PEOPLE IN HEALTH CARE

No other profession enjoys the amount of adulation or gets its share of brick bats as does the medical profession. The problems of ill-health being what they are in our country, every discussion and debate on such issues revolves around the question of availability of doctors. This factor has assumed such a major importance that the doctor-population ratio has come to be accepted as a standard measurement of health services and indirectly of the health of a population. In this process the important contribution made by the other categories of health workers remains invisible only to come up when they strike work.

The central role doctors play in diagnosing and treating diseases is not merely confined to the provision of such services but extends to the entire field of health care including the right to define what constitutes disease and the right to treat it. The medical profession argues that if high quality services are to be made available and if 'purity' of medical practice is to be maintained it is essential that the profession retains complete control through registration and legislation. Further, the medical profession argues that diagnosing and prescribing are superior to all other skills and only those who possess such skills have the necessary authority to direct the course of health itself. That all such arguments merely form a facade for maintaining monopoly over a valuable commodity can be seen by looking at the way medical practice evolved into its present professional status.

The Beginnings of Medicine as a Profession

The emergence of the medical profession can be traced to 14th-15th century Europe which witnessed a class alliance between the upper middle class male 'regular' doctors and the feudal church leading to the ruthless extermination of other healers, mostly women, through well organised witch-hunts. Similarly, two centuries later in America the 'regulars' tried to gain monopoly over medical practice by attempting to pass state legislation in collusion with the emerging industrial and commercial bourgeoisie. Initially such attempts met with mass protests which culminated into a popular health movement. Unfortunately, the effort against legislation could not be sustained and the movement degenerated into a number of medical sects.

The 'regulars' attempt at cornering the market for their expertise was based on two factors. Firstly, the 'regulars' need to eliminate competition now arose as, for the first time, the practice of medicine was being viewed a full time economic activity. Secondly, if this activity was to bring in a substantial income, it was necessary to improve the image of the activity by giving it a professional status. As a mark of distinction the regulars adopted the Hippocratic oath and code of ethics as their standard. It is important to note that all this took place before medicine had attained any scientific aura or had developed any rational medical interventions. In fact, the regulars of that time practised what was known as heroic therapy which included blood-letting, purging and applying leeches among other such horriffic remedies.

With the support of the industrial and commercial bourgeoisie, it was just a matter of time before specific and effective interventions in the disease process developed which further consolidated the power the medical profession had gained through legislation and the physical extermination of other healers. It was this monopoly that shaped the form and content of medical care to its present form. The predominant hospital structure and the emergence of other categories of workers such as the nurses, laboratory, x-ray technicians, pharmacists and others has evolved and revolved around the functions that a doctor performed.

It was also not a mere accident that nursing emerged as a suitable profession for women or that it was subordinated to doctoring. By the time medical practice had become established as the domain of male regular doctors, women had been eliminated from health care for all practical purposes. The authority that doctors had in defining normality allowed them the power to advance pseudo-scientific theories and sexist arguments regarding the intellectual capabilities of women to prevent them from entering medical colleges. Women from the upper classes were increasingly being told to conserve their energies for the supreme function of being a woman, that is procreation, and were therefore forced to lead a sedentary life. For the women from this class who did not or could not marry, life had little option. Apart from teaching there was hardly any respectable 'genteel', non-

industrial occupation which would be socially acceptable and at the same time provide a certain level of economic independence. The goal of Florence Nightingale, the 19th century reformer was to create a paid job in health care for women. To make it acceptable to doctors Nightingale demonstrated in the battle field of the Crimean war that nursing would remain subordinate to doctoring and her attempt to make the occupation acceptable to women was to draw analogies between nursing and housework. The doctor-nurse relationship was projected as a husband-wife interaction and nursing was stated to be 'natural' to women, as it coincided with what was considered to be her natural biolgical function. Since Nightingale's effort was to create a job for the women in health care she made it quite clear that it would in no way question the supremacy of doctors or the subordinate position of nursing. Feminist historians however question the acceptance of nursing as a *natural* sexual division of labour. By taking patriarchy as an analytical category they have tried to argue that what is generally considered a natural sexual division of labour is in reality a *social* division of labour which designates men to be superior to women in all social interactions, concerning men and women.

