Healing and Harming: The "Noble Profession" of Medicine in Post-Independence India, 1947-2015

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Healing and Harming: The "Noble Profession" of Medicine in Post-Independence India, 1947-2015

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Healing and Harming: The "Noble Profession" of Medicine in Post-Independence India, 1947-2015

A dissertation presented

by

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Abstract

This dissertation, based on archival research in Marathi, English, and Hindi, explores the history of people's perceptions of and experiences with biomedical doctors in post-independence India. I analyze and historicize a contemporary dominant narrative among India's doctors, that the "deterioration" in the patient-doctor relationship has its origins in the intensified privatization and commercialization of healthcare which followed the Indian state's economic liberalization policies in the 1980s and 1990s. I show that contrary to this understanding, medical practice in India was considerably commercialized, and public dissatisfaction substantial, even in the early post-independence decades (1950s-1970s). I suggest that answers to public distrust in physicians lie less in commercialism and more in the dominance of privileged-caste and -class Indians in the medical profession. This dominance nurtured a caste privilege-based elitist outlook within the mainstream profession and its leadership, and created an insurmountable socioeconomic distance between doctors and the large majority of the public. People in India had trustful relationships less with doctors and more with local, community-based practitioners (who freely practiced many forms of medicine). What doctors deemed as people's "trust" in them and their profession was often simply a manifestation of people's general deference toward the elites of the society. This dissonant interpretation has been a constant feature of the narratives around the doctor-society relationship in post-independence India, but has remained largely unacknowledged in the medical and public discourse, and continues to create multiple challenges for healthcare policy today.

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ACKNOWLEDGMENTS

In secondary [middle] and high school, I was among those students who developed a preliminary interest in history. However, I was not among those few who later chose to follow it as a career and calling. I studied and trained in medicine, though I occasionally sought out and read material on the history of healthcare. During my few years of medical practice, I developed a strong interest in public health and health policy. These interests took me to Harvard University, and it is there that I first came across a rich and vibrant education system where so many different subjects, courses, ideas, skills, and programs were on offer. My older interests in history and the history of medicine were rekindled.

David Jones was kind and generous enough to humor the request of someone like me, only partially and probably transiently interested in the discipline of the history of medicine, to meet him in April 2015, when I was in the final weeks of my MPH program. I communicated with him occasionally even after I returned to India, and it is because of his patient and precise guidance, and famously speedy and meticulous responses, that my scattered ideas about a potential research topic coalesced well enough for me to apply to a doctoral program at Harvard—and graduate with a PhD six years later.

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During my doctoral years, I engaged in public writing to help make academic scholarship and ideas more accessible, and often to contribute to the struggle against disinformation and the normalization of lies and twisted morals in my home country. I thank the editors and journalists who helped me in these endeavors, and also helped me be a better writer and communicator: Naresh Fernandes, Cheri Kuncheria, Vasudevan Mukunth, Supriya Nair, C Rammanohar Reddy, Vikram Shah, and Siddharth Varadarajan. I also thank the many journalists, activists, and intellectuals who have bravely held on to and injected sanity and humanity (or, as my mother would call it, *maanuski*) into an increasingly evil public discourse in India and many other parts of the world. I shudder to imagine how scholars and social scientists like me would be able to sustain critical thinking and work toward the objective of sorting out truths, half-truths, lies, and fantasies, in the absence of their courageous interventions. It is also difficult to imagine how my loved ones and I would have been able to live through the COVID-19 pandemic without vaccines and the labor of frontline workers and scientists, and the work of those who fought (and continue to fight) the politicians, the pharma company executives, and the "influencers" who made it harder and trickier to work our way out of the pandemic. I cannot thank all of them enough, even as I acknowledge the tragedy that the pandemic and its human enablers unleashed.

Throughout my doctoral journey, the love and faith of family and friends have been the most powerful and the most comforting form of support and sustenance. Taking a cue from Irshad Kamil's poetry which tells us that words can sometimes ruin what we wish to say (*Jo bhi main kehna chahoon, Barbaad kare alfaaz mere*), I will refrain from expressing in words the gratitude I feel toward my parents, brother, vahini, Mihika, and Samarth in India; and Julia, Jacqui, Norman, Mollie, Tom, Janet, Linda, Hailin, Cathy, and Tai in the United States. As well as Alder, Alok, Ananya, Anuja, Bhagyashree, Cait, Kartik, Kaustubh, Neeti, Nidhi, Preety, Roosa, Shruti, Sonali, Sujay, Suyash, and Yuga.

As a medical doctor and public health graduate, much of what I encountered, learned, and researched during my PhD challenged what I thought I already knew and understood well. I was at an age when it is not easy for people to acknowledge the flaws in and the incompleteness of their prior ideas and beliefs, but I discovered that I was able to do that well. This ease with critique and radical ideas, and the appreciation of introspection and critical thinking, come from the life-changing teaching and mentorship of two of my school teachers: Homkalas Sir and Sharayu Teacher. They laid the foundations of rational thought in my outlook, and nurtured my mind to be comfortable with radical concepts. I am forever indebted to them.

Many of independent India's founders were also similarly inclined: open to new concepts, rational thought, even radical ideas. It is primarily the socialized education system and the affirmative action policies which they institutionalized, that helped me train in medicine and become a doctor, which is the origin point of almost everything in my life today. I thank profusely those sane and humane founders of India, most especially Bhimrao Ambedkar and Jawaharlal Nehru. In the typical phenomenon of privileged people "kicking the ladder," many in India today are working to dislodge several of the country's founding ideas and initiatives which they themselves utilized and even continue to benefit from, including socialized

education and healthcare. As someone who has used that ladder and is intimately aware of its importance in improving the lives of people and communities, I certainly intend to help repair and restore it to the best of my abilities, and to always work to buttress its foundations. There are also many individuals and groups engaged in this ever-important work during these trying times, and I dedicate my dissertation to those steadfast humanists.

"... issues of health and socio-economic justice are concretely inseparable."

- Sheila Zurbrigg in *Rakku's Story: Structures of Ill-Health and the Source of Change* (1984)

INTRODUCTION

The mid-2010s were a tumultuous time for the biomedical profession in India. A series of media reports suggested that incidents of physical assault against doctors, mostly by persons accompanying patients, were undergoing a sudden and worrying spike. While such physical assaults were not uncommon, doctors seemed to agree that the frequency and nature of attacks had worsened during that decade. Many wrote detailed commentaries on the topic, reflecting on how and why the medical[1] profession had reached such a stage that the public was "losing trust" in doctors and often expressed their distrust and anger through violence. My journey into this dissertation began as a response to such commentaries and reflections, and as an attempt to better understand the changes over time in people's perceptions of and attitudes toward doctors in India.

One such commentary, for example, is seen in a young doctor's 2015 blog post which attained immense popularity among doctors and medical students and was covered by major Indian as well as foreign media outlets. He claimed that conversations with doctors "across two generations and various specialties" had convinced him of a rising "sense of despair and disillusionment" among these doctors, who were finding themselves "wondering where things went wrong." Senior doctors and heads of departments, he wrote, often say that "they are happy that they are not starting off their careers in today's India."[2] A veteran doctor argued in 2017 that "unless mistrust, miscommunication, and misperceptions are taken care of, attacks on doctors will not stop completely. We condemn attacks on doctors, but the profession must

[1] I will occasionally use the unqualified term "medical" to mean "biomedical," and "doctor" to refer to biomedical doctors.

[2] Roshan Radhakrishnan, "Why I Will Never Allow My Child to Become a Doctor in India," God Years (blog), May 2015.

look at itself and bridge the social disconnect between society and medical profession."[3] In a 2019 commentary in the *National Medical Journal of India* (NMJI) on the "deteriorating doctor-patient relationship," another senior doctor claimed that "till a few decades ago… doctors were highly respected members of Indian society,… [but today] the respect shown to doctors by their patients and their families is a thing of the past and has been replaced by suspicion, distrust and anger." At the same time, "the proportion of money-minded doctors seems to have increased over the past few decades."[4]

Through many such analyses, doctors and other commentators were arguing that at some point of time in the recent past ("a few decades ago"), a major break had occurred in how people in India looked at doctors: before the break, doctors were "highly respected" members of the society, and after, a "social disconnect" had crept in which made people approach them with "suspicion, distrust, and anger." Several reasons for these changes were cited, including the proliferation of private medical colleges and corporate hospitals in the 1980s-90s which led to increased "commercialization" of healthcare, as well as inadequate investments by the Indian state in improving public health facilities and healthcare in general. Government action and inaction were also said to be fueling commercialization: the state's insufficient support and budgetary allocation for the public healthcare system was thought to have left people generally dissatisfied with government doctors and health centers, ceding more space, power and even prestige to private, for-profit care providers and centers. As options to access care through public institutions diminished, increasingly larger numbers of people were opting to receive care from private providers who were

[3] Avinash Supe, "Violence against Doctors Cannot Be Tolerated," *BMJ Opinion*, March 29, 2017

[4] Anil Chandra Anand, "Indian Healthcare at Crossroads (Part 1): Deteriorating Doctor-Patient Relationship," *The National Medical Journal of India* 32, no. 1 (February 2019): 41–45

themselves in competition with one another and engaged in monetary and other malpractices.[5] In a 2015 book, two influential doctor-activists succinctly conveyed this dominant understanding: "Since the 1990s, like all sectors of Indian society, the health care sector has been swept up in the whirlwind of globalization, liberalization and privatization. How did it come to pass that a well-intentioned, service-oriented profession was transformed into a market-driven commodity, and then into a corporate-led, profiteering industry?"[6]

Thus, interspersed in the commentaries of doctors (and other experts) during this tumultuous time was a quasi-historical narrative of the changes in public attitudes toward the medical profession over the post-independence period, and of the role that government policies played in these changes. As a medical student and practicing doctor in India during 2004-2014, I had encountered similar ideas and opinions, and was aware that such explanations and purported histories formed the crux of the received wisdom among doctors in India. But for several reasons, including the fact that my additional training in health policy in 2014-15 had stimulated me to be more inquisitive about the state of medical care and public health in India, I began to develop an interest in dissecting this received wisdom. Perhaps doctors had enjoyed substantial public trust in the past, I thought, but what was the genealogy of the later loss of trust over the post-independence decades? What were the factors that effaced the gleam off the earlier "golden era" of Indian doctors enjoying a "highly respected" position in Indian society? Six years later, after an immersive historical inquiry, I have realized that I underestimated the limits of my received wisdom. As

[5] Anand, "Indian Healthcare at Crossroads (Part 1)"; Shweta Marathe et al., "The Impacts of Corporatisation of Healthcare on Medical Practice and Professionals in Maharashtra, India," *BMJ Global Health* 5, no. 2 (2020); Neeraj Nagpal, "Incidents of Violence against Doctors in India: Can These Be Prevented?," *The National Medical Journal of India* 30, no. 2 (April 2017): 97–100; Radhakrishnan, "Why I Will Never Allow My Child to Become a Doctor in India."

[6] Arun Gadre and Abhay Shukla, "Introduction," in *Dissenting Diagnosis* (Random House, 2016).

the rest of this introduction, and the following chapters, will show, there are large question marks even on the claims of a trustful patient-doctor relationship in the past.

The Dissertation in Summary

This dissertation is a history of people's experiences with and perceptions of biomedical doctors in India in the post-independence period (1947-2015), and takes contemporary claims by doctors on these matters as the primary point of departure. Thus, while the dissertation follows a broad chronological narrative beginning in the 1940s and ending in the 2010s, my concern is less with detailing a comprehensive history of public attitudes, and more with subjecting dominant contemporary claims regarding public perceptions and the patient-doctor relationship to a historical analysis. Narrowing my inquiry to questions arising from the present-day discourse helped me distill my focus, which primarily concentrates on the changing mutual relationships between the Indian (federal) state, the biomedical profession, and the public. More specifically, I analyze the changes in the broader attitudes of the state and the public toward the profession, as well as how doctors responded to and created their own narratives of these changes.

The central questions which inform this dissertation are: How have people's experiences with and perceptions of doctors changed over time in post-independence India? How have the Indian state's actions and policies influenced these experiences and perceptions? How did doctors interpret and respond to the changes in public attitudes and the state's policies throughout this period? How does a historical enquiry help better understand the contemporary dominant narrative among doctors that commercialism in biomedicine primarily originates in the Indian economy's liberalization phase of the 1980s-1990s?

I start by discussing, in Chapter 1, how biomedical doctors came to be chosen as the "country's doctors" by the Indian state at independence, since it was through this decision that the state displayed its own trust in both doctors and biomedicine. I first briefly trace how biomedicine came to be embraced by India's anti-colonial, nationalist leaders as the most appropriate mode of healthcare for free India. Apart from their conviction that India's development would be best achieved through modern science and biomedicine, I also emphasize the shared elite status (including similar privileged-caste backgrounds) of India's nationalist leaders, administrative elites, and doctors. A shared vision of progress through modernization, combined with a shared past of privilege through tradition, together facilitated the choice by early Indian leaders to appoint biomedical doctors as the primary providers of state-directed healthcare. Doctors, however, also had personal visions of progress which often clashed with the state's vision of development. This clash of interests was most visible in the state's insistence that doctors serve in villages, and doctors' consistent ambition to practice in urban areas. Thus, in the early decades of independence, the state entrusted biomedical doctors with the task of providing healthcare to the nation and devoted considerable resources to building new medical colleges and hospitals, but was unable to convince most doctors to practice in villages where the majority of the Indian public lived. There was a contradictory asymmetry in the relationship between the state and doctors, in that despite possessing substantially more power than the profession, the state ended up conceding far more to doctors and failed in extracting any major concessions from them.

How did the state's resolve to provide healthcare to the public through the agency of biomedical doctors manifest on the ground and within localities? In Chapter 2, I show that in the early decades of independence, doctors remained an alien group for much of rural India: alien not only through their consistent absence from villages, but also *in* their occasional presence. A large number of villagers,

especially those from underprivileged castes and communities[7], saw doctors primarily as representatives of caste-, governmental, and urban elites. Combined with the fact that the rural Indian landscape was liberally populated with many kinds of local, traditional healers and practitioners of medicine whom villagers continued to patronize, the alienness of doctors meant that they were rarely the trusted, first-line providers of care for a large majority of rural Indians. In urban India, on the other hand, doctors were abundant, but there was a paucity of "human touch" in their interactions with many patients. Public hospitals, which commanded an overwhelming presence in cities and major towns, were simultaneously major providers of healthcare for underprivileged urban residents, and a major site of humiliation and exploitation. The behavior of hospital staff, including of many doctors, was frequently characterized as rude, careless, and callous, with casteist and classist prejudices often influencing how doctors interacted with people. Such behavior from the staff, coupled with the general overcrowding and insanitary conditions in public hospitals, meant that these hospitals were rarely the first choice of care for a large number of urban Indians, who frequently preferred—like their rural compatriots—local practitioners based in their communities. Cities also housed a number of private clinics, nursing homes and hospitals, including private wards in public hospitals, all of which were primarily used by the urban elite who were also the class and caste equals of doctors. Doctors generally enjoyed a friendly relationship with them, and these elites frequently shared the same elite urban spaces, e.g., social clubs like the Rotary and Lions Clubs. Thus, the relationship of the medical profession with the privileged public was vastly different from that with underprivileged people: the extent of doctors' camaraderie and courtesy in the former often matched the amount of indifference and disrespect in the latter.

[7] These primarily included Dalits from Hindu, Muslim, and other religions; Adivasis (also known as "tribal" communities); and a number of other "lower-caste" communities depending upon local social and political contexts.

It is in this larger context of the biomedical encounter, during the mid- to late 1960s, that the Indian state's approach toward doctors (and healthcare in general) began to undergo major shifts: the earlier contradictory asymmetry of power gave way to the state's increasing disregard for the medical profession's inputs in health policymaking. In response to the continued reluctance of doctors to provide meaningful care in rural India, the state began to look beyond both biomedicine and doctors, with some of the major Indian indigenous systems of medicine (particularly Ayurveda), in addition to homeopathy, receiving increasing patronage at the federal level in the 1960s and 1970s (and continuing to this day). The state also invested in commissioning a large cadre of community health workers for rural India, who began to be deployed beginning in 1977. All these changes were vehemently opposed by doctors, though they enthusiastically supported the state in its simultaneous preoccupation with the "population problem." Doctors conceptualized, organized, participated in, and generally supported, several "family planning" policies and activities, many of which were coercive. It is these major developments in the wake of Prime Minister Nehru's demise, which occupy the bulk of Chapter 3. Throughout India, the state-led family planning program came to be looked at with suspicion and anger by especially the underprivileged public who bore the brunt of its coercive adverse effects. Doctors' direct and indirect participation in the program contributed to the existing alienation between them and the people. Consequent to experiences which ranged from unpleasant to horrifying, people's perceptions of both doctors and the state's healthcare system suffered considerably in the 1970s.

In Chapter 4, I discuss parallel developments in the 1970s and 1980s that primarily impacted the relationship of doctors with the elite public. This period was characterized by a substantial increase in the number of medical graduates in India: mainly a result of the Indian state's continued patronage of and investments in medical colleges and hospitals since 1947, aided by a gradual rise in the number of private

medical colleges. The majority of new graduates, like their predecessors, chose to engage in private practice in urban areas, further saturating the urban medical marketplace. The resultant competition among doctors, in addition to the growing influence of pharmaceutical marketing and the rise of medical specialists, catalyzed significant changes in medical practice in urban India. The privileged urban public, including those from the so-called "middle-class," began to increasingly complain about unnecessary tests and procedures by doctors, their "depersonalized" demeanor, their and "business-like" attitudes. Thus, even though a large number of (underprivileged) Indians had dissatisfying experiences with doctors in the past, the mainstream discourse began to record and preserve testimonies of serious disillusionment with doctors only beginning in the 1970s, with these narratives becoming particularly common in the 1980s. This discrepancy stemmed from the fact that India's "public discourse," which includes entities like English-language newspapers and magazines, film, television and art, and the writings and speeches of elite Indians, was (and is) almost exclusively created and controlled by the country's elite public with little direct input from other Indians. Following these changes in the discourse, doctors began to take note of the privileged public's complaints and discuss possible solutions in medical and lay forums. However, even as they paid attention to the elite public's dissatisfaction with the depersonalization of medical practice, the profession continued to ignore the disrespect, neglect, and dehumanization which marked many doctors' interactions with underprivileged patients.

With time, privileged urban patients had more to complain about than just depersonalization and overtreatment. By the 1980s, the "negligent doctor" became an increasingly common topic of discussion in newspapers and popular media, with the elite beginning to discuss medical negligence both in terms of personal experiences and in the form of narratives on negligence and exploitation faced by the underprivileged in government hospitals. At the same time, the ethical integrity of the profession and its

leaders came under severe attack with reports of sex-selective abortions, kidney trading, and other forms of malpractice perpetrated by doctors. Public discourse in India now began to increasingly register the sentiment of "loss of trust" in doctors, and by the late 1980s and early 1990s, disillusioned patients were increasingly suing doctors for medical negligence under a new law (the Consumer Protection Act). However, the ability to express disillusionment with doctors in mainstream public forums, and take to court those who had potentially done harm, were accessible mostly to people with at least some socioeconomic privilege. In such a scenario, the everyday forms of elitism, casteism, patriarchy, and exploitation in the biomedical encounter experienced by people from underprivileged communities, remained largely unaddressed.

In Chapter 5, I discuss how doctors reacted to the 1980s-1990s discourse on the loss of public trust in the medical profession. The increasing numbers of lawsuits against doctors in the early 1990s catalyzed tremendous rhetoric and action, including a legal challenge against the Consumer Protection Act's oversight on doctors, filed by the Indian Medical Association in the Supreme Court of India. Doctors wrote and spoke prolifically, and generated a large number of narratives about the history of public trust in doctors. In these commentaries, the rise in medical malpractice and the loss of people's trust in doctors were said to result from the rise in the number of private medical colleges and corporate hospitals, as well as a rise in the number of patients who acted as "doubting Thomases." The narratives ignored and left unacknowledged the longstanding presence of profiteering and malpractice in the Indian medical profession. The occasional reluctant acknowledgment of the existence of corrupt and unethical practices was almost invariably accompanied by the caveat that these were uncommon and were the work of "a few black sheep." Elements from these narratives continued to be employed in the late 1990s and the 2000s, with a significant addition being the Indian state's economic liberalization policies and the consequent

privatization of healthcare services as major reasons for the "deteriorating" patient-doctor relationship. But even during these decades of massive changes, analysis, and rhetoric, there was little discussion on the dominance of the privileged castes in the profession and its leadership, and on how caste-based privilege shaped and colored doctors' worldviews and narratives as well as their attitudes toward a large majority of patients. As in the past, the routine dehumanization of underprivileged patients in biomedical encounters remained a rarely-mentioned topic.

There are thus four main sets of arguments I make in this dissertation. First, the idea of a period (or a "golden era") during which people in India universally had trustful attitudes toward biomedical doctors, lacks basis in reality, and can only be applied as a general rule, at best, to the relationship between Indian doctors and the elite urban public. Even as early as in the 1950s and 1960s, doctors remained alien for much of the rest of the Indian population, and trustful relationships were more common between people and the local healers and practitioners in their community, than between people and doctors (who were rarely as easily accessible and approachable).

Second, caste-based privilege has historically been a significant social aspect of the biomedical profession in India, but nonetheless has been invisibilized both in the medical and the public discourse. As a result, the effects of caste-based beliefs, ideas, biases, and worldviews on the medical profession's priorities and actions, and through that on the patient-doctor relationship, remain underexplored. In terms of the questions that this dissertation tackles, I argue that any discussion on the history of public trust in doctors is incomplete without the acknowledgment that a large number of (non-elite-caste) Indians never could, as a social rule, look at most of the doctors around them as "one of their own." (I must also note that there is

an urgent need for more research on the dynamics of caste and caste-based privilege in the workings of the Indian biomedical profession, both at home and abroad.[8])

Third, since only a small proportion of Indians, mainly the elites with caste-based privilege, could look at doctors as one of their own, and since these elites also created and controlled the mainstream public discourse, the so-called "public" image of the profession reflected the experiences and perceptions of the elites of India (as against of the "people" of India). For example, the mainstream discourse began registering serious disillusionment with doctors only in the 1970s and especially in the 1980s, when urban private medical practice became increasingly depersonalized, specialized, and expensive. I thus argue that the privileged-caste dominance in both the medical profession and among the elite public has meant that for all practical purposes, "loss of public trust" in doctors translates to the decline of the privileged public's faith in and reliance on doctors.

Finally, I argue that the economic liberalization "break" of the 1990s was not a radical break in the trajectory of healthcare services in India, but an additional step in the longer history of commercialization and profiteering in biomedical practice. Most of the dynamics which doctors, journalists, and social scientists today attribute to the post-liberalization period (e.g., unnecessary surgeries and the physician-pharma industry nexus) predate the liberalization era by several decades. In attributing the proliferation of these practices chiefly to the changes brought about by a political economic moment (liberalization), there is a risk of missing the central role played by the human agency of individual doctors and professional

[8] There is growing evidence on how the large number of mostly privileged-caste Hindu Indians who emigrated to Europe and the United States in the twentieth century, have held on to casteist beliefs, worldviews, and traditions in their new "Western" homes. See, e.g., Priyanka Mogul, "Has Caste Discrimination Followed Indians Overseas?," *The Diplomat*, December 6, 2017; Thenmozhi Soundararajan, Equality Labs, and Firstpost, "Caste in the USA," 2020; Pramod Theetha Kariyanna, "The Caste System Is Thriving in Medicine in the U.S.," *KevinMD.Com* (blog), June 4, 2018.

leaders, who, with their commitment to private enterprise and blindness to caste-based privilege, had normalized and institutionalized unethical practices as well as the exploitation and dehumanization of patients, long before the faceless behemoth of the Indian economy set its eyes on liberalization and privatization.

My dissertation thus engages with several themes in the history of India, the history, anthropology, and sociology of medicine and healthcare in India, and the history and sociology of caste in India. Before I discuss those engagements and contextualize the dissertation and its arguments within the existing literature on these topics, I must note that in my dissertation and in the broader scholarship, there are many aspects of the biomedical profession in post-independence India which remain underexplored. I am hopeful that more scholars will turn to working on these topics in the coming years, for example: the role of doctors in the criminal justice system; the intersections of Hindu supremacy and nationalism with biomedical practice; the phenomenon of private medical colleges and the role they have played in propagating the dominance of caste elites in the biomedical profession; biographies and experiences of doctors from underprivileged caste and religious backgrounds; biographies and experiences of non-mainstream, "dissenting"[9] doctors; histories of gender and the biomedical profession; and regional histories of biomedicine and doctors.

[9] I borrow the descriptive "dissenting" from a recent book which implied that doctors who do not partake of the mainstream conservative attitudes of the medical profession, do not indulge in the common malpractices, and work to make medical practice more "ethical" and evidence-based, were presenting a "dissenting diagnosis." Arun Gadre and Abhay Shukla, *Dissenting Diagnosis*, (Random House, 2016).

Biomedicine in India

In this dissertation I primarily focus on the relationship of the public and the state with biomedical doctors in post-independence (post-colonial) India. There is a large corpus of scholarly literature on the history of medicine and public health in South Asia, and my dissertation builds upon several themes from it, while adding some novel ones.[10]

The history of biomedicine (or "Western medicine") charted in the existing literature has primarily dealt with the early modern and modern periods in South Asia until the end of colonial rule in the 1940s. In my dissertation, I carry this story into the society and politics of post-independence India. David Arnold describes how the native nationalist elite in colonial India came to champion biomedicine and favored it as "state medicine" when they assumed control of the new post-independence state.[11] In this dissertation I show that the early exclusive state patronage for biomedicine underwent some dilution through the post-independence decades, with the state extending varying degrees of patronage to some of the major indigenous systems of medicine (primarily Ayurveda), as well as to community health schemes which utilized biomedicine and indigenous systems together. The growing body of historical scholarship which examines biomedicine and public health in post-independence India through a historical lens has shown that despite its overtures toward the indigenous systems of medicine, the Indian state continued to accord preeminence to biomedicine in its policies and budgetary allocations.[12] My dissertation provides additional

[10] For overviews of and commentaries on this literature, see the Introduction chapters in: Projit Bihari Mukharji, *Nationalizing the Body: The Medical Market, Print and Daktari Medicine* (London: Anthem Press, 2009); Projit Bihari Mukharji, *Doctoring Traditions: Ayurveda, Small Technologies, and Braided Sciences* (University of Chicago Press, 2016); Biswamoy Pati and Mark Harrison, eds., *Society, Medicine and Politics in Colonial India* (Routledge India, 2018).

[11] David Arnold, "The Rise of Western Medicine in India," The Lancet 348, no. 9034 (October 19, 1996): 1075–78.

[12] Sunil Amrith, "Political Culture of Health in India: A Historical Perspective," *Economic and Political Weekly* 42, no. 2 (2007): 114–21; Amrita Bagchi, *Health Care in Post-Independence India: Kolkata and the Crisis of Private Health Care*

evidence for these claims, charting the nature of the support which the state and the elite accorded to biomedical education, health centers, and technologies. In the post-independence period as during the British Raj, biomedicine has continued to dominate medical and public health policymaking in the country.

Existing scholarship has richly documented how the subaltern public in India responded to biomedicine and to the colonial state's public health policies. There is broad agreement that depending upon the context, people, including the underprivileged public, both resisted and welcomed these entities into their communities, cultures, and lives, while at the same time continuing to patronize their existing "traditional" modes of care. This agency exercised by the public in choosing their healing systems and healers—including the agency of local practitioners in employing biomedical therapeutics when their patrons demanded it—has been highlighted in the works of anthropologists and sociologists in the post-independence decades.[13] In my dissertation I contribute to these analyses of the agency of the subaltern

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Services (London: Routledge, 2022); Sanjoy Bhattacharya, *Expunging Variola: The Control and Eradication of Smallpox in India, 1947-1977* (Sangam Books Limited, 2006); Niels Brimnes, *Languished Hopes: Tuberculosis, the State, and International Assistance in Twentieth-Century India* (Orient BlackSwan, 2016); Sarah Hodges, "'It All Changed after Apollo': Healthcare Myths and Their Making in Contemporary India," *Indian Journal of Medical Ethics* 10, no. 4 (2013); Sarah Hodges, "Hospitals as Factories of Medical Garbage," *Anthropology & Medicine* 24, no. 3 (September 2, 2017): 319–33; David Jones and Kavita Sivaramakrishnan, "Transplant Buccaneers: P.K. Sen and India's First Heart Transplant, February 1968," *Journal of the History of Medicine and Allied Sciences* 73, no. 3 (July 1, 2018): 303–32; David Jones and Kavita Sivaramakrishnan, "Making Heart-Lung Machines Work in India: Imports, Indigenous Innovation and the Challenge of Replicating Cardiac Surgery in Bombay, 1952-1962," *Social Studies of Science* 48, no. 4 (August 1, 2018): 507–39; Mohan Rao, *From Population Control To Reproductive Health: Malthusian Arithmetic* (New Delhi: SAGE Publications, 2005); Kavita Sivaramakrishnan, "An Irritable State: The Contingent Politics of Science and Suffering in Anti-Cancer Campaigns in South India (1940–1960)," *BioSocieties*, July 20, 2019; Archana Venkatesh, "Women, Medicine and Nation-Building: The `Lady Doctor' and Development in 20th Century South India" (The Ohio State University, 2020).

[13] Veena Das, *Affliction: Health, Disease, Poverty* (New York: Fordham University Press, 2015); Goran Djurfeldt and Staffan Lindberg, *Pills Against Poverty: A Study of the Introduction of Western Medicine in a Tamil Village.* (Curzon Press, 1975); Stefan Ecks, *Eating Drugs: Psychopharmaceutical Pluralism in India* (New York ; London: NYU Press, 2013); Cecilia Van Hollen, *Birth on the Threshold: Childbirth and Modernity in South India* (University of California Press, 2003); R. S. Khare, "Folk Medicine in a North Indian Village," *Human Organization* 22, no. 1 (1963): 36–40; Helen Lambert, "Wrestling with Tradition: Towards a Subaltern Therapeutics of Bonesetting and Vessel Treatment in

public by showing that while people did exercise it in frequently choosing local care providers over biomedical doctors and hospitals, this agency quickly evaporated once they were within formal biomedical spaces, where principally caste-based power asymmetries between patients and doctors took centerstage.

Like in most other places, multiple ideas and traditions of healing and care abound in different parts of India, with some of them formalized as medical "systems." There is considerable scholarly literature on the histories of the formalized traditions like Ayurveda, Unani, and Siddha, including of the response of their practitioners to the state-enabled dominance of biomedicine and of the modernizing changes which many practitioners introduced in these systems.[14] In the post-independence period, the Indian state, through its federal and state governments, frequently aided this modernization process, for example, by establishing colleges in which biomedical ideas were taught alongside those of these systems,

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North India," in *Medical Marginality in South Asia: Situating Subaltern Therapeutics*, ed. David Hardiman and Projit Mukharji (Routledge, 2013), 121–37; Charles Leslie, "The Culture of Plural Medical Systems," in *Asian Medical Systems: A Comparative Study*, ed. Charles Leslie (University of California Press, 1976); T N Madan, "Who Chooses Modern Medicine and Why," *Economic and Political Weekly* 4, no. 37 (1969): 1475–84; Aneeta A. Minocha, *Perceptions and Interactions in a Medical Setting: A Sociological Study of a Women's Hospital* (Hindustan Publishing Corporation, 1996); Arima Mishra and Suhita Chopra Chatterjee, *Multiple Voices and Stories: Narratives of Health and Illness* (New Delhi: Orient Blackswan, 2013); M. Nichter, "The Layperson's Perception of Medicine as Perspective into the Utilization of Multiple Therapy Systems in the Indian Context," *Social Science & Medicine. Medical Anthropology* 14B, no. 4 (November 1980): 225–33; Sarah Pinto, *Where There Is No Midwife: Birth and Loss in Rural India* (Berghahn Books, 2008).

[14] Rachel Berger, *Ayurveda Made Modern: Political Histories of Indigenous Medicine in North India,* (New York, NY: Palgrave Macmillan, 2013); Guy N. A. Attewell, *Refiguring Unani Tibb: Plural Healing in Late Colonial India* (Orient Longman, 2007); Paul R. Brass, "The Politics of Ayurvedic Education: A Case Study of Revivalism and Modernization in India," in *Education and Politics in India: Studies in Organization, Society and Policy*, ed. Susanne Hoeber Rudolph and Lloyd I. Rudolph (Cambridge: Harvard University Press, 1972); Anthony Cerulli, "Politicking Ayurvedic Education," *Asian Medicine* 13, no. 1–2 (September 10, 2018): 298–334; Sabrina Datoo, "Imagining Indian Medicine: Epistemic Virtues and Dissonant Temporalities in the Usman Report, 1923," *Asian Medicine* 15, no. 1 (November 19, 2020): Charles Leslie, "Interpretations of Illness: Syncretism in Modern Ayurveda," in *Paths to Asian Medical Knowledge*, ed. Charles Leslie and Allan Young (University of California Press, 1992); 83–106; Projit Bihari Mukharji, *Doctoring Traditions: Ayurveda, Small Technologies, and Braided Sciences* (University of Chicago Press, 2016); Kavita Sivaramakrishnan, *Old Potions, New Bottles: Recasting Indigenious Medicine in Colonial Punjab (1850-1945)* (Orient BlackSwan, 2006).

and by investing in research institutions which often employed modern experimental ideas. There have also been histories, though fewer, of what have been called "subaltern therapeutics", as well as of homeopathy.[15] Such indigenous practices (and homeopathy), modernized to varying degrees, have continued to be widely utilized in India throughout the post-independence period, and many people, like in other parts of the world, have been comfortable with utilizing multiple medical systems and practices. Several scholars have shown that when people choose one medical system over another on a particular occasion, that choice generally has little to do with a full-fledged belief in that system, and more to do with several contextual factors, including the "expectancy of cure."[16] Such fluid utility of different medical systems, or "medical pluralism," is not dissimilar to the "eclectic pluralism" which Sanskritist Wendy Doniger has discerned in the literature and cultures of South Asia, "in which one person holds a toolbox of different beliefs more or less simultaneously, drawing upon one on one occasion, another on another," with "multiple narratives coexist[ing] peacefully."[17]

In any analysis of public perceptions of the practitioners of a particular form of medicine—as is the case in this dissertation—medical pluralism entails a separation of people's approach toward the system from their approach toward individual practitioners: negative or positive experiences with a practitioner, for example, do not translate to a complete rejection or acceptance of the accompanying system of medicine. For example, I show in Chapters 2 and 4 that even when people were skeptical of biomedical

[15] Shinjini Das, *Vernacular Medicine in Colonial India: Family, Market and Homoeopathy* (Cambridge: Cambridge University Press, 2019); David Hardiman and Projit Bihari Mukharji, *Medical Marginality in South Asia: Situating Subaltern Therapeutics* (Routledge, 2013).

[16] S. M. Bhardwaj, "Attitude-toward Different Systems of Medicine: A Survey of Four Villages in the Punjab-India," *Social Science & Medicine* 9, no. 11–12 (December 1975): 603–12.

[17] Wendy Doniger, *The Hindus: An Alternative History* (Oxford University Press, 2010), 44.

doctors and preferred other practitioners, their interest in and preference for biomedical therapeutics remained largely constant. I also show that even as public critiques of the biomedical profession increased, especially since the 1980s, it has not translated into any major shift away from utilizing biomedicine. As Cecilia van Hollen has written, the Indian critique of biomedicine has "not been counterhegemonic: it is based on a critique of the discriminatory ways in which allopathic services are (or are not) provided rather than on a critique of allopathy [biomedicine] itself."[18]

As described above, the state and the public have received considerable attention in the literature on biomedicine and healthcare in India. However, the biomedical profession has not as yet been subject to comprehensive historical analyses. Perhaps the most telling marker of the relatively lesser attention afforded to studying doctors is the absence of any specific histories of the prominent Indian Medical Service (IMS) of British India.[19] Even though biomedical professionalization in colonial India has as yet received less attention from historians, some have discussed select aspects of the history of the profession. Projit Bihari Mukharji, for example, has written about early practitioners of biomedicine ("daktari medicine") in nineteenth-century Bengal, while Mridula Ramanna has discussed aspects of biomedical education, practice, and institutions in colonial western India.[20] There are also histories of women biomedical doctors in late nineteenth and early twentieth century India.[21] For the post-independence period, the work of

[18] Cecilia Van Hollen, *Birth on the Threshold: Childbirth and Modernity in South India* (University of California Press, 2003), 16-17.

[19] Mark Harrison had a chapter on the IMS in his 1994 book which came out of his dissertation: *Public Health in British India: Anglo-Indian Preventive Medicine* (Cambridge: Cambridge University Press, 1994).

[20] Mukharji, *Nationalizing the Body*; Mridula Ramanna, *Western Medicine and Public Health in Colonial Bombay, 1845-1895* (Orient Blackswan, 2002); Mridula Ramanna, *Health Care in Bombay Presidency, 1896-1930* (Primus Books, 2012).

[21] Geraldine Forbes, "Medical Careers and Health Care for Indian Women: Patterns of Control," *Women's History Review* 3, no. 4 (December 1, 1994): 515–30; Jharna Gourlay, *Piety, Profession and Sisterhood: Medical Women and Female*

Roger Jeffery stands out in terms of its focused emphasis on biomedical professionalization and his use of the historical literature and primary sources.[22] Recently, Archana Venkatesh has written a thesis on women doctors in early post-independence India, with oral history as her primary method.[23]

In this dissertation, I look at biomedical doctors chiefly through the analytical categories of caste and privilege. Though elitism in the biomedical profession has often been discussed in the existing literature, only a few works have explicitly emphasized the role of caste-based privilege.[24] In a highly succinct line, Jeffery wrote in 1977 that the "natural habitat of the [Indian] doctor is the Westernized middle class of the cities."[25] A decade later, Aneeta Minocha argued that even though doctors in India had lost much power and influence in the domain of health policymaking, they continued to be socioeconomic elites.[26] My dissertation expands the understanding of elitism in the biomedical profession to include not

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Medical Education in Nineteenth Century India (KP Bagchi, 2018); Ambalika Guha, "The 'Masculine' Female: The Rise of Women Doctors in Colonial India, c. 1870–1940," *Social Scientist* 44, no. 5/6 (2016): 49–64; Maneesha Lal, "The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin's Fund, 1885-1888," *Bulletin of the History of Medicine* 68, no. 1 (1994): 29–66; Sujata Mukherjee, "Women and Medicine in Colonial India: A Case Study of Three Women Doctors," *Proceedings of the Indian History Congress* 66 (2005): 1183–93; Mridula Ramanna, "Women Physicians as Vital Intermediaries in Colonial Bombay," *Economic and Political Weekly* 43, no. 12/13 (2008): 71–78; Samiksha Sehrawat, "Feminising Empire: The Association of Medical Women in India and the Campaign to Found a Women's Medical Service," *Social Scientist* 41, no. 5/6 (2013): 65–81.

[22] Roger Jeffery, "Allopathic Medicine in India: A Case of Deprofessionalization?," *Social Science & Medicine* 11, no. 10 (July 1977): 561–73; Roger Jeffery, "Recognizing India's Doctors: The Institutionalization of Medical Dependency, 1918-39," *Modern Asian Studies* 13, no. 2 (1979): 301–26; Roger Jeffery, *The Politics of Health in India* (Berkeley: University of California Press, 1988).

[23] Venkatesh, "Women, Medicine and Nation-Building."

[24] Some examples include Projit Bihari Mukharji, "Structuring Plurality: Locality, Caste, Class and Ethnicity in Nineteenth-Century Bengali Dispensaries," *Health and History* 9, no. 1 (2007): 80–105; Venkatesh, "Women, Medicine and Nation-Building."

[25] Jeffery, "Allopathic Medicine in India," 564.

[26] Aneeta A. Minocha, "The Medical Profession in India: Elite without Power," in *Power Elite in India*, ed. Khadija Ansari Gupta (Vikas Pub. House, 1989).

just class and education based privilege, but also caste-based privilege (which, as I show, intersects with other kinds of privilege). This is thus a history of the biomedical profession in India as primarily a community of privileged-caste elite Indians, and explores how their elite backgrounds informed their interactions with the public as well as influenced people's experiences with them.

Caste and Gender in Biomedicine in India

Perhaps the most powerful manifestation of privilege is its invisibilization in everyday life and discourse. Caste-based privilege, ideas, worldviews, and hegemonies undergird biomedical education and training, organization and leadership in the various professions, status hierarchies in health sector personnel, as well as the formulation of health policy itself, even though these intersections have rarely been acknowledged in mainstream medical, academic, and public discourse.[27] In this dissertation I render visible the significant role of caste-based privilege in the inactions, actions, attitudes, and articulations of both India's doctors and its elite public.

The monopolization of colonially-introduced modern institutions and professions by the elite castes and communities in India is well-known. Anil Seal wrote in 1968 that "under every empire, the learned Hindu castes were the natural recruits for the bureaucracy" and took advantage of "whatever form of secular education the current regime had demanded. So in the nineteenth century, yesterday's scholars of

[27] Dean Spears and Diane Coffey, *Where India Goes: Abandoned Toilets, Stunted Development and the Costs of Caste* (Noida, Uttar Pradesh ; New York, NY, 2017); Sobin George, "Reconciliations of Caste and Medical Power in Rural Public Health Services," *Economic and Political Weekly* 54, no. 40 (October 5, 2019): 43–50; Awanish Kumar, "Caste and Public Health," *Frontline*, May 22, 2020; Anna Ruddock, *Special Treatment: Student Doctors at the All India Institute of Medical Sciences* (Stanford, California: Stanford University Press, 2021).

Persian now became enthusiasts for English."[28] Writing about modern education in southern India, R. Suntharalingam observed that "the Brahmin preponderance was quite overwhelming," with their domination apparent at "every level of higher education in South India, whether literary, scientific, or professional."[29] The preponderance of Brahmans and other privileged castes and communities (for example, the Parsis), was also a characteristic of biomedical education in India since the beginning. For many decades after their establishment, the vast majority of the students in the early medical colleges came from the privileged castes. Mukharji writes that on the foundation of the Medical College in Calcutta in 1835, the East India Company government decreed that "the benefits of the college shall be open to all classes of native youths between the age of fourteen and twenty…provided they possess respectable connections and conduct…"[30] "Respectable connections," in practice, translated to recommendations from privileged-caste men. All four students from the first batch of the college came from the privileged castes, and were offered well-paying jobs at government dispensaries. In general, candidates with "good caste" received preference in appointments at dispensaries during the colonial period.[31] When women entered the biomedical profession, they were predominantly individuals from privileged castes and communities. Among the very early pioneer doctors who graduated in the late 1800s and early 1900s and

[28] Anil Seal, *The Emergence of Indian Nationalism: Competition and Collaboration in the Later Nineteenth Century* (Cambridge University Press, 1968), 11.

[29] R. Suntharalingam, *Politics and Nationalist Awakening in South India, 1852-1891* (University of Arizona Press, 1974), 113.

[30] Projit Bihari Mukharji, *Nationalizing the Body: The Medical Market, Print and Daktari Medicine* (London: Anthem Press, 2009), 3.

[31] Seema Alavi, *Islam and Healing: Loss and Recovery of an Indo-Muslim Medical Tradition, 1600-1900* (Palgrave Macmillan, 2008), 190.

have been profiled by historians, probably only one, Rukhmabai Raut, came from an underprivileged caste.[32]

The dominance of the elite castes in the medical profession remained strong throughout the colonial period and continued even in the post-independence period despite major constitutional and administrative reforms to increase the representation of other castes and communities in education. In an oral history study on women doctors in early post-independence India, Archana Venkatesh wrote: "The majority of women doctors in India came from elite backgrounds, which is reflected in my own sample and in admissions records for medical colleges." In 2016-17, Venkatesh interviewed 22 women doctors who had practiced between 1950 and 1990, using a snowball sampling method where her interviewees put her in touch with their former classmates and colleagues. Twenty of her interviewees were Hindu, with one Dalit, three "lower caste," and 16 from the privileged castes.[33]

The dominance of the biomedical profession, and especially of its leadership,[34] by doctors from privileged-caste backgrounds, has played an important role both in shaping public attitudes toward doctors, as I show in Chapters 2 and 4 (and briefly discuss in the following section), and in shaping

[32] Among these pioneer doctors were Anandibai Joshi, Kadambini Ganguly, Motibai Kapadia, Jamini Sen, Haimabati Sen, Mussammat Indennessa, Pramilabala Roy, Virginia Mary Mitra, Bidumukhi Bose, Bindusbasini Bose, and Muthulakshmi Reddy. See Geraldine Forbes, "Education to Earn: Training Women in the Medical Professions," in *Women in Colonial India: Essays on Politics, Medicine, and Historiography* (New Delhi: Orient Blackswan, 2005); Kavitha Rao, *Lady Doctors: The Untold Stories of India's First Women in Medicine* (Chennai: Westland, 2021); Sharmita Ray, "Women Doctors' Masterful Manoeuverings: Colonial Bengal, Late Nineteenth and Early Twentieth Centuries," *Social Scientist* 42, no. 3/4 (2014): 59–76.

[33] Archana Venkatesh, "The Home and the Nation: An Oral History of Indian Women Doctors, National Development and Domestic Worlds," *Oral History* 47, no. 2 (2019): 43–54.

[34] This is apparent, for example, from a perusal of the names of the office-bearers at the Indian Medical Association and other medical associations, and of the medical membership of the Indian National Congress. For the latter, see Roger Jeffery, "Doctors and Congress: The Role of Medical Men and Medical Politics in Indian Nationalism," in *The Indian National Congress and the Political Economy of India*, ed. Mike Shepperdson and Colin Simmons (Avebury, 1988).

doctors' reactions to public critiques, as I discuss in Chapter 5. The substantial role played by caste also helps explain the relatively subdued relevance of gender to the major questions of my dissertation. Historians have shown how in the late nineteenth and early twentieth centuries, the entry of women into biomedicine in India was largely encouraged by both European and Indian (male) elites, under the belief that Indian women were inaccessible to male doctors but would be convinced to utilize biomedicine if it were provided by women doctors.[35] The positive public image which this elite- and state-led encouragement reposed on women doctors (the "lady doctor" image), in addition to women doctors' privileged-caste backgrounds and the restriction of their medical practice to mostly women patients, meant that the caste identity of women doctors ended up playing an overwhelmingly more important role than their gender identity, in individual patient-doctor interactions.

