# A SOCIOLOGICAL STUDY OF THE MEDICAL PROFESSION

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Submitted in fulfilment of the requirement of the
Degree of Doctor of Philosophy


To

**The North-Eastern Hill University**

Shillong

**June, 1986**

# CONCLUSION

## I

We would here like to recapitulate the salient features of our study in relation to the objectives discussed in the introductory chapter.

To begin with, the problem was the conceptual placement of the specific universe of our study in the context of its larger universe so that the relationship of the doctors with the wider society could be seen in perspective. The doctors in Shillong were obviously a micro-representation of the larger community of doctors because they had undergone the same rigours of training as their counterparts elsewhere in the country. If they shared a common knowledge base with other members of their occupational group they were different from them in terms of their societal backgrounds and by the fact of working in a different cultural milieu.

In our opinion these cultural-environmental differences assume crucial importance over and above the facts internal to the occupational training since they (the cultural-environmental factors, in our view) make the organisation of their practice different from others. That is why we hesitated in accepting them as a 'professional' group without first ascertaining the nature of their occupational behaviour.

We therefore discussed, in Chapter I, the concept of Profession as applied to allopathic medical practitioners. In spite of a lack of unanimity amongst the various scholars two points become clear about the definition of the term 'profession':

i) it has been viewed as a static structural category; and

ii) autonomy and monopoly in the work organisation are important aspects of an occupational group termed as profession.

Contrary to the general view we consider it as a process in which a particular occupational group secures control over its affairs as against such occupational groups which are either under state control or under client control or both. We agree with Johnson[1] that such a control is exercised by the colleagues as a collectivity over each other. The question of colleague-control along with aspects of autonomy and monopoly assumed greater importance in our study of the doctors practising in Shillong.

II

Allopathic system of medicine was introduced in India by the British to look after the health of their civil and military officials posted here. The theory and practice of this system of medicine was quite different from those of the

indigenous systems prevalent in the country and it did not take long for the former under the state patronage to become a competitor of the latter.

Organisation of allopathic practice in India, therefore, has to be seen in its historical background which has been described in Chapter II. We have discussed the growth of medical education in the country and the establishment of the Medical Council of India (MCI). The MCI had come into existence after the General Medical Council of Great Britain (GMC) withdrew its recognition of the Indian medical degrees in 1930.

Though the GMC and the MCI have certain features in common yet they have evolved out of different historical processes. The concept of GMC arose in U.K. where it was established after an agitation, protracted over three centuries, by the medical reformers in England. The agitationists had wanted an exclusive right to permit medical practice to only those who had undergone training under their supervision. The creation of GMC, however, did not ban unqualified medical practice but only preserved the right of qualified and registered practitioners in terms of signing of death certificates and state appointments, etc.

There was no such movement of the medical practitioners in India and the MCI was created by the State to regulate

the training and practice of allopathic system of medicine for the benefit of the citizens.

It appears that the creation of MCI has granted autonomy to the medical occupation to govern the recruitment, training, and granting of licence to the neophytes. It also enjoys the powers to delicence its members who do not conform to the norms. But we find that this autonomy is subject to State control. The MCI has to adhere to the provisions laid down in the Indian Medical Council Act and any deviance would cause an enquiry by the government. The Enquiry Commission has a majority of members representing the State. A large number of members of MCI, though all belong to the medical occupation, as nominees of the government, have dual loyalties — one, to the nominating authority (the government), and the other, to their occupational group. Besides these, each state in the country is required to have its own State Medical Act and a medical register thus dividing the control of medical practice into territories.

The de facto situation also reveals that the MCI feels quite helpless without an active cooperation of the State in its affairs. The following long quotation taken from an MCI document will illustrate the point:

> "Not withstanding the curricular contents prescribed by the Medical Council of India and amended from time to time, no scientific evaluation of what has been in vogue for more than 2 decades has been undertaken nor a study made of the medical graduates from the different colleges of the country. Only on the basis of such evaluation it can be decided whether any deficiency in the training programme exists. Such evaluation can be undertaken by the Council provided the necessary facilities are sanctioned by the Central governments." (emphasis ours)

> "Deficiencies which exist at present, if any, are attributable more to a failure of implementation of Council recommendations and the absence of a system of continuous monitoring of the training scheme. It is not due to defects in the course and curriculum prescribed."2 (emphasis ours)

The MCI has two main duties: (i) to ensure that those not qualified in 'modern scientific medicine' (allopathy) do not get their names on the medical register; (ii) the names of those who prove to be unworthy are expunged from it. For the second purpose, the MCI does not have a policing system and relys mainly on the specific complaints brought to its notice. Complaints can be lodged about a defaulting practitioner by fellow practitioners which requires a strong colleague-control system within the occupational group. Complaints can also be lodged by the consumers of service — the lay public — who may not be aware of such a provision. Complaints can also be lodged by the State on behalf of the public or on its own behalf.

