Organising Doctors: A Difference in Approach

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ANANT PHADKE (*SHR*, II (3) p 151-2) in his critique of my article (*SHR*, II p 57-66) has chosen to employ rude words e g, "shame-faced defence of the interests of the doctors". Rude words may have their appropriate uses but, as I am inclined to believe, are never known to be good substitute for argument. To confess, my article has not been intended to be any sort of defence of anyone and I have not happened to feel any sort of shame in informing certain aspects of a certain section of the medical profession which is yet misunderstood. Reading Phadke's own article (*SHR*, II (3) p 198-50) on the same topic I find I can identify the difference between our basic approaches to the problem but before that let me clarify a few minor points raised by him.

Phadke takes me to task for my original title "Medical Profession in Health Care" which the working editors thoughtfully changed to "Doctors in Health Care" in order to, I presume, save me from ignominy. Phadke claims that the "medical profession being only doctors" is a popular but mistaken notion and it should include nurses, social health workers, etc. On the other hand, I had no intention to suddenly change a popular category of almost universal usage and if I did, I am sure, would have invited another, irrelevant debate. I do not feel much enthusiasm to emulate the purists' example of using the word 'doctor' for only medical doctors which is also a popular but thoroughly mistaken category. Phadke insists that general practitioners should be said to be involved in "petty commodity relations" and not "precapitalist mode of production" because the former is a "part of a capitalist social formation". Frankly, I do not understand the significance of the difference between the two. The production relation of the GP is neither capitalist nor post-capitalist and further, it is also a part of pre-capitalist social formation.

In his own article, Phadke deals with the subject from the traditional and over-worked idealistic approach to which I alluded in my article: "The profession has hardly been looked into as what it is, but often analysed on the basis of what it should be" That is why, Phadke wants to organise the doctors towards the end of fulfilling the tasks set by his own lofty ideal. He starts by uncritically superimposing the formulation of a particular western school of analysts on the Indian situation. This school categorises the highly skilled wage earners of advanced capitalist society as "new middle class" and Phadke adopts this formulation to place the Indian wage-earning doctors to that class and therefore attributes them similar contradictory role towards social revolution.

This he does without even a cursory glance to the Indian reality. By no stretch of imagination could the Indian society be labelled as an advanced capitalist society. The section of Indian wage-earning doctors is yet to be consolidated in a well-defined social layer. In my article, I have briefly narrated the social events which tend to show that this section of doctors is in the process of consolidating towards a distinct social layer, quite different from the other sections, under the influence of objective forces—particularly economic and political—despite individual tendencies to the contrary. Again, I find that Phadke's assignment of these doctor's role in the function of Capital (according to the same formula of new middle class of developed capitalism) is at variance with reality. I have not found these doctors, as a class, performing "the function of capital, of supervising, extracting work from the paramedics" in order to earn a part of the surplus value (from unidentified source). In fact, the current trend shows different picture. In Bihar, UP and West Bengal, this newly organising band of doctors has joined hand with the already unionised hospital workers in common struggle on common demands—particularly trade union—and democratic rights. Phadke 's estimate that these doctors earn a "comparatively high salary" also appears, devoid of clarification, to be another borrowed assumption. With whom has this comparison been made? With employees of the lower hierarchy, or with employees of the same hierarchy or with their work value/utitlity value/market price?

From this dubious promise, Phadke asks the left "to determine its strategy of organising this layer of doctors". He castigates the leadership of the doctors' organisations for organising them on a trade union platform; discounts trade unionism itself as unworthy because this will only consolidate their already earned privilege; laments that there is no "well-thought out strategy in organising doctors; and calls for appealing towards a small section of enlightened doctors "on the basis of comprehensive revolutionary medical programme which asks doctors to throw away their privileges as elite doctors in return for the promise of decent, meaningful working life."

Well, there may not be nobler ideal and more humanitarian appeal to the heart and conscience. But such idealistic approaches have never helped. Trade unionism does not owe its origin and development to anyone's desires and wishes. Trade unionism develops from objective compulsions. Economism is one of the primary driving force behind trade unionism. Forgetting that we live in a country where even the mature organised working class itself is bogged down in economism, Phadke is so angry with doctors' trade unionism that he admonishes me for giving importance to the West Bengal doctors' movement in 1974 which did not raise any slogan in the peoples' interest. I do not understand why narration of fact or event should be taken as shame-faced defence? Rather I believe it is of no use theorising without a look at facts and events. True to his disinclination to face facts, Phadke has missed an entire paragraph in my article where I narrated the subsequent events revealing how the doctor's organisation later came to understand the linkage between economic aspirations and egalitarian health care service and raised, an entirely new set of demands voicing people's interests.