That caste frequently overpowers gender in the public lives of elite Indian women has been pointed out by Dalit and other feminist writers since at least the 1990s.[36] Shailaja Paik, for example, writes that feminist scholarship in India has ignored the experience of Dalit women and "constructed a homogeneous 'Indian woman'." Reformers and writers have "signified Brahmin women's problems as those of Hindus and therefore, Indians... By fixing Brahmin women and Brahminical practices as "Indian," scholars have subsumed the powerful collusion of (dominant) caste, class, and patriarchy into Indian identity itself."[37] Sharmila Rege has argued that "the writings and manifestoes of different dalit women's

[35] Lal, "The Politics of Gender and Medicine in Colonial India."

[36] Uma Chakrabarti, *Gendering Caste Through a Feminist Lens* (Popular Prakashan, 2003); Joanna Liddle and Rama Joshi, *Daughters of Independence: Gender, Caste and Class in India* (Kali for Women, 1986); Shailaja Paik, "Dalit Feminist Thought," *Economic and Political Weekly* 56, no. 25 (June 19, 2021); Anupama Rao, ed., *Gender and Caste* (Zed Books, 2005); Sharmila Rege, *Writing Caste/Writing Gender: Narrating Dalit Women's Testimonies* (Zubaan, 2006).

[37] Paik, "Dalit Feminist Thought."

groups underline the fact that the unmarked [Indian] feminism… had, in fact, been in theory and praxis a kind of brahmanical feminism."[38] It is also worth noting that popular Hindi-Urdu cinema, or Bollywood—itself a cultural creation primarily of elite Indians—began depicting elite women as doctor-protagonists as early as in the 1930s (e.g., the 1935 eponymous film *Dr. Madhurika*), a trend which has continued throughout the post-independence period. However, Bollywood still awaits a major protagonist character in the form of a Dalit or Adivasi doctor.

The sheer hegemony of caste-based ideas, rituals, and traditions in Indian social life, and the power with which the privileged castes enforce these ideas and the attendant hierarchies, mean that the patient-doctor relationship in India cannot be described in a singular, uniform manner. Depending especially on the caste (and at times class) background of both the doctor and the patient, this relationship assumes several forms on the ground. As Rege has eloquently written, caste in India is "not just a retrograde past but an oppressive past reproduced as forms of inequality in modern society."[39] My dissertation shows that the history of biomedical practice in post-independence India indeed aligns with this claim.

Trust, Commercialization, and Caste in the Biomedical Encounter

The understanding of "trust" I use in this dissertation is best described by Judith Allsop paraphrasing Diego Gambetta: "Within the sociological tradition, trust… involves the ability to take for granted the motivations and behaviour of others in social interaction. All trust is in a certain sense based on

[38] Sharmila Rege, "Dalit Studies as Pedagogical Practice: Claiming More Than Just a 'Little Place' in the Academia," *Review of Development and Change* 12, no. 1 (June 1, 2007): 1–33.

[39] Rege, *Writing Caste/Writing Gender*, 4.

'presumed reliability', or 'blind trust'. People in interaction decide whether or not to give others the benefit of the doubt."[40] In the biomedical encounter, this means taking for granted that the care provider's (including the doctor's) most fundamental and overwhelming motivation is the well-being of the patient. According to Indian doctors' received wisdom, people in India harbored such presumed reliability and faith in the medical profession for decades until the 1990s, after which an increasingly commercialized healthcare system pushed many doctors to prioritize monetary considerations over patient well-being, leading gradually to a "loss of trust" in the medical profession. (To quote Gadre and Shukla again: "How did it come to pass that a well-intentioned, service-oriented profession was transformed into a market-driven commodity, and then into a corporate-led, profiteering industry?") Following this understanding, I explore in this dissertation whether people in India in the early post-independence decades indeed believed that the motivations and behavior of doctors prioritized patient well-being over other considerations, and whether such "presumed reliability" of people in doctors was consistent across different socio-economic backgrounds.

The adverse impact of commercialization of medical services on patient-doctor trust has been extensively analyzed in the Indian setting. Rama Baru has described how even before the rise of major corporate hospitals in the late 1980s, there were complaints of doctors in public hospitals neglecting their duties toward patients because they allegedly spent more time and energy in their private practice.[41] Caroline Wilson argued, in the context of Kerala, that the increased presence of market-based competition

[40] Judith Allsop, "Regaining Trust in Medicine: Professional and State Strategies," *Current Sociology* 54, no. 4 (July 1, 2006): 624.

[41] Rama Baru, "Privatisation and Corporatisation," *Seminar*, no. 489 (May 2000); Rama Baru, "Commercialization and the Public Sector in India: Implications for Values and Aspirations," in *Commercialization of Health Care - Global and Local Dynamics and Policy Responses*, ed. M Mackintosh and M Koivusalo (London: Palgrave Macmillan, 2005), 101–16.

and multiple choices (of private providers) for patients after the 1990s did not necessarily lead to better services and patient-doctor interactions: "Patients often receive different opinions and do not know what appropriate action to take. Coupled by high levels of awareness of commercialisation and resentment over the high cost of care, this has undermined patient trust, encouraging patients to move between different service providers."[42] Shweta Marathe et al. write that "until the 1980s, medical practice was dominated by general practitioners and family physicians, where the doctor-patient relationship was personalised with an assurance of continuity of care. Information asymmetry meant patients were open to exploitation and unnecessary intervention, but as doctors were paid by individual families, this provided a degree of self-regulation due to a need to maintain a web of social networks and trust of patients." However, they write, after the 1980s and the intensification of commercialization of medicine, including doctors' primary dependence on hospitals (as against patients) for their payments, their relationship with patients underwent major changes. Rising costs of care coupled with rising reported incidents of medical malpractice, often linked to "pressures" put on doctors by hospital management, have "exacerbated distrust" in the patient-doctor relationship.[43]

In my dissertation, I complicate this literature on commercialization and distrust in doctors. My intervention is twofold. While there is little doubt that an intrusion of commercial interests in care provision leads to reduced trust in care providers,[44] I show that in India caste, more than

[42] Caroline Wilson, "Dis-Embedding Health Care: Marketisation and the Rising Cost of Medicine in Kerala, South India," *Journal of South Asian Development* 4, no. 1 (April 1, 2009): 98.

[43] Marathe et al., "The Impacts of Corporatisation of Healthcare on Medical Practice and Professionals in Maharashtra, India."

[44] Mark Schlesinger, "A Loss of Faith: The Sources of Reduced Political Legitimacy for the American Medical Profession," *The Milbank Quarterly* 80, no. 2 (2002): 185–235; Ellery Chih-Han Huang et al., "Public Trust in Physicians-Health Care

commercialization, has historically exerted a pervasive influence on public trust in doctors. The overwhelming dominance of the privileged castes and communities in the biomedical profession has meant that the profession has never been representative of the larger public of India: while the vast majority of Indians (and thus patients) are from subaltern communities and cultures, the majority of doctors hail from elite backgrounds. In a nation where caste-based identities, rituals, and traditions, and caste- and class-based hierarchies, occupy a central role in people's lives,[45] this differential between doctors and their patients assumes great significance, although it has not been accorded adequate attention in the existing scholarship. To return to the definition of trust I mentioned above: if trusting a doctor involves a "presumed reliability" that the doctor would accord prime importance to the patient and their interests, then the lived realities of many in India logically led them to be either wary of, or distrustful of, most doctors: to a large number of people, as Djurfeldt and Lindberg observed in rural Tamil Nadu in the late 1960s, doctors were representative of the ruling elite (the "masters"), rather than someone they could consider to be one of their own.[46] I thus argue that in any analysis of trust in the medical profession, it is important to pay attention to people's perceptions of doctors as individual persons within the local social and cultural matrix, irrespective of the presence or absence of market forces or commercialization in the medical field.

My second intervention in the commercialization and trust literature is temporal. While it is widely believed, by both doctors and many social scientists in India, that commercialization and

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Commodification as a Possible Deteriorating Factor: Cross-Sectional Analysis of 23 Countries," *Inquiry: A Journal of Medical Care Organization, Provision and Financing* 55 (December 2018).

[45] R.S. Khare, "Ritual Purity and Pollution in Relation to Domestic Sanitation," *Eastern Anthropologist* 15, no. 2 (1962): 125–39; M. N. Srinivas, *The Remembered Village* (University of California Press, 1976); Dean Spears and Diane Coffey, "Purity, Pollution and Untouchability," in *Where India Goes: Abandoned Toilets, Stunted Development and the Costs of Caste* (Noida, Uttar Pradesh ; New York, NY, 2017).

[46] Djurfeldt and Lindberg, *Pills Against Poverty*, 163-64.

"commodification" of medical services began more or less in the 1980s-1990s with the proliferation of private medical colleges and corporate hospitals and with the state's economic liberalization policies, my research shows that this timeline needs considerable correction. People in India were complaining about doctors resorting to medically unnecessary tests, procedures, and surgeries for monetary benefits at least as early as the late 1960s. At the same time, the medical care field in India, especially urban India, was heavily commercialized even prior to independence, and witnessed an expansion of commercialism in the early post-independence decades. Mukharji, for example, writes about the trope of the "renowned but exploitative doctor" in early twentieth century Bengal.[47] Imrana Qadeer has argued that the Indian state's policies in the early post-independence period ended up expanding and amplifying the influence of private medical practitioners.[48] In this dissertation, especially in Chapter 4, I show that in post-independence India, discussions on the adverse influence of commercialism of medical practice, including the influence exerted by pharmaceutical company representatives, began proliferating in the 1970s, with even popular movies depicting doctors indulging in ethically questionable actions. The absence of this longer history of commercialism and malpractice in contemporary accounts, in which the overwhelming emphasis is on the abstract process of liberalization, leads to a diminishing of the significant role which doctors themselves played in institutionalizing both commercialism and corruption in healthcare services in India.

[47] Mukharji, *Nationalizing the Body*: 71.

[48] Imrana Qadeer, "Health Planning in India: Some Lessons from the Past," *Social Scientist* 36, no. 5/6 (2008): 51–75.

The Developmental Indian State

Development was among the foremost legitimizing components of the rhetoric of India's anti-colonial nationalist leaders, and later of the post-independence state. Partha Chatterjee has written that by the 1940s, "the dominant argument of nationalism against colonial rule was that it was impeding the further development of India: colonial rule had become a historical fetter that had to be removed before the nation could proceed to develop." Development thus became a "constituent part of the self-definition of the post-colonial state."[49] In post-independence India, the state's development agenda was informed by its faith in, among other things, modern science as an essential enabler of progress.[50] I discuss in Chapter 1 that specifically in the medical sciences, it was biomedicine (or "modern scientific medicine" as its Indian champions called it in the 1940s and 50s) that ended up acquiring preeminence in the nationalist discourse as the form of knowledge and practice which could bring about the most comprehensive improvements in people's health.[51] Since "the claim to care for the welfare of the Indian people, in a way that no colonial government could do, was central to constructing the legitimacy of the post-colonial state,"[52] public health based on biomedicine became a significant aspect of post-independence policy, and doctors ended up at the top of the hierarchy of personnel in the healthcare sector. The Indian state's agendas and priorities

[49] Partha Chatterjee, ed., *State and Politics in India* (Delhi ; New York: Oxford University Press, 1997), 276-77.

[50] David Arnold, "Nehruvian Science and Postcolonial India," *Isis* 104, no. 2 (2013): 360–70; Jahnavi Phalkey, "How May We Study Science and the State in Postcolonial India?," in *The Circulation of Knowledge Between Britain, India and China: The Early-Modern World to the Twentieth Century*, ed. Bernard Lightman, Gordon McOuat, and Larry Stewart (Brill, 2013), 261–84; Gyan Prakash, *Another Reason: Science and the Imagination of Modern India* (Princeton, N.J: Princeton University Press, 1999).

[51] Also see Arnold, "The Rise of Western Medicine in India."

[52] Sunil Amrith, "Political Culture of Health in India: A Historical Perspective," *Economic and Political Weekly* 42, no. 2 (2007): 114–21.

have, however, been in a constant flux throughout the post-independence period. I show that it was perhaps only during the first decade or so of independence, especially under Rajkumari Amrit Kaur as Health Minister, that biomedicine received extensively more state patronage than other systems of medicine like Ayurveda, Unani and homeopathy. In later decades, these other systems and their practitioners began to receive increasing patronage, even if biomedicine remained preeminent in the broader healthcare apparatus of the state.

Since the state in India has often played an outsized role in influencing the lives and experiences of ordinary Indians,[53] its interventions in healthcare services through biomedicine unsurprisingly ended up strongly impacting biomedical practice and the patient-doctor relationship. For example, before for-profit hospitals and hospital chains expanded into rural India in more recent decades, most rural residents could access biomedical doctors primarily, if not only, through the vast and continually expanding network of government health centers, including those maintained by autonomous government entities like the Indian Railways and state-owned industrial complexes. In cities, too, public hospitals and health centers have been heavily utilized especially by underprivileged Indians throughout the post-independence period. For a large number of people, hence, their interactions with doctors were mostly mediated through the state and its entities, and doctors were perceived to be akin to other elite state actors. To quote Djurfeldt and Lindberg again, many rural Indians considered doctors to be "equals to the *durei*, i.e., the 'masters' who run the country, and the white masters who once ran it."[54]

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[53] Sunil Khilnani, *The Idea of India* (New Delhi: Penguin Books India, 1997); Sudipta Kaviraj, *The Imaginary Institution of India: Politics and Ideas* (Columbia University Press, 2010).

[54] Djurfeldt and Lindberg, *Pills Against Poverty*, 163-64.

I argue in the dissertation that such equivalence between the medical profession and the state in the eyes of the public, coupled with the similar elite-caste backgrounds of doctors and powerful members of the state administration and bureaucracy, has contributed to deepening the power asymmetries between doctors and the underprivileged public. In the absence of radical, egalitarian social reform in the country,[55] the primacy which the state accorded to elite biomedical doctors meant that many Indians were forced to contend with tremendous power inequities during most visits to healthcare centers and hospitals. Hence, while on the one hand the state's development interventions expanded people's access to biomedicine, on the other hand they amplified the alienation, dehumanization, and exploitation which underprivileged Indians have historically experienced in the country's public spaces, as the following chapters will show.

[55] Gopal Guru, "The Indian Nation in Its Egalitarian Conception," in *Dalit Studies*, ed. Ramnarayan S. Rawat and K. Satyanarayana (Durham: Duke University Press Books, 2016).

1. ELITE WITHOUT COMPETITION

In September 1946, with independence from colonial rule on the horizon, an "Interim Government" was formed in India under the leadership of Jawaharlal Nehru, the anti-colonial leader and future Prime Minister. One of the first official acts of this government's Health Minister, Shafaat Ahmad Khan, was to preside over a conference of provincial Health Ministers (who also, by this time, were native Indians) in Delhi in October 1946. This three-day-long conference was exclusively devoted to discussing the recommendations of an eminent committee on healthcare that had been commissioned by the colonial Government of India. Officially named the Health Survey and Development Committee, it was more commonly known as the Bhore Committee after its chairperson Joseph Bhore, a seasoned Indian bureaucrat. The Bhore report received unanimous approval at the Health Ministers' conference. The ministers also endorsed the fundamental "objectives" that the report had recommended for future policymakers to follow.[1]

In championing the Bhore Committee's recommendations, the Health Ministers gave their stamp of approval to the system of medicine which the committee unequivocally proposed as the most appropriate for India: biomedicine, or the "modern scientific system of medicine."[2] All of the report's chapters implicitly or explicitly advocated biomedicine as the basis for India's future medical and public health infrastructure. For the Bhore Committee, modern scientific medicine was "a corpus of scientific knowledge and practice belonging to the whole world and to which every country has made its

[1] "Agenda Item No. 2, in 'Draft Agenda for the Health Ministers' Conference to Be Held on the 2nd, 3rd and 4th August, 1948'," 1948, f. 12-7/48-M in DGIMS Medical Section, National Archives of India (hereafter referred to as "NAI").

[2] Along with "Western medicine" and "allopathy," this was a commonly used term in the late colonial and the post-independence period to denote what today is better known as biomedicine.

contribution."[3] They devoted only the length of two and a half pages, in their 500 pages of recommendatory proposals (volume 2 of the report), to India's indigenous systems of medicine. Although the Health Ministers' conference acknowledged this oversight, even passing a resolution which called for setting up more educational institutions in the indigenous systems,[4] their support for the Bhore Committee's larger vision for healthcare in India, based fully on modern biomedicine and public health, was inescapable.

How did India's nationalist leaders and experts end up according primacy to the medical knowledge system and practices introduced by British colonial officials and institutions, particularly even as practitioners of indigenous medical systems had been strongly challenging such primacy to biomedicine accorded by the colonial government?[5] For me this question is important because it was this official dominance facilitated by the state which brought more and more people in contact with biomedicine and biomedical doctors in post-independence India, and because the Indian state's intimate association with biomedicine and doctors exerted considerable influence on public attitudes toward them. In this chapter, therefore, I will first briefly discuss how biomedicine entered the social, cultural, and political milieu of

[3] Joseph Bhore (Chairman), *Report of the Health Survey and Development Committee*, vol. 2, p. 456 (New Delhi: Manager of Publications, 1946).

[4] "Agenda Item No. 11, in 'Draft Agenda for the Health Ministers' Conference to Be Held on the 2nd, 3rd and 4th August, 1948'."

[5] It is worth noting that "indigenous" medical practices and knowledge systems in the South Asian region, like in many other regions, were and continue to be numerous. The more prominent among these have been Ayurveda and Unani. Several historians have explored in detail the organized efforts by Ayurvedic and Unani practitioners to modernize their practice and to secure official recognition and privileges especially during the late colonial period. E.g., Guy N. A. Attewell, *Refiguring Unani Tibb: Plural Healing in Late Colonial India* (Orient Longman, 2007); Rachel Berger, *Ayurveda Made Modern: Political Histories of Indigenous Medicine in North India,* (New York, NY: Palgrave Macmillan, 2013); Claudia Liebeskind, "Arguing Science: Unani Tibb, Hakims and Biomedicine in India," in *Plural Medicine, Tradition and Modernity, 1800-2000*, ed. Waltraud Ernst (Routledge, 2002); Projit Bihari Mukharji, *Doctoring Traditions: Ayurveda, Small Technologies, and Braided Sciences* (University of Chicago Press, 2016); Kavita Sivaramakrishnan, *Old Potions, New Bottles: Recasting Indigenious Medicine in Colonial Punjab (1850-1945)* (Orient BlackSwan, 2006).

colonial India and how India's prominent nationalist leaders came to project it as the most appropriate system of medical care for their people. I will then analyze the relationship between the state and the biomedical profession in the early post-independence years. Though biomedical doctors were recruited by the state to be, so to say, the country's doctors, the profession's relationship with the state was ambivalent. Doctors welcomed the primacy the state accorded to their profession, but were not as enthusiastic about other aspects of the partnership, chiefly the expectation that doctors should work in villages (where almost 83% of the country's population resided, as per the 1951 census). Though political leaders and even other elites were keen on seeing the country's doctors become "country doctors" in large numbers, doctors had decidedly metropolitan ambitions.

I thus show that the early years of independence were marked by a friction between the ambitions of, on the one hand, the state to bring biomedical care to the people of India through the agency of doctors, and, on the other hand, of doctors to follow specialist studies, undertake research, and establish lucrative private practice (all of which necessitated an urban domicile). Ultimately it was the Indian state which blinked first: within a decade of independence it became clear that the developmental ambition of providing only the "best" kind of medical care to the populace through the agency of the "best" agents was perennially going to be thwarted by doctors' opposing ambitions, and finding little leverage, or perhaps even motivation to make doctors alter their ambitions, the state decided to tone down its own. The results of the clash between the state's goals and doctors' ambitions during the early post-independence years were instrumental in informing the Indian state's future policies around providing healthcare services to its people.

Medicine and Nationalism

Some time around 1888, the family of a young man in the western Indian region of Kathiawar was discussing what career he should take up now that he had matriculated. A trusted elderly friend opined that the prestigious and powerful post of the "Diwan," which the man's late father used to hold, could become his if he studied law and became a barrister. Studying in India would be a prolonged affair, so the friend suggested going to England, where the young man could become a lawyer and return to India within a mere three years. The man was excited at the idea of sailing to England, but was afraid that the law examinations would be difficult to pass. Could he not instead be sent to qualify for the medical profession, he gingerly asked. His older brother shot the idea down: "Father never liked it [the medical profession]. He had you in mind when he said that we Vaishnavas[6] should have nothing to do with dissection of dead bodies. Father intended you for the bar."[7] Though this young man, Mohandas, soon sailed to England and chose the legal profession—and later became the political leader known globally as Mahatma Gandhi—a number of other socioeconomically privileged Indians were indeed choosing to study "Western medicine" by the late nineteenth century, mostly at institutions in India.

David Arnold argues that "Western medicine" in India has "explicitly colonial origins": its introduction and dissemination occurred in accompaniment to the activities of the English East India Company beginning in the eighteenth century.[8] But by the time Gandhi proposed to study at a British medical school, many Indians had become well acquainted with "Western" medicine. A considerable

[6] Vaishnavism is a large sect within what is broadly known as Hinduism.

[7] Mohandas Gandhi, "Preparation for England," in *The Story of My Experiments with Truth*, 1927.

[8] David Arnold, "The Rise of Western Medicine in India," *The Lancet* 348, no. 9034 (October 19, 1996): 1075–78.

number had trained at the institutions established by the British and begun practicing either in government service or privately, in the process creating the antecedents of an Indian biomedical profession as well as blurring the "western" antecedents of the medical care system they were practicing.[9] In 1884, for instance, local "Western" medicine doctors in Bombay (now known as Mumbai) constituted the Bombay Medical Union (BMU), with the primary objective of establishing and promoting "a friendly intercourse among medical men of the city." Indian doctors were also joining the truly "explicitly colonial" Indian Medical Service (IMS)[10] and, after the establishment of the Indian National Congress (INC) in 1885, were using the INC platform to petition the government for reform in the IMS and in medical policy in India in general.[11]

By the early 1900s modern medicine and public health had "crossed a cultural threshold" in India and become an "active ingredient in indigenous rhetoric and social practice."[12] When Gandhi became the most prominent Indian nationalist leader in the 1920s, he counted doctors like B.C. Roy and Jivraj Mehta among his close associates. When Indian nationalists assumed charge of some public health ministries at the provincial level in the 1920s, "the vast bulk of government expenditure remained on western medicine, and the Indian ministers also seemed perfectly willing to appoint IMS men to senior positions and to listen to

[9] Mridula Ramanna and Projit Bihari Mukharji have shown how Indian practitioners trained in the British Indian medical colleges and schools combined a multiplicity of ideas in their practice, many of them originating in the practitioners' own social and cultural milieu and not in the training they received; see Mukharji, Projit Bihari. 2009. *Nationalizing the Body: The Medical Market, Print and Daktari Medicine*; Ramanna, Mridula. 2002. *Western Medicine and Public Health in Colonial Bombay, 1845-1895*.

[10] For more on the IMS, see Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine* (Cambridge: Cambridge University Press, 1994), especially Chapter 1.

[11] Roger Jeffery, "Doctors and Congress: The Role of Medical Men and Medical Politics in Indian Nationalism," in *The Indian National Congress and the Political Economy of India*, ed. Mike Shepperdson and Colin Simmons (Avebury, 1988).

[12] David Arnold, "Health and Hegemony," in *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*. (Berkeley: University of California Press, 1993), 241.

their advice." One provincial minister justified such decisions by saying that "his first duty was 'to attempt to bring the benefits of modern and scientific medicine and surgery within reasonable reach of all'."[13] During the same time, many among the wealthier Indian elite were increasingly contributing to modern medical hospitals and dispensaries. For example, in 1925 A.L. Nair, the proprietor of a medical supplies company, provided funds for the construction of the Bai Jamnabai Nair Hospital (named after his mother) in Bombay.[14] During a discussion in March 1914 at the Governor-General's Council in Delhi, a member from the United Provinces of Agra and Oudh provided a helpful glimpse of these developments:[15]

> The old systems of medicine, the *Ayurvedic* and the *Yunani*, are somewhat losing ground... there is less scope now for useful work through that system [sic] unless greater efforts are put forward by those who practise those systems in order to give them a more scientific basis... I admit that efforts are being made in this direction and they are laudable, but for the great bulk of the people now-a-days the western system of medicine is the one upon which reliance has to be placed for the cure of many of the ills to which mankind is heir... My experience is that there is at the present time a tendency among people of enlightened views possessed of means, and who are disposed to give any amount of money towards charitable objects, to avail themselves of medical institutions as one of the best upon which they could bestow their endowments, and I know from personal experience in my own province that institutions like these have sprung up in recent years.

On the professional front, Indian doctors began to venture beyond regional societies and were envisaging national-level medical conventions. The first All-India Medical Conference was held in Calcutta (now known as Kolkata) in 1917, and four more took place over the following decade. In 1928 at the fifth conference, a resolution was passed to form a national-level association of Indian doctors—the All-India Medical Association (which later became known as the Indian Medical Association, or the IMA)—with

[13] Jeffery, "Doctors and Congress": 168.

[14] Later known as the Bai Yamunabai Laxman Nair Hospital. "National Medical College: Annual Function," *TOI*, March 14, 1927.

[15] Madan Mohan Malaviya, "Resolution Re Employment of Women Medical Practitioners," in *Abstract of the Proceedings of the Council of the Governor-General of India*, 1914, 780–84.

the object of "looking after the interest of medical education, public health and the medical profession in India."[16] The establishment of the IMA was a major moment in the development of India's biomedical profession during the colonial period.[17] The IMA and its monthly journal (*Journal of the Indian Medical Association*, or JIMA), quickly became the preferred platform for elite doctors[18] to articulate their positions on matters relating to their profession and to its relationship with the state and the public. Writing three decades later in 1957, the then editor of JIMA described IMA's foundation event in a triumphant tone: "This was a new voice heard for the first time in the history of scientific medicine in our country, and this voice raised a hope in a thousand breasts that if only the medical men of India could unite and organise, speak and act from a common platform, there was every possibility of equalling or even excelling the achievements of organised British, American, and other foreign medical associations."[19]

Thus, despite its "explicitly colonial origins," "Western" medicine had, by the 1930s, been co-opted and recast by many in India. This co-option was part of a more broad-based "reimagination and reinscription" of modern science and reason by the Western-educated elite in colonial India, as Gyan Prakash has perceptively written. Educated in colonial institutions and employed in colonial administration and modern professions, "this elite stood on the interstices of Western science and Indian traditions." Among the elites Prakash quotes in his book are the engineer M. Visvesvaraya, who wrote in

[16] P. K. Guha, "History and Progress of the Indian Medical Association," *Journal of the Indian Medical Association* 28, no. 1 (January 1, 1957): 21.

[17] There are no published scholarly histories of the IMA as yet.

[18] Generally urban-based biomedical doctors who possessed the necessary financial resources, social connections, and time to be able to participate in a few or several of the activities like writing journal articles, editing journals, communicating with foreign institutions and practitioners, and participating in governmental committees and panels.

[19] Guha, "History and Progress of the Indian Medical Association," 21.

1920 that the modern world required "a new type of Indian citizenship" founded in science and industry; and the physicist Meghnad Saha who wrote in 1935 that India had to pay close attention to "the application of discoveries in modern science to our national and social life." Though modern science was introduced as a "code of alien power," Prakash says that it was "domesticated as an element of elite nationalism."[20] In the fields of medicine and public health this domestication manifested in the form of eloquent critiques of British colonial policies: "if health and medicine formed part of the perceived benefits of Western civilization and science, they also gave grounds for criticism of British rule and its wanton neglect of Indian people."[21] Sunil Amrith argues that the relatively large number of Indians trained in biomedicine "allowed for a new level of debate, which scrutinized colonial public health efforts, while staking a claim that Indian medical officials might be better placed to improve the health of the Indian population."[22]

In other words, many among India's elite were beginning to argue, by the 1930s, that Indians trained in "modern scientific medicine" were best-placed to lead their fellow compatriots toward improved health. Though there was also a related strand of opinion arguing that the colonially-neglected Indian indigenous systems of medicine must be accorded major roles in medical and public health infrastructure, "this argument failed to capture the Indian National Congress, the premier political party and nationalist organization."[23] The INC was an organization composed of members holding a wide spectrum of views on

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[20] Gyan Prakash, *Another Reason: Science and the Imagination of Modern India* (Princeton, N.J: Princeton University Press, 1999): 12.

[21] Arnold, "Health and Hegemony," 242.

[22] Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65* (Palgrave Macmillan, 2006): 23-24.

[23] Arnold, "The Rise of Western Medicine in India," 1078.

any given subject (M.K. Gandhi, for example, had over time developed a disdain for organized medicine, including biomedicine, and wrote in 1909 that "to study European medicine is to deepen our slavery"[24]). However, the ideas which began to dominate the nationalist political space in the 1930s, as independence gradually became a concrete possibility, were those of younger leaders like Nehru, Bhimrao Ambedkar and Subhas Chandra Bose. Among them Nehru rose to be the most influential, his political importance being "greatly enhanced by his being regarded by influential sections in British politics as the acceptable face of Indian nationalism, and the most desirable man to deal with when India eventually had to be granted independence."[25] Crucial to the story of medicine and nationalism was the fact that Nehru was "not only the most important nationalist leader after Gandhi, but also the most uncompromisingly modern of all Congress leaders."[26] As Gyan Prakash shows, for Nehru the solution to the challenges facing India required the combination of science with statecraft. With respect to medicine specifically, Nehru believed that the indigenous "ancient systems of medicine, excellent though they were, later became static and unscientific. They satisfied themselves with following precedents and failed to improve the science by experimentation and investigation. The indigenous systems may have excellent remedies for certain ailments, but they lack scientific basis. People talk of allopathy, homoeopathy and various other pathies and methods. But what is important is - are you going to follow a scientific method or not?"[27] Biomedicine, considered emblematic of the science and the scientific method that Nehru and other Indian elites endorsed and trusted, was thus

[24] M.K. Gandhi, "The Condition of India: Doctors," in *Hind Swaraj or Indian Home Rule*, 1910.

[25] Benjamin Zachariah, *Developing India: An Intellectual and Social History, c. 1930-50*, (OUP, 2005): 56.

[26] Prakash, *Another Reason*. 95.

[27] Jawaharlal Nehru, "Doctors and Public Service," in *Jawaharlal Nehru on Science and Society: A Collection of His Writings and Speeches*, ed. Baldev Singh (New Delhi: NMML, 1988), 52.

destined to secure pride of place once political power became theirs. This was never more clear than in the early 1940s, when the INC's National Planning Committee came up with its recommendations for a future independent India.

The National Planning Committee and the Bhore Committee

In October 1938, the Indian National Congress held a conference of British India's provincial Ministers of Industries, most of them INC members. The ministers resolved that the major pressing problems in India, including poverty and unemployment, could not be solved without industrialization, and that a "comprehensive scheme of national planning" needed to be formulated to carry out the industrialization. This planning was entrusted to a committee which later became known as the National Planning Committee (NPC) of the INC, and Nehru was appointed Chairman.[28] The NPC proceedings were dominated in the early months by concerns around industrial planning, and health-related planning entered their discussions only later, during the second session in June 1939. In this session several subcommittees, including one on "national health," were appointed to "co-ordinate the manifold activities of the nation." The vocabulary used in the terms of reference for this subcommittee already betrayed a privilege of biomedicine by these nationalist leaders. One entry, for example, dealt with the "provision of the necessary health units, comprising physicians, nurses, surgeons, hospitals and dispensaries, sanatoria and nursing homes"; another entry dealt with the importance of "scientific surgical appliances" and

[28] "Preface," in *National Health (Report of the sub-committee, National Planning Committee Series)*, by Sahib Singh Sokhey, Chairman (Bombay: Vora and Co. Publishers Ltd, 1948), 9–16. Gyan Prakash mentions that the revered engineer M. Visvesvaraya was initially slated to head the committee. But the physicist Meghnad Saha intervened, suggesting to Visvesvaraya that the committee "should be chaired by a powerful nationalist if planning were to have real weight in politics." Prakash, *Another Reason*, 195.

medicines.[29] The membership of the subcommittee, too, was telling: all of the members were formally trained in biomedicine. The chairperson, Sahib Singh Sokhey, was an IMS officer and the secretary, J.S. Nerurkar, was a medical officer with the Bombay city government and professor at Seth G.S. Medical College.

In the subcommittee's opinion, the debates around the "question of so-called indigenous systems of medicine" were "not only already producing considerable dissipation of effort and funds, but also beginning to side-track the medical development of the country."[30] An essay by member S. Abdur Rahman, titled *The Study of Indigenous medicine and medical relief in India*, and attached as an appendix to the report, provided additional insights into their rationale. Rahman made a universalist-humanist argument in favor of biomedicine, saying that "as a scientific phenomenon there can be only one medical system." Like many Indian elites of the time, he heaped praise on the antiquity of the Ayurvedic and Unani systems of medicine and on their famed utility for centuries prior to the British colonial rule. However, in more recent centuries the practitioners of these systems, except a few "pioneers," had failed to assume a "scientific outlook," an outlook emblematic of modern science (Rahman preferred to term it "international science"). There were probably many therapeutic options in the indigenous systems that needed to be "properly tapped," which could happen if the state trained Ayurvedic and Unani practitioners in "institutions with a scientific outlook." But apart from such instrumentalist uses, the indigenous systems had little appeal for Rahman, and evidently for the subcommittee in general. In their

[29] *National Planning Committee: Being an Abstract of Proceedings and Other Particulars Relating to the National Planning Committee*, 1948: 97.

[30] "Report of the National Health sub-committee," in *National Health*: 42.

opinion there existed only one medical system—the modern scientific system of medicine—since there was "only one anatomy, one physiology and one pathology."[31]

The interim report of the subcommittee was submitted to the NPC in August 1940. The NPC approved of the recommendations in general, passing several resolutions to that effect.[32] The resolutions all implicitly and explicitly endorsed "scientific medicine" as the most appropriate medical system for India, and called for medical training "in every field" to be based on the "scientific method." In other words, the principal native political organization in British India, destined to be the party that would form government after the British left, had resolved to make biomedicine the primary system of medicine and public health for the country. Within only a few years of these events, the NPC resolutions were further reinforced by one of the final major healthcare-related acts of the British colonial government: the constitution of the Health Survey and Development Committee (Bhore Committee) in 1943.

Perhaps the earliest archivally documented mention of what later would become the Bhore Committee is an entry by officer S.H.Y Oulsnam in a file of the Education, Health and Lands (E.H.&L.) department of the Government of India, with the subject line: "Appointment of a Health Survey and Development Committee."[33] Penned on 15th July 1943, the contents of the note suggest that preliminary informal discussions on constituting such a committee had perhaps been going on for some time prior to

[31] "Appendix VIII," in *National Health*: 190-2.

[32] "Resolutions of the National Planning Committee," in *National Health*: 225. Soon after, political events in India forced the Congress to suspend further work on the NPC, and these reports were officially published for public consumption only after independence, in 1948. By then, in the field of healthcare, the Bhore Committee report had unanimously been accepted by political leaders at the Centre and the provinces as a blueprint for India.

[33] "Constitution of Health Survey and Development Committee," 1943, f. 52-118/43-H, Dept of Education, Health & Lands, National Archives of India [hereafter "NAI"].

this date, initiated most probably[34] by Sardar Jogendra Singh, the Member of the Viceroy's Executive Council in charge of the E.H.&L. department. Singh was a veteran public administrator, having previously been Prime Minister of the Patiala State and Minister of Agriculture in the Punjab province.[35] Oulsnam's note mentioned the immediate impetus behind the government's unusual decision to constitute a high-level committee on health reform in the middle of the Second World War. Most provincial governments, he wrote, were making plans for post-war reconstruction and development of the health sector, so "it was clearly incumbent on the Central government to take the initiative and assist provincial governments in the elaboration of a post-war health policy."[36] While this was the immediate stimulus, it is possible that decades-long criticism by Indian leaders and experts of the government's healthcare interventions and non-interventions, as well as the more recent experience of the devastating Bengal Famine, might have played a role in the urgency. The Famine had, as Amrith says, "undermined the imperial claim to be working for national welfare."[37] Besides, he argues, the colonial state might also have wanted to placate the Indian elite after its unpopular and violent response to the 1942 Quit India movement.[38] Additional speculation on the motivations behind the decision to constitute the Bhore Committee can be made by extrapolating from subsequent official communication. An internal note from 1945 talks about the importance of health in

[34] Unfortunately several aspects of the constitution of the Bhore Committee and of its internal meetings and discussions are yet to be historically analyzed, despite the abundance of general scholarship on it. Most documents pertaining to these issues are at the National Archives of India in New Delhi, and as of October 2019, these were not available for viewing by researchers as I realized after much effort.

[35] "Sir Jogendra Singh Dead: Former Member of Viceroy's Council," *TOI*, December 4, 1946.

[36] "Constitution of Health Survey and Development Committee."

[37] Amrith, *Decolonizing International Health*: 70.

[38] Ibid, 57.

"any programme directed towards improving the standard of living in the post-war period. If dissipation of financial resources and administrative effort is to be avoided, plans for the improvement of health organisation must be based on a competent review of the health problems as a whole… The Government of India believe that the time has come when, in spite of the difficulties arising from the war conditions, such a review must be undertaken."[39] This need to go ahead with the exercise despite the ongoing war was also mentioned in an earlier press communique shared by the government in October 1943.[40] Besides, the personal interest of Jogendra Singh might have been a significant driving force behind this governmental commitment. He had taken charge of the E.H.&L. Department beginning July 1942, and the veteran bureaucrat Joseph Bhore, after being invited to chair the committee, congratulated Singh for initiating, "soon after assuming charge of your duties, the investigation of a question which affects most vitally the country's efficiency and the development of its national life."[41]

Irrespective of the motivations behind this intervention by the colonial government, it is clear that the E.H.&L. Department was serious about making the committee's work a success. In the aforementioned note by Oulsnam, preliminary details about the proposed committee are mentioned: that it should be composed of both officials and non-officials, that the majority should be persons "acquainted with the problem of health administration," and that the Chairman should be a non-medical person. The 65-year-old Bhore was a former Indian Civil Service officer who had worked in the E.H.&L. department in the

[39] "Health Survey and Development Committee - A Brief Note on the Purposes of and Recent Developments in the Committee," 1945, f. 38-22/45-H, Dept of Education, Health & Lands, NAI.

[40] Bureau of Public Information, "C&O 3/46 Part 8 - Post-War Reconstruction: Public Health Committee (Including Training of Nurses in the UK) (Apr 1944-Feb 1948)," IOR/L/E/8/4485, British Library: India Office Records and Private Papers.

[41] "Letter, Joseph Bhore to Jogendra Singh (August 7, 1943), in 'Constitution of Health Survey and Development Committee,'."

past. His "long administrative experience," it was thought, would help carry the work of the committee to a "successful conclusion."[42] Being long-standing members of the British Indian administration, Bhore and Jogendra Singh might even have interacted with each other in the past—including possibly during lunches at the Viceregal Lodge in Shimla[43]—and this acquaintance probably played a role in Bhore's name being suggested for the post. He was soon sent an official invitation, which he readily accepted. Allowing Bhore some glimpse into what he envisaged the committee to accomplish, Singh wrote that with the Health Survey and Development Committee (HSDC) he aimed to "not produce another report but a plan which the provinces can work out within a definite number of years."[44]

On August 6 1943, Jogendra Singh made the first public announcement of the constitution of the HSDC, during the proceedings of the Council of States in New Delhi. As part of an answer to a question on the delay in the publication of annual health reports, he informed the council that he was appointing a committee to consider the "whole problem of health."[45] He mentioned his initiative yet again a week later. These initial announcements do not seem to have garnered much public response, evident from an editorial in the *Times of India* on August 20 in which the author lamented the little attention provided to the "notable announcement." But the fact that "health had been recognised as an important element of

[42] "Constitution of Health Survey and Development Committee."

[43] Both their names can be found in lists of attendees at major official events: "Impressive King's Birthday Parades All Over India - Viceroy Takes the Salute at Simla," *The Times of India*, June 4, 1931; "Sugar Conference - Official List of Subjects for Discussion," *The Times of India*, July 8, 1933.

[44] "Letter, Jogendra Singh to Joseph Bhore, in 'Constitution of Health Survey and Development Committee,'" August 20, 1943.

[45] "Fourteenth Session of the Fourth Council of State, 1943" (August 6, 1943), Council of State Debates, Parliament of India Digital Library.

post-war reconstruction" was considered noteworthy and the choice of Bhore, who possessed "both wide administrative experience and a zealous nationalism," was applauded.[46]

Later in October, Singh shared additional details about the HSDC during the annual meeting of the Central Advisory Board of Health.[47] By then the composition of the committee had been finalized after lengthy internal discussions throughout August and September. Disappointingly for practitioners of the indigenous systems of medicine, the committee did not have a single representative. In mid-September the president of the Ayurvedic and Unani Anjuman Tibbiya had written to Jogendra Singh, after coming across a news report on the proposed HSDC, and requested that a representative from his institution be nominated on the committee. We do not know if Singh responded to him, but we know that no such representatives found a place on the committee.[48] The Bhore Committee was, similar to the NPC's subcommittee on health, dominated by experts trained in biomedicine. Out of a total of 24 members, other than the six non-technical members and the chairperson Joseph Bhore, all the other seventeen had received training in biomedical institutions.

During the committee's inaugural meeting in October 1943, the substantial amount of work before them was divided into five subject headings and each subject was allotted to an advisory committee. The five advisory committees thus formed were those on industrial health, medical relief, medical research, professional education, and public health. The full committee then met for a 10-day session in January 1944, and beginning in April the different advisory committees went on tours throughout India to survey

[46] "India's Health," *The Times of India*, August 20, 1943.

[47] "Post-War Public Health," *The Times of India*, October 5, 1943.

[48] "Constitution of Health Survey and Development Committee."

the existing conditions of hospitals, medical colleges, administrative units, etc. as well as to solicit opinions of experts from different regions. During December 1944 and early 1945, some foreign experts (from the UK, the US, Australia, and the USSR) were invited to India to participate in the deliberations of the committee, including going on tours with them. The report was finally published in March 1946.[49]

The Bhore Committee report is an extraordinary, unique document straddling the boundary between colonial and post-colonial India and complicating the vexed question of "continuity-or-change" between these two periods. Despite being preoccupied with the Second World War, the British colonial government devoted a considerable amount of resources and finances toward the committee and its work. The early deliberations between Bhore, Singh and Oulsnam suggest that they expected the work to be done within six to nine months: but the committee took more than two years to arrive at its final report, in the meantime undertaking several tours all over India and also meeting with specially invited foreign experts (some on government expense and others sponsored by the Rockefeller Foundation[50]). The Government of India also made sure, especially through the Bureau of Public Information, that the committee's activities and work received adequate coverage in the press. But despite being commissioned by the British colonial government, it can be argued that the Bhore report was, unlike the "Western medicine" it championed and put complete faith in, not "explicitly colonial" in origin. The committee had a distinctly Indian character to it. It was most probably the Indian Jogendra Singh, as part of the Viceroy's Executive Council, who proposed the constitution of the committee. He also directed the administrative support for it throughout its tenure. The chairman Bhore was Indian, and only five of the total 24 members were non-

[49] Bureau of Public Information.

[50] Amrith, *Decolonizing International Health*, 58.

Indian.[51] Some members even had strong links with the nationalist Indian National Congress (most prominently B.C. Roy). The report strongly criticized the state of public health in India and past healthcare policy, implicitly critiquing British colonial policymaking. As we saw earlier in the chapter, the "provisional national" Interim Government, headed by Nehru, welcomed the report and accepted its recommendations as appropriate public health strategies for India. India's first Health Minister after independence, Rajkumari Amrit Kaur was also committed to the report and implemented several major reforms in her 10-year tenure on the basis of the Bhore Committee's recommendations.

At the same time, as Sunil Amrith and Shirish Kavadi have shown, the content of the Bhore report was heavily influenced by the ideas and convictions of the Swiss-born and US-settled Henry Sigerist and the Canadian John Grant.[52] The report approvingly cited and sought to learn from achievements in other countries, especially the Soviet Union, New Zealand, Canada, United Kingdom, and Japan—and in this respect it was similar to the Constitution of India, work on which began not long after the report came out.[53] The Bhore report thus cannot easily be categorized using a simple colonial/post-colonial binary: it was simultaneously British colonial, Indian, and international in origin and content. After independence, of course, it was fully Indian in praxis and discourse, employed both rhetorically and practically as a blueprint for healthcare policy by the self-assured early post-independence state. In the early years of independence, while Nehru, Kaur, and officials from the Union [federal] government often quoted from the Bhore report in their numerous speeches and writings, leaders at the provincial level also invoked the

[51] Bureau of Public Information.

[52] Amrith, *Decolonizing International Health*, 57-63; Shirish N Kavadi, "John B Grant and Public Health in India," *Indian Journal of Medical Ethics* 4, no. 2 (March 21, 2019).

[53] Rohit De, "Constitutional Antecedents," in *The Oxford Handbook of the Indian Constitution*, ed. Sujit Choudhry, Madhav Khosla, and Pratap Bhanu Mehta (Oxford ; New York: Oxford University Press, 2016).

Bhore report or ideas from it frequently. Bombay's Minister for Public Health M.D.D. Gilder, for example, said at a public function in April 1950 that the government's aim was "not absence of disease but positive health for the masses."[54] Promotion of "positive health" was indeed one of the central objectives that the Bhore committee recommended for future health planning: "the [national health] services should make adequate provision for the medical care of the individual in the curative and preventive fields and for the active promotion of positive health."[55]

While India's political leaders were probably not always directly inspired by the Bhore committee's ideas, major elite commentators in the country did employ a common set of ideas and vocabulary with respect to healthcare planning, and the Bhore report helped consolidate these ideas and values and became a concise shorthand for them. Socialized healthcare services with the state dominating care provision, an aspiration to bring health outcomes to the levels observed in "progressive" countries, and a belief in the power of "scientific medicine" to make such progress possible, were among the most common ideas that animated the speeches and writings of India's leaders and administrators during this time—all of them enthusiastically and earnestly championed in the report. Thus, for the state and its agents in the years immediately following independence, the Bhore report acted as a convenient anchor around which the majority of their healthcare-related ideas and efforts revolved.

The greatest responsibility of translating the Bhore report's recommendations into policy in early post-independence India, especially the one suggesting biomedicine to be the basis of healthcare services in India, fell on Health Minister Amrit Kaur. The 1946 conference of provincial Health Ministers

[54] "Positive Health for Masses - Dr M.D.D. Gilder on Govt's Policy," *The Times of India*, April 10, 1950.

[55] *Report of the Health Survey and Development Committee*, vol. 2: 17.

