THE SOCIOLOGY OF MEDICAL PROFESSION: A STUDY OF PHYSICIANS' RESPONSE TO THE STATE OF RURAL HEALTH SERVICES IN GAYA DISTRICT

Dissertation submitted to Jawaharlal Nehru University
in partial fulfilment of the requirements
for the Award of the Degree of the
MASTER OF PHILOSOPHY

MANOJ KUMAR SINGH

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067
INDIA
1994

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY

New Delhi-110067

CERTIFICATE

Certified that the dissertation entitled "THE SOCIOLOGY OF MEDICAL PROFESSION : A STUDY OF PHYSICIANS' RESPONSE TO THE STATE OF RURAL HEALTH SERVICES IN GAYA DISTRICT" submitted by Mr. Manoj Kumar Singh is in partial fulfilment of six credits for the award of the degree of MASTER OF PHILOSOPHY of this University.

This dissertation has not been submitted for any other degree of this university or any other University and it is his own work.

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

DR. IMRANA QADEER
CHAIRPERSON

DR. S.K. SAHU
SUPERVISOR

Gram: JAYENU Tel: 667676, 667557 Ext. 259, 262 Telex: 031-73167 JNU IN

CONTENT

		Page No.
1.	ACKNOWLEDGEMENT	I
2.	LIST OF TABLES	II
3.	LIST OF MAPS	III
4.	ABBREVIATION USED	IV
5.	CHAPTER-I INTRODUCTION	1-36
6.	CHAPTER-II DESIGN OF THE STUDY	37-47
7.	CHAPTER-III PRESENTATION OF DATA	48-111
8.	CHAPTER-IV DISCUSSION AND ANALYSIS	112-127
9.	CHAPTER-V SUMMARY AND CONCLUSIONS	128-129
10.	REFERENCES	130-132
11.	BIBLIOGRAPHY	133-139
12.	APPENDIX- I	140-144
13.	APPENDIX- II	145-146

ACKNOWLEDGEMENT

At the outset I would like to thank my supervisior Dr. S.K.Sahu who has not merely been a "guide" but has cared and nurtured me. It is only because of him that this work has been completed.

I express my profound gratitude to Dr. Anand Kumar and Dr.Avijit Pathak of the centre for the study of social systems J.N.U. who taught me the very basic of sociology at the M.A. level and provided valuable support throughout the work-period.

Prof. D. Banerji, Dr. (Mrs) P. Ramlinagaswami Dr. I. Quadeer, Dr. Ritu Priya and Dr. K.R.Nayar of the CSMCH, J.N.U. provided me with basic in sight of community health during the M.Phil course work. Mrs Rastogi provided me with valuable docunents time and again, Dr. L. singh of the CSMCH J.N.U. helped in his own inimitable way.

The collection of data was completed by the help and co-operation of CMO, Gaya and the physicians posted in the different PHCS of Gaya District. The financial support for this work came from the J.N.U.

This work would not have seen the light of the day without the in valuable support of my parents and my younger brother, Ashok and Amit.

My friends Arvind, Amarendra, Anand, Bibhuti, Biplove, Dr. Mohanty, Rajib, Sabastin and Triloki have helped me a lot during the preparation period of my dissertation.

I am thankful to the secratarial assistance received from Mrs. T. Kameswari Viswanadham without which this dissertation could not be finalised.

Manoj Kumar Singh

LIST OF TABLES

			Page No
CHAPTER-3			
1.	TABLE -1	Showing districtwise population of Bihar 1991 census.	48-49
2.	TABLE -2	Population distribution per PHC 1991 Census.	58
3.	TABLE -3	Total no. of physicians posted and available at time of study per PHC.	59
4.	TABLE -4	Motivation factors of physicians of join this service in rural area.	73
5.	TABLE -5	Physicians expectation from the service.	74
6.	TABLE -6	Physicians satisfaction from Education and Training as Community Health Physician (CHP).	74
7.	TABLE -7	Satisfaction of Physicions by Infrastructural support provided to them at the PHC.	75
8.	TABLE -8	Community Response toward PHC services.	96

LIST OF MAPS

1. Map of BIHAR Showing Gaya District.

2. Map of GAYA District.

ABBREVIATION

AIIMS:	ALL INDIA Institute of Medical science.
BIMARU;	BIHAR, MADHYA PRADESH, RAJASTHAN, UTTAR PRADESH.
CHC:	Community Health Centre
CHP:	Community Health Physician
CMO:	Chief Medical Officer
FRCH:	Fellow of Royal College of Health.
IMS:	Indian Medical Service.
M.B.B.S.:	Bachlor of Medicine and Bachelor of Surgery.
MLA:	Member of Legislative Assembly
M.O.:	Medical Officer.
MCC :	Mao Communist Centre.
M.P.:	Member of Parliament.
PHC:	Primary Health Centre.
PSM:	Preventive and Social Medicine.
ROME:	Re-Orientation of Medical Education.
SC:	Schedule Caste
ST:	Schedule Tribe
UNESCO:	United National Educational Social and Cultural Orgnisation.
WHO:	World Health Organisation.
O\C:	Officer-in-Charge.
IMA:	Indian Medical Association.

CHAPTER I

INTRODUCTION

CHAPTER I

INTRODUCTION

Medicine is an old tradition of human civilization. Medicine as an occupation started with the shaman who was not only the physicians but the priests, sorceres, poet, story tellers and even chief. In the Mesolithic culture men with imaginative and psychological gifts became 'shaman' or medicine men. With the beginning of urban civilization, neolithic farming began and folk medicine was handed to the priestly class who displayed high standard of surgical and therapeutic skills. In the pre-historic period cause of disease were attributed to super natural power or wrath of Gods and spirit, and were treated and prevented by resorting to amulets, charms, medical rites, sacrifice and talisman.

The Indus people had highly endured civilization. Shiva was considered to be first propounder of Ayurveda and the needs of Ayurveda were performed during this period. In the Brahmnic or upanishad period (800-600 B.C.) the medical beliefs were mainly of a medico-religious nature. The general practitioners - the vaidyas indulged in crude form of medical theory and used herbal drugs and superstitious rules. Rational medicine was ushered during the creative period 600 B.C. - 200 A.D. with the advent of Buddhism and Jainism. License to practice were given by the kings and quackery was controlled with punishment including death. The

payment to the physicians was either in kind or in cash. From 100-1500 A.D. the muslim brought the unani system of medicine in India. They practiced and patronised it during their regime. The specialists of this system are called Hakims. Although vaidyas had penetrated into rural areas whereas Hakims had confined themselves to the urban areas and enjoyed the patronage of muslim rulers. Common people had great faith in both these system of medicine. Hakims and pandits co-existed. Unani Medical School were established in Lahore, Delhi, Agra, Lucknow and Hyderabad. Siddha system has been practiced in South India especially in Tamil Nadu.

Thus the provision of medical aid to the people developed mainly as a doctor-patient relationship without an attempt to organise the service on the basis of meeting the requirements of the community as a whole. The early efforts of health administration were directed to the alleviation of suffering and to rehabilitation of the sick. The modern conception of a simultaneous application of preventive and remedial measures to maintain the health of the individual and of the community was absent in those days. It was the development of modern science, such as bacteriology, parasitology and pathology, in the latter half of the last century which brought to the forefront the importance of specific organisms as the causative agents for individual disease and indicated clearly the particular modes of spread of these diseases. So the promotion of public health is comparatively modern conception.

The main landmark of the development of public health administration in India occurred during the British period. After the fall of Mughal Empire, British ruled over India and introduced the modern medicine. However, Portuguese were pioneers in the field of modern medicine. Modern hospital was first set up by them in Goa soon after the conquest in 1510 A.D. But special medical department created by Britishers in 1740. The main factor which shaped the colonial health policy in India were its concern for the troops and the European civil officials. The old climatic theory was that the Indian climate caused disease in the abdominal cavity while that of Europe caused disease in in 'thoracic cavity'. This gave way to the theory of Miasma, resulting in a policy of segregation and sanitation which began in the mid 19th century and continued through until the end of the century. The Medical services became more important as numbers of war increased. Army health was primary concern for colonial health policy. To fight prevailing disease like plague, cholera among army the health service were established only for the benefit of Britishers. Indians began their work as compounder. For their formal training 'Native Medical School' started in 1822 at Calcutta and in 1835 in Madras. The Calcutta school was converted in medical college in 1835 on western model. Another medical college was set up in 1845 in Bombay and Madras in 1852. Nursing as a profession emerged in India in 1864 as a part of the military hospital but there was no

arrangement of formal training. The first diploma in midwifery was started in 1854 in Madras and provision for training to six nurses was made in 1871. In 1857, British Government established three university at Calcutta, Bombay and Madras. M.B.B.S. degree was awarded by these universities but they received recognition from general medical council of Great Britain. It started recognise the M.B.B.S. degree of Indian universities from 1892. After 1855, entry to Indian Medical Service by competitive examination made possible to Indians to enter the services. IMS started dominating all senior government posts and it had right of private practices. Decision was taken to form Indian Medical Association in 1928. In 1930, British council discontinued the recognition of medical degree awarded by Indian universities. Medical council of Indian was formally constituted in 1934 for maintenance of the uniform minimum standard of medical education in Indian medical college and to secure international recognition of the degree awarded by Indian universities.

The last decade of 19th century was a period of significant landmarks in determining the course both of the colonial health policy and of medical research in India. The medical research and IMS was dominated by British army. The preparation of anti-plague vaccine was the contribution of Waldemar Haffkine in 1893. His trial were extremely successful. He founded Bombay Plague laboratory which was replaced by Plague Research laboratory in 1899. In 1900 a

Pasteur Institute also came into existence in Kasauli as semi-autonomous institution headed by Royal Army medical corps officers. Between 1864 and 1920, there had been a remarkable success in protecting the health of the troops. The mortality rate had fallen by 90% and 80% respectively. But small pox, cholera, Malaria and Plague still prevailed among general masses. Scientific development were barred from scientific position in the bacteriological department until the end of the British rule. Now, medical research policies have been reflecting adhocism and the compulsions of the medical profession; and the stimulus for medical research in the country continues to be exogeneous in origin. The problem of eradicating communicable diseases still remain and today it is the single most cause of sickness and debilitation among adults and mortality among infants.

Thus the British involvement in sanitation and medical research in India resulted with two significant outcomes -- first it initiated the kind of public health system which evolved in the country. Second, it created an infrastructure for medical research. These two streams of development are inter related and they were influenced by both internal and external factors. Besides it, colonial ruler imposed their own values to inculcate medical education to Indians which has more far-reaching impact.

The opportunity for medical education in medical institutions were made available to students who mostly

belonged to the very privileged upper class of the society.

The Medical council of India accepted the British norms of medical education in order to gain recognition of Indian medical degree from the British medical council. This enabled some of the physicians who were the select among the select to go to great Britain to get higher education. And rest of the physicians tend towards the private practices. Thus colonial policy gave the birth of private practices. According to Banerjee, the four factors - (1) the colonial value system; (ii) the class orientation of Indian physicians (iii) their enculturation in British modelled Indian medical college, and (v) more extensive indoctrination of the future key leaders of Indian medical professions in the Royal college - provided a very congenial setting for the creation of what Lord Macaulay had visualised as 'Brown Englishmen' (Banerjee, 1985)[1]. These physicians who had been indoctrinated in western values acquired dominant leadership positions in all facets of health services in India. This arrangement proved convenient to both the colonialists and the privileged few among Indians. This ensured the physicians power, prestige, status and money at home, while their mentors from foreign countries were assured of a considerable influence on them because the top leadership of the medical profession in India remained heavily dependent

on these mentors. Such types of education was grown the super-specialization type of knowledge which increased the professionalism among Medical Personnels. It becomes much more curative oriented with power, money and status.

On the eve of independence, The Health Survey and Development Committee[2] was appointed by the Government of India in October 1943 to make (a) a broad survey of the present position in regard to health conditions and health organisation in British India, and (b) recommendations for future development. The committee submitted its report in 1946 and it was published in the year India gained its independence. The proposals of the committee were (i) No one should fail to secure adequate medical care because of inability to pay for it. (ii) The health programme from their inception must lay emphasis on preventive work; (iii) Health Service should be placed as close to the people as possible (iv) The Doctors of the future-the basic Doctor as report called him - should be a social physician. (v) Medical Services should be free to all without any exceptions and the contributions from those who can afford to pay should be through general and local taxation. (vi) Full time salaried staff should be employed by government to ensure that Doctors served in areas where they were most needed; (vii) greatest attention should be paid to environmental sanitation, nutrition and health Education. To achieve these objectives the committee has suggested both

long and short term measures. The short term measures consist of the setting up of primary units covering a population of 40,000 and secondary unit with as many as 16 doctors covering a population of 600,00 at a sub-district level. It requires two medical doctor and 36 non-medical staff in one primary unit. The long term measures suggested include the setting up of a district headquarters be staffed by the 269 medical officers and 1,398 non-medical staff, the raising of bed population ratio to 2 per thousand, and the establishment of more medical college having training centre for nurse. To bring about social orientation of Medical Education the department of PSM should be established in Medical College.

Medicine is fast undergoing change in its pattern, concomittant with advance in the field of natural and applied sciences. The impact of these change on the society has become a fertile field of study for social scientists. Although much has been accomplished in the field of medical education, rapid social changes and fast growing population in developing countries have thrown up additional demands on the medical profession and indirectly on the planing of medical education. There is persistent demands for more and better health services in inaccessible rural and urban areas in greater quantity, improved quality and increasing coverage.

The scientific and technological pace of medicine has

experienced phenomenal growth in the past few decades. yet, these advances in medical science have not reached the vast majority of people living in rural areas. At a time when health care is considered a right of every citizen, there are those who receive very inadequate care or none at all. For this reason, during the recent years the medical education in India has come in for a spate of criticism from the public., the politicians as well as from the medical educationists. The government is allocating a considerable amount of funds for medical education.

The doctors trained at public expenses do not like to go to village on remote areas where eighty percent of our population live. The present day medical education creating a vast medical profession in India has not only failed in delivering its objective but has failed miserably.

Of the set of commitments that the Indian state made to the people at the dawn of independence, health care has been ostensibly high on the agenda. Over the decades the state evolved in keeping with the development model it pursued a policy for health which emphasized the creation of health care infrastructure - medical college doctors, hospitals etc. Over the past forty six years India has seen dramatic expansion in the number of medical and health related personnel and in the variety of specialized positions, they occupy. But their training and educational policies has still limited with colonial administration in India. Therefore the rise of modern medical profession is closely

limited with the administrative and educational policies of the colonial rulers.

Time and again the social scientists have tried to understand and analyse the medical profession from a western theoretical perspective which has not provided adequate empirical analysis to understand the problems of medical profession in India. For an understanding of a sociology of medical profession one should have a clear theoretical perspective of profession.

Profession: A Theoretical Frame

There is a belief among social scientists that professions are 'occupation with special power and prestige'. Society grants these rewards because "Professions have special competence in esoteric bodies of knowledge linked to central need and values of the social system and because profession are devoted to the service of the public, above and beyond material incentives". A profession is distinct from other occupations in that "it has been given the right to control its own work". Broadly there are two conceptions of Profession: One is idealistic and second is operational.

According to idealistic conception, profession is occupation distinguished by intellectual training altruistic orientation and a code of ethics for its practitioners. It emphasizes only the desirable dimensions of professions -

i.e., cognitive, normative and evaluative. This is an idealistic conception because these attributes remain more of an ideal than a reality. The operational conception puts its accent on how an occupation organizes itself into a profession, which is to say, that how it lays claim to monopoly, autonomy and authority.

Theoretically, there are two distinct approaches in the study of profession i.e. functional and conflict. The functional theory assumes that society has certain needs and that it develops certain institutional structures in order to fulfill such needs. Following this assumption, the functional perspective posits existence of functional linkage between professions and society. The functional theory adherents the structural functional approach which consider 'profession as a "form of division of labour" based on code of ethics and work autonomy as an occupational group based on specialized knowledge and as a group performing rational, functionally specific and universalistic role". It highlight altruistic and service oriented nature of profession. As against this, the conflict orientation seeks to explain profession in terms of their power-relation to society. In present context, professional are help to negotiate with power elites for acquiring monopoly, autonomy, and authority which the power-elites only grudging grant to professions. this power of profession is used not so much to serve the needs of masses as of the ruling and privileged classes and most important of all to perpetuate

their own power and control over society.

Characteristics of Profession

The first fundamental characteristic of profession is the abstract body of knowledge. A body of knowledge is concerned with the basic fields of inquiry,: scientific, institutional or aesthetic. In the evolution of every profession, there emerges the research and teaching functions. In technological profession a division of labour between theory oriented and and practice-oriented persons evolves. Thus the higher education is key variable in professionalization. As this occurs in more and more professions it becomes a generalised social assumption that all educated people university trained and certified are per se professionals so that anything they do is professional.[3]

The second characteristics of profession is strong service orientation. Assumption is that the members of the occupational group called 'profession' utilize their knowledge and superior skills on behalf of other members of the society. So, they are altruistic; for them, their own particular interest is secondary and the interest of other members of the society is primary.

The third distinctive characteristic of profession is Professional authority. The prolonged specialised training is a body of abstract knowledge imparts the professionals a type of knowledge that highlights the common man's comparative ignorance. It is easy to understand it by

drawing a distinction between a 'customer' and a 'client'. A professional occupation has a client, while non-professional occupation, a customer. Whereas customer exercise his own judgement about his own welfare in non-professional occupation, the professional dictates the client in professional occupation about what is good or bad for him. Because of lacking of requisite theoretical knowledge, the client can know neither his own needs nor can evaluate the calibre of the professional service. The client's subordination to professional authority invests the professional with a 'monopoly of judgement'. Thus professional authority is confined to those specific spheres within which professionals has been educated. To this Parsons calls 'functional specificity'.[4]

The fourth characteristic of Profession is community sanctions. Every profession seeks community sanction to its authority. In doing so, every profession gradually comes to enjoy a series of powers and privileges - formal and informal. The formal authority of profession is enforced by the community's state power. Every profession succeeds in taking control over its training centres, achieved through an accrediting process exercised by one of the associations within it. The power and privileges enjoyed by a profession gives it monopoly. It became easier for a profession to establish that this profession depends on superior skill obtained by specialized training that it delivers a superior and that it serves the human needs of sufficient social

significance. Thus, this monopolization of expertise insured and justified the monopoly of opportunities in a market of services or labour and monopoly of status and privileges.

The fifth characteristics of profession is the Professional-Client relationship. The Professional client relationship revolves around three types of interaction which exists between professional and their clients. First, the professional-client relationship hinges on the belief that professional possesses expertise and the client is in need of that expertise. Second, the relationship between two is governed by norms which require that the interaction be initiated by the client and the termination of interaction be initiated by the professional. Although client has always at liberty to leave the professional at any time and thus terminate the relationship. Third, the interaction between client and professional consists of four substantive content (a) Privilege communication; (b) professional alone capable of interpreting and the client must return to the professional for additional help, (c) Decisions of professionals limited to the specific interaction period, confined both to 'here and now' situation and to the particular client; (d) unaccountability i.e. decisions rendered by the professional and ordinarily appealable to an outside authority.

The sixth characteristics of profession is the

professional ethics. Every profession has ethical code which makes the profession's commitment to social service a matter of public record. These codes carry more altruistic overtones and are public service oriented., The ethics of profession are usually described in terms of client professionals and colleague-colleague relations. Members of a profession share technical knowledge with each other and support each other vis-a-vis clientele and community.

The last and seventh characteristics of the profession is emergence of professional culture consisting of values, norms and symbols. Every profession operates through a network of formal and informal group. Among the formal groups are organisations which serve as a meeting ground for client and professionals, educational and research centres which replenish professionals associations which promote group interest and aims. Within these formal groups, there are a number of informal groupings. Central concept of professional culture is career concept. To the professional person his work becomes his life. Professional work is never seen solely as a means to an end, it is seen as an end in itself.

According to Etzioni,[5] profession should be categorized on the basis of organisation which can be divided into three types. (1) Professional organisation - This is further divided into two sub-types (a) Full fledged professional organisation in which knowledge is produced, applied, prescribed and communicated. Professional has also superior

authority to influencing the objectives and activities of the organisation. (b) Semi-professional organisation in which employ professional have shorter training and less theoretical knowledge.

Second, Service organisations in which the professionals are provided with the infrastructural facilities and auxiliary staff required for their work.

Third, Non-professional organisation in which the professionals are assigned to specific division or positions depending on the situation.

Profession (Organisation)

Professional Organisation	Service Organisation	Non-Professional Organisation

Full-fledged Professional Organisation	Semi-Professional Organisation

In the above context, there are growing trends among doctors to shift their work to organisations. Such type of significant transformation occurred due to their becoming 'salaried professional' or 'professional employees'. Their status and style of functioning are depending upon the nature of political system in which they work. In socialist countries, they are state employed, while in capitalist countries, they are private practitioners. In mixed economy, India promotes both private and public sectors in

all spheres of life. In this context, Indian public hospitals as an organisation proximates the autonomous professional organisation. Doctors have to work under prescribed organisational constraints and under certain normative prescriptions of an external agency like governing board. The fusion between professions and organisations leading to the emergence of new occupational species i.e. 'organisational professionals'. Within the realm of 'organisational professionals', doctors are full-fledged professionals, House Surgeons and Nurses are semi-professionals. The root of this organisational professionals lies on the colonial policy.

