Medical sociology has received due recognition and popularity only recently and a considerable interest has developed in the study of social and cultural aspects of physical ailments. It is conceived as the scientific study of the social, cultural, and emotional elements in human health and illness (Mangus, 1955).

In many Western countries, a substantial ground has been covered in this area and a large number of books, research articles, notes and reviews have been published in recent past. Writing about the status and position of medical sociology, Hyman (1968 : 119-155) observed that the Medical Sociology Section was the largest speciality group in the American Sociological Association in 1968. In India, however, no significant development has occurred in this area and the branch has to go a long way in order to develop a well-knit science having its own concepts and theories. Moreover, this condition has to be changed further, if we desire to make a profitable use of the applied social sciences.

A limited number of publications on India are available by Indian and non-Indian sociologists and social anthropologists. A trend report on Sociology of Medicine in India submitted to the Indian Council of Social Science Research records only 108 works (published and unpublished) in this field (Ahluwalia, 1974). These studies are mainly based on data collected on medicine in course of the field works done in the village and tribal societies. Some of them are the results of master's and doctoral dissertations. A sizeable portion of these works is still incomplete and results are available in mimeographed form. While some of these studies are exploratory and manifest authors' sweeping generalizations more than any substantial theoretical groundings, some of them, on the other hand, have successfully attempted to develop a sound theoretical framework.

The present paper is based on published works on which reports are available. Main areas on which reports have been found are — studies of the etiology of disease and disorder, sociocultural responses to illness, medical education and medical profession. Under these topics, this paper discusses some selected studies.

STUDY OF THE ETIOLOGY OF DISEASE AND DISORDER

Although among the non-Indian sociologists, it is recognised as the most popular field of enquiry but Indian sociologists and social anthropologists have no significant contribution in the area. It concerns itself with the investigations of the social factors in the onset and distribution of illness dealing mainly with variables like age, sex, social class, rural-urban differences and so on. In recent years, specific attention has been paid to the relationship of social mobility, social isolation, social stress and social class to physical and mental health.

In the oft quoted book Village Life in Northern India, Lewis (1958) has a sizeable chapter on concepts of disease causation and cure. This chapter which is based on the intensive interviews of eight Rampur villagers gives a very detailed and deep information on the notions of etiology of

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some common but dangerous diseases. Diseases included are malaria, smallpox, typhoid, cholera, dysentery, pneumonia, tuberculosis, rheumatism, puerperal fever, eye inflammation and hysteria. Starting with the analysis of the usefulness of studies of what people believe about health and disease, he proceeds further to analyse the indigenous beliefs and practices of the community in connection with these physical hazards. Lewis has also attempted to correlate the notions of etiology with that of the methods of treatment adopted by the villagers. In the concluding portion, he analyses the overall medical and health conditions of the village and ends with the observation that "a knowledge of local beliefs should be of help both in treating particular ailments and in learning to understand the basic concepts of the village people" (Lewis, 1958 : 301). This analysis, however, is based on a very arbitrarily selected sample and facts thus perceived may not be representative of the actual situation prevalent in other North Indian villages.

Opler (1963) has explored the prevailing Hindu view of health and illness in Rural India. The following commonly believed causes of numerous diseases have been listed by him: (a) imbalance of the three humours (doshas), (b) faulty diet, (c) lack of harmony with the supernatural world, (d) activities of ghosts, especially unrequited and aggrieved ghosts, (e) displeasure of deities, (f) imbalance of forces which control health, or inappropriate behaviour in physical, social, and economic matters. The notion of harmony and balance is the central theme in the Hindu concept of disease and disorder. This idea, Opler observes, is "a basic cultural conviction of the Hindus. Just as the equilibrium among the doshas may not be altered with impunity, so must a harmonious organisation or relation be maintained in regard to many other matters in Indian culture." Some of these, according to him, are the varna, caste and jajmani systems (Opler, 1953 : 35). The conclusions drawn here by Opler seem to be the over simplification of prevailing situations of the present Hindu society in India. The role of doshas is not easily recognised by the common rural folk. In fact, such traditional concepts are no longer found in the purview of the villagers except among few who have some training in Ayurvedic medicines. Besides, the author has used terms and expressions which no longer describe and analyze the changing aspects of the Hindu social structure.