(mentioned at the beginning of this chapter), while approving the Bhore report in general, had recommended the constitution of another committee to investigate how the indigenous systems could be best utilized for the benefit of the population. This committee (the Ram Nath Chopra Committee) submitted their report in early 1949, though the recommendations were not as far-reaching as practitioners of Ayurveda and Unani might have expected.[56] In September 1949, Health Minister Kaur expressed her views on the Chopra Committee to the Union government's Cabinet of Ministers. She recommended promoting and facilitating research into the Ayurvedic and Unani systems on "scientific lines," predicting that the research would enrich these systems and also would be incorporated in biomedicine, "so that eventually there will emerge only one system of medicine." In addition, all Ayurvedic and Unani practitioners were to be registered in a national Register so as to prohibit practice by unqualified persons. However, in keeping with the Bhore Committee's vision and that of the modernizing nationalists like herself, Kaur recommended that the Union and Provincial governments continue to employ "modern scientific medicine" as the "basis of the development of the National Health Services in the country." The Cabinet approved her recommendations, and it has been the guiding policy of the Indian state ever since, despite minor modifications and concessions to the indigenous systems of medicine.[57] As David Arnold

[56] "Need for Research in Indian Medical Science Proposed: Chopra Committee's Recommendations," February 20, 1949, PIB Archive; Wujastyk, "The Evolution of Indian Government Policy...:" 64-5.

[57] In 1970, Prime Minister Indira Gandhi's Cabinet modified this policy by including the Ayurvedic, Unani, and Homeopathic systems in addition to modern medicine. None of the histories of indigenous medical systems in India I referred to mentions either of these Cabinet policies, and it is unclear how much practical influence they exerted in discouraging or encouraging the indigenous systems, especially in the provinces. However, the 1949 decision certainly reflected the early post-independence state's abiding commitment to biomedicine. "Change in the Policy Regarding Development of National Health Services," 1968, f. 12-2/68-APC, Ministry of Health section, NAI.

wrote on the fiftieth anniversary of India's independence, "Western medicine was never so powerful in India as when it shed its colonial identity."[58]

Development and Doctors

While the enthusiasm of the Nehru-led government for biomedicine can be explained, as discussed above, in terms of individual Indian leaders' specific modernizing ideas and attitudes, their particular enthusiasm for the Bhore report stemmed also from the report's alignment with the new state's developmental objectives. Most of the report was devoted to suggesting plans for establishing structures and institutions of healthcare to serve India's vast, mostly rural population: "We have taken the countryside as the focal point of our main recommendations, for it is the tiller of the soil on whom the economic structure of the country eventually rests… The essential aim of our proposals is to ensure the health of the masses of the people through the effective working of the centers we are recommending for rural areas."[59] The emphasis on rural India was accompanied by an emphasis on the primacy of the state as the primary facilitator of appropriate conditions for well-being, and as the primary provider of healthcare services. The state being responsible for healthcare was, according to the committee, a recent, "modern" concept worth emulating in India. As Sunil Amrith has written, this was a time when "from South Africa to the West Indies, reports emerged planning for a future of expanded [state-led] welfare provision, in which public health would play an important role."[60] The Bhore report mirrored these global

[58] Arnold, "The Rise of Western Medicine in India:" 1078.

[59] *Report of the Health Survey and Development Committee*, vol. 2, 4-5.

[60] Amrith, *Decolonizing International Health,* 56-57.

developments: "The ferment of ideas arising out of the World War has resulted in an increasing awareness, on the part of Governments and peoples, of the need for measures which will ensure social security, and health protection is becoming recognized as an essential part of social security. The idea that the State should assume full responsibility for all measures, curative and preventive, which are necessary for safeguarding the health of the nation, is developing as a logical sequence."[61] Besides, the committee was concerned that the extent of destitution in the Indian population meant that if the state did not rise to the occasion by providing services free of charge, biomedicine and public health—and consequently health and well-being—would remain inaccessible to the vast majority of Indians.[62]

Similar ideas were also espoused by the Nehru-led early post-independence state as part of its developmental ideology which "was a constituent part of the self-definition of the post-colonial state."[63] According to Partha Chatterjee, developmentalism, which included such activities as inter-vening in the economy and attempting directly to promote the welfare of the population, was perhaps the principal governmental function that legitimized the position of the nationalist leadership within the new post-colonial state.[64] As Khilnani has written, the state "accumulated for itself many quite disparate responsibilities," and "convinced of its own ability to remould Indian society, it became a full-time trustee for its people." Thus, part of the appeal of the Bhore report for post-independence Indian leaders lay

[61] *Report of the Health Survey and Development Committee*, vol. 2, 7.

[62] The committee did leave room for modifications in the future: "It will be for the Governments of the future to decide ultimately whether medical service should remain free to all classes of the people or whether an insurance scheme would be more in accordance with the economic, social and political requirements of the country at the time." *Report of the Health Survey and Development Committee*, vol. 2, 14.

[63] Partha Chatterjee, "Development Planning and the Indian State," in *State and Politics in India*, ed. Partha Chatterjee, (Delhi ; New York: Oxford University Press, 1997), 277.

[64] *State and Politics in India*, 12.

precisely in the committee's belief that only such a "trustee state" would be able to meaningfully implement their extensive recommendations and improve the living conditions of the Indian population, and would also mark itself radically different from the colonial state which had, as Amrith put it, "never been more than 'firefighters'" in the domains of medicine and public health.[65]

The voluminous nature of the Bhore report, and its authoritative statements and recommendations on multiple aspects of medical and public health policy which were later taken up by political leaders (often only in parts and not in full, and often in the midst of vastly changed political and social contexts), make it difficult to assess precisely the nature and extent of its impact on health indicators and healthcare services in the country. However, the report proved to be immediately impactful in one significant aspect of policy: ensuring the primacy of biomedicine and biomedical doctors in the developmental ideology of early post-independence India. By incontrovertibly indicating that it was only through "modern scientific medicine" and its doctors that efficient and efficacious medical care could be provided to the people of India, the Bhore committee made it easier, even axiomatic, for the modernizing political leadership to repose trust in doctors as their most important allies in the developmental domain of healthcare. The post-independence state responded in kind, and its trust in doctors and biomedicine manifested in policy in several ways, apart from the Cabinet decision mentioned above. The fundamentally three-tier, hierarchical infrastructural model of healthcare centers ("radiating" from the periphery to the center) which India follows to this day, has its origins in the Bhore report.[66] The most peripheral and

[65] Amrith, *Decolonizing International Health*, 2.

[66] *Report of the Health Survey and Development Committee*, vol. 4, 5-8.

important among these centers, the primary health center (PHC),[67] was to be led by "whole-time, salaried" doctors who would perform "both curative and preventive functions."[68] Work on such PHCs began soon after independence, and by 1960 the government claimed that 2,800 PHCs were present all over India (although perhaps not all of these were fully functional and fully staffed).[69] In the early decades of independence, the PHC thus became a crucial site at which the developmental state's trust in doctors, and the Indian public's trust in the developmental state, interacted (as I will discuss in later sections and later chapters, both these relationships proved .

Another early policy development was the retention of government ownership over the medical colleges and institutions managed previously by the British colonial administration, as well as the taking over of several more institutions. Thus all the British Indian medical training institutes, including the earliest ones at Calcutta, Madras (now known as Chennai) and Bombay, came under the control of the post-colonial Indian state. At the second conference of provincial Health Ministers in 1948, all the provinces expressed elaborate plans to "provincialize"[70] existing hospitals and dispensaries and to build new ones.[71] The Government of U.P., for example, had provincialized all the maternity and child care centers previously run by the Indian Red Cross & Society and planned to ultimately develop them into Primary Health Centers. The Bihar and Orissa Governments provincialized all medical care centers previously

[67] In the Bhore report this is termed "primary health unit."

[68] *Report of the Health Survey and Development Committee*, vol. 4, 5-8.

[69] A. Lakshmanaswami Mudaliar et al., *Report of the Health Survey and Planning Committee* (New Delhi: Government of India Ministry of Health, 1962), 72-73.

[70] In this context, provincialization meant bringing institutions previously under the control of local bodies or voluntary agencies, under the provincial government's control.

[71] "Draft Agenda for the Health Ministers' Conference to Be Held on the 2nd, 3rd and 4th August, 1948."

under the control of Local Bodies. Such provincialization happened throughout India, and was accompanied in most provinces, with the notable exceptions of Madras and Bombay, by the "amalgamation" of curative and preventive services (a major Bhore Committee recommendation): the previously separate medical department and public health department at the provincial and district levels were combined into a single controlling directorate. Even at the federal level, the two colonial-era posts of Public Health Commissioner and Director General, Indian Medical Service (DGIMS) were abolished and a new "amalgamated" post of Director General of Health Services (DGHS) was created.[72]

The principle of combining preventive and curative healthcare took on additional dimensions in the Bhore committee's recommendations for medical education. Under a section titled "The Type of Doctor for the Future," the committee outlined what attitudes and skills they expected from future physicians. It was important that the nation's resources, limited as they were, were spent "on the production of only one and that the most highly trained type of doctor, which we have termed the 'basic' doctor." Education in the community and in preventive aspects of medicine was to be an "inseparable component" of this training.[73] The expectation of the committee was that the majority of the future doctors of India would be "absorbed" by a rapidly expanding state medical service concentrated in villages and small towns, and that such a holistically trained "basic doctor" would be a far better fit there than a doctor who was adept solely in conventional clinical medicine. These ideas drew heavily from Henry Sigerist's writings on the "social physician," and the report even carried a quote from his writings:

[72] "Office Memorandum, Office of Director General, Indian Medical Service," August 12, 1947, IOR/L/E/8/5827, BL, IOR.

[73] *Report of the Health Survey and Development Committee*, vol 2. 339-40

"Scientist and social worker, ready to co-operate in teamwork, in close touch with the people he disinterestedly serves, a friend and leader he directs all his efforts towards the prevention of disease and becomes a therapist where prevention has broken down, the social physician protecting the people and guiding them to a healthier and happier life."[74]

The perceived necessity of "having only one grade of doctor - the highest" also led to the Bhore report's recommendation that medical institutions in India should grant a single basic degree in biomedicine—that of the graduate—as against the two separate degrees (of licentiate and graduate) which was the norm for almost a century since the 1860s. Although, beginning in 1906, Indian universities had discontinued admissions to their licentiate programs following the recommendations from the Director-General of the IMS, licentiate education had continued outside the university sphere in the "medical schools."[75] These schools, mostly managed by provincial governments or private entities, had existed for decades alongside the bigger "medical colleges," to train students in the subordinate-grade medical courses for posts like Hospital Assistant and Sub-Assistant Surgeon.[76] With universities discontinuing their licentiates, many provincial governments began offering licentiate education in such "medical schools," since in their perspective it was important to keep open for the public what was then the most convenient and least expensive avenue for biomedical education. It is pertinent to note here the peculiar application of the words *school* and *college* with respect to medical education in India. As was noted by the Calcutta University Commission, medical school referred to a "medical teaching institution in which students are

[74] *Report of the Health Survey and Development Committee*, vol 2: 18.

[75] "Report of Committee (G) Appointed by the Senate on 7th April 1905," in *The University of Bombay: The Calendar for the Year 1906-1907* (Bombay, 1906), 675.

[76] "Exhibition of the Byramjee Jeejeebhoy Medical School," *The Times of India*, October 3, 1879.

not trained for a degree," and medical college referred to a degree-granting university institution.[77] For example, in 1915-16 there were five medical colleges in the country and thirty medical schools (17 of which were government-managed).[78] With time, several private medical schools closed and some government schools were upgraded to medical colleges. When the Bhore Committee made a count circa 1944, the number of colleges and schools stood at 19 each.[79] The committee estimated that there were nearly 30,000 licentiates (63% of all doctors) and 17,650 graduates, making a total of around 47,650 biomedical doctors in India.[80] In the Bhore Committee's picture of the future, the medical schools and their licentiates, even though on the wane, had to completely make way for the university/college and the "basic doctor."

Thus there was already a push toward abolishing the licentiate course when the Bhore Committee began their deliberations in 1943, and some prominent licentiate doctors themselves were advocates of such a change.[81] In 1938 the provincial Government of Madras took the lead by discontinuing new admissions to two medical schools and embarking on plans to convert one of them into a medical college,[82] and in 1942 the Medical Council of India passed a resolution recommending that all medical schools be either upgraded to colleges or discontinued.[83] But the medical school also had its articulate defenders, who

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[77] "Medical Education," in *Report: Calcutta University Commission, 1917-19*, vol. 3 (Calcutta: Superintendent of Government Printing, 1919).

[78] Government of India Bureau of Education, *Indian Education in 1915-16* (Calcutta: Superintendent of Government Printing, 1917).

[79] *Report of the Health Survey and Development Committee*, vol. 1:158-163

[80] The report provides slightly different numbers elsewhere, but the general ballpark was 47,000 total doctors.

[81] N.W. Karkhanis, "Letter to the Editor: The Future of Licentiates," *The Times of India*, October 19, 1938.

[82] Major-General E.W.C. Bradfield, "Medical Schools," in *An Indian Medical Review* (Delhi: Manager of Publications, 1938), 98.

[83] *Report of the Health Survey and Development Committee*, vol. 1: 165.

believed that the licentiate degree served a useful purpose both in terms of its affordability for students and its utility for the general public. In a letter written to the *Indian Medical Gazette* in September 1944, M.A. Nicholson, Superintendent of the King Edward Medical School in Indore, said that the licentiate deserved to be the basic foundation of the organization of India's medical profession. Despite the hierarchical structure within the profession itself, the general public throughout India considered licentiates as simply doctors (a fact that Nicholson thought was often overlooked), and the licentiates were often the only biomedical doctors in many areas. If the course were abolished completely, Nicholson believed it would become difficult to provide healthcare services in non-urban regions.[84] There were such dissenters even within the Bhore Committee, in which the majority opinion gravitated toward discontinuing the licentiate. The six dissenters, out of the 24 members, were Frederick James, N.M. Joshi, L.K. Maitra, Vishwa Nath, P.N. Sapru, and Abdul Hamid Butt (Nath and Butt were medical doctors, and the rest were legislators). They were not opposed to the ambition of having for India a uniform medical training of the highest type, but they felt that this could wait: "the early realization of this ideal must be sacrificed to the immediate needs of the country." These needs were, in their assessment, a "large-scale production of trained medical personnel of all kinds, in as short a time as possible," something that could potentially bring about "rapid and substantial improvement" in the health services of the country. The majority view, on the other hand, was wary of what they thought was a compromise between quality and numbers: "there will always be the temptation to increase numbers by lowering the standard of training," and that could lead to "deplorable consequences." In their vision of the future where the doctor was expected to assume multiple responsibilities, including that of the "social physician," they considered the licentiate training to

[84] M. A. Nicholson, "The Medical Profession in India and Its Education," *The Indian Medical Gazette* 80, no. 1 (January 1945): 57–58.

be inadequate and inferior, the continuance of which "must inevitably postpone fulfillment of the ultimate aim which may be defined as a complete health service for the community at the hands of a fully trained and competent staff." Instead of investing in the licentiate, they preferred investing in the training of a "larger number of efficient ancillary men."[85] As it turned out, the Union government and most provincial governments in post-independence India chose to accept these recommendations: they discontinued the "inferior" licentiate programs and converted their medical schools into medical colleges. However, the fundamental debate on what ought to be India's priority when it came to skilled medical attention for the population—the quantity of personnel, or the perceived quality of personnel—has continued to animate health policy debates to this day.

The country's first Health Minister, Amrit Kaur, headed the ministry for ten years, and was a passionate supporter of the Bhore Committee's ideas and vision. She worked to strengthen the foundations of biomedical education, training and practice in India, at the same time engaging in several public health initiatives.[86] In June 1948 she went to Geneva as the leader of India's delegation to the First World Health Assembly, and successfully lobbied for locating the regional headquarters of the WHO's South-East Asia bureau in India.[87] Located in New Delhi, the WHO regional headquarters became a major center for ambitious Indian doctors to work at and to develop international connections. New medical colleges and

[85] *Report of the Health Survey and Development Committee*, vol. 2: 336-354.

[86] The most prominent among the public health initiatives were national programs for the control of infectious diseases like tuberculosis and smallpox. See Bhattacharya, Sanjoy. *Expunging Variola: The Control and Eradication of Smallpox in India, 1947-1977*. Orient Blackswan, 2006; Brimnes, Niels. *Languished Hopes: Tuberculosis the State and International Assistance in Twentieth-Century India*. New Delhi: Orient Blackswan, 2016.

[87] 1 World Health Assembly, "Eleventh Plenary Meeting," in *First World Health Assembly, Geneva 24 June to 24 July 1948: Plenary Meetings: Verbatim Records: Main Committees: Summary of Resolutions and Decisions* (World Health Organization, 1948), 81.

other healthcare-related training institutes were added, and the four major existing hospitals in the capital Delhi were taken up for "reorganization," including measures such as amplifying the staff and infrastructure. Several medical graduates were sent abroad for post-graduate training on fellowships under the government's schemes for overseas training: in 1947 a total of 78 doctors went abroad on government funding. The government considered this expenditure necessary because of the lack of postgraduate training facilities in the country, and of the need for such training so as to have well-qualified researchers and teachers in medical colleges in India. At the same time, plans were being deliberated for establishing an all-India institute which would act as a model training and research center for biomedicine in India, as recommended by the Bhore committee. Investments were also being made in upgrading select existing hospitals and colleges in the provinces.[88] The All-India Institute of Medical Sciences (AIIMS) began operations in the late 1950s despite strident opposition from some legislators who wanted a greater role for the indigenous systems, especially Ayurveda, with one of them equating the Parliament Act which established AIIMS as an enactment of "Hamlet without the Prince of Denmark."[89] For Kaur, however, the establishment of AIIMS was among her most cherished achievements.[90]

Clearly, the early post-independence Indian state under the leadership of Nehru and ministers like Kaur, in pursuit of its developmental objectives and ambitions, rallied spectacularly behind doctors, whom it considered to be important agents in its developmental vision. But as it turned out, most doctors had their eyes set elsewhere.

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[88] "Healthy Life for Every Citizen | Introduction of Modern Methods of Treatment | Record of Health Ministry's Work during Partition Crisis" (Ministry of Health, August 15, 1948), PIB Archive.

[89] "'No Apathy to Ayurveda': Medical Institute Bill Voted," *The Times of India*, February 22, 1956.

[90] Rajkumari Amrit Kaur, "A Dream Come True," in *Selected Speeches and Writings of Rajkumari Amrit Kaur*, ed. G. Borkar (Archer Publications, 1961), 278–82.

Doctors' Dilemmas: Government Service or Private Practice?

Some time after independence in late 1947, the office of Bombay's provincial Health Minister Manchersha Gilder (better known as M.D.D. Gilder), received a letter from a young doctor, demanding to know why her services had been suddenly terminated by the Bombay government. The doctor, Leela Ranade, was employed at the government-run Cama & Albless Hospital, which she had joined in the capacity of Registrar in 1945. She had studied medicine at the Grant Medical College, graduated in 1941, and worked at Cama first as House Surgeon and then as Registrar. Ranade was confident that her work had been blameless and that there must be some other reason for why she was being laid off. Gilder did not, however, grant her audience. She wrote in her memoir that his office responded by saying that meeting him would be a fruitless activity. At the back of her mind Ranade thought she knew what the reason for her dismissal was: she had married a local Communist leader. While Gilder probably did not care about her relationship with a Communist, she believed, Bombay's Home Minister Morarji Desai most probably objected to having a Communist leader's spouse to be affiliated in any way with an institution of his government.[91] The termination letter Ranade received was an advance notice, but once Gilder refused to meet her, Ranade herself resigned and left Bombay to settle down in Poona (now known as Pune), gradually establishing herself as a popular private practitioner. Government service was not, anyway, her first choice: she was planning to set up private practice in Poona after getting her advanced M.D. degree,

[91] Soon after independence, the Communist Party of India alienated the Congress Party (now the ruling elites as against fellow anti-imperialists) through actions that "gave a sharp revolutionary angle to the party's public profile" and coincided with the party's role in industrial strikes in several parts of India. Hari Vasudevan, "Communism in India," in *The Cambridge History of Communism*, ed. Norman Naimark, Silvio Pons, and Sophie Quinn-Judge (New York: Cambridge University Press, 2017), 500.

but went to Cama only because her supervisor, the renowned Jewish Indian doctor Jerusha Jhirad, insisted on her working there.[92]

Even though Ranade's is an extreme example of non-professional intrusions in government-employed doctors' workplace, it helps understand the asymmetric power balance that characterized the relationship between powerful politicians and individual doctors, tilting strongly to the state's side. Having developed and flourished during the British colonial rule, the Indian medical profession was not unfamiliar with the phenomenon of a powerful, ever-looming state, and a major part of the twentieth century was indeed spent by Indian doctors agitating against the racially biased rules and regulations of the colonial Indian Medical Service (IMS).[93] Doctors had strong views about these power dynamics, especially the undermining of independence and autonomy that Ranade's case exemplified. Many of these views found an expression in December 1946, at the All-India Medical Conference organized by the IMA in Madura (now known as Madurai). Officially registered in 1928, the IMA was the most vocal and the largest organization of Indian biomedical doctors. Though the earliest medical societies in India cited academic discussions and knowledge-sharing as their primary objectives, the IMA was exclusively political in origin and activity. At the first All-India Medical Conference held in Calcutta in 1917, delegates discussed such issues as whether the organization of the medical profession in India was "normal, or pathological from neoplasm or microbes within, or from mechanical pressure without."[sic] The IMA was formed a decade later at the fourth such all-India conference. Compared to 222 members in 1929, the Association boasted

[92] Leela Gokhale (Ranade), *माझी गोष्ट [My Story]* (Mumbai: Mouj Prakashan, 2019): 132-146.

[93] For a striking example, see Chakrabarti, Pratik. "'Signs of the Times': Medicine and Nationhood in British India." *Osiris* 24 (2009): 188–211.

of more than 10,000 members by 1946 when the Madura conference was held.[94] This was the first conference after the publication of the Bhore report, and IMA president Capt. P.B. Mukerjee discussed the report in detail in his speech, praising it for "boldness, vision and lofty ideals." The only draw-back of the report, "if a draw-back it may be called, lies in its size." He said that the four volumes of the report were difficult to commit to by doctors who were "hardly in a position to snatch even a half hour from their busy practice to devote to socio-medical, medico-economic or medico-political studies."[95] This was not, of course, the only draw-back in the Bhore report for Mukerjee. As the later parts of his speech made clear, he found a fundamental ideological conflict between the medical profession's interests as he and many other doctors imagined, and some key recommendations of the Bhore Committee.

For doctors like Mukerjee, among the more contentious of the committee's recommendations was the proposal to base the healthcare services of India on the foundation of whole-time, state-employed, salaried medical practitioners and to prohibit these state-employed doctors from engaging in private practice. One reason to oppose this idea could have been a reluctance to give up what had become a convenient and profitable status quo for the medical profession in colonial India: doctors employed in the hospitals and dispensaries maintained by the colonial state were by convention (if not always by law) allowed to supplement their incomes through private practice.[96] To the Bhore Committee, this was an undesirable state of affairs. They wrote that following extensive surveys and conversations with medical and public health practitioners, they had come to believe that a freedom to engage in private practice

[94] Guha, "History and Progress of the Indian Medical Association."

[95] "XXIII All-India Medical Conference, Madura, 1946," *Journal of the Indian Medical Association* 16, no. 6 (March 1947): 189.

[96] Mukharji, *Nationalizing the Body*: 15-16.

generally resulted in "the more prosperous sections of the community" receiving greater medical attention than the poor. Besides, they envisaged the future state doctor carrying out both curative and preventive duties in the community, and if given the freedom of private practice, "it is almost certain that a doctor's preventive duties will not receive the attention which is essential."[97]

P.B. Mukerjee's opposition to the Bhore Committee's rationale on this issue, however, went beyond the desire to preserve the colonial-era status quo. For him, more fundamental principles were at stake with regard to what he termed a "regimentation" of the medical profession into a "State Service." He was apprehensive that the institution of a whole-time salaried service by the government might ultimately lead to the profession becoming a full-time "servant" of the government or local administrative authorities. He liberally and approvingly quoted the contemporaneous British Medical Association's arguments against salaried medical service for doctors: "Once the dividing line is passed and doctors are absorbed in a service which in effect makes them all employees of the central or local governments, their independence and professional freedom will come to an end... They will no longer have that direct responsibility to the patient which has hitherto been the inspiration of medicine and the mainspring of medical knowledge and ethics." At the same time, he was skeptical of the idea to "combine preventive and curative duties" in every medical officer of the state (that is, the concept of the "basic doctor" inspired in part by Sigerist's ideas). The way Mukerjee saw it, India's poor state of health services and other infrastructure, combined with high levels of ill health among people, made it almost impossible for physicians to even handle just the curative aspects of ill health: "I think that, for the present and for some years to come, a separate preventive health service will have to be maintained for providing undivided attention to and efficient discharge of what is

[97] *Report of the Health Survey and Development Committee*, vol. 2: 14-15.

now known as Public Health Work." Mukerjee was also not convinced that the problem of doctors devoting disproportionately more time and attention to paying patients than to poor patients, was as major an issue as the Bhore committee maintained it was. The "medical man knows that pathology affects the tissues of human beings, irrespective of their bank-balances... If there are exceptions, the right way of dealing with them would be to leave them to the good sense and disciplinary control of the profession and the Medical Councils." It was a bad idea to prohibit private practice also because, fundamentally, private practice was one of the medical profession's "most valued privileges and cherished rights."[98]

This impassioned plea to protect the right to private practice and professional independence was coming at a time when the dominant opinion in nationalist India on the cusp of freedom leaned toward state control and socialization of public services. Yet the plea was not odd from the perspective of the IMA and the medical profession. Even though in the initial decades of "Western" medical education the allure of jobs in the colonial state service stimulated many Indians to take training in medical schools and colleges, some doctors soon discovered better incomes when government service was combined with private practice, and often in solo private practice. Projit Mukharji and Mridula Ramanna, in their monographs on medicine in eastern and western India respectively, have outlined many instances of private practice by government-employed Indian doctors, especially in the later part of the nineteenth century.[99] Making a name for oneself as a private practitioner soon became an aspirational goal for doctors, an aspiration buttressed by the huge popularity of select practitioners in the big cities where young medical students received training and looked for role models. In Bombay, Bhau Daji was a prominent example. An 1855

[98] "XXIII All-India Medical Conference, Madura, 1946:" 191-4.

[99] Mukharji, *Nationalizing the Body*. Ramanna, *Western Medicine and Public Health in Colonial Bombay.*

Lancet issue described how he "had scarcely been appointed to one of these [government Sub-Assistant Surgeoncies], when he resigned, finding that his own industry and abilities were quite sufficient to command practice, without the help of adventitious aid. From this time his career has been one of such prosperity and success as probably none of our first English physicians could boast in any part of the first ten years of their professional lives… Two years since, he established a charitable dispensary, for supplying the poor gratuitously with medicine and advice."[100] In the early 1900s, some of the popular doctors in Madras city, like M.C. Nanjunda Rao, were "earning thousands" in their private practice, and also making an impression on young medical students.[101] By the early twentieth century the private medical profession in India had grown so much in size in the bigger cities that some provinces modified rules to disallow wealthier patients from accessing free medical treatment in public hospitals, ostensibly so that private Indian doctors would receive sufficient clients in their practice.[102] Even within the Bhore Committee itself, some of the members were popular private practitioners: B.C. Roy, U.B. Narayanrao, and R.A. Amesur.

While many Indian doctors seemed to cherish their right to engage in private practice, it is important to note that Mukerjee's interpretation of the Bhore report's ideas on private practice was not entirely accurate. A close reading of the report shows that the committee, despite their emphasis on social physicians, never envisaged a future without private medical practitioners or one in which all doctors were "regimented" into a state medical service. In this sense the report even differed from the earlier NPC subcommittee's report which imagined a medical organization under which private practice would

[100] "Sketch of an Indian Physician," *The Lancet* 65, no. 1637 (January 13, 1855): 48–49.

[101] S. Muthulakshmi Reddy, *Autobiography of Dr. (Mrs.) S. Muthulakshmi Reddy* (Madras: M.L.J. Press, 1965), 9.

[102] "Free Medical Treatment: New Policy Advised," *The Times of India*, March 3, 1913.

"gradually disappear."[103] In the Bhore committee's rationale, a government-controlled state medical service with whole-time salaried doctors was essential because most of India was poor, lived in the countryside, but all past efforts to settle doctors in the countryside had had little, if any, success. Without such a nationwide service of salaried doctors, they reasoned, the majority of Indians would not receive any medical care (clearly the already existing modes of care, including those from indigenous practitioners, were not considered desirable by the committee). These doctors were to be prohibited from engaging in private practice and were to devote all their working time toward preventive and curative health services. A full implementation by the state of their recommendations "will probably lead to the absorption into the public service of the *large majority* of existing doctors as well as of those who will be trained in the future. Further, *if* these services prove efficient and satisfactory to meet the needs of the people, it may be expected that the scope of activity for practitioners who, by choice, remain outside the State health services, will become limited to a section of the community consisting almost entirely of its wealthier members" [emphasis added].[104] In other words, the Bhore report's projection for private practitioners, even at a skeptical extreme, was that they would be outnumbered by government doctors and that they would have to limit their practice to well-to-do patients. Even this scenario was, as their choice of words makes clear, dependent upon a number of variables. So Mukerjee's concern that in the future medicine in India would become a "governmental department," was an exaggerated prediction. However, his critique is valuable in that it provides important insights into how members of the medical profession saw their relationship with the government, and into their impassioned commitment to autonomy and private enterprise. It was

[103] *National Health (Report of the sub-committee, National Planning Committee Series)*: 46.

[104] *Report of the Health Survey and Development Committee*, vol. 2: 14-16.

obvious that even though the post-independence state was about to enlist the medical profession as one of its chief allies in development efforts, doctors had their own (personal and professional) developmental ambitions, and were not always going to follow the paternalistic lead of a "trustee state."

As it turned out, after independence, the Bhore committee's lofty vision of having government-employed "social physicians" throughout the country, was pulled down to lower altitudes by ground realities. The success of that scheme, as the committee itself predicted, depended greatly on whether the government could implement the "expansion of health organization" as they had suggested. The expansion of healthcare infrastructure required funds, personnel, and attention, resources which were in short supply with the new post-independence government. While the committee members, during their deliberations in 1943-45, anticipated that India would gain political freedom in the near future, they could not anticipate the tremendous social upheaval and violence that would accompany it, in the form of Partition and the ensuing displacement of millions. These developments, and several military conflicts, consumed a substantial portion of independent India's resources during the first decade of independence. With Partition, the healthcare needs of displaced people and families fell on the new Ministry of Health, which got preoccupied with those arrangements. The state of tremendous flux in Indian politics and society in the immediate years after independence ended up waylaying many of the plans of the nationalist leaders, including the implementation of the Bhore committee's recommendations which, to begin with, had been considered to be highly resource-intensive.[105] Soon the Bhore report went from being a document that embodied an assertive new nation's ambitions, to representing its failures. One year after independence, in August 1948, an editorial in the *Times of India* lamented that the "low standard" of health in India was

[105] Jivraj Mehta, "India's Progress on the Health Front," *The Times of India*, August 15, 1949.

deplorable and that the "prolonged absence of any action on the recommendations of the Bhore committee" was "bewildering."[106]

Interestingly, the state also acknowledged these failures, with Jivraj Mehta, prominent nationalist leader and then Director General of Health Services (DGHS),[107] conceding in 1949 that "no one can be proud of the state of health in India, past or present." But he also maintained that the government was nevertheless working hard despite the "cramping limitations of Central and Provincial expenditure." He even mentioned what the state considered some of its successes in those two years. The Ministry of Health had done a commendable job in keeping the incidence of disease and epidemics low in the refugee camps set up across India, some of which housed people numbering in the thousands. Many of the displaced refugee doctors had been provided employment, and all displaced medical students (from what was now Pakistan) had been reallocated to medical colleges within India. Legislation had been passed for the regulation of the nursing, dentistry and pharmacy professions. The Employees State Insurance Scheme legislation had also been passed, thus paving the way for providing affordable health insurance to organized industrial and factory workers. Though the public health goals which the government wished to achieve were still far from total fruition, Mehta said that the government "had certainly made a beginning and a substantial beginning at that."[108]

Even as the state was busy making a beginning in its public health goals, doctors continued to pursue their own personal and professional goals. For most doctors these goals had little to do with the

[106] "National Health," *The Times of India*, August 29, 1948.

[107] The DGHS was the highest technical advisory position for medical matters in the Central government machinery.

[108] Jivraj Mehta, "India's Progress on the Health Front," *The Times of India*, August 15, 1949.

state's developmental objectives or with government service. The IMA conference at Madura had already indicated that there were serious issues of friction between the state's expectations and the medical profession's ambitions. This friction was most marked in the long-standing problem of encouraging doctors to live and practice in rural areas. For the state, making biomedicine and doctors accessible to India's villagers was a highly important goal, and the Bhore Committee had outlined an institutional structure for fulfilling that goal: primary health units helmed by salaried "basic doctors" and staffed by other "ancillary" personnel. However, for the majority of doctors, the prospect of government service or rural practice did not contain any special appeal. This was evident even to ther Bhore Committee. In the mid-1940s, their estimates put the total number of doctors at more than 47,000, out of which "only about 13,000 are reported to be on the staff of medical institutions maintained by Governments and other agencies." In other words, more than 80% of doctors in India were in private practice, most in urban areas. The committee mentioned the example of Bengal, where there were 3 and a half times as many doctors in urban areas as in rural areas.[109]

A 1951 article by U.B. Narayanrao distilled well the attitudes of doctors toward working in villages. Narayanrao was a senior private practitioner in Bombay, former president of the All India Licentiates' Association, and had been on the Bhore Committee as a representative of licentiate doctors. He deplored the constant appeals of "go to the villages" that were being "dinned into the ears of the medical profession, in season and out of season, both by our leaders - medical and lay - as well as our government." Though there were tens of thousands of medical practitioners throughout the country, the concentration of most of them in cities and towns had created "poverty amidst plenty." But he did not

[109] *Report of the Health Survey and Development Committee*, vol. 1: 13-14.

believe that doctors were going to be induced to go work in villages simply by appealing to high ideals and to the medical profession's "missionary" spirit. The high costs of medical education meant that "only the rich and middle-class persons" could afford medical education. Doctors from neither of these groups were likely to go to villages: the rich because they could afford to specialize and remain in cities, the middle-classes because they could not afford to risk an uncertain practice in a village setting when they had families to maintain and debts to repay.[110] Besides, the generally privileged socio-economic profile of doctors meant that they either originally hailed from urban regions, or had families and friends in cities, either scenario equipping them with connections and resources that could be mobilized and utilized when the time came to set up practice in the city. For example, when Leela Ranade left Bombay for Poona after being forced to resign from her Bombay-based public employment, her father-in-law, a Poona native, promised her all the assistance he could provide in helping build a clinic for her practice, and within a few years she had her own clinic. She was also able to start a consulting outpatient practice in some rooms of a building owned by her in-laws as she waited for her clinic to be established.[111]

In his article Narayanrao also made the point that many villagers already had someone from whom to take medical advice, and these practitioners were "cheap, easily available," and enjoyed their faith: if the city-trained doctor went there, they would most probably be considered an "intruder." Then there were the "educational and psychological" backgrounds of new medical graduates, which were shaped by such factors as their training in big cities and well-equipped hospitals, being taught by specialists who imparted more "academic than vocational" training, being rarely exposed to the preventive and health-promoting

[110] U. B. Narayan Rao, "Problems of Rural Medical Relief in India. Poverty Amidst Plenty," *The Indian Medical Gazette* 86, no. 3 (March 1951): 105–10.

[111] Gokhale (Ranade), *माझी गोष्ट [My Story]*: 146-47.

aspects of medical science, and nurturing ambitions to become a "flourishing practitioner" like the city-based seniors of their profession. If the graduate were asked to go to villages straightaway,[112]

> he will feel like fish out of water. The environmental change will make him feel like the lonely Alexander Selkirk.[113] All his ambitions of becoming great and prosperous will be shattered. He draws a very gloomy picture of his future. He will have no facilities for higher studies or bringing his knowledge up to date, no social amenities, and education of his children will be difficult... To add to all these drawbacks, he has not got that self-confidence required for independent practice, divorced as it will be from all the hospital and consultation facilities that he was used to.

Rao's predictions came largely true. Even though the Kaur-led Ministry of Health invested heavily in medical colleges and raised the number of doctors in India, a large majority of them preferred metropolitan domicile. In 1959, P.C. Mahalanobis, one of the more prominent members of the government's Planning Commission,[114] remarked that the Bhore Committee had proposed a long-term program "most of which still remains unimplemented." Out of some 70,000 doctors registered in India then, less than 10,000, or around 14%, were in rural areas (the rural population distribution in the 1961 census was nearly 82%). Since "doctors and drugs are extremely scarce," large inequalities in access to medical services plagued the country. In Mahalanobis's mind, there was one solution which could be tried, but he seemed to be choosing his words carefully, since that solution had already been rejected by most of the wise members of the Bhore Committee more than a decade ago. He believed that India could "reintroduce training extending over, say 3 years for a junior type of doctor" who would be "prepared to serve in villages" for a modest allowance and a qualified permission to engage in private practice. His

[112] Rao, "Problems of Rural Medical Relief in India. Poverty Amidst Plenty."

[113] Selkirk (1676-1721) was a Scottish sailor who was the prototype of the marooned traveler in Daniel Defoe's novel Robinson Crusoe. The Editors of Encyclopaedia Britannica, "Alexander Selkirk," *Encyclopedia Britannica*, accessed January 13, 2022.

[114] The Planning Commission, as an advisory body to the Government of India, was created in 1950.

calculations showed that it would be five times cheaper to "train and maintain" a junior doctor. Clearly referring to the lofty ambitions of the early years of independence, he noted: "Junior medical schools were abolished after independence on the view that our countrymen cannot be allowed to have anything less than the best. And yet to provide a sufficient number of university trained doctors and adequate hospital and medical services upto the standard of the rich countries of the world is absolutely impossible at present."[115]

This acknowledgment by a prominent representative of the government indicated that the "trustee" state had blinked: it was beginning to accept that it could not persuade most of India's doctors to go work in villages. At the same time, the generally lower levels of investments in basic rural infrastructure and healthcare services, and the differentials between states in such investments, meant that governments probably were also not adequately prepared to make rural service mandatory and guarantee proper employment for all graduating doctors under such a mandate. In the early years after independence, thus, the relationship between the state and the medical profession was characterized by a contradictory asymmetry wherein the state, despite being considerably more powerful, conceded substantially to the profession and at the same time failed in extracting from the profession any major concession. Nevertheless, the proposed solution of training and employing "junior doctors" suggested that even though the state was backing down on its promise to India's villagers of providing "proper" doctors, it was still intent on making the benefits of biomedicine (the "proper" kind of medicine for a modern nation) available to them. In any event, the licentiate (or the "junior doctor") system was not revived, and has never

[115] P. C. Mahalanobis, "Next Steps in Planning," *Sankhyā: The Indian Journal of Statistics (1933-1960)* 22, no. 1/2 (1960): 143–72. It should be noted that the Bhore Committee did suggest increasing the numbers of auxiliary health workers, and also had remarked that licentiate doctors did not necessarily work and settle in villages.

been revived despite regular calls for its reinstatement.[116] But Mahalanobis's speech makes it clear that the state was still firmly of the belief that biomedicine, and some version of the biomedical doctor (even if "junior"), were the best modalities of healthcare for the people of India. As subsequent chapters will show, this conviction of the state also itself underwent constant revisions with time, and governments both federal and state frequently altered the terms of what they considered adequate healthcare for India's rural populace.

Conclusion: People's Health in Elite Hands[117]

This chapter primarily explains how the early post-independence state in India enlisted doctors as among the most valued allies in its developmental ambitions, entrusting them with the job of going to all corners of the country and improving the health of the people. Through this action the state, being a " full-time trustee for its people," indirectly struck a contract between the public and the medical profession. This paternalistic action seemed natural to the Indian National Congress (INC) which "claimed to represent all Indian people since its transformation from a club of Western-educated elites to a mass movement under Gandhi."[118] The INC was composed almost entirely of socio-economically elite individuals, and the "elite's view of the truth of the political world would become the state's view."[119] In

[116] I will discuss this issue in more detail in Chapter 3.

[117] This phrasing is inspired by the title of a book published by two public health activists in the 1990s: N. H. Antia and Kavita Bhatia, *People's Health in People's Hands: Indian Experiences in Decentralized Health Care, a Model for Health in Panchayati Raj* (Foundation for Research in Community Health, 1993).

[118] Anand Teltumbde, *Republic Of Caste: Thinking Equality in the Time Of Neoliberal Hindutva* (New Delhi: Navayana Publishing Pvt Ltd, 2018), (Location 601, Kindle edition).

[119] Sudipta Kaviraj, *The Imaginary Institution of India: Politics and Ideas* (Columbia University Press, 2010), 23.

this political decision to engage biomedical doctors as the "country's doctors," the state was aided by the seemingly apolitical domain of technical expertise in the form of the Bhore report. The aura of veneration which surrounded the report in the early years of independence, coupled with the Bhore Committee's own rhetoric (for example, that the report spoke for the "tiller of the soil"), worked to the favor of the developmental state, which found it easier to legitimize its decisions by citing the wisdom of the august members of the committee.

While the state used the Bhore report to mediate between the public and the medical profession, I suggest that the profession also used the report to mediate between the state and the public, written as it was by a committee in which elite biomedical doctors and researchers dominated, including the foreign doctors whose inputs were especially valued. The most important outcome of this double mediation was that biomedicine and biomedical doctors came to be nominated by the developmental state, with little opposition, as the trustees of the health of the Indian people. At the moment of independence, biomedical doctors had no competition in the corridors of power in India.[120] While in the colonial period biomedicine remained in the fringes of the lives of most Indians, the activities of the interventionist developmental state in the post-independence decades made it possible, even if often very gradually, for more and more people to encounter biomedicine and its doctors. However, although political leaders and their elite associates considered these to be significant changes, with the state transforming itself from a foreign "firefighter" entity into an Indian "trustee" one, the majority of the public experienced these developments—as subsequent chapters will show—less as change and more as continuity.

[120] They did have plenty of competition on the streets of India, as I will show in Chapter 2.

2. ELITE WITHOUT HEGEMONY

In the book *Decolonizing International Health*, historian Sunil Amrith mentions a moving story of an Indian doctor, Kamala Ghosh, who briefly corresponded with the physician-historian Henry Sigerist in the early 1940s. Ghosh was a member of the Women's Medical Service and had worked at hospitals for women and children in different parts of India. She got to meet Sigersit in person on a visit to the United States while on leave. She expressed an interest in his books and the idea of socialized medicine, and said she aimed to work on medical relief and healthcare planning when back in India. Clearly, Ghosh nurtured an ambition to incorporate Sigerist's ideas and insights into the policy discourse in her home country. On her way back, war conditions [the Second World War] forced her to travel in an oil tanker as a medical officer. According to a contemporary radio broadcast, she said (presumably to an interviewer) that she was first and foremost a doctor and "refused to say anything about her adventures." Unfortunately, before she could reach India, enemy fire destroyed the tanker, and the promising doctor died at sea.[1]

Had Ghosh lived and returned to India, it is likely she would have worked in the countryside and aspired to practice as, in the Bhore Committee's words, a "basic doctor"—an idea inspired in part by Henry Sigerist's writings on the "social physician" as I discussed in the preceding chapter. While this might have earned her the approval of the developmental Indian state and of many of the country's modernizing political and medical leaders, it is pertinent to ask at this point what the people of India themselves thought about the prospects of having biomedical doctors in their midst. Were people as unequivocally enthusiastic about receiving care from doctors as the Indian state and the Bhore Committee imagined them to be? What were people's general experiences with and perceptions of doctors, and how did those differ with

[1] Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65* (Palgrave Macmillan, 2006), 58-59.

differing socioeconomic backgrounds, especially considering that most doctors in India came from a relatively uniform, privileged-caste background (as discussed in the Introduction chapter)? These are the major questions I will explore in the present chapter.

When I began this research project in 2016, I was following a question which many in India were asking at that time: Why is public trust in doctors so low? This question was often accompanied by the claim that "in the past" the biomedical profession enjoyed considerable respect and trust. Such claims became common in the 1990s when the profession was shaken by the application of the Consumer Protection Act[2] to the patient-doctor encounter and when doctors began to write wistfully about "the past"—which in most writings was a vaguely defined period prior to the 1980s—characterizing it as one in which patients used to treat doctors "as gods."[3] In some such narratives, this was a "golden era" for the medical profession and the patient-doctor relationship, marked by high levels of trust between people and doctors.[4] This chapter therefore commences not only my historical inquiry into people's experiences and perceptions of doctors, but also my assessment of the claims of present-day doctors regarding the trajectory of public perceptions.

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[2] The Consumer Protection Act of 1986, and more importantly a 1995 Supreme Court judgment on it, recognized the patient-doctor encounter as a commercial transaction in which patients could, in most contexts, lawfully sue doctors and hospitals in specially-formed Consumer Courts/Forums. I will discuss these developments in detail in Chapter 5. See Arun Bal, "Consumer Protection Act and Medical Profession," *Economic and Political Weekly* 28, no. 11 (1993): 432–35.

[3] Atul K. Agrawal, "Correspondence: Medical Maladies," *The National Medical Journal of India* 7, no. 6 (1994): 305. I frequently came across this characterization throughout my medical training and later practice. The divine parallel exists in the discourse of many patients too. Anthropologist Aditya Bharadwaj was told by a patient in the early 2000s: "... previously I remember 20 years back we use to think God is, I mean doctor and God together you know, doctor used to be the God...." Aditya Bharadwaj, "Sacred Conceptions: Clinical Theodicies, Uncertain Science, And Technologies Of Procreation In India," *Culture, Medicine and Psychiatry* 30, no. 4 (December 1, 2006): 451–65.

[4] Suresh K Pandey and Vidushi Sharma, "July 1 Is National Doctors' Day: How to Regain the Lost Public Trust in Healthcare?," *Indian Journal of Ophthalmology* 66, no. 7 (July 2018): 1045–46. See also Chapter 5.

