are articulated - what is known, in fact, as the anatomo-clinical method - constitutes the historical condition of a medicine that is given and accepted as positive. Positive here should be taken in the strong sense. Disease breaks away from the metaphysic of evil, to which it had been related for centuries; and it finds in the visibility of death the full

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16 Ibid., p. 196.

form in which its content appears in positive terms."[17]

From the modern perspective, classical medicine appears false and unintelligible. But from an archaeological viewpoint what remains unintelligible is not without its systematic order. Imbibing such a perspective, Foucault marks out the chronological threshold between the classical age and modern age of medicine.

Contemporary Medical Pluralism : Summing Up

Both the cultural critiques of medicine and the anthropologists who study 'ethno medicine' miss out on issues significant to the question of medical pluralism. For the cultural critiques the opting out by the patients for non-western medical system is not entertained seriously and only in passing as a way out of dependency. But in fact when medical pluralism is active from the patients' point of view, as it is in contemporary times, it is not with the intention of winning back his autonomy from a professional but it is more with a view towards finding a solution, an answer, to his most immediate problems concerning his illness. A patient can therefore quite as easily jump from his "golden age" heritage with its prescribed professional and subscribe to the modern system and its professionals, as he can also do the reverse. On occasions different systems are combined, as we found

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17 Ibid.

earlier in this chapter. In each case it depends on the severity of his illness, the kind of services available, and on the patient's resources. All medical systems, modern and premodern, justify their own theories and therapies at the expense of the other going ones. But additionally, we have also tried to say that medical pluralism from the doctor's or healer's side is in a significantly attenuated form, if it exists at all, in contemporary societies.

For the anthropologist concentrating on ethnomedicine in contemporary societies the lack of awareness of medical pluralism is for different reason. By depending on exclusively pre-modern (not only non-western) systems of medicine he is solely interested in the illness for which there are only cultural specific diagnoses and cures. It is for this reason that ethnomedicine perhaps unwittingly creates an impression that there is a rational and universal system of medicine on the one hand and a non-rational (if not irrational) magical, super-natural and culturally specific medicine on the other. On this issue of rationality and irrationality we have disagreed earlier and we believe that our brief over-view of the works of Kuhn and Foucault aids us significantly to form our judgement and helps us to understand medical pluralism as indulged by the patient.

Let us now enquire into the medical system under socialism and see if under socialism the patient gets his

initiative back even when, as is the case of China a deliberate programme was launched to this end and which also simultaneously attempted to curb, if not extirpate, professionalism among Western medical doctors.

Medicine under Socialism

Vicente Navarro, who is a proponent of socialist medicine strives to establish a fundamental nexus between contemporary capitalism and the ideology, content and organization of medicine. He draws a sharp distinction between 'medicine under capitalism' and 'medicine under socialism'. He postulates that it is not industrialism, but essentially capitalism that is the cause of the Illichian variety of social and structural iatrogeneses.[18] He rejects focussing on the process of industrialization *per se* and emphasizes the economic and political conditions that determine underdevelopment and the type of industrialization that is used.

But Navarro has also conceded that socialism did not bring about an altered way of organising the professional, nor to horizontal integration of medical services.[19] True more

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18 V. Navarro, "The Industrialization of Fetishism or the Fetishism of Industrialization : A Critique of Ivan Illich", *Soc. Sci. & Med.*, vol. 9, 1975, pp. 351-63.

19 V. Navarro, *Social Security and Medicine in the USSR : A Marxist Critique* (Massachusetts, Lexington Books, 1977).

services were being offered and a large number of people can now have access under socialism to health services, and this itself is incontrovertibly a major achievement. But the Illichian criticism, in a sense, still stands. The Chinese case in this sense is very illustrative.

The practice of medicine in China is centuries-old. Western medicine was introduced in China less than 200 years ago. The first Western medical school, St. John's University was established in Shanghai in 1880. The first formal school of traditional Chinese medicine was established in Shanghai in 1 920. Before then, a physician taught medicine through apprenticeships. A physician accepted only one student, who spent years learning from his mentor. Both types of school still co-exist in China. The notable feature is that the 125 Western medical schools outnumber the 24 traditional schools.[20] Students in traditional schools are required to learn anatomy and physiology.

The contrast lies between rural 'barefoot doctors' and physicians in urban hospitals. Rural 'barefoot doctors' practice medical care part time while working in the commune factory. They often rely on local herbs as therapy. In contrast, large urban hospitals use western medicine and their armamentaria is familiar to the ones that physicians from more developed countries employ. Even in the Chinese

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20 C. Macek, "Herbs and Heal in Chinese Armamentarium", JAMA, 27 January 1984, pp. 439-41.

hospitals, where traditional medicine is practised, some of the tenets of Western medicine are employed.

