USING SOCIOLOGICAL CONCEPTS IN THE STUDY OF INDIAN MEDICAL SYSTEMS: MEDICAL SYSTEM, ROLE & PROFESSION.

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ABSTRACT

Now-a-days there is renewed interest all over the world in the medical systems other than modern medicine, identified as 'alternative' or 'complementary' medicine. Research on these medical systems of India, as well as of other Asian societies continues to thrive. In this study, efforts has been made to place these systems in a framework using the tools of sociology. The research undertaken encompassed more than this, private clinics and the government hospitals of these systems in Hyderabad and miscellaneous, clinics, such as bone seters also.

Introduction: Medical Systems

In contemporary societies around the world, there is renewed interest in medical therapies identified as "alternative" or "complementary" medicine. These two terms describe their perceived relationship to biomedicine, the dominant medical therapy available, to varying degrees, in all countries. In the 1970s and 1980s, social scientists, dissatisfied with words like "folk" and "traditional," struggled to agree on a conceptual term to define the array of medical systems found in Asia, Africa, and Latin America. All of these terms remain in use—traditional, folk, indigenous, and classical—but now are often subsumed by "alternative." Modern or scientific medicine became "cosmopolitan" medicine for a brief period (Leslie 1976) and now seems to have stabilized under the term, "biomedicine." This paper will review the sociological concepts that provide a framework for understanding the structure of traditional medical systems in India. The concepts reviewed in this paper are medical system, role, and profession. While these are broad conceptual frameworks, they have well-honed specifications in the social sciences. Research I conducted on medical systems and their use in Hyderabad City, India led me to use these concepts to make sense of observations made and data collected on the use of these systems by patients and the practice of these systems by practitioners.

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The research on traditional medicine in Hyderabad on which this discussion is based, took place in the private clinics of ten practitioners of Ayurvedic and Unani medicine and in the major government hospitals of these systems. Data were collected through interviews with practitioners and patients as well as through participant observation. In these settings, the social structure and culture of India and the therapies, instruments, and ideologies of biomedicine and traditional medicine influence 1) the role behaviour of the practitioner, 2) the daily practice of medicine, and 3) the behaviour and expectations of patients. In this paper discussion will be limited to influences on the role behaviour of practitioners. Analysis of these three types of activity was made in two kinds of medical settings, private clinics and government hospitals.

MEDICAL SYSTEMS:

Each society has explanations, institutions, healers, and therapies which constitute a system enabling its members to cope with health and illness. Peter Kunstalder provides a comprehensive definition of a medical system,

". .the term 'medical system' thus includes medical practitioners using various therapeutic devices, interacting with patients (or populations) to treat or prevent illness, and also the definitions and means of recognition of health and illness (the ways of deciding whether a particular condition belongs in the category which requires healing or even preventative action, if available); diagnosis (identification of the illness, classifying its appearance by history, circumstances or symptoms, often involving attribution of cause of classification into a category of conditions for which appropriate actions are known); treatment (application of actions understood and intended to modify the causes or effects of the illness); and evaluation of the recognition - diagnosis - treatment in view of the outcome of the case (1975:351-352). (emphasis added)"

In India, "traditional" medicine and "allopathic" medicine, are the terms commonly used in referring to the two major divisions in the medical systems. The term, "traditional," widely used in medical anthropological and other related literature, refers to the myriad medical systems and practices found in Africa, Asia, and Latin America. In reality, these two systems differ considerably in terms of their history, theory of knowledge, literature, and types of practice. Many of these systems, especially in Africa and Latin America, are based on oral knowledge transmitted from one healer to another and more properly fall into the category of "folk" medicine. In Asia, especially in China and India, the medical systems are part of the classical heritage of these great civilizations. According to Hakim Mohammed Said, tradition refers to what is oral or unwritten and thus "is misleading as far as the three major disciplines of Arab, Chinese, and Indian medicine are concerned." (1982:21)
As Mitchell Weiss suggests, a more useful distinction might be made between folk tradition and classical tradition. (1982a:2) In India, this would refer to "the classical tradition based upon a number of authoritative texts, ayurveda" and "the wide variety of practices constituting the folk medicine. Such practices may be either loosely or not at all related to the systematic classical tradition. "(1982a:1)

Moreover, as Weiss points out, "Just as there must be care in distinguishing the classical from the folk tradition in the analysis of present-day or earlier medical practices, one must also distinguish between practices within that classical tradition at different periods in the course of its development. There is no doubt that the practice of ayurveda has changed considerably over time. Although it is a traditional system, it is also living tradition reflecting the impact of interactions with cosmopolitan medicine, nationalist and Hindu revivalist trends, British colonialism, Moghul rule and internal developments in the Hindu culture at large prior to and during the course of all of the preceding. (1982a:4-5)"

Indigenous is another term used to describe local, native medical systems. In the case of India, the Unani system (based on Greek and Perso-Arabic medicine) came to India along with the Muslims after 1100 A.D. In the central government departments of medicine, Unani is commonly referred to as indigenous or as an Indian system of medicine, along with Ayurveda.