Reading Between and Beyond the Archival Shelves

A cursory look at the conventional archives indeed provides a sense of the existence of a "golden era" in the 1950s-60s, as imagined by later doctors. The mainstream medical and public discourse is characterized by, for example, a regular use of the phrase "noble profession" to denote doctors and their calling. The phrase was commonly employed by doctors in their writings and in addresses to students and new graduates.[5] Politicians and journalists often invoked the phrase, especially when discussing the importance of doctors in improving healthcare in rural areas and for marginalized communities. In 1952, while addressing a conference of the Association of Otolaryngologists of India, a provincial health minister said that it was important to "bring this noble profession closer to the people, to enable them to know it better and appreciate its important role in the making of new India."[6] In a convocation address in 1954 to young post-graduates, S.L. Bhatia, former Dean of Bombay's Grant Medical College, told them that they were entering the "noblest" of all professions.[7] Even today, senior physicians invoke similar sentiments when referring to the social and professional aspects of the early years of their career. For example, prominent Chennai physician M.K. Mani (nearing age 90 now) recently wrote that "in the early years after Independence, medicine was regarded as a good profession [and] doctors were respected and well paid."[8]

[5] Almost all major speeches by doctors at the Indian Medical Association's annual conferences invoked the "noble profession" label; e.g., B.V. Mulay, "Welcome Address - XXVII All-India Medical Conference, Sholapur, 1950," *Journal of the Indian Medical Association* 20, no. 5 (February 1951).

[6] P. V. Cherian and L. Hiranandani, "Association Notes," *Indian Journal of Otolaryngology* 5, no. 1 (March 1, 1953): 28–40.

[7] S. L. Bhatia, "Convocation Address at the College of Physicians and Surgeons of Bombay," *The Indian Medical Gazette* 89, no. 5 (May 1954): 308–11.

[8] M.K. Mani, "Corruption in Everyday Medical Practice," in *Healers or Predators?: Healthcare Corruption in India*, ed. Samiran Nundy, Keshav Desiraju, and Sanjay Nagral (Oxford University Press, 2018).

Apart from such discourse, the portrayal of doctors in popular culture also generally upheld the positive public image of the profession, as I will explore in detail later in this chapter.

But it is important to note that these conventional archival sources privilege the voices of doctors and other elites (newspaper editors, journalists, filmmakers, authors, etc.). As I will discuss further in the chapter, individuals from these groups shared similarly elite caste and class status, as well as championed many aspects of the early post-independence ("Nehruvian") state's vision of and commitment to modernization.[9] Looking at additional, parallel sources from this period, on the other hand, reveals a complex and hitherto unexplored picture of how the non-elite public, several times more numerous even if several times less powerful, approached and experienced their encounters with doctors.

To recover such lesser known perceptions and attitudes of the public, I have followed the lead of historians who have argued that the history of medicine is incomplete without consideration of the voices of the multiple actors and interests involved in the medical encounter. Erwin Ackerknecht, citing some prominent examples of how what doctors actually did on the ground was often different from what they said in their writings, urged for a "behaviorist approach" in medical history.[10] Though he was writing about the clinical aspects of medicine, I have attempted in this chapter to apply the behaviorist approach to the interpersonal aspects of medical encounters also. I have refrained from taking at face value the social promises and claims that doctors made in their writings, and wherever applicable, have attempted to

[9] See, for example, Sudipta Kaviraj, "On State, Society and Discourse in India," in *The Imaginary Institution of India: Politics and Ideas* (Columbia University Press, 2010). A more dramatic example is a 1967 documentary film made by the Government of India's Films Division, featuring young Indians from elite backgrounds expressing their ideas and beliefs, in which one can discern a heavy influence of the post-independence developmental and modernist rhetoric: S.N.S. Sastry, *I Am 20* (Films Division of India, 1967), https://youtu.be/fA8h74ZW8Ok.

[10] Erwin H. Ackerknecht, "A Plea for a 'Behaviorist' Approach in Writing the History of Medicine," *Journal of the History of Medicine and Allied Sciences* 22, no. 3 (July 1967): 211–14.

investigate their application on the ground. In 1985, urging historians to do medical history "from below," Roy Porter argued that it "ought centrally to be about the two-way encounters between doctors and patients," adding also that the encounters often took "more than two, because medical events have frequently been complex social rituals involving family and community as well…"[11] This is an important point because, as will become clear below, people's perceptions of care providers in India were frequently filtered through social and cultural norms (including especially caste). I also follow the lead of Nancy Tomes whose exploration of the historical trajectory of the "American patient" in the twentieth century made her caution against the "golden age" narrative in traditional U.S. histories of medicine: "a deeper look soon demonstrates that these supposedly golden years were hardly so quiet."[12]

Before I delve into the non-mainstream and non-medical archives, it is worth noting that even a careful reading of some of the conventional sources can at times be illuminating. Although in the early post-independence years doctors enjoyed substantial political and administrative support, in at least some medical journal articles we witness doctors refraining from painting an unabashedly optimistic and self-congratulatory picture (something which many later doctors engaged in, as I will show in Chapter 5). Some doctors, for example, approached the rhetoric of "noble profession" with caution. U.B. Narayanrao, a practicing physician who had been on the Bhore Committee, was openly skeptical of such exhortations. He wrote in 1951 that "Go to the villages, you medicos" and "Yours is a noble profession" were "slogans" and misguided appeals which only led to the neglect of more radical and structural changes in healthcare

[11] Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory and Society* 14, no. 2 (1985): 175–98.

[12] Nancy Tomes, *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers*, (Chapel Hill: The University of North Carolina Press, 2016), 3.

delivery.[13] In Narayanrao's view, the medical profession was termed noble by politicians and others less in recognition of and more in expectation of laudable deeds. Some doctors were also acutely aware of the instability and volatility of public trust in them. Chamanlal Mehta, President of the IMA, appealed to doctors in 1950 "to resolve to serve the people... and thus bring back to the profession, the dignity, trust, and love of the people *once enjoyed* by it."[14] [emphasis added] Another senior doctor in 1954 compared unfavorably the social status of doctors then with what he remembered from his early days of practice: "It has become a common comment nowadays that we have become costly, apathetic and parasitic. I remember in my young years... we were respected as angels and now quite the reverse has happened."[15] Clearly, some doctors even during the "golden age" were cautious of making any sweeping claims about public attitudes toward the profession.

This caution in the writings of contemporaneous doctors helps set the stage for the analysis of public perceptions which occupies the rest of the chapter. Primary sources conveying the direct voices of patients and the public from this period are rare, but there exist several surrogate sources in which we can discern people's attitudes toward doctors and biomedicine. Important among these are newspaper reports and articles, speeches by political representatives, popular media like film, and survey and ethnographic observations by anthropologists and sociologists. The use of such sources also implies that the voices of patients I discuss in this chapter are voices which were filtered, distilled, even modified, by elite scholars,

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[13] U. B. Narayan Rao, "Problems of Rural Medical Relief in India. Poverty Amidst Plenty," *The Indian Medical Gazette* 86, no. 3 (March 1951): 105–10.

[14] Quoted in T.N. Banerjee, "Presidential Address - XXVII All-India Medical Conference, Sholapur, 1950," *Journal of the Indian Medical Association* 20, no. 5 (February 1951), 189.

[15] Sain Das Vohra, "XXIII Punjab Provincial Medical Conference, Jagadhri (President's Address)," *Journal of the Indian Medical Association* 23, no. 5 (February 1954).

journalists and other actors. However, I have attempted to analyze them by taking into account this filtration and the power asymmetries involved. Together, these additional sources showcase a picture of the patient-doctor encounter in early post-independence India which is fuller and more complex than what present day accounts portray. (It is important to note that some regions of India, mainly the northeastern states and the regions of Jammu, Kashmir and Ladakh, are under-represented in my sources and hence in my analysis.)

The rest of the chapter consists of five sections. In the first and second, I discuss people's experiences of and attitudes toward doctors and biomedicine in rural and urban regions respectively. In the third I delve deeper into people's experiences by revealing the caste-based hierarchies and prejudices which frequently undergirded the patient-doctor encounter. In these three sections, I primarily focus on the underprivileged public of India. In the fourth section I discuss the perceptions and attitudes of the influential urban elites, using popular Hindi-Urdu films (Bollywood cinema) as a broadly representative source. Finally, in the concluding section, I bring all these analyses together and attempt to provide a more comprehensive understanding of the patient-doctor encounter and of people's perceptions of doctors in the early post-independence decades.

Medicine Beyond the Metropolis

Broadly speaking, public attitudes toward biomedicine developed differently in India's urban regions as compared to villages. There are many potential reasons for this differential. Cities, as "symbols of the uneven, hectic and contradictory character of the nation's modern life" since the nineteenth century,

witnessed vastly different changes from the rest of the country.[16] Residents of the bigger cities in British India became acquainted with modern science and biomedicine earlier than those of the towns and villages, primarily through hospitals and medical colleges which largely remained concentrated in urban India even in the late colonial and the early post-colonial periods. The majority of Indians who studied medicine at British Indian institutions chose either to work at government medical centers (concentrated mostly in cities and district headquarters), or to establish private practice in cities and large towns (e.g., Bhau Daji's popular practice in Bombay, mentioned in Chapter 1). It was only in the later decades of the nineteenth century that the colonial government encouraged the opening of dispensaries in smaller towns and villages, and at the same time undertook country-wide vaccination campaigns. So for many villagers, what marked their initial contact with biomedicine were out-patient dispensaries and public health activities like smallpox vaccination.[17] Both of these arguably were not as awe-inducing as the elaborate rituals of in-patient hospital care and emergency surgery which dominated the initial contact of urban Indians with modern medicine. Besides, city-dwellers, already accustomed to the presence of industrial equipment and modern means of transportation, were probably quicker than rural Indians to adapt to modern therapies and procedures. Considering these broad differences between the urban and rural regions, which did not radically change even after independence, it will be useful to look at patient-doctor encounters separately for these regions. This binary was indeed not always sharp (for example, when elites in villages went to city

[16] Sunil Khilnani, *The Idea of India* (Macmillan, 1999), 11.

[17] For a history of dispensaries and doctors in rural Bengal, see Projit Bihari Mukharji, "Structuring Plurality: Locality, Caste, Class and Ethnicity in Nineteenth-Century Bengali Dispensaries," *Health and History* 9, no. 1 (2007). Jennerian smallpox vaccination had begun to reach the countryside as early as the first half of the nineteenth century. See S. Bhattacharya, M. Harrison, and M. Worboys, "Competing Paradigms, Uncertain Outcomes: The Troubled Origins of Smallpox Vaccination in British India, 1800-1900," in *Fractured States: Smallpox, Public Health and Vaccination Policy in British India, 1800-1947* (Hyderabad: Orient Longman India, 2005), 14–75.

hospitals for treatment, or when we take into account the towns, villages, and other remote regions of India where Christian medical missions had begun providing medical care since the mid- to late-1800s[18]), but it is a useful heuristic distinction for the current discussion.

In the later decades of the colonial period, the broad rural-urban differences in healthcare in India came to be increasingly highlighted by Indian doctors as well as nationalists.[19] In 1931 Bombay-based doctor A.P. Pillay authored a monograph titled "Welfare Problems in Rural India." Cities, he wrote, were "on the whole sufficiently well provided so far as medical and maternity relief and proper sanitary measures are concerned," but rural areas were not. As an example, he mentioned the Sholapur district in western India, where there were only seven dispensaries for 700 villages with a total population of 600,000 persons.[20] Later the Bhore report mentioned several instances of "unsatisfactory" health services and "insanitary" conditions in villages, including the large discrepancies in the distribution of doctors in rural and urban India.[21] However, it must be noted that many of India's villages had indeed experienced some contact with biomedicine during the colonial period. In this respect, Khilnani's point about the pan-India reach of urban ideas and artifacts is helpful: "Only a fragment of India's population has direct access to the cities, but images of them have spread throughout the society and have fired the imagination of all Indians."[22] In the early twentieth century, such images included those of hospitals and therapeutics like

[18] See, for example, David Hardiman, *Missionaries and Their Medicine: A Christian Modernity for Tribal India* (Manchester ; New York : New York, NY: Manchester University Press, 2008).

[19] Amrith, *Decolonizing International Health*, 21-46.

[20] A.P. Pillay, *Welfare Problems in Rural India* (Bombay: D.B. Taraporevala Sons & Co., 1931), 17.

[21] Joseph Bhore et al., "A Brief Survey of the State of Public Health," in *Report of the Health Survey and Development Committee*, vol. 1 (New Delhi: Manager of Publications, 1946).

[22] Khilnani, *The Idea of India*, 12.

modern surgery: for example, cataract surgery had become "immensely popular" among rural communities in northern India, with villagers seasonally going to Delhi to get their cataracts removed.[23] In other words, as the Indian countryside entered the post-independence period, it was far from a tabula rasa for the developmental state's healthcare actions.

Anthropologists and other social scientists studying different rural regions of the country during this time reported a similar familiarity with biomedicine, although this familiarity did not necessarily translate into preference. During the early 1950s, anthropologist McKim Marriott observed that villagers were aware of biomedicine, and sometimes even sought it; however, it was not their most common or most sought-after medical relief avenue: "indigenous village medical services are overwhelmingly preferred to western medicine." (He used the term "indigenous practitioners" to refer not only to Unani and Ayurvedic physicians, but also other traditional practitioners, or "folk healers,"[24] that characterized rural society in India). He wrote: "in the lives of most villagers, [biomedical] clinics serve as momentary stopping places on the sick man's pilgrimage from one indigenous practitioner to another, and hospitals serve all too frequently as last resorts of the dying."[25] In a village in the southern Indian state of Hyderabad, sociologist S.C. Dube noted that the local biomedical dispensary was utilized only occasionally, "for want of proper equipment and a qualified medical practitioner," and that "magic and divination" were utilized "to a

[23] Samiksha Sehrawat, "Popularity of Eye Surgery and Problems of Colonial Hospital Finance in Delhi," in *Colonial Medical Care in North India* (Delhi: Oxford University Press, 2013).

[24] For an overview of such "subaltern" therapeutics, see David Hardiman and Projit Bihari Mukharji, *Medical Marginality in South Asia: Situating Subaltern Therapeutics* (Routledge, 2013).

[25] McKim Marriot, "Western Medicine in a Village of Northern India," in *Health, Culture, and Community*, ed. Benjamin D. Paul (Russell Sage Foundation, 1955).

considerable extent" by the people.[26] Similar observations were made by anthropologist F.G. Bailey in a village in Orissa (eastern India). The dispensary was not in the village, but eight miles away, and few villagers went there. Even within the village, there was "not a great demand" for doctors, especially as the "field of curing [was] largely a ritual field and the market for secular specialists [was] limited."[27] During a survey of villages in western India in 1952-53, Y.B. Damle was told by the doctor at the local public dispensary that in his opinion only 20% of the villagers came to him for treatment.[28] People considered several ailments to be out of the ambit of doctors, and many also believed that doctors and biomedicine were powerless in the event of illnesses which traditionally were associated with enraged deities and gods. In a northern Indian village, anthropologist D.N. Majumdar observed that villagers bribed the government smallpox vaccinators to spare their kids from the shots, as they believed that as they believed that the goddess Sitala (whose wrath was considered to be the cause behind smallpox epidemics) was too powerful for such medical men. For problems like convulsions and epilepsy, they primarily went to the local healers known as ojhas.[29] In the southern Indian town where Dube conducted his research, villagers often said: "Where herbs and medicines do not work, proper chants and spells do not fail us."[30]

There was thus an important overlooked aspect looming behind the ambitious objectives of the new Indian state to bring biomedicine to rural India. The government, and the urban elite in general,

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[26] S.C. Dube, Indian Village (London: Routledge and Kegan Paul Ltd., 1955), 26.

[27] F. G. Bailey, *Caste and the Economic Frontier: A Village in Highland Orissa* (Manchester: Manchester University Press, 1957), pp 113-14.

[28] Y. B. Damle, "Communication of Modern Ideas and Knowledge in Indian Villages," *Public Opinion Quarterly* 20, no. 1 (January 1, 1956): 257–70.

[29] D.N. Majumdar, *Caste and Communication in an Indian Village* (Bombay: Asia Publishing House, 1958), p 285.

[30] S.C. Dube, *Indian Village*, p 26.

seemed to believe that once modern medical facilities were instituted in villages, villagers would simply start using them and preferring them over all their existing avenues of care. This belief in the universality and superiority of modern science, coupled with a dismissive attitude towards older traditions, was characteristic of modernizing English-educated elites, nationalists, and planners. Political theorist Sudipta Kaviraj finds these attitudes to be crucial in the early conceptions of democracy and constitutionalism in the country, which borrowed heavily from the European Enlightenment ideas and from contemporary international discourse. In Kaviraj's view, it seems in retrospect that the nationalists, including Nehru, "were wrong to disregard tradition entirely, taking the typical Enlightenment view of treating those ideas and practices as 'erroneous.' They also wrongly believed that to rescue people from tradition, their intellectual and practical habitus, all that was needed was simply to present a modern option; peoples' inherent rationality would do the rest."[31]

These retrospective insights of Kaviraj were experienced first-hand by social scientists during this time. When physician-anthropologist GM Carstairs surveyed a Rajasthan village in the early 1950s, for instance, he spent several months running an intermittent "dispensary practice," and soon realized that his therapies were only one of several sorts of healing used by residents there, and "by no means the most popular."[32] Pitted against the existing forms of healing, Carstairs said his modern method "carried no such aura of conviction" for the people.[33] Marriott, during his survey, invited an English physician to set up a temporary practice for one week. While his services were indeed used by people, Marriott was surprised to

[31] Sudipta Kaviraj, "Modernity and Politics in India," *Daedalus* 129, no. 1 (2000): 137–62.

[32] G. Morris Carstairs, "Medicine and Faith in Rural Rajasthan," in *Health, Culture, and Community*, ed. Benjamin D. Paul (Russell Sage Foundation, 1955).

[33] Carstairs, "Medicine and Faith in Rural Rajasthan," 112.

see that after the doctor's departure, "nearly all of those few persons who had begun his treatments soon fell back upon their indigenous practices and practitioners [instead of actively seeking it in nearby villages and towns]."[34] Rural Indians in general were, thus, not as enthusiastic about biomedicine and public health as the country's modernizing planners, including the Bhore Committee, would have wanted them to be. Their overwhelming response to biomedicine can probably be summarized in one word: nonchalance.

Some villagers, however, found appeal in certain aspects of biomedicine and public health. Those who lived closer to large towns or cities were more likely to try out modern therapeutics and even begin to express confidence in their healing powers. The village which Majumdar surveyed was around eight miles from the large city of Lucknow. He noted that at least one resident was looking more favorably toward biomedicine: "[He] is convinced that the local [traditional healers] are not so effective in treating diseases as the city doctors are. He preferred an injection to an offering made to propitiate the gods. He praised the Public Health Staff who occasionally visited the village to clean drains and disinfect wells." The residents also showed a liking for one particular city-based doctor who occasionally visited the village: this doctor had a "soft corner" for the villagers, since his family had strong ties with the village.[35] Anthropologists Morris E. Opler and Rudra Datt Singh noted that there was a popular practitioner of biomedicine in a village close to the one they were studying. This person previously was a compounder in the Indian National Army of Subhas Chandra Bose, and was now applying the knowledge he gained there to treat

[34] Marriott, "Western Medicine in a Village of Northern India."

[35] Majumdar, *Caste and Communication in an Indian Village*, p 322.

villagers, who "were developing a faith in him and his system of medicine."[36] (Anthropologist Sarah Pinto observed the presence of such practitioners in the early 2000s in northern India, and refers to them as "ersatz": they straddle permeable medical and public health-related institutional boundaries, and are characterized by self-made medical authority and absence of official certification.[37]) Dube also noted that some villagers were choosing to visit biomedical facilities in the cities of Hyderabad and Secunderabad.[38] In what appears to be an outlier, but nevertheless noteworthy, observation, Kamla Nath found that women in a Punjab village would often consult a private physician in a nearby town, and that some of them kept medicines such as Anacin and tincture iodine at home, for use in minor ailments. Visits to the doctor were so common that one of her informants said, "We go to the doctor, even when a thorn pricks us."[39] The comfort with biomedicine in this region could have been a result of, among other things, the familiarity of the village with modern technology in general. As Nath writes, the village had electricity (uncommon for Indian villages during this time), much of the cropped area was irrigated with electric motors, and the villagers utilized chemical fertilizers and "improved" seeds and implements.[40] Since the village was in the region of Punjab, known for providing a large number of soldiers to the Indian military (in the colonial period as well as later), it is also likely that a familiarity with and experience of biomedicine through the military contributed to their perceptions.

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[36] Morris E. Opler and Rudra Datt Singh, "Economic, Political and Social Change in a Village of North Central India," *Human Organization* 11, no. 2 (1952): 5–12.
[37] Sarah Pinto, "Development without Institutions: Ersatz Medicine and the Politics of Everyday Life in Rural North India," *Cultural Anthropology* 19, no. 3 (August 1, 2004): 337–64.

[38] Dube, *Indian Village*, pp 26-27.

[39] Kamla Nath, "Women in the New Village," *Economic and Political Weekly* 17, no. 20 (May 15, 1965): 813-816.

[40] *Ibid*.

Among those who did avail of biomedicine, scholars observed that persons from privileged castes were disproportionately more numerous. Opler and Singh wrote that "those of the higher castes often go to [biomedical centers in the city of] Benaras for medical attention."[41] There was a local formally qualified biomedical doctor in the Bengal village which Gourang Chattopadhyay studied, and eight privileged caste families "regularly gave calls" to him, that is, requested him to come for home visits, though this luxury could not be afforded by most other residents.[42] Such caste-based discrepancy in access was mostly of socioeconomic rather than cultural origin (that is, it cannot be explained away by saying that underprivileged-caste communities did not believe in modern science/medicine, or that they gave "no importance to health matters"[43]). For example, in many villages, visiting a doctor almost always involved some sort of financial transaction: even if a dispensary or a private doctor offered services for free, many persons from marginalized communities believed that they would not be seen there, and when seen, they felt obliged to pay some fees.[44] Underprivileged-caste villagers might also have faced casteist obstacles in proper access and treatment: doctors and other staff being dismissive and insulting, or other residents of the villages barring them from accessing the health centers.[45] Besides, rural dispensaries were often stocked with little to no medicines, and some doctors ignored their dispensary duties in favor of private practice in

[41] Opler and Singh, "Economic, Political and Social Change in a Village of North Central India."

[42] Gourang Chattopadhyay, *Ranjana: A Village in West Bengal* (Calcutta: Bookland Private Limited, 1964), 191.

[43] This explanation was given to explain the low attendance of Dalit and Adivasi patients at a governemnt hospital, in Madhu Nagla, *Medical Sociology: A Study of Professional and Their Clients* (Jaipur: Printwell, 1988), 61.

[44] S.C. Dube, *Indian Village*, p 75.

[45] See the section "Doctors lacking the 'human touch'" later in this chapter for a discussion on casteist discrimination against patients.

the village.[46] A village doctor who Carstairs observed, for example, told people that "free medicines provided by the government were not very good anyway—let people come to his house privately, and he would let them have others."[47]

Clearly, the personality and conduct of individual doctors, as well as the caste identities of individual patients, were important factors which determined whether the Indian villager in a medically pluralistic society[48] chose to visit a particular doctor or not, and these factors played independently of any "faith" in biomedicine itself. Since the majority of Indian doctors were from the privileged castes, villagers of marginalized castes could not as easily approach them as those from elite castes. Besides, doctors who compelled people to see them during their private hours instead of dispensary hours, would have been less popular, especially when other, older modes of care were available. On the other hand, doctors who displayed kindness and sympathy were admired and villagers would be welcoming of them, as seen by Majumdar in the case of the doctor who had a "soft corner" for his ancestral village. In his study of modern medical practitioners ("*daktars*") in colonial Bengal, Projit Mukharji has also observed that in rural dispensaries, the social identity and personal traits of the individual doctor were frequently important determinants of whether people chose to go to them.[49]

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[46] Chattopadhyay, *Ranjana: A Village in West Bengal*, p 14.
[47] Carstairs, "Medicine and Faith in Rural Rajasthan."

[48] The concept of "medical pluralism" was popularized in the 1970s in an important volume edited by anthropologist Charles Leslie, and is used to refer to "a division of labor between different forms of curing, which were treated by people as 'complementary or supplementary resources'." Charles Leslie, "The Culture of Plural Medical Systems," in *Asian Medical Systems: A Comparative Study*, 181.

[49] Projit Bihari Mukharji, *Nationalizing the Body: The Medical Market, Print and Daktari Medicine* (London; New York: Anthem Press, 2009), 80–105; Projit Bihari Mukharji, "Structuring Plurality: Locality, Caste, Class and Ethnicity in Nineteenth-Century Bengali Dispensaries," *Health and History* 9, no. 1 (2007): 80–105.

Even though some villages and smaller towns were beginning to experience the presence of biomedical doctors, it is important to remember that most of the countryside was still an uncharted territory for the medical profession.[50] While the number of primary health centers (PHCs)[51] was gradually rising, many of them were staffed by personnel other than doctors, and remained only one among several options available to people, with some surveys finding that "only ten to twenty percent of villagers utilize the government health services."[52] In the vast and heavily populated countryside of India, however, the absence of doctors did not translate to an absence of biomedicine. Modern medical therapeutics were not the exclusive domain of government centers or even biomedical doctors, and other practitioners—including graduates of Ayurvedic, Unani and homeopathic medicine, "ersatz" practitioners[53], and local, traditional care providers—utilized biomedicine to varying degrees. A study done in the rural areas of Punjab and Kerala, for example, showed that a large majority of care providers employed a mix of indigenous and modern medicines (including injections).[54] Another study of traditional healers in a southern Indian district found that a "substantial proportion" of them was "willing to adopt some modern medical innovations" and "borrowed freely from the pharmacopoeia of modern medicine."[55] This

[50] As I discussed in Chapter 1, by the beginning of the 1960s, Indian policymakers were revisiting their previous ambition that "our countrymen cannot be allowed to have anything less than the best," and were beginning to mull over alternatives to university-trained doctors for rural India.

[51] Primary Health Centers were the most important peripheral centers of the rural health infrastructure established by the state following the recommendations of the Bhore Committee (which called it the primary health unit).

[52] Alfred K. Neumann et al., "Role of the Indigenous Medicine Practitioner in Two Areas of India—Report of a Study," *Social Science & Medicine* 5, no. 2 (April 1, 1971): 137–49.

[53] I use the term "ersatz" as Sarah Pinto uses (see above)

[54] Neumann et al., "Role of the Indigenous Medicine Practitioner in Two Areas of India—Report of a Study."

[55] C. A. Alexander and M. K. Shivaswamy, "Traditional Healers in a Region of Mysore," *Social Science & Medicine* 5, no. 6 (December 1971): 595–601.

widespread use of modern drugs and injections by non-biomedical personnel, existing even in cities, was a constant sore point for the Indian Medical Association (IMA), which regularly criticized these practitioners and chastised government authorities for not taking sufficient action against those who prescribed biomedical drugs without "appropriate" qualifications.[56]

When villagers did avail themselves of biomedicine, the most sought-after component of the therapeutic repository was the injection. Dube noted that "as a result of contact with the cities, the villagers have developed a great liking for the injections, expecting them to work like magic and provide quick and certain cure."[57] Majumdar mentioned a resident who "preferred an injection to an offering made to propitiate the gods."[58] Carstairs observed that "the administration of intramuscular injections, with its ritual of aseptic precautions and the dramatic quality of the act of acupuncture, is especially highly valued among those who have had some contact with allopathic [i.e., biomedical[59]] doctors."[60] Among the reasons that social scientists cited for the popularity of injectable therapeutics were the practical ritual associated with injections, promises of extravagant results by practitioners,[61] the "success of cholera and typhoid

[56] Many addresses and speeches at the annual conference of the IMA during this time criticized "unregistered medical practitioners" and "quacks." E.g., Sain Das Vohra, "XXIII Punjab Provincial Medical Conference, Jagadhri (President's Address)," *Journal of the Indian Medical Association* 23, no. 5 (February 1954): 235.

[57] Dube, *Indian Village*, p 26.

[58] Majumdar, *Caste and Communication in an Indian Village*, p 322.

[59] For a useful historical context to the use of the word "Allopathy" in the South Asian context, see Shinjini Das, "Debating Scientific Medicine: Homoeopathy and Allopathy in Late Nineteenth-Century Medical Print in Bengal," *Medical History* 56, no. 4 (October 2012): 463–80.

[60] Carstairs, "Medicine and Faith in Rural Rajasthan."

[61] Marriot, "Western Medicine in a Village of Northern India," p 241. These could be both biomedical doctors and other practitioners as discussed above.

inoculation programs," and the expanding "use of penicillin for which injection is the normal mode of application."[62] Commenting on the popularity of injections in the "Third World" in 1984, HV Wyatt argued that it was the mass campaigns against yaws and kala-azar in the 1920s and 1930s ("a single injection healed the ugly lesions in a week: cause and effect were visible"), and the pervasive use of penicillin injections for acute infectious diseases beginning in the 1950s, that were significantly responsible.[63]

Irrespective of the specific reasons, the preference for injections in rural India was widespread and was common knowledge in medical and public health circles in the 1950s and 1960s (it is possible that injections were equally preferred by urban residents and by the elites, but these phenomena were probably not as interesting for social scientists as was the popularity of injections among villagers, and have not been as voluminously recorded).[64] In 1959, demographer and sociologist S. Chandrasekhar (who later was appointed India's Minister of Health in 1967) mentioned in an article that injections are "very popular" in rural India.[65] In a study of people visiting a primary health center in a northern Indian village, researchers found patients complaining about not being prescribed injections by the doctors.[66] A foreign scientist conducting a trial on the efficacy of oral anti-TB drugs in southern India in the 1950s wrote about taking appropriate precautions in light of Indian villagers' preference for injectables: "We learnt that unless we

[62] S. M. Bhardwaj, "Attitudes toward Different Systems of Medicine: A Survey of Four Villages in the Punjab-India," *Social Science & Medicine* 9, no. 11–12 (December 1975): 603–12.

[63] H. V. Wyatt, "The Popularity of Injections in the Third World: Origins and Consequences for Poliomyelitis," *Social Science & Medicine* 19, no. 9 (1984): 911–15.

[64] For an overview of the use of the term "injection" and its various meanings in speech and writing in early twentieth century Bengal, see Projit Bihari Mukharji, "Injection," *South Asia: Journal of South Asian Studies* 40, no. 2 (April 3, 2017): 333–35.

[65] S. Chandrasekhar, "Family Planning in Rural India," *The Antioch Review* 19, no. 3 (1959): 399–411.

[66] M. G. Ranganna, B. G. Prasad, and J. K. Bhatnagar, "A Study of Medical Care Services Provided by the Primary Health Center, Sarojini Nagar, Lucknow, India," *Medical Care* 6, no. 5 (1968): 412–19.

work in out-of-the-way villages we shall find that the all-oral chemotherapeutic combination that we propose may well be seriously affected by the habit of the patients, who are not getting on well, obtaining streptomycin injections by private enterprise from private doctors!"[67]

From the above discussion, some general characteristics of public perceptions of doctors and biomedicine in rural India stand out. Chiefly, the biomedical doctor remained an inaccessible entity for the majority of India's villagers in the early post-independence period, even though biomedical therapy itself was more accessible and common (e.g., via public health campaigns, and indigenous and "ersatz" practitioners prescribing modern drugs and injections). People's perceptions of biomedicine were hence not exclusively tied to doctors. The popularity of injections and other modern therapeutics among the general public and in the care provided by local traditional practitioners, indicates that certain maladies were widely believed to be managed well with modern therapeutics, and that villagers were not, unlike the IMA, particularly bothered about whether the provider was "appropriately" qualified or not. As Bhardwaj wrote in 1975, the "expectancy of cure" mattered more to the people than a "commitment to a system of medicine," an observation buttressed by the fact that even though most traditional practitioners took a fee, people went to them more commonly than they went to the government centers which were "free" but only occasionally provided medicines or injections.[68] There were few doctors working in villages, and most of these were employed in government facilities (though some engaged in private practice on the side). Since the doctor in the village was almost always an extension of the state and almost always a member of

[67] Niels Brimnes, *Languished Hopes: Tuberculosis the State and International Assistance in Twentieth-Century India* (New Delhi: Orient Blackswan, 2016), 185.

[68] Bhardwaj, "Attitude-toward Different Systems of Medicine."

the privileged castes, people's perceptions of doctors were strongly influenced by caste equations and by their perceptions of the state (points to which I will return in the conclusion).

In other words, the hallowed doctor of the developmental state was a largely alien figure—in terms of both physical absence and elitist presence—to India's "tillers of the soil."[69]

Doctors' Dominance Without Hegemony in Cities

At a time when an increasing number of rural residents in India were beginning to admire the power of the hypodermic needle, urban residents were experiencing the entire gamut of modern medical therapeutics. In Indian cities at the dawn of independence, with their large colonial-era public hospitals and numerous private clinics, nursing and maternity homes, biomedicine already commanded a dominant presence.[70] There also existed special facilities for particular demographics, like hospitals and dispensaries for railway, industry, and military employees. Almost all the nationally-renowned doctors of India during this time, like B.C. Roy, Sushila Nayar, Jivraj Mehta, Muthulakshmi Reddy, S.L. Bhatia, and A.L. Mudaliar, were practitioners, researchers, or administrators based in urban centers. Most of the new medical colleges in the early post-independence decades were opened in cities, and these brought with them still more doctors and modern healthcare technologies for city-dwellers.

In this virant urban healthcare milieu, however, it was the public hospital which dominated medical care as well as public imagination. Perhaps the most noticeable feature of public hospitals was overcrowding, a phenomenon which carried over from the colonial period. The 1946 Bhore Committee

[69] The Bhore Committee had used that phrase to refer to the mostly rural, underprivileged public of India.

[70] In the South Asian context, "nursing homes" most commonly were small hospitals, with some in-patient beds, run by private practitioners. These often were also fitted with operation rooms.

report, for example, made several comments on overcrowding in hospitals and noted its adverse effects on patient care: "the time devoted to patients was so short as to make it perfectly obvious that no adequate medical service was given to the people."[71] In hospitals in Calcutta, patients were sometimes reported to be "huddled together in inhuman conditions in ill-staffed, congested wards."[72] In Bombay city hospitals, inadequacy of beds was common, and overall the conditions were considered "unsatisfactory."[73] Politicians and administrators frequently tried to allay public anxieties about over-crowded city and district hospitals.[74]

A lively discussion in the Madras Legislative Assembly from March 1954 offers helpful glimpses into the state of urban public hospitals during this time. Member K.B. Menon mentioned the "long queues" of out-patients, the "insanitary conditions," and the "low quality of food" provided to patients in Madras city hospitals, saying that those conditions were detrimental to the patients as well as the staff. He mentioned an incident in which a patient "got out of control and used violence," saying that in public hospitals "patients get overstrained because of their weak health" and are not able to bear the "inconveniences" they are put to. In his view the main cause of overcrowding in the Madras city hospitals was the relative paucity of appropriate facilities and staff at the health centers in peripheral districts and

[71] Bhore et al., *Report of the Health Survey and Development Committee*, 14.

[72] "Cholera Strikes Down 1000 in 'Healthiest City in the East,'" *Blitz*, April 6, 1957.

[73] "Conditions in Hospitals 'Not Satisfactory,'" *TOI*, October 24, 1961.

[74] "Civic Hospital Facilities: State Directive Hinted At," *TOI*, June 25, 1954; "Villagers Must Get Health Specialists' Services: Official's Suggestions for Improving Hospitals," *TOI*, January 9, 1962.

towns. He surmised that nearly 50% or more of the patients in the city hospitals were from the "mufassal"[75].[76]

Another member, S Deivasigamany, lamented that even the district hospitals (which were mostly in the bigger towns as against metropolitan cities) were often so crowded that in-patients were asked to sleep on the floor because the beds had run out. He suggested that "instead of having more centralized hospitals in district headquarters and in the City of Madras," the government should establish hospitals and rural dispensaries in the mufassal and put "good doctors" in charge. In addition, the government should send "mobile units" every few weeks to villages which had no medical facility in their vicinity. Deivasigamany was also interested in the "ancient institution of bone-setting"[77] and said that patients who were dissatisfied with the treatment they received in hospitals often went to the native bone-setters and were satisfied with the latter's therapy. He urged the Madras government to encourage these traditional practitioners.[78] The state health minister A.B. Shetty acknowledged many of the issues raised by the members and promised action. While assuring them that the government was trying to reduce overcrowding, he also argued that overcrowding was "an indication of the popularity of our hospitals" and "of the faith of the people in modern medicine." In response to Deivasigamany's suggestion that the state government support indigenous bone-setters, he joked that the former probably "belonged to the

[75] Often also spelled as "mufassil," in colonial administrative parlance it referred to local district and town regions, and could also be used as a shorthand for rural areas.

[76] *Madras Legislative Assembly Debates - Sixth Session*, vol. 14 (1-4) (Madras: Superintendent, Government Press, 1954), 177-180.

[77] For an overview of the tradition of bone-setting in India, see Helen Lambert, "Wrestling with Tradition: Towards a Subaltern Therapeutics of Bonesetting and Vessel Treatment in North India," in *Medical Marginality in South Asia: Situating Subaltern Therapeutics*, ed. David Hardiman and Projit Mukharji (Routledge, 2013), 121–37.

[78] *Madras Legislative Assembly Debates - Sixth Session*, vol. 14 (1-4), 181-82.

nineteenth century," and said that the state had "the best orthopedic surgeons," compared to whom the bone-setters were "nothing."[79]

This lively exchange between public representatives reveals many important aspects of medical care in cities. While city public hospitals were indeed utilized by many residents each day, "faith" in the efficacy of modern medicine (as Health Minister Shetty claimed) might have been only one among many reasons for their patronage. When Shetty said that overcrowding indicated the popularity of the hospitals, one member quipped that it was actually an indication of the "desperation" of people, and another said that people went there "to die."[80] The lack of affordable and accessible alternative avenues for medical care was thus another probable reason why people in cities, particularly the underprivileged, chose to go to public hospitals. Besides, for some migrants, the absence of any known networks of care providers as in their native villages, would have tended to make the public hospital the default option for care, especially as most public hospitals offered (nominally) free consultations and were located in accessible, central locations of the city.

Urban hospitals were also utilized by people for the surgical facilities they offered. In the case of emergency care and life-threatening ailments and injuries (including the "occupational hazards" for workers in factories and industries), modern surgery was widely considered an appropriate and effective option. Urban areas housed many hospitals for military, railway, and factory employees, with surgical procedures forming a substantial portion of the care provided. For Indian soldiers, care in modern medical institutions, especially rehabilitation after injury, was a part of the "assurance made by the Sirkar [colonial

[79] *Ibid*, 191-6.
[80] *Madras Legislative Assembly Debates - Sixth Session*, vol. 14 (1-4), 192.

government]… a message that the Crown had not forgotten their service."[81] The large network of hospitals and dispensaries for railway employees also took care of persons injured in railroad accidents.[82] Workers injured in industrial accidents were treated by default in public hospitals, and the larger industries and factories had their own network of modern medical dispensaries and hospitals, where doctors were employed as consultants.[83] Besides emergency surgeries, elective ones like cataract operations and tonsillectomies, as well as various abdominal and thoracic procedures, were common both in public and private hospitals in cities.[84] For example, a 1944 report on blindness in India talked about how the country's eye doctors struggled "against time to get through the mass of treatment and operative work queuing up endlessly before them."[85] It was common for young surgeons to attach themselves to public hospitals as "honorary" faculty and use the hospital facilities to operate on both the hospital patients and their own private patients.[86] Public maternity care centers and hospitals also seem to have been utilized in

[81] Aparna Nair, "'These Curly-Bearded, Olive-Skinned Warriors': Medicine, Prosthetics, Rehabilitation and the Disabled Sepoy in the First World War, 1914–1920," *Social History of Medicine* 33, no. 3 (August 1, 2020): 798–818.

[82] *Royal Commission on Labour in India, Evidence: Vol VIII, Part 1 - Railways* (London: His Majesty's Stationery Office, 1931).
[83] Joseph Bhore et al., "Health of the Industrial Worker," in *Report of the Health Survey and Development Committee*, vol. 1; Kunj M. Patel, *Rural Labour in Industrial Bombay* (Popular Prakashan, 1963), 139-40.

[84] The late 1940s and early 1950s saw the publication of new medical journals like the *Indian Journal of Otolaryngology* and the *Indian Journal of Ophthalmology*. The new journals and the existing ones (like the *Journal of the Indian Medical Association*) regularly carried research articles on surgical procedures. For an overview of cardiac surgery in Bombay in the early independence years, see David S. Jones and Kavita Sivaramakrishnan, "Making Heart-Lung Machines Work in India: Imports, Indigenous Innovation and the Challenge of Replicating Cardiac Surgery in Bombay, 1952-1962," *Social Studies of Science* 48, no. 4 (August 1, 2018): 507–39, and "Transplant Buccaneers: P.K. Sen and India's First Heart Transplant, February 1968," *Journal of the History of Medicine and Allied Sciences* 73, no. 3 (July 1, 2018): 303–32.
[85] Jogendra Singh et al., Report on Blindness in India by the Joint Committee Appointed by the Central Advisory Board of Health and the Central Advisory Board of Education (New Delhi: Manager of Publications, 1944).

[86] The memoir of Arun Limaye, a surgeon who trained in the 1960s and practiced in the 1970s in western India, provides several examples of such honorary surgeons. Arun Limaye, क्लोरोफॉर्म [Chloroform] (Mumbai: Granthali, 1978). See also B.N. Colabawala et al, "Surgeons' Fees: Letter to the Editor," *The Times of India*, August 9, 1963.

large numbers. In the city of Bombay, for example, as early as the 1930s, 73% of all confinements took place in biomedical maternity institutions.[87] As was observed in a northern Indian town in the 1960s, the presence of women doctors and women nurses as care providers in such hospitals (especially their maternity wards), probably played a significant role in urban women's decision to go there for childbirth.[88]

Apart from the public hospital, pharmaceuticals were an important component of the medical marketplace in urban India. Mark Harrison argues that biomedicine "ultimately gained the upper hand" in countries like India "because its impact was magnified by the near ubiquitous presence of Western pharmaceuticals, some marketed globally, others locally or regionally." Since the late nineteenth century, global economic and political forces "placed many more people in contact with Western medicine and its products. Medicines and medical services were widely advertised and available in shops and in the workplace through numerous vendors and practitioners. 'Doctors' and druggists without formal qualifications traded in streets and bazaars, offering Western medicine at a price that many could afford."[89] Such bazaars were a unique characteristic of urban India, and, along with the public hospital and dispensaries, helped make modern pharmaceuticals commonplace. Similar to interactions with biomedical hospitals and personnel, people's experiences with pharmaceuticals would not have all been satisfactory. But, as Harrison contends, many people were newly experimenting with a range of therapeutic alternatives to traditional remedies, and "although most of these remedies offered little more than hope, there were

[87] *National Health (Report of the Sub-Committee, National Planning Committee Series)* (Bombay: Vora and Co. Publishers Ltd, 1948), 129. This figure was mentioned in a background paper written for this report by physician Lakshmibai Rajwade, but there is no source provided.

[88] T N Madan, "Who Chooses Modern Medicine and Why," *Economic and Political Weekly* 4, no. 37 (1969): 1475–84.

[89] Mark Harrison, "A Global Perspective: Reframing the History of Health, Medicine, and Disease," *Bulletin of the History of Medicine* 89, no. 4 (December 28, 2015): 639–89.

enough reasonably effective drugs on the market (quinine tablets for example) to sustain the growing belief in the efficacy" of biomedicine.[90] That urban Indians were enthusiastically buying and selling drugs of different medical systems is evident from Nandini Bhattacharya's study of the drug marketplace in colonial Indian cities: "The [pharmaceutical] bazaar market had thrived in the late nineteenth century and encompassed not only botanical and mineral products, but also a great number of processed therapeutic products that included 'tinctures, pills, and homeopathic medicines'."[91] In the early post-independence period, the centrality of the drug trade for urban life and economy was underscored by the constant media reporting on counterfeit drugs and rising drug prices.[92] The scripts of some popular movies also incorporated the discourse on drugs: in the 1959 Hindi-Urdu film *Anari*, a major subplot revolves around the death of a person after consuming medicine from a contaminated bottle manufactured by a "reputed company."

In addition to the bazaars, drug stores, and public hospitals, cities housed private practitioners and their establishments. As the Bhore Committee observed, nearly three-quarters of India's doctors were in private practice in the early 1940s, and private practitioners tended to "concentrate in urban areas." They gave the example of Bengal, where there were 3 and a half times as many doctors in urban regions as in rural areas.[93] More than a decade later another committee observed that the proportion of doctors in private practice in different Indian states was 40-70%, and that "many young doctors elect to settle down in cities,

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[90] *Ibid*

[91] Nandini Bhattacharya, "Between the Bazaar and the Bench: Making of the Drugs Trade in Colonial India, ca. 1900–1930," *Bulletin of the History of Medicine* 90, no. 1 (March 30, 2016): 61–91.

[92] See, for example, "Wide Variations In Drug Prices In Bombay: Citizens Concerned," *ToI*, May 25, 1961.

[93] Bhore et al., *Report of the Health Survey and Development Committee*, pp 13-14.

in the hope that while retaining their independence they can eventually become successful practitioners."[94] Apart from the nursing homes, cities also had bigger private hospitals, including ones managed by charitable trusts. Government statistics in 1957 listed a total of 2265 biomedical hospitals for India out of which 238 (10.5%) were private. Bombay had 23 private hospitals out of a total of 47, Madras had 4 out of 16, Calcutta had 26 out of 55, and Delhi had 9 out of 25. Thus almost a quarter of India's private hospitals were in these four metropolitan cities.[95] However, most private establishments except for maybe charitable hospitals, were not as accessible and affordable for the general public as public hospitals. A common complaint in cities was the high expenses involved in visiting private biomedical doctors, with surveys observing that "most people cannot afford the fees charged by private practitioners."[96] A 1960 survey of the middle-class residents of five major north Indian towns found that "considerable resentment" was shown by some families about the "prohibitive and heavy" fees charged by doctors.[97] In 1963 a front-page report in the *Times of India* complained that surgeons in Bombay charged exorbitant fees and were "beyond reach of many," serving only the "affluent society."[98]

In cities, a large number of residents belonged to the underprivileged communities. The economic barrier of high fees and the caste barriers between them and most doctors ensured that public and

[94] Mudaliar et al., *Report of the Health Survey and Planning Committee*, 134.

[95] *Directory of Hospitals in India.* (New Delhi: Directorate General of Health Services, 1957). It is likely that these numbers are not fully accurate, particularly considering that many smaller clinics and nursing homes might have been missed, but they still provide a good idea about the distribution of hospitals in the public and other sectors.

[96] Mudaliar et al., *Report of the Health Survey and Planning Committee,* 80. Complaints against doctors charging high fees were common even pre-independence, as Projit Mukharji shows in his study of colonial Bengal: see Mukharji, *Nationalizing the Body*, pp 70-74.

[97] Bhagwan Prasad, *Socio-Economic Study of Urban Middle Classes* (New Delhi: Sterling Publishers, 1968), 11.