Background of Professionalisation of Medicine in India: A Brief Review:

Before the colonial rule, Indian Health Services were dominated by Ayurvedic and Unani system of medicine, Siddha system of medicine was practiced in South India, especially Tamilnadu. Indian medicine in ancient and medieval times was a stable and professionalising system flourishing with extended support from its advocates (Poonam Bala)[6]. The fundamental theories and concepts of the Ayurveda as conceived in the Charaka and Susruta Samhitas which define the ethical codes and the duties and expectations of medical men claims to a 'professionalising system of medicine'. These professional attributes also found expression in the established system of training of physicians, special course of training, the prestige associated with the profession and

its pre-eminence in society.

Practice of Western medicine or Modern medicine came into India through two institutional sources. First was the Christian missionary organisations. Healing was a part of the proselytiating strategy of the Christian orders. The Second source was the profession of allopathic physicians and surgeons who came with the civil and military personnel of the East India Company.

With the British rule in India and the subsequent shift in medical policy in 1835, indigenous medicine probably lacked official patronage. The British authorities provided services for the Army and when Services were extended over a wide range, they were carried out under the supervision of the Army personnel. Thus Western medicine remained largely a metropolitan affair and western medical education developed in the Bengal Presidency, primarily to train hospital assistants for military and civil hospitals. Impact of western medicine on Indian population was less until 20th century. Arnold (1985) argues[7] that health facilities provided were not accepted by vast population due to religious barriers. The second reason was the lack of sensitive policy towards the dominant social and religious conditions in India in order to tackle health hazards. The third reason was the lack of the governments ability to intervene directly in health conditions because of limited knowledge of disease causation and hence its prevention and

cure. Ramasubhan (1982)[8] identifies the development of the public health system and of medical science in 'Britain as 'organic' and in India as 'non-organic'. The development was non-organic because it was shaped by external factors of the theories of disease causation and sanitation developed in Britain, and the priorities of colonial government. In so far as public health policies were carried out in India, they were extension of health policies in Britain. But, till 1835, the indigenous medicine received more state patronage because indigenous population recognized Ayurvedic and Unani system of medicine.[9]

After 1835, the western medicine gradually achieved dominant position in society and also in regards of state patronage. This medicine passes through different phases of the patterns of training, certification, recruitment, practice and organisational structure. Here, the practitioners of western medicine adopted the patterns of training and values associated with the profession of medicine in Britain. It led to growing dependence on West for recognition of standards, degree, knowledge, skill, medicine and instruments. From 1892, the General Medical Council of Great Britain had recognised the degrees awarded by the Indian Universities. But, Indian people had lukewarm attitude towards Western medicine. They like to use Ayurvedic and Unani medicines. Later this trend was appreciated by Gandhi in his book 'Hind Swaraj'[10]. At the initial stage, western medicine only served army personnel

and Europeans who were residing in India and subsequently westernized Indians in Calcutta, Bombay and Madras. Even today, western medicine equally serves the requirements of urban and educated rural middle classes. The bulk of rural population and urban poor are deprived of health care facilities. They take the help of ethno-medicine, Ayurveda, Homeopathy and Unani medicine depending on their availability. While now a days western medicine became the part of Indian life. Its roles are extremely valuable in the prevention and cure of diseases.

With this background, Indian social scientists tend to study the health profession in India. Although many studies deal with sociology in Medicine, not sociology of Medicine. These systematic study of medical profession began in the 1970s. Some notable contributions have appeared both on health professionals and on organisational aspect of health professionals. Credit is due to Madan for initiating study of health professionals with his work 'Doctors in a North Indian City: Recruitment, Role- Perception and Role-Performance followed by another work 'Doctors and Society, which was conducted at All-India Institute of Medical Sciences, Delhi during 1975-77 as a part of UNESCO sponsored study of doctors in India, Malaysia and Sri Lanka. Another prominent work of the decade on health professional is Doctors and Nurses by Oomen which is the study of health professionals in organisations, covering both doctors and nurses with focus on occupational role structures. Venkat

Ratnam also studied the structure of medical services in Tamil Nadu. Social background of doctors and nurses in hospitals, organisation structure and role-perception, role expectations and role-performance. Karl Taylor work on 'Doctors for villages' emphasised that the rapid expansion of rural health services left the Primary Health Centres doctors and his staff with an impossible burden of responsibility. A great deal has also been published in the '70s by Rao on 'Doctors in Making., that is, on medical students, their background, characteristics, professional socialization, work value and professional aspirations. During there were important studies conducted by Ramalingaswami on 'Social background of Medical students' and 'Cost of Estimation of Medical Education' made a relevant contribution. Chandani's works on 'Medical Profession - A sociological exploration' is an important study in regard to determining factors of joining this factors-social background of doctors etc.[7]. Nagla's work 'Medical sociology' deals with the socio-cultural background of doctors, their attitude towards their profession and measures of satisfaction. In another studies, in post-Independent India, is conducted by Banerjee in 19 villages of eight states of India in which the role of health functionaries were studied in rural health context. Madan explained in his study of North Indian city i.e. Ghaziabad that doctors harbour a 'patient and disease oriented' rather than a 'person and health oriented'. In his study of AIIMS[12], he points out that doctors perceive

their roles primarily as the 'healer'. With regard to role-performance he finds a big gap between the normative model of doctors role which is largely of western extraction and the actual role-performance of doctors in Ghaziabad which he finds questionable on some unprofessional practice. He observes that doctors usually look upon their profession basically 'in terms of making a living rather than in terms of some notion of social responsibility.' The practice of medicine emerges as a kind of business and the first concern of doctor is to enhance his earnings. He further explained that colleaguial relations among doctors are not always of professional accord. They see each other as competitors, more so the private practitioners who avoid discussing their patients with each other. In fact, they depend more on the medical representatives than on their colleagues for learning the latest developments in medicine. Assessing the role of doctors as a modernizing elite, Madan found that not to speak of having a general modernizing influence in society, the doctors did not always operate in terms of latest developments of knowledge and technique. To that extent, they did not represent a modernizing element among the professionals. They are more modernists than modernizers.

Oomen's work 'Doctors and Nurses'[13] focused on doctors role set involving his relations with three role-partners - patients, nurses and colleagues. Regarding doctors attitude towards patient he finds that most of the doctors tend to

view patient not as a person but as 'a bundle of clinical symptoms'. He observed that the majority of doctors in public hospitals do not consider the welfare of patients as their most important role-obligation. Concerning nurses' attitude towards patient care, he explained that more nurses reveal a humanitarian perspective in contrast to doctors who betray an instrumental orientation. Nurses' relation with doctors are marked by an undercurrent of hostility, primarily due to authoritarian and overbearing attitude of doctors, which the former regent. As regards role commitment, doctors are found to be committed to their profession more than the nurses. Furthermore, the orientation of doctors' commitment is 'affective' while that of the nurse is 'instrumental'. Doctor's role commitment is also positively related to the length of experience, but not so of the nurse. Like Madan, Oomen also reported that relations among doctors in public hospitals as 'hostile and suspicion prone'.

Taylor's work on 'Doctors for the villages'[14] is a study of the attitude of interns towards rural health services and towards their training in rural health care. It covers seven medical colleges of all over India. He explained that most medical students receive a western oriented scientific clinical education which pays little attention to social and cultural factors. In fact, by directly or indirectly ridiculing popular belief, most specifically oriented physicians seriously damage their

rapport with patient. The rapid expansion of rural-health services left the Primary Health Centre doctors and his Staff with an impossible burden of responsibility. The doctors were expected to translate hopes into realities and it was he who found that this process is not simple. In Medical education, surgery, pediatrics, general practice and internal medicine were very high in personal preference while public health and preventive and social medicine was placed at the bottom of preference scale. Lack of opportunities of services parents doctors, to go into village. Inadequate provision of drugs supplies and equipment, lack of opportunity for professional advancement and post graduate education, poor access to libraries were identified by the interns as the most important deterrants for effective rural work. He added that interns with rural background and from lower socio-economic strata expressed greater interest in rural health centre work than the others.

Some recent studies indicates castes and groups which have access to medical education. In the study of Tamilnadu, Venkata Ratnam[15] found that the actual performance of roles is not in accordance with prescriptions, it means practitioners are not properly socialised. They have not acquired the professional qualities of 'effective-neutrality', 'knowledge by research', and the rules of bureaucracy. He also found that among the doctors the largest representation is from high

caste non-Brahmin with 40% and the lowest representation is from the S.C. with 6%, the low caste non-Brahmin groups having more or less equal representation of 25% each. In his Ghaziabad study, Madan found[16] that the clean Middle castes (81.8%) mainly Jats, Kurmis, Yadavs, Kayasthas, Khajris, Banias dominated the medical profession. Chandani's study of Jodhpur[17] found that more than half of the doctors belonged to the clean middle castes (53.3%) followed by the clean upper castes(36.8%). It is interesting to find that Brahmans were the largest single caste 34% in the profession of medicine in Jodhpur while scheduled castes doctors is quite low (2.6%). In her study Ramalingaswami[18] found that in spite of all the reservations that are prevalent in every medical college, all students belong to middle and upper-classes. So health service has upper class and urban oriented character. In her another study 'Estimation of Cost of Medical Education[19]' which conducted 14 out of 106 medical colleges in India, she found that the high recurring costs of medical education determined the nature of this elite oriented profession. Medical Education is one of the most expensive forms of higher education. It has to be highly subsidized by the State. So the question of expenditure incurred by the State in educating a medical graduate is very high and the question is raised as to whether the returns for the investment are commensurate with their functioning in the various institutions.

Career motivation is another area in which the studies have yielded some insights. According to Banerjee[20] 'Service to suffering humanity' is the platitudinous reply which most medical students and doctors make to question about why they become doctors. But Oomen[21] found that self orientation rather than humanitarian orientation is the predominant motivation behind doctors choice for medical profession. Chandani[22] found that 'altruism' and not 'individual-aggrandizement' was considered an impelling factor in joining this profession. Courtesy, dedication, expertise and humanism were the other attributes of doctors as she explained. She found that they, however, did not seem to possess these qualities in real life situations. Madan reports in this term mixed motives. But Rao[23] investigated this theme broadly. The result of his studies reveal significant differences in the work values, professional aspirations and perceptions of campus climate of first year and final year students. The increase in years of exposure to medical education is accompanied by rise in students interest in the economic and status dimensions of the job, but decline in their academic and service orientation. He further reports that medical students attach great value to 'service to others' but little value to work in rural areas.

Nagla study[24] shows that Doctors have desired to have urbanism as a way of life for professional progress, social benefits and monetary gains etc. Social cultural background

of doctors differs them from General masses. Abidi works on 'Women Physician: Role and Role Conflict'[25] intend to study all the aspects of both social and professional roles. Among working women, professionals stand out better in arranging alternative service for children and household chores. Role conflict is reported to be closely related to motivation to seek employment. physicians being professionals show more career commitment and their professional productivity is less affected by their social roles. Double role of women is still not fully recognised by society. The situation of role-conflict may persist according to the type of family motivation to seek employment as well as own commitment consistency towards dual roles, their personal and social satisfaction and autonomy in managing their two different sets of obligations.

The most informative and explorative study in Post-Independent India is conducted by Banerji[26] in 19 villages in 8 States of India. He explained that PHC has lack of doctors and medicine and basic infrastructure. People have to travel to the nearest town to buy the medicine. Banerjee found that highly expensive, urban and curative oriented medical education actively encourage the physicians to look down on existing facilities within the country particularly in rural India. Thus physicians looked for jobs abroad, causing the so-called 'Brain-Drains. Foreign trained physicians often demand high salaries, sophisticated and

well-equipped medical institutions as the price for returning home. They create conditions under which the younger physicians try to follow their footsteps and spire to go abroad and become super-specialists.

The social cultural background of physicians, lack of basic amenities and infrastructure in rural areas caused the factor that 80% of the population live in rural areas, while 20% doctors are there and 20% population are in urban area than 80% doctors are there. This further create social and cultural gap between patients and medical professionals. Because of this gap, it has been seen that community is not much more open about their own family life cycle, sexuality, aging and so on and sometimes also doctors are not interested to knowing these factors. They have no idea about socio-economic status of patient. Although poor people have not accessibility of health services, one respondent in 19 village study of Banerjee informed that the Nurses are 'Mem Sabs' for them (masses). They are only available to dominant peoples or Mukhya's house.

Banerjee further reports that the medical profession is in the midst of profound crisis. One manifestations of this crisis is in the form of the sharp increase in the number of strikes by physicians. There were frequent outbreaks of strikes by junior doctors in teaching hospitals for higher emoluments. The demands of the striking physicians are increased emoluments, better promotional avenues and better

status of Physicians in government organizations

Another indication of the crisis of the medical profession in India is manifested in the form of sharp decline in the ethical standards in the practice of medicine. Practice of medicine is now becoming a commercial activity. Like their counterparts in other commercial fields, physicians are now getting away with gross professional misconduct and negligence, even when they are held responsible for avoidable deaths, deformities and sufferings to the patient who have literally entrusted their lives to them.

The cumulative effect of the numerous shortcomings in the medical profession is the virtual breakdown of the Public Health system. During the colonial days there were public health specialists who had a reasonably good information system to get to know about the outbreak of epidemics. They also had competence to promptly investigate these epidemics and take appropriate anti-epidemic measures. This competence has now virtually disappeared. There is a virtual 'epidemic of epidemics' in different parts of the country like Kalazar, Japanese encephalitis, pyogenic, meningitis, cholera and gastro-enteritis, bacillary, dysentery, infective hepatitis and so on. INvestigation of these epidemics are often of a very casual nature.

The picture is indeed very grim. The political leadership must be responsible for bringing about such a

decay and degeneration in the medical profession. Exercise of patronage and nepotism, corrupt practices and grossly unjustifiable interferences in the day to day working of health institutions and organisations have been the hallmark of their activities. However, the network of medical personnel to the political leadership is increasing the power of doctors. It further create stratification, among physicians. Physicians those who have FRCS degree and also political backing joined the teaching as well as private practices thereby they create medicine as an industry. Even those physicians who have only MBBS degree with political backing are in the best position than those who are posted in Taluka and Tehsil level hospitals.

Banerji has argued how the health policies of the government of India have let down medical profession, as they have landed it into a situation where it is the drug industry which dictates the profession what to prescribe. Jeffery[27] characterize allopathic medicine is undergoing a process of deprofessionalization, than to state involvement in it.

Banerji reports that with the increasing specialisation, the profession got fragmented into desperate groups with the advent of increasingly advanced form of technology considerable deskilling took place. The corporate sectors made significant investments into health care industry because of which deprofessionalization took place and also doctors lost their economic and technical

autonomy. They are dictated by the corporate managers, whose primary concern is profit. Mackinlay[28] pointed out that with the growing of commodification of health by private sector, physicians become proletariat in this sector. They become labourer who produce profit. But on the contrary of it, with the growing of commodification and increasing corporate sectors, not only physicians become proletarised but also they gain power in country like India. Due to lack of basic facilities and crude belief of the people, people rush to the private institutions and thereby doctors monopolized the population. This lead to the breakdown of public institutions. Economic power perculating the power of Medical professionals. State also supported it. Drug industry supported this power to medical profession because of market forces.

While understanding the cost of Medical Education, Ramalingaswami[29] conducted the study of final year MBBS students of fourteen Medical colleges to assess the awareness of students regarding the poverty and its relation to illness and rural health infrastructure. She found out that the majority of medical students who are about to complete the course of MBBS are not aware of the relation between poverty and illness in a countryside as well as these students are not having clear idea about rural service network in different states. She further concludes that the present Medical education has not geared up Rural realth training programmes through the PSM department. As a result

of which the doctors who are coming out from their Medical colleges after completing their course are not suitable for the rural posting. Because of their elitist background as well as poor understanding of rural areas and poverty stricken life of the villagers.

In the Reorientation of Medical Education programme[30], it was found out that a high degree of reluctance from the teacher to move into the rural areas and 80% did not agree that rural education would help them in making knowledge more comprehensive. 72% of teachers involving in ROME programme were not keen in staying in villages for more than overnight. So, as a result of which the ROME programme could not bring out the expected result in developing the skill and caliber of the fresh medical graduate posted to the rural areas.

In some of the studies conducted in the tribal areas, it has been brought out very often that physicians posted at PHC located in the tribal areas are ill-motivated and more ignorant about life-patterns of tribals as well as their health problems. In one of the study Sahu[31] found out that the doctors working in the Oraon villages were not in a position to meet the felt needs of Oraon patients in a rural industrial area of Rourkela. He further concludes that the doctors were more often ignorant about the cultural life process of Oraon as well as their health practices. As a result of these, the doctors working in tribal areas could

not provide the health delivery package through the PHC and other health institutions to the vulnerable tribal population.

The WHO in its inter-regional conference (1966)[32] for establishment of Basic Principles of Medical Education in any developing countries laid down the following objectives:

- that, every practitioner in a developing country should be as familiar as possible with all aspects and their implications, preventive and curative, of the prevalent medical problems of his country;
- that he should be competent to contribute effectively to their solution;
- that he should be so imbued with the principles of learning and skilled in the method, that he will be able to continue further education in medicine for the whole of his professional life.

Conceptualisation of the Present Study:

The above review and analysis of the different studies conducted by several eminent scholars has provided multi-dimensional data of the medical profession in India. The medical profession has been responsible to deliver the primary, secondary and tertiary health care package to the vulnerable population. The physicians continue to receive their training in large well equipped hospitals, where teaching is heavily loaded with study of disease and individual care mainly within the tertiary institutions i.e.

hospitals. Their undue dependence on sophisticated diagnostic and therapeutic aids are passed on to the trainee physicians. According to Medical Council of India (1982)[32], it has been stated that one of the sadest ironies of the medical education system in India is that the resources of the community are utilized to train doctors who are not suitable for providing services in rural areas where the vast majority of the people live and where the need is desperate.

From the dawn of independence, the Government of India has made a constant effort to create a sensitive medical profession to cater to the felt needs of the vast population in the rural areas who have been virtually ignored by the health institutions. In the context of the Directive Principles of State Policy of the Constitution of India and the political commitments, leaders of independent India unhesitatingly defined the social objective for medical education to ensure that medical and health services are available to the entire population of the country. Taking very deliberately a socialistic attitude towards the health services, the aim was to make available health services particularly to those sections who had so far been ignored. All the documents of the Five Year Plans dutifully enunciated these social objectives of the medical education in India to form a socially sensitive and committed medical profession in the country.

India has signed the famous Alma Ata Declaration (1978) to achieve "Health for All by 2000 A.D." In order to fulfill this laudable goal a lot of emphasis has been given on primary health care and more on improving the rural health infrastructure in the countryside. According to 1981 Census, only 27.2 per cent of all qualified Allopathic Doctors are located in rural areas where over 70 per cent of the population resides. In fact, from 1961 to 1981 (i.e. over three decades) the number of doctors located in rural areas declined. Indeed, this situation demands that the profession must take positive action, invoking the ethical principle of justice to make doctors' services available to those who have no access to them.

Prevailing situation of Bihar State demands an urgent attention, since this State has been designated as one of the 'BIMARU States of India'. 40.7 per cent population of this state are under the poverty line, with an overall literacy rate 38.5. The present birth rate of Bihar is 344.3, with a total fertility rate 5.4. The present death rate is 12.1, having an infant mortality rate 91 and life expectancy at birth is 53.

In this deplorable condition of Bihar a broad question has been raised how far the medical profession of Bihar is sensitive to this situation and are committed to improve the health status of the rural population through rural health services network. A society expects a lot of return from its various professions for which society spends. From the

cost of medical education, it is evident that the large public fund is spent in medical education for making a physician. So questions arise how far the medical professionals posted in the rural areas are sensitive to the factors contributing to ill-health? How far they are committed for this role? How far they protect their image as social physician? To what extent they try to improve their status, position and prestige? Whether they try to understand the socio-economic problems of the area in which they serve and try to develop the community participation and involvement to develop a meaningful primary health care? How far they become Spokesman for the underprivileged? whether they try to maintain their class/caste position in the rural areas?

With these above questions this study was carried out by the investigator in Gaya District of Bihar. Gaya District was purposely selected since this district represents the overall socio-economic conditions of Bihar in general.

CHAPTER II

DESIGN OF THE STUDY

CHAPTER II

DESIGN OF THE STUDY

In order to design this study an attempt was made to clarify some of the basic issues. With the advancement of knowledge it was made clear that health services is not the only means to achieve health of the population. The socio-cultural-and economic as well as political factors which equally contribute to achieve good health of the community.

