SOCIOLOGY OF MEDICAL PROFESSION IN INDIA : A REVIEW OF SELECT LITERATURE

A DISSERTATION SUBMITTED TO THE JAWAHARLAL NEHRU UNIVERSITY
IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

MASTER OF PHILOSOPHY

Supervisor

Dr. J.S. Gandhi

Submitted By

Chandra Kant Mishra

CENTRE FOR THE STUDY OF SOCIAL SYSTEMS

SCHOOL OF SOCIAL SCIENCES

JAWAHARLAL NEHRU UNIVERSITY

NEW DELHI

1989

जवाहरलाल नेहरु विश्वविद्यालय
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI-110067

CERTIFICATE

Certified that the dissertation entitled: "Sociology of Medical Profession in India: A Review of Select Literature" submitted by Chandra Kant Mishra is in partial fulfilment for the degree of Master of Philosophy of this University. This work has not been done earlier and it is an original contribution. Therefore, I recommend that this dissertation be placed before the examiners for evaluation.

(Dr. J.S. GANDHI)
Supervisor

Associate Professor
Centre For The Study of Social Systems
School of Social Sciences
Jawaharlal Nehru University
New Delhi-110 067

(PROF. R.K. JAIN)
Chairman

Chairman
Centre for the Study of Social Systems
School of Social Sciences
Jawaharlal Nehru University
New Delhi-110 067

Gram : JAYENU Tel. : 667676, 667557 Telex : 031-4967 JNU IN

CONTENTS

A C K N O W L E D G E M E N T

First of all, I would like to thank Prof. R.K. Jain for providing me permission to work on this topic.

I owe a deep debt of gratitude to my supervisor Dr. J.S.Gandhi for his fatherly love and affection. He helped me unstintingly with his advice and criticism in preperation and completion of the present work. This work would not have completed without his help.

Vinita my darling friend, is source of inspiration in my life. She helped me to come out from depressing phases and boosted my confidence and morale.

My thanks are due to my friends Sanjeev, Mukesh, Hadi, Rakesh, Vijay, Rohit and Pinki. They helped me in some way or the other to complete this work. My thanks is also due to staff of J.N.U. Library, Teen - Murti Library, Sapru House Library and B.H.U. Library for their coopration and help.

I express my deep sense of gratitude to my parents and family members, who still have faith in my capabilities.

Last but not the least, I express my sincere thanks to my friend Kunjan for typing this work.

Date - 21-7-1989

Chandra K. Mishra
(C.K.Mishra)

Centre for the Study of Social System
School of Social Sciences
Jawaharlal Nehru University
New Delhi -110067

C H A P T E R - 1

INTRODUCTION

Medicine as a profession has had its measure of public esteem in every society. Every society has its own system of medicine and medicine men who within their own limitations contributed to the physical welfare of the people. In all societies men of medicine were held in high esteem and tradition is kept alive in modern societies. This is further emphasized by the fact that a career in the profession of medicine is considered, to be a highly prestigious one. It ranks as one of the top profession in almost all the contemporary societies of the world- both modern and modernising. Perhaps the new developments that have taken place in medical science in the present century have helped the profession to persue and even to enhance its ancient reputation. The changes that have occured are so fundamental and profound that the founding fathers of modern medicine would find the science perplexing. Much scientific knowledge has been added and skills developed in the last fifty years and more that modern medicine now consists of numerous specialities and sub - specialities.

The early work done by the Indian sociologist were with the study of Tribe, peasent villages families and caste. Later, there was a shift to study social change and urban India. As a matter of fact these were the studies of "urban variants of some traditional rural groups or institutions"[1]. Sociology of profession was not a priority area. Mishra's[2] was the first waork dealing with emergence and magnitude of profession. First empirical work of various profession was made by Dubey[3].

In India, the speciality of medical sociology has emerged recently and it has been recognised as a sub - speciality of sociology. At present a number of sociologists are taking keen interest in this field as is evinced from publications in learned periodicals. The first pioneering work has been done by Madan[4] in this field. After that many scholars have done their work which have been discussed in subsequent chapters.

THE STUDY:

The main aim of the present study is to identify the main issues related to health professionals and their various dimensions and manifestations in relation to the health culture of the Indian society. Medical profession is very much part of a complex social system and organisation

in itself in various ways. The necessity of these studies is essential to comprehend the health care status in a country and the social conformity of its various existence has been emphasized by various scholars. This study has gleaned the outcome of different studies so far conducted. The following study has been designed to make a more conclusive and comprehensive understanding, of the issues involved in the larger perspective of medical professionals in Indian socio - cultural millieu.

The present study becomes relevant as we are trying to gauge the level of health services status and their status through different institutions in the country. Presently, an attempt has been made to identify the issues and concept and methodological lapses which developed in the field of institutional health care due to unidimensional approach of understanding the patients and their health culture eyes of medical professionals of various categories. An effort has been made to grasp the health and institution in more comprehensive manner.

METHODOLOGY :

Different scholars have studied the medical profession in different ways but revolved around

certain issues which are quite trivial to assess the whole situation in Indian medical system. To develop a clear conceptual framework, a study on the role of hospital in institutional medical care in India has to be defined on clear concept and sound methodology which should be interdisciplinary in nature. Considering the fact that there have been no interdisciplinary approach have been taken so far, this kind of study needs adequate field work. This could have not been done by me in present condition as I did not have ample time to carry out an elaborate and exhaustive field work in the present course of research in M. Phil.

This study is based on the secondary sources and available library documents, government documents, besides the available books on medical profession. This is an exploratory study for further comprehensive field study in medical profession. Present exercise is not an effort to bring forth totally or absolutely unknown facts rather it is an endeavour to compare and correlate the existing bits of pieces of knowledge of medical profession in Indian socio - cultural set up. This study would help to the theoretical armoury of social medicine of a broad based approach in the next research work in the field conditions.

CHAPTERIZATION :

This study has been chapterized in such a manner to give a clear and vivid picture of medical profession in India. It has been divided into the following :

Chapter I - Introduction

Chapter II - Profession and Society : An overview

Chapter III - Medical Profession in India : Review of Literature

Chapter IV - Analysis and Assessment

Chapter V - Conclusion

Limitations of the study :

Although this study covers a good range of literature available on medical profession in India, this work has serious limitations in that it does not provide an overall and comprehensive view of the medical profession in India. The reason partly lies is that hardly any, if at all, comprehensive studies have been conducted on such aspects of the medical profession, such as para - medicals, nurses etc. --- all of which integrally relate to the functioning of medical profession. This limitation is also accountable in terms of the fact that the present study is committed only to the review of existing literature in the

field of research and as such is not free to carry out emperical investigations in the neglected areas.

Notes

1. T.N.Madan,Docters in a North Indian City: 'Recruitment, role perception and role performance' in S. Saberwal (ed.) Beyond the Village, Indian Institute of Advance Study, Simla, 1972.

2. B.B.Mishra -Indian Middle Classes, Oxford University Press, London ,1961.

3. S.M.Dubey - Social Mobility among the Profession, Popular, Bombay ,1975.

4. T.N.Madan - op.cit (1972).

CHAPTER - II

Profession and Society : An Overview

The profession probably constitute the most important system of modern medicine. The principle difference between the situation in ancient and medieval times was that in the later the teachers, administrators, lawyers and physicians had recieved. A possession with intellectual bearing and formal training is the hall mark of modern society. Oxford English Dictionary defines profession as "a vocations in which a professed knowledge of some department of learning or science is used in its application to the afffair of others of in practice of an art founded upon it ".

Thus, profession is defined as a vocation one professes with a sense of commitment, consistency and theoretical and scientific knowledge based on a prolonged specialised training of that particular work, which is derived from altruistic motive that occupation generally lack. However, occupations also specialize in certain skill. Pottery and wearing, black smithing etc. are illustrative of this but the major difference rests in their basic nature as occupation may be hereditary whereas professions are necessarily acquired. Also professions are institutionals

entities whereas occupations are essentially traditional. Therefore, there is a thin layor seprating occupation from professions. In profession one enters after fulfilling essential qualifications while occupations never allow any outsider to come in.

An increasing field of specialization and a gradual narrowing down of specialized fields has been one of the notable features of professional growth in modern times.[1] Parsons calls profession "the most important single component in the structure of modern societies".[2] The term as used today has no counterpart in the ancient society. To be sure, there existed the three classic professions - theology, law and medicine. But the practitioners did not unite to form an organized professional body. In Rome, the physicians was as a general rule only a slave in a wealthy household, on the other hand accountants engineers and architects were employees of the state.[3] In ancient times there were no training schools, where those who followed the vocation which we call profession recieved instructions, that the practitioner seldom or never formed distinct social groups and that they were frequently in a dependent position.

