DOCTORS IN HEALTH CARE
Their Role and Class Location

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Doctors have played a central role in health care services. In India medicine has enjoyed both state and popular support since the independence. State health services expanded rapidly as did the number of doctors. Many of these doctors went into private practice or migrated to other countries and others into the state health services. This article explores the much debated subject of the class location of the medical profession. Is the general practitioner a productive labourer or a capitalist ? Does the doctor in service belong to the working class ? The author draws attention to the effect of the state sector on the medical profession and traces the growing agitational movements and organisation of state doctors in the country, with special emphasis on West Bengal. Against this backdrop he queries the stereotypical definition of medical care as a commodity.

Doctors are the most important people in health care. Even the official expert group on health, after unrestrained criticism of the doctor-dependence of our health system, concedes "Moreover, the doctor as the leader of the team can play an important role and influence the values and the quality of caring among the whole staff if he shows these concerns himself" (HFA, 1981). Radical critiques on health care call for reversal of the doctor-dependence of the health system but nevertheless wish for a change towards socialisation and social orientation of the medical profession. Popularly, doctors are looked upon as next to gods since they deal with life and death and no wonder doctors are often beaten up when a patient dies or there is allegation of negligence on the part of the doctor. The popular view offers the medical profession the key position in health care; expects it to protect the health of the people; regards it as the greatest depository of knowledge and wisdom regarding health; believes that the weakness of the health care service is due to lack of adequate number of doctors. From the Presidents of India down to the Taluk functionaries they have all been exhorting the medical profession to be patriotic enough to go to the remote villages and stay there to serve the under-privileged rural people.

Surprisingly few attempts have been made to investigate, analyse and understand the medical profession in the perspective of concrete reality. Despite its crucial role, the medical profession is commonly assessed on the basis of subjectivism. Just as the modern medicine had been borrowed from the west, the Indian critiques of the Indian medical profession appear, more often than not, to have been borrowed from the western radicals. The profession had hardly been looked into as what it is, but often analysed on the basis of what it should be.

Development of the Profession

In India the art and practice of healing devolved on to a group of socially engaged men, and several systems of medicine developed and have survived till to-day. Each system was somewhat well-developed corpus of knowledge and its practice had traditionally been taken up by successive generations. Following the changes in the relations of production and exchange, independent practitioners emerged. Later, systems of modern scientific medicine (allopathy) and Homeopathy came from the west and took roots.

In the 19th century, modern medicine had little to offer. The 20th century, heralded the appearance and development of a scientific basis and since the thirties, appearance of chemotherapy and improved surgical techniques created a surge of interest in, and attraction towards, modern medicine owing to its dramatic life-saving achievements. Popular attraction received a further acceleration around and after the second world war as a result of the invention of newer wonder drugs and technology. The practice of modern medicine, likewise, earned a heightened respectability and soon rapidly emerged as a profitable livelihood.

Demands for the expansion of the hospital services have been raised from all corners. The situation is a parallel of what prevailed during the expansion of hospital services in the National Health Service (NHS) of UK. "For the politician, it might be assumed, there could be no better advertisement than a shining new hospital: a visible symbol of his or her commitment to improving the peoples'

health. For the doctors, new hospitals meant the opportunity to practise what is considered to be higher quality medicine. For the consumer, in turn, new hospitals surely meant better services with higher standards of treatment (Klien, 1984). No wonder therefore, in a market economy, almost all aspiring doctors moved towards the practice of curative medicine with its life-saving and relief-producing implements. Iliffe has put it succinctly, "Just as abortion would be a sacrament if men became pregnant, so health professionals would stampede into preventive work if prevention could be made into a marketable commodity" (Iliffe, 1983).

Introduction of welfare activity by the state saw the expansion of state health care service and the number of health personnel increased rapidly (Table I). Later, indigenous systems and homoeopathy, for reasons not discussed here, also received state patronage.

Table I

Year	No. of Med. Colleges	Students admitted	Qualified
50-51	28	2675	1557
60-61	60	5874	3387
70-71	95	12029	10407
80-81	106	10934	12170

Figures are incomplete as a few centres failed to report.

Source : Health Statistics of India (1982) : C.B.H.I., Ministry of Health & F.W., Govt. of India.

Table II Year 1981.

Total No. registered	Went abroad	Returned from abroad	Regd. in Employment	No. admitted in P.G. Courses	Total No. Regd. Doctors in other systems
268,712	4766	2381	16406	8241	382,686

Source : Health Statistics of India (1982) and University of Calcutta.