Contrary to Phadke's assumption, I have not tried to determine doctor's role in social revolution—certainly not at this stage. I wanted to draw an eventful picture of a sec-

tion of the medical profession in the perspective of hard reality. Because I found that the observers almost always dealt with the medical profession from individual presumptions and pre-determined positions without bothering to sift empirical findings. Even the bitter critics of doctors have fallen prey, perhaps unwittingly, to the concept of noble profession and, for no coherent reason at all, expect the doctors to remain unaffected by the nuances of the commercial society and to conduct themselves as holy men. Hence, the exploitative practice of the doctors which is an utter contradiction to the ideal of noble profession, shocks them. Why should the noble doctors behave as other wage-earners do? Why should they indulge in trade unionism and economism as the common workers do? Why should they demand 8-hours duty as everyone does? Why shouldn't they, as noble ones, "throw away their privileges as elite doctors in return for promise of decent, scientific, meaningful working life", as the other commoners do not do? When these doctors do not oblige, Phadke goes searching for a "small critical mass of doctors" who may persuaded to raise a sufficiently strong clamour for "a revolutionary change" in the medical system.

I have little hope he will find one and even if he is fortunate to find them, his ideal may remain unrealised. One thing is certain. We cannot run a medical system without doctors—certainly not by a small critical mass of revolutionary doctors. Before jumping ahead to determine the role of doctors in social revolution, let us try to understand and determine their role in health care. What role do we envisage for the doctors in today's health care? What are they performing? What are the nature and cause of short-comings in role performance? What changes should we demand and strive for in the medical system and what will be the role of the doctors in such dynamic situation? In order to find answers to these questions we have to purge ourselves of the myth of noble profession, step out of our idealistic world of believe and turn a fresh look towards doctors as just a social layer with the relevant particularities. We have to collect real life data and analyse them. We have to know how the doctors practise medicine in the state hospitals, how they, as a class or interest group, interact with the recipients, non-doctor workers and the employer. In this context, discussion on professionalism, role expectation, role performance, as well as agitative movements become relevant.

When we do this, we may be able to understand and determine the service-doctors' role on the basis of their own conduct and not through any wishful thinking. Then only will we be in a position to determine their relationship with a people's health movement for a just health care service. The relationship—I quote Thompson again – "must always be embodied in real people and in a real context".

Without going into details, I may draw attention to the experience of USSR and China. There, in the post-revolutionary period, the state had to deal with the entire medical profession in reshaping health care service. Revolutionary exhortations were found to be inadequate. The instrument of incentive and disincentive was ultimately resorted to and it brought results. The problem has yet to be resolved. Professionalism, job satisfaction, economism, role expectation, role performance, private practice, technocratic scienticism etc, are still living problems.

References

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Light on 'Blind Spots'

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ANANT PHADKE in his review (RJH, June I: 1) of our book *When the Search Began* contends that: "It is not clear from their account as to why the response to this scheme was better than to the earlier one. No economic or political activity has been reported. Perhaps the support of the medical college including the doctor's monthly visit made this difference."

This and other such statements need some clarifications. The insurance scheme demanded Rs 3/person/year as contribution from 75 per cent of the village population and offered hospital services at 75 per cent subsidised cost (See Introduction). Though highly subsidised, hospital charges were beyond the reach of poor villagers. The Jwar Insurance Scheme provide free hospitalisation for all unexpected illnesses and thus provided a sense of security. It was essentially this modification which attracted people and not any economic or political activity.

Regarding Phadke's comments on cost analysis, a close look at the cost analysis will reveal the following:

Hospital indoor admission rate per year = One per 10 population
Government expenditure for 10 people 28×10 = Rs 280/year

Contribution from the people = Meets the cost of peripheral health infrastructure plus spares Rs 18.50

Therefore the amount which can be spared for hospitalised treatment per patient = Rs 280 plus Rs 18.50 Rs 298.50

With a proper referral established between the hospital and the specialised care hospital, I feel that with the amount available, and health insurance coverage for indoor admissions can be provided. It is futile to compare this cost-analysis with existing government PHC set-up where distribution of funds provides only 12 paise/person/year towards drug cost. What is important I believe is that the alternative strategy appears feasible.

Elsewhere Phadke comments that the increase in percentage coverage for health insurance from 46.5 in the first year to 71.5 per cent in the third year does not tally with the earlier claim. The data quoted earlier is from village Nagapur—the village where by trial and error health insurance scheme evolved over the years. The data on increase in coverage (on page 14) is pooled information from the new villages where health insurance scheme was introduced and then implemented once it was found feasible. The strategy of our entry