While trying to understand the role of Medical profession in the present rural health services of Gaya District in Bihar, we have designed the present study keeping in view the following basic conceptual ideas propounded by many eminent scholars in the field of community health.

The advances made in medical sciences in the past few decades have undoubtedly made a great dent in prolonging lives, improving health care and lowering disease and death rates. However, the improvement in the field of health and disease context is not entirely due to the advancement in medicine. The reduced incidence of several diseases can also be attributed to the gradual improvement in the standard of living (Banerji)[34]. But Bihar state presents an entirely different picture.

The domain of health and illness is full of contrasts for each society, which has evolved its own mechanism to

cope with the problems of health and illness and the ways in which these have been defined (Morris, 1973).[35] Problems relating to health and disease are neither viewed with the same seriousness nor call for equal health care. There exists a wide variation in medical care, depending on the nature and seriousness of the illness. While some are not prepared to accept the seriousness of a health care problem, others define the problem in terms of insuring against catastrophic illness and treatment sometimes swallows the whole of the patient's income. Still others see the problem as one of the insuring medical care for all in order to cover those who need medical care most but do not get it (Sahu)[36]. The rural areas of Bihar comes out glaringly as most neglected and backward areas as far as the health services are concerned.

Currently the talk of community health and appropriate technology has become the "in thing"! For a young professional's career, for an ambitious health administration as well as for a politician, slogans of "Health for All by 2000 A.D", "Community Participation", "Rural health" and "Primary Health Care" have become steps in the ladder of promotion and achievements. Not many of them, however, make the effort to understand the status of health of the people who continue to sweat, toil and fall sick as they have been doing for centuries (Qadeer).[37]

It is this paradox of technological progress coupled

with a national commitment to achieve the target of health for all versus the actual state of health of the majority of rural people of Bihar and the role of physicians posted in rural areas is the central point of this study and prompts to explore the following questions of this study:-

- How far the medical profession is sensitive to meet the felt needs of the people in the rural areas?
- What is the motivation and expectation to join the Services in the rural health institutions i.e. PHC/Dispensaries?
- To what extent they have the skill to manage these health institutions?
- Are they aware of the present health policies and programmes launched for the upliftment of health of the rural people?
- Whether physicians posted in the rural area are over professionalised?

Objectives of the present study

With the above broad questions, the main objective is to explore the "sociology in/of medical profession posted in the rural areas". The following are the specific objectives of this present study.

- To study the socio-cultural economic background of the physicians posted in the rural areas;
- To study their motivation and expectations to join the services in the rural areas;
- To study their job-satisfaction

- To study the kind of problems they encounter in their day to day performance
- To study their skill to manage the rural health institutions as social physician;
- To study the perception of the subordinate paramedical staff and community towards the functioning of the physicians and vice-versa;
- To study how much do they get support from higher authorities at the district level;
- To study their understanding and knowledge about the present health policies and programmes as well as other socio-economic developmental measures for rural areas;
- To study their awareness about the socio-cultural and economic life condition vis-a-vis health problems of the community they serve.

With these objectives, the present study was carried out in Gaya District of Bihar since this is one of the 'BIMARU' states of India. Gaya District was purposively selected since this represents the general socio-economic life condition of rural people of Bihar. The investigator also belongs to this district. The other compelling reason of selecting Gaya District is to complete this study in a short period - for 4 months - as part of the requirement for M.Phil. Dissertation with a very little financial support from the Jawaharlal Nehru University. All physicians posted in the Primary Health Centres of Gaya were enlisted and the study was carried out.

Period of Study

This main study was preceded by a pilot survey in September 1993. During the pilot survey the District Chief Medical Officer (Civil Surgeon of Gaya) was contacted and the official permission to carry out this study was obtained and also detailed information about the staffing pattern of the PHC, their location and communication was obtained. The first contact was established with all the PHCs.

The main study was initiated in October 1993 and was completed in the month of January, 1994.

Study Sample:

A list was prepared for all the physicians posted in PHC of Gaya district. In total, there are 18 Primary Health Centres (PHC) in Gaya district. In every PHC, is supposed to be managed by four physicians along with other para-medical staffs. But actually, there are 63 physicians available in 18 PHCs instead of 72. Out of 63 physicians at the time of study, 31 physicians were available and out of the rest 2 were on leave, 5 on deputation, and 25 were absent from the PHCs without any leave record. Out of the 31 physicians only 28 physicians were selected for study since the other 3 did not cooperate to provide data about them.

Besides the physicians 36 paramedical staffs were included in this study from all the 18 PHCs. For every PHC

an attempt was made to collect data from two community leaders, out of which one is the Village Panchayat 'Pramukh'.

Techniques used for data collection

Since this study was designed to collect qualitative as well as quantitative data the following socio-anthropological techniques were used:

(1) Through the non-participant and participant observation, a large number of qualitative data were gathered from the PHCs about the role of the physicians;

(2) Formal and informal interview techniques provided scope for deep probing.

(3) An interview schedule was constructed to collect certain data for qualification of the qualitative data.

(4) Case study method was adopted to strengthen the qualitative and quantitative data. With the help of case studies in-depth data could be generated.

(5) Finally the cross checking and verifying of the data was carried out at district and other institutional level.

Data Collected

The following data was collected with the help of above research techniques adopted in the field by the investigator:

(1) A detailed background of the each Primary Health Centre including staffing pattern, population, infrastructural facilities available;

(2) Socio-economic background of the selected physicians including their service experience;

(3) Data regarding job-satisfaction, motivation and expectations of the physicians;

(4) Data regarding the status, prestige and power of the physicians;

(5) Data on encounter and experiences of the various problems faced by the physicians working in the PHCs.

(6) Information was gathered on the skills of the physicians to manage the PHCs and rapport and relationship with other paramedical staffs.

(7) Information relation to perception and experiences of the subordinating paramedical staff and the community leaders about the role and functioning of the physicians and vice-versa.

(8) Data were also collected regarding the local power-politics and its support and influence on the functioning of the physicians.

(9) In-depth data were collected on the level of understanding and awareness of the physicians about the socio-economic life process of the community and the various developmental programmes, socio-economic problems, exploitation, miseries, major health problems, local health practices, indigenous medical practices etc.

Rapport with the study sample

Since the investigator belongs to Gaya district, he was well conversant with the local set up and it was easy for him to establish contact with district officials and various other institutions.

When the investigator reached Gaya in September 1993, with a letter of introduction from the supervisor to CMO, he failed to meet him inspite of several attempts. CMO was found busy in different towns and meetings. With the instruction of CMO, the steno could provide the detailed information about the rural health infrastructure of Gaya district with the help of other officials at the district level. According to them, it was found out that there are 18 PHCs in which 72 doctors are posted. But after reaching the PHCs, it was discovered that only 63 doctors were posted and other posts were lying vacant. The Investigator got the permission from the CMO office to carry out this study in all the PHCs of Gaya district. He tried to meet the physicians during their office hours and also outside their office hours. He introduced himself as a student of Jawaharlal Nehru University doing research on Problems of Doctors posted in Rural areas of Gaya district. He explained them that without their cooperation and support, this study cannot be conducted successfully. Thereafter, 28 physicians out of 31 available on all the PHCs agreed and came forward to provide all information and data required

for the study.

The investigator also clarifies the purpose of study with the para-medical staff of the PHCs and could manage their rapport to cross-check the data about the physicians. Though initially they were hesitant to talk about their senior officers but making it clear to them that their information would be kept confidential, they provided all information required by the Investigator about the physicians.

Further, the investigator also could establish a very good rapport with local village leaders while staying in the village.

Difficulties faced during the study:

Even though the investigator belonged to Gaya district and was well aware of the situation of the district, he faced lot of problems and difficulties while collecting data. In this qualitative field study, a great deal of support and cooperation you were required from various samples that is the physician, para-medical staff. Community leader and the community. Since recently the Bihar administration has undergone a lot of change, the administration of Gaya district has been affected in the same degree. Initially, the investigator faced lot of difficulties in the CMO. Dr. Ashok Kumar Paswan in Gaya district. Somehow with repeated attempts, the investigator got a permission to carry out the study in PHC from the CMO

office and could get to manage the baseline information regarding the health infrastructure of rural areas of Gaya district.

While the investigator tried to contact the physicians in the PHCs, he was ignored on several pretexts by the physicians and other staff. Without getting disheartened and constant effort he could establish the rapport with them and made it clear to them that the study is an important contribution to improve the Rural Health Service of Gaya district by understanding their problems and expectations. Though initially physicians were hesitant to provide their personal data regarding their experiences and their socio-eco-background realising the importance of this study, they later on fully cooperated and supported the investigator to complete the field work with the required data. The Investigator also faced the difficulties for the demand of money and other benefits from him to provide the data. This problem was tackled by convincing them that being a student to carry out the study he cannot offer such benefit. Some redtapism and corruption in the administration of the different health institutions created a lot of problem to get access to requisite secondary data.

Besides this the investigator faced a lot of difficulties in reaching to the PHCs such as Mohanpur, Gurua Dumaria, Koach, Atri and Paraiya because of lack of adequate communication and transportation facilities.

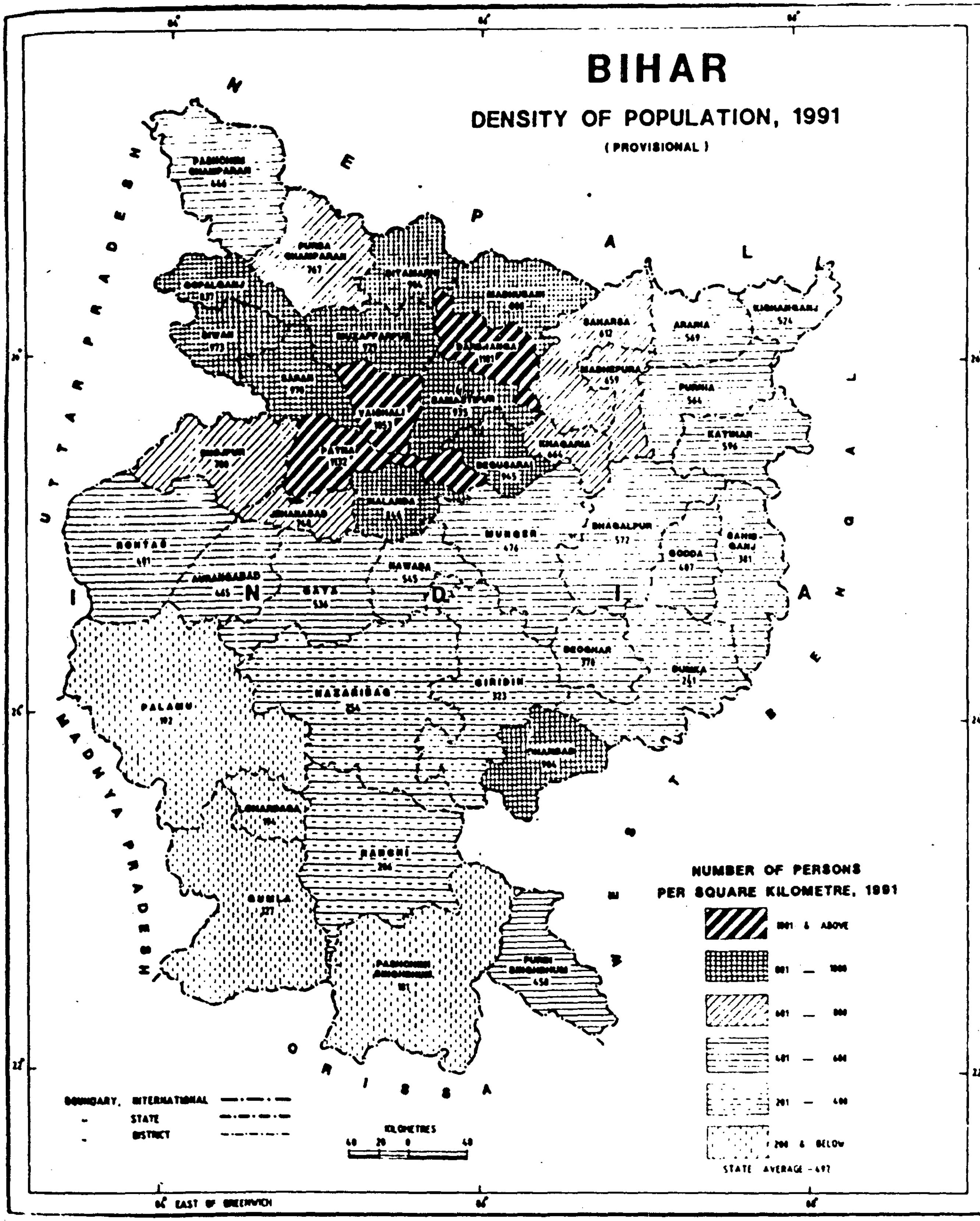
Because of the rampant private practice by the doctors, they are not able to give much time to talk to the investigator in some PHCs.

Limitation and Relevance of the Study

This study was initially designed to develop on the secondary data but because of inadequate literature on physicians working in Rural area, a small fieldable study was designed in Gaya district. But the total sample of physician was available 28 out of 63. Though the sample is small but for a exploratory study to understand the sociology in and sociology of Medical profession working in Rural areas 28 physicians alongwith 36 para medical staff and the community leaders as provided adequate qualitative and quantitative data. This exploratory micro study would help us for further designing a proper study with a larger sample to study the multi-dimension problem associated with the Medical Profession working in inaccessible rural areas. The data which have been generated in this study will add to the existing body of knowledge available in the sociology of medical profession.

CHAPTER III

PRESENTATION OF DATA



BIHAR
DENSITY OF POPULATION, 1991
(PROVISIONAL)
NEPAL
UTTAR PRADESH
MADHYA PRADESH
WEST BENGAL
ORISSA
INDIA
PASCHIMI CHAMPARAN
PURBA CHAMPARAN
SITAMARHI
MADHUBANI
GOPALGANJ
SIWAN
SARAN
MUZAFFARPUR
DARBHANGA
VAISHALI
SAMASTIPUR
PATNA
BHOJPUR
JEHANABAD
NALANDA
BEGUSARAI
KHAGARIA
SAHARSA
MADHEPURA
ARARIA
KISHANGANJ
PURNIA
KATIHAR
ROHTAS
AURANGABAD
GAYA
NAWADA
MUNGER
BHAGALPUR
GODDA
SAHIBGANJ
DEOGHAR
DUMKA
GIRIDIH
HAZARIBAG
PALAMU
DHANBAD
LOHARDAGA
RANCHI
GUMLA
PASCHIMI SINGHBHUM
PURBI SINGHBHUM
NUMBER OF PERSONS
PER SQUARE KILOMETRE, 1991
STATE AVERAGE - 497
BOUNDARY, INTERNATIONAL
STATE
DISTRICT
KILOMETRES
EAST OF GREENWICH

CHAPTER 3

BIHAR AT A GLANCE

The population of Bihar on 1st March 91 was 86,338,853 as against 843,930,861 of the country. Bihar with 10.23% of the country's population is the second most populous state in the country.

According to 1991 census there are 50 districts in the state. The name and population of districts is given below :

S.No.	Districts	Population
1.	Araria	1,611,145
2.	Aurangabad	1,537,946
3.	Begusarae	1,813,214
4.	Bhagalpur	3,198,471
5.	Bhojpur	2,867,318
6.	Darbhanga	2,509,083
7.	Deoghar	918,323
8.	Dhanbad	2,709,170
9.	Dumka	1,497,266
10.	East Champaran	3,042,303
11.	East Singhbhum	1,617,170
12.	Gaya	2,665,217
13.	Giridih	2,224,006
14.	Godda	858,678
15.	Gopalganj	1,701,365
16.	Gumla	1,153,557
17.	Hazaribagh	2,838,836
18.	Jehanabad	1,173,071
19.	Katihar	1,821,590
20.	Khagaria	986,731

Table Contd..

Table Contd....

S.No.	Districts	Population
21.	Kishanganj	986,672
22.	Lohardagga	288,585
23.	Madhepura	1,178,060
24.	Madhubani	2,828,640
25.	Munger	3,055,135
26.	Muzafferpur	2,946,601
27.	Nalanda	2,003,313
28.	Nawada	1,358,433
29.	Palamu	2,451,048
30.	Patna	3,623,225
31.	Purnea	1,876,287
32.	Ranchi	2,205,034
33.	Rohtas	2,890,165
34.	Saharsa	2,514,751
35.	Sahebganj	1,297,391
36.	Samastipur	2,715,297
37.	Saran (Chapra)	2,562,930
38.	Siwan	2,159,346
39.	Sitamarhi	2,388,822
40.	Supaul	6,018,805
41.	Vaishali	2,144,252
42.	West Champaran	2,330,610
43.	West Singhbhum	1,789,796
44.	Chatra	4,062,672
45.	Bokaro	14,047,870
46.	Buxar	9,016,886
47.	Babhua	7,091,710
48.	Banka	10,038,674
49.	Jamui	8,62,589
50.	Lohardagga	288,585

According to 1991 census, there were 591 Community Development Block and 271 towns in the state. The number of cities has grown up to 16. The literacy rate of state is considerably low (38.54%) compared to the All India average of 52.11%.

Population of Bihar = 86,338,853

Males = 45,147,280

Females = 1,191,513.

ST - 7.66 (India = 8.08) SC - 14.55 (India = 16.58)

Decimal population growth (1981-91) =

Absolute = 16,424,119

Percentage = 23.49

Percentage of country's population = 10.23%

Density of Population = 497/Sq.Km.

Sex Ratio = 912 Females per Thousand Male

Literacy Rate Total = 38.54%

Males = 52.63

Females = 23.10

Per Capita Income = Rs.2122/-

CBR = 30.5

CDR = 9.8

Natural Insurance

(CBR-CDR) = 20.7

IMR = 690

Male life expectancy at birth = 54.9

Female life expectancy at birth = 52.3

Now it constitute the area of 1,73,877 Sq.Km. It is bounded on North by Nepal, on east by West Bengal, on west by Uttar Pradesh and Madhya Pradesh and South by Orissa. Bihar has number of river, the most important in Ganga. Others are Sone, Poonpoon, Falgu, Karmanasa, Durgawati, Damodar, Subarnarekha, Baraker, Koel, Koshi, Gandak, etc. Principle foodgrains crops are paddy, wheat, maize and pulses. Main cash crops are sugarcane, potato, tobacco, oilseeds, onion, chillies, jute and mesta. Forests cover about 29 lakh hectre which is almost 17% of the geographical area. Bihar is renowned for its rich mineral resources, viz., coal, mica, copper, ore, uranium, limestone, china clay, fire clay, bauxite kyanite, etc. This state has pioneer producers of important industries minerals such as coal, mica, bauxite, iron-ore, copper ore, uranium ore, iron and pyrite. It is the sole producer of cooking coal, pyrites and uranium. In the core sector, Bihar has steel plants at Bokaro and Jamshedpur. Sponge iron project at Chandil, Copper Complex at Ghatsila. coal mining industries, heavy engineering and forging plant at Ranchi, Caustic Soda Plant at Garhwa, Fertilizers at Sindri, Oilrefinery at Barauni and alloy steels at Patratu and Adityapur. Important places of tourists are Patna, Rajgir, Nalanda, Gaya, Bodhgaya, Pawapuri, Sasaran, Vaishali, Hazaribagh, Ranchi, Vikramsila, Manes, Bhimbandh, Topcharichi, Deoghar, Jamshedpur.

The whole Bihar is divided into three natural division i.e. (1) North-Ganga Plain (2) The South Ganga Plain (3) The South Bihar (Chotanagpur) Plateau.

Socio-Economic Profile :

The whole of Bihar is of course backward and increasingly impoverished. But North Bihar and Chhotanagpur beame more poor and underdeveloped than the remaining part of the Southern Bank of Ganga. The northern gangetic plain remained at it were frozen in time except for demographic growth and intensification of exploitative system of extraction of the agrarian surplus. In north Bihar, there was a petrochemicals came up near Barauni in the 1960s. The land of this region is very fertile and agricultural quiet productivity. But there is the tremendous population pressure is one of the world's most densely populated areas, the repaciousness of exploiters arrayed in a complex hierarchy and the vagaries of nature itself-river shifting course, floods and drought have kept the area backward and most of its people in exereeciating poverty. The grass is not greener on the other side of the river but South Bihar is certainly better-off in relative terms while Chotanagpur continued being exploited for its mineral and forest wealth. North Bihar remained industrially backward with few urban centres. Given this mixture of immense minerals resources in Chhotanagpur a fabulously fertile but over populated and urban developed agrarian terrain in the north and

developing capitalist peasantry and ever expanding bureaucracy in the South Gangetic Plains, Bihar desperately need to have its three geographical regions connected by road and rail networks.

The amount of land per capita here is much less than half of the national average. Per capita income as per estimates of 1986-87 is Rs.1,082 against the national average of Rs.2,975, 57.49% of the population of Bihar is below poverty line. The share of rural population to the total population is 87.63% . The percentage of men workers to total population is 20.68%, of marginal workers to total population is 2.67% and of non-workers to total workers is 67.55% .