These doctors opted for private practice or other employment or post-graduate education for specialisation, or migration to foreign countries. For the last few years more than 2000 doctors have been settling abroad annually. There is no available data to indicate the number of doctors engaged in each category but the distribution follows the market situation and economic compulsion. Old pattern of general practice recruits less and less. Number of women doctors has been steadily increasing since 1976-1977 and they generally settle towards certain culturally chosen occupations e.g. gynaecology and obstetrics, pediatrics, pathology, plastic surgery, anaesthesiology, non-clinical disciplines in medical colleges and also dental surgery. Most of the women opt for employment and independent women private practitioners prefer G & O and Pediatrics. Unemployment is a late development (Table II).

Class and the Medical Profession

Private Practice and General Practice

In West Bengal, approximately 70 percent doctors are engaged in private practice. They include independent practitioners, Insurance Medical Practitioners of ESI (M.B.) Scheme, part time practitioners of the state and private sector employees. The General practice has been changing with changing social relations, scientific developments and cultural attitudes. In earlier times, the general practitioners (GP) could not demand any consultation fee and had to distribute drugs to his clients. He then used to incorporate what he considered to be his due consultation fee, within the price of the drug. As a result, the consumption of non-essential drugs and compounded drugs was high. Also the actual price of a compounded drug is difficult to check and verify. Later, consultation fee has gradually been introduced and has received public acceptance, resulting in the development of a class of GPs who are only prescribers.

Indian society has a long tradition of voluntary efforts for charitable medical care to the community. In fact, a good number of clinics and hospitals had been established through philanthropic endeavours. In order to earn and maintain 'nobility', the price doctors had to pay was to attend to emergency patients, give free 'service' to a few indigent patients and offer honorary service in the voluntary institutions. Besides respect, speedy recognition and fame, this attachment to charitable institutions used to bring other material returns. The doctor used to test the emerging therapeutic techniques on poor patients without informed consent and without risk and later employ the technique thus perfected, in cases of paying clientele in the private practice. Actually, the situtation is so advantageous that there is serious competition among the contending doctors to secure honorary employment in the charitable medical establishments. A sort of corrupt practice was also rampant where the patients had to pay the honorary doctor in order to avail of the free hospital service. This malpractice has now been almost eliminated in West Bengal due to higher level of consciousness of the people, but is still in vogue in many other states.

The GP therefore, acts as a retailer of drugs; sells his skilled labour, designated as 'service' to

individual buyers; and it may further be argued that he employs his knowledge and skill as capital and sells the product of his own labour in the market as commodity. Is he a productive labourer or capitalist? Karl Marx, in his inquiry into the social status of independent handicraftsmen and peasants as well as that of producers of non-material production e.g. artists, actors, teachers physicians, etc., said "It is possible that these producers, working with their own means of production, not only reproduce their labour power but create surplus value, while their position enables them to appropriate for themselves their own surplus-labour. ..... And here we come up against a peculiarity that is characteristic of a society in which one definite mode of production predominates, even though not all productive relations have been subordinated to it. ... The means of production become capital only in so far as they have become seperated from labourer and confront labour as an independent power. But in the case referred to the producer – the labourer is the possessor, the owner, of his means of production. They are therefore not capital, any more than in relation to them he is a wage-labourer" (Marx). The GP is actually engaged in a precapitalist mode of production, but nevertheless produces commodity of use value and sells it for exchange value. Our much maligned GP is not altogether a demon or blood sucker. He is just a small commodity producer who still renders essential service which the state is unable to provide for. A close study of the GP will reveal how the western medicine took roots here, changed the health culture and in the process changed its own.

Speed of expansion of the market of private practice has lately been thwarted and is gradually being squeezed for several reasons. Increase in the purchasing capacity of the people cannot keep pace with the increase in the number of doctors thrown into the market. Secondly, expansion of the state sector in medical care has been impressive and concentrated in the urban areas and these are totally free or heavily subsidised. Socially dominant classes who can afford to purchase medical care, have been able to capture the largest share of the free/subsidised state service. As a result, private sector medicare did not develop to the expected level. Thirdly, private practice has a latent period to reach profitability. Lately, increasing numbers from the lower income groups have been recruited in the medical profession, who cannot afford to sustain this latent period. All these have resulted in increasing trend towards employment and migration abroad, unemployment and underemployment.