Like Lewis, Ishwaran (1968) has also included a full chapter on the discussion and analysis of health and illness in his study of Shivapur, a South Indian village. It is not an attempt in the direction of any theoretical exposition; however it provides a detailed description of health notions of a village. He classified the various diseases into five categories: (a) divinely ordained but in a milder form, (b) divinely ordained at a more serious level, (c) diseases with more immediate physical causes, (d) epidemics, and, (e) those due to magic and sorcery. The type of medical specialists consulted along with the image of physicians has also been provided to demonstrate the existing doctor-patient relationships. Discussing the close interaction between the medical system and the social system, Ishwaran (1969 : 126) writes, "...there is a close connection between the 'medical system' and the social system of Shivapur. The social norms and circumstances affect crucially the attitudes of all concerned in the medical system — the doctors, the patients and the community. The family, kinship, and the caste contexts shape their attitudes. Much misunderstanding of the behaviour of villagers with regard to their health and illness problems can be avoided if their social structure and belief-system
are clearly grasped". Although the study provides ample data on sociocultural aspects of health and illness, however, the sweeping generalizations and subjective modes of presentation have made it empirically less sound and analytically less attractive.

Concepts of etiology of some common diseases have also been investigated by Karna (1971 : 166-209) in a North Bihar village. Causes recognised by villagers, here, have been grouped under two categories — sacred and secular. While in sacred causes, he includes illness due to wrong done to some god and action of some witch; in secular category only natural causes have been examined. Specific attention has been paid to the study of beliefs concerning such diseases as cholera, malaria, paralysis, pneumonia, typhoid, asthma, tuberculosis, and smallpox. The variations in these notions on account of caste and educational status have also been explored and examined. Like Lewis (1958), Karna also reveals that a large number of concepts are found among villagers and usually they have no common notions about various diseases.

Considering the vast field of beliefs and notions of diseases prevailing in all parts of the country, studies referred above are too discouraging to have any respectable status in this area of enquiry. Our rural and tribal populations have a vast store of medical beliefs and practices which are not always based on sorcery and magic. They have some useful pharmacopoeia in the belief. If sociologists can help in discovering those indigenous articles of healing, it would be a great service to the society.

STUDY OF THE SOCIOCULTURAL RESPONSE TO ILLNESS

The most common work in this field is the investigation of social and cultural definitions of health and illness. It also concerns itself with the people's response to illness and its changing patterns in varied social and cultural groups. Some very useful work has been done in this field in Indian rural communities.

While conducting a medical clinic incidental to pursuing research on Indian culture and personality, Carstairs (1955 : 107-134) studied medicine and faith in rural Rajasthan. According to his description, sickness is as much a moral as a physical crisis to the people of rural India. In their conception, the roots of illness extend into the realm of human behaviour and cosmic purpose. He found that the misunderstanding between the physicians and the patients in the village is as a result of the difference in the very concepts of etiology of disease, methods of treatment and the image and role of a physician. A prominent role played by faith has been found in curing and one of the villagers, in fact, informed — "But really, Sahib, it is tassili (faith) that makes a sickman well. No matter how rare a medicine you give a patient unless both you and he have faith in it, he never will be cured" (Carstairs, 1955 : 131). He thus, concluded — "it was not enough to bring good medicines and efficient hygienic techniques to these country people. Before they can take effect, they must be accepted, and this will never come about so long as a wide gulf separates the thinking and the experience of Western doctors from that of their village patients. There are three ways in which this gulf can be bridged: by the slow diffusion of information about sepsis and infection: by a better understanding of the expectation with which the people approach the doctor; and, by presenting new techniques in a way which will link them up with what they are expected to supersede" (Carstairs, 1955 : 132-133).

A similar study by Marriott (1955 : 239-
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268) in a village in Uttar Pradesh also attempts to contrast between Western and rural Indian medicines. Although both Carstairs and Marriott present a similar case in terms of doctor-patient relationships, their primary frame of reference is different. While the former's approach is psycho-cultural, the latter has social structure as his basic mode of exposition. Marriott has shown how western medicine has a marginal position in the social structure of village India. The world of villagers, according to him, consists of three great social realms — kinship and family, village and caste, and the outside world. Analysing the place assumed by the indigenous and Western medical practitioners, he found a number of differences between the role and status of these two types of curers. Dispensers of magic and religious exorcists are called "wisemen" and so are Hakims and Vaids. They are assigned a high social status and enjoy the confidence of the villagers, whereas, the Western medicine has still existed only in the outer realm beyond family and beyond caste and village. It is as a result of this value orientation that no Western specialist can parallel the structural position of these native curers. Two views—those of Carstairs and Marriott — taken together present a better perspective of health culture of the people.