[98] "They Serve The Affluent Society: Surgeons Beyond Reach Of Many," *The Times of India*, July 23, 1963.

charitable centers ended up becoming the primary avenues of biomedical care for them. Thus, inequality came to dictate and shape the demographics and the patterns of usage of urban India's medical care institutions: public hospitals became the medical mainstay of India's millions of poor and underprivileged, while private clinics and hospitals became the default option for the privileged few. (It should be noted that apart from public hospitals, many underprivileged persons (and also those from privileged communities) used the services of indigenous and "ersatz" medical practitioners, as the example of the bone-setters in the Madras Legislative Assembly exchange shows.)

Modern Ayurvedic and Unani physicians, trained in specialized colleges which had begun to be established in the late colonial period, were also an important part of the urban medical care landscape. Many leaders of these professions were urban-based and were active in propagating their medical systems through print media and specialized dispensaries and pharmacies in cities and towns.[99] In the late 1960s, T.N. Madan found that residents in a north Indian town "combined different systems of medicine" as they believed that "some diseases are more readily controlled or eradicated by treatment according to a particular system."[100] This was similar to observations in parts of rural India where people frequently utilized multiple practitioners and methods of care. Other signs of the popularity that indigenous and "ersatz" practitioners enjoyed among the public, both rural and urban, can be found in the writings of elite doctors, who often talked about indigenous practitioners with scorn (not dissimilar to Shetty's sarcastic comments above). In a statement that typified prevailing sentiments around this issue, the Bhore committee preferred

[99] Rachel Berger, *Ayurveda Made Modern: Political Histories of Indigenous Medicine in North India* (New York, NY: Palgrave Macmillan, 2013) and Edward Montgomery, "Systems and the Medical Practitioners of a Tamil Town," in *Asian Medical Systems: A Comparative Study*.

[100] Madan, "Who Chooses Modern Medicine and Why."

to characterize the popularity of indigenous systems (mainly Ayurveda and Unani) as a kind of "hold" over people's minds: "We realize the hold that these systems exercise not merely over the illiterate masses but also over considerable sections of the intelligentsia."[101]

To summarize, thus, in the early decades of independence (and later), the vibrant urban Indian landscape consisted of a medical smorgasbord in which doctors and biomedicine, with their large public hospitals and small clinics, enjoyed, to employ Ranajit Guha's characterisation, dominance without hegemony.[102]

Doctors Lacking the "Human Touch"

While social scientists during this time were indeed interested in many aspects of urban life and urbanization, there are few studies on urban people's beliefs and attitudes regarding health and medicine, unlike in the case of rural communities as seen above. A survey of multiple sources, however, does provide some pointers. Most significantly, perceptions and attitudes toward doctors and biomedicine in cities were primarily refracted through the public hospital. As discussed, people frequently complained about basic infrastructural issues in government hospitals, like lack of hygiene, overcrowding, and "floor beds." Newspapers regularly carried reports on such issues and editorialized on the need for the state to invest in public health and medical infrastructure.[103] It would be safe to assume that the experiences of most patients at these hospitals were unsatisfactory and even frustrating. Anthropologist R.S. Khare wrote

[101] Bhore et al., *Report of the Health Survey and Development Committee*, vol 2, 455.
[102] Guha has famously characterized the nature of the colonial state in South Asia as one in which its power derived not through persuasion and a hegemony of its ideology among the populace, but from coercion and dominance. Ranajit Guha, *Dominance without Hegemony: History and Power in Colonial India* (Cambridge, MA: Harvard University Press, 1998).

[103] "Blight on Health," *ToI*, March 20, 1951; "Planning for Health," *ToI*, February 17, 1954.

evocatively about how rural Indians experienced the atmosphere of urban public hospitals when they made a rare visit there: "... the entire party - the patient, the kin, and the escort - are bewildered by the maze of formalities through which they have to pass before they can hope to get medical help. In the unfamiliar and, to them, inhuman atmosphere, they become painfully conscious of what strikes them as apathetic, almost mechanical treatment."[104]

Even though direct patient testimonials from the urban underprivileged (who formed the majority of the visitors to public hospitals) are rare, the speeches of public representatives sometimes alluded to public perceptions and experiences. The Madras Assembly debates cited above, for example, throw light on how for some people it was "desperation" which pushed them to get admitted to the overcrowded and unsanitary wards of public hospitals. On a similar note, a member of the Bombay Legislative Assembly said in 1957 that people did not "like to go to Government hospitals." Another member said that the staff in public hospitals "had yet to learn that the tax-payer has a right to expect proper treatment." Government needed to make sure, he suggested, that "our doctors, nurses, and even ward boys are trained to be sympathetic to patients."[105] Thus, apart from infrastructural issues, disrespectful and "unsympathetic" behavior by staff was a major cause of dissatisfaction with public hospitals. In 1948 a government committee noted that many people preferred indigenous system practitioners because "the treatment of their patients by the Vaidyas and Hakims is generally more sympathetic and personal than that of [doctors] in charge of Government dispensaries and hospitals."[106] In 1954 the Health Minister of PEPSU (the Patiala

[104] R. S. Khare, "Folk Medicine in a North Indian Village," *Human Organization* 22, no. 1 (1963): 40.

[105] "No Proper Treatment of Patients in Hospitals: Congress Member Assails Govt. in Assembly," *TOI*, July 3, 1957.

[106] Col. R.N. Chopra et al., *Report of the Committee on Indigenous Systems of Medicine: Vol 1 - Report and Recommendations* (New Delhi: Ministry of Health, Government of India, 1948), 70.

and East Punjab States Union), while addressing the Civil Surgeons of the state, referred to some common public complaints against government hospitals and doctors, like "the practice of asking poor patients to get their own bandages, cotton wool and food. While costly patent medicines, special preparations, dainty dishes and other luxuries are made readily available to the more affluent patients... the common man may have to wait, in anguish and for days, to get his fracture attended to." Such "callous" behavior of hospital staff needed to stop, he averred.[107] A decade later, Prime Minister L.B. Shastri also remarked on the disrespectful attitudes of doctors toward the underprivileged, and "appealed to the medical profession to change its attitude towards the common man... A man who came to the hospital in tattered clothes deserved the same consideration that was shown by doctors to a Minister."[108]

The "Letters to the Editor" section of the *Times of India* and the *Indian Express* often carried accounts by patients or their relatives of unsatisfactory visits to doctors, both Government and private, with doctors variously referred to as being "careless," "rude," and "unhelpful." (It is only persons with some kind of socioeconomic privilege who would have been able to write and send such letters to newspaper offices, which also indicates that on some occasions, urban public hospitals were patronized even by privileged individuals.) A Madras-based patient, describing an unsatisfactory experience getting treatment for a rat-bite in a municipal hospital, wrote in 1947: "How anxiously do patients go to Government hospitals and how indifferently do doctors dispose them of!"[109] A 1957 letter from a person who believed that a private doctor's "careless" attitude was responsible for the avoidable death of an elderly

[107] Ibrahim Haji Mohamed Mistry, "Hospital Horrors - to the Editor, Times of India," *TOI*, September 30, 1954.

[108] "Change Attitude to Common Man: Shastri's Call to Doctors," *TOI*, November 24, 1964.

[109] R. Nagaraja Rao, "Letters to the Editor - Hospital Hospitality," *The Indian Express*, November 23, 1947.

person, pondered: "The layman often wonders whether the average, modern doctor is not casual and careless—he thinks his duty is done by merely scribbling a prescription, whereas a little more positive attitude of helpfulness towards patients may well save many a human life."[110] In response to the article on the PEPSU Health Minister's address (see above), a social worker from Bombay rued that "conditions in most of the hospitals in other parts of India are no better," and that the "atmosphere" of many city hospitals "lacked the human touch."[111]

The human touch of the medical profession was especially absent in the case of Dalit patients. As noted in the Introduction chapter, India's biomedical profession was largely composed of privileged-caste Hindu Indians. Discriminatory and insulting attitudes toward Dalits and other "lower caste" Indians were—and continue to be—a central component of the worldview and atittudes religiously adhered to by many Hindus from the dominant castes.[112] Such worldviews also seem to have been part of the culture of the country's biomedical profession since its early decades. In 1855 a fourteen-year-old Dalit girl—student of the revolutionary leaders Savitribai Phule and Jotiba Phule—rhetorically asked in an essay: "Suppose [our] women suffered from some puerperal disease, from where could they have found money for the doctor or medicines? Was there ever any doctor among you [Brahmins] who was human enough to treat people free of charge?"[113] Later in 1928, the economist, intellectual, and Dalit leader Bhimrao Ambedkar

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[110] K.R. Daver, "Doctors and Patients - To the Editor, Times of India," *TOI*, June 22, 1957.
[111] "Hospital Horrors - to the Editor, Times of India."

[112] The heart-rending memoirs and testimonies of Dalit, Adivasi, and other underprivileged-caste individuals attest to this. Among those who reflected on these experiences and theorized about the attitudes and worldviews of privileged caste communities, the works of Jotirao Phule and Bhimrao Ambedkar have been most influential. See B.R. Ambedkar, "The Annihilation of Caste (An Undelivered Speech);" Jotirao Phule, "गुलामगिरी [Slavery] [1873]," in *महात्मा फुले समग्र वाङ्मय [Collected Works of Mahatma Phule]*, ed. Dhananjay Keer and S.G. Malshe.

[113] Translated excerpt from the Marathi essay "Mang Maharachya Dukhavisayi" (About the Griefs of the Mangs and Mahars) by Mukta Salve, published in 1855 in the journal *Dnyanoday*. Translation accessed from Susie Tharu and K.

referred to the continuing caste-based discrimination in medical practice in his testimony to an official Commission of the British Indian government. He said that "depressed class" persons were "not allowed entry into [government dispensaries], unless the case is a very very serious one; such as, for instance, the non-admission would bring the officer's conduct to the notice of the higher authorities." Another leader said that "the Hindu medical man who is orthodox always takes objection to examine a man belonging to the depressed classes."[114]

One incident attained particular notoriety around this time, and was publicized in Mohandas Gandhi's journal *Young India*. A.V. Thakkar, a close associate of Gandhi, shared the testimony of a Dalit primary teacher's encounter with a doctor in a Gujarat village:[115]

> My wife was delivered of a child on the 5th instant. On the 7th she was taken ill... I went to call in Dr.—, but he said 'I will not come to the untouchable's quarters. I will not examine her either.' Then I approached the [local officials] and requested them to use their good offices for me. They came and on the [official] standing surety for me for the payment of Rs. 2 as the doctor's fee, and on condition that the patient would be brought outside the untouchable's quarters, he consented to come. He came, we took out the woman who had a baby only two days old. Then the doctor gave his thermometer to a Musalman who gave it to me. I applied the thermometer and then returned it to the Musalman who gave it to the doctor... The doctor would not condescend to examine her, simply looked at her from a distance...
> The woman did not live. After her death her husband, the teacher, wondered: "What shall one say

about the inhumanity of the doctor who being an educated man... treated an ailing woman lying in for two

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Lalita, eds., *Women Writing in India: 600 B.C. to the Present, V: 600 B.C. to the Early Twentieth Century* (New York: The Feminist Press at CUNY, 1993). The translated text uses the word "doctor." It is unclear if the original referred to modern medicine doctors or to indigenous physicians. Considering that in most parts of India childbirth was traditionally a domain of women (especially women midwives) and not of male indigenous physicians, it is likely that Salve was referring to modern medicine physicians.

[114] "Dr B.R. Ambedkar and Dr P.G. Solanki, representing the Depressed Classes," in *Indian Statutory Commission Volume XVI - Selections from Memoranda & Oral Evidence by Non-Officials (Part 1)* (London: His Majesty's Stationery Office, 1930), 61.

[115] M.K. Gandhi, "Man's Inhumanity to Man," in *Young India 1927-28* (Madras: S. Ganesan, 1935), 163–64.

days worse than a dog or a cat?" Commenting on the incident, Ambedkar noted that the doctor felt "no qualms of conscience in setting aside the code of conduct which is binding on his profession."[116]

Ambedkar certainly would not have been pleased with the attitude of many doctors even in the post-independence period when the Constitution he helped draft had made caste-based discrimination a legal offence. In January 1951, for example, a telegram from a member of the PEPSU state's Depressed Classes League mentioned an incident in Patiala where a Harijan (Dalit) woman had been "crudely" treated and "forcibly expelled" from a hospital by a lady doctor, causing "great resentment" among the Harijans of the region.[117] In July 1956 a reader claimed in a letter to the editor of the *Times of India* that it was "well known that Harijans are discriminated against in public hospitals."[118] In the late 1960s, a Dalit employee with the Indian Railways complained to the administration that the "lady doctor" at the local health center had behaved rudely with his pregnant wife and dismissed her genuine complaints and pain, and that the doctor's overall "negligent" behavior had eventually ended up in his wife giving birth to stillborn twins. In his assessment, the doctor's shocking behaviour stemmed from her caste-based discriminatory attitudes.[119]

Dalit and other underprivileged patients (including Adivasis) thus ended up bearing the brunt of the "callous" attitudes of doctors and other hospital staff. There was a tragic irony in the Bhore Committee's vision of India's ideal doctor as a professional "in close touch with the people he

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[116] B.R. Ambedkar, "Chapter 5 - Unfit for Human Association," in *Dr Babasaheb Ambedkar: Writings and Speeches*, vol. 5 (Dr. Ambedkar Foundation, Ministry of Social Justice & Empowerment, Govt. of India, 2014).
[117] "Enquiry into the Allegations Made by the President, Depressed Classes League, Patiala," 1951, f. 3(12) - P/51. Dept of States, Political Branch, National Archives of India.

[118] A.S.T. Zaidy, "Missionaries and Harijans - To the Editor, 'The Times of India,'" *TOI*, July 21, 1956.

[119] "Ministry of Home Affairs: Negligence of Lady Doctor Khare of Nagpur Hospital," January 1969, f. 69/H/13/3/1-36, Dept: Railways, Branch: Health, National Archives of India.

disinterestedly serves"—with many professionals turning out to be cold to any form of "close touch" with many patients, and with a lot of patients constantly experiencing a lack of "human touch" from doctors. A writer described, in one succinct line, the experiences of thousands of Indians each day in urban public hospitals (and indeed at several other healthcare centers), and committed to print in 1956 a state of affairs which continues to exist in public hospitals to this day: *Hundreds are humiliated everyday because thousands go for treatment where facilities are not enough for five hundred*.[120]

It must be noted that there were doctors and other care providers who went against the grain, whose attitudes toward patients were characterized by the "human touch," and who were found inspirational by many of their students. Surgeon Homi Dastur of Bombay's G.S. Medical College, for example, was celebrated for his commitment to provide care "of the highest standard" to underprivileged patients. Even though outpatient attendance for neurosurgery was small, he set up a daily outpatient clinic for the speciality despite resistance from hospital authorities, deeming it "unfair to ask patients with grave illnesses who had traveled long distances to go away untreated and return on a single, specified, outpatient day."[121] At the Madras Medical College, K.S. Sanjivi's dedication to patient welfare and professional ethics was well-admired.[122] Such practitioners, however, formed a minority and do not seem to have been a dominant force in the workings of the mainstream profession. This is evident even in how they have been memorialized by later generations of doctors, by using language which denoted exception rather than

[120] "Flibbertigibbet", "A Profession Under Fire," *The Economic Weekly* 8, no. 31 (August 4, 1956): 913–14.

[121] Sunil Pandya, "Turning Points In My Medical Career," *Mens Sana Monographs* 4, no. 1 (2006): 154–65.

[122] M. K. Mani, *Yamaraja's Brother: The Autobiography of Dr. M.K. Mani.* (Bombay: Bharatiya Vidya Bhavan, 1989), 18-19.

norm. For example, Dastur's impeccable adherence to ethics is described to be potentially "surprising" to a patient, and Sanjivi is deemed to be "very different from most of his contemporaries."

Clearly, for a large number of especially underprivileged Indians—whether in villages, towns or cities—doctors as a professional community were at best alien and distant, and at worst disrespectful and "callous." However, the medical profession did enjoy a consistently cordial relationship with one particular group of people: the elite of India, who were by and large their class and caste equals. These elites, especially those who were domiciled in urban India—including "the rising technocracy, the professional-managerial class, intellectuals and top bureaucrats"[123]—also happened to create and control the mainstream public discourse, and it is their interventions which, as the next section will show, have helped provide the "golden age" gloss to the patient-doctor relationship during this period. Among the most visible of these interventions was cinema.

"Noble" Doctors in Cinema and the Elite Worlds

In an edited volume on medicine and film, Leslie Reagan, Nancy Tomes, and Paula Treichler argue that "medicine's moving pictures represent a rich cultural and historical archive that deserves serious scholarly attention."[124] Indian movies from the 1940s-60s, the time period being studied in this chapter, indeed attest to their claim that medicine provides mass media with "reliably popular content."[125] Many movies from this period had doctors as important characters, including lead protagonists. Many also

[123] Satish Deshpande, *Contemporary India: A Sociological View* (New Delhi: Penguin Viking, 2003), 77.

[124] Leslie J. Reagan, Nancy Tomes, and Paula A. Treichler, *Medicine's Moving Pictures: Medicine, Health, and Bodies in American Film and Television* (University of Rochester Press, 2007), 2.

[125] *Ibid*

portrayed people's interactions with doctors and with biomedical institutions.[126] In my analysis I will use these cinematic portrayals mainly to supplement the preceding documentary analysis-based observations and arguments. I will follow the scholars of South Asia who have found cinema to be an important source for social and cultural history. Jyotika Virdi says that Hindi-Urdu cinema's popularity "rivals—or more likely outstrips—the literary text."[127] Rachel Dwyer argues that cinema plays a "significant role in creating a way of comprehending the way society is and how it should be."[128] Thus, the cinematic representations of biomedicine, particularly when contextualized with other material, provide a useful source to understand not only prevailing ideas about medicine, healthcare, and illness among the mostly elite individuals who created cinematic content, but also how they hoped those ideas "should be." These portrayals are, the way I use them, a repository of medicine-related "imaginaries and imaginary worlds, showing ways in which change is visualized in films, [and] depicted in narratives, images and sounds."[129]

Though historians of medicine working on South Asia have scarcely explored popular films, medical anthropologists have often utilized cinema in their studies, and much of the analysis that follows takes inspiration from the fine-grained explorations and dissections by these scholars.[130] Perhaps the most significant phenomenon which stands out in these cinematic portrayals is the hegemony of doctors and

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[126] The movies I have utilized in my study are popular Hindi-Urdu and Marathi language films. Unless otherwise stated, they are Hindi-Urdu movies (more commonly known as Bollywood cinema).

[127] Jyotika Virdi, *The Cinematic Imagination: Indian Popular Films As Social History* (New Brunswick, N.J: Rutgers University Press, 2003), 8.

[128] Rachel Dwyer, *Bollywood's India: Hindi Cinema as a Guide to Contemporary India*, (London: Reaktion, 2014), 8.

[129] *Ibid*, 9.

[130] See, e.g., Lawrence Cohen, "The Other Kidney: Biopolitics Beyond Recognition," *Body & Society* 7, no. 2–3 (September 2001): 9–29; Sarah Pinto, *Daughters of Parvati: Women and Madness in Contemporary India*, (Philadelphia: University of Pennsylvania Press, 2014), pp 182-5; Dwaipayan Banerjee, "Cancer Films," in *Enduring Cancer: Life, Death, and Diagnosis in Delhi* (Durham: Duke University Press Books, 2020).

biomedicine. The 1940 movie *Doctor* was probably the first popular Indian film to portray a biomedical doctor as the main protagonist.[131] Subsequent years saw the release of more such films: *Pagal* (1940), *Anjaan* (1941), *Najma* (1943), and *Shararat* (1944). These movies displayed an internalization and acceptance of, as well as comfort with, modern medical vocabulary and symbols: the operating room, stethoscope, the doctor's medicine chest, injections, microscopes, X-rays, thermometers, et al. It was customary in most films to address the doctor in a respectful way, mostly as "Doctor *sahab*" (this form of address, and its variants, were common also in real-life patient-doctor encounters).[132]

The films which I studied in detail (*Doctor* and *Najma*) did not feature any non-biomedical practitioners, implicitly privileging biomedicine throughout. Indeed, in one scene in *Doctor*, the term "vaid"—traditionally the term for Ayurvedic physicians—is used only to firmly establish the distinction between traditional and biomedical systems. In this scene, a young second-generation medical graduate (Somnath) is shown playfully chasing the family butler (Dayal) with a syringe in hand, threatening to inject him. When Somnath's grandfather inquires what the matter is, he says that Dayal had called him a vaid: *How can you call a doctor with multiple degrees from abroad as a vaid? Please do not insult the [modern] medical sciences*. In both *Doctor* and *Najma*, biomedical procedures are shown to be life-saving, and to be the only effective therapeutic options in emergency situations. In *Doctor*, the protagonist physician saves the life of a newborn by employing elaborate resuscitation techniques, while in *Najma*, there is a dramatic climax scene where a skilled biomedical doctor operates upon a severely injured patient at home and saves his life. *Doctor* also had a nationalist undertone, in that the protagonist was a patriotic doctor who cared

[131] The original film was in Bengali, and it was later dubbed in Hindi dialog.
[132] The word "sahab" became a common form of address during the colonial period. It was used by people in India primarily to address European officers and other men in particular, and any officers or persons considered of a higher socioeconomic status in general.

about the marginalized, impoverished people of India, and decided to live and practice in a village which "needed" his services.

Coming on the heels of these movies, the 1946 film *Dr Kotnis ki Amar Kahani* became the most popular and most admired representation of doctors and biomedicine in the early independence years. It was based on the true story of Dr Dwarkanath Kotnis, from the western Indian city of Solapur, who went to war-torn China in 1938 as part of a medical mission sponsored by the Indian National Congress. In China, he "worked for four years at constant risk of death, fell in love with and married a Chinese lady who was his comrade and colleague in his work, and died a martyr's death while still on duty in a remote corner of North-West China."[133] The movie plot embellished this adventurous true story, and was "acclaimed for its patriotic and human approach to the world problems of war, Fascism and Imperialism."[134] In the film, the military and surgical aspects of biomedicine were highlighted, and Dr. Kotnis was often shown to be tirelessly performing successful surgical procedures on wounded Chinese soldiers, constantly saving their life and limb. Thus, by the time independence dawned a year later, popular Indian cinema had acknowledged and assimilated the broader developmental discourse of the superiority of modern public health and medicine and of the importance of its major agents, the doctors, to the new nation. Persons from the underprivileged majority of India, always appearing only briefly in the busy world of hard-working doctors, were perforce shown to be grateful recipients of doctors' attention, advice, and surgical acumen.

[133] "Shantaram's 'Dr. Kotnis,'" *TOI*, March 29, 1945.

[134] "'Dr. Kotnis' Film in 21st Popular Week," *TOI*, August 3, 1946.

The trope of the biomedical doctor selflessly serving the poor and the marginalized and contributing to the nation-building project, seen prominently in *Doctor* and *Dr Kotnis*, would regularly reappear in the 1950s and 1960s. In *Nirala* (1950), the doctor, belonging to a wealthy family and returning to India after higher education abroad, decides to settle down in a village because he has "studied medicine only to serve the poor." In *Chirag Kahan Roshni Kahan* (1959), the selfless service aspect of the (male) Indian doctor was elevated to a sacrificial level: in a highly dramatic gesture, the protagonist obstetrician swaps his own newborn with the dead newborn child of his patient to help save her life (it was already established that his own wife had just died in childbirth, and that with the husband of the patient also dead, the baby was "the only hope" for her). Later in 1963, *Dil Ek Mandir* took the sacrificial trope to its acme: the doctor immersed himself to such a degree in preparing for the operation of an advanced lung tumor-afflicted patient, that he neglected his own health, slept fitfully, and skipped meals. The operation was a test of his therapeutic skills, a test which eventually he passed, giving his patient a new life. But the accompanying stress took its own toll, by killing the doctor himself.

Apart from mostly male doctors engaging in service and sacrifice, there were other commonly employed imageries in the movies of this period. Most doctors were shown to possess impeccable professional integrity: in many films, the physician explicitly said in words and showed in action that for doctors, nothing was more important than their duty toward their patients. The doctor characters were also invariably well-dressed and personable, mostly wearing western suits and ties (emblematic of modernity), and often driving cars (representative of the "respectable" classes). As in the rest of the elite discourse in the early post-independence years, there was an invisibilizing of caste-based privilege,[135] with

[135] Satish Deshpande, "Caste and Castelessness: Towards a Biography of the 'General Category,'" *Economic and Political Weekly* 48, no. 15 (2013): 32–39.

no explicit mention of the caste backgrounds of the doctors, even though several indirect markers ended up indicating privileged caste and class backgrounds: urban-based large, comfortable homes, wealthy parents, ability to pursue education abroad, and (at times) names and surnames common among privileged-caste communities. Additionally, most cinematic doctors were engaged in private practice, which in the India of the 1950s as even of today, is a domain dominated by the privileged castes.[136]

Thus, in the popular cinema of the early decades of independence, doctors were largely portrayed as selfless, hard-working, compassionate, and skilled, and biomedicine was shown to be impeccable, even miraculous, in its therapeutic potential. Importantly, ordinary, subaltern patients were represented as perennially grateful beneficiaries of both these entities. One important reason for such positive and optimistic portrayal was that, as scholar Reeta Tremblay has noted, a concern for nation-building pervaded the cinema of the early post-independence years. Movies had a didactic quality, and filmmakers tried "to educate and instill moral values amongst the audience, at least take upon themselves the task of enlightening them through their supposedly privileged access to truth, reason, and their ability to discriminate between good and evil."[137] Juxtaposed with the ideas, attitudes and expectations of the developmental state, which scholars have often dubbed as a "pedagogic state," the "didactic" quality of the films made by elite urban filmmakers is unsurprising.[138] Thus, while popular cinema did cater to the millions, it did not necessarily represent those millions or their experiences, and often represented what the elites imagined or hoped their experiences to be. The largely uniform and uniformly positive portrayal of

[136] See, e.g., Somashekher C., "Social Profile of Indian Physicians," *Artha Journal of Social Sciences* 7, no. 1 (2008): 11–28.

[137] Reeta Chowdhari Tremblay, "Representation and Reflection of Self and Society in the Bombay Cinema," *Contemporary South Asia* 5, no. 3 (November 1, 1996): 303–18.

[138] For the post-independence Indian state as a "pedagogic state," see Gyan Prakash, *Emergency Chronicles: Indira Gandhi and Democracy's Turning Point* (Princeton, New Jersey: Princeton University Press, 2019).

biomedicine in popular Hindi-Urdu cinema thus eschewed the diversity in people's perceptions. It chose to depict, so to say, the dreams of the Bhore Committee as against the realities of the "tillers of the soil."

While the emphasis on the didactic motivations of these films is useful, it is also important to note another significant reason why filmmakers' perceptions about doctors were different from those of the majority of the public. As noted above, filmmakers, along with doctors and other groups of the privileged public, constituted the numerically small but socioeconomically powerful urban elite communities, most of them working in the white-collar sector. Often, this meant that there was almost always a doctor member in the extended family, or in the large social network, of an elite individual. A helpful (even if only partial) glimpse into the close social networks of elite Indians can be gleaned from reading the biographies, mempoirs, and other reflections of Indian doctors from this time: doctors very often tended to be the children or siblings of doctors, lawyers and barristers, university professors, engineers, college principals, bureaucrats, and other elites.[139] Doctors, thus, were accessible to elite Indians not just economically as professionals, but also socially-culturally as "friends and family": as someone they knew well, or as someone who was known to someone they knew well. Shared social networks and similarly privileged caste backgrounds meant that for the urban elites, doctors were, far from being "alien" as they were to most other Indians, "one of their own." A striking example of doctors and other elites sharing the same elite space (as well as "first-world problems") is seen a 1954 documentary film made by the Government of India's Films Division. It was a propaganda feature on the role of taxes in nation-building, and showed four

[139] Some examples include: Noshir H. Antia, *A Life of Change: The Autobiography of a Doctor* (New Delhi, India: Penguin Books, 2009); C.G. Pandit, *My World of Preventive Medicine* (Indian Council of Medical Research, 1982); S. Muthulakshmi Reddy, *Autobiography of Dr. (Mrs.) S. Muthulakshmi Reddy* (Madras: M.L.J. Press, 1965); K.P. Thomas, *Dr. B.C. Roy* (West Bengal Pradesh Congress Committee, 1955); M. K. Mani, *Yamaraja's Brother: The Autobiography of Dr. M.K. Mani.* (Bombay: Bharatiya Vidya Bhavan, 1989).

men in an elite urban club sitting at a table: a lawyer, a businessman, a landlord, and a doctor. (The doctor is peeved at "paying through one's nose" for his taxes, and immediately everyone else begins to express their frustrations.)[140] Even outside films, doctors and other urban elites were active members of urban social clubs like Rotary, Rotaract, and Lions.[141] As sociologist Roger Jeffery noted in the 1970s, "the natural habitat of the doctor [in India] is the Westernized middle class of the cities."[142] Clearly, whenever elite Indians visited a doctor, it would have been a vastly different interaction—one between socioeconomic and caste equals and characterized by camaraderie and mutual respect—from the highly asymmetric interactions which most other Indians had with doctors. For filmmakers, these realities of their own lives must surely have influenced the imaginaries they created on the screen.

[140] Bhaskar Rao, *Your Contribution* (Films Division of India, 1954), https://youtu.be/EfspPYju7uI.

[141] See, e.g., "Doctors Offer Free Aid: Medical Camps in Surat," *TOI*, August 3, 1955; "Preventive Aspects of Diseases: Importance Explained," *TOI*, November 3, 1960.

[142] Roger Jeffery, "Allopathic Medicine in India: A Case of Deprofessionalization?," *Social Science & Medicine* 11, no. 10 (July 1977): 561–73.

Doctor (right-most) sitting with other elites at a club. *Your Contribution*. Films Division of India, 1954. Courtesy: YouTube and Films Division India

The urban Indian elites were also active consumers of global modernity, and their attitudes toward biomedicine in general paralleled those of other modernized communities in the world. As Allan Brandt and Martha Gardner show, these attitudes, marked by optimism, confidence, and certainty in the "progressive and triumphal march of rational investigation" created "an aura around medicine that seemed inviolable."[143] English-language newspapers in India regularly published columns and advertisements that discussed the benefits and "miracles" of the modern sciences. For example, a 1949 report on the "wonder drug" chloromycetin discussed how it was "another milestone in the progress of medical science," and a 1964 opinion piece claimed that modern science "can and will show the light, provided man can face up to

[143] Allan Brandt and Martha Gardner, "The Golden Age of Medicine?," in *Companion to Medicine in the Twentieth Century*, ed. Roger Cooter and John Pickstone (Routledge, 2000), 21–37.

it."[144] Besides, the biomedical doctor (especially the surgeon) was a celebrated figure in urban elite consciousness, evident not only through movie representations but also popular literature: for example, a thrilling short story published in the Sunday edition of the *Indian Express* in October 1947 featured a surgeon and his student as the main protagonists.[145]

It must be noted, however, that even among the elite, the hegemony of biomedicine came with qualifications. As the Bhore Committee wrote, many persons from the "intelligentsia" had faith in indigenous medicine. Besides, it was common for elite Indians, as for others in India and elsewhere in the world, to believe that both biomedicine and other systems of medicine could be individually efficacious in their own ways. For example, the doctor Leela Ranade (mentioned in Chapter 1) was open to incorporating ideas from the Ayurvedic system in her worldview and practice, and for some time was also a consultant at an Ayurvedic hospital in Pune.[146] Skeptical attitudes toward some of the claims and optimism around biomedicine, and modern science in general, were also not uncommon among the elites. A 1964 article in *ToI* expressed indignation at how representatives of biomedicine "refuse even to look at the philosophy behind ancient Indian medicine," and accused the champions of modern science of nurturing prejudices and bigotry of their own.[147]

However, even if there were elites who critiqued biomedicine and the medical profession, it still remained the case that whenever they were in need of care, their socioeconomic background ensured they

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[144] "New Wonder Drug - Chloromycetin," *The Times of India*, April 3, 1949; P.R. Gupta, "The Spirit of Science," *The Times of India*, November 22, 1964. Several advertisements talked about modern "miracle" drugs and cures.

[145] Amar, "Short Story: The Final Test," *The Indian Express*, October 5, 1947, Google News Archive.

[146] Gokhale (Ranade), *माझी गोष्ट [My Story]*, 146-7.

[147] Gaganvihari Mehta, "Sceptical Scientists - Limitations Of Search For Truth," *The Times of India*, February 6, 1950; "Prejudices of the Learned," *The Times of India*, February 16, 1964.

could enjoy convenient and reasonably quick access to a biomedical doctor (or an indigenous medicine physician) as well as to respectful care in a decent healthcare setting (the latter were very often the nursing homes and maternity clinics of private practitioners, like the one in Bombay where Leela Ranade got her tonsillectomy done[148]). Evidently, much of the rest of India was relegated to only vicariously experiencing such care when they made the occasional visit, not to a healthcare center, but to the equally overcrowded and unsanitary local cinema house.

Conclusion: The Duality of "Doctor *Sahab*"

As I mentioned in the Introduction chapter, according to the dominant contemporary narrative of the biomedical profession, there was a high level of public trust in doctors in India in the early post-independence decade. I argue, however, that this narrative does not take into account the entire gamut of diverse and complex experiences and attitudes of the people of India. One important reason for this discrepancy relates to the nature of the conventional historical archive and the conventional contemporary discourse, both of which are constructions of the socioeconomic elites in India, and which thus almost exclusively privilege and propagate their ideas, beliefs and experiences. It is only after bringing in other archives and reading existing archives in new ways, that we can begin to move toward a more comprehensive picture of public perceptions.

Such a picture makes it clear that, firstly, the sustained absence of doctors from much of rural India meant that they had little to no influence in the lives of a large number of Indian people. Secondly, the underprivileged individuals and families who did come in contact with doctors encountered, at the

[148] Gokhale (Ranade), *माझी गोष्ट [My Story]*, 86.

outset, immense asymmetry of power, accentuated by the fact that the majority of doctors were from privileged castes and classes. Such power asymmetry made it difficult for patients to register a protest or complaint if the interaction were unsatisfactory (like a doctor brusquely examining them and handing over some scribbled prescription). At the same time, the power asymmetry also meant that patients almost invariably displayed outward deference to doctors in individual interactions. In this context, the phrase "Doctor *sahab*" assumes unique significance. The word "sahab" is a Hindi-language term, but it has corresponding variants in other languages, and it roughly translates to "sir." The mostly male doctors during this time (and indeed until this day) were often addressed as *sahab*. While in the minds of most doctors it probably denoted an acknowledgement of their special status as skilled and trusted professionals and as agents of modern medical knowledge, in the minds of many patients it often simply denoted an acknowledgement of doctors' class and caste status, and of their status as agents of the government or the urban elite. This duality in meaning of the most common way in which people addressed doctors, represents in many ways the multiplicity of ways in which people perceived and approached them. For example, a person might have displayed deference to a doctor and called them *sahab*, but might still have lacked faith in the doctor's treatment (and later perhaps gone to another practitioner, like the bone-setters which were mentioned in the Madras Assembly discussions analyzed above). As this chapter shows, it was far easier for people to interact with and form a relationship with local practitioners from their communities, who lived close by and generally belonged to similar social backgrounds.

In 1969-70, sociologists Göran Djurfeldt and Staffan Lindberg studied people's health-related ideas and attitudes in a village in southern India. They observed attitudes similar to those of people in other

parts of the country as detailed in the present chapter. These attitudes are summarized in this telling quote from one of their interlocutors:[149]

> If I go to the [biomedicine] clinic, I have to spend half a day for the treatment. I have to stand in a queue. I have to walk there which may be difficult when I am sick. I have to spend money for the treatment. But I can get free treatment [consultation] from the local *manthiravathi* ["religious medicine-man"]. He will come to my house. I can freely talk to him. His medicines are not costlier. When I go to the clinic I am not informed about the disease and its treatment. I can talk about that freely with the local *vaittiyan* ["indigenous medicine-man"].

Djurfeldt and Lindberg write that biomedical doctors were, in general, considered representatives of an "alien culture," and derived their status "not from their medical abilities, but from the culture they represent: they are equals to the *durei*, i.e., the 'masters' who run the country, and the white masters who once ran it."[150] With social hierarchies in general and caste in particular being central to interpersonal relationships and attitudes in India,[151] it is unsurprising that for the vast majority of Indians, except the elite, the primary identity of most doctors was that of an alien *sahab* rather than of a trustful healer. In other words, for underprivileged individuals who formed the vast majority of India's population, it was power, not trust, which characterized their relationship with doctors.

It is also important to look at people's perceptions of doctors separately from their attitudes toward biomedical therapies. Doctors and modern medical centers were absent from many parts of India during this time, but people could and did access biomedical therapies through other avenues like ersatz practitioners and local healers, as discussed above. The presence of thriving informal markets for drugs and

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[149] Göran Djurfeldt and Staffan Lindberg, *Pills Against Poverty: A Study of the Introduction of Western Medicine in a Tamil Village.* (Curzon Press, 1975), 163.

[150] Djurfeldt and Lindberg, *Pills Against Poverty*, 163-64.

[151] See, for example, R.S. Khare, "Ritual Purity and Pollution in Relation to Domestic Sanitation," *Eastern Anthropologist* 15, no. 2 (1962): 125–39; M. N. Srinivas, *The Remembered Village* (University of California Press, 1976).

injections throughout India provides substantial evidence for public acceptance of these therapeutic modalities. Thus, while biomedical doctors remained alien and distant, biomedical therapeutics were able to break the intimacy barriers (literally and figuratively) and become familiar healthcare options for India's underprivileged, often through the agency of local practitioners who freely employed these in their practice.

The mainstream public discourse failed to reflect most of these complexities and intricacies. The overwhelming state support which doctors received during this time, coupled with their elite socioeconomic status and the dominance of an optimistic discourse around modern science, all covered doctors in an aura of reverence. With time, however, many of these enabling factors came to crumble under the pressures of sweeping social, political and economic changes, as the rest of this dissertation will show.

3. ELITE WITHOUT POWER

In Salman Rushdie's novel *Midnight's Children*, which describes events in the early decades of post-independence India, one of the major characters is an obstetrician-gynecologist, Dr. Narlikar. He is portrayed as an expert ob-gyn who "dislikes babies" and is a tireless advocate of birth control. In a particular scene at his clinic, Rushdie describes him talking to a friend whose wife is about to give birth. Reassurances of not to worry are accompanied by birth control messages: the doctor says to the friend, "Birth Control is Public Priority Number One. The day will come when I get that through people's thick heads, and then I'll be out of a job." The friend, awkward and nervous, pleads with the doctor: "Just for tonight, forget lectures — deliver my child."

In the 1970s, the period under study in this chapter, a large number of Indians would indeed have liked to say that last line to their doctors. This was a time when the Indian state had entered into a new type of collaboration with the biomedical profession, enlisting it in its "population control" efforts, and many doctors in government as well as private practice contributed to birth control propaganda, known commonly in India as "family planning." This project was broadly (and enthusiastically) supported by the rest of the urban elite, and was mostly directed at non-elite, underprivileged communities throughout India.

The change in focus of the state's healthcare rhetoric, from "positive health"[1] to population control, began soon after the death of four-time Prime Minister Jawaharlal Nehru in May 1964. The experiments in healthcare which the state had embarked upon at independence, began to be more critically assessed and evaluated. These assessments, by political leaders, policymakers, and elite commentators, were

[1] One of the central concepts used in the Bhore report and employed in rhetoric by political leaders in the 1950s. See Chapter 1.

rarely enthusiastic. It was argued that while genuine achievements had been attained, the country's large and "growing" population had ended up diluting the impact of those achievements, and would also make future public health efforts less effective. Population control was proposed as the proverbial "magic bullet" solution and doctors were brought on board. The critical assessment of existing policies also led to another major shift: policymakers concluded that the Indian state needed to step back from its primary dependence on doctors to provide healthcare for the nation. They began to increasingly advocate for using the services of indigenous practitioners, auxiliary health personnel, and community health workers. While such ideas had appeared in the policymaking domain in the past, with even Nehru endorsing some of them, they gained more traction in the 1970s.[2] Within the medical profession itself, a vocal minority collaborated with social scientists and other scholars, and began to talk about the need for "alternative" approaches to medical practice, medical education and public health. They channeled their alternative visions through books, articles, and local organized groups which stood in contrast to the ever-growing presence of the largely conservative Indian Medical Association.

After a relatively smooth ride in the Nehruvian years, the relationship between the medical profession and the state underwent a reversal of the contradictory asymmetry discussed in Chapter 1,[3] and in the 1970s, the state did not blink but carried ahead with its major agendas whether or not the mainstream profession supported them. A combination of confrontation and collaboration now came to characterize their relationship. But why did the Indian state begin to modify its earlier Bhore Committee-

[2] The lecture by P.C. Mahalanobis of the Planning Commission, discussed in Chapter 1, is one example. Also see: "Meeting Medical Needs of Rural Areas - Nehru Suggests Cadre of 'Assistant Doctors,'" *Times of India* [hereafter *ToI*], November 24, 1961.

[3] That is, in the early years after independence the state, despite being considerably more powerful, conceded substantially to the profession and at the same time failed in extracting from the profession any major concession.

inspired approach toward healthcare and biomedical doctors? What forms did this shift in approach take when translated into policy? How did these changes influence people's encounters with healthcare centers and doctors? In this chapter I will explore the new dynamics between the state and the profession in the 1970s, and analyze how people's experiences with and perceptions of doctors were affected by these changes.

There are two parallel narratives in the chapter: doctors supporting the state in its population control policies, and doctors opposing the state in its community health policies. Since both policies emanated from the state's re-evaluation of its earlier healthcare models based largely on the Bhore report, I first briefly trace the origins and content of this re-evaluation. I then analyze how the mainstream medical profession responded differently to these simultaneous policy changes, and argue that the profession's response to each change neatly aligned with the interests and biases of its primarily privileged-caste membership and leadership. I also show that these changes and the profession's outlook on them were accompanied by the rise of smaller groups of "dissenting doctors" who were uncomfortable with the dominant ideas and perspectives in the mainstream profession. Finally, throughout the chapter, I discuss the changing nature of the underprivileged public's encounters and experiences with doctors in the 1970s.

Healthcare = Sterilization

In this section I describe the major characteristics of the Indian state's family planning program in the late 1960s and 1970s and its impact on people, primarily using the existing rich scholarship on these topics. This background helps contextualize the enthusiastic support which the mainstream medical profession gave to population control activities even as a large majority of the public resented and resisted them in many ways.

In the 1960s and 1970s the single most important healthcare policy development in the country was the state's increasing, and increasingly narrow, emphasis on population control strategies. This approach stood in contrast to the earlier ambition of providing comprehensive modern medical and public health services to everyone as part of a modern state's responsibility toward its citizens. The clearest harbinger to this change in emphasis came in November 1965, a year after Nehru's death, when the Indian representative to the United Nations General Assembly, K.C. Pant, discussed the experience of the Government of India in addressing social and economic problems. He decried the "almost romantic notion of social development" which had prevailed in many countries (including, clearly, India), and welcomed what he believed to be a recent shift of emphasis from the pursuit of social objectives "as an end in themselves" to the pursuance of social goals "considered in relation to economic development."[4] The main cause for the shift was that developing countries lacked resources to embark upon "ambitious" social programs. India, for example, had until then "devoted much attention to the development of health as an end in itself and had achieved some spectacular results," but those achievements had ended up putting "a greater population pressure than ever before." "Obviously," Pant told the members of the UN General Assembly, India's experience showed that "health programmes must be undertaken in conjunction with birth-control programmes."[5]

Many scholars have painstakingly illuminated and analyzed the dynamics behind the increasing seriousness and single-mindedness with which the Indian state pursued population control measures

[4] It must be noted, however, that the Union government's Planning Commission frequently emphasized the economic instrumentalist argument to justify public health investments. Amrith argues that "The Planning Commission declared explicitly that public health was but an instrument in the goal of development": Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65* (Palgrave Macmillan, 2006), 86.

[5] *United Nations General Assembly Twentieth Session - Third Committee, 1326th Meeting, 1 November 1965*, 189-90.

(dubbed collectively as "family planning" until 1977 and then "family welfare") during this period.[6] The most obvious markers of the state's seriousness were the massive financial resources spent on family planning: the Second Five-Year Plan (1956-60) had allotted Rs. 50 million to family planning efforts, which increased to Rs. 500 million by the next Plan (1961-65) and to Rs. 3.15 billion for the fourth Plan (1968-74).[7] In the logic of the planners and policymakers of India, population control deserved such massive investments because India's major challenges like poverty and underdevelopment were directly related to its "high" population. In 1974, an official in the Ministry of Health said at an academic seminar on the family planning program: "Control of population is a must if our social or economic goals have to be reached… Population is the center of this hub around which everything revolves. A runaway population growth will certainly make our tasks more and more difficult bringing in its train a series of social, political and economic problems which may completely set at naught the heroic efforts [in development work] we are making."[8]

The investments in population control were spent in several ways, including the recruitment and employment of multiple categories of healthcare personnel (family planning field workers, auxiliary nurse midwives, supervisory staff), construction of new family planning centers, subcenters and "mobile units,"

[6] For example: Marika Vicziany, "Coercion in a Soft State: The Family-Planning Program of India: Part I: The Myth of Voluntarism," *Pacific Affairs* 55, no. 3 (1982): 373–402; Mohan Rao, *From Population Control To Reproductive Health: Malthusian Arithmetic*, (New Delhi, Thousand Oaks, 2005); Aprajita Sarcar, "Mythical Families: The Small Family Norm and Everyday Governance of Population in India, 1954-1977" (thesis, 2020); Matthew Connelly, "Population Control in India: Prologue to the Emergency Period," *Population and Development Review* 32, no. 4 (2006): 629–67.

[7] Major sources on the history of the family planning program cite differing numbers in terms of financial allotments, but all agree on the massive increases in successive Five Year Plans. The numbers cited here are taken from Rao, *From Population Control To Reproductive Health*.