Doctor-in-Service

Expansion of organised medical care service through state, public undertakings, ESI, big private industry and voluntary organisations has resulted in a marked increase in the number of doctors in employment. Though private medical practitioners still constitute about 3/4th of the medical profession, the doctors-in-service attract the major, if not entire, attention in any debate on health care owing to the fact that the organised sector is the trend-setter and almost always features in planning and debate In this context, the present discussion dwells largely on the doctors-in-service among the practitioners of modern medicine. However, no discussion on the medical profession or for that matter, medical care is compreshensive unless it also includes private practitioners of modern medicine and of the other systems.

The non-practising employed doctor is actually a wage earner destined to identify himself with the aspirations of similar wage-workers of the so-called white-collar category. Though the 'noble profession' ideology provides an excellent instrument for the private practitioners to maximise profit in their trade, it has ironically proved to be a constraint in the way of fulfilling his aspirations. Because of the stigma of 'noble profession', he cannot claim fixed duty hours; cannot claim 'overtime' i.e. extra remuneration for extra work; cannot employ 'red-tapism' in his daily work-load; cannot even utilise his earned leave to escape from the drudgery of frequent emergency duties. He is further handicapped in regard to democratic rights so much so that unionisation of doctors is frowned upon by the society; agitative action is taboo; call for strike in hospitals is taken to be sheer blasphemy. On top of it, the doctor has little hold in the administration of medical care and in the matters of policy-making, programming and power hierarchy, the doctor is placed in a lower position subordinate to the generalist administrator But more about this later.

Do they, then, belong to the working class? The question has never been raised or debated. On this issue, the dogmatic marxists adhere to Reductionist ideology. "Reductionism involves a version of historical materialism which presents all social phenomena as 'reducible' to, or explicable in terms of, the 'economic base'. Thus political struggles or social ideologies are explained as manifestations or 'reflections' of economic forces. In this presentation marxism is reduced to asset of

relatively simple and universal 'laws'. ..... Such a position is guilty of 'essentialism', that is of seeing the economy as embodying the essence of all social phenomena which are then simply expressed or made manifest in the social world" (Hunt, 1978). This methodology necessarily attempts to define classes at the economic level and attaches little importance to the forces operating at the political and ideological level Working class is differentiated by the difference between productive and unproductive labour. Mere wage-earning or labour-selling do not provide entitlement for entry into the working class. "The working class in the capitalist mode of production is that which performs the productive labour in that mode of production. ..... Although every worker is a wage-earner, every wage-earner is certainly not a worker, for not every wage-earner is engaged in productive labour" (Poulantzas, 1975). While in cases of white-collar wage-workers of the industry, transport and mercantile enterprises, Marx concludes that they are productive labourers, the physicians-actors-teachers etc. are also productive labourers. He observes, when they sell their labour power (manual or mental) in a capitalist establishment which appropriates their surplus labour and makes a profit by selling the products as commodities. But he adds, "All these manifestations of capitalist production in this sphere are so insignificant compared with the totality of production that they can be left entirely out of account" (Marx, 1978).

Technology, capitalist organisation of production and productive forces are much more developed now than at Marx's time, though the development of medical care service as a sector of capitalist industry is still rudimentary in India. The new working class of advanced capitalism — the technicians, engineers, scientists etc. — is held, by Serge Mallet, not only to be revolutionary but the 'avant-garde' of the revolutionary socialist movement (Mallet, 1975). Services have long been developed into profit making industry in the developed countries.

Here in India, doctors as wage-earners are now commonplace. To what class do they belong? The established left still subscribes to the liberal concept of health care and therefore, has yet to face this question. The progressive view, however, is confusing, to say the least. "The capitalist can organise the production of surplus value through the provision of health care and can realise higher profits in this service industry. It is immaterial whether the surplus value is realised directly through the productive activities in the clinics and hospitals owned by the Capitalist or indirectly, through the provision of health care by the State to maintain or increase the productive capacity of the labour." (Jesani and Prakash, 1984). Such an assertion is based on dubious premises that medical service has developed into an industry; that the State also acts as a productive enterprise; and that State Health Care Service is an organised investment by the capitalist class on the industrial productive labour.