In China, during the pre-revolutionary period, a small number of Western-oriented medical centers, catered to the needs of the elite population. The major section sought medical services from traditional practitioners. In the period after the Great Leap Forward, health service delivery was rather centralized. It favoured urban areas and industrial workers. In contrast, the Great Leap Forward and Cultural Revolution sought a more equitable distribution of health resources and produced experiments in the transfer of personnel and funds to the countryside to achieve this objective.

Parmelee _et. al_[21] elaborate the lines of referral in both rural and urban areas, which are fully standardized. "For the rural population, a decentralized network of health centers at the brigade level represents the first line of health care. These centers are staffed by 'barefoot doctors' and aided by auxiliary health workers in the production teams.... The commune health facilities are staffed by physicians and other health personnel, and have departments for such specialities as medicine, surgery, obstetrics, gynecology and pediatrics.

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21 D.E. Parmelee, _et al._, "Medicine under Socialism : Some Observations on Yugoslavia and China", _Soc. Sci & Med._, vol. 16, 1982, pp. 1389-96.

Like brigade health centers in the countryside, urban neighbourhood and work units clinics are usually staffed by paramedics who make referrals to physicians in hospitals and medical centers."[22]

It may be recalled that the 'barefoot doctors' are paramedics who are trained for at least six months to conduct basic preventive work, treat minor conditions and refer more complicated cases to the commune level. Paracles et. al. mention that recently their role has been re-evaluated and new programmes to upgrade their training and standardize the quality of care they dispense have been introduced.

There exists the institutionalized transfer of personnel between levels in China. On the one hand, paraprofessionals from the rural segments receive training at urban centres. On the other hand, physicians from urban centres are despatched to the countryside to do disease-prevention work. Scholars believe, somewhat overtly, that such an institutionalized transfer of personnel between levels, represents the leadership's desire to de-professionalize medicine. But as Lampton points out there has been a transition from an overtly de-professionalization policy to emphasize on the modernization of medicine through development of high technologies and urban medical centres.[23]

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22 Ibid., p. 1393.

23 D.M. Lampton, "Changing Health Policy in the post-Mao Era", Yale Journal Biol. Med., 54, 1981, pp. 21-26.

One of the spin-offs of the cultural Revolution was to solve fundamental health problems in the rural areas at that level through participation and de-professionalisation. It aimed at creating a centrally co-ordinated system of delivery policies. The Minister of Public Health acquired a prominent role in the 1970's. Guidelines for medical education and professional life took a new turn. Lampton narrates how medical education policy confronted difficulty in its immediate post-cultural Revolution. He writes: "The concept of a referral chain in which country and commune health centres play major curative roles requires that the physicians at these levels possess relatively broad medical skill....The problem which medical educators have traced is simply producing omnicompetent individuals in three years while at the same time, meeting the system's requirements for specialists".[24]

The barefoot doctors were called "worker doctors" and they worked in the urban factories. This type of health-workers are now on the way out. Their places are being occupied by professional doctors. The worker doctors received short period of initial training, usually three months and provided limited primary care functions on the factory floor. Worker doctors, like bare-foot doctors, performed health work part

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24 D.M. Lampton, The Politics of Medicine in China : The Policy Process, 1949-77 (Kent: Dawson & Son Ltd., 1977), p. 235.

time while continuing their other duties. They were paid a salary similar to that of other workers in the factory. The urban counterpart to the worker doctor and barefoot doctor from the late 1960s to the late 1970s was the 'street doctor' or the 'Red Medical Worker'.

But disillusionment with post-cultural Revolution medical education was not limited to the 'regular' medical school curriculum. The modalities of training bare-foot doctors have come in for severe criticisms. Lampton writes: "... peasants do not have faith in the capacities of these paramedices they demand referral to higher (and more expensive) facilities, thereby increasing the burdens of such institutions....(T)he inexperience of the barefoot doctors and the shortage of good medicine are the main reasons why city hospitals are over-crowded with patients from rural areas seeking treatment."[25]

These changes have reflected an increased amount of professionalism in the policy-making process. In the period between 1973-1977 research was again favoured and along with it came exhaustive medical training and quality care. The name of Chien Hsin-chung comes to mind immediately in the context. In 1972, the barefoot doctors' training period was extended to 18 months and soon after six years of training for being a full professional was reinstated.

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25 Ibid., p. 237.

The number of barefoot doctors has dropped since the mid-1970s. From broad perspective, the total number of barefoot doctors in China has declined from 1.8 million in 1975 to approximately 1.5 million in 1980.[26] This shift seems to be interlinked with the current Chinese emphasis on quality rather than quantity.