With this regional imbalances, Bihar has a clearly dualistic economy. The plain are essentially agricultural whereas the plateau has mining, manufacture and forestry. And the only economic links between the two is one of the exploitation through revenue gatherings. It has been claimed that 75% revenue of Bihar are extracted from Jharkhand. Even at cursory look at the major revenue sources of the state - sales tax, excise, electricity duty, royalties on minerals. Proceeds from sales of forest produce etc. indicates that the major sources of revenue are located in Chhotanagpur i.e. Jharkhand. This economic dualism in state is matched by cultural and social dualism centuries of the interaction between tribals and other have not been able to create an integrated civilization.

Caste composition of Bihar is diversified. In some region and in some particular area or village is dominated by particular caste. Presently central Bihar is suffered from caste war. Poverty, illiteracy casteism, corruption are the features of Bihar today criminalisation of politics is increasing along with Madhya Pradesh, Rajasthan & Uttar Pradesh. So a nomenelature has been developed i.e. "BIMARU". These days its a very backward state of India.

Economically, this state is ideally suited for agriculture. It has 115 lakh hectares cultivated land out of a total of 174 lakh hectares. Presently only 85 lakh hectares of land are being cultivated. The principle foodgrains crops are rice, wheat, maize and pulses. Main cash crops are sugarcane, oilseeds , tobacco, jute and potato. Forest cover about 19% of the total area. Bihar has a number of rivers. Ganga is most important among them 40% of total mineral available in Bihar. Despite all these things, Bihar still suffering from poverty, illiteracy and so on.

The development of an a-historical cultural tradition is integrally linked to the evolution of crude rusticity as the major feature of feudalism from below. In this situation of social stagnation the main regulating mechanizm was not force but hegemony and the manifestation of the process of cultural hegemony was caste. And caste became the expression of both domination and subordination, of

socially legitimized coercion as well as of social conflict. Among many backward regions in the country. What distinguishes Bihar's own particular brand of backwardness is its ability to sustain stagnation. The result in the intensification of the process of degeneration in the state to spectacular limit.

The economic dualism of Bihar is matched by cultural and social dualism. Centuries of interaction between the tribals and others have not been able to create an integrated civilization. The mainstream population has adopted and internalized many aspects of tribal life, but the 'tribal' still remains 'the other', the internal enemy whose existence allows for a certain social consolidation among the rest.

Regarding the Health Services of Bihar it is evident that because of the backward socio-economic conditions lot of communicable diseases are still in epidemic form, communicable diseases like Kala-Ajar has been concentrated in the alluvial plains of the Ganga and Brahmaputra as far as Assam, Vaishali. Darbhanga, Samastipur, Purnea, Madhubani and Kutihar are effected by the Kala-Ajar.

The state of Bihar has witnessed tremendous progress during the post-independence era in the provision of health service to the people. The broad objective of the health programmes been included in the five-year-plans of the state has been to provide preventive as well as curative

measures to the rural masses by establishing health centres in the Community Development Blocks of the state. The major scheme taken up by the state government during this period were programmes of eradication of malaria, small-pox and cholera those of leprosy control. As many as 582 health centres in Stage I and II blocks started functioning by 1964. In addition to these centres, 70 blocks were selected for the integrated programmes to be launched with the assistance of International Organisations like the WHO and UNICEF.

Health Statistics of Bihar

No. of Hospital = 298

No. of Dispensaries = 427

No. of Beds = 38 (on 1000 pop)

Total No. of Nursing Population = 9,029

Midwives = 6,351

Health Visitors = 1,509. ANM = 6273.

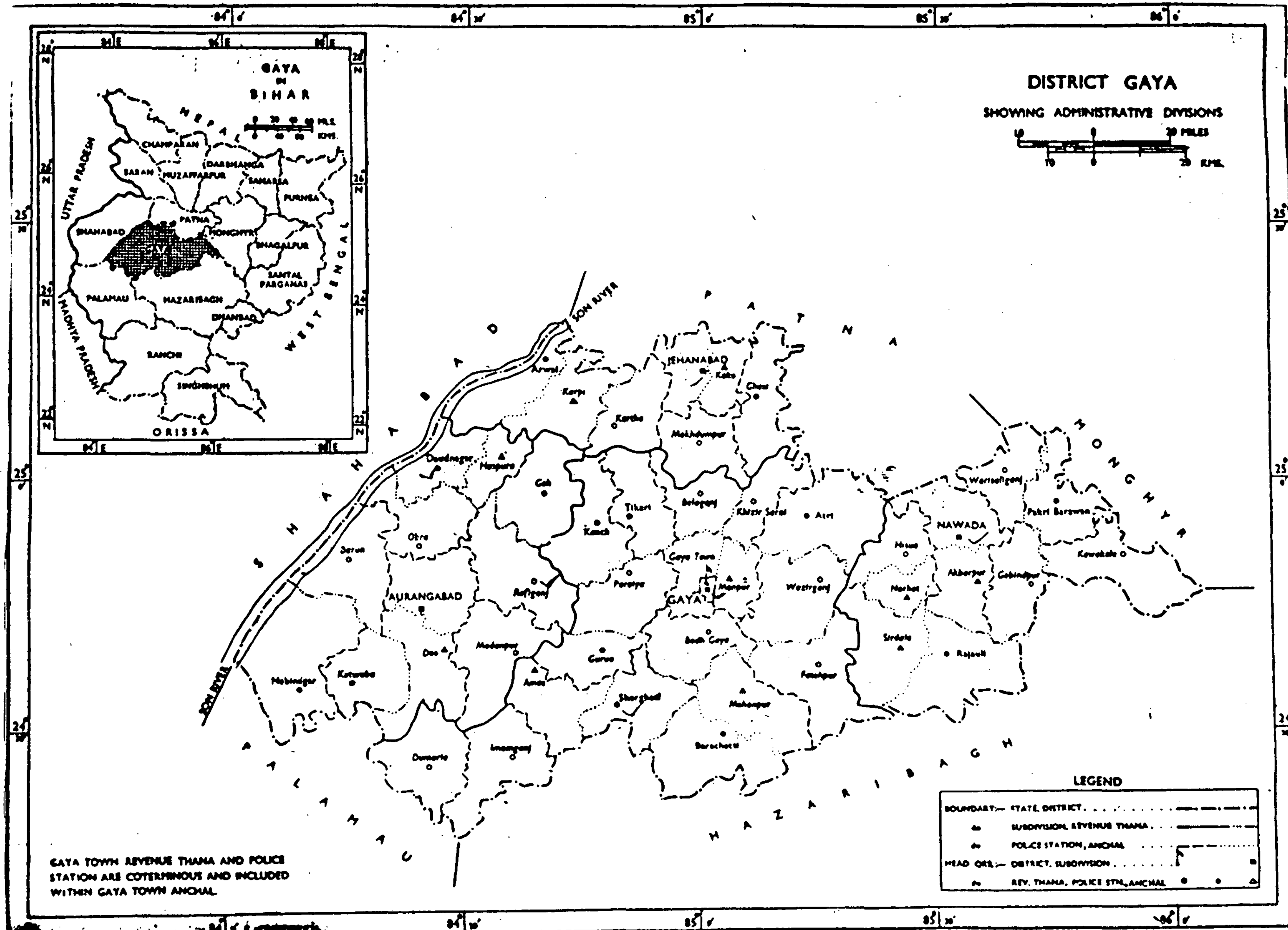
Registered Medical Practitioners = 13,851
(graduates)

3,599 (licentiate)

Total = 23,450

Profile of Gaya District

Ninety-two kilometres south west of Patna (Capital of Bihar). Gaya is situated at the bank of Falgu. It is one of the most important places of pilgrimage for the Hindus, most of whom offer Pindas or funeral cakes here. The Vishnupada, a temple built over the footprint of Vishnu on the solid


DISTRICT GAYA
SHOWING ADMINISTRATIVE DIVISIONS
GAYA IN BIHAR
NEPAL
UTTAR PRADESH
MADHYA PRADESH
WEST BENGAL
ORISSA
CHAMPARAN
SARAN
MUZAFFARPUR
DARBHANGA
SAHARSA
PURNEA
PATNA
SHAHABAD
MONGHYR
BHAGALPUR
SANTAL PARGANAS
PALAMAU
HAZARIBAGH
DHANBAD
RANCHI
SINGHBHUM
SON RIVER
JEHANABAD
NAWADA
AURANGABAD
GAYA
HAZARIBAGH
PALAMAU
SHAHABAD
PATNA
MONGHYR
LEGEND
GAYA TOWN REVENUE THANA AND POLICE STATION ARE COTERMINOUS AND INCLUDED WITHIN GAYA TOWN ANCHAL

rock that crops up on the west bank of the Phalgu river and round which the old town of Gaya proper was built, may be regarded as the centre of this pilgrimage, and is the largest and most important temple in Gaya.

Out of fifty districts Gaya is one of the most important district of Bihar. This district covered the area of 6,545.0 Km^2 out of the total area of Bihar 173, 877 sq.Km.

Total Population of Gaya District = 2,665,217

Male = 1,385,255

Female = 1,279,962

Literate Person = 861,437

Male = 612,732

Female = 248,705

Total Percentage of State Population = 3.09%

Decimal Growth Rate 1981-1991 = 23.94%

Density of Population = 536 Sq/Km

Sex Ratio = 924/1000 male

District consist of 18 Community Development Block. Each Block has one PHC and three health sub-centre and three Family Planning sub-centre which constitute total no. of PHC is 18 and health centres is 54 and again Family Planning sub-centre is 54. There are about 28 hospital in organised sector. Each PHC has 4 medical officer with 15 staff. But 14 posts of doctor is vacant at PHC level. It means some PHC has only three doctors and some has four doctors.

Profile of the Primary Health Centre :

Being situated in Central Bihar and treated as one of the developed district of the State Gaya is still suffering from the problem of poverty and illiteracy. Some of its area is still backward. As a result of inequality among the population Gaya declared MCC (Mao Communist Centre) infected district. The entire district suffered from this problem. Glaco and Cholera is the main communicable disease. Some PHC is disconnected from the road and some are surrounded by river.

Population Distribution Per PHC

S.No	PHC	Total
1.	Manpur	84667
2.	Bela Ganj	136018
3.	Koach	114473
4.	Tikari	168751
5.	Amas	125201
6.	Imam Ganj	132705
7.	Sherghati	145043
8.	Gurua	109547
9.	Barachatti	117628
10.	Mohanpur	122319
11.	Atri	164750
12.	Khizar Sarai	111430
13.	Fatehpur	164058
14.	Wazir Ganj	179202
15.	Paraiya	129366
16.	Bodh Gaya	138610
17.	Dumaria	77710
18.	Nagar Prakhand	413325

Data Collected PHC about Doctors

S.No.	Name of the PHC	Posted Physicians	Available Physicians
1.	Manpur	3	2
2.	Bela Ganj	3	2
3.	Koach	4	2
4.	Tikari	4	1
5.	Amas	5	1
6.	Imam Ganj	3	2
7.	Sherghati	5	5
8.	Gurua	4	2
9.	Barachatti	4	3
10.	Mohanpur	2	1
11.	Atri	3	2
12.	Khizar Sarai	4	1
13.	Fatehpur	4	1
14.	Wazir Ganj	2	2
15.	Paraiya	3	1
16.	Bodh Gaya	4	3
17.	Dumaria	2	0
18.	Nagar Prakhand	4	0

Manpur PHC covered 84,667 thousand population. Distance of this PHC from District hospital is about three KM. The PHC established in Gaya town but deals with Moffussil area . It is easily accessible from district headquarters. PHC has less supply of medicine and lack of operation theatre and other equipments. Daily attendance of the PHC is near about

25. Three doctors instead of four are posted here. Out of three two were present According to incharge of the PHC third doctor was on leave.

Belaganj PHC covers 136018 population. About 20km north of Gaya, this PHC is situated at Patna Gaya Road. Like Manpur PHC three doctors are posted instead of four. Out of three two were present. Third one is doing private practice at Manpur in Gaya. PHC has lack of vehicle, road and also suffers from less supply of medicine and resources.

Koach PHC covers a total population about 144473. About 36 km from Gaya, this PHC is situated in interior area of the district. Although this PHC is connected from district headquarters by road but its maximum village is disconnected from the road. Four Medical Officers are posted here. Out of four only two are present at the PHC including incharge of the PHC. One was on leave and nobody has idea about another one. PHC has lack of basic facilities like residence, vehicle, electricity,. Security etc. There is only one residence for one doctor. For staff there is no residential facility.

Tikari PHC covers the population 1,68,751. About 20km from district headquarters this PHC situated at Gaya-Goh road. PHC is going to be converted into referral hospital's Community Health Centre. PHC has no building of it own vehicles and staff quarter . Four doctors are posted in this PHC. But only one was available. Two were on leave and one

was at Gaya on deputation. Only one was available. As PHC is going to be converted into Referral Hospital but still it is running on Family Planning building.

Amas PHC covers the total Population near about 125201. It is about 50 km from district headquarters. PHC is situation at National Highway (G.T. Road). Although it is situated at National Highway but its area is disconnected from road. PHC has four doctors. Out of four only one was available there. According to the incharge of the PHC, Another three doctors live in other places and do private practice. Among three. One lady doctor who is attached in nursing home at Gaya, while another doctor is doing private practice at Sherghati and Madanpur. PHC has also lack of its own building, vehicle, residence etc. It is situated just beside the National Highway. It also suffers from the problem of less supply of medicine staffs are also not sufficient. Average daily attendance of PHC is 40 during summer and rainy season and 20 in winter.

Dumaria PHC covers the population 77710 and is about 70 Km from District headquarters. Dumaria is the most interior block of the district. Two rivers disconnect it from the mainstream. Investigator took the whole day to reach there after facing some problems .PHC is converted into referral hospital. There are two doctors. But, during the investigations nobody was there. According to available staff of the PHC, incharge medical officer lives at Imam

Ganj and sometimes visits the centre. Another Medical officer is posted here more than four years back lives in Magra and doing private practice. Although this PHC has been declared as CHC but still it suffers from the lack of basic infrastructure like road, residence, electricity,vehicle. Transportation is acute problem . Due to lack of it the people face difficulties to get access to health services. Hardly one or two buses are available to Dumaria in a day from Gaya. One staff of the PHC claimed that he is a compounder, but he had no idea about the doctors of this PHC.

Imamganj PHC covers total population of about 1,32,705. This PHC is situated at the distance of 53 Kms from district head quarter. PHC has three doctors. Incharge M.O. lives at PHC while one M.O. lives at Rani Ganj health sub-centre and another one lives at Kothi health sub-centre. PHC does not have basic facilities like house,vehicle,staff, etc. Daily average attendance of the PHC is near about 50.

Total population of Gurua PHC is 1,09,547. Distance of this PHC from district head quarter is 55km. Four doctors are posted here out of four only two were available at the PHC. One is in Gaya on deputation and another one is practicing at Ranchi. PHC has lack of staff, vehicle, building and house, bed etc. Main diseases are Scabies, leprosy, Gastro enteritis. It is also situated at interior area . It is very difficult to reach here from the district head quarter. Communication and transport is the main

problem to get access to health services to the people. Daily average attendance of the PHC is about 25-30.

Total population of Shergati PHC is 1,45,043. About 30 KM from district head quarter it is situated at national highway (G.T. road) . It has PHC cum Referral hospital. Five doctors are posted here .It has it's own building, vehicle and sufficient house and staff. Commercialisation of medicine is growing. Lots of private practitioners are also here. It is easily accessible from district head quarter and also from other PHC's. That's why physicians from other PHC are concentrated here to do private practice. According to o/c of the PHC there is non-availability of medicine. PHC staffs are satisfactory. Despite availability of all facilities in the PHC electricity is the remain major problem.

Barachatti PHC covers 1,17,628 lakh population . About 48 Km from district head quarter it is situated at national highway (G.T.road) It is very easy to reach this PHC from district head quarter. Four doctors are posted here. Among four only three were available at PHC. Among three only two became ready for talking to researcher. Another one that is lady doctor ignored it. Another one is doing private practice at Aurangabad PHC has full of its basic facilities like vehicle, building, house, Staff etc. But there is lack of electricity. Although this PHC is situated at national highway but its area is disconnected from it. Some area is

covered under forest. After 6 'o' clock in evening everything is closed. The daily average attendance of this PHC IS 30-40.

Mohanpur PHC covers the population of 122 319. About 65 km from district headquarters it is situated in remote area. It is very difficult to reach here from district headquarters. It takes 6-7 hours by bus which frequency is very less. Two doctors are posted at this PHC. Among two only one was available. According to O/C of the PHC, another doctors come when Family Planning camp has been organised. PHC has its own building and staff quarters. But maximum part of the PHC building including staff quarter is occupied by police force due to acute naxal problem. That's why staff did not live here. PHC also suffers from the problem of electricity, vehicle, inadequate medicine, equipment and less number of staff. House facilities of doctors is not here. Daily average attendance of the PHC is 20-25.

Paraiya PHC covers 1,29,366 lakh population. About 6 km from district headquarters it is surrounded by river and disconnected from Gaya. There is no way to reach there except foot or railway line. But there are only two train in a day. Although it is situated at Howrah Delhi Main rail line. Two rivers disconnect it from its surrounding area. Three doctors out of four are posted here. But only one was available at PHC. Another physician is attached at Mathurapur additional PHC. Even O/C of the PHC was not

there. He comes at PHC weakly. He has his own private clinic in market. PHC is functioning in Health sub-centre building. This PHC has lack of building, vehicle, house staff and medicine. Only one house is there for O/C of the PHC. To reach to the PHC by masses is not easy task. Due to lack of transportation system staff do not come regularly and when they come, stay only 1 and 11/2 hour. According to present doctor daily average attendance of PHC is 70.

Atri PHC covers 1.64,750 lakh population. About 33 km from district headquarters this PHC also situated at remote area of district. It is somehow connected by road from Gaya but again it has very less frequency of buses Out of four, three doctors are posted here. Among three two are available. No body has idea about third one. PHC has lack of basic facilities like vehicle, medicine, staff. It has its own building and some staff quarter. Some times there is vehicle but there is no fuel in the vehicle. Daily average attendance of PHC is 20.

Khizarsarai PHC covers 1,11,430 lakh population. About 20 km from district headquarters it is connected by road. Accessible to this PHC is very easy. Four doctors including one lady doctor is posted here. But at PHC only O/C of the PHC was available. According to him, another three come irregularly. Lots of private practitioners are here near the PHC. staff is sufficient but they do not available here. PHC has lack of basic facilities like vehicle, house

electricity, water-supply etc. Daily average attendance of PHC is about 45.

Wazirganj PHC covers the 1,79,202 lakh population. About 25 km from district headquarters it is situated at Gaya-Nowada Road. It is connected from district headquarters by Rail as well as Road. To reach here is very easy task. Only two doctors are posted here. Among two, one live only daytime. As he complained that there is no electricity in night. PHC has lack of vehicle, medicine, staff and their quarters. There is only one house in PHC compound which is damaged. Staff is not satisfactory. There is no water facility in PHC compound. People has less attraction towards it. Daily average attendance of PHC is 15-45.

Fatehpur PHC covers 1,64,058 lakh population. About 52 km from district headquarters this PHC situated at remote area of the district. It is very easy to reach by either train or bus but it is very difficult to go its area. Areas of this PHC is disconnected from mainstream and some area is covered by forest. Four doctors are posted here. But only one was available. Who come frequently at PHC from Bokaro. O/C of the PHC WAS NOT available. Another doctor who is here for a long time also absent from the PHC. He has his own private clinic. PHC has its own building, house and staff quarters. Staffs are sufficient. But its lack of vehicle. Daily average attendance of the PHC IS 30.

Bodhgaya PHC covers 1,38,610 lakh population. About 13

km due south of district headquarters it is one of the most important tourist place of India. The most outstanding monument at Bodhgaya is the Mahabodhi temple. It is easily accessible from district headquarter Auto, Bus, Tanga is main transport from district headquarter to this PHC. Four doctors are posted here. But only one was available despite being a tourist centre. Except vehicle, this PHC avail all the facilities. O/C of this PHC live in Gaya and involved in Private practice. He cam sometimes only for hour-two hours. when researcher consult him for concerned data, he refused to give it and explained. that he know all such type of things. According to him, he has no time. Staff are also not sufficient. 80% is daily average attendance of the PHC.

Nagar Prakhand PHC is covers 413325 lakh population. It is situated in district town. But nobody was here four doctors are posted here.

Socio-Economic Background of Selected Physicians Including their Service Experience

The Physician of Manpur PHC belong to upper caste. His qualification is M.B.B.S. His early income is 60,000 Rs per year. He has experience of this service for last twenty seven years as he joined in this service 9th December 1966. Since he is in this service for last twenty seven years he got the experience about family accommodation and child education during transfer period. He is posted in this PHC for last 1 year (25th February 1993). He is 52 year old. Another physician belong to middle class family and he

belong to schedule caste. His qualification is M.B.B.S. His yearly income is 70,000 Rs per year. He has experience of his service for last three year. It is his first posting. He is posted in this PHC for 3 years (since 24th Jan 1990). He is 32 year old.