[8] A. Chandra Shekhar, "Valedictory Address," in *Problems and Prospects of Family Planning in India*, ed. Hem Sanwal and S.N. Agarwala (Lucknow: Population Centre, India Population Project, 1975).

use of mass media for family planning propaganda, and provision of incentives to "motivators" and "acceptors" of family planning procedures.[9] A substantial proportion of these personnel and infrastructure was deployed in rural India, where the fertility rates had been particularly worrying to Indian policymakers. Thus, beginning in the late 1960s, the earlier ambition of the Indian state to provide healthcare services to the Indian people took on the more constricted form of providing family planning services. At the same time, the state ended up greatly amplifying its presence and interventions into the lives of ordinary Indians—mostly the subaltern communities—in the name of population control and development. In contemporaneous sociologist D. Banerji's assessment, the family planning program "stumbled from one major blunder to another," with its very early emphasis on the "clinic" approach,[10] later giving way to an emphasis on the mass programs employing the intrauterine device (IUD), and then the "target-oriented" programs which set specific targets for mainly sterilization procedures, "leading eventually to the disastrous mass vasectomy camp approach" of the early 1970s.[11]

Scholars have shown that there was substantial resistance to the interventions of the state. As early as in 1970, some villagers were "slamming doors on the faces of family planning field workers," and telling the auxiliary nurse midwife in "no uncertain terms that she is welcome only when she talks of topics other than family planning."[12] Sociologists Göran Djurfeldt and Staffan Lindberg observed, in a southern Indian village, that people got angry and "often began to quarrel with" interviewers when they were asked

[9] Debabar Banerji, *Family Planning in India: A Critique and a Perspective* (People's Publishing House, 1971).

[10] That is, having birth control services available in public health centers for anyone who seeked them, but not actively directing people to them.

[11] D. Banerji, "Family Planning in India: The Outlook for 2000 AD," *Economic and Political Weekly* 9, no. 48 (1974): 1984–89.

[12] Banerji, *Family Planning in India*, 70.

questions on family planning. One of the researchers working with them was "nearly thrown out of the village" when people mistook her for a government field worker in family planning.[13] A study in 1972-73 in northern India found that "most villagers were hostile to family planning… they ridiculed or disliked family planning workers."[14] In the previous chapter I discussed how in the early post-independence years, rural government centers were only uncommonly patronized by communities, and how a number of underprivileged people often had disappointing and stressful experiences with the staff and doctors there. Now, with these "primary health" centers turned into "family planning" centers for all practical purposes, when most villagers did not consider it a priority in any manner, such public hostility and anger was not surprising.[15]

In the mid to late 1960s, the Indian government instituted a "target-oriented time bound" approach wherein public personnel working mainly in villages and towns had to complete specific numbers of IUD insertions and sterilization operations within a strict time frame, failing which they could be administratively punished, including termination of services.[16] This top-down pressure was often passed by officials on to ordinary people. In October 1969 a reporter with the *Times of India* (*ToI*) observed in some parts of Uttar Pradesh that if persuasion and inducement failed, some grassroots officials, especially those belonging to the revenue collection department, used intimidation: "the threat that the villagers will

[13] Goran Djurfeldt and Staffan Lindberg, *Pills Against Poverty: A Study of the Introduction of Western Medicine in a Tamil Village.* (Curzon Press, 1975): 199.

[14] Bhaskar D. Misra, "A Holistic Approach to Study Family Planning Programme in U.P.," in *Problems and Prospects of Family Planning in India*: 142.

[15] Mahmood Mamdani, *The Myth of Population Control: Family, Caste, and Class in an Indian Village* (Monthly Review Press, 1972); Mohan Rao, *From Population Control To Reproductive Health: Malthusian Arithmetic* (New Delhi: SAGE Publications, 2005).

[16] Banerji, *Family Planning in India*, 17.

be awarded poor land after the holdings of the landowners have been consolidated."[17] Family planning procedures done under such coercive circumstances were, unsurprisingly, marked by complications and lack of follow up. The experience of rural women with the IUD, for example, left much to be desired. The *ToI* reporter observed that often ill-fitting loops were used, that women experiencing bleeding after the procedure were rarely attended to, and that "many women have been forced to eject the loop themselves." In one particular center the loop procedures were performed not by trained healthcare workers but "by the wife of a public health department official although she has no formal training."[18] During a mass vasectomy camp in 1972 in the same state, researchers observed that the "quality of the operated cases was poor and the incidents like death of vasectomised persons or operation of unmarried boys gave an overall bad impression to the general masses."[19] Distrust in and hostility to surgical sterilization among men was widespread. A rural school teacher in Maharashtra told a reporter that sterilization had "bad effects... due to carelessness of the doctor or defects in [the procedure]." He recalled how there were quarrels in families where the husband had been operated upon but the couple had still conceived.[20]

After Prime Minister Indira Gandhi's declaration of Emergency in June 1975, these pressure tactics and structures of disincentives were complemented in many regions by blatantly coercive sterilization efforts.[21] The coercion intensified especially after April 1976 when a new National Population

[17] S.C. Kala, "Family Planning - Uttar Pradesh," *TOI*, October 19, 1969.

[18] *Ibid.*

[19] M.E. Khan and V. Chandra, "Some Observations on Kanpur Urban Mass Vasectomy Camp: Back to Square One," in *Problems and Prospects of Family Planning in India*.

[20] "'Our Farmers Are Not Lazy': Says a Village Headmaster," *Himmat*, July 16, 1965.

[21] For a brief overview of the Emergency in India, see Sunil Khilnani, *The Idea of India* (New Delhi: Penguin Books India, 1997), 43: "Invoking dictatorial powers inherited from the British Raj and carefully preserved in the Indian Constitution,

Policy was announced by Health Minister Karan Singh. The Union government decided that it was not "practical simply to wait for education and economic development to bring about a drop in fertility," instead opting for a "direct assault" on the population problem. The Population Policy encompassed several new measures as part of this "assault," including notoriously the indication to State governments to institute compulsory sterilization programs: "We are of the view that where a State legislature, in the exercise of its own powers, decides that the time is ripe and it is necessary to pass legislation for compulsory sterilization, it may do so."[22] To understand how the Emergency-era family planning program translated on the ground and was received by the public, D. Banerji and his associates went back to some villages they had studied in 1972. The new research, conducted mostly in the final months of 1976, revealed significant differences in intensity between pre and post Emergency family planning activities. People now were subjected to new pressure tactics by peripheral government officials to undergo sterilization. Banerji listed a long list of essential necessities and activities which people mentioned as having been informally linked by officials to acceptance of sterilization: issue of licences for shops, cane crushers and vehicles, loan applications, ration cards, supply of canal water for irrigation, job applications, and obtaining bail. Even primary school teachers, who were among the most common and respected faces of the state in rural India, were allocated sterilization targets by the state, "with all the accompanying threats and action if they failed to achieve these targets." In many villages, coercive measures manifested in completely unprecedented ways. Groups of officials from the public health, revenue and other local departments, with police in tow,

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[Indira Gandhi] prevailed upon the president to proclaim an Emergency in June 1975, which suspended democratic rights and judicial procedures. The Emergency accelerated the concentration of power within the interiors of a few bungalows and offices in New Delhi [that is, in the Prime Minister and her selected group of confidants]."

[22] "National Population Policy: Statement by Dr. Karan Singh," *PIB*, April 16, 1976.

were reported to have "raided villages - sometimes in the very early hours of the morning (predawn raids) - to round up sections of the people for family planning." The victims of such organized raids frequently were the "weaker sections" [that is, persons belonging to marginalized communities like Dalits, Adivasis and Muslims]. The fear of such government-backed raids was so strong that villagers would flee to neighboring fields "at the very sight of any approaching vehicle."[23]

The 1970s were thus marked by widespread apprehension and even anger against the public healthcare system in general and family planning in particular. The emphasis of the Bhore committee on "positive health" and on strengthening basic primary health infrastructure, and of the Amrit Kaur-led Ministry of Health on using modern public health and medicine to improve fundamental health indicators, were swept aside in the forceful deluge of family planning propaganda and sterilization camps. There was an almost manic emphasis on a single health-related indicator—the birth rate—at the expense of all others.[24] That the majority of people resented the government for these developments was evident in early 1977 when the Emergency was tottering to its end and preparations for a new election were underway. Reporters and opposition leaders began to throw light on the "excesses" perpetrated during the Emergency, including "family planning excesses." Even Indira Gandhi, up for re-election, promised a probe into "excesses committed by officials during the last few months."[25] She lost the election

[23] D. Banerji, "Community Response to the Intensified Family Planning Programme," *Economic and Political Weekly* 12, no. 6/8 (1977): 261–66.

[24] Notably, a manic emphasis characterized another public health program during this time, which was also, like sterilization, "vertical" and shunned the more inclusive conceptions of healthcare: smallpox vaccination. See Sanjoy Bhattacharya, *Expunging Variola: The Control and Eradication of Smallpox in India, 1947-1977* (Sangam Books Limited, 2006).

[25] "PM Promises Probe into 'Excesses,'" *TOI*, March 14, 1977.

nevertheless, and commentators attributed revulsion against family planning measures as a major reason behind public discontent against her administration.

Despite evident public discontent, however, the biomedical establishment was highly supportive of and participated in the family planning program throughout this period and later. In the next section I attempt to answer why Indian doctors agreed to participate in what was, for all practical purposes, a largely coercive state-led sterilization program in the garb of "family planning."

"Birth Control is Public Priority Number One"

Family planning was among the topics regularly discussed at the Indian Medical Association's annual All-India Medical Conferences (AIMC). At the Baroda AIMC in 1965, IMA President Shantilal Sheth argued similarly as bureaucrat KC Pant did at the United Nations (discussed above), saying that if the "rate of population increase" was not controlled, "the sheer number will restrict our mobility and completely change our life paralyzing society and culture." Lamenting that "very little progress" had been made in the program of family planning, he offered to the government assistance and cooperation from the IMA and argued that such a partnership could lead to "quicker progress and tangible results."[26] Senior doctor-politician Jivraj Mehta discussed India's growing population at the 1967 Jabalpur AIMC, and expressed pleasure at the recommendation by a conference of Deans and principles of medical colleges that the undergraduate curriculum contain a course of training in family planning and that students be trained in the practical aspects of family planning during internship.[27] At the same conference IMA President

[26] Sheth, "Presidential Address," 308-09.

[27] Mehta, "Inaugural Address - 43rd All-India Medical Conference, Jabalpur," 238.

Pranlal Trivedi talked about "population explosion" and commended the government of India for "taking up the issue in right earnest." He conveyed that the IMA was in favor of liberalizing abortion laws for better population control, something that the Indian government had been deliberating over during this time. He also expressed concern that despite the IMA's offer to support governmental family planning efforts, many state governments had "miserably failed to utilise the services of the Association, the only exception being the State of Maharashtra which has achieved exceptional results."[28] The Health Minister of the state of Madhya Pradesh, who was the chief guest at the Jabalpur AIMC, contended that general practitioners had an important role to play in the state's family planning program since they were close to people, approached by the public with "faith, confidence and respect," and thus ideally suited to judge and advise on the desirability of family planning measures.[29]

Apart from general practitioners (who formed the bulk of the IMA membership in the 1960s and 70s), obstetrician-gynecologists also championed the family planning program, and many of them, especially those who taught and practiced at government medical institutions, participated in research on IUDs, oral contraceptive pills, and sterilization procedures. In 1967, ob-gyns based at Calcutta's Nilratan Sircar Medical College recommended in a paper that "highly fertile women, coming from poor homes, aged 25 years or more and having had the desired number of children," should be offered sterilization as a part of the national population control programme.[30] In the same year at the All-India Obstetric and

[28] Pranlal R. Trivedi, "Presidential Address: 43rd All-India Medical Conference, Jabalpur," *JIMA* 50, no. 6 (March 16, 1968), 248.

[29] Rai, "Forty-Third All-India Medical Conference Jabalpur," 246.

[30] C. S. Dawn, S. Samanta, and D. L. Poddar, "Female Sterilisation as a Method of Population Control. Presented at the 14th All India Obstetric and Gynecology Congress, Nagpur, November 26-28, 1967," *Journal of Obstetrics and Gynaecology of India* [hereafter JOGI] 18, no. 2 (April 1968): 276–78.

Gynecological Congress, eminent ob-gyn B.N. Purandare talked about how ob-gyns were "silently" contributing to the family planning program "without much of press propaganda or drawing of incentives." He claimed that they had carried out "hundreds of loop insertions and postpartum sterilizations." He urged that all family planning methods should be made available to ob-gyns who "alone are competent enough to discriminate the good and bad points of each one of them and advise on the right type after gynaecological examination of the patients. If [the] over three thousand gynaecologists all over the country are taken into confidence by the governmental authorities concerned, a better impact can be realised on the family planning movement."[31]

Similar sentiments were aired during the Presidential address at the 1975 Congress by C.L. Jhaveri. Invoking Malthus and the "horrors of over-population," Jhaveri approvingly talked about the sterilization policies of the Indian state, especially of the Bombay Municipal Corporation which, he claimed, had organized more than 700,000 sterilizations over eight years. Throughout India a record number of sterilizations were taking place with the "active cooperation" of the medical profession, mainly ob-gyns. The Indian government also had by then legalized abortion as part of its family planning program, and Jhaveri asked ob-gyns to "accept the challenge" provided by the legislation, which had made it logistically easier and legally less complex for doctors to perform abortions in accidental and unwanted instances of pregnancy.[32] The general support and even enthusiasm of Indian doctors for the family planning program culminated in the National Conference on Population Control organized by the IMA in September 1975, a few months into the national Emergency declared by Indira Gandhi. It was a three-day-long affair in

[31] B. N. Purandare, "Presidential Address - The 14th All India Obstetric and Gynecology Congress, Nagpur," *Journal of Obstetrics and Gynaecology of India* 18, no. 1 (February 1968): 1–8.

[32] C.L. Jhaveri, "Presidential Address - XVIII All India Obstetric and Gynecology Congress," *JOGI*, 1975, 93–101.

Delhi, attended by several eminent doctors and also government officials, including Health Minister Karan Singh. Participating doctors discussed a whole gamut of issues including the role of doctors in population control (where the roles of women doctor, surgeons, and general practitioners were discussed separately) and recent technology and developments in family planning methods.[33]

Clearly, when it came to population control, the medical profession and the state were in a highly cooperative and collaborative relationship, even if to the detriment of the ordinary public. While the general enthusiasm of biomedical practitioners for reductionist approaches and interventional medical procedures could be an enabling factor here, there is still more to be said about why many doctors were supportive of the state's family planning program. A large part of the explanation lies, I argue, in the elitist social, cultural and economic background of the majority of India's doctors, whose support for population control aligned with the broader elitist imagination of India's "population problem." This imagination predated the decade of the 1970s. For example, the Indian National Congress's National Planning Committee, constituted in the late 1930s, had among its subcommittees one exclusively dedicated to "population." The subcommittee believed that India's population was showing an "unrestricted increase" and that family planning and a "limitation of children" were essential and needed to be encouraged by the Indian state.[34] Sanjam Ahluwalia has argued that since the late 1800s the discursive domain of doctors and other elites was suffused with discussions and debates on the size of India's population. At the beginning of the twentieth century these discussions became more common and more urgent, with eugenic thought

[33] *Recommendations and Documents - National Conference on Population Control, September 19-21, 1975* (New Delhi: Indian Medical Association, 1975).

[34] *Population (Report of the Sub-Committee, National Planning Committee Series)* (Bombay: Vora and Co. Publishers Ltd, 1948): 144-45.

making an entry and becoming normalized in the Indian elite discourse.[35] Sarah Hodges has shown that several voluntary societies and associations related to eugenics were formed in the early 1900s, often by doctors, and their "most immediate contribution was the distribution of contraceptives and contraceptive information to their membership." In other words, she contends, eugenic work in colonial India was indistinguishable from birth control activities.[36]

The keen interest of elite Indians in birth control and eugenics stemmed from their concerns around India's "growing" population as evidenced by the decennial censuses which had become a kind of "media event" in colonial India, and the neo-Malthusian scenario of catastrophes that were thought to ensue. Eugenicists asserted that "Indians could manage their own reproduction and in so doing breed a better India."[37] This seemingly nationalist understanding was, however, heavily colored by caste, class, and religion-based biases and discriminatory attitudes. Ahluwalia cites one elite advocate of eugenics and birth control who claimed that the primary cause for India's poverty was "thoughtless, irresponsible and extensive breeding, particularly among the middle and poor classes." She argues that "eugenic concerns of racial degeneration coupled with Malthusian dread of an ever-increasing population" fueled the birth control advocacy of many elites in the early twentieth century, some of whom complained how "India resembled a vast garden literally choked with weeds, fine roses being few and far between."[38]

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[35] Sanjam Ahluwalia, *Reproductive Restraints: Birth Control in India, 1877-1947* (University of Illinois Press, 2010): 1-22.

[36] Sarah Hodges, "South Asia's Eugenic Past," in *The Oxford Handbook of the History of Eugenics*, ed. Alison Bashford and Philippa Levine (Oxford: Oxford University Press, 2010).

[37] Hodges, "South Asia's Eugenic Past."

[38] Ahluwalia, *Reproductive Restraints*, 31.

In the 1920s, many Indian doctors began to advocate for the inclusion of birth control training in the medical curriculum. Ahluwalia lists a number of editorials and articles which appeared in Indian medical journals since the 1930s, with the phrase "population problem" or some variant of it in the title. For example, an editorial titled "India's Teeming Millions" was published in the *Calcutta Medical Journal* in November 1938, and a report, "Rapid Increase in the Population of India," was published in *Indian Medical Record* in August 1938.[39] Like with their other elite counterparts, the writings of doctors in favor of birth control often betrayed their classist and casteist imaginations of the supposed problem of overpopulation. Writing that contraception was being used almost exclusively by upper and middle-class Indians, the *Calcutta Medical Journal* argued that "the practice of birth control in India was slowly but surely killing the growth of 'A-grade' population." Another doctor wrote in 1945 that "control of breeding is more necessary in the case of the poor; but they do not practice it and go on begetting children freely without any check. It means an increase in the number of inferior stock which is undesirable in the interest of the future generation."[40]

Though medical journal articles after independence did not feature such explicitly eugenic advocacy of population control, that did not necessarily mean that doctors had changed their fundamental opinions in any major ways, and their class and caste backgrounds, and discursive spaces, remained essentially the same as before. Besides, many doctors were trained in or practiced in the 1920s-40s, and thus carried over the classist, casteist and eugenic understandings of the "population problem" and birth control to the new nation—and to a new generation of doctors, most of whom shared similarly elite backgrounds.

[39] *Ibid*, 146.

[40] *Ibid*, 147.

Thus in the 1950s and later, we see doctors continuing to talk about the "population problem" and ways to address it, and though they did not publicly mention ideas like "improving the stock" of the Indian population, they almost always targeted the "masses" and the "teeming millions" in their writings and speeches. One explicit example of elite doctors incorporating eugenic thought into their framing of the population problem is a letter to the *ToI* by Bombay-based "lady doctor" Shantabai G. Doshi in December 1957. Doshi argued for population control to form the basis of India's planning efforts, but cautioned against relying on voluntary family planning because the "masses are steeped in ignorance, apathy and tradition." She believed that a "certain amount of compulsion" had become necessary and suggested that India could make a beginning in that regard by making sterilization compulsory for "at least those suffering from leprosy, consumption, etc."[41] Such a demand, to sterilize "adults suffering from incurable diseases or insanity," even made it to the Indian Parliament: a resolution to this effect was introduced by member Lilavati Munshi in August 1953. Her resolution did not come to pass, being opposed by other members including Health Minister Amrit Kaur. Interestingly, during this debate, a member who also was a doctor, R.P. Dube, expressed "wholehearted" support for such enforcement of sterilization.[42]

To summarize, in terms of why doctors were so supportive of the state's family planning program, the most important answer in my view lies in the casteist and classist lens through which they looked at the underprivileged communities whose "teeming" numbers they asserted needed to be "controlled." Arguing that the educated classes—which mostly meant privileged elites like themselves and their caste and class peers—already were practicing birth control, doctors believed that it was the underprivileged and the

[41] Shantabai G. Doshi, "Population Control - To the Editor," *TOI*, December 10, 1957.

[42] "Resolution Regarding Sterilisation of Adults Suffering from Incurable Diseases and Insanity," *Rajya Sabha Debates*, August 28, 1953.

marginalized who needed to be targeted by the family planning program. While for some elites and doctors such targeting meant better health education and effective propaganda, many others believed that the efforts needed to be more interventional and less voluntary. As C.L. Jhaveri later recounted, influential ob-gyns in the 1950s, like G.M. Phadke and V.N. Shirodkar, were advocating for mass sterilization even while the government itself was emphasizing only the extension approach (that is, keeping services available for those who voluntarily demanded them).[43] In this respect, the hosting of the National Population Conference by the IMA in September 1975 is telling. It was organized when the country was already a few months into the Emergency, with many democratic rights being summarily suspended by the government. In addition, the Indian public's resistance to population control measures was well known by then. That the IMA nevertheless staged such a conference and invited government dignitaries, including the Health Minister, was highly symbolic of the intimate concurrence between the state and the profession when it came to population control directed at India's subalterns. The conference was also symbolic of the paternalistic attitudes on the part of both the state and the medical profession, since both evidently ignored or downplayed public resistance. As mentioned at the beginning of this chapter, the condescending attitude of doctors toward India's "masses" made it even to fiction during this period. Salman Rushdie's 1981 novel *Midnight's Children* featured the Bombay-based ob-gyn Dr. Narlikar (whose name suggests he belonged to the elite Brahmin caste), who was said to write pamphlets and "berate" the nation on the subject of contraception in the 1940s, and who once told his friend that "Birth Control is Public Priority Number One."[44]

[43] Jhaveri, "Presidential Address - XVIII All India Obstetric and Gynecology Congress," 7.

[44] Salman Rushdie, *Midnight's Children* (London: Jonathan Cape, 1981), 114.

While doctors were wholeheartedly participating in population control efforts and going to mass sterilization camps to offer their services, they were still not going to villages, at least not in numbers that the state would have liked. In the next three sections I will take up this parallel story, in which the Indian state decided to move away from its dependence on biomedical doctors and directed its attention to finding "cheaper" alternatives for rural India. But when the state did finally come up with a solution which would have meant less public admonitions for doctors to "go to villages," doctors were, surprisingly, not happy.

Villages: Where There Was No Doctor

In this section, I discuss the background for the state's new policies for rural healthcare in the 1970s. As I showed in previous chapters, biomedicine and doctors were afforded immense political and budgetary attention by the Indian state during the 1950s and 1960s. The number of medical colleges increased from 30 in 1947 to 106 in 1979, while the number of doctors rose from around 47,000 in the mid-1940s to around 108,000 in the mid-1960s, and then to approximately 235,631 in the late 1970s.[45] Thus there was a fivefold increase in the number of doctors in India in the first three decades of independence. The rise was so rapid that the All-India Medical Conference (AIMC) in 1967 urged the Union and state governments to suspend the building of new medical colleges and the expansion in the number of seats "until adequate steps are taken to provide sufficient staff, equipment and necessary number of hospital beds for imparting necessary training to students."[46] Veteran physician-politician Jivraj

[45] V. Ramalingaswami et al., "Health For All: An Alternative Strategy" (Delhi: ICMR and ICSSR, 1981), 235-239.

[46] "Forty-Third All-India Medical Conference Jabalpur - Resolutions Passed at the Conference," *Journal of the Indian Medical Association* (hereafter *JIMA*) 50, no. 6 (March 16, 1968): 254.

Mehta was also highly critical of the rapid increase in the number of medical admissions and colleges. In his address to the 1967 AIMC, he said that India's politicians were tackling the population explosion problem on the one hand but on the other hand were "creating the problem of the explosion of admissions of medical students."[47]

In the post-Nehru period, however, despite the increase in the number of colleges and doctors, the state was beginning to realize that one of its main goals—bringing doctors to India's villages—was far from being even partially achieved. We get some insights into the dilemmas of the state in the speech of R.C. Rai, Health Minister of Madhya Pradesh, at the 1967 AIMC. He told the gathered doctors that despite the "tremendous expansion" of medical education, there were few doctors available for rural medical relief, with most choosing to go into private practice in cities, or abroad, or for postgraduate studies.[48] There were also few doctors willing to take up non-clinical subjects, which was causing a shortage of teachers in medical colleges, although here the minister acknowledged that the government needed to "revise" pay scales. He was also worried about the increasing cost of medical treatment, remarking that the prices of certain life-saving drugs were "rather high."[49]

That the majority of doctors were not keen to live in villages was known to policymakers since before independence. In the conference of provincial Health Ministers in 1948, rural medical relief was discussed at length. Documents prepared for the conference detail the different schemes initiated by

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[47] Jivraj Mehta, "Inaugural Address - 43rd All-India Medical Conference, Jabalpur," *JIMA* 50, no. 6 (March 16, 1968): 240.

[48] In 1968, nearly 7% of Indian doctors were estimated to be working abroad (8000 in number). Throughout the 1970s, the percentage figure hovered around 7-8. See Roger Jeffery, "Migration of Doctors from India," *Economic and Political Weekly* 11, no. 13 (1976): 502–7.

[49] R.C. Rai, "Forty-Third All-India Medical Conference Jabalpur - Address at the Inauguration of the Pharmaceutical, Scientific and Family Planning Exhibition," *JIMA* 50, no. 6 (March 16, 1968): 243.

provincial governments to encourage doctors to settle in villages. For example, the East Punjab government was mulling allotment of land and houses, as well as loans, to doctors. Other states were offering honoraria and allowances, and providing "mobile clinics" in some villages. At the same time, the fundamental challenges involved in the migration of doctors to villages were acknowledged. The background documents for the conference display bureaucratic awareness that "the problem of providing health services to the rural population is one of great complexity."[50] A glimpse into this complexity is seen in the 1950 article by physician U.B. Narayanrao on rural medical relief, discussed in Chapter 1. Despite the difficulties and complexities, political leaders and administrators continued to try out different solutions to this long-standing problem.

Apart from monetary and land incentives as described above, politicians and elite commentators often made moralistic appeals to doctors. In early 1948 Health Minister Amrit Kaur expressed surprise at the fact that many of the doctors displaced by Partition and in search of employment were unwilling to take up posts in rural areas. Speaking at the Lady Hardinge Medical College in Delhi, she said she was hurt to "find among our displaced doctors, both men and women, no or little desire to restart their medical life in villages or even in small townships. A miserable room in a city like Delhi attracts them more. This is a wrong attitude and while government must share the blame to the full in not having made the village attractive and liveable, educated and trained persons... have got to be pioneers and migrate to the villages and become one with the villagers if India is to rise to her full stature."[51] In April 1964 at the All India

[50] "Agenda Item No. 7. Memorandum on Rural Medical Relief, in 'Second Health Ministers' Conference - August 1948'," 1948, f. 564-P/48 in DGIMS, National Archives of India (hereafter NAI).

[51] "Medical Aid for Masses: Health Minister Urges Doctors to Migrate to Villages," *Press Information Bureau* (hereafter *PIB*)*, Govt of India*, March 17, 1948.

Institute of Medical Sciences (AIIMS), Prime Minister Nehru urged graduating doctors to work in villages, arguing that "no matter how good and well-intentioned an institute might be, it will not be able to serve a useful purpose unless its services reached people in rural areas."[52] In November the same year, Prime Minister L.B. Shastri made similar appeals, describing a visit to a rural dispensary and the experience of being "pained" to see that it had "no doctor, no nurses, and not even trained compounders."[53] Such appeals did not, unsurprisingly, have any appreciable effect on the ground. Seventeen years into independence, the articulation of what appeared to be half-hearted and perfunctory appeals by Prime Ministers to recently-graduated young doctors, showed that the state did not have many arrows left in its quiver.

Some state governments mulled re-starting the Licentiate in Medicine and Surgery (LMS) course, though strong opposition by both the Medical Council of India and the IMA ensured that the idea was not implemented.[54] Apart from these, the state time and again seemed to indicate that it would introduce policies of "compulsory rural service for doctors for a specified period." Such plans made it to newspapers on several occasions in the 1960s.[55] Despite the rhetoric, it is clear that there was little to no implementation of such plans, at least at the federal level. In 1972, a National Service Act was passed by the Parliament, under which the state was entitled to enlist any qualified persons, including doctors, for four

[52] "Doctors Must Go to Villages - Nehru's Call at Convocation," *TOI*, April 16, 1964.

[53] "Change Attitude to Common Man: Shastri's Call to Doctors," *TOI*, November 24, 1964.

[54] "Bid To Revive Licentiate Medical Course Opposed: MOST RETROGRADE MOVE SAYS I. M. C. PRESIDENT," *TOI*, November 6, 1960; S. C. Sheth, "Presidential Address," *JIMA* 46, no. 6 (March 16, 1966): 304. In Chapter 1 I also discussed a similar proposal by Mahalanobis.

[55] For example: "Revival of Short-Term Course Assailed: 'Few Licentiate Doctors in Rural Areas,'" *ToI*, December 29, 1965; "Licentiates in Medicine: Course Likely to Be Revived," *ToI*, November 1, 1960

years of service wherever it deemed necessary. Jeffery observed in the 1980s that even this Act had "not been implemented, in spite of occasional threats to use it to fill empty medical posts in rural areas." He attributed this to the state's "refusal to consider compulsion."[56]

At the same time as the state was making largely unsuccessful appeals to doctors to go to villages, it was also making heavy investments in building new medical colleges and expanding medical seats. While this reflected some optimism on the administrative side that young doctors could be coaxed to go to villages—or even mandated to work there for a limited period of time—another important reason for these investments was the prevalence of a "doctor-centric" model of healthcare in India. The continuing influence of the Bhore and Mudaliar[57] committees, both composed of and influenced heavily by biomedical doctors, and their strong emphasis on the statistical measure of the "doctor-population ratio," meant that policymakers were looking at quantitative increases in doctor numbers as an essential prerequisite for better healthcare provision to people. The discourse on the doctor-population ratio was not new. In the 1930s the National Planning Committee's subcommittee on Health had opined that "to cover all the various medical needs of our country, at least two medical men or women per 1,000 of population" were needed.[58] The Bhore Committee commented on the supposedly inadequate ratio in India (1:6300) by contrasting it with that in England (1:1000) and the United States (1:750). While they acknowledged the inaccuracies and challenges involved in such blanket comparisons, they concluded that it was still important for India to raise the ratio "considerably" if the standard of medical relief were to

[56] Roger Jeffery, *The Politics of Health in India* (Berkeley: University of California Press, 1988), 259.

[57] The Mudaliar Committee was commissioned in the late 1950s to survey India's healthcare in the 10 years following the Bhore report and to suggest new recommendations which took into account the changed circumstances of the country.

[58] *National Health (Report of the Sub-Committee, National Planning Committee Series)* (Bombay: Vora and Co. Publishers Ltd, 1948): 42.

"approach the levels already attained" in England and the U.S.[59] The emphasis on the ratio continued beyond independence, and politicians and policymakers frequently alluded to how the government was working to increase the doctor-population ratio. The Planning Commission, for example, wrote in 1961 with some anxiety that the expansion of training facilities for doctors had "barely kept pace with the growth of population, the population-doctor ratio remaining at 6000:1 over the decade 1951-61," and noted that the ratio would remain unchanged for the duration of the third Plan.[60] In 1965 Health Minister Sushila Nayyar also mentioned the ratio in her address to the Central Council of Health, and said that the government was working to bring the ratio to 1:3500 by 1975-76, which was one of the recommendations of the Mudaliar Committee.[61] Later in the 1970s, the pharma company Hoechst incorporated anxieties over the doctor-population ratio into an advertisement published in an IMA publication. The ad was an ode to doctors in India, who remained "undeterred" by the strain of the supposed paucity of doctors caused by the doctor-population ratio in India being "as high as 1:5000." The Indian [male] doctor "continues his relentless efforts to alleviate suffering," efforts to which the company contributed "by bringing him newer and better drugs." The punch line of the ad was: "If only his day had 30 hours."[62]

However, it had become clear to the Indian state by the late 1960s that despite its success in increasing the total number of medical colleges and doctors, few out of the increasing number of doctors were ever going to work in villages (although many were migrating to the US and UK, where they did

[59] Joseph Bhore et al., *Report of the Health Survey and Development Committee*, vol. 1 (New Delhi: Manager of Publications, 1946): 36.

[60] Planning Commision, Government of India, "Chapter 32: Health and Family Planning," in *Third Five Year Plan*, 1961.

[61] "1 Doctor for Every 5,800 of Population by 1966," *TOI*, July 21, 1965.

[62] Ad published in: "II National Conference on Medical Education, March 21-23 1976 (Preliminary Issue)," in *Medical Education - Undergraduate, Postgraduate, Continuing* (New Delhi: Indian Medical Association, 1976), 9.

indeed work in rural settings[63]). At the same time, important political and social changes were underway in rural India, and the ruling Congress party, until recently secure in the massive appeal of Nehru's personality and political acumen, was realizing that it could no longer take the Indian public's approval for granted. As Kaviraj has written, "politicians of all parties had lost the inexhaustible fund of legitimacy that Nehru's generation had from their leadership in the national movement. The new generation of leaders, including Congress leaders like Indira Gandhi, had to acquire support in the short term by electoral promises of resource distribution."[64] In the preface to the fourth five-year plan document, dated July 1970, Prime Minister Indira Gandhi pointed to India's new political challenges when she wrote: "We have a larger and, understandably enough, a more articulate population." She talked about rural disparities and about how a "burning sense of social justice" needed to be a crucial inspiration behind policymaking. To secure social justice and reduce disparities of income and wealth, a "reorientation of our socio-economic institutions" was necessary.[65] Khilnani has characterized this policy reorientation of the 1970s, which was part of Gandhi's broader populist politics, as "gestural radicalism."[66]

Gandhi's reorientation ideas extended to healthcare and medicine, a shift best represented by a short handwritten note dated November 1971, penned by her and addressed to Minister for Planning C. Subramaniam. She asked him whether the Planning Commission would be able to "set up some small groups to study problems in depth." Among the topics she mentioned was medicine: "How to provide

[63] Eram Alam, "Cold War Crises: Foreign Medical Graduates Respond to US Doctor Shortages, 1965–1975," *Social History of Medicine*, March 8, 2018.

[64] Sudipta Kaviraj, *The Imaginary Institution of India: Politics and Ideas* (Columbia University Press, 2010), 226.

[65] Indira Gandhi, "Preface," in *Fourth Five Year Plan*, 1970.

[66] Sunil Khilnani, *The Idea of India* (New Delhi: Penguin Books India, 1997), 44.

inexpensive treatment to rural, forest, and hill areas.. How to utilize local herbs and indigenous systems... Can some concept of "peasant doctors" be worked out?" She ended the note by mentioning the example of China, which was known to have developed a "useful combination of the old and the new and to involve local people."[67] As the next two sections will show, this reorientation exercise by the Indian state under Gandhi eschewed the earlier primary dependence on biomedicine and biomedical doctors, and culminated in instituting a large cadre of community health workers for rural India.

Looking Beyond Biomedicine

A year prior to Gandhi's note to Subramaniam, in 1970, her Cabinet had made the decision to provide official recognition to the "Indian systems of medicine" (ISM).[68] This was in contrast to the 1949 decision of the Nehru government's Cabinet that "modern scientific medicine should continue to be the basis for the development of the National Health Services in the country."[69] A note prepared in April 1970 for the then Union Cabinet stated that there was a "strong feeling" among practitioners of the Indian Systems of Medicine that the 1949 decision was inhibiting the growth of these systems. At the same time, a panel on Indian Systems of Medicine set up by the Planning Commission had urged a review of the 1949 policy "in view of the progress in the development" of the ISM. This progress included such developments as: the opening of several ISM colleges, as well as higher educational institutions for Ayurveda at Varanasi and Jamnagar; the setting up of Statutory Boards/Councils/Faculties for ISM in different states; and the

[67] "Proposal to Set up Small Groups," November 27, 1971, f. 17(1204)/71-PMS, NAI.

[68] In common official usage this term encompassed the medical traditions of Ayurveda and Unani, although at times the Siddha system was also implied. Homeopathy, though not of Indian origin, was also accorded similar policy concessions by the Union government during this time as Ayurveda and Unani.

[69] The 1949 decision was discussed in chapter 1.

Union government's consistently rising investment in ISM, from Rs. 375,000 in the first Plan to nearly Rs. 163 million in the fourth Plan. With these developments as the backdrop, the Cabinet meeting took place on April 16, 1970, with Health Minister K.K. Shah in attendance. The 1949 decision, which had underpinned the Union government's healthcare policy for more than two decades, was modified thus: "The Union and State Governments should decide that modern scientific medicine (Allopathic) and Ayurvedic, Unani and Homeopathic systems of medicine should contribute towards the development of the National Health Services in the country."[70]

Increasing reliance on ISM—and thus a step away from exclusive dependence on biomedicine—was one of the central aspects of the new approach of the Indian state toward healthcare. The reasons for this were manifold. Practitioners of the ISM, especially Ayurveda, had been lobbying with the Union and state governments for years to augment the official recognition of these systems, and had already achieved varying degrees of success with many prominent state governments. For example, Rajasthan and Kerala had separate ministries for Ayurveda, and "thousands of Ayurvedic and Unani dispensaries [had] been set up by state and local governments throughout the country."[71] Besides, there was an active demand for ISM-based health services within the elite public in India, as indicated by the fact that though the first Ayurvedic dispensary under the Central Government Health Scheme (CGHS)[72] was established only in 1963 "on an experimental basis," the CGHS was running five Ayurvedic and two homeopathic

[70] "Change in the Policy Regarding Development of National Health Services," 1968, f. 12-2/68-APC, Ministry of Health section, *NAI*.

[71] Paul R. Brass, "The Politics of Ayurvedic Education: A Case Study of Revivalism and Modernization in India," in *Education and Politics in India: Studies in Organization, Society and Policy*, ed. Susanne Hoeber Rudolph and Lloyd I. Rudolph (Cambridge: Harvard University Press, 1972): 347.

[72] This was an elite health insurance scheme run by the Union government for its employees.

dispensaries in just Delhi by 1970.[73] But perhaps the more pressing reasons for the state's shift toward ISM had to do with the slow rate of expansion of public biomedical centers (mainly, the rural primary health centers, or PHCs), the growing costs of biomedicine, and the growing population of India, with the political challenges that these entailed. As described above, the Bhore and Mudaliar Committees' plan of three tiers for healthcare provision, with the rural PHC as the basic tier, was running into problems in the absence of doctors willing to work in these PHCs. In such a scenario, indigenous systems of medicine held a particular attraction for policymakers. In April 1968, for example, Health Minister Satya Narayan Sinha indicated that the Government was making "a concentrated effort" to provide medical relief in rural areas, but that "in spite of the vast expansion of medical and health activities, there was a large gap to be covered." He suggested that "the Vaids and Hakims could fill this gap."[74] In 1972, the Secretary in the Ministry of Health expressed similar ideas. He said there were about 300,000 practitioners of the Indian systems of medicine and homoeopathy, and the services of many of them could be "utilised to cover the rural areas after providing them some training."[75]

Local, community-based practitioners of chiefly Ayurveda and Unani were thus projected as a legitimate alternative to biomedical doctors for rural healthcare in India.[76] The government which replaced

[73] "Change in the Policy Regarding Development of National Health Services"; "More Ayurvedic and Homeopathic Dispensaries Under CGHS: Shri Murthy's Inaugural Address," *PIB, Govt of India*, March 15, 1969.

[74] "Development of Indian Systems of Medicine," *PIB*, April 25, 1968.

[75] "Promotion of Indian Systems of Medicine: Two-Day Conference of State Directors Begins," *PIB*, July 18, 1972.

[76] It is important to distinguish these practitioners from the graduates of Ayurvedic and Unani medical colleges, who belonged to the "modernized" and "professionalized" forms of these traditions. As Paul Brass wrote in 1972, "neither of the professionalized forms of medicine [modern and Ayurvedic] have [sic] spread widely in the rural areas, where people have to depend upon a diverse assortment of allopaths, vaidyas, hakims, homeopaths,..." Brass, "The Politics of Ayurvedic Education: A Case Study of Revivalism and Modernization in India": 352.

Indira Gandhi's in 1977 also subscribed to this idea, and its administrators frequently invoked the supposed rural reach and inexpensive care provided by ISM practitioners. In March 1978, Health Minister Raj Narain pointed to the economic aspects of encouraging the ISM, discussing how ISM-based drugs were "relatively cheaper in production" and that their production could also "be done on a small scale."[77] The conference of the State Directors of the ISM in September 1978 recommended that practitioners of the ISM be "utilised" in family welfare and Rural Health schemes, and that "qualified ISM practitioners should be employed in Primary Health Centres and sub-centers."[78] The Minister of State for Health, speaking at this conference, said that the provision of "effective mass health care" was possible only through the ISM as "they already were available all over the country in the rural areas."[79]

The late 1960s and the 1970s thus were marked by an increasing acceptance and legitimation by the state of what they called the Indian systems of medicine, and of local practitioners in these systems. Within just two decades of independence and soon after the death of Nehru, the state was beginning to abandon its exclusive reliance on biomedicine and doctors for providing healthcare to its people. The Bhore committee-inspired "basic doctor" approach ended up being only a transitory experiment in India's healthcare policy. In fact, as the 1970s proceeded, sharper and radical critiques of the Bhore and Mudaliar committees' approach became common. The most powerful and influential of these critiques eventually coalesced into the idea of instituting an "army" of community health workers for India's villages.

[77] "First C.G.H.S. Ayurvedic Hospital Opened: Shri Raj Narain's Call for Proper Utilisation of Indian Systems of Medicine," *PIB*, March 10, 1978.

[78] "Recommendations of State Directors of Indian Systems of Medicine Conference," *PIB*, September 25, 1978.

[79] "Mass Health Care Through Indigenous Medicine: Shri Jagdambi Prasad Yadav's Address at Meeting of State Directors of Indian Systems of Medicine," *PIB*, September 21, 1978.

Looking Beyond Doctors

The late 1960s and early 1970s was a time when the Bhore report-inspired healthcare philosophy of the Nehruvian developmental state was coming under attack from multiple quarters, and the state began to reorient and recalibrate its approach toward healthcare provision. Indira Gandhi's letter, as shown above, signified the major themes of this search for alternatives: inexpensive care, simultaneous employment of the traditional and the modern, and community participation. These themes were brought together by Gandhi in an address to the Association of Physicians of India (API) in 1976. Referring to the post-independence continuation of the British colonial models of medical curriculum and training, models in which even the Bhore and Mudaliar Committees had suggested few alterations, Gandhi said that India's healthcare system was based on the "European model of the last century," with medical education ignoring "the existing curative and craft traditions." The "West-derived educational system," she believed, emphasized "personal advancement rather than responsibility to the community. These have led to city-centredness, neglect of villages, loss of social perspective and brain drain. It is obvious that our medical organization should be community rather than hospital-based."[80] It is possible that such arguments, coming from the Prime Minister and said to a congregation of some of the most elite doctors of the country at an API conference, might have led to much discomfort in the audience. This was both a direct critique of India's biomedical establishment and an implicit critique of the healthcare policies of the earlier

[80] Quoted in R. N. Sinha, "Barefoot Doctors or Health Auxiliaries: A Plan of Action," *JIMA* 67, no. 5 (September 1, 1976): 134–36. While Gandhi's interest in finding alternatives and in indigenous medicine goes back to at least 1971 as I discussed above, this particular attack on the "West-derived educational system" might have been precipitated, at least partially, by the 1975 decision of the UK's General Medical Council to suspend the recognition of Indian medical degrees for practice in the UK. This decision was heavily criticized by Indian politicians and doctors, and considered as an unjust attack on the quality of education in the country. See "G.M.C. Statement: Recognition Of Indian Medical Qualifications," *The British Medical Journal* 2, no. 5969 (1975): 512–512; Roger Jeffery, "Recognizing India's Doctors: The Institutionalization of Medical Dependency, 1918-39," *Modern Asian Studies* 13, no. 2 (1979): 301–26.

decades which had encouraged and helped ensconce this establishment. Under Gandhi's leadership, the state was not simply dissatisfied with the principles and policies of its earlier leaders, but also wanted to embark on a radical rehaul.

The quests for alternatives to India's existing "West-derived" models came together and thrived in a unique organization: the Indian Council of Social Sciences Research (ICSSR). This was an autonomous body of the Government of India founded in 1969, and among its primary objectives was devising and sponsoring social sciences research programs and projects. In the mid-1970s, ICSSR initiated a research project under the title of "Alternatives in Development." The importance of this project for the institution is evident from the fact that a review committee in 1978 found it to be the second most funded endeavor by the ICSSR, next only to Population Studies.[81] The project focused on several topics in development and gave rise to multiple publications and policy recommendations.[82]

A series of two articles in 1979 by the political scientist Rajni Kothari, for the ICSSR newsletter, expounds in detail the philosophy of the Alternatives in Development project. Referring to the Russell-Einstein manifesto of 1955[83], Kothari said that the way to a "new Paradise," promised by the two scientists, did "not seem so clear" in his day, with the world instead marked by immense injustice and inequities. In his analysis, the primary cause for that state of the world was the "acquisitive ethic of modern man which in course of time led to a situation in which a minority of nations have in pursuit of a parasitic and wasteful

[81] "Report of the Second Review Committee" (New Delhi: Indian Council of Social Science Research, August 1978): 19-20.

[82] For example: Rajni Kothari, *Democratic Polity and Social Change in India: Crisis and Opportunities*, Alternatives in Development (Bombay: Allied Publishers, 1976); J. P. Naik, *Equality, Quality, and Quantity: The Elusive Triangle in Indian Education*, Tagore Memorial Lectures 1975 (Bombay: Allied Publishers, 1975); C. T. Kurien, *Poverty, Planning, and Social Transformation*, Alternatives in Development : Planning (Bombay: Allied, 1978).

[83] Sandra Ionno Butcher, "Russell-Einstein Manifesto," in *The Oxford International Encyclopedia of Peace*, ed. Nigel J. Young (Oxford University Press, 2010).

style of life, shored up a large majority of world resources." He grouped global South elites with the people of affluent nations, arguing that the former had embraced the wasteful lifestyles and philosophies of the latter, which had led to countries of the "Third World" failing to pursue policies "that are called forth by their socio-economic, demographic and cultural conditions which happen to be quite different from the conditions that obtained in the developed nations during their respective phase of development." Although modern science had liberated humans from the "horrors of nature and the horrors of religious doctrine," its origins in the "Western" culture that looked upon it as "an instrument of power and domination rather than as a liberator of the human spirit as such - which is how knowledge was looked upon by the ancient Chinese or the Indians, or even the ancient Greeks," had led to exploitation, competition and perpetual tension.[84] Kothari's theoretical analysis in these essays distilled many of the ideas that others in India had been proposing and debating since the beginning of the "decades of disillusionment"[85] in the late 1960s, with some reflected in the pronouncements of Prime Minister Gandhi as we saw above. The quest for alternatives was thus an academic as well as political quest for sustainable models for India which would replace the dominant "Western" models, would be appropriate to "Indian conditions," and be inspired by "traditional" Indian ideas.

