Medical Officers—The 'New Middle Class'?

I WAS a little bit surprised by Sujit Das's rather sharp response (Organising doctors: a difference in approach, *RJH*, Vol I:2) to my critical comments (*SHR*, Vol II:3) on his article and my separate piece on 'Organising Doctors' in the same issue.

Das feels that my remark that his article is a "shamefaced defence of the interests of the doctors" is a rude one. The dictionary-meaning of "shamefaced" is "bashful, shy, retiring, modest. . ." and has no rude connotations.

I am not sure whether I should go into a detailed debate about the questions of terminology raised in the second paragraph of his response. Some people including Das may find it irrelevant. I would only point out that a mode of production is a relatively stable set of relationship consisting of a specific intertwining of productive forces and production relations and which reproduces itself over and over again. Petty-commodity relations by their very nature cannot constitute a mode of production (a stable, self-reproducing mode) but must disintegrate over a period of time; general practitioners would, over a period of time, more and more be replaced by hospital-owners-capitalist doctors on the one hand, and the wage-earning doctors on the other hand.

Now about the central issues: The main difference in approach according to Das is:-

1) "Phadke wants to organise doctors towards the end of fulfilling the tasks set by his own lofty ideal" Das, however, believes that "such idealistic approaches have never helped".

I plead guilty to his first charge; I would only hasten to add that the "lofty ideal" is not my personal invention. All those who believe in scientific socialism from the point of view of human liberation believe in a "lofty ideal" of a revolutinary charge. His second charge is however, a little off the mark. I have not taken any idealist approach. I have started with a "materialist analysis of position of doctors", and have then tried to point out the contradictory class-location of medical officers—medical officers being one important layer within the category of wage-earning doctors. Based on this materialist dialectical analysis, I have questioned the existing strategy of organising this new middle class "*mainly* on the basis of their trade-union demands" (emphasis added).

2) Das disagrees with my critical attitude towards doctors: It is, of course, true that a socialist health system cannot be run without doctors. But it is also true that a revolutionary socialist transformation in the medical system cannot be *initiated* by a new middle class organised mainly on trade union demands. Such a change can only come (as a part of a broader revolutionary transformation) through revolutionary coalition within and outside the health system in which medical officers as a *social layer* may or may not participate. It should be the attempt of marxists to bring at least a section of this new middle class to the side of the revolutionary programme; and my contention is that this cannot be done by organising them mainly on their trade union demands. Upholding the interests of medical officers as wage-earning health-workers is not enough. Scientific socialists have to be critical about their interests as officers. There has to be an independent platform clamouring for a revolutionary-change in the 'health-system'. Such a platform will take a dialectical approach to the contradictory interests of medical officers. It is not necessary that the majority of the new middle-class comes to the side of the revolutionary programme. There is a more numerous other section of doctors (junior doctors) and much more numerous paramedics who are more likely to come to the side of a revolutionary programme in the field of health. Those medical officers who do not join such a platform today will have to accept and implement after the revolution, the programme chalked out by this platform. Das, however, disagrees basically with my characterisation of the medical officers as part of the new middle class. For two reasons—the first reason is rooted in his misunderstanding of the concept of the new middle class. I have explained my understanding of this term at some length in my note '(Organising Doctors; Towards What End?)' and it should be clear to anyone that I have not 'adopted this formulation' of identifying "the highly skilled wage-earners of advanced capitalist society as new middle class." For me, their position as new middle class is not due to their "skills" but derives from their role as officers. Das's second reason is that "by no stretch of imagination could India be labelled as an advanced capitalist society;" and the new middle class is a product of advanced capitalist society. India is, of course, not an advanced capitalist society like the West, but yet we have monopolists like Tatas and Birlas. In certain sectors, we do have signs of advanced, monopoly interests; and the new middle class (executive engineers, foremen, supervisors, medical officers all those who perform the function of the labourer as well as that of capital as officers) is very much a reality in India.

3) Das disagrees with me on empirical grounds also. ("I have not found these doctors, as a class, performing the function of capital, of supervising, extracting work from the paramedics. . .") The problem is tht Das continues to talk about "doctors in service" as a homogenous category,

whereas I have distinguished between doctors with hardly any administratively supervisory or executive function, e g, the junior doctors on the one hand, and the medical officers who have to perform these functions on the other. If one goes to any Primary Health Centre, one would immediately come across a series of executive, supervisory tasks over the work of the paramedics that the medical officer has to do. It is because of their status as 'officer' that the MOs at PHC get well-built quarters or bungalows (though no such accommodation has been built in many new PHCs;) whereas the junior doctors share one room amongst 2-4 doctors. The MOs get a salary which is higher compared to that of the junior doctors though junior doctors are many a times clinically more competent and are more overloaded with work. The MOs can be compared with the parademics also. The salary and the facilities that the medical officers have, are more than would be explained purely by their training if we compare them with the paramedics (like the ANMs). It is because of their dominant position as officers that many medical officers illegally earn money with impunity through private practice. Medical officers *as wage-earners* have many problems and that is why they have been unionising. But marxists, scientific socialists should not point out only to their problems but also must bear in mind their status as officers.