When church was predominating, the various professions for which the universities trained did not become clearly distinct because all professional man were

ecclesiastic. When the culture of middle ages slowly started shedding its religious character the professions started emerging out of the church firmly and started organizing. In England from 16th century onwards ceased obligatory upon student to take orders, and physicians and lawyers continued to be trained in universities and after graduation joined their own professional organizations. By the end of 16th century with the exception of teaching the professions had become secularized, this means they form their own secular guilds. However, teaching continued to be dominated by church until sometime after the reformation and teachers continued to be the members of the priesthood[4]. Throughout the 18th century, divinity law and medicine continued to be the recognized profession. This limited qualification, omitting surgeons, apothecaries and teachers, was due to the fact that the professions were regarded as the occupation of gentlemen. Gengleman did not consider surgery as a fit vocation. Teachers were excluded because they were classified as clergyman. Architects and civil servants were excluded because they had not established professional associations[5].

By the end of 18th century, the industrial revolution and the impact of scientific age created new areas of specialized intellectual activity. It increased the need

for new professions and they began to proliferate rapidly. Licensing system has long been associated with the evolution of professions either by state or by voluntary agencies. This was done to protect the public from incompetent practitioners and to protect the competent from unfair competition. In ancient times, the licences were issued by the church and were informal and in medieval times, the universities provided both the preparation and the licenses for the professions.

Before the opening of the 19th century, the recognition of new profession was extremely slow process, but during the last few years professions have multiplied by leaps and bounds. Therefore, we have come to such a phase where the day to day functioning of society heavily relies upon the professions which have become so indispensable and imperative owing to the proliferating needs. Professions play a predominant role in the history of developments of society.

The formulation, implementation, monitoring and evaluation of any policy and programme has to be carried out within the framework of professions because of the magnitude of the present day problems.

PROFESSIONAL PERSPECTIVE :

Till today, "there is no universally acknowledged theory of profession. moreover it lacks a well defined unit of analysis because of which the study of professions field such as sociologies of medicine, law, teaching, etc". [6] An occupations professionals nature is the core of the professional perspective. The professional perspective focusses on two aspect of an occupation , namely , organisational and personal.

The 'organisational' seeks to examine the recruitment of personnel, training, professionalization, regulation and control. The personal aspect, on the other hand, focusses on their personal conduct and performance of their professional roles and their professional orientation.

In the realm of conceptualization of a profession two main approaches have been adopted. They are : the profession as a structure and professionalization as a process [7] .

STRUCTURAL APPROACH : ✓

The structural approach focuses upon profession per se, as is. It is premised on the assumption that profession comprise a class or type structurally distinct from other occupation which, by implication, are non

professional. Thus,the aim of investigation guided by the structural approach is a quest for the essential differentiating the types from others.More specifically, it is to identify the occupational characterstics which may be said to constitute the distinguishing attributes of profession. Goode writtings on profession are prime illustration of the structural approach.

PROCESSUAL APPROACH :

This approach focusses upon the trasformation of a non - professional occupation into a profession. It is premised on the assumption that this is an evolving process consisting of sequential stages through which all would - be professions pass and, furthermore, that the stages are ascertainable. Accordingly, the aim of investigation guided by this approach, is to trace this evolution; it is to describe what sociologist would call "the natural history" of professionalization , to formulate a model that typifies this process. In addition , it is to identify those social forces , both internal and external to occupations which facilitate or impede the professionalization process.[8] Wilensky's often quoted article on professionalization is a prime illustration of the Processual approach.[9]

The above two conceptions are derived from two theoretical position in the sociological study of profession. This can be termed as Functional and Conflict theory.

Functional Theory : From a functionalist prospective , society is regarded as a system. The approach found its best exposition in Durkhiem "division of labour" and its function in maintaining "social order" and "cohesion". To avoid "anomic" form of division of labour, Durkhiem emphasized on the increasing roles of occupational professional groups and syndicates. To Durkhiem, professions do not represent only the unrestricted economic interests but they are rooted in moral codes and ethics. Parsons also found a great deal of similarities between profession and bussiness. Both are rational, functionally specific and universalistic.

Societies central needs are well served through the professions as at the present day, society is increasingly compartmentalized into numerous parts owing to the proliferation of societal needs and plethora of social problems. An elluminating illustration of the indispensability of profession would here be worth taking stock of. Why pofession has become omnipotent and omnipresent ? 'Technical competence'of professional backed by authority to accomplish modern hurculean task for the weal of the people with zeal make professions all distinct.

Conflict Theory :

Conflict theorist view professions as a part of stratification and class structure. This orientation recognizes society as comprising of collectivities possessing society varying interests. Marx view, knowledge and professional skills are a commodity having their market value. They can be exchanged for money. It is a fact that profession are based on knowledge and specialised training but the commercial and profit oriented aspects of professions are concealed in the structural-functional approach.

It has to be clearly borne in mind that to grasp the distinction between the above two theories, their pros and cons ought to be well understood. S.L. Sharma postulates that "the two perspective need not be viewed as absolutely antitheoratical,because they have in common certain elements of a profession such as specialised knowledge, work autonomy, code of ethics and community sanctions. They differ in only the primary which they accord to these different elements"[10]. In view of functionalist, professionalism means observance of codes and ethic, service, community orientation, affectual neutrality, rationality and objectivity. According to Marxist professionalism may be characterised by the extension of exchange relations and use

value. Thus, the professions are the part of the labour market.[11]

Attributes of Profession :

The profession occupy a position of great importance in modern society. In a society characterized by division of labour based upon technical specialization many important features of social organisations are dependent upon professional functions. According to Greenwood there are five distinguishing atributes of a profession.[12]

1. A basis of systematic theory.
2. Authority recongnised by the clientele of the professional group.
3. Broader community sanctions and approval of this authority.
4. A code of ethics regulating relations of professional persons with clients and with colleagues.
5. A professional culture sustained by formal professional associations.

Having put the attributes in a nut-sheel, we suppose that it would be clear to elucidate each of them in some detail. The acquisition of the systematic theoretical body of knowledge involves the lengthy period of socialization. A profession underlying body of theory is a

system of abstract propositions that describe in general terms the classes of phenomena comprising the profession's focus of interest. Acquisition of professional skill requires a prior or simultaneous mastry of theory underlying that skill. Preperation for a profession, therefore involves considerable pre-occupation with systematic theory. The spirit of rationality in a profession encourgages a critical attitude towards the theoretical system.

The second attribute which is professional authority implies the absence of knowledge in the man in the street who is isolated from the professional who acquires competence in a scientific way which gives him what is known as authority. In a professional relationship the professional dictates what is good or bad for the client who has no choice but the accede to professional judgement. The professional's authority is confined to these specific spheres whithin which the professional has been educated. Parsons calls these as af functional specificity.[13]

The third attribute of a profession is the sanction of the community. Every profession strives to pursuade the community to sanction its authority within certain sphere. This is done by conferring upon the profession a series of power and privileges,which may be either formal or imformal. Among its power is the

professions control over its training centres. This is achieved through an accrediting process exercised by one of the associations within the profession.

"The profession also acquires control over admission into the profession by two routes".[14]

(1) The profession convinces the community that no one should be allowed to wear a professional title which has not been conferred by an accredited professional body.

(2) The profession pursuade the community to institute in its behalf a licencing system for screening those qualified to practice the professional skill.

The fourth attribute of the profession is the regulated code of ethics. Every profession has a built in regulated codes. The profession's ethical code is partly informal. The formal is the written code to which the professional usually swears upon being admitted practice. The informal is the unwritten code. Through its ethical code the professional commitments to the social welfare becomes a matter of public record, thereby insuring for itself the continued confidence of the community. The professional should not discriminate his clients on the basis of sex, income, religion, race, social status etc. Parsons calls this element in professional conduct as universalism. He also talks about disinterestedness in the professional client

relationship. A lot of importance is being attached to universalism because, the central focus of a professional's role performance lies in technical competence. As and when requested by the clients, the professional has the moral obligation to assist the former in the event of even the latter's hardship.

The profession's fifth attribute is the professional culture, which consists of values, norms and symbols. The social value of a profession which is the bedrock of its function has the social good uppermost in its mind. The norms which are guide to behavior in social situation requires for seeking admittance into the profession, for gaining entry into its formal and informal groups and for progressing within the occupation hierarchy. The behavioral norms encompass every standard inter - personal situation likely to recur in professional life. The symbols of a profession are its insignias emblems and distinctive dress, its history, folklore etc.

Professional culture also includes career concept. Central to the career concept is a certain attitude towards work which is uniquely professional. Professional work is never viewed as a means to an end, but end in itself. To the professional person his work becomes his life.

Gandhi[15] notes one important

consideration about professions is the attribution of "Service Motive"to them. According to this motive professional behaviour towards client is strongly motivated by a professional desire to render service rather than to earn profite.

The governmentalization of profession has served significant consequences of professionals. In 1939, Marshal argued that "the profession today is being weaved from " - - - - - - excessive individualization and are adopting themselves to the new standard of social service."[16] While Marshal was of the opinion that the excessive individualism which formed profession traditionally is giving place to the collective service orientation. Lewis and Mande argued that the Welfare state leads to poor salaries, poor condition of work and second rate qualification. Further, according to them,"increased dependence on the state results in progressive lowering of social and economic status of profession." Governmentalization of professions has negative consequences of or the 'material interests' of professionals but has positive pay-off for the public, the client.