What then is the status of the producers of 'health care'? The above assertion automatically places the employed doctors into the category of the working class. But alas, the entire medical profession carries, in the radical viewpoint, the same class background as the bourgeoisie and performs its predestined social task of legitimising-strengthening and maintaining the bourgeois medicine. Why this confusion? "The mere quantum of the so-called marxist analysis of health, done in the West has so impressed us that we have literally lifted their formulations and transplanted them on the Indian scene, without even thinking whether they are applicable. Further, in our hurry to fill in the gaps in our knowledge, we have concentrated on theory of health and medicine. That theory, however has been sought by filling the accepted theoretical constructs with Indian data and developments rather than beginning with health and health services itself to test the assumptions as well as the theoretical constructs" (Quadeer, 1984). In other words, in order to understand and analyse its status, role, trend and potential in health care, we have to make an actual study of the medical profession in its concrete reality.

Professionalism

"Professionalism within health care is based on the idea of 'service' and on the practice of trade. It is a market concept expressed in the relationship between a customer (the patient), a tradesman (the professional) and assorted suppliers (the drug industry, other superior professionals). Trade secrets are necessary for the maintenance of the market relationship, and permit professionals to define themselves as special, and beyond the control of those ignorant of these "trade secrets". The autonomy of health professionals — particularly doctors rest on the range of their trade secrets" (Iliffe 1983). With this conception it follows that professionalism could be curbed or even abolished with the

abolition of market economy i. e. private trade or commodity market in health care. This appears to be another instance of radical presumption. Professionalism is not a creed peculiar to the medical profession nor to the bourgeois ideology. Professionalism not only regins in private medical trade but also exists among the employed non-practising professionals, among the medical teachers of non-clinical disciplines and among the doctors engaged in public health work.

Professionalism exists in pre-capitalist economy and continues in the post-revolutionary societies where the ownership of the means of production has undergone a change and private trade almost abolished. In a round table discussion on private medical practice organised by WHO, it has been revealed that private practice, in certain forms exists and is developing in the socialist countries (Roemer, 1984). Medical co-operatives are springing up where state-employed doctors are allowed to spend upto two hours a day and are entitled to a 50 percent share of the payment received from the patients in cash for the services rendered. Even in China, barefoot doctors who are essentially paramedics, are allowed part-time private practice. A common practice developing in these countries is that of giving gifts to doctors in hospitals and often the gifts are relatively large amounts of money. All this is done to ensure better quality of service (which is by no means certain). How is the quality of service to be determined ? How are measures and gradations to be made ? There is as yet no acceptable indicator or scale. Hence, quality will be determined differently by different social ideologies and health cultures, and the latter are manipulated by professionalism. Specialisation and mystification are only other facets or instruments of professionalism utilised to maximise the price of medical service in private practice.

Specialisation, however, is not an exclusive exploitative imposition. It is also an integral part of social division of labour, not only unavoidable but necessary in any social formation including the one based on non-exploitative mode of production. What is relevant is not to confuse social division of labour with capitals' division of labour. In an analysis of modern chemical industry in UK Nichols and Beynon have shown that though technical division of labour is a must in any industry in any mode of production, in the capitalist mode the technical imperatives are subordinated to political imperatives and technology exists to serve and augment capital. "Certainly in any mode of production, given the existence of specialised training, some men will be more technically competent to solve certain problems than others This is so obvious as to hardly require stating. But something else which should also be obvious is often ignored. For concern with the technical structure of complexes like Riverside (the factory site) can also too easily obscure the fact that they are not even designed to make chemicals, but to make chemicals for profit The reality is that their division of labour is capital's division of labour ..... (Nichols and Benyon, 1977) Professionalism, also, could make its contributions in the struggle against the ruling class and the state. The history of the development of health care service in Great Britain has shown that the professionalism of the doctors thwarted, at different stages, the attempts of the state to reduce or withdraw the medical benefits demanded by the people. Here in India also, professionalism often reinforces the demands of the people for the egalitarian distribution of medical services against the discriminatory practice of the state.

What do we expect from the doctors? Here, the bourgeois, left, radical and popular views converge and appear as if grossly influenced by the ideology of professionalism. A doctor should render utmost efforts irrespective of the socio-economic status of the patient; should always ungrudgingly serve emergency patients without consideration to his own convenience; should always be guided by the code of ethics formulated by the profession; should act as a friend-philosopher-guide to the patient; should exude hope and confidence in his conduct etc. etc. Concomitantly, the community accorded certain privileges to the profession. The doctor knows best; he should not be questioned; he has the unchallengeable right to handle and manipulate the patient's body; his good faith is taken for granted even in cases of the patient's death and disability.