Contrary to Das's assertion, I have not 'discounted trade unionism as such', nor have I said that doctors should behave as if the world around is not commercial. I only wanted to point out the fact that Das has not given any class-characterisation of doctors though the title of his article raises this expectation and though he raised this question in the text also. Instead, the article gives an account of the problems faced by the doctors without looking at their contradictions and hence becomes a kind of a one-sided defence of the interests of doctors.

—ARS

(*Continued from page 77*)

responsibilities to serve the needs of the dominant class. Total state control is a hightened level in the process of socialisation. On the other hand, at the present moment it is obvious that total state control is not equivalent to people's control. Our conception of people's state or proletarian state has received a jolt from the experience of the socialist countries. People's participation also remain elusive without sharing in power. A rethinking is perhaps in order to conceptualise people's control in political and organisational terms.

But then it is also on observable fact that total state control or major state control, in whatever form, have brought about more equitable distribution of health care among the people. Its contribution in human values has proved to be immense.

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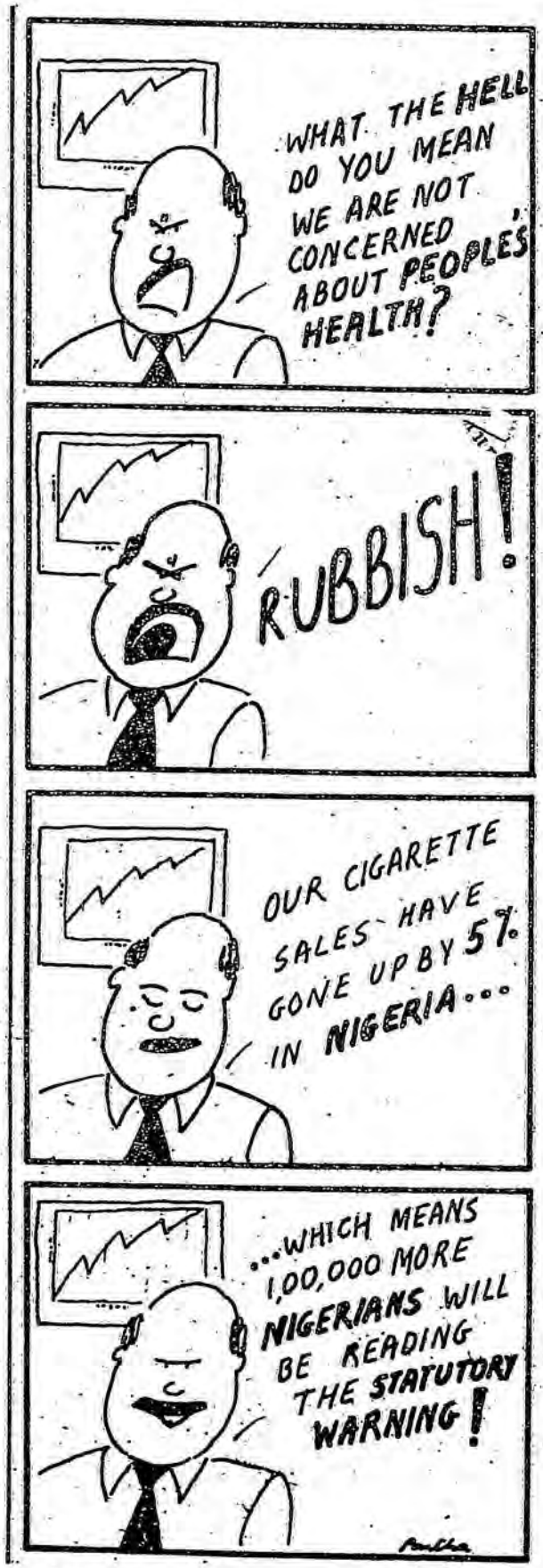
—Smarajit Jana



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"When one individual inflicts bodily injury upon another, such injury that death results, we call the deed manslaughter; when the assailant knew in advance that the injury would be fatal, we call his deed murder. But when society places hundreds of proletarians in such a position that they inevitably meet a too early and an unnatural death, one which is quite as much a death by violence as that by the sword or bullet; when it deprives thousands of the necessaries of life, places them under conditions in which they *cannot* live—forces them through the strong arm of the law, to remain in such conditions until that death ensues which is the inevitable consequence—knows that these thousands of victims must perish, and yet permits these conditions to remain, its deed is murder just as surely as the deed of the single individual; disguised, malicious murder, murder against which none can defend himself, which does not seem that it is, because no man sees the murderer, because the death of the victim seems a natural one, since the offence is more one of ommission than of commission. But murder it remains."

—Frederick Engels

(From *The Condition of the Working-Class in England,* 1892)