Sociologist in India have more or less neglected sociology of medicine as a field of study. The sociologist's interest in the field of medicine is relatively new. Health is a function of improvements in the

overall environment is medical care, provided by qualified personnel. Among medical workers, doctors, occupy an important place.

A medical practioner enjoys a respectable position in the community of society. As a healer in folk medicine or as a practioner in the indegenous system of medicine in different cultures or as a professional skilled docter, he always enjoys a respectable position in the community because of his power to heal, knowledge and skill to diagnos the ailment to prescribe curative, preventive and rehabilitative measures. The practice of modern medicine is charaterized by a significant combination of genral and particular elements. The pursuit of allopathic or modern medicine is generally believed to represent an eminently important and rational use of scientific knowledge and technology in a modernizing society.

MEDICAL PROFESSION IN INDIA :

The medical profession has been extensively studied from the point of view of both professional and professional organisations. The studies of professionals cover medical student, doctors and nurses. The studies of organizational aspects of the medical profession cover the social content and orientation of medical education, the state involvement in the requlation of the

medical profession and the role of the medical profession in social change and modernisation.

Broadly three types of studies can be distinguished in organizational aspect of medical profession.[17]

i. The social content and orientation of medical education.

ii. The state involvement in the regulation of medical profession.

iii. The role of medical profession in social change and modernization.

In brief, the research on the medical profession in India reflects two main theoretical orientation - role analysis and dialectical analysis. While the studies of professionnal are informed by the role perspective, those of the organizational aspect of the medical profession are pre-occupied with Marxian perspective. There is not a single study in the ethnomethodological tradition which is hardly surprising considering that such a trend has not yet got going in the west.[18]

- - - - - - - - - - -- - -- - - -

Notes

1. B.B.Mishra - Indian Middle classes - Their Growth in Modern Times, Oxford University press, London, 1961.

2. T.Parsons, - 'Professions' , In David L. Sils ed. International Encyclopedial of Social Sciences, Vol.12, Macmillan and free Press, New York, 1968, P.P. - 536 - 47.

3. H.Becker, - Sociological work, Aldine, Chicago, 1970, P.P.88 - 90.

4. A.M. Carr - Saunders and P.A.Wilson - The Professions, Routledge and Kegan Paul, London, 1933.

5. A.M. Carr Saunders and P.A. Wilson, 'Emergence of profession' in Sigmund Nosow and W.H. Form(ed) Man work and society - A Reader in the Sociology of occupation, Inc. publishers, New York, 1962.

6. S.N. Sharma - Sociology of Profession in India in Survey of Research in Sociology and social Anthoropology,I.C.S.S.R., 1985,P.253.

7. George Ritzer - 'professionalisation, Beauracratisation and Rationalization' , Social Forces, Vol.53, June 1975, P.P.827 - 34.

8. Theodore Caplow,"The Sociology of work", University of Minnesota, Minneapolis, 1954,P.P.139 - 40.

9. Harold.L.Wilensky - "The Professionalization of everyone", American Journal of Sociology, Vol.70, Sep.1964,

P.P. 137 - 58.

1Ø. S.L. Sharma - op.cit. P.256.

11. M.S. Larson - "The Rise of Professionalism" University; of California Press, London, 1977.

12. E.Greenwood - "Attributes of Professionalism ", Social Work, July 1957,P.P.44 - 45.

13. T.Parsons - "The Profession and Social Structure" Social Forces, 17 May 1939,P.P.457 - 467.

14. E. Greenwood - op.cit. P.46.

15. J.S.Gandhi - Lawyers and Touts" Hindustan Publishing Corporation, Delhi, 1982,P.9.

16. T.H. Marshal - "The Recent History of Professionalism in relation to Social Structure and Social Policy",The Canadian Journal of Economics and Political Science, 1939,P.P. 329 -3Ø.

17. S.L. Sharma - op. cit., P.266.

18. Ibid,P.P.273 -74.

C H A P T E R - III

Medical Profession In India : Review of Literature

The sociology of medicine is comparatively a new devolopment in india, but it is very important field of study in the west. The U.N.E.S.C.O. trend report and bibliography for sociology of medicine listed 622 published work in this field[1].The published work on this subject in India is quite limited.

Indian hospital studies began after being guided and inspired by the American model and thoughtways and eventually producing almost the same kind of result.The studies can be categorised under different heads viz. docter patient, docter nurse, nurse patient, organisational study per - se and the medical student as well as their education pattern in a medical college hospital besides some studies on hospitals against the backdrop of public administration. The studies have been carried out by individual scholars, organization voluntary and government in different parts of India at different moment of time.

The study of **Mecim Marriot** on "western medicine in a village of North India" throws light on the place of modern medicine in village of western Uttar Pradesh. She has compared modern medicine with different types of indigenous

medicine and with their methods of establishing relations with their clients. There are a number of obstacles and conflict between the role performed by indegenous practitioners and the modern practitioners which provide the obstacles to the acceptance of western medicine by the people of western Uttar Pradesh. According to Marriot there are three realms of human group for the village folk, they are kinship, caste and outside world, each demand different degree of trust. The first two are met with suspicious.[2] She has also emphasized the cultural definition of medical roles. There are certain important aspect of interpersonal relatins in the medical sphere. These are trust, responsibility, charity power and respect. It is not his technical skill which gives prestige to a healer but his spritual power gained through 'Piety'. In this study we find that the healer or indigeneous practioners are more prevalent than the modern medicine practioners in a village of western Uttar Pradesh.

Carstairs in his study "Medicine and Faith in Rural Rajasthan" has pointed out that there are three ways by which modeern scientific medicine can be accepted by the people. By the slow diffusion of information about sepsis and infections, by a better understanding of the expectations with which people approach to doctors, and by presenting new technique in a way which will link them up with what they are expected to supercede.[3]

"According to the findings of Carstairs traditional medicine establishes 'faith'and 'assurance'in the patient but modern medicine lacks this 'aura of conviction' of traditional medicine and in required to 'justify itself dramatically and without delay."

Jona Kirpatrickstudy was carried in Brown Memorial Hospital, Ludhiana in the Year 1965 - 66[4]. 105 Patient were considered (only females). She basically wanted to see the type of reaction during the treatment of those non cristian in cristian hospital. - - - - - The micro - institution is typified by confrontation between clientele and hospital as institutions a situation that varies cross nationally more with social structure than with culture. Micro - structure involving patients and hospital staffs, and their socialization in terms of role expectation and unofficial behaviour and analysed from the perspectives of symbolic interaction and the definition of situation. The micro institution include reference to illness definitions, concept of the hospital, diet and its complication, ritual and secular status in the ward, the patients sick role in relation to the social structure.(P.125)

Patients do keep christianity at a high esteem. They think quite high of chirstian docters and nurses. So they expect quite a lot from this hospital and its staffs.

But some patients (Hindus) have reservation for hospitals foods. There is some favouratism which is distinct of the hospital staff towards the christian patient noted by the scholars. There is a latent conflict in case of religious ideologies between cristian staff and non - cristian patients. The scholar emphasizes that there is a necessity of fostering harmony, understanding mutual acceptance between the patient and his family with the doctors and staffs.

K.A. Hasan[5] in a case study 'Doctors Patient Relationship' in his book 'Medical Sociology of Rural India' analysed the effects of the introduction of modern scientific medicine in the village and also describe the behavioral factors which are involved in the failure or success of the physicians in the village. It was found that when the cause of disease were not understood and when more elaborate forms of treatment were not available only then modern practitioners was consulted and his prescriptions accepted by the villagers. The village folk are not used to spend on medicine and consultation fees of physician because folk medicine is based mostly on charity and the payment of medicine is indirect in the form of kind. People also demanded free treatment in indigeneous system. They did not realise that they were receiving minor treatments, the consultation of doctors and his services of administrating infection etc., free of cost. Hasan, while explaining the

relationship of doctor and patient, wrote that the personal equality between the physician and patient could not be maintained in the village life. The patients and their relatives could talk to a folk medical practitioners more freely than the modern medicine practitioners because the interpersonal relationship between villagers and physician and villager and folk practitioner were considerably different from each other. They met with the folk practitioner without fear and the physician were met with fear, suspicion and lack of understanding.

T.N. Madan[6] carried out a study on 'Doctors in Northen India City : Recruitment, Role Perception and Role Performance'. The study was based on the private practitioners. He has made an attempt to find out, "who are the doctors in terms of their social background, how and why they have been trained, and how they related themselves to their work, and implicitly or explicitly to society".