Since Unani has been in interaction with Ayurveda—just as other Islamic cultural and social institutions have been with their Hindu counterparts for several centuries—the term, indigenous, may not be inappropriate.

As far as homeopathic medicine is concerned, by and large, it is placed, along with Ayurveda and Unani, under the rubric of indigenous systems of medicine in government organizations. (The late 1970s witnessed movements to separate out each of these systems into their own directorates, at least at the central government level.)

Allopathy, a term commonly used in India to refer to biomedicine medicine, continues to be used in everyday parlance in India, although the social science literature commonly uses the term, biomedicine.

In the 1970s, Fred L. Dunn (1976:135) and Charles Leslie (1976:6) argued for the use of the term, "cosmopolitan" medicine, to characterize the worldwide, dominant system of medicine, preferring this term to "modern," "scientific," and "western." The use of these latter three terms implies that other regional great traditions of medicine (such as the Chinese and Indian) or folk medicine are not scientific or are unchanging and that the major medical system is limited to practice in the Western nations.

In India, each of the traditional systems is made up of the components enumerated by Kunstadter; so, too, are the
biomedical and folk systems. In addition, all of these systems interact with one another. Patients patronize the various systems, practitioners incorporate therapies and diagnosis of other systems into their own, and definitions of and beliefs about health and illness spill over from one system to the other. Therefore, the health care system is a complex one, composed of individual systems quite independent in their makeup, and, yet, interdependent because of shared components. The extent of the interpenetration of elements (for example, therapies) from one system to another varies; whether the various systems acknowledge or accept interaction is another issue. The reality is that all of these systems provide medical care, are patronized, and may share some, if not all, elements with the coexisting medical systems.

In this article, the primary focus is on ways to analyse the practitioners themselves, although necessarily the elements identified by Kunstadter, all parts of the social matrix of medicine, enter into the analytic framework.

ROLE ANALYSIS:

M.S.A Rao's (1977) discussion of role analysis provides a useful framework for examining the behaviours of traditional practitioners in both private clinics and institutional settings. To understand practitioners in institutional settings, however, some consideration also must be given to the professionalization process they are undergoing and the nature of the bureaucratic settings in which they work. Within the broader review of role analysis, Rao's specific discussions of role sectors, role perceptions, and social settings are helpful in understanding the changes brought about by professionalization and by working in new kinds of settings.

Explanation of the different activities of the practitioners may be made based on their different types of education and training. However, the problem of explaining the variation in behaviour on the part of individual practitioners within each group remains. Rao elucidates one way of considering such permutations-breaking down the concept of role into its component parts. The dissection of role allows detailed analysis of occupational groups and professions in developing societies in which economic differentiation and increased organizational complexity is taking place. Rao describes the complex interaction of the modern and the traditional in role playing:

"In the context of social and cultural change in India it is seen that different traditional and modern sources of legitimacy operate at the same time in different areas without necessarily producing conflicts. There is a great autonomy of role areas, and the presence of multiple, diverse, and divergent norms gives a wide scope for manipulation to the individual in both role playing and role taking. (1977:305)"
Rao suggests that role can be discussed by referring to role sector, role norms, role perception, role sequence, and role setting. Examples of each of these in relationship to a practitioner of traditional medicine are as follows:

1) Role sector refers to the interactions a practitioner may have with the different categories of people he encounters in carrying out his role. These would include, for example, doctor-doctor interactions, doctor-patient interactions, doctor-nurse interactions, and so on. Within each of these sectors, interaction may vary based on the particulars of the relationship with the individual doctor, nurse, and patient.

2) Role norms refer to the rules of behavior governing interactions with those in the role sectors. According to Rao, "Autonomy of the different role sectors in a role set permits the existence of logically divergent norms between different sectors" (1977:299). Rao sees the possibility of dual norms and values coexisting in such interactions without the conflict some sociologists would see ensuring from such duality. (1977:299)

3) Role perception refers to the model or ideology the physician uses to guide his behavior. In the case of the traditional practitioner, at times the model of the Western professional model bears on behavior; at other times, the model of the traditional practitioner is foremost.