How the method of treatment varies with the types of cause identified is the subject matter of study made by Valunjkar and Chaturvedi (1967). Religious rites play a prominent role in the treatment of diseases like smallpox and plague because they are associated with supernatural causes. Some other studies (Khare, 1963; Minturn and Hitchcock, 1963 : 203-361; Gould, 1957 and 1955; Hasan, 1964; Kama, 1971 : 210-250) have similar focus in their investigations.

The cultural frontier of health as studied by Hasan (1967) is, perhaps the only study published so far where one single village has been taken up entirely for the investigation of health problems. In this microcosmic study of Chinfra, a village near Lucknow, he has demonstrated how health is related to the habits, beliefs, and values of the rural folk. He was guided by questions like — Do the habits, beliefs, values etc. of the village folk connected with walking, sleeping, eating, drinking, working and defecating etc. influence their health status? Is there any relation to their economic activities and dwelling pattern with their health status? Do people overutilize some and reject other health services offered by the State or the medical practitioners? Hasan has provided useful ethnographic data with regard to the sanitary habits and personal hygiene, food taboos and drinking habits, etiology of disease, doctor-patient relationship and several other aspects of health and disease. The most important shortcoming of the work, however, is its failure to make use of such vast store of data for any theoretical exposition. Moreover, a thorough reading of the book gives an impression that it has not been undertaken to contribute in the field of social sciences but has been mainly addressed to the medical profession. Nevertheless, Hasan's attempt is commendable as he has collected useful material for future research and investigation in the field.

In course of his study of social structure and culture change, Mann (1967) focused some attention on the problems of change in the field of concepts of disease also. To examine the extent of change in the concept of diseases in village Alipur near Delhi he describes the earlier diseases and their concepts which include — diseases of (opra) 'Bhoot' or 'Bhootani', 'Mata', or 'Tok' and 'Hai’ (evil eye). In the second part, he attempts to show the impact and role of important agencies like schools, the Health Department and the Community Development Project on the concepts of
disease. He has displayed the numerous factors and processes of change wherein new ideas of innovations have been accepted by the majority of villagers. He has drawn our attention to the changing aspects of disease concepts but has failed to impress because it lacks analytical depth. It makes his approach only impressionistic.

Masihi (1969) studied the people's concept of health and the methods of treatment in a fringe village. With some theoretical introduction, he goes on to explain the respondents' explanation about the probable causes of the physical malady and the modes of treatment resorted to. In the discussion of the problems of health care, he found a great reliance on the indigenous systems of disease cure. The modern doctors who charge high consultation fees and prescribe more medicines are favoured less in comparison to the Bhuva who does not charge any fee but cures immediately. This phenomenon expresses a quite contradictory pattern when compared to that of the village studied by Mann (see above) which was also a fringe village exposed to many urban influences. This pattern has to be taken into account in future enquiries.

Madan (1969) has carried out a study in urban areas. The process of modernization is operating in every aspect of life and so is true with the field of medicine. Medicine is also an important field where old methods are giving place to the new ones. But the question is 'who are the people in a developing society who adopt modern medicine, and what are their reasons for doing so?' With a view to answering this question a preliminary enquiry was carried out in Ghaziabad town near Delhi. The influence of factors like age, education, social background (urban or rural), occupation, income, and religion on the acceptability of modern medicine was also explored. Madan has some noteworthy conclusions based on this study. The first important conclusion is that the majority of people interviewed preferred allopathic system of medicine and they hardly resist the growth of modern medicine. The effectiveness of the system has been regarded as the most common reason of this acceptance. Secondly, social background of rural-urban upbringing is not significantly associated with the choices of medicine, so is the case with the factor of age. Thirdly, the association between Hinduism and Ayurveda has been proved by the data. Fourthly, occupation and income have come to be regarded as significant determinants of the choice of any system of medicine. But Madan has concluded with the remarks that the present conclusions are 'limited by the fact that they are based upon data drawn from a single North Indian city. No claims are, therefore, made about the general applicability of our conclusions' (Madan, 1969 : 1484). However, this work is a significant contribution in the study of the Socio-cultural response to illness.