What do the doctors think about their own role expectation? In a large study in two medical college hospitals in Tamilnadu, Venkatratnam revealed that the doctors' understanding of their role expectation is a composite of their own individual perception, occupational compulsions and organisational (professional and institutional) principles (Venkatraman, 1979). Role expectation comprises of professional, academic, research, managerial and social. Many interesting facts and controversial issues regarding doctors' responsibility towards patients, role towards other health workers, requirements of teaching-training-research, level of

communication with patients, social responsibility and so on have been revealed in the above study and these should be analysed before rushing to issuing sermons on doctors' role expectation. Peculiarly, the ICMR-ICSSR report, while castigating the profession for its negative attitude towards preventive and promotive health care recommends for their 'alternative model' of health care service that "the doctors will still continue to play an important role in the new health care system. But this will not be over-dominating and will be confined more and more to the curative aspects of the referral and specialized services for which they are trained" (HFA 1981).

Universally, the understanding of role expectation of the doctors suffers from an idealistic approach. All expect the doctor to be humane, shorn of commercial urge, dedicated to patient's welfare, imbibed with principles of social justice etc etc. No one asks why the doctor should follow such a model or what objective conditions may compel him to do so? Or for that matter, what objective conditions persuade the doctor to do as he does?

Perception of role performance differs between the professionals and the consumers for obvious reasons. Confusing and paradoxical situations prevail. While the State hospitals and the doctors are almost always on the dock by the consumers and mass media for the severe shortcomings in role performance, the very same hospitals and the professionals are very much in demand for their high quality and indispensible medical service. True, the service is attractive because it is free. But even amongst affluent consumers the notion prevails that the hospital doctors are more skillful, knowledgeable and equipped. Generally, the doctors' notion on role performance is that they do their best under the given circumstances and they could do more if they have a free hand in the administration which is responsible for the constraints. The factors underlying these confusions and paradoxes are being unravelled by the growing momentum of the organised movement of the doctors.

Doctor's Organisations and Agitations : West Bengal

Medical practitioners got themselves organised under Indian Medical Association in the thirties. Later, practitioners of each speciality discipline built up separate associations. The basis of these associations is professionalism, academic and pseudo-academic. It should be mentioned that non-clinical and even public health disciplines organised their own associations. But the associations could not cope with the task of tackling the emerging aspirations of the employed doctors. In fact, a contradiction developed between them. Ironically, the bone of contention was economic as well as ideological. The ideology of professionalism appeared to be a drawback for the service-doctors. The pay packet of service was unattractive not only in comparison with the income in private practice but also compared unfavourably with that of the similar category of government officers, for instance the civil service, or the engineering service. This situation had been a hangover from the British days when doctor's pay packet was deliberately kept low with the understanding that they would make it up with the earning from private practice, a privilege then enjoyed by all service-doctors. Later, with the expansion of the state sector, more and more doctors had been employed on non-practising basis but this principle of wage policy did not change.

In matters of job requirement, job perquisites and job satisfaction, there was nothing glamourous to look forward to. Duty hours was virtually feudal - a doctor was 'on call' for 24 hours a day for emergency need and seven days a week; almost all health centres in the rural areas were manned by one doctor in each; there was no ceiling on the number of patients one had to attend daily; a rural medical officer, in addition to his clinical duties, was entrusted with the tasks of family planning, MCH, School Health, Immunisation, Epidemic Control Administration and what not. System of recognition and appreciation of good and dedicated service was absent. Avenues for higher education, promotion, research, or even a transfer to a better post after a scheduled period of service, were severely limited. Because of longer period of training to acquire qualification, a doctor usually enters service at a later period compared to others and consequently is entitled to a lower pension and lesser amount in the retirement benefits.

The state hospitals were always understaffed and underequipped and hence, the scope of practicing what the doctor was trained for, was thereby limited. On top of these, the health administration was run by the generalist administrators. These people had no career attachment to the health department; were not answerable for failure or mismanagement; had no inclination to learn the problems of the health care service as well as of the employees. The doctor had no voice in health planning, hospital service development and technical development. The autonomy enjoyed by the profession

in regard to clinical practice in the NHS of UK was not even partly granted to the doctors here. On the other hand, the political authorities found it convenient to put the blame on doctors and other health workers for all their failures, misdeeds and incompetence in the health sector. Consequently, doctors and the health workers, as they were the ones, at the counter, had to suffer the burden of public wrath in the form of physical assault, humiliation, abuse and so on.