4) Role sequence refers to the stages of the physician's career in terms of the groups with whom he might interact at different stages. For example, at an early stage, contacts might be primarily with patients and colleagues in medical practice; at a later stage, relations with colleagues in professional associations might assume greater importance.

5) Role setting refers to the setting of medical practice. Thus, the clinic and hospital settings each shape the behaviors of traditional physicians in particular ways. The geographical location of practice rural or urban - may also be an influential factor. According to Rao, "... differentiation of roles and their role setting is essential to understanding the process of both continuity and change." (1977:296)

As indicated above, Rao's guidance on role and its components helps the analysis of the many characteristics of practitioners and their practices in private and in institutional settings. The skeleton of the concept of role must be fleshed out with Indian cultural and social substance. For, as Rao further indicates,

"There seems to be a great deal of variation in terms of the equipment of actors, specific nature of relationships of the actor to the role other, cultural content of
relationships, the social setting in which interaction takes place, the personal network relations of which an interaction isolate is a part, and the norms that govern different interaction processes. (1977:304)

Rao’s framework for cultural and social structural analysis assists us in coming to terms with the considerable variations in each of these aspects cited above. Little research on these multiple and interconnected characteristics has been done on traditional practitioners as a whole in India; urban traditional practitioners especially have been neglected. The following dimensions, which come into play when roles are enacted, are an interpretation of Rao’s list (1977:304) tailored to fit the physicians studied:

1) "Equipment of actors" - the reputations, heritage, personal qualities, style of dress, type of clinic, and education and training of the practitioners fall into this category.

2) "Specific nature of relationship of the actor to the role other" - Here, the status relationship between doctor and patient as well as the obligations and rights involved in that relationship must be considered.

3) "Cultural content of relationships" - An array of factors associated with health and illness enters into the doctor-patient relationship. Among these are ideas of privacy and modesty, beliefs about illness, health, medicines, and diet.

4) "Social setting in which interaction takes place" - The private clinic and hospital are the realms in which doctor-patient interaction takes place. The arrangements of these social settings are based on the social structural and cultural aspects of Indian society that come into play in health care settings.

5) "The personal network relations of which an interaction isolate is a part" - The wider network of relationships of doctor and patient play a role in establishing their mode of interaction.

6) "The norms that govern different interaction Processes" - As mentioned earlier, the norms guiding the physician may derive from the ideal model of the traditional practitioner and/or the cosmopolitan practitioner. In addition, the norms governing other types of social relationships in India may come into play, especially if doctor-patient ties stem from friendship or kinship roots.

ROLE SECTORS; PROFESSION

When they serve in government-sponsored institutional settings, practitioners differ in certain respects from private, clinic-based practitioners because of the influences of the different features of the practice settings. Moreover, the institutional-based practitioners engage in various ac-
tivities, such as establishing standards for education and training and forming research organizations, which frequently are characterized as being part of the process of professionalization. By and large, these activities are not concerns of clinic-based practitioners unless they also happen to work in government service, or like one clinic doctor in the study, are active in political and organizational activities in traditional medicine.

Theories about professions and the professionalization process and controversies about them abound in sociology. After reviewing A.M. Carr-Saunders and P.A. Wilson's 1933 study which foresaw the professionalization of everyone and Harold Wilensky's later challenge to this proposition, Leslie suggests,

"The concept of professionalization is subject to controversy of this kind because it is a poly-typical concept. That is, it includes several parameters, and application of the concept to a particular case requires judgmental determinations of the relationships and relative significance of these parameters. This does not mean that the concept should be abandoned for narrowly defined terms, but that like other concepts close to ordinary language usage, it must be used with the mental flexibility called common sense. (1972:42)"

W.J. Goode finds two core characteristics of a profession, ". . . a prolonged specialized training in a body of abstract knowledge, and a collectively or service organization. (Tumer and Hodge 1970:24)"

Bernard Barber expands the list to four, adding the following attributes to Goode's two,

. . . a higher degree of self control of behaviour through codes of ethics internalized in the process of work socialization and through voluntary association organized and operated by the work specialists themselves; and a system of rewards (monetary and honorary) that is primarily a set of symbols of work achievement and thus ends in themselves, not means to some end of individual self interest. (Tumer and Hodge 1970:25)"

To these four elements, Roger Jeffrey adds State sanctions. (1977:562) Gaining licensing from the State has been an important issue historically for tradi-
tional practitioners in India (see, for example, *The Usman Report*, 1923) and remains an important criterion for distinguishing different types of practitioners.