T.K. Oommen[7] study on "Doctors and Nurses" describe the occupational role structure of professional allopathic doctors and nurses working in public hospitals in Delhi. He focusses on the consequences of the transformation of the occupational roles of doctors and nurses from that of private practitioners to as public servants. He also attempted to find out the effect of the organizational set up on their work. He

identified three perspectives :

1. Objective evaluative to construct an ideal type notion of profession.

2. Symbolic realistic viewed as symbol and ideal and actual.

3. Class interest representing a different perspective concerning a reality of profession.

He also explained the relationship between profession and social structure, role commitment of the professionals and their role perceptions and role behaviour of doctors and nurses. He found that the social background of doctors contributes to their high prestige in professions whereas the origin of nurses degress the prestige of nursing profession. Oommen found a whole range of fit or discrepancy between the role conception and role performance and explained it in terms of the presence or absence of status. Congruence, whether between doctors and their patients or between them and the Nurses.

Additionally he also found this variance related poositively to the seriousness of situation exigency (i.e. emergency or non - emergency), and also the degree of autonomy or sense of exclusive responsibility weith which they performed their role[8]. He found that nurses faced more role conflict than doctors, especially male doctors.

9

Venkatratnam analysed in his study on 'Medical Sociology in an Indian Setting', the hospitals and their doctors and Nurses. He tried to find out the doctors and nurses role in hospital in terms of -----

1. Their prescription.
2. The role expectation and actual role performance of their own roles and of each other.
3. Role satisfaction and/or dissatisfaction in terms of the difference between role expectation and
4. The Sociological truths that emerge from an analysis of the role play of doctors and nurses in the hospital.

He demonstrated the frustration of occupational group as product of economic or the large value system of the society when he analysed the perception of role performance by doctors of their own and nurses role. He showed that doctor did not perform their role satisfactorily because they were not socialized to professional qualities of affective neutrality, acquirment of knowledge by research of teaching the medical students and following the role of bureaucracy. Universalistic interia are absent in these hospitals as against particularistic demands. The situation of nurses is quite different from that of doctors. Nurses said that their position is hospital is quasi dependent because by profession they are

subordinate to doctors. They said that doctors did not fulfil their role according to their (i.e. nurses) expectations.

Indu Mathur's[10] study was carried out in Jaipur at "Sawai Man Singh Hospital", in the years of 1967 - 68. In this study both the sides have been considered almost equally - the patient and the staffs (including doctors). Precisely, the dimensions dealt with are formal position and the informal relationship, situational and formal position and the degree of power, pattern of communication system and efficiency of the organisation extra organisational factors and deviations both profesionals and non - professional in the organisatioin, status groups both within and outside the organisation, and the ideologies and attitudes of the members, information control and theraputic ends and interaction system and achievement of social goals by the organisation. Information have been gathered on the deviance of "the role to be performed" versus" role being performed" (P.7).

This was also a teaching hospital like the Brown Memorial Hospital of Ludhiana and Cristian Medical College which is affiliated to it. The women patients are only allowed to visit the hospital after the decision is taken by the male members of the society. Male are superior to females in most of the Indian families and which is very conspicious in rural areas. She also

found that there is a communication gap between the patient and the staff --- mainly with doctors.

The study of **Aneeta Minocha**[11] was carried out in Lady Hardinge Medical College, New Delhi in the year of 1966 -68. Only female patients were taken. There are some important findings of the scholar which warrant a thorough attention, to be realised and they are as follows :

Two major factors of modern medicine affects the modern doctor patient relationship --- Firstly, the groth of specialization has resulted in changing the doctors role from "know all" and "care all", generalist to a specialist in a narrow field rendering the relationship more impersonal. Secondly, modern machine is increasingly being practised in the context of organisation such as hospital in which number of functionaries, as member of team, playing role in the treatment process. Patients interaction with the doctors have been analysed in the light of patients traditional norms beliefs and attitude which they held as a member of a wider society.(P.161).

According to the scholar the cultural barrier between the doctor and the patient is determintal to the proper treatment of the patient. So far as stay in a hospital is concerned it is quite expensive for many and, many and majority

want to get rid of the hospital even without completing their course of stay or even without completing their course of stay or even without medical advise. There are definite chances of communication gap because in most of the cases the message of the female patients are passed through male relatives/caretakers. Many respondents ignorant to such a level that they do not know anything about nurse, and majority of them visited the hospital for the first time. The implicit aim of the study is to obtain an understanding of peoples response to modern medicine. She also notes that Indian females being conservative by nature found male doctors for all types of consultation little difficult . (P.P.249 - 51).

According to scholar, the understanding of peole's adjustment ot forces of modernisation would be faciliated by studies of ideas, beliefs, values, tools and techniques, in the important area of health and disease.

T.N. Madan[12] conducterd a study of "Doctors at the All India Institute of Medical Sciences". He made an attempt to discuss three closely interrelated and important issues. They are as follows: first, the respondent perception and conceptualization of their professional roles. Second, their evaluation of the place of their professional work or role performance, that is the AIIMS, and third, their over all conception of the manner in which they relate as professionals to

the society in which they live and work. Crucial element in the attitude of doctors at AIIMS was their positive evaluation of modern medicine. Therefore, it is not at all surprising that they should believe that we should have much more of modern medicine in India than we have in terms of trained personnel, research and health care delivery system.

* **A.L. Srivastava**[13] in his study on Sir Sunder Lal Hospital, Varanasi analysed the nature of interaction among the doctors, the patient and the para - medical staff in a hospital. The hypotheses and findings of his study are as follows

1. The hypothesis, that the patient approach the problem of health and disease according to the cultural norms which they adhere to, is partially provided.
2. The expected behavior of doctor is not translated into reality.
3. Illiteracy and language problems are major barriers to closer interaction among doctors, patients and para medical staff.
4. The data partially provide that the beauracractic structure and process in hospital is affected by the socio - cultural demands on hospital personnel.
5. the dissatisfaction of para - medical staff affects the doctor patient relationship indirectly.

6. The major cause of the conflict in the hospital is the beauracratic control and non - recognition of the professional competence of its personnel.

The findings of the study showed that the doctors behaviour towards their patient is not so mush influenced by the socio - economic status of the patients, but the socio - cultural status of patients and doctors influence, their interaction pattern. The doctors are specific in relation with their patients but patients insist upon a diffused and intimate relationship with a doctor.

Madhu Nangia[14] in her study on medical college hospital, Rohtak analysed professions, professionalization and professionalism and tried to identify the basic attributes of profession which differentiate occupation from professions. She had made an attempt to describe the phenomenon of professional working in complex organization(i.e. Hospital). She also described the social improtance of medical practice and illustrates the wide variety of problems presented to doctors. She found that medical profession is dominated by male doctors hence, it is predominantly a male occupation. Her findings revealed that most of the doctors were satisfied with their profession, though they were facing some problems like the unsatisfactory financial rewards, loss of freedom to move, very

hard work with the unfair terms of service etc. Because of these problems some of the doctors felt frustration in their work.

Another study carried out by **Krishna Mazumdar**[15] at Calcutta hospital has helped to find out larger unexplored areas, so as to get a comprehensive picture of the particular and different parameter of man vis a vis hospital. The study was carried out in the year of 1975 to 1978, at Calcutta medical College hospital. The findings of the study can be stated as ----

There is a big gap between the staffs (including doctors) and the patients at all levels. The hospital is yet a kind of alien institution for the patients. There is schism between the community's perception of the hospital and the hospital in itself. There is a system of preferential treatment which is quite prevalent. There is a necessity to make it realise by hospital to the patients that the hospital is their own organisation.

"Occupational attitude of physician" is a study conducted by **Rammanna and Bambawale in 1976**[16]. They tried to find out the degree of interaction between the doctors and the patient in order to perform the role obligation of doctors, whether the amount of time spent per patient is in relation to patient illness and his rewards, whether the doctors are able to attain affective neutrality in their interaction with the

patients. They found that the general practitioner combined physical cure alongwith the psychological and emotional cure of the patient. The paid physician who has less monetary gains were compensated by curing patients with abnormal complications. The consultant got patients from general practitioners and government hospitals with their case history. Because of the shortage of time doctors could not give time to their patients for emotional and psychological satisfaction alongwith the physical cure when they examined the time spent by doctors to per patient in relation to the patients illness and their rewards they found negative relationship between the two. The maximum degree of interaction between the doctor and patient and minimum degree of interaction was between the consultant and paid physician and their patients. They (all these three types of doctors) performed their role without considering emotional involvement. And each type of practitioner had their own ways of practicing and the rewards were more than in any other profession.

Ambika Chandani[17] conducted her study on the practitioners of modern dedicine in Jodhpur city. This is a comparative study of institutional doctors and private practitioners. The study was based on the interview with 152 doctors of whom 119 institutional and 33 were private practitioners.

In this study she found that serving of patient was the basic motive of medical professionals, but doctors approve private practice also. Doctors prefer to work in city than in a village because they were not adequately trained to deal the problem of rural areas. This reflects the cruelest ironies of the prevailing system of medical education, because they look down to the facilities in rural area. She concluded that doctors are pretending to be professional and rendering service to the society whereas they are a variety of bussinessmen in local conditions.