What did the doctors do to overcome these adversities? It is worth while to note that the state service was last in the list of priorities of a new medical graduate. The order being private practice, specialisation, migration abroad and if all fail — then he opts for service. Lately, because of competition, the options have shrank greatly and large numbers are now competing among themselves for limited state service; doctors from Orissa, Assam, Bihar, Bangladesh are now applicants to the West Bengal State Service.

In this situation how have the service-doctors reacted? Quality has been the first victim and expectedly so. No matter whether 50 or 500 attend the outpatients clinic the experienced doctor manages to tackle them within 3 hours or so. In a 100-bed hospital, 200 patients stay indoor regularly but the same number of doctors and health workers treat them without spending any additional time in the hospital. The next escape route is private practice — both authorised and unauthorised. In west Bengal except in the case of clinical teachers of the majority of medical colleges and doctors in the district and subdivisional hospitals, private practice is not allowed. In fact, 7/8th of the State doctors are non-practising. The States of Orissa, Andhra, Maharashtra, Punjab, Hariana and others have either entirely or partly non-practising state service. Some other states have indicated that they will too follow suit. The entire Union government and the public undertakings sector is non-practising. Expectedly, most doctors aspire for the limited practising privilege of the service and in the non-practising sector, unauthorised private practice is growing wherever there is scope and opportunity.

The question of the alleged reluctance of the doctors to serve in the rural institutions should be understood and analysed with this background in mind. Concerned people have swallowed the government propaganda that because of such reluctance on the part of the doctors, the government despite earnest efforts and liberal financial allocation, fails to provide medical care to the rural people. By absorbing this propaganda uncritically, the health activists on the one hand, unwittingly agree with the government that medical care is synonymous with the presence of a doctor, fall in another trap that provides for offering barefoot doctors Homoeopaths-Ayurveds and simple home remedies for the villagers in the garb of tradition, indigenous culture and community medicine. The fact is otherwise. It is deliberate government policy to keep the service conditions of the rural medical officers unfavourable with a view to discourage the doctors from taking up rural postings; and in this attempt, one must admit, the government has been successful to the exent that even the occasional few socially conscious people-oriented young doctors, after a stint of rural service, try their utmost to move to the urban area or quit. The Siddhartha Roy Congress government's regulation of 1974 stipulated that physicians with specialist degrees would enjoy a higher pay, a special allowance and would be exempt from rural postings. It was only natural that young doctors went in for specialisation just for the sake of avoiding rural posting, if not for higher emoluments. The Left Front government has not felt it necessary to change the regulation" (The Statesman, 1985). This policy in fact, induced even those doctors, who had already settled in the rural areas, to move for any type of specialisation and settle in urban areas. Does it show reluctance on the part of the doctors or that of the government? Lately, the Marxist Left Front government in West Bengal introduced against the protest of the medical profession, a short term three year medical course to train up doctors who would fill up the rural vacancies. Next year, the junior doctors in the State launched agitation for jobs in the State service and demanded that all rural posts be immediately filled up by currently eligible 3000 unemployed young medical graduates. Under public pressure, the Left Front publicly declared that there were no such vacancies and they were unable to provide jobs, not even in the rural areas. The short-term medical course had to be wound up In any case, the discrimination against the rural medical officers persists. No one, of course, raises the question why doctors, of all people, must go and serve the villagers who are ignored in respect of all other consumer goods: It must be understood that the recent organised demand of the junior doctors for rural appointment is not due to any sudden surge of patriotism but simply due to pressure of unemployment.

In course of time, however, the consoling compensation through private practice turned out to be insufficient. Service-doctors and junior doctors ventured to organise their own bodies on trade union basis to voice their grievances which did not find deserving place in the earlier professional bodies like IMA which was dominated by private practitioners. In 1973, junior doctors launched a movement in West Bengal demanding better pay and service conditions, and better provisions in the State hospitals They had to go on strike and come out partially successful by obtaining pay hikes. In 1974, the State doctors (in alliance with the State engineers) resorted to strike for 41 days but maintaining the emergency services. Their demands were not only economic but encroached on the political and ideological level. They demanded exclusive executive power for the scientists, technologists and professionals in the scientific and technical departments of the State administration which were the preserve of the generalists, and parity in pay scale with the Indian Administrative Service (IAS). This agitation generated intense debate throughout the country and the issue has not yet been settled. The West Bengal government ultimately made a few concessions but unfortunately, with the subsequent imposition of Emergency in the country, the terms of the agreement were not implimented, leaders were sacked and doctors terrorised. The fall out of this agitation was visible elsewhere; the pay scale of the doctors in the Union government and public undertakings were soon revised upwards to bring it on par with that of the IAS at the lower level.