Even the training of barefoot doctors has changed significantly in the late 1970's. Training has not only been lengthened as mentioned earlier but also upgraded in the sense that it has become longer and more theoretical. Formal study of pre-clinical sciences such as microbiology and pharmacology is now included. Kaplan and Sobin document "Formal area-wide examinations of barefoot doctors began to be administered in 1979 in the Shanghai and Beijing municipalities.... Those who passed were certified as accredited barefoot doctors.... Those who failed were to receive further training and be given another chance to pass the examination."[27]

Irrespective of the paucity of data on 'Health Care Personnel' in China at crucial periods, one thing can be drawn conclusively from the adjoining table entitled "PRC Health Care Personnel, 1949-1979". The 'Higher-level' which is

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26 F.M. Kaplan and J.M. Sobin, Encyclopaedia of China Today (London: Macmillan Publishers Ltd., 1982), p. 295.

27 Ibid., p. 297.

PRC HEALTH CARE PERSONNEL, 1949-1979

Year	Higher Level	% increase	Middle level	% Increase	Lower Level	% increase	Traditional Level	% in-crease
1949	40,000*		n.a.		n.a.		500,000*	
1957	74,000	85	261,000		n.a.		n.a.	
1965	150,000*	102.7	500,000*	91.5	n.a.		n.a.	
1978	391,000	160.6	1065,000	113	663,000		346,000	
1979	436,000	11.5	1108.000	4	739.000	11.3	357,000	3.1

Higher Level : Western style Doctors, Pharmacologists, Laboratory Doctors

Middle Level : Assistant Doctors, Nurses, Midwives, Pharmacists, Laboratory Technicians

Lower Level : Nursing workers, Pharmacy workers, Laboratory workers.

Traditional : Chinese style Doctors and Chinese Herb specialists.

* Estimates

N.A. Not Available

Percentage increase calculated from the data summarized from *Encyclopaedia of China Today* (London: Macmillan Publishers Ltd., 1982), p. 296.

made up of Western style doctors, pharmacologists, and laboratory doctors shows a marked percentage increase over 'Middle Level' which is constituted of assistant doctors, nurses, midwives, pharmacists and laboratory technicians in the corresponding periods. It clearly shows professionalisation policy with its co-efficient the modernization of medicine through development of high technologies and urban medical centres.

Summing Up : The Chinese Experience

It may be recalled that during the entire period of the Cultural Revolution, the Chinese Medical Association (CMA) was perhaps the only organisation that opposed the innovation of health services and training. Several important political leaders who once shared identical views were now silenced. Zhou En lai too did not come out firmly against professionalism as such and tended to equivocate on the matter. But problems were mounting because the flow of patients to hospitals made it clear that the barefoot doctors lacked the legitimacy that was essential. In order to shore this end up even Mao Zedong had to concede to lengthening the course of barefoot doctors to 18 months. Around 1974, the earlier regimen of six years training for professional doctors was also reinstated and professionalism in this field returned in Mao's life time.

Who were the forces opposing Mao? The professional doctors of the CMA. The other opposing political leaders were either in disgrace, or had other matters in their minds outside medical care. It may be perhaps ridiculous to say that the CMA brought Mao to his knees. It may perhaps be more valid to say that the people in the communes and villages of China wanted a professional on whom they could entrust their dependence during illness rather than place it in the hands of a barefoot doctor, who, as he was not a professional in the strict sense, lacked the legitimacy that is demanded by the patients. All in all a state of affairs that should necessitate some rethinking on the overall discussion of professionalisation in medicine and on the somewhat utopian manifesto of returning to the patient his initiative in curing himself. Perhaps utopian is not too strong a word as the brunt of our earlier pages was to show dependence and professionalisation through history and in pre-history.

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CHAPTER V

CONCLUSION : PROFESSIONALISM AND DEPENDENCE IN MEDICINE

As we had stated in our opening chapter, our study was primarily in the nature of an enquiry. During the course of our enquiry we depended solely on literature in anthropology and to some extent, in history to regroup existing knowledge and information to bear upon the twin and related problems of the professionalisation of the doctor/healer and the dependence of the patient on the healer. In our introduction we began with the cultural critiques and moved on to anthropology to enquire into the premises of their research. But here, in the conclusion we shall move in a reverse direction if only to highlight how relevant pre-history and history are for critically evaluating and appreciating cultural critiques of medicine.

The questions surrounding the issues of professionalisation and dependence have motivated a large chunk of scholarship on the sociology and anthropology of medicine and health care. For instance, issues like rationality and medical pluralism also become prominent in such an enquiry. In the preceding pages we tried to demonstrate their critical relevance. If, as has often been mentioned, that the members of primitive societies are solely committed to supernatural

forms of therapy, then the role of the healer in primitive societies is undermined at the expense of sorcery, witch-craft, etc.

Such a position elides significant aspects in the anthropology of medicine. It overlooks the role of the healer who blends the natural with the super natural in his overall armamentarium, but may in particular episodes depend entirely on one and not on the other. If we keep this in mind then the role of a healer in primitive societies becomes more amenable for a cross cultural review, and so does the role of the patient.