The physician of Belaganj PHC belong to Pasi caste and has Middle class background. His qualification is M.B.B.S, M.D., His yearly income is 50,000 1 year. He is 40 years old. But according to him, he is in this service for last 6 years (since march 1988). Since he is in this service for last 6 year he got service experience that patient of rural area come PHC in late position while their diseases become complicated. He is posted in this PHC for last three years. Another physician belong to muslim community and middle layer of society. His qualification is M.B.B.S, D.O., M.S. His yearly income is near about 50000 Rs. 1 year. He is also in this service since March 1988. It is his first posting. In the beginning he was in steady leave. In this PHC he is posted for last 2 and half years. He is 31 years old.

The physician of Koach PHC had middle class background and belong to Kharwaha caste (schedule tribe). His qualification is M.B.B.S His yearly income is near about 50,000/ year. It is his first posting. He has 4 years service experience. He is in this PHC as well as in service since January 1990. He is 36 year old. Another physician of this PHC has also middle class background and belong to

Rajput caste. His educational qualification is M.B.B.S. His yearly income is near about 50,000 1 year. He has 23 years of service experience. Earlier he was in Army Medical Care (1972-77). He is posted in this PHC for last 3 years. He is 49 years old.

The physician of Tikari PHC has middle class b background and belong to Brahmin caste. His educational qualification is M.B.B.S. His yearly income is near about 80,000 1 year. Since he is in this job since January 19991, so he has 3 years service experiences. He is posted here for last 1 and half year. He is 33 years sold.

The physician of Amas PHC has middle class background and belong to Hindu family. His educational qualification is M.B.B.S. His yearly income is near about 70,000 1 year. He has 18 years of service experience. Here he is posted for last 6 months (since July 1993). He is 50 year old.

The physician of Imamganj PHC has middle class background and belong to Barber caste. His educational qualification is M.B.B.S, D.C.O. His yearly income is near about 80,000 1 year. He has twenty one years service experience. Here he is posted for last two years. He is 48 years old. Another physician of this PHC also has middle class background and belong to HIndu community. His educational qualification is M.B.B.S, D.C.H. He has 10 years of his service experience and here he is posted for last 1 and half year. He is an age of 36. His yearly income

is near about 50,000 1 year.

The physician of Gurua PHC has middle class background and belong to Kurmi caste. His educational qualification is M.B.B.S. Yearly income is about 60,000 Rs 1 year. He has eleven years of his service experience. Here he is posted for last two year. His age is near about 40 years. Another physician of this PHC. Another physician of this PHC also has middle class background and belong to Raunia Bania. His educational qualification is M.B.B.S. His yearly income is near about 55000 1 year. He has experience of 4 years of his service. He is posted in this PHC for last 3 years. It is his first posting. He is an age of 32 years.

The physician of Sherghati PHC has middle class background and belong to Kurmi caste his educational qualification is M.B.B.S., D.C.H. His yearly income is near about 85,000 1 year. He has twenty one year of his service experience. He is posted in this PHC for last 3 years. He is an age of 48. Another physician of this PHC belong to middle class muslim family. His educational qualification is M.B.B.S. His yearly income is about 45,000/year. He has 12 years of service experience. He is posted here for last 3 years. He is an age of 50 years. Another physician of same PHC is belong to middle class Bhumihar family. Her qualifications is M.B.B.S, D.G.O. Her yearly income is about 80,000 1 year. As her husband is also posted here as an M.O. This income is combined of both husband and wife. She has 17 years of her service experience and posted in

this PHC for last 2 years. Her age is 44. Another physician of same PHC has also middle class bhumihar background. His educational qualification is M.B.B.S, D.A. His wife is also here as an M.O. His yearly income is near about 80,000 1 year. He has 17 years of service experiences. Here he is posted for last 2 years. He is 46 years old. Another lady physician belonged to middle class Brahmin family. Her educational qualification is M.B.B.S. Her yearly income is near about 70,000 1 year. It is her first posting. She has a service experience of only 3 years. In this PHC she is posted for last 3 years. She is 30 years old. She has not any field experience.

The physician of Barachatti PHC has middle class background and belong to Tanti caste which come Annexure - 1 of the constitution. His educational qualification is M.B.B.S. His yearly income is 92,000 1 year. He has twenty one year service experience. In this PHC he is posted for last three years. He is 51 years old. Another physician of the same PHC is belong to middle class Brahmin family. His educational qualification is M.B.B.S. His yearly income is 80,000 1 year. He has 12 year service experience. Here he is posted for last 1 and half years. He is 33 years old.

The physician of Mohanpur PHC belong to middle class Bhumihar Brahmin. His educational qualification is M.B.B.S. His yearly income is near about 50,000 1 years. He has 18 years service experience. In this PHC he is posted for last

2 and half years. He is 52 years old.

The physician of Paraiya PHC belong to middle class Hindu family. His educational qualification is M.B.B.S. His yearly income is near about 50,000 1 year. It is his first posting. He has only three year of service experience. Here he is posted for last three years. He is 32 years old.

The physician of Atri PHC belong to middle class Bhumihar family. His educational qualification is M.B.B.S. His yearly income is near about 70,000 1 year. He has experience of 18 years of services. He has posted here for last three years. He is 47 years old. Another physician of the same PHC is belong to middle class Rajput family. His educational qualification is M.B.B.S. His yearly income is near about 80,000 1 year. It is his first posting where he posted for last three years. So, he has only 3 years experiences of his service. He is 32 years old.

The physician of Khizarsarai PHC has low class background and belong to Kushwaha family. His educational qualification is M.B.B.S, D.T., M. & H. His yearly income is near about 10,000 1 year. He has experience of eighteen years of his services. Here he is going to be completed two years. He is 43 years old.

The physician of Wazirganj PHC is belong to lower class Bhumihar family. His educational qualification is M.B.B.S. His yearly income is near about 10,000 1 year. He has six years experiences of his services. Here he is posted for

last three years. He is 40 years old. Another physician of the same PHC belong to middle class Muslim family (Momin, Annexure 1 in M.B.C.). His educational qualification is B.Sc., M.B.B.S. His yearly income is about 40,000/year. He has experience of six years of his service. Here he is posted for more than one year. H e is 39 years old.

The physician of Fatehpur PHC has upper class background and belong to Chaurasia family. His educational qualification is M.B.B.S, F.C.G.P., DOMS. His yearly income is near about 95,000/year. He has experience of twelve years of his services. Here he is posted for last two years. But he live in Bokaro and frequently come to the PHC. He is 43 years old.

The physician of Bodhgaya PHC belong to backward class. His educational qualification is M.B.B.S. His yealry income is near about 30,000/year. He has experience of six years of his services. Here he is posted for last three years. He is 38 years old.

Job-Satisfaction, Motivation and Expectations of the Physicians

Table - 4

Motivational Factors of the Physicians to Join Service in Rural Area

Total No.28

Motivational Factors	Number of Doctors	Percentage
To serve Humanity	15	53.57
To gain status prestige & money	9	32.14
Family background (Those who having doctors in his family)	4	14.28

Table - 5

Physicians Expectation from the Services :

Factors	No.of .	Percentage
1. To serve the ailing people	12	42.85
2. To gain name and fame in society and earn money	13	49.28
3. No expectation	2	7.14
4. Other Factors	1	3.57

Table - 6

Physicians Satisfaction from Education & Training as CHP

Total Doctors - 28

Satisfaction from Training	20	71.42%
Not Satisfied from Training	7	25%
No Idea about Training	1	3.57%

Table - 7

Satisfaction of the Physicians By Infrastructural Support Provided to them at the PHC

Infrastructural Support		Number	Percentage
House	Satisfaction	12	42.85
	Dissatisfaction	16	57.14
Transport	Satisfaction	6	21.42
	Dissatisfaction	22	78.57
Staff	Satisfaction	19	67.85
	Dissatisfaction	9	32.14
Pay	Satisfaction	11	39.28
	Dissatisfaction	17	60.71
Leave	Satisfaction	16	57,14
	Dissatisfaction	12	42.85

As far as motivational factors is concerned, out of 28 doctors, only 15 doctors respond about the humanity factors which motivate them to join this profession. It constitute 53.57% doctors while 32.14% respond that due to money and social status they joined this profession. Others 14.28% joined this profession due to fault legacy.

49.28% doctors has expectation of gaining money and social status through this service. Only 42.85% respond that this expectation from this service is to serve the ailing people. While 7.14% have no any expectation from this profession.

Doctors has lack of social science orientation of knowledge. When I asked that whether they are satisfied from training or not as Community health physician. 71.42% doctors responded they are very-very satisfied from the training while only 25% response was about not satisfaction from training. 3.57% was confused about this training and practices.

Rural area has lack of basic infrastructure which effect the accessibility of health services to the people. Only 42.58 doctors satisfied from their house facility while 57.14% dissatisfied from this. 78.57% dissatisfied from transport, provided to them. Only 21.42 satisfied from it. 67.85% responded about the non-availability of staff at PHC while 32.14% responded about the availability of staff. 39.28 is satisfied from their pay while 60.71% dissatisfied from their pay. 57.14% satisfied from leave granted to them whenever 42.85% dissatisfied from it.

The physician of Manpur is very satisfied from the service but disappointed about the facilities like house, salary provided by Government. His main motive was to do social service and his expectation from the service to gan personal status in society. Another physicians of same PHC is satisfied from his job. His family has no doctors, that's why it become motivational factors to him to choose this profession. His expectation from this services is to serve

the people.

The physician of Belaganj PHC is not satisfied from his job due to lack of basic facilities like vehicle, schools, electricity etc. His brother popularity of service was motivated him to join this profession. His expectation from the services is to gain name and fame, money in the society. Another physician of same PHC joined this profession with the motivation to serve the people. he has expectation of proper adjustment in society according to profession. But he and his family is not satisfied from the job due to posting is not according to qualification. Pay is also not satisfactory.

The physician of Koach PHC is satisfied from job. To earn money and do social service is motivational factor for him to choose this profession. He has expectation from service is to earn the money and do the social service. Another physician of the same PHC is satisfied with job but his family is not satisfied with his posting due to lack of house facilities. For him to earn the money is main motivation factor to choose this profession. His expectation from the service is to serve the people and earn the money.

The physician of Tikari PHC is not satisfied with job and posting because of poor job facilities and stabilisation and lack of educational facilities to the children. Humanity is the motivational factor for him to choose this profession. To do social service is his expectation from

this services.

The physician of Amas PHC is not satisfied with his job due to lack of facilities and salary is not according to the labour. His family is also dissatisfied because of lack of telephone facilities, house and problems of children education. His father was also a physician who become motivational factor for him. To gain money is his expectation from this service.

The physician of Imamganj PHC is not satisfied with job because being a medical personnel with specialization, society do not provide much recognition. Family is also not satisfied with posting due to lack of basic facilities, educational facility to children, security etc. Family background and service to needy people was the motivational factor for him to join this service. To gain fame in society is his expectation from this service. Another physician of same PHC is satisfied with his job. Only this family is not satisfied with his posting due to lack of basic facilities in rural area. To do social service is motivational factor to him to choose this profession. To provide better treatment to the people is his expectation from this services.

The physician of Gurua PHC is satisfied with his job because patient feel relief after his treatment. His family is not satisfied with his posting due to lack of house, electricity and better educational institution. He has will

serve countryside people as motivational factor. His expectation from this service is to give medical service to poor people. Another physician of same PHC is very satisfied with his job because it gives him relief and pleasure. Only family is not satisfied about his posting because of lack of transport system, electricity, educational institution, recreational facilities etc. To gain status in society is his motivational factor to join this service. His expectation from this service to become specialization n paedatrics health problems?

The physician of Sherghati PHC is not satisfied from job because of less benefit in this service. His motivational factor was to serve the people. he has not any expectation of the same PHC is very satisfied from the service vice due to good salary, residence and transport. His family is also satisfied with his posting at Sherghati. Service to the patient is motivational factor for him to join this profession. His expectation from service is to serve the ailing and downtrodden people. Another physician of same PHC is not satisfied with his job due irregular payment and lack of basic facilities. Her family is not satisfied with her posting because posting is very far from home and there is lack of good educational institution for children. Her motivational factor to choose this service was to serve the people. Her expectation from the service is to gain name and fame in society. Another physician of same PHC is also not satisfied from job because of irregular payment

of salary and lack of basic facilities. His family is not satisfied with his posting due to posting is far from home and problem of children education. To do social service and gaining money was the motivational factors to him to join this service. His expectation from this service is to gain name and fame in society. Another physician of same PHC is not satisfied with her job due to lack of proper environment and irregular payment. Her motivational factor to choose this service was to do social service. She has not any expectation from this service.

The physician of Barachatti PHC is satisfied from his job and posting. His family is also satisfied from his posting. To serve the people was motivational factor for him to choose this service. His expectation from this service is to serve the people. Another physician of the same PHC is not satisfied with job due to non-co-operation attitude of staff mainly colleague, driver and compounder. His family is not satisfied with his posting due to problem of the water supply, lack of electricity, lack of better education institution for children. To earn the money was the motivational factor for him to choose this service. His expectation from this service noting only hand to mouth at Barachatti.

The physician of Mohanpur PHC is not satisfied with his job due to lack of working facilities, housing facilities and communication facilities. His family is also not satisfied wit his posting because they are at the verge of

destruction, children education become a problem due to lack of proper guidence and guardianship. So frustration prevails in life. With the motivation of high ambitions he choose this service with the expectation of serving the suffering humanity after facing so many problems.

The physician of Paraiya PHC is satisfied with his job. His family is not satisfied with his posting due to lack of electricity, house, good school of child education etc. To serve the poor sector community was his motivational factor. His expectation from this service is to provide cheapest, widely acceptable health service to the community.

The physician of Atri PHC is very satisfied with his job. His family is not satisfied with his posting due to lack of electricity and problem for children education. Guidence of gurdian is motivate him to join this service. His expectation from this service is to serve the people. Another physician of same PHC is very satisfied with his job and his family is also satisfied with his posting. To serve the people was the motivational factor for him to choose this service. His expectation from service is to get better facilities to the employ's in hospital.

The physician of Khizarsarai PHC is satisfied with his job because of there is no facilities of pathological investigation, no X-ray, no blood bank facility and anaestheties are not posted at PHC. His family is not satisfied with his posting due to lack of facilities of

children education and poor residential quarter. Medical aid to rural population was his main motivation to join this service. His expectation from this service is to get better service in future.

The physician of Wazirganj PHC is not satisfied with job but he is doing his job to serve the community. His family is not satisfied with his posting because there is no proper school for children and lack of electricity. To provide facilities and respect to the doctors in society become his motivational factor to choose this service. His expectation from this services that he will serve the society and gain something in return of it. He will never mind. Another physician of the same PHC is very much satisfied with is job. But his family is not satisfied with his posting due to his posting is very far from home. Motivational factors for him to choose this service is 1. fair and honest earning, 2. without much stress services to human being. 3. development of scientific approach to human problem. His expectation from this service is to gain due respect, satisfactory money and love from society.

The physician of Fatehpur PHC is not satisfied with job and posting. His family is also not satisfied with posting. The cause of dissatisfaction is transfer at distance places which disturbed the child education and settled life. His motivational factor to choose this service was to serve the ailing persons. His expectation from the service is that

this profession will make him able to serve the needful patient.

The physician of Bodhgaya is very much satisfied with his job and posting due to availability of all facilities at PHC. His family is also very much satisfied with his posting in this PHC. His father was doctor. This thing become motivational factor for him to join this profession. His expectation from this service is that this service is better way to serve the poor peoples.

Status, Prestige and Power of the Physicians

The physicians of Manpur explained that because of easy medical facility and free service to the people we got good prestige in society. People respect us and this service also determined the status in society. Due to good behaviour, other physicians of same PHC got good respect from the people.

The physicians of Belaganj PHC got good respect from the community. Community regarded him as prestigious person of society because of healing power. Another physician of same PHC is alienated from status and prestige since he is only a doctor, community do not give maximum respect. He has no any administrative power.

The physician of Koach PHC enjoys prestigious position in society because of his good services. Community gave him good respect. Another physician of same PHC also enjoy

prestigious position in low socio-economic group due to this group have few money and they get free services from Doctor Babu. Community give good respect to him.

The physicians of Tikari PHC has not any stakes in society. People regard him as general mass due he cannot fulfill their expectation properly because PHC is suffering lots of problem of basic facilities. The private practitioners get more recognition than government physicians from the community. Those who have administrative power enjoy good power and prestige among community. Physician has lack of it.

The physician of Amas PHC do not get good respect from community. As a leader of community health team he is found the situation like 'Survival of the fittest' in the field. The paramedical staff mainly compounder enjoy good status because he live regularly in PHC. People called him 'HAKIM'.

The physician of Imamganj PHC get good respect from the community due to good behaviour and good professional experiences. But lack of medical awareness among community the turn up toward physician is less. Another physician of the same PHC also enjoy good prestige among community due to good treatment and proper investigation. He deputed at Raniganj health sub-centre which is situated in interior area where he is only physician who practice governmental health centre as well as private.

The physician of Gurua PHC get good respect from the

community specially low socio-eco group because he provide free service to them. But he cannot earn more money due to legacy of government service. His other colleagues and private practitioners earn more money and enjoy prestigious position in society. Another physician of same PHC also get good respect from the community due to good services.

The physician of Sherghati PHC explained that community don't give respect to him. Only poor section of society give some respect. Physician is growing here it minimise the status and charm of this profession. The another physician of the same PHC get maximum respect from the community. He enjoy good status among poor and middle section of society. Another physician of the same PHC get some respect from the community. Large section of society don't respect her due to they want illegal work from physicians. Poor section of society give good respect to her. Another physician of the same PHC get maximum respect by some people due to good behaviour but some disregard him due to not to do favourable work. Maximum respect is given by poor section of the community. Another physician of the same PHC get maximum respect by very few people. Others do not regard her due to she don't like to do illegal work because she has power to mould the report etc.

The physician of Barachatti PHC get maximum respect from the community due to his popularity among the people. Another physician of the same PHC also get maximum respect

from middle section of community because they know middle section of community because they know the importance of government doctor. But according to him, power and prestige of the physicians depend on his caste background in this PHC.

The physician of Mohanpur PHC get maximum respect from community. But, according to him, this things is deteriorating day by day because physician could not provide such facilities which community desired. Community thinks that physician are selling gas, medicine and other equipment of the PHC. But physician serves suffering humanity, every section of society give maximum respect. This PHC is suffering from naxalite problem. Physician has not power to tackle him, that why physician have to pay something to this group for security of life.

The physician of Paraiya PHC get respect from community due to community realise the importance of community health services. But, according to him, due to growing of commercialisation, community never accept physician as an important person in their day to day life.

The physician of Atri PHC get maximum respect due to his well behaviour towards community. Another physician of the same PHC get respect from community because he serve the people which they are in distress. Due to this reason, people of all section of the community give prestigious position to him.

The physician of Khizarsarai PHC get maximum respect from 95% of the community due to they feel that physicians are second God while 5% show their prominence. Some perform their rude behaviour in front of physicians. Social backward and educational class give good respect and regarded important person in their day to day life.

The physician of Wazirganj PHC get no respect from community. He has to listen disenchantment of the people. This thing happened due to physicians are not treating upto people's expectation because there is lack of life-saving and good quality of drugs. Community think that physicians are the roots of all prevailing evils in health department but it is not so. Another physician of the same PHC get maximum respect from poor people of community which rich people takes this services as purchased matter.

The physician of Fatehpur PHC get good respect from the people due to his good services. Poor people give maximum respect to local physicians because they have no money to go distant places and bear the physicians fees and medicine costs.

The physician of Bodhgaya PHC get good respect from the community because he has sincerity with his job and also available every time in PHC.

ENCOUNTER AND EXPERIENCES OF PHYSICIANS

The physician of Manpur encounter with the transportation problem and illiteracy to understand the health problem. proper sanitation is main social problem among community. Another physicians encounter with poverty and illiteracy problem of the masses. Sometimes people demand money in place of medicine. Less supply of medicine at PHC is major problem.

The physicians of Belaganj PHC encounter with the problem of poverty, illiteracy, ignorance, temptation etc. Communication problem miserable condition of road, lack of electricity, less supply of medicine, effects the health status of people. Sometime, people demand more medicine than its needs. The Another physicians of the same PHC have some experience. Patient come very late when problem become very complicated.

The physician of the Koach PHC encounter with the problem of communication and transportation, security etc. There is less supply of medicine. Community expectation about medicine in PHC is more and supply is less. The another Physician of the same PHC encounters community problem about less supply of medicine, although supply of medicine is adequate. Transportation is more acute problem here.

The physician of the Tikari PHC encounters with the

problem of not bringing the patient in the PHC. People want physicians at their home. He has experience of lack of infrastructure of the hospital and shortage of medicine at PHC and problem faced by him at PHC is family establishment and educational facility of children.