All the above studies taken note of were conducted in single hospitals. The following studies and almost similar in all other respects with the above ones but here the numbers of hospitals consulted are more than one. The present study; has been carried out by **Shankar Pathak**[18] in four Delhi hospitals viz., Irwin, Safdarjung, Hindu Rao and welingdon. The scholar reached to a conclusion that twenty percent of patients were not satisfied with the behavior of the hospital staffs while eighty percent were satisfied, otherwise not much of impressive findings were made.

Another big study carried out by **Mohan Advani**[19] can be considered as comprehensive one, where he has consulted twenty small, medium and big size hospitals of Delhi. The study was carried out in 198Ø.

Before carrying out the study hypotheses of the scholar were as follows :

Better the functioning of the hospital system (from doctors point of view) better will be their role performance, larger the hospital greater will be satisfaction among doctors. Community general hospital will attract the patient from lower socio - economic strata. Greater use of influence by the patient would be viewed as deviant behavior and patient using influence would be percieved as problem patient, larger the hospital lesser will be the use of sympathetic words of the doctor while interacting with the patient, patients would rate doctors high on their performance variation will occur because of the size of the hospital, smaller the hospital greater will be the deriation from professional ethics, smaller the hospital better is the doctor patient relationship((P.1Ø).

* The major findings of Advani on the doctor - patients relationship are as follows :

The doctor should have sympathetic attitude. He should reassure and give moral support to the patient, the doctor should enquire about the disease and related problem while treatment being taken and in the stage of recovery,the doctors should give instruction about diet and preventive measures. The doctors should give a patient hearing,

the doctor should pay attention to physical examination. The doctor should extend the help to patients facing difficulties in getting the treatment. The doctors should clarify the doubt. the doctors should not spend more time in writting on registers names and giving medicine etc. The doctor should bot be tense, aggressive and should not deflate patient status. The doctor should be harmonious, he should take something to make patient happy(P.65).

While discussing with three doctors on the same issue they replied as :

Doctor expect patient to be co - operative. The patient should explain the disease clearly, briefly, frankly and specifically. The patient should ask again and again for conformation. The patient should not seek many professional favours. The patient should trust the doctor.

It has been generally seen that the patients do not ask for orientation of conformation. It was also significant that neither the doctor nor the patient show any clear cut aggression or tension towards each other (P.81).

Studies Conducted by Several Govt. and Autonomous Organisations :

The studies conducted on different issues of hospital can be accredited to National

Intitute of Heath Administration and Education (Formerly NIHAE) now National Institute of Health and Family Welfare (NIHFW) to Indidan Institute of Public Administration as well as Institute of Applied Manpower Research besides the works of Ministry of Health and Family Welfare. A study was conducted by Indian Institute of Public Administration in the year 1969 under the chairmanship of J.N. Khosla.[20] This committee studied Irvin and Lady Hardinge Hospital of Delhi.

This study made an attempt to identify the peoples reaction to the services offered in large hospitals and at the same time ascertain the difficulties which according to them acts as diterrant to their certain satisfactory services from these public hospitals. The study took the groups of service givers and service recievers into consideration for a broader picture. The study considered the O.P.D. patients as well. The observation made about Lady Harding Medical College Hospital are following :

The literates tend to visit the hospital more than iliiterates in maternal and child Health Centre. Mothers who were experienced i.e. second or third delivery, preferred to undergo domestic delivery than hospital. They also stated that ones faith and personal satisfaction can not always be despensed in state run hospitals.(P.107).

The short coming of the hospitals stated by the patients can be administratively remedied through :

Establishment of hospital based education programme for maternity cases. Formulating procedure for coordination so that excess demands for admission are provided with proper accomodation. Improvement in hospital staff patient relationship. And the bed capacity to be increased in terms of quantity. The study of Irwin Hospital's O.P.D. produced the following results. Eighty percent of the patients in O.P.D. wanted immediate treatment than waiting hours together. Majority of the patients had complaint of doctors using non - understandable technical jorgons which is a common feature among many hospital doctors. Majority of the patient are not interested to go to the hospital twice except the old and aged who would visit hospital even more than once. Many of the patient did not want to consult the doctor in presence of the other patients . Patients are concious about the illness and they visit the doctor and take the medicine.

Another study was carried out by NIHAE under **T.N. Kuppuswami**[21] . This study is on "patient and hospital" and was carried out in 1975. The main questions asked to the patients were about ward equipment, sanitary accomodations, meals, different activities during stay in the hospital and finally about

the staff of the hospital. Almost everything was appreciated except eighty percent complaint of lack of recreational facilities and mismanagement, only ten percent liked the overall set up. Though the results obtained are very plain and simple but one has to take a very serious note of that. Kuppuswami also advocated for survey of hospitals after every three years to have an up to date knowledge about it and to take necessary action according to the requirement.

Another independent study from Central Bureau of Health Education was carried out by A.K. Bhatia[22] in 1970. Which was on "Needs and problems of patients". The study was carried in orthopaedic unit of New Delhi. The study derived the following conclusion :

The patients were much worried about their illness, recovery and rehabilitations. Ninety percent patients were happy because they were provided with all round informations from the nurses. Seventy percent were satisfied with their doctors giving all round informations to their patients. Some complained of persistant plain and long duration of stay in the hospital. Forty five percent felt thay did not get enough opportunity to talk and ask questions to nurses and only ten percent were satisfied with the opportunity recieved to discuss their problems with their doctors. Cent percent patients said that they never had an opportunity to meet the

social worker in the hospital. The patients can only ask questions regarding their illness only after getting discharged or during rehabilitation. Cent percent patients were dissatisfied due to the absence of entertainments. Ninety percent were not satisfied with the food facilities. Sixty percent complained of the lack of privacy in the ward. The patients were staying on the floors as well they were unhappy so far as the communication of the two is concerned, the patient and the doctor.

The above study gives a very clear picture of various dimensions, and the most important part which is crystral clear after all these studies is that there is huge problem in Management and administrative land. Though there are some psycho - social or socio - cultural problems do exist but these have mainly stem from the managerial administrative parameters.

Finally Bhatia suggests that "------- further the needs and problems of patients should be taken into consideration while organising educational programme for patients keeping in view that the patients are human being ".

In the preceeding section we have reported some structural studies on medical profession and some studies on human relations in social organization in the hospital settings which involve social interaction. In the spirit of

abvove discussion we have tried to find out the problem of health and medical professionals, in village as well as in urban society.

Notes

1. E.Freidson (ed.) - The Hospital in Morden Practice,Free Press, New York, 1961.

2. Mecim Marriot - Western Medicine in a village India in Health Culture and Community (ed.) B.D. Paul, Russel Sage foundation, N.Y.,1955,P.239

3. G.M. Carstairs - Medicine and Faith in Rural Rajasthan in B,D. Paul (ed.)Health Culture and Community , Russel Sage Foundation, N.Y., 1955,P.P.192 - 193

4. Jona Kirpatrick - The delivery of hospital services in North India,(ed.) G.R. Gupta Main Currents in Indian Sociology, Vikas, New Delhi, 1981

5. K.A. Hasan - Medical Sociology of Rural India ,Sachin, Ajmer, 1979

6. T.N. Madan - Doctors in a north Indian City : Recruitment, role perception and role performance in Satish Sabarwal (ed.) Beyond the village, Indian Institute of advanced study, Simla, 1972

7. T.K. Oommen - Doctor and Nurses : A Study in occupational Role Structure , Macmillan, Delhi, 1978

8. Ibid,P.P.228 - 231

9. R. Venkatratnam, - Medical Sociology in an Indian setting, Macmillan, Madras, 1979

10. Indu Mathur - Human organisation of a Hospital, Alakh, Jaipur, 1975

11. Anita Minocha - Some aspects of the Social System of an Indian Hospital, Delhi University, Delhi, 1974

12. T.N. Madan (ed.) - Doctors and Society, Vikas, New Delhi, 1980

13. A.L. Srivastava - Human Relations in Social organization, Chugh, Allahabad, 1979

14. Madhu Nagla - Professionals and Their clients : A study ;of Doctor Patient Relationship in Sheo Kumar Lal,Kirti Khanna, A. Chandani and U.R. Nahar (ed.) - Readings in the sociology of professions,Gyan, Delhi, 1988

15. Krishna Mazumdar - Socio - Psycho Economic Problem among hospital patient of west Bengal, Calcutta University, Calcutta,1978

16. A. Rammanna and Usha Bambawale - "Occupational attitude of physician", Sociological Bulletin, Vol. 2, No. 2, Sep. 1978,P.P.190 - 207

17. Ambika Chandani - The medical Profession : A Sociological Exploration, Jainsons, New Delhi, 1985

18. S. Pathak - Social Welfare Health and family planning in India, Marwah, New Delhi, 1979

19. Mohan Advani - Doctor Patient Relationship in Indian Hospitals, Sarghi, Jaipur, 1980

20. J.N. Khosla - Citizen and Hospital Administration, Indian Institute of Public Administration, New Delhi, 1969

21. T.N. Kuppuswami - Patient and Hospitals, NIHAE, Vol.VIII, No. 1, Delhi, 1975

22. A.K. Bhatia - Needs and problem of patients, The Nursing Journal of India, New Delhi, 1970.

C H A P T E R - IV

Analysis and Assesment

"Induction of western medicine into any third world countries have been done in many unfavourable conditions. Colonial conquest and exploitation considerably aggraveted the ecological conditions which generated various diseases of poverty. In addition, access to western medicine was limited to the colonial rulers and upper crust of native gentry.[1] The Indian scene was no exception to this. The state supported the western medicine and it became the most sought after by the native intellectual elites, and the introduction of western medicine laid to decay, degeneration and disintegration of the pre - existing system. The poor were affected to the highest degree than anyone else in this country.