The heritage handed down to the nursing occupation by Nightingale and other reformers has left its indelible mark on the issues identified by the nursing profession in the later years. Nurses have taken up issues related to registration, professional status and for a certain degree of organisational autonomy. But at no time has the nursing profession questioned its subordinate position. In fact one of the barriers for expanding the nurses role to a nurse-practitioner came from the nurses association in the US, who were reluctant to accept the responsibility for diagnosing and treating.

In India one could say that the health care system expanded only after independence. Although on the whole its evolution was similar to the development that took place in the West, there were certain dissimilarities. For instance, even as far back as 1883 several universities in India began to accept women as medical students. The Bhore committee in its recommendations at 1946 stated that at least 20-30 percent of seats in medical colleges should be reserved for women students. The change in attitude of the profession towards women students was perhaps related to the constraints placed by the purdah system on women in general which prevented the male medical profession's entry into areas such as maternal and child health. The post independent years have seen attempts to provide medical services through an alternative health care structure by establishing primary health centres and subcentres to cover rural populations. But throughout all these developments adequate care was taken to ensure that the monopoly exercised by doctors would be maintained and remain unquestioned.

The Bhore committee stated categorically that only the physicians trained in allopathy, should be called doctors and the doctor was to be the unquestioned leader of the medical team whether it was in the operating room or in the primary health centre. It emphasised the training of one level of doctors and recommended the abolition of the Licenciate course. Without analysing the class background of the doctors or their class interests the members of the committee hoped that training sufficient number of doctors would ensure that they would opt for the villages. That the committee was not sufficiently interested in the other categories of health personnel can be seen by the number of pages devoted in their report on the training of doctors and all other categories of workers. Later committees too have emphasised the role of doctors at the cost of neglecting all other health personnel. The need to train a 'lower' category of practitioner is discussed time and again but is always rejected on the plea that it would lead to quackery. At the same time when the suggestions that a 'lower' level of nurse be trained was made by the nursing council it was greeted as the most feasible solution given the low resources available in the country. Similarly when the Shrivastav committee made its recommendation in 1975 for training village level workers, it also allayed the fears of the medical profession by stating that since the role of these functionaries was educational, their curative skills would be limited to just a few remedies for simple day to day illnesses.

The end result of all such actions has been to create a structure which is rigidly hierarchical reflecting the class structure in the broader society. Just the way the economic status or caste of a person largely influences his/her future position in any socio-economic activity, in medical practice too these factors very often determined which level of hierarchy s/he will occupy in the health structure. This streamlining into 'suitable' rung in the hierarchy is generally mediated through the person's performance in and access to education. For instance, the three categories of nursing personnel we have in India that is the B.Sc. nurse, the Registered

Nurse Registered Midwife (RNRM) and the Auxiliary Nurse Midwife (ANM) required different levels of educational qualifications to enter into their respective training schools. This determines the class that will be predominant in each of these categories which is further consolidated by the differential salary structure and status afforded to these three categories in the nursing profession.

Since medical care is a valuable commodity and the right to provide it has been appropriated by doctors, all other categories of health workers and the functions they perform remain subordinate to that of doctors. This monopoly is often carried to ridiculous lengths, such as the prohibition on nurses to start an intravenous drip or give an intravenous injection.

Reports discussing the problems of health personnel have also mostly focused on the problems faced by doctors. One hears repeatedly that doctors have to face innumerable problems such as lack of educational facilities for their children, lack of 'entertainment' in the village and less opportunities for professional growth; and that unless these facilities are provided it would be unrealistic to expect doctors to work in the villages. But these 'problems' really pale in significance if one considers the difficulties an ANM faces during the course of her work.