The physicians of the Amas PHC encounter with the problem of communication with Community and less supply of medicine.

The physician of Imamganj PHC encounter with the problem of less awareness about medical and para medical services among community. After seeing the immunization and family planning thing, community fled away. He has also the experience of innocence among community. The another Physician of the same PHC encounter with the problem of transportation and more demand of medicine by the community.

The physician of the Gurua PHC encounter with the problem of less bed facilities at PHC and less medical education among community. Community don't want to take vaccination. And Community also get less quality of drug due to absence of 'supply of high quality drugs'. Another physician of the same PHC has experience of communication gap, transport and illiteracy problem among community. He cannot give sufficient amount of drugs due to less supply of medicine.

The physician of Sherghati PHC encounter with the problem of non-cooperation and bad education of the

community. The another physician of the same PHC encounters with the problem of education and lack of money among the community. They are also not got proper medicine due to less supply of it. Another physician of the same PHC has experience of political disturbances at PHC for writing injury report in favour of some concerned party. Community also demand mere medicine from her. There is less supply of medicine. The fourth physician of the same PHC encounters with the problem of demand of the capsules and tonic by the people in every diseases. Besides it, he also felt the political disturbances for writing injury report at PHC. There is less supply of medicine. Communication gap is also there. Another physician of the same PHC encounters with the problem of ignorance with the community.

The physician of Barachatti encounters with the problem of transportation and illiteracy among community. Community want physician should be available at his home in night. Less supply of medicine is acute problem for physician at PHC. Another physician of the same PHC has experience that people don't turn up towards PHC and claimed about non-availability of medicine at PHC. Those who turn up demand Tonic and fancy medicines. The problem of casteism at PHC has been faced by physicians.

The physician of Mohanpur PHC encounter with the problem of lack of working facilities. Proper and effective planning, inadequate medicine, instructions at PHC level.

He has bad experience of lack of appropriate medicine during emergency. He has also encountered with the problem of child education, allowance and working facilities. That is why frustration prevails in his life.

The physician of Paraiya PHC encountered with the problem of unacceptance of national programme like immunization and family planning by the community. People are very non-cooperative with physicians.

The physician of Atri PHC encounter with the problem of absence of basic facilities at PHC. He is also encountered with the problem of ignorance and transportation. Another physician of the same PHC has experience of lack of communication essential medicines and basic infrastructure at PHC.

The physician of Khizersarai PHC encounter with the problem of anger of villagers due to less supply of medicine, absence of vehicle to transfer the patient from local unit to referral unit and poor condition of health sub-centre.

The physician of Wazirganj PHC encounter the problem of non-cooperation attitude of the villagers. Physicians show his less interest to visit the sub-centre due to lack of vehicle and also not getting travelling. and other allowances. Another physician of the same PHC encounter the problem of demand of medicines by community. Inadequate communication to reach timely to spot at PHC level.

The physician of the Fatehpur PHC encounter with the problem of less supply of medicine by the authority, problem of communication, electricity, good water supply, superstition illiteracy at PHC.

The physician of Bodhgaya PHC encounter with the problem of irregular supply of medicine, less awareness about medical facilities and poor community and lack of vehicle etc.

MANAGEMENT SKILL OF PHYSICIANS

The physicians of Manpur get sufficient support from the staff. Lack of basic infrastructure, staff quarters sometimes it is very difficult to cope with them. To fulfill the basic infrastructure of PHC for its better functioning, one can get good rapport with para-medical staff and people, according to another physicians of same PHC. Both physicians satisfied with their training.

The physician of Belaganj PHC told that PHC management done by regular visit of health sub-centre and regular visiting the area. Another physicians explained that by doing day and night duty, they impressed the community as well as paramedical staff. As far as possible, help has been taken from local MLA, M.P., Mukhiya and police. According to both physicians, training is appropriate to manage the rapport with the para-medical staff.

The physician of Koach PHC explained that he got appropriate training to manage the PHC works and establish the good rapport with para-medical staff. Another physician of the same PHC also got regular training to manage the PHC.

The physician of Tikari PHC tried to manage the salary and allowances at time for their staff due to late payment of salary effects the work. The late payment of salary is usual phenomena. He got appropriate training to manage the PHC. But, training of the physician should be more community oriented.

The physician of the Amas PHC explained that paramedical staff has lack of basic facilities. Physician of the PHC has to do all administrational and curative. His training should be more community oriented. As a leader of Community Health Team, physicians are found the situation like survival of the fittest in the field. Physicians have to develop the skill of 'tackling' the problems.

The Physician of the Imamganj PHC got appropriate training to manage the PHC work. But the para-medical staff should be provided better training and sufficient funds should be given to PHC to make its works. Physician of the PHC is lowest unit of administration but its roots lies on community. That is why his view should be taken in planning and policy formulation. Another physician of the same PHC got good training but training is entirely different from what he is practicing in the field.

The physician of Gurua PHC got good training to manage the PHC. To some extent, he got the cooperation of para-medical staff. Another physician of the same PHC is satisfied with his training to manage the PHC work. Besides it, they are not doing extra work to manage the PHC and establish the rapport with paramedical staff.

The physician of Sherghati PHC is not developed any skill to manage the PHC and establish the rapport with paramedical staff. He is not satisfied with staff's work. Another physician of the same PHC have always developed the skill of rehabilitative, preventive and health education to the community. Another physician of the same PHC does not satisfied with her training due to its theoretical venture. According to her training should be more community oriented and practical. She tried to develop good cooperative relations with staff. For it, PHC also should be well-equipped. Another physician of the same PHC is very dissatisfied with his training due to its theoretical nature. It should be more community oriented and practical. Another physician of the same PHC has not worried about its management and its staff.

The physician of Barachatti has got good training and explained that PHC should be managed properly when basic facilities will be there. Another physician of the same PHC explained that there is non-cooperation attitude between physician and para-medical staff. Although he tried to

establish rapport with some of them after visiting the health sub-centre regularly.

The physician of Mohanpur PHC has got training time to time to manage the PHC work and implementation of other national programmes. Good rapport with para-medical would be established when they got basic facilities at PHC.

The physician of Paraiya PHC is not satisfied with training due to it does not develop the skill of community health physician. It is more curative oriented. The para-medical staff do not get any facilities in this PHC. So the work of PHC always suffers.

The physician of Atri PHC got appropriate training to manage the PHC. But he fails to establish good relation with staff due to non-availability of basic facilities to them. Another physician of the same PHC explained that training is sufficient for performing the functions at PHC in rural areas.

The physician of the Khizersarai PHC is not satisfied with present training for development of the skill to manage the PHC in rural area. According to him, in rural area, special problems are present. To solve it separate cadre should be started. Good rapport with para-medical staff would be established when each and every physician will get separate Assistant clerk and basic facilities at PHC level will be provided to them.

The physicians of the Wazirganj PHC is not satisfied with his training because in this advanced age of medicine, new medicines are invented but physicians are not properly informed from their association. And Physicians and paramedical staff should get. training according to advancement of age. Good rapport between the two will be maintained by non-interference attitude of high authority in PHC matters. Another physician of the same PHC is satisfied with his training due to training is provided for the curative and preventive treatment which is helpful for management of the PHC affairs.

The physician of Fatehpur got his training property. According to him, his work is team work, his staff are cooperative and training is appropriate.

The physician of Bodhgaya PHC is not satisfied with training because it is not rural or community oriented. Paramedical staff got good facilities here. Physician rapport with them is quite good but they are inadequate.

PERCEPTION AND EXPERIENCE OF PARA-MEDICAL STAFF AND THE COMMUNITY LEADER ABOUT THE PHYSICIANS

Table 8

Community's Response Towards PHC Services

No.of PHC = 18	No.of Respondent	Percentage
Good Response	16	57.14
Not Good Response	10	35.71
Not Response at all	1	3.57
No Idea about Response	1	3.57

Regarding community behaviour towards doctors, 71.42% got well behaviour from the community while 28.57% responded about not good behaviour of the community.

As far as community response towards PHC concerned. 57.14% doctors responded that there is good response from the community towards PHC while 35.71% explained that there is good response from the community towards PHC. Whenever 3.57% doctors responded that they have no idea about community while 3.57% again responded that comity response towards PHC is neglect.

There is good relationship between physicians and staff in Manpur. The PHC is located in urban area. Local people and leader is hardly worried about it. According to para-medical staff O/C of the PHC is more able to do work than other physicians.

Community of the Belaganj PHC has not good attitude towards doctors. They prefer to go to Gaya District Hospital and other private practitioners. Main complaint from community side is that there is non-availability of medicine. They have to buy the medicine from market. Sometimes local physicians visited village with nurse and compounder. No staff was available at PHC.

The compounder of Koach PHC explained that there is good relationship between physician and staff. Some physicians and staff do not live here due to non-

availability of housing facility. According to him, PHC work is suffering due to presence of private practitioners in the town. They hijack and misguide the patient. One respondent of the same PHC but belonging to village Iguna told that physician of the PHC is very helpful and good but physicians who is posted in his village is very corrupt. Health sub-centre of Iguna is functioning in private house. One physician is posted there, but he never lived there. Sometimes, he comes but only confined to the house owner. Medicine and other equipment is occupied by house-owner. Villagers are alienated from this service. Once villagers complained to the higher authority, but everything went in favour of concerned house owner because he is very rich and influential person.

One of the staff of Tikari PHC informed that PHC is suffering from lot of internal conflict. Almost everybody involved in it because it is a question of survival in Tikari. There is supply of medicine, but medicine is distributed among physicians and paramedical staff from where it goes to medical shops for selling.

The Malaria officer of Amas PHC informed that no physicians live at PHC. The o/c comes weekly from Patna. One is O/C and physician of this PHC live at Madanpur and doing private practice there. Comes only for drawing the salary. Even staff including him (Malaria Officer) come at 12 O' clock and went away at 3.30 p.m. Respondent of the same PHC informed that present o/c is good bust he was

worried about physician involvement in local party politics. According to him earlier one physician named Mr. Santosh Singh was posted here. He involved petty politics with some muscleman of his own caste and started harassing other people. Masses went against him and he has been compulsorily transferred. Although he was influential, sometimes O/C is here, otherwise no physician is here. During emergency case, people meet Hakim i.e. Compounder.

The one paramedical staff of Gurua PHC informed that one physician of this PHC is doing private practice at Ranchi and comes monthly for drawing his salary. Another physician has lack of medical knowledge. He failed to tackle small problems, like cough, fever etc. The O/C has good knowledge about treatment. After all there is good relation between physician and paramedical staff.

The one paramedical staff of Sherghati PHC informed that staff are engaged in hijacking the patient from PHC to private clinic of concerned physician. Except two, three physicians has their own private clinic. Staff are dividing according to group of physicians. There is no very cooperative relation among physicians and paramedical staffs lot of petty politics going on at PHC. Only Family Planning work has been done at PHC level.

The community leader of Barachatti PHC informed that PHC has one lady physician who is just like a Mitti Ka Lotha. She is not useful for ladies problems. She hardly

met at PHC. PHC is always vacant. One physician lives at Aurangabad. Another has his own clinic at market Prabhari of the PHC has been seen sometime at PHC. People are going here for minor problem. Patient also went to PHC physician according to the caste. There is conflict among physicians and paramedical staff. Nobody is cooperative.

One of the respondent of Mohanpur PHC informed that there is only one physician in this PHC, but he is laborious. People like to go to him for Family Planning Camp has been done regularly. Physicians sympathetic towards community.

The paramedical staff of Paraiya PHC informed that physicians are very soft corner towards their staff. Physician as well as staff has to face lots of problems like house, road, electricity, school for children here. So, only one physician live here. Other physician comes either family planning camp day or duty day. Some staff also come from outside. Because of transportation problem, they come around 12 O' clock and leave around 2 p.m. Sometimes some staff creates problem for taking leave and doing less work. One respondent of the same PHC claimed that physician never give medicine to the patient. They neither give medicine nor give cost of medicine. No medicine available at this PHC. One physician lives in Bullock and when people consulted him, he takes his own fees.

The one of respondent of Atri PHC informed that people have no idea about functioning process of PHC. They would like to go private clinic because local hospital is always closed. Even for family planning. They went to private clinic. He claimed about O/C of the PHC that this physician posted here for a long time. Now he opened a medical shop and always available in his own private clinic.

The one community leader of Wazirganj PHC informed that the functions of PHC is only confined to the Family Planning Programme. Nobody is available at PHC. The ideal physician at present is Dr. Sagir Ahmed. He is influential person. He is posted somewhere else but serving the people of Wazir Ganj. His minimum fees is around Rs. 40 for normal case and Rs. 100 - 800 for delivery case. When he comes at home, he takes extra charges. He is here for a long time. Another physician of PHC has private clinic at market but he is new and have less experience. Even Dr. Sagir is not good because some cases become more complicated in his clinic be he has lots of network in this area though he draws the patient. The one of the para-medical staff of this PHC informed that all physicians of this PHC is good. But he is not happy with the facilities provided to him. There is no staff quarters and no other facilities.

RELATIONSHIP BETWEEN LOCAL POWER POLITICS AND PHYSICIANS

Both physician of Manpur PHC know the local Mukhiya. MLA but according to them, they never concerned for any

problem.

The physician of Belaganj PHC claimed that problem is created by local political persons when quarrel between two groups occurred in the area. Some local leader want injury report in favour of particular concerned group. Some political lumpen creates the problem of posting before time. But all things has been overcome by the negotiation with local MLA and present sitting M.P. Another physician of the same PHC pointed out that such political elements create problem rather than solve it.

The physician of the Amas PHC explained that local sitting MLA Mr. Ramadhar Singh belongs to Indian People's Front group. He always creates problem rather than solving it. He expects something from posted physicians. One night he called the physician in market where he stayed and shown his supremacy over the physician without any matter. In this situation, it is very difficult to stay or live at PHC.

The physician of Imamganj informed that local politicians are not worried about the physician, PHC and patient. They only consulted when some tender come for the construction of sub-centre building or repair of PHC. Otherwise they never to see the problem of PHC. Physician and patient, where fund will come all local politicians will come.

The physician of Gurua PHC informed that there is not

good relation between physician and sitting M.P. Mr. Rajesh Kumar. In the absence of O/C physician, the sitting M.P. came at the PHC and demand money. The staff and other physician refused to do so. He become angry and threatened that he will destroy the building of the PHC and all of its employs also. He always wants to use physician and paramedical staff for their personal benefit.

The physician of Sherghati PHC pointed out that local leader are creating lots of problem. They always forced the physician to do illegal work like write injury report in favour of the person who belong to his group, give fake certificate to their supporters etc. Another physician of the same PHC has same problem from local leaders.

The physician of Barachatti PHC pointed out that local leader give very negative impact on PHC. They are backing those physicians who are belonging to their caste. They always forced the PHC physicians to mould the injury according to his group convenient.

The physician of Mohanpur PHC pointed out that local MLA assumed to raise the our problem but that process only assurance us, all the quarters built for health department are in capture of police department, medical employs are wandering, no staff living in campus, medical work is team work. Only physician cannot do anything. This PHC cannot impart any emergency service due to this cause but nobody take notice and problem is as picture. It is not only the

case of this PHC. The political condition of Bihar is the only cause of run-down condition of not only Health Department but every walk of life in Bihar. Politicians have poisoned the social as well as institutional health of Bihar who teach to hate man to man on the basis of caste, creed, communities. So many evils parted by the politicians for his personal gains.

The physician of Khizersarai PHC pointed out that local leaders like Mukhiya, Sarpanch are helpful, whenever physician consulted regarding emerging problem in camp, they solved it. Local MLA is also more worried about PHC problem and as far as possible, he tried to solve or raise it at his own level.

The one physician of Wazirganj PHC explained that local leaders are hardly worried about PHC problem. When he faces his own personal problem (like posting and others) local MLA solves it after receive some amount of money.

The physician of Fatehpur PHC explained that local leader has very important role to organising the camp of Family Planning. Even they solve the personal problem also. One of the physician of this PHC got transferred to somewhere else. He established his good private practice here. Now he doesn't want to go there. For him local leader went to Patna to bring the stay order.

The physician of Bodh Gaya PHC identified himself as Personal Physician of M.P. Rajesh Kumar.

AWARENESS OF THE PHYSICIANS ABOUT THE COMMUNITY

The physicians of Manpur has less knowledge about community. He provides health education during his field visit. Another physician has some knowledge about community since he is here for the last three years. Main communicable diseases are Diarrhea, vomiting, Measles, Chicken pox etc.

The physicians of Belaganj PHC has some awareness regarding community like their illiteracy, way of life, poverty. According to both of the physicians, low socio-eco-status community has more health problems. Community is very backward and main occupation is agriculture. Coax, T.B., Leprosy, Malaria, Gastro-enteritis etc., are main communicable diseases.

The physicians of Koach PHC has knowledge that poor section of community has more health problem. Main social problem among community are illiteracy and poverty. Economically, area of this PHC is poor. Yadav and Bhumihar are the dominant caste of this PHC. Leprosy and G.I.T. (seasonal) are main communicable diseases.

According to the physician of Tikari PHC, poverty and population density is the main social problem among community people belonging to low socio-eco-status has more health problem. Main occupation of the community is agriculture. Economically, area is backward, Diarrhea,

Vomiting, Measles, T.B., are the main diseases of this area.

The physician of Amas PHC pointed out that underdevelopment is main social problem among community. Low socio-eco-group of the people has more health problems, because of unhygienic way of giving. Main communicable diseases are diarrhea, vomiting and leprosy. There are two leprosy centres in this PHC. Immunization and Family Planning is major health programme of this PHC.

The Physicians of Imamganj PHC pointed out that people belonging to lower socio-eco-group has more health problem due to poverty. Kaccha Kuana is existing in whole area that caused for gastro enteritis. Main communicable diseases are T.B. and Gastroenteritis. T.B. is prevailing lower section of community while gastro is prevailing all sections of the community. Poverty is the main social problem of this area. Main health programme is going on i.e. Health education, Family Planning, MCH and Prevention of communicable diseases. Main emphasis on creating health awareness and Family Planning. Another physician of the same PHC has lack of knowledge about community. He give data that poverty and illiteracy is major social problem of this area. Family Planning and immunization has been done by physician as a part of Government policy.

The physician of Gurua PHC explained that poverty and illiteracy is the main social problem. Poor section of society has more health problems. Main occupation is

agriculture. School health, MCH, immunization is the major programme run in this PHC. Scabs, leprosy, gastroenteritis is the most prevalent diseases. Another physician of the same PHC pointed out that main problem among community is drinking water, poor sanitation and unhygienic condition of people. Customs of Devil spirit and beliefs in quacks treatment among community is still prevailing. Harijan and muslim of this PHC has more Health problem.

The physician of Sherghati PHC held the view that main problem among the community is bad education. Poor section of society has more health problem. Immunization, Family Planning and prevention of diseases are major health programmes going on in this PHC. Another physician of the same PHC has knowledge that poverty and illiteracy is main social problem among community. Economically area of this PHC is backward. Cholera, Measles, diphtheria, Polio, T.B., malnutrition among poor is the main disease of this phc. another physician of the same phc explained that there is communication gap between physician and community. Poverty and illiteracy is the main social problem among community. Another physician of the same PHC informed that there is major health programme carry on that is family planning, MCH, Immunization. People has problem illiteracy. They are also non-cooperative in field. Another physician of the same PHC explained that ignorance is the main social problem among community. Due to ignorance and poverty, poor section of the society has more health problem. She has no much

more knowledge about community.

The physician of the Barachatti PHC said that poverty and illiteracy is the main social problem. It is poor or backward area, Yadav and Harijan are dominant castes. Diarrhea vomiting and skin diseases are major health problems. People belonging to socio-eco group has more health problems. Major health programmes like Environmental sanitation, school health, MCH and immunization launched in this PHC. People living standard is very low in this PHC. Another physician of the same PHC pointed out that major social problem is casteism. Two health programme are carried out by this PHC i.e. Family Planning and Immunization. Economically, the area of this PHC is backward.

The physician of Mohanpur PHC pointed out that poverty and inequality is main social problem. Rajput and Yadav are main dominant caste. Agriculture is the main occupation of the people. Another social problem prevails among community is 1. Quake system; 2. Orthodox belief; 3. economical rundown condition. People belonging to low income group has more health problem. Main communicable diseases of this PHC is water born diseases like diarrhea, leprosy, T.B. and polio. MCH, Immunization, School Health, Family Planning programme is carried out by this PHC.

The physicians of Paraiya PHC pointed out that this PHC belongs to very backward area. Yadav and Harijan are the

dominant caste. Illiteracy and poverty is the main social problem of this PHC. Pregnant women and children upto 5 - 6 years of age has more health problem. The Health programmes like Family Planning and Immunization is carried out by this PHC. Main communicable diseases are Diarrhea, T.B., and Skin diseases. The living standard of the people is very low.