This agitation made a breakthrough on several grounds. People saw to their surprise that renowned professors and principals of the medical colleges, eminent specialists and senior engineers holding high ranks in the state service, walking in processions, squatting on the pavements and holding street-corner meetings. It then struck them as a novelty that the 'noble' doctors could resort to agitative ways that befit only common workers. Doctors, it was stressed, had no right to jeopordise the well being of the patients by striking. This agitation, perhaps for the first time, focussed people's attention on the affairs of the medical service, particularly into the government assertion that the doctors and health workers were responsible for all the ills in the system. This agitation was followed by a series of agitative movements all over the country, mostly by the junior doctors but also by the state doctors in Delhi, UP, Orissa, Assam, Maharastra Andhra, Bihar - though with different demands as was expected owing to different levels of development. Everywhere, organisations of service-doctors sprang up independent of the IMA. The agitation in West Bengal also brought changes in the orientation of Bengal IMA, which despite its long history of co-operation with the government had to come out actively in support of the service-doctors and junior doctors.

Sporadic movements on various issues such as reduction of job burden, physical security at the work-site, better provisions for emergency care, improvement of rural medicare and more scope for higher education have taken place culminating in the 1983 statewide movement. The junior doctors demanded, besides better pay, service conditions and provisions for emergency care and a health policy with priority to preventive care. The Left Front Government took recourse to unprecedented repressive measures using party cadres and the police. Brutal police violence on the junior doctors brought state doctors onto the scene, also in an unprecedented manner. Perhaps for the first time in the world, state doctors in their strike action withdrew from the emergency services. This was an organised retaliation of the doctors against organised terrorism of the Left Front government who reiterated the earlier declaration of the Congress regime that the doctors had no right to strike. The government had also earlier started denying the doctors the right to any agitative activity. This was strange and definitely unacceptable to doctors who had to earn democratic rights through hard struggle in 1974 when the conduct rules for the government servant had been revised. The doctors received, unprecedented public support even though they committed such so-called anti-humanitarian acts as deserting the emergency counters. The government finally had to withdraw the victimisation and punitive measures and concede the immediate demands of the strikers.

There are now indications that service doctors are now beginning to realise that the aspirations of their occupation are directly related with the nature, object, standard and extent of the state health care services. They have now raised the demand for clear declaration of the aims and objects of the state health policy and a controlling role in implementation, a plea to share responsibility with power. The service-doctors in West Bengal demanded that free state medicare be exclusively reserved for the indigent population only, which produced indignant protests not only from the privileged middle class

but a few political parties with 'Left' labels. Different mass organisations are now holding meetings and seminars on the health policy and state health acare administrtion There has also been a renewed spurt in the agitative movement of the junior doctors and service-doctors in other states for instance Bihar, UP, Orissa, Maharastra and Delhi.

These organised movements of the service-doctors brought many undiscussed issues into public attention. Should the doctors be treated as a special occupational group with limited democratic rights and additional responsibilities to society? And if so, why? What are then the limits of the forms of agitation for the doctors, if they have grievances to agitate for? Are the doctors also entitled to fixed duty hours just like others? Why should doctors alone have a moral or social obligation to serve the villagers who are deprived of, and are discriminated against in respect of all other commodities and services? Should the generalists enjoy the power and the doctors bear the responsibility of state health care service? And finally, who doctors are primarily responsible to, the employer or to the patients or to their professional ethics?

The foregoing development and issues persuade us to take a new approach — the marxist approach — to determine the role expectation and analyse the role performance of the medical profession. In a market economy, the medical profession cannot but be governed by its rules and to expect them to swim against the current is an utterly idealistic proposition. The service-doctors tend to behave as other wage-workers do. They try to extract as much wage with as little labour as possible, in contrast with the employer's tendency to extract as much labour with as little wage. It is all very well and easy to define 'medical care' as a commodity in the capitalist mode of production but it needs explaining how the universally free state medicare remains a commodity and behaves as a commodity. Or what here is the relation of production between the owners of the means of production and the sellers of labour power? It needs study to understand why the primary need of food-clothing-shelter is denied to a dying citizen but free medicare service is demanded and created and, the nature of the class struggle that brings about this state response. All these studies in the concrete reality of the Indian situation will bring us back to the question of class identification.