In summary, a profession is characterized by: an abstract body of knowledge; long, specialized training; autonomy; high prestige and remuneration; and State sanction.\(^2\) For our purpose, the important issues in considering professionalization among traditional practitioners are:

1) Professionalization is in process. Therefore, all of the attributes of a profession are not fully realized; 2) As professionalization continues, receiving licensing and establishing educational and medical facilities have proven to be the gains most readily achieved; 3) Traditional practitioners have dual models of professions (their own traditional model and that of cosmopolitan medicine) to draw upon.

J.A. Jackson's suggestion about how to view a profession is pertinent to the situation of the traditionally practitioner. He recommends,

"... the definition of the problem in dynamic terms which recognize that in relation to the range of criteria by which a profession may be denoted, there may be considerable variation at different times and under different circumstances. (1970:5)"

Leslie enumerates the following barriers to professionalization among Ayurvedic practitioners: 1) Emphasis on tacit knowledge rather than technical knowledge; 2) Lack of colleague control among traditional practitioners. Leslie acknowledges that organizational settings have been established within which traditional medicine is taught and practiced but he argues that factionalism in these centers, which Brass found to be a destructive factor, prevents realization of true professional status; and 3) Reliance on client control. Leslie cites as an example of this that traditional practitioners, while decrying the use of antibi-
otics and other forms of modern medicine, state that they must use them in order to please their patients. (1972:50-53)³

While many of the observation of Brass and Leslie remain valid, changes during the past ten to fifteen years in the form of increased funding and the expansion of traditional medical organizations and institutes within India and of encouragement and funding for traditional medicine from international bodies, such as the World Health Organization, have enhanced the legitimacy of the traditional medicine. Receiving these types of official legitimation may lessen the need for traditional practitioners to spend time and effort justifying and securing their positions in the health care system. They may have time to consolidate their gains, to undertake projects designed to standardize and validate their therapies and treatments, and to reach a consensus on the goals of their individual medical systems.

Rao guides us partway through the thicket of the professionalization underbrush by his discussion of role sectors, role perceptions, and social setting:

"In analyzing changes in an occupational role, the notion of role set is highly significant. With the growth of economic differentiation and organizational complexities, the role set in professional roles has become more complicated and more role sectors have been added. For instance, with the growth of trade union activities among the teachers, a new role sector has emerged, viz., teacher and teachers' union. (1977:298)"

In complex traditional societies many occupations that are considered modern would already be present. An individual may continue to follow the same occupation but a variation in the social setting makes all the difference in his role playing. One of the ways in which professionalization of occupations takes place is the emergence of new role sectors within a role set. A consideration of the linkages (or their absence) between role sectors throws light on the nature of role development. It also brings to light the problem of relatively in role consensus and role perception. (1977:305)"

If we apply Rao's insights to traditional practitioners in institutional settings, we can make the following observations: 1) increased organizational complexity, partly brought about by bureaucratic medical settings, leads to contacts with more individuals (for example, associations for traditional medicine, government research councils) which enlarge the number and the types of role sectors in which practitioners are involved and 2) explanations and justifications given for the types of decisions made about educational standards and the use of modern medicines and techniques often throw into relief signs of instability in role consensus and fluctuations in role perceptions. However, such discussions also create the possibility of establishing role consensus and of stabilizing role perceptions.
Increased organizational complexity, enlargement of the numbers and types of role sectors, and standardization of education and practice are aspects of the process of professionalization traditional practitioners are undergoing. Bureaucratic organizations in which they work may alter the type of medical practice they carry out in both desirable and undesirable ways. At the same time, because they are centers in which practitioners can legitimately incorporate cosmopolitan medical equipment, these institutions become secure sites for effecting changes in the technology and treatments used in traditional medicine. This incorporation process achieves two things: It shapes a new type of traditional practice in which a large group of practitioners participate and, because it uses the symbols of biomedicine medicine, it makes traditional practice resemble a group already granted the status of a modern profession by the society.

Through the wider range of contacts made in new types of role sectors, the types of relationships in which traditional practitioners are involved become more like those biomedicine's practitioners engage in. At the same time, making professional practitioners engage in. At the same time, making professional contacts in research organizations and other kinds of associations opens up the possibility that members of these groups may exert influence on one another. Such interaction and influence may lead to the establishment of norms for medical practice and research.