The social, economic and political forces which were responsible for to shape up the medical practices and the system in then India was much lop - sided as well as elite - oriented. The situation today is no different in Indian medical practice and system as well. The health institutes came up in different cities and towns with predominance of urban and rural elites as the most welcome clients. The education in general and the professional education in particular were the

privileges of the most affluent classes in the British India.

For a period of time this (western) medical system reigned supreme and the native indigenous practices were thrown almost in oblivion. Even though there has been a constant effort seen on the part of policy - planners and decision - makers to have more and more western prototype of 'hospitals' in India, yet all these efforts are marked by unscrupulous stratification at all levels of hospital installation viz. Taluk, District, Town and Metropolis - where we can see the differences in hospitals. At one end hospitals are fully equiped with facilities and manpower, whereas, at the other end they lack the same.

It is quite clear from the normal trend that more a patient is economically sound, more he seeks the luxurious medical retreat, where every kind of services rendered to the client is superior and splendid in comparison to the other run - of - the - mill hospitals. The social scientist and the health educators have been more of an extension workers and preachers of the western medical system without, in the least, realizing that this system has to have a common denominator with the traditional Indian practices and system at the one or the other level and also that, there has to be a perfect cultural integration of various medical and not a forceful compromise or a bizare cocktail of the two. i.e. the western and the traditional.

The social scientist and other experts have helped to promote the kind of native practices and medical ideologies to be perpetuated by denying the lay man with the relevant medical and surgical knowledge of most adequate and perfect nature. In other words there was no one to give an adequate requisite counselling for the patients at the right time in right places. The innocent lay patient is rather branded by the social scientist and the doctors as 'unwise','non scientific' and 'irrational'rather than making the system more adequate and more accessible to the poor and needy patients.

Roger Jeffery[2] in his article concludes that "------- the colonial rulers and their native followers helped and promoted the western medicine and practice which was accessible to a pocketful of natives in terms of its (medicine)and benefits (medical)".

The studies conducted by **Anita Minocha**[3], **Indu Mathur**[4], **M. Advani**[5], **J. Kirpatrick**[6], **A.L. L.Srivastava**[7], **Krishna Mazumdar**[8], **Shankar Pathak**[9], **Ambica Chandani**[10] have by and large followed the functioinalist approach for their study and a general appreciation of their understanding and analysis are as follows :

These studies have been conducted on different hospitals in India. They consider hospital as a social system and its staff and patients as a part of the total

social structure and system. These authors have noted that there is a significant social barrier between the doctor and the patient in various fields besides the economic one. Many authors have justified the improper treatment recieved by the patient in the hospital as due to the incompatability of the patients own social, cultural and religious conservatism. But the staffs and the hospital and culturally, socially conceptually alien to the patient (specially for those who visit the hospoital for first time), and he is an odd man out in the hospital health care system. The studies also mention that the urban, literate, non - conservative, relatively economically sound patients recieve better treatment and are much satisfied with the hospital set - up and its medical practices, which are totally unlike his rural counterpart.

It has been noted by some scholars that smaller hospitals foster relatively stronger human values unlike the big ones. All the above mentioned studies except that of Mohan Advani are based on interview, questionnaires - shedules, with random sampling of specific wards besides limited numbers of doctors and nurses as well as paramedicals as interrogating samples,while in case of the latter the psychometric and psychological tests were also used to validate or abondon the hypothesis.

It has been noted by almost all the authors that the rural- poor (mainly from the catchment areas), the slum- dwellers of the big cities, and poor economic class seek the hospital- treatment during the final stage and expects the doctor to do miracle or similar 'magical' performance. This attitude of the patient has been condemned by the doctors and other staff of the hospital and hs been justified to an extent by the above mentioned studies and their authors.

Some authors mentioned about "ward culture", the development of kind of habit or behavior, within the wards in the case of patients who stayed there at least for ten to fifteen days. It was found that the expecations of patients have been paid deaf ear by the nurses and doctors as well as class-IV staffs when the patients demanded any help. In general, even though a handful of better- off (economically, politically and socially) were satisfied with their treatment in the hospitals, the majority of the poorer patients were actually disgrantted with the experience. This feature was so conspicious of the hospitals studied, that most of the authors thought the "preferential treatment" as one of the indispensabele features of the contemporary hospitals.

Though it is paradoxical but still it is a common feature that the staffs, doctors and the

patients unite on certain specific issues shuch as the desirability of more number of beds, additional staff, better hygiene and cleansing, better supply of medicines, efficient management and administration of the hospitals.

So far as the mutual interests and demands do not clash with each other, there is no conflict situation but the moment there is a clash the situation becomes more tense and hostile. The patients complaint only when the situation really gets out of their control. Some aspects reflecting discontent and dissatisfaction with the hospital systems are as follows :

The senior doctor do not care for the patients as per their assigned duties. Rather, most of them delegate their duties to the juniors and at times even to the nurses. The medicine is not administered in time by the nurses. The doctors do not disclose the disease even on repoeated requests by the patients. If something is disclosed it is couched in technical language and as such of no use and value to them.

The doctor by and large show an alien behavior towards the patients, except in case of influential or well- to- do patients. The doctors during any kind of failure try to shun it, and make the subordinate responsible for it.

Indu Mathur and **Anita Minocha** notes in

their studies that patients are comparatively much more close to 'nurse' than doctors in most of the cases. The admission of a patient without any acquaintance with the hospital staff is a real troublesome affair. They also note that there are certain specialities i.e. Gyn/Obs. in which only female doctors are prefered because the illiterate female patients do not have any problem in communicating with them. It was also noted by the authors that small children want to live in wards with their parents only.

J. **Kirkapatric** and **Indu Mathur** found that the patient's relatives, parents or neighbours are not encouraged to stay 'back in the hospital'. But otherwise, these often prove to be real helping- hands and at times also surrogate for the over busy- nurse or paramedicals.

We shall now make brief critical comments on the above studies underscoring their methodological, conceptual and empirical inadequacies .

Anita Minocha's study is based on three wards and an O.P.D., and the patients studied were all females. Most of the staff members were also females. No psychological, psychometric or projective tests were conducted. Her conception of ward- culture is very indistinct and non-definitive as she has studied only three wards. It is also important to note that such brief stays of patients do not really

build up a 'culture'.She ideal- type of a patient as illiterate, ignorant, traditional and reluctant to recieve guidance is not always and universally true. The communication gap is not merely the fault of the patient - ignorance but also of the doctors and staffs who prefer and use the technical jargons more inadvertantly than it is necessary.

Jona Kirpatric's study is near repetitions of the earlier mentioned studies, except that it is against a different backdrop. The hypothetical framework is not a comprehensive one. The issue of custodialism vis- a- vis group relationship has been extension of the peripheral features of hospital. The O.P.D. was not considered, and neither the discharged patients. The method of data- collection is an old and conventional one.

The study of **Mohan Advani** is relatively conclusive and comprehensive. The study has taken psychological, socio - psychological and psychometric parameters besides using the old conventional technique of choosing samples; all aggregrating upto one thousand patients in twenty hospitals of Delhi. The prominent objection can be raised in the selection of types of hospitals. We can indeed compare different hospitals, but before this we have to be sure that we are not comparing the incomparabeles. Therefore, a comprehensive schema of various

attributes of hospital as a work - place or organization has to be worked out and thus used in selecting the similar or proximate organizational structures. Moreover, to cover within a short span of time, twenty Delhi hospitals comprising of big, medium and small, is indeed a very tall order. One surmises, therefore, for such a huge sample size in such a relatively small, whether or not, a real justice can be done to the problem of this magnitude.

The studies conducted by **T.N. Madan, T.K. Oommen** are attempts to find out how far the students of medicine and nursing are playing role in keeping their own image, professional image and the patients need fulfilment besides trying to throw some lights on the educational system. The methodology of Madan's study on AIIMS. is not sound because only questionnaire observation and interviews were conducted to pursue the data collection. The very concept of "modernisation" and 'moderniser' can not be assessed by a single institutional study, only one hundred doctors can not be component of modernisation. No questions were asked to the respondents regarding the improvement of the total systems and the hospoital. The study did not deal with any concrete socio- cultural arguments or thought-ways.