The physician of Atri PHC pointed out that agriculture is the main occupation of the people. Yadav, Bhumihar, Rajput is dominant castes of this area. Poverty, illiteracy, lack of health awareness among people is the main social problem. Lower class of people have more health problems. The problem like Gala is prevailing in all sections due to damaged well. The major health programme launched by this PHC is immunization, family planning and control of epidemics. Main communicable diseases of this PHC are diarrhea, chicken pox, and Gastroenteritis. T.B., and leprosy is also prevailing one of the village i.e. Pathar Katti under this PHC. Another physician of the same PHC explained that lack of education and money is main social problems among community. Low socio-eco-group is suffering from more health problem.

The physician of Khizersarai PHC pointed out it is also backward area. Yadav and Bhumihar are dominant caste. Main occupation of the people is agriculture. Lack of health education, poor hygiene condition and malnutrition is the main social problem among community. Low strata people has

more health problems. Major health programmes like MCH, family welfare, Immunization and epidemic control carried out by this PHC. Main communicable diseases of this PHC are well disinefection and diarrhea vomiting.

The physician of Wazirganj PHC pointed out that main social problem among community is lack of education and social customs. The poor economic strata and unplanned family has more health problems. Main occupation of the people is agriculture. Economically it is also poor area. Malnutrition is prevailing among children. Family Planning and immunization is major health ;programmes carried out by this PHC. Main communicable diseases of this area is Diarrhea, vomiting and T.B., Another physician of the same PHC pointed out that superstitions, dogmatism, sectarianism and unscientific approach to different diseases are main social problems among community. Poor people have more health problems due to poverty and unhygienic conditions. MCH, school health, Immunization and Environmental sanitation is the major health programme carried out by this PHC.

The physician of Fatehpur PHC pointed out that ignorance, illiteracy and superstitions is the main social problem among community. Poor people due to low economic condition have more health problems. Main occupation of the people is agriculture. Immunization and Family Planning are two major health programmes carried out by this PHC. Main

communicable diseases of this PHC are diarrhea, vomiting and gastroenteritis.

The physician of Bodhgaya PHC pointed out that poverty is the main social problem among community. Poor people have more health problems, because they do not know about medical facilities rendered by the government, MCH and Family Planning Programme is carried out by this PHC. Diarrhea, vomiting is main communicable diseases of this PHC.

CHAPTER IV

DISCUSSIONS AND ANALYSIS

CHAPTER IV

DISCUSSION AND ANALYSIS

Health is a function, not only of medical care, but of the overall integrated development of society- cultural, economic educational, social and political. The health status of a society is intimately related to its value system, its philosophical and cultural traditions, and its social, economic and political organisation. Each of these aspects has a deep influence on health, which in turn influences all these aspects. Hence is not possible to raise the health status and quality of life of a people unless such efforts are integrated with the wider effort to bring about the overall transformation of a society. The objectives of integrated development are to eliminate poverty and inequality, to spread education and to enable the poor and underprivileged to assert themselves. Health development can be integrated with the larger programme of overall development in such a manner that the two because mutually self-supporting. such co-ordinated and simultaneous efforts to improve and change the entire social order generally yield better results because they are interdependent and mutually supporting (ICSSR, ICMR 1981). Good health and good society go together. This is possible only when supportive services such as nutrition and improvements in the environment and in education reach a higher level Bihar state, bring one of the `BIMARU' states

of India is yet to achieve such a environment.

The health problems and practices of any community are profoundly influenced by an interplay of social, economic and political factors. The common belief customs and practices connected with death and disease have been found to be intimately related to the treatment of disease. It is necessary to take a holistic view of all the cultural dimensions of the health of a community and to relate such a holistic perspective to the overall culture of the concerned community.

The conceptualisation and measurement of health and the quality of life gaining increasing attention in the health services. Since the concept of health has different meanings in different social systems, the health problems of a community can not be studied in isolation from the social network of the concerned community.

Widespread poverty, illiteracy and malnutrition, lack of personal hygiene, absence of safe drinking water, sanitary living conditions and health education, maternal and child health services and ineffective coverage by national health and nutritional services have been delineated in several studies as the possible contributing factors for the dismal health condition prevailing in state of Bihar.

Since health manpower constitutes perhaps the most crucial element in the health system infrastructure, the

training and development of health personnel must ensure that they are not appropriately skilled technically and managerially, but are also socially motivated and responsible. The relevance of this training and development to the real health needs of people in community has to be ensured. The concept and practice of health promotion and protection, prevention of diseases and disabilities and education of the public on health matters must form the core of health care.

From the last decade on two, the concept of developing health manpower in close correlation and co-ordination with the needs of health services has been with us. In reality, however, there are still gaps in this correlation, though some valiant attempts have been made in restructuring the curricula of medical education in recent years. Coordination among universities, medical colleges and other institutions of higher learning, on the one hand and the health services and organization on the other, remains weak. There is a mismatch in the numbers and categories of many categories of health manpower, which has led occasionally to the paradoxical situation of surplus admist shortage.

The World Health Organization adopted a resolution in 1977, on Health for all by the year 2000. This can be attained by providing Primary Health Care in all the countries. By Primary Health Care we mean essential health care made universally available to all, at their place of

living, at a cost which the community and country can affor with their active participation. This should be part of th total health care system of the country and in co-ordinatio with other sectors. For achieving these objectives ther should be sufficient number of Primary Health Centres in th rural areas and properly trained medical and paramedica staff in the PHC.

At present we propose to have one PHC for 30,00(population in plain area and 20,000 population in hilly an(tribal areas. One PHC is now suppose to cover 50 to 6(villages. One subcentre for every 5,000 population. For this kind of rural health infrastructure we must have proper health manpower. The medical officers should be properly trained. They should be aware of the problems of 80% of the population living in rural areas. This can be done by bringing about changes in medical education. The objectives of medical education should be clearly defined. These can be derived from the tasks that the medical officers have to perform in the Primary Health Centres. Many studies have been undertaken in this connection. The main health problems of rural areas are non-availability of medical care, unsafe water and provision of disposal of refuse and extreta, poor housing, and nutrition, communicable diseases, no trained person to conduct deliveries ignorance, poverty and illiteracy. The main tasks of the medical officers in PHCs is providing health services according to the felt needs of the community. This can be achieved only by team approach with the help of extension education, Sanitary Inspector,

Lady Health Visitor, ANMS and multipurpose workers and peoples participation. The physician is the managerial physician to develop the team to achieve above goal.

Since health manpower constitutes perhaps the most crucial element in the health system infrastructure. The training and development of health personnel must ensure that they are not only appropriately skilled technically and managerially, but are also socially motivated and responsible. The relevance of their training and development to the real health needs of people in communities has to be ensured. The concept and practice of health promotion and protection, prevention of diseases and disabilities, and the education of the public on health matters must form the core of health care.

Primary health care is conceptually the central function of the health system, where the first level of contact between the people and the system is the starting point and the other levels of the system provide referral, technical and supervisory support. Thus it is clear that there is a need for a leadership role here to move from concept to practice. In operational terms, this calls for health leadership to organise and effectively maintain the complex network of national health system in which all levels are structurally and functionally in harmony.

For the last decade or two, the concept of developing power in close correlation and coordination with f health services has been with us. In reality,

however, there are still gaps in this correlation, though some valiant attempts have been made in restructuring the curricula of medical education in recent years. Coordination among universities, medical colleges and other institutions of higher learning, on the one hand, and the health services and organisations, on the other, remains weak. There is a mismatch in the numbers and categories of many categories of health manpower, which has led occasionally to the paradoxical situation of surplus amidst shortages. A team approach to health personnel mix to deliver integrated health service is also widely accepted. Its implementation, however, remains patchy. Experimental field studies and ad hoc efforts may not be adequate.

The medical profession over the ages acquired two major role in society. The first the more ancient one of ministering to the sick and sorry. of providing medication, treatment and relief for illness and injury.

The second role evolved later and gradually. It was that of a mentor to the society on health matters. It carried out this role by organising and instituting measures for the prevention of sickness. By advising and suggesting measures for the promotion of health. The second role less dramatic and less spectacular has not the glamour associated with the provision of relief from suffering. But it is perhaps more substantive and important as it promotes and preserves the weal, welfare and integrity of the society. The two roles however are not exclusive but

mutually supplementary.

The critical task launching a system of primary health care is a development of man power resources necessary to make the care available to the people. Health Personnel will also have to undertake the additional responsibility of taking social initiatives to promote interesectoral action in health. Thus, the task of manpower development for implementing primary health care is threefold: to produce personnel who have acquired competence in offering people-oriented technologies', to produce Personnel of the different categories required in adequate number to ensure that services are available to all sections, and, perhaps most important, to so orientate health personnel as to reduce, if not totally eliminate, the gap between the culture of the health provides and that of the people.

A significant feature of the approach of primary health care is that despite all the emphasis on promotion of community self-reliance and deprofessionalisation of health services through extensive use of health auxiliaries, it does not advocate the progressive elimination of health professionals. Indeed, to extend the coverage, primary health care will create still greater demands for health professionals than the old system. However, this approach does call for a basic change in the attitude of health professionals; they must be responsive to community needs.

This has well recognised at the Alma-Ata Conference. It is the forces of democratisation which would create

political conditions which will actively nurture socially sensitive professionals, who, in turn will initiate the basic changes envisaged in the concept of primary health care. Obviously, in any country democratization does not come overnight. It comes about as a result of active efforts of the deprived section to wrest their democratic rights, struggle for primary health care has rightly been called a struggle for democratisation among the masses.

There are four areas where health professionals play a major role: administration of the health services; providing services to deal with the more complicated health problems; providing education and training to all categories of health workers; and planning, evaluation and research to support the health services. These four components offer a convenient way of classifying the numerous varieties of professionals who are involved in a health service system.

Numerous studies, including a comprehensive study of 19 villages by Banerji reveal that people all over the country are actively seeking the help of the government health system but are totally frustrated with its response. No one could be satisfied with having to walk to a PHC 5 km away and discover that the doctor is never there or, if he/she is there, the only thing that the patients are given is a piece of paper (the prescription). They have to travel to the nearest town to buy the medicine. This disturbing situation is evident from the findings of the ICMR study of PHC

services.

According to 1988 ICMR study on Primary Health Care Services, only 15% of the PHCs in country had the requisite ration of one PHC for a population of 30,000 ad in Uttar Pradesh the PHC had to cater to a population of about 120,000. Only 15 percent of the PHCs had the requisite number of health personnel. The shortage of Lady Health Visitors (LHVs) was acute; while an LHV should supervise four auxiliary nurse midwives, the usually supervised five to nineteen The report added that about 10 percent of PHCs did not have any record of pregnant women, and the majority had no facilities for the routine follow-up of pregnant women with tetanus toxoid. Eleven Percent of the PHCs were administering iron and folic acid to 60 percent of the pregnant women. The majority of PHCs had no facilities for the routine checkup of pregnant women for weight, blood pressure and haemoglobin. None of the PHCs maintained records of births and infant and maternal deaths. Nor were birth weights recorded. All medicines, especially antibiotics, were in short supply. Emergency equipment and life-saving drugs such as oxygen and steroids were not available in a large number of PHCs.

Studies on the utilisation of services as reported by the population centre, Operation Research Group, Population Research Centre, etc. reveal the following:

Only 6.3% of deliveries are institutional while the

remaining are conducted at home. Only 18% of births are attended to by trained birth attendants (28%) in rural areas and 12.3% in rural areas).

Over 90% of the population is aware of the PHC or sub-centre as a source of medicare and health services, but only 31% reported using the formal health care system. Of this group only 40% used the informal health care system as well, which consists of private practitioners, Vaids, Hakims and other traditional system of care.

Of the users of formal government health system, 9 to 23% expressed their dissatisfaction with the services. Attempts were made to elicit from the non-users the reasons for non-use: 65% said the services were poor, 55% said they could not travel the distance, and 16% complained of the non-availability of medicines.

The doctor not being available was not a major cause but the non-availability of the ANM at the sub-centre definitely was a major cause for 26% of the women not seeking MCH facilities at the centre.

Long waiting hours and unsympathetic attitude of the staff were other reasons. The role of the health worker was seen as important in the utilisation of services. Much depends on the behaviour of the staff and the frequency of visits of the health workers to the village. 86% of the respondents reported that the health workers visited their village. The ANM was reported to visit once a week (55%),

the LHW once a month (55.4%) the doctor once in three months (13%). The CHV's visits were even rarer, once in four months, as reported by 16% of the respondents.

The present study it has been brought out clearly t the doctors posted in the PHCs of Gaya district were fo to be not much well acquainted with the life process of villagers as well as their health problems. The to strength of the doctor posted in the PHCs the majority w either on leave or away from the PHC for their Priv Practice. This demonstrates clearly that the physici were not providing leadership to the sub-ordinate staff meet the day to day needs of the patient. Most of t patients were of the opinion that the absence of doctors the PHC creates problem for them for not getting adequa advice in the time of need. The sub-ordinate staff in m of the PHC informed the investigator that because of absen of doctor and non-availability of other facilities such drugs, and other essential materials to meet the needs the patient. They feel absolutely helpless and in so occasion it was also found out that the subordinate sta make money through clandestine private practice.

The majority physician present in the PHC held that d to lack of proper infrastructure like house, road, drugs a subordinate staff in the PHC creates unfavourable conditio to stay in the PHC. Inspite of their complaints to t higher authority these problems have not been solve

Because of their better socio-economic background most of the physicians prefer to stay in the urban areas rather than staying PHC itself. But physicians who are from the background of schedule caste, schedule tribe and other backward caste have tried to adjust themselves with the life-process of villagers in the PHCs.

Regarding job satisfaction, motivation, expectation of the physicians very few physicians are satisfied in their job but majority of them found to not satisfied because of the poor socio-economic life process of the villagers and lack of suitable infrastructure. Most of the young doctors who have joined recently in the PHCs and their services they were found to be more motivated than the older group and reason of strong motivation is this to achieve better status and prestige among the villagers.

The physicians who were found to be present in the PHC have high professional hope and to achieve this they found to be closer to the dominant power-structure of the village and also closer to the local politicians. And most of the physicians fairly were not happy for their posting in the PHC for the inconvenient life which they lead.

Majority of the physicians informed the investigator that they were well aware about status, prestige and power. And to place them in the eyes of the dominant villagers, they tried to satisfied the needs in terms of making available their private practice. In the absence of drugs

and other facilities through their private practice they tried to meet the needs of the villagers and make money for improve their status and power in the profession. Most of the time it was observed that the majority physicians use their professional power to influence and extract undue advantage from the resourceful villagers as well as the poorer section who were not able to pay them. It has been found out in most of the PHC the subordinate staff who were not having the high opinion about the doctors since they were not getting proper leadership and supervision to serve the people.

Regarding encounter and experience of the physicians, most of the PHCs, the physicians were of the opinion that most of the PHCs in Gaya district are not properly located, not properly communicated with adequate transport, less supply of medicine and inadequate staff. This provided a bad experience to them and they have encounter lot of difficulties in meeting the needs of their day to day role as a physician in PHC. Because of the illiteracy, severe poverty, and dearth of socio-economic infrastructure of the villagers, the physicians had felt helpless at the time of villagers suffering from various serious health problem. Not able to meet the day to day demands of the community, the physicians had felt bad and miserable and had developed an attitude to turn a deaf ear to the demands of the community. But most of occasions it has been observed that physicians have tried to satisfy the needs of the local leaders for

their own advantage and vested interest like getting transferred from PHCs or to achieve better status in the profession.

Regarding the management skill of the physicians, in the most of the PHCs para-medical staff felt that the physicians were neither well informed about their work nor provides better supervision at the time of need in the field level. The para-medical staff informed the investigator most of the time, they provide good support to the physicians. The paramedical staff feels that since physicians are generally from urban background and they required their help, because the lack of knowledge about village and villagers. For example the physician of Sherghati PHC was over-dependent of paramedical staff since she was a lady doctor and were not having adequate infrastructure in the PHC. The very often the para medical staff of the PHC have complained to the investigator that physicians were busy most of time in private practice and this has created lots of corruption in the PHCs and powerful local para- medical staff took advantage over the physicians and use them for their own vested interest.

The most of the PHCs villagers were having the complaints not getting medicine and as developed apathy and dissatisfaction from the role of the physicians further they were having the complaint that the only work which PHC does is that the family planning programme. The majority of the poorer community in the village felt that they were deprived

from the service of the doctor because of private practice and their higher fees which they demand. The day to day felt needs of their at the time of their suffering, they have preferred to go to the local private practitioners (COAX) who provides then chief medicine and are available all the time in village. Further they felt that the urban educated physicians posted in the PHC were not made for them rather for the richer people.

About the understanding of the community, life of the villagers and their problem, the majority physicians posted in the PHC were found to be ignorant less informed and were not interested to know. Most of the time it has been found out by the investigatior that posted in the PHC blamed the villagers for their superstitious ideas, ignorance and lack of knowledge about modern medicine. This attitude of the physician had created the distance between community and them and because of this attitude the physicians did not get the community support in their various programmes which PHC offers.

The findings of this study about role of physicians in the ruler health services were very close to the findings of other scholars and studies conducted by other institutions discussed earlier. Since the health profession gets the leadership from the physicians who have not been moulded and trained as per the requirement of the PHC in the rural setting. Because of the inadequate training, lack of motivation, lack of understanding about the rural life, the

physicians of the Gaya district do not contribute towards the development of better rural health services in Gaya district. It can be deduced that despite the various problems in rural areas the physicians getting posted to the PHCs have not tried nor they have played a meaningful role as a community physician in making the rural health services in the Gaya district.

From the sociological angle it can be finally analysed that the problem has been rooted right from the initial stage of medical education as well as providing community orientation through their field training. Further if a meaningful interdisciplinary study is carried out keeping in view multidimensional problem of the medical profession, then one can arrive at a conclusion to identify the gaps between community and the physician at primary, secondary and tersory care in India. For this a wider study with a larger sample can provide scope for analytical data.

CHAPTER V

SUMMARY AND CONCLUSIONS

CHAPTER V

Summary and Conclusions

The Medical Profession has been responsible to deliver the primary, secondary, and tersory health package in all over the country. The physicians continued to receive their training in large well-equipped hospital where teaching in heavily loaded with study of disease and individual care mainly within the tersory institution i.e. hospital. Recently question has been raised why the physicians are not interested for the rural areas. Even the physicians are not interested to get posted into PHCs and CHCs. This has resulted serious problems for rural health services in India. With the declaration of Health for All by 2000 A.D. lots of emphasis has been given to primary health care. To build up the primary health care in the backward states a lot of the physicians role, status, motivation and their leadership required for the rural health services which has been neglected so far. Lot of social science studies have been carried out on the Medical Profession by several eminent scholars. Since Bihar is one of the most backward states in India, no study has been carried to analyse the role and response of physicians posted in the rural areas. This study was conceptualize and designed to study the response of the physicians posted in rural area of Gaya district in order to generate and explore data as a part of analysis of sociology of Medical Profession.

In the present study attempt was made to list out all

the PHCs in Gaya district and to include all the physicians posted in all those Primary Health Centres. In that process all the 18th PHCs of Gaya district and 28 physicians present out of 63 posted were included in this study. With the help of socio-anthropological technique such as observation, interview, (formal and informal) focus group interview, case studies, the data were collected.

The main findings of this study is that the most of the physicians does not stay in the PHC due to lack of proper infrastructure like house, road, drugs and subordinate staffs. Most of them are not satisfied from the job because of the poor socio-economic life process of the community and lack of suitable infrastructure. The physicians have high professional hope and to achieve this they are very close to the dominant power-structure of the village and also closer to the local politicians. Most of the PHC in Gaya district are not properly located, not properly communicated with adequate transport, less supply of medicine and inadequate staff. Due to lack of community oriented medical education, there is a big gap between villagers and physicians. Illiteracy, severe poverty and dearth of socio-economic infrastructure of the villagers effects health status of the people of Gaya district. Because of the inadequate training, lack of motivation, lack of understanding about the rural life, the physician of this district do not contribute towards the improvement of the health status of the community.

REFERENCES

References

1. Banerjee, D. (1985). Health & Family Planning Services in India - An Epidemiological socio-cultural and political perspective - Lok Prakash, N. Delhi.

2. Government of India (1946). Health Survey and Development Commitee (Bhore Committee), Vol. I - IV (Delhi: Manager of Publications).

3. Pandey, Rajendra (1988): 'Whither Professionalism' in Lab., S.K.(ed): 'Readings in the Sociology of Profession, GPH, New Delhi p.p.-71

4. Parsons, T., (1838): "The Professions and Social Structgure", Social Forces, Vol.17, May, 1939, pp. 457 - 467.

5. Etzioni, A. (1969): The Semi Profession and their orgfanisation. The Free Press, New York, pp. XII - XIII.

6. Bala, Poonam (1991): 'Imperialism and Medicine in Bengal: ' A socio-historical perspective, Sage. New Delhi p.p. - 67.

7. Arnold, D. (1985): 'Medical Priorities and Practice in Nineteenth Century British India', South Asia Research, Vol.5, No.2, p.p. 167-83.