In a 1977 lecture, J.P. Naik discussed how this quest could play out in the fields of medicine and healthcare. Naik was a prominent activist, intellectual and freedom fighter, and in the 1970s, as Member-Secretary of ICSSR, had become an important force behind the Alternatives in Development project. His

[84] Rajni Kothari, "Alternatives in Development: Towards a Conceptual Framework," *ICSSR Newsletter* 9, no. 1–2 (1979): 1–10. The other article in this series was: Rajni Kothari, "Alternatives in Development: Perspective on Alternative Development Strategies for India," *ICSSR Newsletter* 9, no. 3–4 (1979): 1–14.

[85] I borrow this phrase from Vikrant Dadawala, "The 'Indo-Anglians' in Search of the World," *CASI Student Programs Blog* (blog), June 16, 2020.

1977 lecture, on "An Alternative System of Health Care Services in India," was organized by the Indian Association for the Advancement of Medical Education. Like other intellectuals during this time, he discussed India's "uncritical" following of "Western" models which supposedly emphasized curative, hospital-based, and doctor-centric care, and which ended up benefiting mostly the urban "well-to-do" communities. Employing an evocative analogy, he said that after thirty years of independence, "we find ourselves in the position of a traveller who sets out on a long journey, and even before he has travelled about three-tenths of the distance to his goal, finds that his purse has been stolen, his car has developed serious trouble and grave doubts have arisen even about the correctness of the route he had decided to follow." He did not propose complete rejection of the models of industrialized nations (repeatedly saying that one need not look at these issues with an "either-or" approach), but suggested that "we may be *guided* by the experience of the West (or of the whole world) but not *conditioned* by it [emphasis original]." Here he mentioned Mohandas Gandhi's famous quote: "Let the winds from all corners of the world blow in through the windows of my house, but I refuse to be blown off my feet by any."[86]

With respect to the "agents" of healthcare, Naik invoked "tradition in ancient India" where care supposedly was provided by selected persons from the community who "generally worked on a part-time basis and provided their services either free of charge or at a nominal cost." A good example of such a care provider was the village *dai* (midwife), he said, who remained an important healthcare provider in many parts of India. But when policymakers adopted the "western model of paid and full-time professionals" the *dai* was treated "with contempt and was to be replaced by an A.N.M. [auxiliary nurse-midwife]." Policymakers believed that modern technology "could not be taken to the people through these old agents;

[86] J.P. Naik, "An Alternative System of Health Care Services in India: Some General Considerations," *Bulletin of the I.I.E.*, 1977: https://archive.org/details/AnAlternativeSystemOfHealthCareServicesInIndia

new wine needs new bottles." But Naik believed that India did not possess the resources to stick to such an expensive method of providing healthcare, and suggested a "modified form of de-professionalization" wherein care was demystified and simplified "into several components which can be efficiently managed by para-professionals and non-professionals." Since India would be needing "thousands and thousands" of such new health agents, existing resources needed to be massively diverted toward their recruitment and training. Naik made a special mention of the report of the Government of India's Shrivastav Committee, "perhaps the first recognition that some alternative or alternatives are needed," and called for the "full implementation" of their recommendations regarding community health workers.[87]

The Shrivastav Committee, or the (strangely named) Group on Medical Education and Support Manpower, was commissioned in November 1974 by the Union Ministry of Health, primarily to deliberate upon a potential cadre of "Health Assistants" who could "serve as a link between the qualified medical practitioners [like nurses and doctors] and the Multi-purpose Workers,[88] thus forming an effective team to deliver health care, family welfare and nutritional services to the people."[89] The "people" here mainly meant rural Indians, who had been "deprived of total medical care" because of "the alienation of doctors from the rural environment."[90] The committee was chaired by J.B. Shrivastav, then Director-

[87] *Ibid*

[88] These were government-employed personnel who worked in rural health centers mainly handling preventive care, record-keeping and health education.

[89] J. B. Shrivastav et al, *Health Services and Medical Education: A Programme for Immediate Action: Report of the Group on Medical Education and Support Manpower.*, Alternatives in Development. Health (New Delhi: Ministry of Health and Family Planning, Govt. of India, 1975): 2.

[90] "Appendix 1, Letter: 'Setting up of a Group on Medical Education and Support Manpower', Dated November 1, 1974, from N.S. Bakshi, Ministry of Health and Family Planning, to J.B. Shrivastav, Director-General of Health Services, New Delhi.," in *Health Services and Medical Education: A Programme for Immediate Action: Report of the Group on Medical Education and Support Manpower.*

General of Health Services (DGHS), and consisted of six other members: J.P. Naik (who also had been a member of government committees in the past), and five others who were medical and public health administrators in official positions. Naik wrote the preface to the committee's report, in which he thanked the Ministry of Health and Family Planning for allowing the ICSSR to publish the report in their series on Alternatives in Development.

The Shrivastav Committee noted the irony of "impressive" achievements in the "production of manpower" juxtaposed with the observation that "the health status of the Indian people is still far from satisfactory."[91] In an implicit reference to the Bhore committee's recommendations and the general thrust of Indian healthcare policy in the early decades, they remarked that "one almost despairs of meeting our health needs or realising our aspirations on the basis of the broad models we seem to have accepted. A time has, therefore, come when the entire programme of providing a nation-wide network of efficient and effective health services needs to be reviewed de novo with a view to evolving an alternative strategy of development more suitable for our conditions, limitations and potentialities."[92] For the committee the radical rehaul translated into moving away from the "essentially urban" and "curative" orientation of India's healthcare services by instituting "large bands of part-time semi-professional workers from among the community itself who would be close to the people, live with them, and in addition to promotive and preventive health services, will also provide basic medical services needed in day-to-day common

[91] Shrivastav et al, *Health Services and Medical Education*, 4.

[92] *Ibid*

illnesses."[93] In the twenty-eighth year of independence, thus, the report of the Shrivastav Committee became the first explicit official articulation of a cadre of community health workers for India.

The report was released in July 1975, only a few weeks after the Indira Gandhi government declared a state of Emergency in India. Health Minister Karan Singh expressed the government's intention to implement its recommendations, saying that his ministry would soon get in touch with state governments on the matter.[94] However, there was little progress on this front by early 1976, when the Deputy Minister of Health informed Parliament that the report was "under active consideration of the Govern-ment. A detailed plan of action for implementation of some recommend-ations is being prepared and will be circulated to the State Governments soon."[95] J.P. Naik's March 1977 lecture, discussed above, also indicated that the recommendations had not been implemented by that time. As it turned out, the Gandhi government went out of power the same month and India had a new Union government in March 1977.

The freshly-appointed Health Minister, Raj Narain, immediately indicated intentions to overhaul India's healthcare policy. To the English language media Narain was a unique political personality, and they frequently used the words "unconventional" and "maverick" for him. When he talked about rural medical care, Narain often expressed views that were unconventional for a Minister of Health in India. For example, not long after his appointment, he told All India Radio that his ministry's endeavor would be that "every citizen be so educated and trained as to be his own doctor" (an idea which would have horrified

[93] *Ibid, 7.*

[94] "Far-Reaching Steps to Streamline Medicare and Training," *PIB, Govt of India*, July 17, 1975.

[95] *Lok Sabha Debates (Fifteenth Session)* (New Delhi: Lok Sabha Secretariat, 1976): 122.

IMA office-holders).[96] More importantly for the themes of this chapter, Narain announced plans to implement a nationwide rural health scheme based on CHWs just a month after assuming charge, in late April 1977.[97]

His draft scheme underwent revisions over the succeeding weeks, and by June he could inform Parliament that the multi-pronged scheme proposed to train "5.8 lakh [580,000] community health workers and equal number of *dais*, increase the number of multi-purpose workers, [and] induct a large number of doctors in the rural areas..."[98] Narain's scheme was based primarily on the report of the Shrivastav Committee, although he did not cite it in his addresses to the media or in the Parliament, likely because of the report's association with the rival previous government of Gandhi. But the link with the Shrivastav report becomes clear on a reading of Narain's speech at the April 1977 meeting of the Central Council of Health, where he introduced his scheme for the first time. The speech contained some paragraphs verbatim from the report, including the description of CHWS as "large bands of part-time semi-professional workers from among the community itself who would be close to the people."[99] In the English-language media the proposed scheme was likened to China's barefoot doctors scheme, and nicknamed as "medicare for the villages." However, Raj Narain "disagreed with the suggestion that the

[96] "Better Medical Facilities for Rural Areas," *PIB*, April 6, 1977.

[97] "Rs. 486-Crore Draft Plan for Rural Health Care," *TOI*, April 22, 1977.

[98] *Lok Sabha Debates (Second Session)* (New Delhi: Lok Sabha Secretariat, 1977), 92-93.

[99] "Excerpts from the Opening Speech by Union Health and Family Welfare Minister Sri Raj Narain, at a Two-Day Conference of Health Ministers and Health Secretaries of States and Union Territories at New Delhi on April 28, 1977," *PIB*, April 28, 1977.

bare-foot doctor concept of China might have been his inspiration," saying his was "an Indian plan suited for Indian conditions."[100]

After further discussion and debate the CHWs scheme was finally launched on October 2, 1977 (Mohandas Gandhi's birth anniversary). The form it eventually took was described in the annual report (1978-79) of the Ministry of Health:[101]

> Every village or community with a population of 1000 selects one person from among its residents, who is willing to serve the community and enjoys its confidence. The community health worker (CHW) is given training in simple and basic health services including preventive and promotional aspects of health for three months at the Primary Health Centre to which he belongs. After training, the CHW goes back to his village to serve the community. He is provided with a kit containing medicines and also a manual. The kit consists of common remedies belonging to the modern system of medicine, besides remedies under the traditional system in vogue in that part of the country. The worker is expected to work in his/her spare time for 2 to 3 hours daily the worker is expected to work in his or her spare time for two to three hours daily. During training the CHW is paid a stipend of Rs. 200 per month. After training an honorarium of Rs. 50 per month and also medicines worth Rs. 50 per month is given to him.

In the succeeding years the government commissioned evaluation studies to look into how the scheme was functioning on the ground and how people were responding to it. These studies showed that while most villagers did not share in the optimism of the scheme's supporters about CHWs being revolutionary for rural India, they welcomed the idea that someone from their own village would potentially be able to give them medications for ordinary ailments. In some places the CHWs, mostly male, even came to be known as "junior doctors."[102] Twenty years after the Nehru government, tentatively

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[100] "Health Plan: Narain to Seek Public Opinion," *TOI*, April 19, 1977.

[101] *Annual Report - 1978-79 - Ministry of Health and Family Welfare* (New Delhi, 1979), 12.

[102] Ashish Bose and P.B. Desai, *Studies in Social Dynamics of Primary Health Care*, Studies in Economic Development and Plannin No. 29 (Delhi: Hindustan Publishing Corporation, 1983); P.M. Kulkarni and G.C. Jadar, "Village Health Guides and the Community," *Health and Population - Perspectives and Issues* 7, no. 3 (September 1984): 226.

realizing the flaws of following a doctor-centric and hospital-centric healthcare model, had mulled over providing such "junior doctors" to rural India—although these were to be in the mold of "proper" licentiate doctors, not CHWs[103]—that concept was finally seeing the light of the day. However, through the glasses that the medical profession was wearing, it was an overcast day heralding gloomy times for hundreds of millions of Indians.

"Dissenting" Doctors

Some time after the CHWs scheme was launched in 1977, anthropologist Charles Leslie was informed by a "Western" physician who had been to India that "all of the responsible people" in the medical community were trying to discourage Raj Narain ("irresponsible" and "head-strong") from his "impetuous" plans. Two years later, Leslie had a conversation with K.N. Udupa, prominent healthcare administrator, surgeon, and advocate of Ayurveda, who said he had been a personal physician to Raj Narian, and after Narian became Minister of Health "they went to a hill station together to work through the ideas of the scheme." In Udupa's account, Narian felt responsible as Health Minister to devise a program that would "genuinely improve the delivery of health care to village people. Although he was strong-minded he was not off his bean in the manner suggested by the Western expert, and he certainly was not the unconscious instrument of politicians and social classes who intended to use a medical placebo to sustain a system of exploitation." Leslie also talked to D. Banerji, medical doctor and social scientist, and an influential critic of the Indian state's healthcare policies. But Banerji showed little enthusiasm for this new alternative policy. Although the scheme created an opportunity for progressive change, Banerji argued,

[103] As discussed in Chapter 1, Mahalanobis proposed in 1959 about reintroducing "training extending over, say 3 years for a junior type of doctor" who would be "prepared to serve in villages."

among other things, "the planners [had] ignored the social organization of rural communities, and made no provision to keep the people who dominate these communities from turning the program to their selfish uses."[104]

Leslie's account provides an overview of the different reactions of the Indian biomedical community to the CHWs concept. Raj Narain seems to have been aware of the resistance from the mainstream medical establishment, as evidenced by his invitation to representatives of the IMA for a discussion in July 1977, when the scheme was still in its preliminary stages.[105] These overtures did not lead to any substantial alteration in the public stands of either party, and the IMA continued to vehemently oppose the CHWs program even after Narain's exit. Doctors' opposition to this scheme was as public and strong as was their support for the family planning program. Their critique of CHWs followed an older pattern of IMA thought, with the crux of their argument being that since government was duty-bound to ensure that the benefits of modern biomedicine reached all people of the country equally, it was fundamentally unjust to have the country's urban public being able to access (supposedly) good quality biomedical care through doctors, while at the same time the rural public was made to depend upon "substandard" care from "quacks" and other non-formal practitioners of biomedicine. A succinct summary of this rationale is seen in a line from a 1965 article published in *JIMA*: "If the life of a town-dweller is precious, the life of a villager is equally sacred."[106] The IMA thus tried to project themselves as an organization working to protect the right of India's rural communities to access "modern scientific

[104] C. Leslie, "What Caused India's Massive Community Health Workers Scheme: A Sociology of Knowledge," *Social Science & Medicine (1982)* 21, no. 8 (1985): 923–30.

[105] "IMA Called for Talks on Rural Health Scheme," *TOI*, July 21, 1977.

[106] T. T. V. Subrahmanyeswara Rao, "On Problems of Rural Medical Relief," *Journal of the Indian Medical Association* 44 (March 1, 1965): 241.

medical" care. With the announcement of the CHWs scheme, and especially with the plan of government to ensure that CHWs could take care of "simple" ailments using some "basic" drugs, the IMA fell back on this idea of "unfair" rural-urban differences in the state's healthcare services.

At the 1977 All-India Medical Conference, which took place only a few months after the first batch of CHWs began training, their criticism of the scheme coalesced into a focused, ferocious tirade. In the Presidential Address J.V.R. Sarma dubbed the scheme as experimental, and asked rhetorically if people in urban areas "would be prepared to entrust our health" to the kind of CHWs the government was training. Sarma predicted disastrous consequences with the scheme's implementation. Since CHWs would be "allowed to parade with a kit of [modern pharmaceutical] medicines," India would see a rise in cases of allergic manifestations, resistance to important drugs, and iatrogenic ailments. In a highly paternalistic tone he asked, "what else will result from a ten-week training given to children of sixth standard let loose on the innocent rural public?" This was a highly discourteous interpretation of the minimum educational requirement for CHWs, that of having passed at least sixth standard [grade] schooling. Besides, in a morbidly sarcastic critique, Sarma said: "Let not the new scheme be pushed through to the detriment of the rural population, unless it is to serve as a novel method of controlling population explosion!!!"[107]

The 1977 IMA conference passed a resolution against the scheme, describing CHWs as a "cadre of semi-literate, ill-trained" health workers. Providing them a medicines kit meant, the resolution argued, an encouragement of "quackery." The IMA doctors suggested that the rural health needs of India could be met "only by harnessing and utilising the total qualified man-power through suitably phased programmes" and related measures. They urged the government to employ CHWs only for "elementary preventive"

[107] J.V.R. Sarma, "Presidential Address: 53rd All-India Medical Conference, Bombay, 1977," *JIMA* 70, no. 9 (May 1, 1978): 199.

healthcare work.[108] Despite such vocal and strong opposition from the IMA, the Indian state went ahead with the scheme. Even when another change of government happened in 1980, with Indira Gandhi coming back to power, the CHWs scheme continued to receive political and administrative support.

Although the IMA and much of the medical profession looked at CHWs as "quacks" and as intruders into a space of medical practice which they believed exclusively belonged to themselves, it is important to note that some doctors did have an alternative, more supportive view on these policies. There were also many who were philosophically and ideologically opposed to the government's (and the medical profession's) emphasis on population control at the expense of population welfare. In the mid-1970s a number of such "dissenting"[109] doctors came together with like-minded academics and social scientists to form an organization called the Medico Friend Circle (MFC). Writing later on the occasion of the 100th issue of MFC's monthly bulletin, Ashvin Patel, one of the founders, reminisced that many of MFC's founder members were "radical and unorthodox Gandhians." Its membership increased rapidly in the initial years, perhaps owing to the "long felt need" for such a forum with "unconventional and critical views" on healthcare. A wide diversity of opinion was represented in the membership, and MFC "criticised the present health system and its approach so eloquently and vociferously that it could attract attention of many young doctors and non-doctors."[110] Several of the contributors to the monthly bulletin of the MFC

[108] "Resolutions Passed at the Conference: 53rd All-India Medical Conference, Bombay, 1977," *JIMA* 70, no. 9 (May 1, 1978): 206–7.

[109] I borrow the adjective "dissenting" from a recent book which argued that doctors who do not partake of the mainstream conservative attitudes of the medical profession, do not indulge in the common malpractices, and work to make medical practice more "ethical" and evidence-based, were presenting a "dissenting diagnosis." Arun Gadre and Abhay Shukla, *Dissenting Diagnosis*, (Random House, 2016).

[110] Ashvin Patel, "Ten Years with MFC: My Personal View," *Medico Friend Circle Bulletin* (hereafter MFC Bulletin), no. 100–1 (April-May 1984).

in its early years, and many among its editorial board, were biomedically trained doctors, including D. Banerji whose writings were mentioned in the preceding sections. The modest but consistent subscriptions of the MFC Bulletin, and the fact that its annual meetings were attended in large numbers and inspired many young doctors and medical students (as attested in the articles and letters published in the Bulletins), show that the rank and file of the medical profession did consist of several dissenting doctors, although overall this section of the medical profession evidently lacked (and continues to lack) sufficient numbers and power.

Broadly speaking, the analyses and opinions which the dissenting doctors expressed were vastly different from the IMA's. With family planning, we have already seen D. Banerji's indictments of the government's population control activities. In September 1976, with the Emergency still ongoing and with the Union govt having allowed states to introduce compulsory sterilization if they wished, Anant Phadke wrote for the MFC Bulletin on how the "propaganda" around population explosion was "unscientific and misleading." He expressed exasperation over the fact that "thousands of doctors had mugged up" the false argument, propounded especially in an influential textbook used by medical students (Park's Textbook of Preventive and Social Medicine), that India was economically underdeveloped because of its growing population.[111] Imrana Qadeer questioned the premise of a population control program which focused almost solely on reducing birth rates through medical means without attending to structural factors that were behind those birth rates. For her, healthcare was a "matter of understanding the problems of populations and not the Population Problem." Since conventional medical education highlighted only the

[111] A.R. Phadke, "Population Explosion - Myth and Reality," *MFC Bulletin*, no. MFC009 (September 1976): 1–3.

biological aspects of birth control, she wrote, most doctors remained "either indifferent to or unaware of" the larger issues and controversies involved in family planning.[112]

The dissenting doctors were as enthusiastic about the idea of community health workers as they were critical about the idea of population control. The career trajectories of two such doctors, Mabelle Arole and Rajanikant Arole, provides an illustrative example. After graduating from the Christian Medical College at Vellore, they worked at a rural hospital in Maharashtra in the 1960s. There they encountered a "repetitive pattern of simple preventable illnesses," with villagers getting "cured" in hospitals, going back into the community, and later returning to the hospital with the same illnesses. They were convinced that "a traditional curative-oriented hospital system[113] does not penetrate the communities and does not see patients as a part of a community in relation to the environment they live in," thus failing to meet "the total needs of the community." With this realization, they decided to gain additional medical and surgical skills abroad and then return to India to implement a better healthcare services program. They studied public health at Johns Hopkins University under the guidance of Carl Taylor who also had worked in India.

Back in Maharashtra in 1970, the Aroles decided to spearhead a community health program in and around the village of Jamkhed. They initially focused on providing curative services including emergency care, as these were actively demanded by the villagers, hoping that the "popularity and reputation" gained through clinical work would act as "a springboard for launching community health programmes."[114]

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[112] Imrana Qadeer, "Population Problem - A Viewpoint," *MFC Bulletin*, no. MFC010 (October 1976): 1–6.

[113] It is interesting to note how they applied the term "traditional" to the structures and philosophies of modern medicine and public health, though it is difficult to know if they were actively implying the irony or not.

[114] Mabelle Arole and Rajanikant Arole, "A comprehensive rural health project in Jamkhed (India)," in *Health by the people*, ed. Kenneth W. Newell (Geneva: World Health Organization, 1975), 70–90.

Originally their plan was to employ auxiliary nurse-midwives (ANMs) as the most peripheral agents for community health, but soon they learned that it was difficult to recruit ANMs who would agree to settle and live in villages, and that it was doubtful if villagers would fully accept them as their health guides. This realization spurred them to look for volunteers from "within the community," and eventually gave rise to the most extraordinary, as well as the most well-known, aspect of their health care project: the Village Health Workers (VHWs). Most VHWs were women from marginalized communities with little formal literacy. In the Aroles' views, which differed substantially not just from the IMA's but also from those of the Bhore and Mudaliar Committees, "the problems responsible for ill-health in rural areas are not complex and do not need highly specialized and scientifically trained people for their solution."[115] Carl Taylor recounted years later that the Aroles were among his "most stubborn" students, who rejected "anything that gave decision-making to the professionals and didn't involve the people."[116] The VHWs at Jamkhed received training to provide not only preventive care and health education, but also "simple treatment using inexpensive drugs." The Aroles' approach is well illustrated in a quote of a physician at Jamkhed. He was explaining to healthcare workers why it was important for them to go into the villages instead of waiting for the villagers to come to the main hospital: "I can teach a chimpanzee how to give an injection [in the clinic] but I need human beings to go to the villages and change the attitudes of the masses towards health."[117] This assertion at once demystified biomedicine and the seemingly powerful therapeutic

[115] *Ibid*, 80.

[116] Tina Rosenberg, "Necessary Angels," *National Geographic* 214, no. 6 (December 2008): 70-74.

[117] Arole and Arole, "A comprehensive rural health project in Jamkhed (India)": 84.

procedure of injections, and emphasized the importance of a comprehensive "total" healthcare instead of the narrow clinical care aspect of it.[118]

Dissenting doctors were receptive to the idea of CHWs in general, and some, like the Aroles, incorporated the idea into their own practice, even as the mainstream medical profession remained unconvinced.[119] Many articles in the MFC during this time expressed support for the idea of community health and the institution of a cadre of CHWs. In a 1978 article for the MFC Bulletin, doctor-scientist Kamala S. Jaya Rao also provided crucial insights into mainstream doctors' opposition to CHWs. She argued that the resistance of the medical profession arose from "ill-founded fears and prejudices." She exposed the dissonance in what doctors said publicly and how they acted privately, by revealing their attitudes and actions not commonly known outside the profession (and which many doctors probably would have preferred remained under the wraps). For example, she wrote that many doctors in cities and towns ordered biochemical investigations from laboratories attached to their and their colleagues' privately-owned establishments, even though it was known that the tests were mostly carried out by people "who have no formal training in laboratory techniques." She said she also knew some male private practitioners who had trained their wives, "whose education never exceeded the high school stage, to assist them even in surgery." In their private worlds, many doctors were thus engaging in or not speaking out against the employment of "unqualified" personnel, but in public, they were condemning the CHWs for, ostensibly, being unqualified or improperly qualified. As for doctors' apprehension that CHWs would

[118] Raj Arole was born into a family of Dalits who had converted to Christianity. An excellent analysis of the Jamkhed project and its intersections with gender and caste can be seen in Patricia Antoniello, *For the Public Good: Women, Health, and Equity in Rural India* (Nashville: Vanderbilt University Press, 2020).

[119] Later in the 1980s, Rani Bang and Abhay Bang, also among regular contributors to MFC publications and meetings, instituted a successful CHWs-based program in eastern Maharashtra: Priya Shetty, "Rani and Abhay Bang—Pioneers of Health Care in Rural India," *The Lancet* 377, no. 9761 (January 15, 2011): 199.

sooner or later begin doing some private practice on the side, Jaya Rao said that this objection was ironic since the medical profession itself was guilty of that particular misdemeanor. She was fully supportive of certain medical care tasks being performed by non-doctors (what has been called task-shifting in recent decades), and was disappointed with doctors' [superiority] complex that "medical knowledge can be gained only by those with a certain level of formal education." Invoking the long history of the exclusive restriction of knowledge-making and sharing by the Indian subcontinent's ritually powerful Brahman castes to their own community, she likened doctors' elitist behavior with "the old brahminical notion that 'sanskritic' knowledge should be available only to men in certain castes."[120]

One can thus trace a significant influence of privileged-caste biases and attitudes in both doctors' whole-hearted support to coercive population control strategies and in their vehement opposition to the CHWs. However, other than in rare instances and through the agency of dissenting doctors like Jaya Rao, there is no evidence of any awareness and acknowledgement of the dominance of the elite castes in India's biomedical community, and of the caste-based ideas and privilege which colored doctors' worldviews and underscored the attitudes of the mainstream medical profession. Caste continued to maintain an overpowering but invisible presence among Indian doctors.[121]

[120] Kamala S. Jaya Rao, "Why an Alternative Health Policy," *MFC Bulletin*, no. MFC025 (January 1978): 7–8.

[121] Unsurprisingly, such simultaneous application of and non-acknowledgment of caste-based privilege also exists in the famed Indian diaspora (including doctors). See, e.g., Priyanka Mogul, "Has Caste Discrimination Followed Indians Overseas?," *The Diplomat*, December 6, 2017; Pramod Theetha Kariyanna, "The Caste System Is Thriving in Medicine in the U.S.," *KevinMD.Com* (blog), June 4, 2018.

Conclusion: "Deprofessionalized" Doctors

The Indian state's faith in the Bhore Committee's broader model had begun to weaken even during the Nehruvian period, as Mahalanobis's arguments for reinstituting the medical licentiate system in 1959 (discussed in Chapter 1) indicate. After the end of Nehru's Prime Ministership, there was a further erosion of this faith. In the 1970s, the redundancy of the Bhore Committee's ideas meant that biomedicine and biomedical doctors began to lose the exclusive political patronage and dominance they enjoyed in the 1950s and much of the 1960s. An influential minority of doctors, social scientists and other intellectuals contributed to this political shift. They expressed disillusionment with the meager presence of doctors in rural areas, the rising cost of biomedical treatment, and the reductionism of biomedicine which to them was evident in the emphasis on hospital-based "curative" care with little acknowledgement of prevention and of the social and environmental determinants of ill health. The mainstream medical profession, led by the IMA, paid lip service to rural medical relief but remained largely removed and distant from the needs and wants of the people. Their ideas, opinions, demands, and advocacy efforts continued to reflect their elite caste and class backgrounds and their highly confined social networks.

Even as these changes were occurring, the state was engaged in a single-minded pursuit of population control as a blanket answer to India's many challenges. In this aggressive pursuit, federal and state governments neglected basic public health and medical services, and government health centers throughout India became sites more of family planning and less of healthcare services. I discussed in Chapter 2 that the perceptions of many underprivileged Indians about doctors were refracted through their perceptions of the state and of the PHCs and public hospitals. In the 1970s, the increased alienation which marginalized people felt in these spaces, the coercion to which they were subjected, and the frequent participation of doctors in those coercive activities, contributed further to the former's estrangement from

the biomedical profession. However, the elite urban public—protected as they were from the relentless persuasion and coercion targeted at the "masses"—were rarely subjected to distressing encounters and experiences involving family planning propaganda and activities.

The state of the biomedical profession in India was expertly analyzed in a 1977 essay by sociologist Roger Jeffery, arguing that India's biomedical doctors were experiencing "deprofessionalization." Among the main reasons for that, he said, were the profession's loss of autonomy and monopoly. Doctors did not enjoy complete autonomy in healthcare decision-making on many levels. For example, doctors working in PHCs were under the control of not only medical supervisors, but also non-medical officials like the Block Development Officer (a local administrative officer). While private practitioners were generally not subject to such state control, they were "vulnerable to client control," especially since most of them practiced in urban areas in a highly competitive environment. Jeffery wrote that doctors also had failed to establish monopoly over medical practice, and their ISM competitors had succeeded in extracting substantial concessions from the state. Apart from insubstantial autonomy and monopoly, the multiplicity of professional associations of different kinds of doctors (including of specialists)—apart from the IMA which was by this time considered primarily an association of general practitioners—"weakened the possibilities for joint action." He thus argued that there was a movement away from the ideals of professionalism (as laid out in the academic literature at that time) in the case of India's biomedical doctors.[122]

[122] Roger Jeffery, "Allopathic Medicine in India: A Case of Deprofessionalization?," *Social Science & Medicine* 11, no. 10 (July 1977): 561–73.

However, Jeffery wrote, the profession remained "prestigious" and enjoyed a "privileged position in Indian society."[123] This privileged position emanated, I would say, from the continued importance of biomedicine in the elite public imagination, from the continued dominance of the privileged castes within the profession with the attendant social and economic capital they brought, as well as from the financial lucrativeness and historical prestige of urban biomedical practice[124] which made it a desirable career option for many young elites. In the 1980s, sociologist Aneeta Minocha similarly observed that doctors were still social elites, but at the same time had experienced an undermining of power and authority "to give direction to national health policy making and planning." In her opinion, biomedical doctors had become an "elite without power."[125]

Evidently, the prestige and public image of the profession had escaped any potential adverse effects of doctors' enthusiastic participation in coercive family planning propaganda and activities, even as many of India's top political leaders had suffered serious consequences. Clearly, the "public image" of biomedical doctors was impervious to the experiences and perceptions of India's non-elite, underprivileged public. In the next chapter, I will further dissect how India's public discourse has always been monopolized by the country's elites, and how that monopolization has informed the narratives of the loss of public trust in the medical profession.

[123] Jeffery, "Allopathic Medicine in India": 561

[124] I will discuss this aspect in more detail in the next chapter.

[125] Aneeta A. Minocha, "The Medical Profession in India: Elite without Power," in *Power Elite in India*, ed. Khadija Ansari Gupta (Vikas Pub. House, 1989).

4. ELITE WITHOUT TRUST

As they sipped their morning chai and coffee on the last Sunday of November 1985, the readers of the special supplement of the *Times of India* were greeted with an important-looking report luxuriously spread over the entire top half of the broadsheet (with more on another page), titled "The Case of the Negligent Doctor." In the early post-independence years, a full report on negligent and ethically corrupt doctors in a major English-language paper would certainly have made its elite readers put their morning drink aside, sit up, and read; but this was 1980s India, and the report probably elicited nothing more than sighs of resignation from readers. Narrating the experiences of people who were navigating India's glacial judicial system in their lawsuits against physicians and surgeons, journalist Ayesha Kagal gave voice to the increasingly common sentiment among many that "God's representatives on earth are losing their sanctity." Although more and more people were beginning to sue doctors who had allegedly caused death or serious disability due to negligence, Kagal wrote, it was still an arduous journey for ordinary people to achieve closure: "Patients are far less organised, inclined to feel isolated, unable to derive, as doctors do, the comfort of knowing that others are in the same position... For the first to do so [to take erring doctors to court in India], it will as always, be more difficult, even as they make it easier for those who will follow."[1]

This detailed report symbolized an important development in healthcare in India: the increasing space being occupied by the phenomena of medical malpractice and medical negligence in the public discourse. A basic search for "medical negligence" in the *Times of India* database turns out three total results for the three decades of 1950-1979, ten results for 1980-89, and 110 for 1990-99. Searches in the scholarly journals *Economic and Political Weekly* and the *Journal of the Indian Law Institute* show no

[1] Ayesha Kagal, "The Case of the Negligent Doctor," The Times of India, November 24, 1985, ProQuest Historical Newspapers.

results for 1950-1979, two for the 1980s, and 24 for the 1990s. Searches for "unscrupulous" and "erring" doctor/s (phrases commonly used in Indian writing to describe doctors with questionable ethics) in the *Times of India* yield nine results for 1950-1979, eight for 1980-90, and 39 for 1990-99. The judicial database Manupatra yields only three judgments mentioning "medical negligence" for 1950-1979, four for 1980-89, 22 for 1990-99, and 166 for 2000-2009. With India approaching the closing decades of the century, doctors were, as many newspaper reports now constantly reminded them, increasingly "in the dock," both literally and figuratively.

The previous chapters showed how, while the underprivileged in India often had unsatisfactory, insulting, even harmful encounters with doctors, the elites generally enjoyed a more friendly relationship with the medical profession. But the report by Kagal shows that even the elite patient-doctor encounter had undergone major shifts by the 1980s, and cynicism came to replace confidence and reliability in doctors. While a large number of Indians had strong reasons to be skeptical of the ethical competence of doctors even in the past (as I showed in the previous chapters), the conventional archives record an upsurge in such critiques only in the 1970s, with a sharp increase in the 1980s. Clearly, during this time, some privileged Indians began to publicly express doubts about the motivations and behavior of doctors, implying that more often than not, doctors' actions betrayed motives that were in conflict with patient well-being. An increasingly larger number of them were discovering doctors to be disrespectful, careless, callous, and "money-minded", and their experiences began to regularly appear and be preserved in the mainstream public discourse.

What caused these shifts? In which ways did doctors end up inviting the elite public's disillusionment and ire? How was the response of the elite public to what they considered the "deterioration" in the standards of care provided by the medical profession? Finally, how did doctors

respond to the elite public's critiques? Did these critiques influence their attitudes toward their underprivileged patients? These are the major questions which I explore in the present chapter. While the chapter begins (and ends) with events in the 1980s, I often revert to the 1950s and 1960s in my attempt to find comprehensive answers to these questions.

Depersonalization and Dehumanization

In the world of elite Indians, the first stage in doctors' journey from the pedestal to the dock passed through specialization. In the 1950s, medical specialists were a minority, though enterprising and vocal, and constantly vying for official forms of recognition for their specialities. One of the first steps to such recognition was the formation of special societies and the holding of regular annual conferences. During this early period, the views aired in these conferences, while advocating for the importance of the particular branch of specialization, also took note of the perils of "overspecialization." Addressing the Third All-India Pediatric Conference in Madras in 1952, A. Lakshmanaswami Mudaliar expressed his approval of pediatrics as a unique specialty whose practitioners were unlikely to "take to a narrow field and have a myopic view of the wider issues involved." He cited the oft-repeated definition of a specialist as someone "who knows more and more about less and less" and expressed relief that in some countries there was a call to "develop the general practitioner specialist who... will not merely concentrate on an ingrowing toe-nail or a small portion of the gut ignoring the fact that a doctor treats not a disease but a personality."[2] A decade later, psychiatrist Roshen Master wrote how specialization was a "double edged sword." Doctors were approaching patients as "cases," with interest only in the diseased organ, and medical students were

[2] A. Mudaliar, "The Third All-India Pediatric Conference: Address of the Chairman of the Reception Committee," *Indian Journal of Pediatrics* 19, no. 76 (October 1952): 153–58.

beginning to emulate this approach of focusing on "'an organ' rather than 'an integrated person'."[3] The elite public also took note of the reductionist approaches which accompanied medical specialization. At the Seventh Annual Conference of the Association of Otolaryngologists of India in December 1954, the Health Minister of Punjab urged the gathered specialists to remember that "as research advances and human science becomes more compartmentalized, it is essential that the care of the whole individual in his environments is not forgotten by the specialists."[4]

Coupled with rising specialization was the increasing "dependence" of doctors on diagnostic instruments and pathological and radiological investigations. As early as 1944, the Dean of Bombay's G.S. Medical College, R.P. Koppikar, lamented to the audience of All India Radio that medicine had "become more specialized and more technical... More and more accurate assessments of pathology with the help of more and more colleagues and instruments and less and less intimate understanding of the patient as a whole, as a person with a home and anxieties and economic problems, has become the order of the day."[5] In a 1956 article Rustom J Vakil, among the earliest cardiologists in India, defended specialization while at the same time decrying "instrumentalization" and the "neglect of the clinical methods of diagnosis."[6] Mudaliar, in an address to obstetrician-gynecologists, asked rhetorically: "Do we always realise that we are not dealing with bed No. 14 or bed No. 20, but we are dealing with human lives, human aspirations,

[3] Roshen S. Master, "Teaching of Psychiatry in India," *Indian Journal of Medical Education* 2, no. 1 (October 1962): 37–46.

[4] Jagat Narain, "Opening Address: Seventh Annual Conference Held at Amritsar," *Indian Journal of Otolaryngology* 7, no. 1 (March 1, 1955): 17–19.

[5] R.P. Koppikar, "Medicine and Society," *Seth G.S. Medical College Magazine* 10, no. 1 (1945): 10–13.

[6] Rustom Jal Vakil, "Modern Trends in Cardiology," *Gosumag (Magazine of the Seth G.S. Medical College)*, 1956.

human longings?"[7] An editorial in the students' magazine of the Seth G.S. Medical College argued that the modern doctor was becoming over-reliant on instrumental aids and mechanized data, forgetting that a "patient cannot be expected to react with the precision of a machine or the exactness of a mathematical formula."[8] Master argued that under the influence of specialization and investigations, doctors were dismissing as "hysterical" or "functional" those patients in whom they did not find any underlying pathology. This led to "dissatisfaction in the patient who could not care less as to whether his symptom was 'organic' or 'functional', for to him it was very real."[9]

Such brewing concerns about the changing forms of biomedical practice and the subsequent changes in the patient-doctor relationship,—though focused chiefly on private urban practice—were crystallized in a series of lectures given in December 1967 by Jacob Chandy: eminent neurosurgeon affiliated with the Christian Medical College (Vellore), chief editor of the *Indian Journal of Medical Education*, and a Padma Bhushan awardee (one of the major civilian honors in India). Chandy's lectures, titled "The Physician and Society," were in English and broadcast on All India Radio under the annual Sardar Patel Memorial Lecture series.[10] Like many doctors before and after him, Chandy contrasted the situation in his time with a recently bygone, supposedly better era: "The physician has been a kind of a hero to the family, [but] this role of the physician, with his intimate relationship with individual and family, is

[7] A.L. Mudaliar, "Sir Kedarnath Das Memorial Oration," *Journal of Obstetrics and Gynaecology of India*, 267-278, 8, no. 4 (June 1958): 1–8.

[8] "Editorial," *Gosumag (Magazine of the Seth G.S. Medical College)*, 1961.

[9] Master, "Teaching of Psychiatry in India."

[10] This lecture series was named after Vallabhbhai Patel, the first Minister of Information and Broadcasting. Many practitioners of modern science were invited as speakers for this series prior to and after Chandy, e.g., K.S. Krishnan (1956), J.B.S. Haldane (1957), M.G.K. Menon (1972), and M.S. Swaminathan (1973). "Sardar Patel Memorial Lecture," *Prasar Bharati Archives*, accessed October 23, 2021.

changing rapidly in the context of scientific developments in medicine." Patients were becoming increasingly "dissatisfied" with the doctor, and beginning to feel that the contemporary physician was "business-like and impersonal, and has lost the intimacy and admiration which used to be predominant before." Specialists were "accused of being more interested in organs and molecules than people, [and] general practitioners of being more interested in material awards than patients." Chandy also mentioned the common critique that in contemporary medical practice, "science has dominated art, and medicine has lost its humanistic value of caring for the sick." While he seemed to agree with many of these critiques, he also believed that the "alleged depersonalization" of medicine partly originated in the necessary mental discipline and rigor that medical students and doctors had to inculcate. Patients might feel that the "physician's dignified, realistic, calm attitude seems as if he is aloof and detached," but medical training taught the doctor that in professional dealings "he is less disciplined when he becomes more free, less emotionally stable when he is more compassionate, and less objective when more imaginative [sic]."[11]

Thus, by the 1960s, doctors like Chandy, Mudaliar, Master, and others were voicing caution in public forums regarding the changes catalyzed by specialization and the increasing use of technology, and especially critiqued the reductionism and depersonalization which were allegedly becoming common in urban, private biomedical practice. However, by focusing mostly on the clinical/medical side of the patient-doctor interaction, and drawing mainly from experiences in urban private practice, these analyses left out many other important aspects of the interaction and of the broader relationship between physicians and the society, especially the underprivileged and marginalized. For example, at an IMA

[11] Prasar Bharati Archives, *1967 - Jacob Chandy Speech on Physician and Society | Part 1 | Sardar Patel Memorial Lecture*, https://www.youtube.com/watch?v=YKYZcThVdgA. There were two other volumes of the lectures, accessible at: https://www.youtube.com/watch?v=Lhcv2cjRPqE and https://www.youtube.com/watch?v=HjOGAmPYUiQ

meeting in Bengal in 1968, a member (Samar Roy Chowdhury) said that in the instances of friction between doctors and patients that he had witnessed in rural centers, "in general a patient or his relations and friends had some genuine or imaginary grievances which were not adequately dealt with by the doctor involved." So his recommendations were for doctors to take a "helpful role in other personal and social problems of the patient and the community and being [sic] always alert and helpful to the patients' needs which sometimes remained obscure." While this was probably helpful practical advice, Chowdhury's analysis ignored the larger social and structural factors which made doctors neglect or brush aside marginalized patients' grievances in the first place: namely elitist and casteist attitudes emanating from caste and class privilege. Commentators like Chowdhury seemed to assume that doctors only needed to be given an encouraging (or at most a mildly admonishing) push toward being more empathetic professionals, and that would be sufficient to make them be more "alert and helpful" to patients.

Thus, even as some doctors were realizing that patients were beginning to express resentment against the medical profession, their analyses remained partial, and missed a crucial early opportunity to account for and work upon the dynamics of caste, power, and privilege in the patient-doctor interaction. Besides, even as they spoke about reductionism and depersonalization in medical practice, they continued to ignore the dehumanizing aspects of the medical encounter which the underprivileged public routinely went through. The severe and not uncommon instances of disrespectful and "callous" attitudes toward patients, some examples of which were discussed in Chapter 2, rarely found mention in analyses by prominent doctors. Casteism and caste-based discrimination, which pervaded social life in India, were

seldom analyzed or mentioned, even when doctors were ostensibly discussing the "social" aspects of the patient-doctor relationship or medical practice.[12]

Furthermore, although disrespectful and negligent behavior of doctors was known and occasionally reported in the mainstream press, there is little evidence that doctors faced accountability, punishment, or deterrence. In September 1952, a *Times of India* (*ToI*) reader wrote about a local government official dying in Jamshedpur in eastern India due to, in their opinion, "not one but several acts of negligence" by the treating physician, but authorities took "no action." The reader argued that it was high time India had "some legislation to safeguard the public from hasty and careless licenced healers."[13] A commentary in the *Economic Weekly* in 1956 discussed a similar state of affairs in Calcutta's public hospitals. A patient had been missing from his bed, doctors and nurses had reportedly been rude to his wife when she enquired with them about his whereabouts, and the patient was eventually found dead in a tank near the hospital building. An official investigation into the incident, however, "established just nothing."[14]

While such extreme incidents from public hospitals occasionally appeared in the mainstream discourse, the more routine instances of disrespect and callousness, which also frequently led to medical negligence and deaths, have rarely been preserved in the conventional archive. One unique source, however, is the 1978 Marathi memoir of surgeon Arun Limaye, which, through its introspectively honest commentary on the medical profession and analysis of medical practice, "created a sensation" when it was

[12] Examples include: the lecture series by Jacob Chandy, titled "The Physician and Society", or an elaborate conference titled "Medicine and Society", in which many prominent doctors and medical teachers participated. K.N. Rao (General Chairman), "Medicine and Society (Seminar)," *The Indian Journal of Medical Education* 5, no. 3 (April 1966).

[13] (Mrs.) M.B. Kagal, "Negligence in Hospital: To the Editor, Times of India," *ToI*, September 27, 1952.

[14] "Flibbertigibbet", "A Profession Under Fire," *The Economic Weekly* 8, no. 31 (August 4, 1956): 913–14.

released.[15] Among the many "sensational" incidents in it was the tragic death of a patient in the public hospital where Limaye worked as a registrar some time in the late 1960s. The man had uncontrolled pain in the abdomen which hadn't subsided in two days with conventional medical treatment. He was operated upon by Limaye's "boss" (a senior surgeon on honorary appointment with the hospital), and Limaye and other junior doctors assisted in the surgery. Next day, however, the patient's condition worsened. It turned out that none of the doctors (including obviously Limaye himself) had followed the protocols for post-operative care necessary with such a major operation. Limaye, who was on his preliminary morning round before the arrival of the boss, wrote out some instructions for the nurse and said that he would come back to the patient after the boss finished his round. The boss made his round hurriedly and announced that he would not be teaching clinics that morning ("he was probably looking forward to the afternoon [horse] race"). Soon after, however, the patient, ignored for too long, breathed his last. Limaye had to call the boss on the phone, bear with his "impatience and rudeness," and inform him about his patient's death. When asked if they should request an autopsy, the boss told him to simply alter the case notes and enter the cause of death as "heart attack."[16]

It is likely that in public hospitals (as well as in private hospitals in the case of patients from underprivileged backgrounds), such unprofessional and negligent behavior of doctors and other healthcare personnel was not uncommon, and largely went unpunished and continued undeterred. It was also common understanding within the medical community that impoverished patients at public hospitals, most of them from the underprivileged castes, were important "learning material" on whose bodies

[15] M.D. Hatkanagalekar, "Marathi: Fresh Fields And New Pastures," *Indian Literature* 24, no. 6 (1981): 7–16.

[16] It is not clear if a more technical term was used in their original conversation and Limaye wrote "heart attack" in the book only for the benefit of his lay readership. Arun Limaye, क्लोरोफॉर्म [Chloroform] (Mumbai: Granthali, 1978), 29-33.

doctors, both younger and established ones, could learn new procedures or otherwise experiment with near-complete impunity. Writing in 1988, doctors Manu Kothari and Lopa Mehta recounted an episode of such impunity:[17]

> We recall a case in which we assisted, early in our medical training. In those days, the operation of the portacaval shunt had become fashionable in medical practice; it offered rich cinema stars a way out of their alcoholic lives, cirrhosis, portal hypertension and the danger of bleeding to death from their oesophageal veins. The surgical chief wanted experience in this kind of surgery and he asked the resident medical officers to keep a case ready. Eighteen-year-old Janardan, the only child of a widow, was admitted with seemingly matching symptoms. On doing the preliminary splenoportogram, the senior doctor discovered that the proposed operative site was but a jungle of veins. On the pre-operative day, the resident medical officer said to his chief, 'Sir, I am afraid we shall nick the vena cava and the patient might bleed to death.' The chief's answer was, 'Doctor, as far as it is not my vena cava, I am not worried.' Janardan was operated upon; he died on the table.