Conclusion

"The separate individuals form a class in so far as they have to carry on a common battle against another class; in other respects they are on hostile terms with each other as competitors. On the other hand, the class in its turn assumes an independent existence as against the individuals, so that the latter find their conditions of life predetermined, and have their position in life and hence their personal development assigned to them by their class, thus becoming subsumed under it" (Marx and Engels 1976). The individual's role in the production process, his location in the social relations of production, the productive or unproductive nature of his labour - all these form the basis of inquiry. But as regards the identification of class, the common interest, common behaviour and common action, which are often independent of individual wills, — or the common outlook towards social events, political and ideological orientations — are also important and often act as positive forces. To this Engels has drawn attention: "The economic situation is the basis, but the various elements of the superstructure-political forms of the class struggle and its results, to wit. Constitutions established by the victorious class after a successful battle etc., juridical forms, and even the reflexes of all these actual struggles in the brains of the participants, political, juristic, philosophical theories, religious views and their further development into systems of dogmas - also exercise their influence upon the course of the historical struggles and in many cases preponderate in determining their form" (Marx and Engels 1965). In order to understand the social role of a group of similarly placed wage-earners, their historical development in relation to the changes in the mode and relations of production as well as their political and ideological expressions vis-a-vis the dominant political and ideological current in the given society, are to be studied. Class is actually, a historically developed, ideologically shaped and economically determined dynamic relationship expressed through class struggle. Thompson's notion of class reveals this aspect. "By class I understand a historical phenomenon, unifying a number of disparate and seemingly unconnected events, both in the raw material of experience and in consciousness. I emphasize that it is a historical phenomenon, I do not see class as 'structure' nor even as 'category', but as something which in fact happens (and can be shown to have happened) in human relationships.... Like any other relationship, it is a fluency which evades analysis if we attempt to stop it dead at any given moment and anatomize its structure.... The relationship must always be embodied in real people and in a real context" (Thompson 1982).

The social role of the employed section of the medical profession is therefore, determined by their role in the dominant mode of production and by their interaction classes in the social events. Sellers of labour power primarily sell their labour power to earn a living not to produce commodities. By the complexity of social division of labour, some have greater interest in their products while others have greater interest in the production process. Each of the occupations has an ideologically determined skill, status and price. All have common despair in unemployment and all undergo the similar feeling of inferiority, helplessness, subordination and subjugation in relation to their employers. Vic Allen, thus describing the wage-earners, concludes that bourgeois sociological stratification of different hierarchical classes and the reductionist categorisation of productive and unproductive labourer without empirical substantation, will not be helpful in an attempt to differentiate between wage earners (Allen 1978). In the case of health professionals, the study should go much deeper and wider. Health and medicine are not mere sterile figures or say, mortality and morbidity statistics. Illness involves pain, fear and desperation in real life and these saturate the milieu wherein medical care operates. Cultural instincts and ideological creeds strongly influence and occasionally determine medicine and medicare. Medicine in its practice and institutional forms is not merely commercial exploitation or oppressive power relations imposed by the dominant class — as radicalism may have us believe — but is a resultant of class struggle, of antagonistic and non-antagonistic contradictions between classes; of interactions at the economic, political and ideological levels.

The question of the role and behaviour of the medical profession is relevant to the building up of a Peoples Health Movement (PHM). PHM is not merely imparting health education to the individual or community. PHM does not end with the exposure of the inadequacy and exploitative nature of capitalist medicine. PHM needs to acquire expertise, to develop sound scientific basis of egalitarian health system, to search for the mechanics of building up of a socialist health culture and to strive for subordination of medical science to social needs and aspirations. It is a stupendous task and the role of the health professionals is crucial. This necessitates objective study of the profession before theorising study of the developing contradiction in the profession and the nature of the contradiction; the dialectics of the medicine; the development of the elements of socialist medicine during bourgeois dominance; the dialectics of cultural change and development. In the ensuing struggle the weapons of the bourgeois science and technology ought to be counterpoised by the weapons of peoples' science and technology. Involvement of the medical personnel will not be determined by humanist exhortation or so called deprofessionalisation but by class contradiction and class struggle. The medical profession or a section of it - be it categorised as the 'new petty bourgeois' (Poulantzas, 1975) or the 'new working class' (Mallet, 1975) will have its own determinant role to play and the PHM activists must need to analyse and understand this role in order to formulate the strategy and tactics in the emerging social events of the health sector.

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