Alongside with this is the notion of rationality. We have not attempted to develop a systematic treatise on rationality, and have rather endeavoured to bring out the comparability between the contemporary patients' behaviour with the behaviour of those in primitive societies. We did this primarily through the medium of the concept of <u>medical pluralism</u>.

It has been our contention that medical pluralism from the point of view of the healer/doctor has never been very pronounced but from the point of view of the patient medical pluralism has been pervasively active. In primitive societies it would perhaps be incorrect to consider natural and supernatural therapeutics to constitute two different streams. One shades off into another and differential

expertise is recognized within an overall unified cosmogony.

In ancient societies and in the medieval period, medical pluralism was more active, but this was perhaps because of the congruent theories of medicine that were propounded in the ancient world, and these theories flourished without interruption for centuries. But what is significant in all this for medical pluralism is that there existed certain recognized and professionalized streams of medicine and which interacted on a fairly large scale; and which also allowed for medical pluralism from the point of view of healer/physician to occur without grave paradigmatic stress. Obversely, too, we find that from the ancient period onwards professtionalization among physicians manifested itself in the fact that certain healers were not recognized and considered to be charlatans and quacks. Quackery perhaps emerges for the first time on a socially identifiable and relevant manner with ancient literate societies. This itself is an indication of the strict professionalism that existed in earlier historical periods.

In the contemporary world different medical systems do of course exist,- but perhaps do not co-exist. Even those streams of medicine which coexisted to a certain extent without major contradictions (one must however note the occasional existence of professional rivalry between Unanis and Ayurveds in Mughal India) now protect their

boundaries rigidly. Then there is of course the modern allopathic western medicine which has emerged as the most important and effective system of medicine the world over; and which, quite expectedly, is governed by strict professionalism.

But from the patients' perspective one finds that he has several options of medical systems. For him it is not so much the question of protecting extant professionalised bodies of physicians much less a vaunted theory of medicine, but the most important consideration is to cure himself. He may, if need be, move from one professionalized stream to another because for him the precariousness of his existence raises questions which cannot always be answered by any one medical system. No doctor, nor any stream of medical science, has all the answers to the questions that the patient's body can throw up. For the patient the main question is himself, and with it the ontological problem of: "why me?"

In spite of all this promiscuity of sorts with medical systems the patient in each episode depends on a doctor, who in each instance wins his dependence by his professionalisation, by his ability to reveal that his knowledge is superior to that of the other professionals. The patient in such episodes obviously acknowledges his inability to overcome his illness with professional help. Thus if a patient should forsake modern allopathic medicine

for any other kind he cannot escape dependence and professionalisation.

Does this mean that the patient in spite of willing to be independent of professionals is eventually locked in this dependency system? To answer the question in a tentative manner we looked into the instance of the barefoot doctor in China and how the people responded to the gigantic attempts made by the Communist Party of China under Mao Zedong to eradicate professionalism in medicine.

From the time of the Great Leap Forward right through the period of the Great Proletarian Cultural Revolution (GPCR) the ruling sections of the Communist Party of the Chinese state put their utmost to deprofessionalize and demystify western doctors and their expertise. But as we tried to show, in the latter half of our previous chapter, Mao Zedong and the Chinese state in his life time had to rescind most of their programmes aimed at deprofessionalizing medicine particularly western medicine. Even the barefoot doctor began to get increasingly professionalized. Alongwith this is the evidence that Chinese hospitals from the county level upwards continued to stay and, in some cases began to get-overcrowded during this period. This perhaps reflected the low opinion people in China had of the barefoot doctor and in the whole ethos of participating in the curative procedure by retaining the initiative with the non-professionals.

Cultural critiques of medicine refer to China during the days of the GPCR, but never talk of how the programmes relating to deprofessionalization had to be withdrawn during Mao's life time.

Our study, therefore, has had a very limited scope and it has only scratched the surface of several relevant issues in the sociology and anthropology of medicine. But by doing what we have done we can perhaps look at the question of dependency and professionalisation from a less utopian perspective which itself might be of some relevance in social planning. In India too we are worried about how to reach health facilities to the vast millions. Perhaps a little caution on utopian lines of thinking might yield more plausible outcomes.

From here what further avenues open up for a more detailed study? We feel that there are several possibilities. From the point of view of social anthropology, one important field of enquiry might be to study how popular thought and professional thought interact? What is the scope of these two forms of construction of reality especially in the context of medicine and health? Obversely, in what ways does this context of medicine and health differ from other contexts where there are also professionals and an established code of professionalism. We believe that ontological questions will have a preponderant position on the question of health and

medicine which will probably lend it its specificities. But certainly any further enquiry on this would necessitate in depth empirical work without which many postulations would remain at the level of conjectures.

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