In the debates about educational methods and the types of medicines to use, two interrelated questions are raised: "what is the proper role model for the traditional practitioners?" and "What should be the appropriate direction for traditional medicine - the shuddha (pure) or the integrated?" The traditional practitioner can draw upon the model of traditional practitioners who received royal patronage and who used classical texts which provide guidance for medical practice, ethics, and methods of education and research. Those practitioners who belong to the shuddha school of Ayurveda, for example, draw upon the classical texts as guides for present day education, research, and ethics. The modernizers among the traditional practitioners defer, in some cases, to the classics; in other instances, the model they draw upon is the one influenced by American and European medical practice followed by the biomedical profession in India. A new generation of traditional practitioners stress the need for research on their systems' treatments and pharmacy along the lines of biomedical research. (Sheehan, Interviews 1992, 1993, and 1994) As T.N. Madan points out, in referring to allopathic doctors,

"... doctors are influenced by the culture of modern science and technology characteristic of the West. Their eyes are fixed on medical education, medical research and medical care as these exist in Europe, the UK, or the USA. (1980:294)"

Madan further suggests that the pro-
fessions have the potential to act as a catalyst in the transformation of Indian society from a caste to a class based society and in the integration of modern and traditional ways of thought and behaviour.

"These debates between and among the practitioners of different systems of medicine are ultimately concerned with the nature of the new society that is in the process of being made in India since independence. They are therefore, of more than a narrow interest. So far, modern doctors and the "modernizers" among the traditional practitioners of traditional systems seem to have had the upper hand.(1980:26)"

What I am trying to suggest in the foregoing discussion of the professionalization process of traditional practitioners is that in their involvement in activities that are "professional-like," two sets of processes are actually going on. On one level, their engagement in education, research, and conferences parallels the activities of the dominant medical system, biomedicine. The resemblance to an accepted professional group serves as a form of legitimation. If they remain at this juncture, they will remain in the state of incomplete professionalization described by Leslie and Brass. However, the very process of engaging in these varying activities may establish role norms and perceptions which may create a shared version of traditional medical practice. If this takes place, then, for those inside this particular "garden wall" there may be the possibility of achieving professional status.

NOTE: Research on the medical systems of India, as well as of other Asian societies, continues to thrive. Contributions by anthropologists, historians, political scientists, and classical scholars enlarge our understanding of these systems from the perspectives of these disciplines. In this paper, the effort is to place the systems in a frame work using the tools of sociology. Select recent works on medicine and health care in South Asia (as a major or partial focus), past and present, include:


FOOTNOTES:

1. The research undertaken encompassed more than these ten clinics and the government hospitals. Five non-governmental (private and charity) clinics of homeopathy as well as the homeopathic government hospital were studied. Miscellaneous clinics, such as bonesetters, were visited. To further clarify the position of homeopathic medicine, in Andhra Pradesh it is included in the Department of Indian Medicine and Homeopathy. Moreover, it is widely practiced in India so it is justifiably a subject for a study of alternate systems. See S.M. Bhardwaj (1980). A fuller picture of my Hyderabad-based research can be found in Sheehan (1983).

2. As Jeffrey suggests, although many sociologists agree on the aforementioned characteristics of professions, there are two schools of interpretation about the primacy of each of these elements.

3. Using Sociological concepts - Sheehan

3. As Jeffrey suggests, although many sociologists agree on the aforementioned characteristics of professions, there are two schools of interpretation about the primacy of each of these elements.

4. The process of professionalization can thus be seen, in part, as a process of increasingly protective measures to define the boundaries between the sacred company of those within the walled garden and those outside. (1970:10)
### REFERENCES

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भारतीय चिकित्सा पद्धतियों के अध्ययन में समाजवैज्ञानिक विचारों का प्रयोग - चिकित्सा पद्धतियां, भूमिका तथा व्यवसाय

हेलन इ. शीहान

आजकल पूरे संसार में आधुनिक चिकित्सा पद्धति से भिन्न अन्य चिकित्सा पद्धतियों के प्रति नवीकृत अभिवृद्धि देखने में आरक्षित हैं। इन अन्य चिकित्सा पद्धतियों को वैकल्पिक चिकित्सा पद्धतियों के रूप में पहचाना गया है। इन भारतीय एवं अन्य एशियाई देशों की चिकित्सा पद्धतियों पर अनुसन्धान कार्य प्रगति को ओर सफलतापूर्वक अग्रसर है। इस लेख में इन अन्य चिकित्सा पद्धतियों को सामाजिक साधनों का प्रयोग करते हुए एक ढांचे में रखने का प्रयास किया गया है। इसके अतिरिक्त हैदराबाद में इन चिकित्सा पद्धतियों वाले निजी चिकित्सालयों, सरकारी अस्पतालों और दूसरे चिकित्सालयों आदि का भी इस अनुसन्धान कार्य के अंतर्गत समावेश किया गया है।