MEDICAL EDUCATION

Mechanic (1968 : 7) has humorously remarked, 'sociologists have given more attention to the sociology of medical education than they have given to the sociology of sociological education'. This remark might be applicable to the American sociology but it is not so for Indian sociology. Some of the popular fields in this area are — student's choice of medical profession, his desire and aspirations for specialized training, the mode of his interaction with the members of the staff, social values of the medical culture, methods of recruitment and overall impact of medical education on the personality of the individual student and so on. There is a vast scope for such studies in India. A number of government and private medical colleges are func-
tioning in every corner of the country which may provide ample opportunities for sociological investigation. Although some enquiries (Sinha, 1958; Fuchs, 1964: 121-138; Harper, 1966: 344-353; Elwin, 1955) have been made about the patterns of training of some types of traditional medicine-men but studies in the field of modern education are very few.

Parvathamma and Sharadamma (1965) have studied the medical undergraduates of Mysore to know the sociological background of students' population. They begin with the consideration of the importance of medical education for sociologists and proceed to make an enquiry into the social composition of student community reading in the Mysore Medical College in January 1965. They have described the caste and sex composition, income level, and the regionwise distribution of students. They have endeavoured to discuss some future guidelines for medical sociology in India but have not been successful in that attempt. Sharadamma and Parvathamma (1968) have undertaken another study also on socio-economic and political backgrounds of medical students in Mysore. However, such investigations are not going to make any significant contribution in the field unless a proper assessment is made by them about the possible role of such background in moulding a basic personality type of medical undergraduates.

In a short article Shah and Ahluwalia (1970) have put forward a case for the introduction of sociology as a part of medical syllabi. Although there is a general agreement about the utility of introduction of social sciences in medical education, many factors have to be taken into account if it has to be introduced at all. Authors have attempted, here, to examine the different aspects of the role which sociology (including social and cultural anthropology) may play in the medical institutions and in the life of medical practitioners. The paper discusses the details of sociological aspects which may be of some use to medical professionals. Though they have analyzed how sociology also gains in this context but this part of their discussion does not impress.

Studies in the field of medical education are very few; however, its importance has lately been recognised which is evident from the recommendations of the U.G.C. Summer Institute on the Teaching of Social Sciences in Medical Colleges, and the reports of the Seminar on Social Sciences in Health Administration (Ahluwalia, 1974).

**MEDICAL PROFESSION**

Madan (1972: 79-105) has a pioneer work to his credit in this area. In this study, he examines the culture of the medical profession in a North Indian town — Ghaziabad. The major objective of his study was — an enquiry into the social background and professional role performance of doctors. He examines questions like — 'who are the doctors — in terms of their social background (religion, caste, place of origin, parental occupation) and some personal attributes (age, sex, marital status, medical training); who decided that the respondent was to become a doctor, and why and how do the doctors go about the task of performing their professional role?' (Madan; 1972: 83). Although his findings, as he himself states, are limited by the fact that they are drawn from a particular type of city, however, they throw useful light on the possibilities of future studies both in the field of sociology of professions and sociology of medicine.

Reviews of the studies in the field of medical education and medical profession as presented above apparently display a major gap in our knowledge of the area.
There are numerous other fields which deserve our immediate attention. Some of them may include — social status of the medical profession, nursing profession, para medical and auxiliary staff and the voluntary organizations of the medical profession.

CONCLUSION

Medical sociology in India is being recognized as a major field within general sociology. Although, many of the studies reviewed here form part of the other bigger projects belonging to the other sociological specialities, however, sociologists are finding medical setting a convenient and useful field for the test of their hypotheses. The rural character of our population gives even a better scope for such studies. The process of modernization is operating in our traditional social organization. As a consequence, the traditional social segmentation and values are actively interacting with the agents of change. Every aspect of our social system is facing such impact and health — culture is not an exception. Naturally, a sociological study of this situation will give new insights not only to the medical sociologists but also to the social scientists interested in the dynamics of change. Some sociologists and social anthropologists (Parvathamma and Sharadamma, 1965; Ahluwalia, 1967; Leslie, 1967 : 27-42; Shah, 1969, and Srivastava, 1970) have stressed the need for such studies and have presented numerous broad areas for fruitful research. There is a need for more sociologists to specialise in this field because a proper growth of medical sociology in India will benefit both general sociology as well as medical science.

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