Nurses : Problems They Face

The problem nurses face needs to be dealt with separately. Their contribution has been mostly towards the care of patients, although they perform important technical tasks too. The rural health services rest largely on the functioning of female health workers and their non-performance could very well paralyse the entire rural health network. Yet their status within the structure of health services has remained one of subordination. Attempts in the past to improve the status and image of nursing has very often been limited to increasing the content of the curricula or the technical content of their work. But this only ends up in reemphasising the fact that 'caring' as a function cannot be held on par with that of diagnosing and prescribing.

As women, nurses have an added problem of sexual harassment which they have to continuously face both within and outside their work situation. One reads of newspaper reports of nurses who are molested, who commit suicide because of sexual abuse or are murdered for their unwillingness to be casual sexual partner. One could hazard a guess that the women health workers in rural areas are probably exposed to such problems to a greater extent. This is not because the rural males are different from their urban counterparts but rather the situation that the nurses are in makes them more vulnerable. Isolated as they are in remote villages, with little support from other health workers these women health workers suffer in silence out of sheer economic necessity to retain their jobs. This could also be the reason why such incidents are under-reported.

Although this problem has been recognised as a major constraint there has been no systematic effort to document these incidents or evolve support systems to tackle such problems. Addition of self defense into all nursing curricula as a skill to be developed by nursing students could perhaps be one such way. But a more realistic solution would only emerge if nurses' unions take up this issue seriously to launch a struggle to make their work place safe. Indeed for such struggles to succeed they will have to become part of much larger struggle of all women. The top two categories of nursing personnel are generally better placed to form unions as they work in hospitals and are physically proximate. The ANMs on the other hand who work mostly in the PHCs and subcentres have little opportunity to come together to raise their collective demand.

The work force employed in the hospital industry is similar yet distinct from that employed in other industries. The distinction lies firstly in the fact that these functionaries work on raw materials (patients) to produce a non-quantifiable product 'health'. Secondly, the physicians and sometimes the nurses who occupy the higher level of hierarchy view themselves as professionals rather than as workers. This often contrasts with the attitude of non-medical hospital workers who view their activity merely as a job. But the situation is changing now. Doctors, nurses and other 'professional' health workers are getting unionised and demanding more and more job benefits, fixed duty hours and overtime pay, in the process assuming the form of wage earners. But even when such issues are taken up they try to use their 'professional' status to push their point. For instance, in the recent strike by the interns from medical colleges in Delhi, a placard was used with the legend 'Doctors lathi charged! What next!'

Although the demands of the 'professional' categories are similar to that of non-medical hospital

workers there is little attempt to identify these issues as common issues and to unionising on the basis of their identity as workers.

One of the limitations of this perspective as well as the whole issue on 'People in Health Care' is that we have concentrated on health workers functioning as part of the allopathic system of medicine. We really know very little about health workers belonging to other systems of medicine in India, in terms of their role and status. Further even among the workers in the allopathic system very little information is available about non-physician health workers.

Finally, a word about the people on whom the 'people in health care' work upon. As patients they are the most powerless in the interaction that takes place in a health care set up. They are neither in a position to direct the course of their treatment nor can they demand a social accountability from health personnel. The self-help movement in the west has been a reaction to such powerlessness. It remains to be seen whether the concept of self-help can ever become a viable alternative to the present system as it exists today.

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In this issue :

Sujit K. Das explores the much debated subject of the class location of doctors and queries the stereotypical definition of medical care as a commodity. Rajkumari Narang looks at various studies in anaemia to illustrate her contention that the choice and treatment of problems in medical research is rarely governed by factors such as people's needs. Imrana Quadeer examines the impact of the rural social and economic realities on the Community Health Worker's Scheme. Sumathi Nair takes a closer look at four Commumity Health Projects and asks what their relevance is today. The issue also carries two articles outside the theme of People in Health Care. Ekbal reviews the marxist critiques of the Ilichian School and Amalendu Das throws light on dust hazards faced by coal miners.