The Act is not effective enough to prevent unqualified from practice. By its restrictive definition of medicine it orients itself only to one particular system of medical theories (i.e., allopathic) and thus leaves other systems out of its purview. Thus the Act does not help the practitioners of allopathic system in establishing their monopoly over the health care system in the market. Maybe the Act, framed by the State, did not intend to provide monopoly to the practitioners of allopathy.

III

The above discussion holds good in the context of doctors of Shillong who as a microcosm are a part of the macrocosm at the country level being a part of the same system of health care. In Chapter IV we have introduced the doctors in Shillong in terms of their personal attributes.

Our data, comparable with those of the studies conducted in other parts of the country, show that the doctors have a strong tendency to return, as near their place of origin as possible, to set up work, since it provides them cultural familiarity with their clients.

IV

Chapter V discusses the background information on their education and career. We have discussed here the economic status of their parental families during their student

days. We have described the type of schools and colleges in which they had studied from matriculation onwards.

Opening of medical colleges in Assam provided greater opportunities to the youth of the region to go in for medical education. It was possible even for those coming from lower middle economic status to pursue expensive education in medical college. It was the low economic background, we think, that prevented many from going in for higher education. A graduate's degree is enough for one to start one's career as a doctor.

Medical education holds attraction because it requires low infra-structural investments, even though the educational cost is high. In the long run the career of a medical practitioner holds promise for a good career. Considerations of higher socio-economic status in society were also seen to be one of the motivations for them to become doctors.

V

After the background information the rest of our study is devoted to the understanding of the dynamics of the universe. We have relied here on the concepts of role perception and role performance.

In the preceding chapter we had discussed the image of 'doctor' in their minds before they had gone for medical

education. In Chapter VI we have described the changes that had come about in their image at various stages. They were found to maintain dual images about their occupation: (a) an ideal image, and (b) a real image.

The ideal image, corresponding with the expectations of the society, was visible through their responses to a set of general questions about their role perception. The emphasis, here, was more on their role in the welfare of the society at large. This was made possible by creating health consciousness in the minds of the people through education and immunisation programmes. Curative aspects involving face-to-face encounters were seen comparatively very low in their scheme of priorities. A reflection of this ideal image can be seen in the formulations of the codes of ethics laid down by the MCI and the Indian Medical Association (IMA). It is also expressed when the doctors show solidarity for collective bargaining with the government in particular and society in general.

The real image finds manifestation in the face-to-face encounters with their role-others —patients being a numerically large group in this category. In their interaction with the patients they draw a rigid line of demarcation between themselves and their patients. Doctor presented himself in complete command of a situation in which a patient found

himself totally surrendered. Patient was thus made to feel completely dependent on the doctor and his science for survival in a crisis situation. Thus we noticed a change in doctors' attitude from that of 'compassion towards fellow-beings' before their medical training to a matter-of-fact approach after the training.

Thus we find a lack of fit between perception of their role as doctors and perception of a doctor's role (in general) in their mind. The latter corresponds with the image and expectations that are held high by the society at large.

VI

This discrepancy was more clearly visible when we analysed their role performance and inter-colleague linkages. The first aspect is described in Chapter VII and the second aspect in Chapter VIII.

Whatever ideal image they might have had about their role doctors presented themselves mainly as 'healers' in their everyday encounters with the society at large. Thus the curative aspect was predominant in their role performance. Our observations of their work organisation revealed categorically the fact that their 'five-minute-long encounters' centred around the immediate health concern of their clients allowing no room for the health education aspect which they had emphasised in the description of their ideal role image.

The concern with the 'healer' role finds prominence in their intra-group relationships besides in the manner the medical practice is organised in the country.

As part of a larger occupational group their intra-group relationships were structured in a similar way as those of others working elsewhere in the country. In Shillong we found them working in two settings — in private practice (solo) and in various health care institutions (government and non-government). They had an internal hierarchy in terms of generalists and specialists. The institution-based doctors had to work under another hierarchical framework designed on the principles of bureaucracy. This framework introduces the dimension of superodination —subordination determined on the basis of one's length and experience in service besides qualifications. Though the doctors were given freedom to organise their work yet they were under State control exercised through the non-medical personnel in the bureaucratic organisation.