The study "Doctor and Nurses" by**T.K. Oommen** is an assessment of the doctors and nurses in Delhi hospital. The methodology of the study is too weak beside's of

its shaky conceptual level. The data have been conducted in the same old conventional sytle, No psychological, socio - psychological or projective tests were conducted to make the study more holistic. The doctors profession has been kept at high esteem which definitely fosters a built in bias in the study. The nurses came next in the prestige and performance scale. The author has put nurses in such a position in the hospital where doctor and patients looks down upon nurses. The study has emphasised mainly on doctors and made it lop - sided one through its caption is "Doctors and Nurses". On the whole the study did not contribute to the socio - cultural understanding of doctor , nurse and the patient of a hospital in relation to society.

The study of **A.R. Venkatratnam** is no exception from others. The methodology is lacking adequate techniques to collect sufficient relevant data. This study has mainly dealt with the doctor of two hospitals - teaching and non - teaching. Nurses and para - medical staff have got no status in the study. Unfortunately, the sutdy has devoted too much on "role expectations" and "role behavior". i.e. how doctors performs their duties and what are expected from them by patients. The study has fallen into the traps of parsonian and weberian model. By and large the study could not contribute much to the understanding socio - cultural realities of institutions and

patient care.

The study of **Ambika Chandani** is methodologically the same. In the study she found that doctors are not exactly professionals but are working like bussinessmen to gain maximum monetery profits. The doctors have been given the maximum attention in this study and others are neglected.

The above studies conducted by sociologist on hospital system have by and large compromised with western models and taken the present hospital situation even without questioning to the very contemporary status of its relevance. According to most of the authors the patients are illiterate, orthodox, traditional, non - scientific, non - rational, caste bias, unjust and vague. And after considering these facts the scholars have demanded from the patient to rise upto the expectations of the organisation and its staffs where he is being treated.

In all the above studies we find that Doctors are mostly male and belong to the higher caste. They also belong to well to do families and mostly come from urban area. Compared to Doctors, a significant proportion of nurses are drawn from the rural areas, predominantly from the cristian community and lower middle class families.

Most studies on the role perception

of doctors reveal a limited self definition of doctors role. T.N. Madan in his study of Gaziabad reports doctors to be more patient and disease oriented. In his study of AIIMS he point out doctors role percieving as a 'healer'. T.K. Oommen's has also made the same observation in his study.

Turning to role performance, Madan finds a big gap between the normative model of the doctors role. In his study of Gaziabad he found that doctors look up at profession basically in terms of a good living rather than some notion of social responsibility. T.K. Oommen in his study finds that most of the doctors tend to view the patient not as a patient but as "bundle of clinical symptoms". He observes that "the majority of doctors in public hospitals do not consider the welfare of patients as their most important role obligation". Madan in his study of AIIMS finds that doctors do not seem to spend more time on patient care but on research. Ambika Chandani in her comparative study of Institutional doctors and private practitioners suggest that private practitioners show greater warmth in dealing with patients.

T.N. Madan and A. Chandanialso notes colleugial relations among doctors are not good. They see each other as competitors and do not discuss their patients within themselves. In public hospitals also Oommen notes this relations

to be hostile.

Concerning the nurses attitude towards patient care, Oommen reports that nurses are more humanitarian than doctors in doing their duties. He also notes a hostile feeling among doctors and nurses because of authoritarian attitude of doctors.

As analysis of various studies in the Medical professions have revealed, this area of study suffers from some serious limitations.

First of all, the profession have been studied were in terms of an ordinary earning occupation and the issues bordering on the doctor - patient and their career problem have been highlighted. Doctors ought to be viewed more in terms of a "profession', which means various aspects of there recruitment, functioning ought to be analysed in terms of conceptual construct of profession already available to us. This will unable us to highlight discripicancies, if any, between professonal idea and professional reality.

Secondly, doctors have been viewed almost as an isolated and not intergrating as a part of their professional - social millieu. As such several imported problems dealing with their professional and social roles and their mutual conflict have been left almost untouched. Also,

doctors have not been methodologically placed as if within the broder hospital setting and viewed in terms of their functional or dysfunctional relationship to the later.

Thirdly, doctors and the relevance of their professional role performance ought to be perciebed in the context of modern, dynamic Indian society. Which is undergoing a process of complex and multiple change. A situation where state is playing very active role in spreading health amenities to the people of every areas, doctors acquire special significance in as much as they ought to obtain adequate inspiration from their professional ethic in order to reach out to the poor on their own.

Therefore, studies should also be focusssed on these extending frontiers of medical profession and medical ethics.

Notes

1. D. Benerjee - Poverty class and Health Culture in India, Vol. I, Prachi, New Delhi, 1982

2. Roger Jeffery - Allopathic medicine in India : a case of deprofessionalisation, Economic and Political Weekly, Jan 21, 1978, P.P. 101 - 10

3. Anita Minocha - Some aspects of the Social System of an Indian Hospital, Delhi University, Delhi, 1974

4. Indu Mathur - Human organisation of a Hospital, Alakh, Jaipur, 1975

5. Mohan Advani - Doctor Patient Relationship in Indian Hospitals,Sarghi, Jaipur, 1980

6. Jona Kirpatrick - The delivery of hospital services in North India, (ed) G.R. Gupta Main Currents in Indian Sociology, Vikas, New Delhi, 1981

7.A.L. Srivastava - Human Relations in Social Organization, Chugh, Allahabad, 1979.

8. Krishna Mazumdar - Socio - psycho Economic Problem among hospital patient of West Bengal, Calcutta University, Calcutta, 1978.

9. Shankar Pathak - Social Welfare Health and Family Planning in India, Marwah, New Delhi, 1979.

1Ø. Ambika Chandani - The Medical Profession : A Sociological Exploration, Jainsons, New Delhi, 1985.

CHAPTER - V

CONCLUSIONS

"This research work focusses on medical profession in Indian society." The attempt was made to describe the medical profession, its socio - cultural background, and also the conditions of professional practice. It was also examined as to how the medical professionals relate themselves to thier work, and also what is their place in the medern Indian society. The relevant material were collected through the published and unpublished documents. i.e. books, magazines, articles, thesis etc. Some informations were also collected from Institute of Family Planning and Welfare, New Delhi. In this section, we shall try to recapitulate some of the observation already made at the end of each chapter.

Profession in India - especially the high profession, has devoloped consequent upon the colonization of the country by the British and devolopment of the 'Captive' economy. Modern medicine was brought in India by European missionaries and colonizers. Before the popularisation of modern medicine the people of India were dependent upon the traditional and indigeneous system of medicine. The medicine as a

profession was started by 'shamans' who funcioned as intermediaries to the spirit. The cause of disease was thought to be the punishment supernatural powers. Then came the professional healers who treated patients in exchange for goods and services. In Rig - Veda 'bhisaj', the bone setters were the medicine men.. The cause of the disease was thought to be the evil work of demons. After that, there came into being, two systems of daignosis and treatment, the ancient and indigeneous Ayurveda and the imported Yunani systems. The practitioners of these medicines belonged to those families who were engaged in the practice of healing on a hereditary basis. People had faith in these healers and they respected them. In an exploratory study conducted by Madan[1] in a north Indian city, he did not find a significant correlation between the religious faith of a decision maker and his choice of treatment in respect of himself or the member of his household.

In the chapter three we have reviewed certain studies of medical profession conducted by different scholars in Indian society and come to the conclusion that in village India people still relied upon the traditional and indegeneous system of medicine. There are only a few respondents who wanted to be treated by modern practitioners. Most of them are scared of modern doctors. Their relationship with the

practitioners is much friendlier under the modern medicine system. But Hasan[2] in his study found that people to modern medicine practitioner only when they find their disease is virtually incurable by indegeneous practitioners. Also, they consider modern practitiner as 'corrupt' people, and this creates an automatic distance between the village folk and practitioner of modern medicine. Only when a physician tried to understand the cultural and cognitive style of the villagers, then, he was accepted by the village folk and integrated with them village society.

The studies also show that modern medicine practitioners are more popular in urban areas. Also, most of the doctors preffered to work in urban areas because of 'better' standard of life and economic gain. The proportion of scheduled castes and scheduled tribe doctors in India society is quite low. The upper castes and upper class families tend to dominate the medical profession. They are generally from urban areas and male are more proponderant in comparison to females. While in case of nurses they come from lower or lower middle class background and female nurses are disproportionally more than male nurses in Indian society.

The doctors are both satisfied as well as dissatisfied in this profession, even though they are

ready to acknowledge that their duty is to reduce pain and minister the sick. In government service, they feel a sense of career security and more learning opportunity than in private practice. If attached to some hospital they deal with a much wider range of diseases and hence they get better opportunity to learn. They are dissatisfied because of low income, interference by senior doctors, unsatisfactory working condition etc. Those who do not want to work in this organizational structure, join private practice which proves more gainful and also affords fredom from fixed routines and rules.