8. Ramasubhan, R (1982): Public Health and Medical Research in India - Their origin under the impact of British Colonial Policy, SAREC Report.

9. Dubey, S.M. (1987): Profession of Medicine in India, S.K. Lal & A. Chandni(ed): Medical Care: Jainsons, N.Delhi, pp.100-101.

10. Gandhi, M.K. (1938): Hind Swaraj, Navjeevan, Ahmedabad.

11. Madan, T.N. (21972): Doctors in North Indian City : Recruitment, Role Perception, and Role performance in Satish Seberwal (ed). Beyond the village : Sociological Explorations, IIAS, Simla, pp.77-110.

12. Madan, T.N. (1980): Doctors and Society, Vikas Publishing House, New Delhi.

13. Oommen, T.K. (1978): Doctors and Nurses : A study in occupational Role structures, MacMillan, Delhi.

14. Taylor, K. (1976): Doctors for the villages', London, Asia.

15. Venkataratnam, R. (1979): 'Medical Sociology in an Indian setting. MacMillan, Madras.

16. Madan, op. cit. (1972)

17. Chandani, Ambika (1985): The Medical Profession: A sociological Exploration, Jainsons, New Delhi.

18. Ramalingaswami, P.(1985) : Social Background of Medical Student.

19. Ramalingaswami, P. ( ): Estimation of Cost of Medical Education.

20. Banerji, D. (1974): 'Medical Alienation in India', "The Hindustan Times, March 13, 1974.

21. Oommen, op. cit. (1978)

22. Chandani, op. cit. 1985.

23. Rao, K.N. (1966), 'Medicine and Society, IJME, 5, 158.

24. Nayla, Madhu. (1988): Medical Sociology, Printwell, India.

25. Abidi, Nigar Fatima (1993): Women Physicians: A Study of Role and Role conflict, Manak pub. pvt. Ltd., Delhi.

26. Banerji, D. (1981): Poverty, Class and health culture in India, Vol.I, Prachi Prakashan, New Delhi.

27. Jeffery, R. (1978): "Allopathic Medicine in India: A case of Deprofessionalisation. 'Economic and Political Weekly', January, 1978.

28. Mackinlay, J.B. & Arches, J. (1985): Towards the Proletarization of Physicians, IJHS, Vol.15, No.2.

29. Ramalingaswamy, op. cit. 1980.

30. Government of India (1975): Report of the Group on Medical Education and Support Manpower (Srivastava Committee) 1975 - Health Service and Medical Education - A Programme for immediate planning, Ministry of Health & Family Welfare, New Delhi.

31. Sahu, S.K. (1991): Health Culture in Transition: A case study of Oraon Tribe in Rural and Industrial News, Khama pub. New Delhi.

32. W.H.O. (1957). Report on Regional

33. Medical Council of India (1982): Working Group on Medical Education in relation to the country's changing needs (by M.G. Garg, LSN Prasad, Hari Vashran & S.S. Manchanda).

34. Banerjee, D. (1988): A Socio-cultural, politiccal and Administrative Analysis of Health policies and Programme in India in the Eighties: A Critical appraisal, CSMCH/SSS/JNU, N. Delhi.

35. Morris, D. (1965): Health Profession its Challenges and Perspective in Medical Sociology by Cockerham, Page 45-42.

36. Sahu, op. cit. , 1991

37. Quadeer, I. (1985). Health Service System in India: An Expression of Socio-economic Inequalities, Social Action - A Quarterly Review of Social Trends, Vol.35, No.3, Indian Social Institute, New Delhi.

BIBLIOGRAPHY

BIBLIOGRAPHY

Abidi, N. Fatima (1993): Women Physician, Manak, Delhi.

Anita, N.H. (1990): Medical Education : In need of Cure, EPW, July 21, 1990

Arnold, D. (1985): Medical Priorities and Practice in Nineteenth Century British India", South Asian Research, Vol.5, No.2

Aurora G.S. (1989). 'Scientific Community in India', Bombay, Amrita Prakashan.

Banerji, D. (1973). 'Social Orientation of Medical Education in India, EPW, Vol.VIII, No.9m, 3rd March, '73.

---------. (1974): 'Anatomy of the Medical Professionof India' Mimeographed , CSMCH/SSS, JNU, N. Delhi - 67

---------, (1974) : 'Medical Alienation in India', 'The Hindustan Times, March 31, 1974.

---------, (1975): Medical Profession and Social Orientation of Health Services in India Seminar, June 1990.

---------, (1977): Formulating an Alternative Rural Health Care Suystem in India': Issues and Perspectives in Naik, J.P. (ed) : An alternative system of Health Care Services in India : Some proposals, Bombay, Allied.

---------, (1978): 'Health as a level for another Development'. Development Dialogue 1 : 19 - 25.

---------, (1981): Poverty, class and Health culture in India, Vol.I, N. Delhi, Prachi.

--------- ,(1985): Health & Family Planning Services in India : An Epidemiological, socio-cultural and political Analysis and Perspective, N. Delhi, Lok Prakashan.

---------, (1986) : Social Science and Health Service Development in India, Sociology of Formation of an Alternative Paradigm, New Delhi., Lok Prakash.

---------, (1989): Crisis of Medical Profession in India, April, 17, 1989, CSMCH/SSS/JNU, N. Delhi - 110 067.

---------, (1990): A Socio-cultural Political and Administrative Analysis of Health Policies and Programme in India : A critical Apprisal, CSMCH/SSS/JNU., N. Delhi.

Bala, Poonam (1991): Imperialism and Medicine in Bengal : A Socio-historical perspective, New Delhi, Sage.

Bald, M. (1994): The Power to heal, The Telegraph, 28th April, 1994, Calcutta.

Blizard, P.J. (1991): International standards in Medical Education or National Standards, Primary Health Care - which direction? Social Science and Medicine, Vol.33, No.10, pp. 1163 - 1170.

Buckley, E.G. (1993): Basic Medical Education in Transition. Medical Education, Vol.27, No.2, pp.113-115, March 1993

Chandani, A. (1985): The Medical Profession : A Sociological Exploration, Jainson, New Delhi.

Colins, J.P. & White, G.R. (1993): Selection of Aukland Medical Students over 25 years. A time for change ? Medical Education, Vol.27, No.4, pp. 321-327, July, 1993.

Dak, T.M. (1991): Sociology of the Health, Rawat, Jaipur.

Das, Arvind, N. (1991): The Republic of Bihar, Penguine.

David, Wilsford (1991): Doctors and the State : The politics of Health Care in France and U.S., Duke Univ. Press, North California.

Dent Mike (1993): Professionalism, educated labour and the State hospital medicine and the new managerialism in the sociological Review, Vol.41, No.2, May 1993, pp. 244 - 273.

Dingwell, R. & Lewis Philip (ed) 1983: Sociology of the Profession: Lawyaer, doctors and others, The MacMilan, Hongkong.

Dubey, S.M. (1975): Social Mobility among the Profession: Study of the Profession in a transitional Indian City, Bombay. Popular.

Dutt, P.R. (1965): Rural Health Services in India, PHC. 2nd Ed., New Delhi, CHEB.

Editorial (1994). What Ails Medicine? Times of India, 31st June, 1994, New Delhi.

Elliott, Phillip (1972): Sociology of the Profession, London, MacMilan.

Elzioni, Amitai (ed) 1969. Semi-Professions and their organisations. Teachers, Nurse and Social Workers, New York, Free Press.

Frankenberg, R. (1981): 'Allopathic medicine, Profession and Capitalist ideology in India: Social Science and Medicine pp. 115-125

Friedson, E. (1975): Profession of Medicine, New York.

Gandhi, M.K. (1938): The Hindu Swaraj, Navjeevan, Ahmedabad.

Gelfard, Toby (1993): The History of Medical Profession in Bynum & Porter (ed): Companion Encyclopaedia of the History of Medicine, Vol.2, pp. 1119-1150, Routledge, London.

Gore, M.S. (1978): Committee Report, Social Sciences in Professional Education. ICSSR, New Delhi.

Government of India (1946): Health Survey and Development Committee (Bhore Committee), Vol.I - IV (Delhi, Manager of Publications).

Government of India (1975): Report of the Group on Medical Education and support Manpower (Srivastava Committee) 1975 - Health Service and Medical Education : A Programme for immediate Planning, Ministry of Health and Family Welfare, New Delhi.

Hoburn, D. (1993): State Authority, Medical Dominance & Trends in the Regulation of the Health Profession : The Ontario Case, Social. Sc. & Medicine, Vol.37, No.2, 1993, pp. 129-138.

Illich, Ivan (1976): Limits to Medicine, Medical Nemesis : The Expropriation of Health : Marion Boyans, London.

Jackson, J.A. (ed) 1970: Profession and Professionalisation, C.U.P., London.

Jacob, Joseph M (1988): Doctors and Rules : A sociology of professional value, London, Routledge.

Jain, Kalpana (1994), 'Dai' is as important as the Doctors, Times of India, 10th Feb., 1994, N.Delhi.

Jeffery Roger (1978): Allopathic Medicine in India : A case of Deprofessionalisation. Economic and Political Weekly, January, 1978.

---------, (1979): Recognising India's Doctors : The Institutionalisation of Medical Dependency 1918-39. Modern Asian Studies, Great Britain.

---------, (1988): The Politics of Health in India, Univ. of California Press. London

---------, (1991)The Impact of Socio-economic and Political Factors on the provision of Health Care in India in Ravi Akhtar (ed) : Health Care Patern and Planning in Developing countries, Greenwood Press, New York.

Kalra, Krishan (1994): Economics of Health CareService. The Financial Express, 19th May, 1994, Bombay.

Kelner J.M. & Bourgeault, Iryl (1993): Patient control over Dying 'Response of Health Care Professional. Social Science and Medicine, Vol.36, No.6, pp. 757 - 765.

Kothari M.L. & Mehta, L.A. (1988) 'Violence in Modern Medicine in Ashish Nandy (ed) : Science Reason and State.

Lal, S.K. & Chandani. A (1987), Medical Care, Readings in Medical Sociology, New Delhi, Jainsons.

Lal, Sheo Kumar & Others : (1988) Readings in the Sociology of Professions, GPH, Delhi.

Lentin, B. (1994) Doctors and Patient : Life under Consumer Protection Act. Times of India, 30 March 1994, New Delhi.

Leslie : Charles (1976), 'Asian Medical System' : A Comparative Study, UCP, Berkeley.

Mackinlay, J.B. & Arches, J. (1985) : 'Towards the Proletarization of Physicians, IJHS, Vol-15, No-2.

----------, (1988) : Corporation of Medicine and Social Transformation of Doctoring, IJHS, Vol-2.

Madan, T.N. (1972), Doctors in North Indian City: Recruitment, Role Perception and Role Performance in Satish Seberwal (ed) Beyond the Village; Sociological Exploration, IIAS, Shimla.

----------, (1980), Doctors and Society, Vikas Publishing House, New Delhi.

Mechanic, David (1992), 'Health and Illness Behaviour and Patient Practitioners Relationships', Social Science and Medicine, Vol.34, No.12, pp.1345-50.

Medical Council of India (1982), Working Group on Medical Education in Relation to the Country's Changing Needs (by M.G. Garg, L.S.N Prasad, Hari Vashrar & S.S. Machanda).

Nagla, Madhu (1988), Medical Sociology, Printwell Publication India.

---------, (1993), Sociology of Medical Profession A Study of Doctors on Workshop, Professions, State and Society, 26-27 Aug. 1993.

Nandy, A & Visvanathan, S. (1990) : Modern Medicine and its non-modern Critics : A Study in Discourse in Dominating Knowledge ed. by F.A. Marglin and S.A. Marglin, Clarendon Press, Oxford, 1990.

Narayanan, K.R. (1994), Challenge before Medical Profession: Mainstream, Vol.XXXII, No.22, April 16, 1994.

Nayar, P.K.B. (1982) ed. 'Sociology in India : Retrospect and Prospect, BRPC, N. Delhi.

Oommen, T.K. (1978), Doctors and Nurses : A Study in Occupational Role Structure, Macmillan, Delhi.

Panackel, Joseph (1986), Medical Education in India in Search of Relevance of Sociological Inquiry into the Reorienting Medical Education, (M.Phil Diss), CSMCH/SSS/JNU, New Delhi-67.

Parsons, T. (1939): "The Profession and Social Structure", Social Forces, Vol-17, May 1929, pp.457-467.

Park, Catherine (1985), Doctors and Medicine in Early Renaissance, Princeton, New Jeressy, 1985.

Phillips, M. (1985) : Doctors Dilemma: Medical Ethics and Contemporary Science, John Dawon, Harvester Press.

Prakash, Padma (1994), Changing Priorities of Health Care, EPW, No-12,19 April 1994, Bombay.

Prasad, R.C. (1983), Bihar, N.B.T.

Quadeer. I. (1982), Limitations of Another Development in Health Social Scientist, 1982.

----------, (1985), Health Service System in India. An Expression of Soci-Economic Inequalities-Social Action - A Quarterly - A Quarterly Review of Social Trends, Vol-35, No-3., Indian Social Institute, New Delhi.

----------, (1990), Beyond Medicine :An Analysis of Health Status of Indian People, Think India, Vol.2, No.1, Jan-Mar. 1990.

Ramalingaswami, P. ( ), Estimation of Cost of Medical Education, CSMCH/SSS/JNU, Vol.24, No.3.

----------, (1985). Social Background of Doctors; IJMS, Vol.24, No.3.

Ramamurthi, B. (1992), Medical College, Doctors and Health Care, The Hindu, 25th August 1992.

Ramasubhan, R. (1982), Public Health and Medical Research in India - Their Origin under the impact of British Colonial Policy SAREE Report.

Rao. K.N. (1966) : 'Medicine and Society', IJME,5,158.

Sahu, S.J. (1991), Health Culture in Transition : A Case Study of Oraon Tribe in Rural and Industrial Nexus, New Delhi, Khama.

---------- , (1993) : The Physician and Health Policy : Issues of Professional Ethics, Paper is presented in the workshop on Professions, State and Society, Organised by (CSSS/SSS/JNU, 26-27 Aug, 1993.

Sethi, P.K. (1993), The Doctor in the 21st Century, Seminar, 409, Sept. 1993, New Delhi.

Shourie, H.D. (1993) Doctors and Patient : A Sacred Tie in Hindustan Times, 19th May 1994, New Delhi.

Stanton, B & Berman. M. (1993), Professional Advancement of Social Scientists within School of Medicine, Medical Care Review, Vol-50, No-3. Fall 1993. pp.259-270.

Stevens, E.Diederiks, J, & Philspeu, H (1992) : Physician Satisfaction, Professional Characteristics and Behaviour Formalization in Hospital in Social Science and Medicine, Vol-35, No..3, pp.295-303.

Stone, Linda (1992), Cultural Influences in Community Participation in Health in Social Science and Medicine, Vol.35, No.4, pp.409-417.

Takulia, H.S. (1967), The Health Centre Doctor in India, Baltimore, John Hapkins Press.

Taylor, C.E. (1976): Doctors for the Villagers, London, Asia.

The World Conference Report (1993): The Changing Medical Profession:Implications for Medical Education, Medical Education, Vol.27, No.3, pp.291-96.

Tollan, A & Magnus, J.H. (1993), Rural Doctors Recruitment: Does Medical Education in rural District Recruit Doctors to Rural Area? Medical Education, Vol.27, pp.250-53.

Venkatapatnam, R. (1979), 'Medical Sociology in Indian Setting', Macmillan, Madras.

Vollmer, H.M. & Mills, Donald L. (1966) : Professionalisation, Englewood, Prentice Hall.

White, Louis P & Wooten, Kevin C. (1986) : Professional Ethics and Practice in Organisational Development, A System Analysis of Issues, Alternatives and Approach, New York, Praeger.

Zubrigg, S. (1984): Raku's Story : Structure of Ill Health and Source of Change, New Delhi, VIHAI.

APPENDIX - I

APPENDIX I

Interview Schedule Constructed for Physicians Working in PHCs

1. Name :

2. Age : 3. Sex :

4. Educational Qualification :

4. (A) From which Medical College Passed - M.B.B.S. or any other degree :

5. Caste status :

6. (A) Family Income :

(B) Income (Present Pay Scale) Salary -

Private Practice -

7. Since when you have joined Government Job :

8. How long you are posted in this PHC :

9. What experience you have gained as Physician :

10. Have you selected this Profession yourself/by family.

11. What is the factors which motivated you to join this profession :

12. What is your expectation you have from this profession:

13. What is the response of people towards Primary Health Centre Services :

14. How the Community behave towards you/your staffs :

14.(A) Do they give maximum respect to you:

If Yes Why -

If No Why -

14. (B) Do the community accept you as an important person in their day to day life :

If Yes - Which section of the community

If No Why -

15. Who seeks/avails your service maximum ?

Which section and why.

16. What are the job assigned to you a physician in this PHC :

17. What, according to you, are the main complaints from the villagers which you considered to be the legitimate or important :

18. Which complaints do you consider are not so important or justified :

19. What are the main socio-economic problems in the community :

20. Which section of the community has more health problems? Why ?

21. What do you think about their health problems : What is the main reasons.

22. What type of problems do you face in the field :

23. Medical Profession has connection with Politics in every society. Do you belong to any political party, ideology or movements.

24. (A) Are you a Member of any Professional Association :

(B) If Yes, What is that :

(C) Since when :

(D) What benefit do you get out of this association :

25. For your local problem to whom do you consult to solve it :

26. Do you know the Sarpanch, Panchayat Samiti Chairman, Zila Parishad Chairman or M.L.A. or M.P. of this area. Have you contacted any of them for solving your Problems.

If Yes, Please explain it :

27. Are you satisfied with the infrastructural support provided to you :

House :

Transport :

Staff :

Leave :

Any other auxiliary benefit :

Other Incentive :

28. Do you get support from your subordinate staff :

(A) If Yes Explain :

(B) If No Explain :

29. Do you get regular support from your immediate authority/bosses.

30. (A) How do you assess your service in comparison to the other colleagues /other Private Practitioners.

(B) Why so :-

31. (A) Do you go for supervision to the field :

(B) Do you get co-operation from your field-staff/ and the staffs at PHC.

32. What kind of supervision you provide to your staffs.

33. Are you satisfied with your Job :

(A) If Yes Explain (B) If No Explain.

34. As a Community Health Physician -

Are you satisfied with your training and education.

(A) If yes, please explain. (B) If no, please explain.

35. As a leader of the 'Community Health Team' What difficulties you encounter as a Physician.

36. Is your family happy about your posting in the PHC.

(A) If yes, please explain (B) If no, please explain.

37. What are the qualities of a good community Health Physician.

38. What are the main functions of the PHC :

39. What functions are actually being performed by PHC :

40. What remedial measure do you suggest to improve the services of PHC.

41. Your suggestion about improving the functioning process of the PHC :

42. What is your assessment of the work done by other member of PHC team i.e. compounder, L.H.V., A.N.M., Block Education Officer, Male or Female Health Workers :

43. What are the activity of the PHC in field of

A.Environmental Sanitation :

B. School Health :

C. MCH :

D. Immunization :

E : Communicable Disease : National Health Programmes.

44. Any other significant points about your Profession : and other professionals.

45. Your views regarding present Consumer Protection Act :

46. Your views regarding Medical Ethics/Equitable Service :

47. What is average daily Patient attendance of the PHC :

48. Knowledge about the following aspects of the Community Development Block .

(A) Socio-economic condition of the community

(B) Political Situation -

(C) Cultural Condition -

(D) Communal Harmony -

APPENDIX – II

APPENDIX II

INTERVIEW SCHEDULE FOR COMMUNITY/COMMUNITY LEADERS

1. Name of the Respondent :

2. Age : 3. Sex :

4. Designation :

5. Occupation :

6. Income :

7. Educational Qualifications :

8. Caste/Community/Religion :

9. Type of Leadership :

10. Do you know the doctors of PHC :

11. If Yes, How many doctors are in PHC :

(a) To whom you know closely :

12. How many times you have gone to the PHC and consulted to the doctors :

13. Is he helpful to you and to the other Villagers :

If no, Please specify :

14. If you are happy with the doctors, have you launched complain against him to higher authority or talk to him:

15. Do you consider he makes extra effort to satisfy you :

16. During the time of emergency he is available to the villagers.

17. What is your opinion regarding the function of PHC and Role of the doctors :

18. As a member of Village, do you consider Doctor is a member of Village (Whether they stay or not, mixed with people or not).

19. Which section of the Villager is closer to the doctor.

20. Have you come across any complain against the doctors of any section of Villager or staff or the PHC. If so what is the nature of complain.

21. According to you who could be a (is an) ideal doctor in your village setting :

22. According to you whether the Private Practitioners or PHC doctor are competent and helpful :

    If so, specify :

23. And whom do you prefer and why ?

24. If the PHC doctor does the private practice how much the changes.

25. Any other point regarding the doctors of your PHC :

26. Name of the Respondents village.