Hierarchy between generalists and specialists also means exclusiveness in the spheres of practice and thus have a direct bearing on the inter-colleague linkages. We noticed an absence of such exclusiveness in their practice. Whereas the specialists always accepted non-referred cases (even general in nature) the generalists were also not very particular about it. Instead the latter showed no hesitation in

attempting to cure such cases. It was only in the absence of proper facilities that specialised cases were referred to hospitals. Strangely enough, in the hospitals specialists were required to attend general clinics. Thus in the city these linkages were weak to the extent of a virtually non-existent referral system. Such client-orientation on the part of the doctors was found obstructing a healthy growth of colleague-control system within the occupational group. Establishment of links at the occupational level with colleagues working in other places was rather a far cry.

VII

An inward looking community of practitioners is expected to show only a passive interest in the affairs of its larger community as a whole. This was clearly evident from our enquiry about their participation in the activities of the Indian Medical Association. The details of the enquiry are discussed in Chapter IX.

The several time election of the same individuals to various offices of the Association's branch indicates lack of interest on the part of the doctors in managing or participating actively in the affairs of the Association. For most of them mere payment of membership subscription was enough for participation. Of course, they showed awareness of the larger issues concerning their occupation which they had

learned through the publicity material circulated by the Association.

The doctors showed clearly a greater respect for the code of ethics in matters of doctor-patient relationships only. It is here that a lapse would endanger their career and evoke punitive action by the State let alone by the Association and the MCI. Of course, the Association, like the MCI, has no mechanism to detect erring members and, therefore, perhaps has failed to implement the other two aspects (specially relating to intra-occupational or colleague relationship) of its code of ethics.

VIII

In polyethnic India we notice the existence of a multiplicity of health care systems which vie with each other in assuring efficient and effective health care to the people. Of these allopathic system is no doubt the most organised and formalised of all and commands greatest concern of the State and the citizens in its activities. This system advances the arguments of its rational bases and service ideal in its favour but in spite of all its efforts it has yet not been able to achieve monopoly in health care delivery.

The duality in their role perception gets reflected in their role performance. Whereas at the macro-level they

exhibit colleague-orientation in the form of occupational association, at the micro level they exhibit client-orientation which results in weak colleague control mechanisms.

Occupational solidarity, of course, is reflected at the level of the IMA on occasions when State mediation is considered undue. Thus strong protests were launched when State suggested creation of a cadre of short-term trained medical personnel on the pattern of 'bare-foot' doctors in China. Active support was given to the cause of agitating junior doctors employed by the State. But then efforts are found lacking in the direction of improving the referral system and strict enforcement of code of ethics particularly in the case of private practitioners and private hospitals.

We, therefore, are of the opinion that the process of professionalisation is not yet complete. If the medical occupation stakes its claim on the grounds of its sophisticated technology and advancements in its science (skill or knowledge base) then for this the credit should be given to the medical scientists and not to the practitioners of medical science.

## IX

We are now confronted with certain questions which need a critical and detailed probing. We propose here that these could form the bases of subsequent independent study.

One of these pertains to determining the sociological relevance of the term 'profession' as an analytical concept. That is, the need to demonstrate the heuristic worth of this concept in the Indian social context. The universal application of the concepts and methods of allopathic medical science does not necessarily imply universal uniformity in the practice of allopathic medicine. Therefore, it would be unwise to view the allopathic practitioners as a distinct occupational category under the banner of professionals similar to that applied to their counterparts in some western societies. Also such an exercise would be doing great injustice to the role played by socio-cultural factors in the organisation of medical practice in India.

Understanding the internal dynamics of an occupational group with the aid of role theory is only one part of the analysis of occupations, though of no less significance. Another equally crucial aspect is its study in the context of its wider politico-economic milieu. The evolution of an occupational group like allopathic medical occupation, can thus be better understood when viewed in relation to the evolution of the political-economic system in the society.

It is all the more necessary to do so in the Indian context which has a plurality of medical systems out of which only the allopathic system is largely benefitted by State

patronage and enjoys the status of profession. We are tempted to raise here another question: whose interests does this special occupational-category-status serve — the sociologists', the State's, or the practitioners' themselves? Decidedly, not of the first who rather will get misled in their analysis by such a usage as has been argued earlier. Then perhaps of the latter two. We have raised this doubt because even four decades after independence not much has been done by way of concrete steps to put the other medical systems back on the rails of their unstunted growth. Such an approach, as proposed above, would perhaps enable us to review other important issues as well related to the national health policy: definitions of health and disease; and the delivery of health care, etc. A detailed discussion of these suggestions, for further study, will lead us beyond the scope of the present work.

By making a statement (on the basis of our empirical findings) that the medical practice in India could not be labelled as a 'profession' we have taken the initial steps towards a more comprehensive analysis of the situation.

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