Doctors in India do not want to work in rural area because of general lack of facilities. They are satisfied to live in urban areas even with less in income, therefore, we find a large number of doctors unemployed because of their plain refusal to go to rural area. **Madan**[3] notes that the pursuit of a relatively higher standard of living often entails much hardship for the doctors without any particular benefit to the patient.

There is a wide cultural gap between the medical profesionals and the people in general because of the social organization of the country. This gap is because of patients perception of their social reality. Accordingly , if they have a choice, they would choose only those doctors with whom they can identify themselves socially, ethnically and culturally.

Madan [4] notes that modern doctors of Asian countries are prevented by their social background, professional training, career goals and life style ambitions for themselves and their children to relate to people in general in the same manner in which they are able to relate to their own class. He discribed doctor as 'modernist' rather than 'modernizers'.

Now there is a need to set the new objectives in social development of medical professionals. The government should provide better facilities and reasonable reward for their work. The government should provide better facilities in rural areas. It will reduce the unemployment among doctors and they will start going to rural areas also.

The problem affecting medical education also needs prompt attention. They relate to diversity in the methods of selection of students, the practice of taking capiation fees by some private colleges for admission irrespestive of merit, under - utilization of post - graduate education facilities and shortage of medical teacher etc. The use of doctors has to be optimized by providing them with adequate facilities at the Primary Health Centres, and some other health institutions. Since the resources are scarce, community efforts and inputs may be mobilized so that a feeling of mutual help is created.

Rural people are also entitled to the same care as urban people and they should get modern medical treatment. So it is very necessary that modern medical relief of the highest standard should be extended as rapidly as possible throughout the countrymen. The penetration of modern medicine into the countryside has been so slow that there is no real prospect of providing medical relief in the rural areas even of minimum standard. The overwhelming proportion of medical colleges, hospitals, research institutes and modern medical practitioners are concentrated in India's urban centres. This is a major problem to be taken into account by the government.

In view of the inadequate finances at the disposal of the State for providing medical facilites to the people at large, medical professional bodies should also restate professional duties and restructure professional goals to be pursued by the members of the medical profession. Sociologically speaking, changes which are initiated and nurtured by the collectivity (here 'professional collectivity') are bound to be more enduring and effective than some extraneously imposed restrictions and injuctions.

Notes

1. T.N. Madan - "Who chooses Modern Medicine and Why?", Economic and Political Weekly, 4.37, 1969,P.P.1475 - 84.

2. K.A. Hasan - Medical Sociology of Rural India, Sachin, Ajmer, 1979.

3. T.N. Madan - op.cit , 1972.

4. T.N. Madan - Doctors and Society, Vikash, New Delhi, 1980, P.296.

B I B L I O G R A P H Y

Advani, Mohan. (198Ø) Doctor Patient Relationship in Indian Hospital, Sarghi Prakasan, Jaipur.

Ahluwalia, A. (1967) 'Sociology of Medicine in India' in Economic and Political Weekly, 1. (42).

---------- (1974) 'Sociology of Medicine in India, in Survey of Research in Social sciences : Major Group IV, I.C.S.S.R., Delhi.

---------- (1974) 'Some aspect of the Social System of an Indian Hospital', Ph.D. thesis, Delhi University, Delhi.

Barber, B. (1963) 'Some Problem in Sociology of Profession', in Daedules. 92 (4).

Basham, A.L. (1976) 'The Practice of Medicine in Ancient and Medieval India', in Charles Leslie, (ed.) Asian Medical System, University of California Press, Berkeley and Los Angles.

Becker, H. (197Ø) Sociological WOrk, Aldine, Chicago.

Benerjee D. (1982) Poverty class and Health Culture in India, Vol. 1, Prachi, New Delhi.

Bloom, S.W. (1963) The Doctors and his Patient : A Sociological Interpretation, Russel Sage Foundation, New York.

Caplow, T. Wilensky and Ritzer (1966) 'The Sequence of Professionalization' in Howard Mcvollmer and Donald L. Mills (ed.)Professionalization, Prentice - Hall New Jersey.

Bhatia, A.K. (1970) 'Needs and Problem of Patienas', The Nursing Journal of India, New Delhi.

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

Caplow, T. (1954) The Sociology of Work, Mcgraw Hill, New York.

Carr -Saunders, A.M. and P.A.Wilson (1933) 'The Profession', Routledge and kegan Paul, London.

Carr -Saunders, A.M. (1934) 'Professions', in Encyclopedia of Social Sciences, Vol. 12.

---------- (1962) 'Emergence of Profession', in Sigmund Nosow and William H. From (ed.)Man Work and Society A Reader in Sociology of Occupation, Basic Books Inc. Publishers, New York.

Carstairs, G.M. (1955) 'Medicine and Faith in Rural Rajasthan in B.D.Paul (ed.) Health Culture and Community, Russel Sage Foundation, New York.

Djurfeldt, G. and Staffen Lindberg (1975) Pills against Poverty : a study of western medicine in Tamil village, Curzon Press, London.

Dubey, S.M. (1975) Social Mobility among the Profession, Popular, Bombay.

Elliot, P. (1972) The Sociology of Professions, Mcmillan, London.

Friedson, E. (ed.) (1961) The Hospital in Morden Practice, Free Press, New York.

- - - - - - (1966) 'Physician', in Encyclopeadia of Social Sciences, Vol. 10.

Gandhi, J.S. (1982) Lawyers and Touts : A Study in the Sociology of Legal Profession, Hindustan Pub. Corp., Delhi.

Greenwood, E. (1957) 'Attributes of Profession', in Social Work, July.

Govt. of India, (1975) Health Service and Medical Education :a programme for immediate action, New Delhi

Gren, Rosen (1980) Sociology of Medicine :Diversity, Conflict and Change, Harper, New York.

Hasan, K.A. (1979) Medical Sociology in Rural India, Sachin, AJmer.

I .M.R. (1967) Devolopment of Modern Medical Education in India,New Delhi.

Jeffery, Roger (1978) Allopathic medicine in India : a case of Deprofessionalization, Eco. and Pol. Weekly, Jan.21.

Khosla, J.N. (1969) Citizen and Hospital Administration, Indian Institute of Public Administration, New Delhi.

Kirpatric, J. (1981) The Dilivery of Hospital Services in North India in G.R.Gupta (ed.) Main Currents in Indian Sociology, Vikas, New Delhi.

Kuppuswami, T.N. (1975) Patient and Hospital, NIHAE, Vol. viii, no.1, Delhi.

Larson,M.S. (1977) "The rise of Professionalism", University of California Press, London.

Leslie, Charles (1973) The Professionalization of indigenous Medicine in Milton Singer (ed.) Enterprenuership and Modernization of Occupation Culture in South Asia, Duke University.

Madan, T.N. (1969) Who Chooses Modern Medicine and Why? in Eco.and Pol. Weekly,Sep.13.

---------- (1972) "Doctors in a North Indian City: recruitment, role perception and role performance" in Satish Saberwal (ed.) Beyond the Village,IIAS,Simla.

---------- (198Ø) Doctors and Society,Vikas,New Delhi.

Marshal,T.H. (1939) "The Recent History of Professionalism in Relation to Social Structure and Social Policy,in Canadian Jr. of Economics and Political Science,Vol.5.

Mathur, Indu (1975) Interrelation in an Organisation,Alakh,Jaipur.

Mishra, B.B. (1961) Indian Middle Classes, Oxford University Press, London.

Mazumdar, k. (1978) Socio - Psycho Economic problem among Hospital patient of West Bengal,Ph.D. Thesis, Cal. University, Calcutta.

Nangla, Madhu (1988) "Professionals and their clients: A study of Doctor Patient Relationship" in S.K.Lal, K.Khanna, A.Chandani and U.R.Nahar (ed.) Readings in Sociology of Profession,Gian,Delhi.

Oommen, T.K. (1978) Doctors and Nurses: A study in occupational role structure, Mcmillan, Delhi.

Parsons, T. (1959) The Social System, Free Press, Illinois.

---------- (1968) 'Professions', in International Encyclopeadia of Social Sciences, Vol.12.

Rammanna, A. and Usha Bambawale (1978) 'Occupational attitude of physician', in Sociological Bulletin, Vol.27, No.2 (Sep).

Sharma, S.L. (1985) 'Sociology of profession in India' in Survey of Research in Sociology and Social Anthropology, ICSSR, New Delhi.

Srivastava, A.L. (1979) Human Relation in Social Organization, Chugh, Allahabad.

Tucket, David(ed.) (1976) An Introduction to Medical Sociology,Tavistock, London.

Venkatratnam, R. (1979) Medical Sociology in an Indian Setting,Mcmillan, Madras.

Wilensky, H.L. (1964) 'The Professionalization of ereryone? American Jr. of Sociology, Vol.7Ø.