We know very little about how patients and their relatives responded to such incidents (at least when the negligence was obvious to the lay onlooker), but the common perception that many patients went to the public hospital only "to die"[18] indicates that underprivileged patients, with little power of any sort in their relationship with doctors and the hospital at large, rarely considered it worthwhile to pursue such matters further. An editorial commentary in the *ToI* in 1952 claimed that the state of public hospitals and the treatment which people received there (medical and otherwise) were so dire that "many refuse to go to a [public] hospital although they cannot afford private medical attention."[19] Another editorial the following year expressed dismay over incidents of negligence in hospitals around the country and the lack of sufficient administrative action following these cases. It pointed out that there were "innumerable" such

[17] Manu L. Kothari and Lopa A. Mehta, "Violence in Modern Medicine," in *Science, Hegemony and Violence: A Requiem for Modernity*, ed. Ashis Nandy (Delhi ; New York : Tokyo, Japan: Oxford University Press, 1989).

[18] As a legislator said in the Madras Legislative Assembly debates discussed in Chapter 2.

[19] "The Doctor's Creed," *The Times of India*, September 19, 1952.

hospital tragedies which went unnoticed, and that the ones which caught the attention of the press were those in which the patients or their relatives were "highly placed" or "would not rest content until the charge of negligence was thoroughly investigated."[20] Clearly, neither of these privileges was within reach for much of the Indian public, and doctors consequently succeeded in keeping their distance from accountability.

Thus, the instances of self-reflection and introspection among doctors during the 1950s-70s remained confined primarily to issues in urban-based private practice and issues which chiefly concerned privileged Indians. While doctors correctly acknowledged that a section of the population was dissatisfied with the purportedly new kind of practice in which organs, molecules and material rewards were valued more than patients, they failed to acknowledge the experiences of other, much larger sections of the population: these were people dissatisfied less with new changes and more with the "same old" kind of practice, in which disrespect was more common than disinterest in patients. No wonder then that the "solutions" proposed remained restricted to moralistic appeals for doctors to perform "their duties conscientiously and whole-heartedly,"[21] and to calls for far-from-radical reforms in medical education and training (for example, an "alliance of medical sciences, social medicine, and 'soul medicine'").[22] While some from the elite public, like journalists, editors, and politicians, occasionally discussed the "horror" which

[20] "Hospital Tragedies," *The Times of India*, February 19, 1953.

[21] "Branch Notes: Bengal State Branch," *JIMA*.

[22] Hari Vaishnava, "A Case for Integration of Social Sciences with Medicine and Medicare," *The Indian Journal of Medical Education*, 1969, 410–13. Jacob Chandy also called for the inclusion of the behavioral sciences in medical education.

patients had to experience in public hospitals,[23] there is little evidence that underprivileged people themselves ever directly influenced the mainstream discourse or policy directions.

Private Practice as Doctors' "Cherished" Right

Apart from depersonalization and increasing dependence on technology, it was the increasing cost of medical treatment which dominated the mainstream public discourse on medical care in the 1950s-70s. As I demonstrated in Chapter 1, many doctors, and especially the IMA, considered private practice to be a "cherished" right, and successful private practice in a comfortable urban setting was considered the primary career aim by most young doctors. With the government investing heavily in medical colleges in the early years of independence, an increasingly large number of doctors had graduated and settled down in cities. As I briefly mentioned in Chapter 2, private doctors, nursing homes, and hospitals were often assailed by the public for their "excessive" fees. In 1960, for example, a Union government bureaucrat, commenting on a file of an official who had taken treatment in a private hospital and applied for reimbursement from the government, lamented that the charges levied by private hospitals were "unlimited" for certain services, particularly when the patient was a well-paying one.[24]

However, it must also be noted that people had been expressing dismay over what they considered excessive fees of doctors even in the past. According to Projit Mukharji, in Bengal the literary trope of the "renowned but exploitative" biomedical doctor had become "fairly popular" by the 1920s. He mentions

[23] S.M. Banerjee, "Indian Medical Council (Amendment) Bill (April 28 1964)," in *Lok Sabha Debates (Seventh Session)* (Lok Sabha Secretariat, 1964), 13281.

[24] "All India Services (Medical Attendance) Rules 1954- Treatment in a Private Hospital," 1960, f. 7-18/60-AIS-III, Dept of Personnel and Training, National Archives of India.

examples of doctor characters in Bengali novels from the 1920s and 1930s who were portrayed as displaying "greed and unprincipled exploitation of medical authority."[25] In February 1947, a few months before independence, future Prime Minister Nehru expressed disappointment that while in the past "there was a sense of physicians being public servants functioning for the good of humanity, now stress is being laid on the business side of the profession."[26]

Doctors were thus frequently reconciling their cherished right of private practice, which also meant that it was the doctor who would determine the price of their services, with constant public reprimands regarding their fees, and with exhortations of "selfless service" from the society at large (and from some medical leaders themselves). One of the most striking examples of such an exhortation is a scene from the 1941 movie *Doctor*, featuring a dramatic and extended conversation between its two protagonists. A physician, who had devoted his life to working in India's villages, is disturbed to find that his son has joined a pharmaceutical company's research wing after graduating as a doctor. He tries to talk the son out of his decision: *You need to go to villages, care for India's destitute, and work for the good of the nation*. The son is unconvinced, and defends his decision by saying he is at least not doing anything which will hurt the country. The father responds that while the son's actions might not prima facie be harmful, they lead to "bad consequences," since the pharma company existed not to help rid India of disease, but to "earn profits." By joining such a company, the son was guilty of engaging in medicine as a business (and not as a service). Every doctor enters medicine, the father says, to serve humanity, but once they get a "taste of money," all thoughts of service disappear. Although this conversation does not fully convince the son, he is

[25] Projit Bihari Mukharji, *Nationalizing the Body: The Medical Market, Print and Daktari Medicine* (London: Anthem Press, 2009), 72-73.

[26] "Doctors Should Be Selfless: Pandit Nehru's Advice," *ToI*, February 15, 1947.

moved and distrubed, and we see that by the end of the film, he has fully changed his mind and become a rural practitioner like his "selflessly" serving father.[27]

Doctors, however, resisted these common exhortations: mostly in practice, by continuing to establish thriving private clinics and nursing homes, and sometimes also in the discursive space. A large number of private medical establishments emerged in India's major cities in the post-independence decades.[28] Amrita Bagchi, who has researched the development of private clinics and nursing homes[29] in post-independence Kolkata, argues that these establishments emerged due to both a desire in "somewhat affluent middle class families, of getting more personalised care than was possible in government health establishments," and a drive in "a set of entrepreneurs among physicians" to address that need.[30] While doctors championed private initiative in practice, they also ensured through public communication that their ideas made it to the public discourse. A doctor's letter to the *Times of India* in 1952 argued that politicians urged doctors to "not look at money," but forget that doctors also have to take care of "earthly necessities" like family responsibilities and "ups and downs" in the profession.[31] In other words, as early as in the Nehruvian years with its so-called socialist pattern of society and with the Bhore Committee's "social physician" rhetoric powering policy, India's doctors had tightly embraced private enterprise and

[27] The movie, as discussed in Chapter 3, contained several nationalistic themes. This conversation was thus an early manifestation of the later, post-independence "didactic" filmmaking discussed in Chapter 3, used here to instruct doctors about the undesirability of mixing money and medicine.

[28] Rama V. Baru, *Private Health Care in India: Social Characteristics and Trends* (Sage Publications, 1998).

[29] Which, in the Indian usage, generally mean small hospitals for general and maternity inpatient care.

[30] Amrita Bagchi, "Health Care in Crisis: The Changing Pattern of Private Health Care in Post Independence Kolkata" (Kolkata, Jadavpur University, 2010): 105.

[31] K.V. Kelkar, "Doctors' Fees: Letter to the Editor," *ToI*, November 25, 1952.

commercialism. The association between doctors and commercialism in the public mind was so naturalized that when an eminent judge suggested in a speech that the "profession of law like the profession of medicine must be socialised," a lawyer wrote to the *ToI* strongly objecting the idea, asserting that medicine was far from socialized in India. He said that even in charitable and public hospitals "large fees are charged for such elementary medical help as taking an X-ray," and claimed that exploitation and "contemptible methods of earning money" were not absent from the medical profession. He also made a highly intriguing point in lawyers' defense (a point which indicates, more than anything else, the classism of elite Indians): "the percentage of physicians owning car0s is much higher than that among lawyers."[32]

For a profession which was fundamentally committed to private enterprise and abhorrent of what it considered government control (as discussed in Chapter 1), a rapid expansion in its ranks as occurred in the early decades of independence, almost axiomatically led to a deepening of commercialism, with doctors increasingly competing for a finite numbers of paying patients. That the Union and state governments lagged in expanding public sector jobs for doctors, and that most of these jobs, in rural regions, were unattractive to them, contributed further to doctors choosing to stay in cities, worsening the competition there. One of the most extraordinary consequences of this was a growing discourse on unemployment among doctors, even as several posts for rural doctors remained vacant.[33] In the words of Imrana Qadeer, healthcare policies in the early post-independence decades "continued to subsidise the private sector [of medical services] through medical education and monetary concessions, thus allowing its rapid growth

[32] P.D. Atre, "Medical and Legal Practitioners: Letter to the Editor," *ToI*, August 3, 1955.

[33] It is important to note that corruption and demands for bribes from local officials might have kept some doctors away from rural postings. A detailed treatment of the subject of unemployment among doctors can be found in Roger Jeffery, "Migration of Doctors from India," *Economic and Political Weekly* 11, no. 13 (1976): 502–7.

from 1970s onwards."[34] Considering 47000 doctors enumerated in the Bhore report as a baseline, the medical profession had more than doubled by 1964 (108,000 doctors), and almost quadrupled by the mid-1970s (180,000 doctors), but comparatively, the larger population of India had barely doubled itself even by 1981.[35] The number of doctors thus rose substantially more rapidly than the population, and a majority of the doctors chose to practice in urban regions. These developments were captured by Roger Jeffery in a mid-1970s study on the distribution of doctors in the Delhi metropolitan region: while the doctor-population ratio in the region was 1:750, the same figure for the whole of India came to 1:4000.[36] As the size of the urban middle class grew, the number of clinical interactions in the private practice sphere also grew, with privileged residents patronizing clinics and nursing homes over the overcrowded, insanitary public hospitals. Jeffery, for example, found that in Delhi the private sector beds increased by a factor of 4.4 between 1954 and 1976. Many working class Indians also were unenthusiastic about public hospitals, and might have often visited private doctors and clinics (if not private hospitals) despite the financial costs. The 1978 memoir of Arun Limaye, who was a private practitioner in Mumbai in the late 1960s and 1970s, mentions clinical encounters with several patients from the economically disadvantaged communities of the city and its suburbs.[37]

Increased competition and increasing numbers of patient-doctor encounters, especially in the commercialized private practice domain, amplified opportunities for the financial exploitation of patients.

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[34] Imrana Qadeer, "Health Planning in India: Some Lessons from the Past," *Social Scientist* 36, no. 5/6 (2008): 51–75.

[35] Roger Jeffery, "Allopathic Medicine in India: A Case of Deprofessionalization?," *Social Science & Medicine* 11, no. 10 (July 1977): 561–73.

[36] Roger Jeffery, "Estimates of Doctors in Delhi: A Note," *Economic and Political Weekly* 12, no. 5 (1977): 132–35.

[37] Limaye, *क्लोरोफॉर्म [Chloroform]*.

The already existing discourse on "medicine as business" now gradually made way to discussions on medically unnecessary prescriptions, procedures, and surgeries ("over-treatment" in general), as well as kickbacks and commissions. Over-treatment was indeed not a new phenomenon. At a symposium on "Medical Practice in Bombay" organized by the IMA in July 1956, veteran physician U.B Narayanrao, who had been a member of the Bhore Committee, rhetorically asked the profession if "we have become injection-maniacs." He also made a reference to the influence of pharma companies' lobbying: "Do we deserve the honour of being dubbed as agents of pharmaceutical manufacturers?" Another physician expressed disappointment over doctors' "habit of prescribing unnecessarily costly drugs," deploring that "some of our prescriptions, when seen by foreign doctors, make us look ridiculous." He was also not happy with how antibiotics were prescribed by doctors in "massive, veterinary doses".[38] Speaking to ob-gyns in 1958, A.L. Mudaliar expressed his disappointment that the profession was "forgetting the art of midwifery." Without being explicit or forceful about his claim, he indicated that ob-gyns were occasionally performing unnecessary procedures and surgeries, including Cesarean sections. The "watchword" for previous generations of ob-gyns was "Avoid meddlesome midwifery," and Mudaliar hoped that younger ob-gyns would also follow that, since they seemed to be taking an "easy, somewhat lackadaisical, method of approach." He invoked the eminent obstetrician Kedarnath Das,[39] who "would never have done a Caesarean section unless the indications were absolute. He would never have applied a forceps just for the pleasure of finishing the delivery a little earlier, so as to enable him to fulfil a social engagement."[40]

[38] "Medical Profession Has Deteriorated in Bombay: Criticism by Doctors at Symposium," *TOI,* July 30, 1956.

[39] Mudaliar's lecture was given as part of an oration series named after Das.

[40] A.L. Mudaliar, "Sir Kedarnath Das Memorial Oration," *Journal of Obstetrics and Gynaecology of India*, 267-278, 8, no. 4 (June 1958): 1–8.

Such early tentative observations on over-treatment reified with time, and ten years later, journalist Haridas Shetty could write a full report on the "abuse" of surgery. The removal of tonsils, he wrote, had become a "mania": "In obscure disorders, the doctor is apt to look into the patient's mouth and if he sees enlarged tonsils, to proclaim 'The tonsils must come out'. If the tonsils have already been taken out, he may look at the teeth; and without much knowledge of the dental condition of his patient, he may order the taking out of all the teeth." According to Shetty, unnecessary procedures and malpractices in general were being fueled by public ignorance on the one hand, and commercialism and the "get-rich-quick-and-scram" profit motive on the other. Through the example of dentists who had to operate on patients referred to them by G.P.s for dental extraction, Shetty provided a useful glimpse into how some doctors rationalized their decisions. If the dentist told the patient that their teeth were fine and did not need removal, the referring G.P. might be embarrassed and offended, and might stop sending patients to the dentist. Besides, with tooth extraction came the lucrative business of selling dentures. So the dentist, "looking at the monetary side of it and urged by the fear of being isolated, decides to 'become practical'." Shetty also observed that appendectomies were similarly being performed in large numbers when not needed.[41]

Narayanrao's old concern about doctors being dubbed as "agents" of pharmaceutical companies echoed in the 1970s in the Ministry of Railways's medical services department. At a meeting of the Chief Medical Officers (CMOs) of the Railways, officials raised concerns regarding the "tendency" among medical officers to "over-prescribe." They noted that the expenditure on medications, especially vitamins and tonics, had undergone a "great increase" in recent years. There was also considerable variation in the prescriptions of railway doctors even within the same zone [geographically-based administrative divisions

[41] Haridas Shetty, "Do We Abuse Surgery," *The Times of India*, November 3, 1968.

of the Indian Railways] with many doctors writing their prescriptions seemingly under the influence of the "propaganda" of pharmaceutical firms: "There is an ever increasing tendency of doctors to write drugs about which they know little, they have not checked up on the drug contraindications, and often they do not know the dosage. Tendency is to write proprietary names and 'one tab three times a day'." While patients frequently complained that Railways pharmacies were often out of stock of common drugs, the CMOs contended that what was often out of stock was only the particular brand names which the local railway doctor prescribed. They believed that doctors needed to start writing "only chemical or pharmaceutical names."[42]

Pharma companies and their marketing agents (called "medical representatives" or MRs in India) had clearly acquired a strong presence in the medical care sector, both public and private.[43] In the thoughtfully titled monograph "Conflict and Choice: Indian Youth in a Changing Society," published in 1970, one of the young Indians profiled was a man in his 20s who worked as a medical representative with an "internationally reputed" company and said that the salary he received was considerable and made him feel like a person of "high status."[44] In a popular Hindi-Urdu movie from the same year (*The Train*), the protagonist police officer, keen to hide his professional identity from an old friend, tells her that he works as a medical representative in Bombay: from the context of the scene it is clear that this is considered a respectable career for a young Indian. Even though MRs were in great demand during this time, evident

[42] "Agenda Item No 19 of the Minutes of C.M.S Conference Held in Boards Office No 21 and 22," 1971, f. 71 /H/5/6/1; Railways: Health, National Archives of India.

[43] There are still very few histories of the pharmaceutical industry and pharma marketing in India, especially for the post-independence period.

[44] Sudhir Kakar and Kamla Chowdhry, "Kannan: The 'Twice-Born,'" in *Conflict and Choice: Indian Youth in a Changing Society* (Somaiya Publications, 1970).

from the several hundred mentions of "medical representative" in the Classified Ads section of the *ToI* in the 1960s and 1970s, they often experienced severe workplace stress. In January 1976 the Lok Sabha decided to discuss a bill to regulate "certain conditions of service" of salespersons including, most prominently, MRs. Minister of Labor Raghunatha Reddy informed lawmakers that certain pharmaceutical companies were indulging in "all kinds of wrong and unhealthy practices" like "harassing their representatives, retrenching some of them and dismissing some."[45]

Clearly, the expanding cultures of private enterprise and competitiveness in the medical profession had provided the pharma industry motivation to intensify its marketing efforts, by fair means or foul. The MR was becoming an increasingly common element of medical services in India, and, through skilled marketing, was exerting a significant influence in the patient-doctor relationship.

"Something is Wrong Somewhere"

Not all doctors were comfortable with the new directions that medical practice was taking. M.K. Mani, a senior nephrologist, wrote in his 1989 memoir about being an uneasy witness to commercialism in Mumbai, in the aptly-titled chapter "Bombay and the Impact of Wealth on Medicine." Mani had studied medicine in Chennai and gone to Mumbai in 1973 to work at a large private hospital, Jaslok Hospital. He saw that in the city the "tactics of the business world were applied to medicine, in an effort to make money. The doctor's consulting rooms were always better furnished than those of his counterparts in other parts of the country. This was not so bad, but other business tactics were also adopted." Among these other tactics was the practice of "giving a commission, popularly known as a cut, to the general practitioner who refers a

[45] Raghunatha Reddy, "Sales Promotion Employees (Conditions of Service) Bill, 1975," in *Lok Sabha Debates (Fifteenth Session) - January 9 1976* (New Delhi: Lok Sabha Secretariat, 1976), 190–92.

patient to a consultant, or to the consultant who refers a case to a radiologist or a laboratory." What this meant for patients was that the GP did not refer them "to the man he considers the best in the field, but to the man who will give him the largest inducement." Mani wrote that the "cut system" existed in other parts of the country too, including Chennai where he was practicing when he wrote his memoir.[46]

In 1975, Maharashtrian doctor Anil Awachat wrote a critique of monetary malpractices in medicine, asserting that people who have a "reverential attitude" to the medical profession are "living in a fool's paradise." This article is remarkable not as much for saying vociferously what already had been said on several occasions and in multiple forums by that time, but for its whistle-blowing character. Awachat mentioned several examples of malpractices of his colleagues (without naming anyone), some of which perhaps even belonged to the category of criminal actions. He said he knew a doctor who used the X-ray plates of a random tuberculosis-afflicted person to "persuade his own patients that they are afflicted. The patient, convinced by the diagnosis, readily agrees to a prolonged and expensive treatment." He claimed to know a surgeon who had "performed a major operation on a patient who was suffering from dysentery [the medical management of which did not involve operative procedures]; the patient was permanently disabled as a result of the operation without knowing why or how." He also claimed that it was "now an accepted practice to perform a caesarian[sic] operation even when a normal delivery is possible."[47] Arun Limaye's memoir also discussed many unethical and corrupt practices common in the medical profession by then, something which, as mentioned above, caused a sensation in the Marathi-speaking world. He was strident in his criticism of the commercialization of medical practice, but in the final pages of his book he

[46] M. K. Mani, *Yamaraja's Brother: The Autobiography of Dr. M.K. Mani.* (Bombay: Bharatiya Vidya Bhavan, 1989).

[47] Anil Awachat, "Doctors in the Dock," *Economic and Political Weekly* 10, no. 52 (1975): 1971–72.

approvingly listed a few doctors: "rare" practitioners who were "compassionate" and "humanist," striding proudly in a profession where the majority had given in to "fraud."[48]

Practices like accepting bribes to furnish medical certificates with false information, or charging people for certificates which were supposed to be provided free of charge, were common. As early as in 1948, there were a "number of cases" of private doctors in India issuing false certificates of yellow fever vaccination, with at least one doctor punished by getting his name removed from the provincial medical register.[49] In February 1964, a news report mentioned how a regional Anti-Corruption Bureau "trapped" a doctor who was demanding a bribe to issue an injury certificate to some persons who went to him for treatment after suffering physical assault. There were also reports during this time of corrupt practices by doctors engaged by the government in its health insurance schemes. Awachat claimed such irregularities occurred in the Employees State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS). ESIS doctors "freely issued" false medical certificates or asked workers with major illness to come to their private dispensaries. Doctors also colluded with workers, Awachat claimed, to ask them to submit false requisition forms against which they would receive medicines which would be funneled into the doctor's private practice. Under CGHS, several private hospitals and nursing homes had been officially enrolled, and Awachat claimed that the reimbursements from this program had "become a source of easy money for doctors." The commonplace nature of such corruption is clear from a 1972 *ToI* commentary, in which the writer said that recent news about a "medical racket" in the postal department in the state of Orissa (now known as Odisha) did "not come as a surprise." The writer recommended termination of

[48] Limaye, *क्लोरोफॉर्म [Chloroform]*, 205.

[49] "False Medical Certificates: Bombay Council Inquiry," *The Times of India*, January 10, 1948.

services of the involved doctors, and claimed that a "very high percentage of doctors" in the postal department medical services was "corrupt."[50]

This proverbial dark underbelly of the medical world didn't escape the attention of filmmakers. The 1971 film *Tere Mere Sapne* depicted almost the entire gamut of malpractices prevalent in urban medicine then. The plot was based on the novel *The Citadel* by A.J. Cronin.[51] In the movie, Bombay replaces London as the city where a young idealist doctor loses his soul in the maze of immoral money-making. A contemporary review was titled "'Tere Mere Sapne': Doctors in the Dock." The movie seemed to suggest, the reviewer wrote, that "the incidence of the moral violation of the Hippocratic Oath is rising, the lucrative prospects of a stream-lined medical career in big cities are bringing about increased disregard of medical ethics, and the medical profession, too, has been infected by the rat race." The review commended the movie's attempt at "grappling with a theme of contemporary relevance."[52] Another reviewer wrote that the film succeeded in "drawing pointed attention to what ails the medical profession," but nevertheless touched "no more than the fringe" of what was a "very live problem" of the day.[53] In the film's plot line, the waylaid young doctor ultimately realizes the folly of his unethical ways, and trudges back to the morally sound path he had traveled in the early years of his practice. The movie was thus both an exposé of the state of medical practice in urban India, and seemingly an appeal to the medical profession

[50] "Current Topics: Medical Racket," *The Times of India*, May 17, 1972.

[51] For more on the novel and its social and political significance in England, see Ross Mckibbin, "Politics and the Medical Hero: A.J. Cronin's The Citadel," *The English Historical Review* CXXIII, no. 502 (June 1, 2008): 651–78.

[52] "'Tere Mere Sapne': Doctors in the Dock," *The Times of India*, June 20, 1971.

[53] "Dream and Reality - Raju's Moviana," *The Illustrated Weekly of India*, May 30, 1971.

to adhere to professional ethics. A plate screened just prior to the film's opening credits declared: *This Film is Dedicated to the Noblest Profession in the World - Medicine*.

It is worth noting that *Tere Mere Sapne* did not fare well in the cinemas, and has hardly been influential even in Indian cinema studies. The same year, however, saw the release of the highly popular and eminently influential *Anand*. Medicine and the patient-doctor relationship took center-stage even in *Anand*. Compared to the former, however, this movie's depiction of malpractices was subdued. While the central plot of the movie concerned the final months of a person (the film's protagonist) afflicted with a fatal cancer, major sub-plots dealt with the limits of biomedicine and with the nature of medical practice amidst the inequalities of urban India. However, one scene from *Anand*, portraying a fervent conversation between two doctors (and friends), is highly relevant to the current discussion. This scene not only depicts an unethical medical practice, it also shows how the doctor rationalized and justified the practice. Banerjee, who is shown as an ethically practicing doctor, witnesses his friend Kulkarni ordering a blood cholesterol investigation for a patient. The viewer is provided clues to interpret that it is an unnecessary investigation in the context. After the patient leaves, Banerjee asks Kulkarni why he did that. "You're such a 'doctor'," responds Kulkarni with a smile, implying that Banerjee was taking too seriously what was taught in medical textbooks and expected of a "true" doctor. Kulkarni believes that ordering what looked like a serious and fancy investigation helped him appear to the obviously wealthy patient as both interested and authoritative, which boosted the patient's confidence in him. He teases Banerjee saying that the latter would instead have advised the patient to walk for two hours in the morning and play some sport for two hours in the evening; then in two weeks the patient would have "needed no doctor." "Both of us," Kulkarni says, "would then be sitting idly in our clinics waiting interminably for someone to come."

Banerjee is unimpressed and considers this to be unethical commercialization of medicine: "If you wanted to do this kind of stuff, why did you study medicine? You could just as well have set up some other shop?" Kulkarni's response shows how he rationalized his behaviour: "Well, if I were a milkman I would have contaminated milk with water; if I were a lawyer I would have taken hefty fees from a murderer and tried to save them from the gallows; in the medical profession I can at least ameliorate the suffering of someone in pain [even as I dab a bit in unprofessional conduct]." Banerjee asks him if he seriously considers this to be the right thing to do. It isn't all that bad either, says Kulkarni, and talks about how he used the seemingly excessive money he took from his richer patients, to subsidize the treatment of poorer patients. Besides, even if those wealthy patients often do not have any physical ailments, they always suspect that they might have one. "So I don't charge them for nothing—I charge them for my treatment of this suspicion." What is wrong in that, Kulkarni asks defiantly. Banerjee's skepticism is disarmed substantially by now, but his unease remains. The scene ends with Banerjee asking: *But don't you think that something is wrong somewhere?*

This remarkable scene reveals several crucial aspects of the overtreatment phenomenon. On some occasions if not all, overtreatment had a dual genesis, stimulated by not only the fee-for-service model and the resulting aggression among doctors to prescribe/perform or perish, but also eagerness among patients to receive the "best" (and also often the "latest") care. The usual asymmetry of power in medical practice which tilted more in favor of doctors, very often swayed the opposite way in urban private practice wherein doctors were, as Jeffery wrote in 1977, "more vulnerable to client control."[54] Perhaps the best example of client control is the specific preference which many Indians had for injections and which healthcare

[54] Roger Jeffery, "Allopathic Medicine in India: A Case of Deprofessionalization?," *Social Science & Medicine* 11, no. 10 (July 1977): 561–73.

practitioners, both biomedical or otherwise, were compelled to abide by, as discussed in Chapter 2. Jeffery cited a doctor who wrote in a memoir that some patients would directly go to a doctor with an ampoule and ask them to administer the injection, and that if the doctor refused on moral grounds, these patients most probably would simply visit another doctor. Even *Anand* depicts a similar instance, in which when the upright Banerjee refuses to succumb to a wealthy patient's demands for drug treatment (which Banerjee considered medically unnecessary), the patient is upset and decides to go visit a different doctor. Columnist Jamila Verghese cleverly satirized the overprescribing doctor and the well-to-do "hypochondriac" patient in a 1969 article:[55]

> Have you ever noticed that funny sort of crack in your voice...? You've got to be awfully careful of that, you know — There's an awful lot of exotic throat diseases floating about... D'you know, I had the same trouble a year ago, and my doc gave me a full course of anti-biotics for two months, and I managed to get over it... My doctor's a wonderful man. Of course he'll charge you a bit more than the others for the X-rays and biopsy etc., but far better the devil you know than the devil you don't.

While overtreatment in several cases was at least partly a consequence of the demands of privileged patients, it must be noted that the possibility of doctors indulging in such practices even when the patients were not well-to-do and demanding, cannot be ruled out. As for the specific rationalization provided by Kulkarni in the *Anand* scene, though a few doctors might even have expertely cross-subsidized their low-income patients with the fees they "extracted" from wealthier patients, it is impossible to gauge how widespread such cross-subsidizing was. Besides, this seemingly noble aspect of overtreatment sits uncomfortably with incidents of maligning or financially hurting colleagues who tried to engage in "ethical" practice. One such example was mentioned above, wherein dentists who refused to perform unnecessary interventions on referred patients feared that the referring GP would never send another

[55] Jamila Verghese, "Oh Doctor, Oh Doctor!," *The Times of India*, February 5, 1969.

patient to them. In his *EPW* article, Awachat described how pathologists also feared such excommunication. He gave the example of a consultant who telephoned a pathologist and asked to (wrongly) report diphtheria in the report of a patient who had tonsilitis. The patient was the son of a rich farmer and the consultant wanted to keep him admitted for at least a fortnight. When the outraged pathologist refused to oblige, the consultant "launched a vilification campaign against him which ruined his practice sufficiently to force him to join government service." Client control as an explanation also breaks down in the case of medically unnecessary invasive investigations and surgeries, particularly considering that every invasive procedure has inherent risks, and major ones carry correspondingly larger risks. Awachat's example of a patient being operated upon even when all he had was dysentery, and then suffering from lifelong disability post-surgery, is a tragic example.

That doctors were feeling the heat of public critiques of commercialism in medicine was evident in IMA President P.K. Dutta's address at the 1978 All-India Medical Conference. He lamented that the medical profession "now commands much less respect than it formerly did. There are good reasons for this sort of development. All of us can see that a commercial mentality of the worst sort is firmly gripping the society and even a section of medicalmen has been displaying this trend rather unabashedly." The instances of corruption by some doctors, he said, showed "the utter disregard of a section of our fellow-professionals for the basic codes of medical ethics." There certainly were "black sheep" in every group, he told the gathered doctors, "but it cannot be denied also that just one or two black-sheep can tarnish the image of the entire fold."[56] Dutta's pleadings and warnings were indeed timely, but as the rest of this chapter (and the next chapter) will show, his analysis of the state of the biomedical profession was only a rare instance of

[56] P.K. Dutta, "Presidential Address," *Journal of the Indian Medical Association* 72, no. 5 (March 1, 1979): 113.

strongly self-introspective ideas being articulated, and self-corrective actions being proposed, at a mainstream forum of the profession.

Thus, while commercialism and overtreatment were an old bugbear of the medical profession, the most remarkable aspect of their 1960s-1970s iteration was that even as newer drugs and procedures made the risks of overtreatment more numerous and more serious, the medical profession not just failed to organize sustained collective efforts to discourage such practices, but also tacitly approved them and normalized them in practice, while "punishing" dissenters on occasion. Though on the one hand medicine in public hospitals remained wedded to lack of funds and errors of omission, private practice on the other hand had, in its relentless pursuit of funds and profits, quietly institutionalized errors of commission.

Family Doctor

The instrumentalization, depersonalization, and expanding commercialism of medicine together brought about many changes in how the privileged of India experienced and perceived medical care. A common refrain of the elites in the 1970s and 1980s was: *Whatever happened to the family doctor?* In the early post-independence years, doctors were frequently a part of influential social networks ("friends and family") together with other elites of the town or city, all forming a small pool of the city or town elites. The image from Chapter 2 of a doctor, a landlord, a lawyer and a businessman all sitting at the same table in a social club perfectly captures these networks. It was not uncommon for privileged individuals to have as a doctor someone who was also a member of their network, and it was common for doctors to express pride in the "intimate relationship" they had with their patients as part of such a "family doctor system."[57]

[57] Joseph Bhore Chairman, *Report of the Health Survey and Development Committee*, vol. 2 (New Delhi: Manager of Publications, 1946), 13.

The family doctor being a "friend" and "guide" for families was also a commonly invoked idea, and when the state wanted to encourage doctors to participate in its new Employees State Insurance Scheme, it advertised the claim that the participating doctor eventually became the family doctor to the members: "a friend and a guide of the whole family."[58]

With time, however, and following the changes described above, interactions between elite patients and doctors began to assume formalized, professionalized, and consumerist forms, as against earlier informal, often casual and friendly patterns. A comic write-up by author Raj Chatterjee in 1976 provided hints of such a change. He wrote about experiencing some shoulder pain and going to "see the quack who was at school with me, by virtue of which long association he is also our family doctor" [the sarcastic use of the term "quack" is meant to signify the intimacy and acquaintance of the author with the doctor]. The doctor prescribed some pills and liniment, but his shoulder pain simply "travelled down" to his foot. At the second consultation the doctor declared that this was a case of gout and prescribed some lifestyle changes which the author found too harsh and never followed. We learn at the end of the story that not long after, the author received "a whacking bill for two 'consultations' from my old school friend."[59] While complaints about doctors' fees were common in the past, this write-up indicated that, in the opinion of some elites, medicine had now become so commercialized and impersonal that even old bonds of friendship could not ensure protection from a "whacking" bill.

The privileged public narratively condensed these new developments into the trope of the "demise" of the family doctor (or the GP). As early as 1968, some commentators had expressed their fears

[58] "Whole-Hearted Support to State Insurance Scheme: Minister's Call to Medical Practitioners," *The Times of India*, November 3, 1952.

[59] Raj Chatterjee, "A Sore Point," *The Times of India*, September 4, 1976.

about the family doctor becoming a "fast disappearing species, as rare today as the one-horned rhino of Assam." They were regarding as "nostalgic" the days when family doctors had time to "sit and talk" and "were prepared to treat everything from a cut finger to a broken heart."[60] In 1975, another commentator wrote an "obituary" of the "kindest man in town," with the title "Whatever Happened to the Family Doctor?" The family doctor was a friend and attentive listener, "to whom one can dare to talk continually about oneself, without interruption, contradiction, or censure." The specialists, most of whom were "ignorant, opinionated, charlatans," were "useful" only when the wise family doctor decided they were needed. But unfortunately, urbanization and specialization were making the family doctor "extinct."[61] In June 1979 a *ToI* article asked loudly in its title, "Where's the G.P.?" This author also blamed specialization: "What happened to the traditional family doctor who was a close friend and confidante of the family and knew the physical and mental aberrations of every member; the good old general practitioner who could cure most afflictions with a smile and a pill? Has specialisation antiquated him?" After describing an unsatisfying experience visiting some specialists and paying their hefty fees, the author mentioned having a drink with his family doctor, "a genuine GP who is also an old comrade from our army days," and expressing his disappointment with the state of affairs. In 1983 another writer lamented: "Gone are the days when three and even four generations of a family were treated by the same doctor for medical, surgical, organic and emotional problems—real or imaginary!"[62]

[60] Aries, "Find Me a Doctor!," *The Times of India*, October 19, 1968.

[61] Shaanti Goklaney, "Whatever Happened to the Family Doctor," *Eve's Weekly*, October 25, 1975.

[62] "City Lights - CATS and PETS," *The Times of India*, October 3, 1983.

In Hindi-Urdu cinema of the 1960s and 1970s, the family doctor was a common element in the social network of privileged families and was often shown visiting sick individuals at their homes. The doctor's role was most often played by older men who deftly projected an amiable, friendly, worldly-wise persona.[63] This was the image of the doctor as a "friend, philosopher, and guide," as Roger Jeffery was frequently told by his informants in the 1970s.[64] Doctors' writings and speeches also confirm this cultural image of the family doctor, often in a narrative of nostalgia. At the Mysore State Medical Conference of 1971, T.K. Dayalu said that the general public was becoming more aware of their rights and privileges and were often changing doctors if they felt dissatisfied. "Gone are the days," he mourned, "when the family doctor can act as a friend, philosopher, and guide."[65] In 1969, K.P. Ganesan expressed disappointment that the family doctor was a "species facing extinction," telling the audience that as someone from a "family of journalists," his decision to choose medicine as a career was primarily influenced by the admiration he had for his family doctor, and that many other doctors of his generation also had been similarly inspired by their family doctors.[66] But by the 1980s, it had become common for privileged patients to go to a specialist directly instead of first being referred by a GP or a family doctor.[67]

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[63] For example: *Tere Ghar Ke Saamne* (1963), *Waqt* (1965), *Kab Kyun Kahaan* (1970), *Chupke Chupke* (1975), *Anurodh* (1977), *Golmaal* (1979).

[64] Jeffery, "Allopathic Medicine in India": 563.

[65] "Association Notes: State Medical Conference - XXXVIII Mysore State Medical Conference Davangere, 1971," *Journal of the Indian Medical Association* 58, no. 8 (April 16, 1972): 302.

[66] K.P. Ganesan, "General Medical Practice and Society," *Journal of the Indian Medical Association* 54, no. 6 (March 16, 1970): 240–44. M.K. Mani writes in his memoir that his decision to choose medicine was inspired by his childhood "hero," a young doctor whom his father had offered a place to stay at their house. M. K. Mani, *Yamaraja's Brother: The Autobiography of Dr. M.K. Mani.* (Bombay: Bharatiya Vidya Bhavan, 1989), 1-2.

[67] Girish J. Sanghvi and Amul N. Shah, "Oh Doctor!," *The Times of India*, March 22, 1981.

While it is difficult to know how accurate these nostalgic descriptions of the family doctor's personality and style of practice are, the common sentiments expressed here by different writers across time suggest that for a number of privileged Indians, the family doctor was an important and frequently beloved figure, and this figure was disappearing from their social lives. It is worth noting that the family doctor's impending demise was repeatedly discussed every few years (even after the 1980s), which reflected the gradual and staggered panning out around the country and within communities, of the changes which were causing the much-lamented demise of the "kindest man": specialization, commercialization, and urbanization. As the population in cities expanded, and as new elites and new doctors migrated to cities and towns where they had little to no prior social networks, it was inevitable for patient-doctor interactions to become more formalized and consumerist than in the past, and for elites to then increasingly express disappointment at the disappearance of the old-style family doctor.

A 1981 short story by the popular author R.K. Narayan, who was 75-years-old at the time, deftly depicted this prevailing elite disappointment using a sharp family doctor-specialist binary. Here the family doctor is older in age, has an informal style of practice, works out of a small clinic where waiting patients often interrupt him with questions even as he is talking to the patient in front of him, trusts individualized prescriptions more than "mass-produced tablets," employs just one assistant who helps fill his prescriptions, and is known for being willing to visit patients in their homes. On the other hand the specialist ("who was a cardiologist and a neurosurgeon, as he called himself") is much younger, works out of an elaborate building with multiple rooms fitted with "electronic and medical equipment," has many employees working for him and with whom he communicates "with a minimum of speech—with a jerk of his head or the wave of a finger," and who is not easily accessible to the public, an unseen healer "like God, not to be seen or heard except when he willed it." Needless to say, the specialist was only barely affordable

to most people. Narayan even quantified the difference in affordability: while the family doctor charged ten rupees for a home visit, the specialist charged a hundred rupees for a consultation at his office. The main plot of this story revolved around the efforts of an elderly woman to convince her young son to get married, with a subplot about her illness. The son, Sambu, was shown to trust the advice of the specialist over that of the family doctor-GP, something which pained the mother.[68]

Narayan thus depicted a medical culture in which young Indians were choosing to trust the technology-mediated medical diagnosis of a specialist more than the friendship-mediated advice of the family doctor. In many ways, Narayan's story anticipated the rise of large, private multi-speciality hospitals in urban India in the 1980s, with the associated rise in popularity of specialist doctors. Clearly, even as a section of privileged Indians was lamenting the decline in the institution of the family doctor, there were others embracing the rise of specialists and, more importantly, of technology which promised to eliminate the apparently annoying (as per the character of Sambu) human biases and errors of the family doctor.

The above reminiscences and representations of family doctors reveal many important aspects of the relationship between the medical profession and the public. Firstly, only the privileged in India could afford the economic and social capital to have a family doctor (apparent from IMA president Ganesan's "family of journalists" or the *ToI* writer who had drinks with the family doctor he knew from his "army days"). In Narayan's story, there are clear markers of the privileged caste and class status of the protagonists, like the large house which had "many mansions and apparently was designed for a milling crowd," and the father who spent "all his hours in adding, subtracting and multiplying figures" on ledgers which looked like "mighty tomes." In fact the "intimate" relationship with individual and family which the family doctor was

[68] R.K. Narayan, "Second Opinion," *The New Yorker*, March 30, 1981.

supposed to represent was, with very few exceptions, possible only among caste equals in the Indian social context. Secondly, and consequent to the first point, the substantial footprint of the family doctor rhetoric in conventional archives suppresses the reality that the family doctor was absent from the lives of a large majority of Indians. Privileged Indians have, in their reminiscences and commentaries, invisibilized the exclusivity of their access to the family doctor, and in thus projecting a cheerful past era in which going to a clinic or a hospital generally meant interacting with a kindly doctor who was a "friend, philosopher, and guide," they have pushed aside the experiences of most Indians for whom encounters with doctors and biomedical healthcare services only rarely involved kindness and friendliness. Such misguiding family doctor nostalgia is common in other parts of the world too, evident from Carl Taylor's cautionary argument that "it is well to remember that the memory of the family physician is cherished by only a limited public in most of the world, those who really had access to general practitioners in the past."[69]

Over the decades of 1960s and 1970s, thus, commercialism and consumerism took on new forms and came to dominate medical practice as well as the patient-doctor relationship in India, especially in the urban regions. In the beginning this state of affairs elicited disappointment and nostalgia for a supposedly better past, but soon the perceptions of the privileged public about doctors began to undergo major adverse shifts, and with those shifts the profession's "public image"—molded by the beliefs of the elites who controlled the public discourse—also underwent adverse changes.

[69] Carl E. Taylor, "The Doctor's Role in Rural Health Care," *International Journal of Health Services* 6, no. 2 (April 1, 1976): 219–30.

Rajani's Story

Two major "scandals" involving the medical profession exerted an overwhelming influence on doctors' public image in the 1980s. The first of these concerned the extraordinarily tragic act of sex-selective termination of pregnancy (with a biologically female fetus). As early as in August 1975, reporters quoted doctors in Mumbai and Pune enthusiastically claiming that new, effective techniques to identify the sex of a fetus (through amniocentesis) could have important applications in the country's family planning program: "... there were many instances where couples had a number of children in their fervent desire to have a male child. Now, if such couple know that their child will be a female, they can go in for medical termination of the pregnancy. [sic]"[70] In 1977, after reports of the use of amniocentesis to selectively abort female fetuses in New Delhi surfaced, the Union government was forced to order public hospitals and institutions to use amniocentesis "only to check genetic disorders and for research." This order, however, simply ensured that the tests continued to be patronized and utilized in private clinics and hospitals.[71] By 1982, as per a *Guardian* report, "unscrupulous private practitioners [had] commercialized the test to make quick money by pandering to the popular prejudice against female offspring." It claimed that even though some doctors in bigger cities were known to be indulging in sex-selective abortions, neither the Medical Council of India nor other relevant authorities had taken any action against such doctors. A Delhi-based doctor at the All-India Institute of Medical Sciences (AIIMS) claimed to know of "at least 50" doctors, supposedly private practitioners, who were "doing brisk business" through such

[70] "Accuracy in Predicting Sex of Unborn Child Claimed," *The Times of India*, August 12, 1975.

[71] "A Clinical Analysis of Sex Tests," *The Times of India*, September 5, 1982.

abortions.[72] D.N. Pai, Mumbai's famous surgeon known for his vasectomy camps under the family planning program, also expressed public support for sex-selective abortions, and downplayed concerns over its effects on India's overall sex ratio as "simply feminist propaganda".[73]

Though many members of the medical profession colluded with mostly elite families to perform these abortions, some collaborated with social workers and women's organizations to oppose this development. At a 1985 conference on law and medicine in Delhi, a doctor called this practice discriminatory and unconstitutional.[74] The next year two Bombay-based doctors commended a *ToI* editorial which had rallied against this "heinous practice." These doctors were "immensely disappointed" that the IMA and the Federation of Obstetrics and Gynecology Societies of India (FOGSI) had maintained an "amazing I-see-no-evil attitude" throughout this development.[75] In 1987 Amar Jesani, a medical ethicist, criticized the lackluster response of the "established medical profession" but also mentioned a group called "Doctors Against Sex Determination" which was contributing to efforts in the advocacy against sex-selective abortions.

Even as the decade came to a close, however, families and doctors were continuing this practice. In a sobering assessment of the state of affairs, a 1990 article in the Lokayan Bulletin mentioned how no action had been taken by government (or medical) authorities against a private hospital which had openly advertised fetal sex-determination services in 1982 with an unstated understanding that families could use the service to identify and abort female fetuses. The public outrage and media coverage had instead

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[72] Inder Malhotra, "Alarm at Girl Foetus Scandal," *The Guardian*, July 19, 1982.

[73] "A Clinical Analysis of Sex Tests."

[74] P.M. Bakshi, "Issues of Law and Medicine - What Delhi Meet Achieved," *The Times of India*, April 2, 1985.

[75] Sanjeev Kulkarni and Kamaxi P. Bhate, "Letters - Foeticide Cases," *The Times of India*, August 21, 1986.

provided additional publicity and business to the doctors there. This "epidemic" of sex determination had spread to most other states in India, and had made inroads into smaller towns. Many members of the mainstream medical profession were intimately involved both in sex determination and in abortions of female fetuses, and the profession's leadership was said to be colluding through silence. The Doctors Against Sex Determination (DASD) group "publicly asked the IMA, the Indian Medical Council [the Medical Council of India] and FOGSI to take a stand on this matter. Barring FOGSI, the other organisations were not ready to discuss this issue. They did not even bother to acknowledge the DASD letters. It is obviously a matter of grave concern that these very organisations are entrusted with preserving and upholding the ethical values of this noble profession."[76]

The second major scandal in the 1980s was the "kidney racket": a shorthand for commercialized kidney donation, with the organs of impoverished Indians being used to provide new lives to middle and upper class Indian and foreign patients whose survival depended upon a kidney transplant. In November 1985, a reader wrote to the *ToI* about "disturbing cases" wherein marginalized people were selling their organs to earn some money, and expressed concern that "criminal rackets will crop up to exploit indigent donors."[77] In parts of India, however, such "rackets" had already erupted by then. In December the same year, *The Boston Globe* carried a report titled "India's Poor Sell Kidneys for Transplants." The report was focused mostly on Bombay, where several private hospitals and doctors had been carrying out "non-related" donor kidney transplants for some years already. A surgeon performing such transplants argued that the practice was not as ethically "black-and-white" as others made it out to be: "If it's meant for saving

[76] Ravindra R.P., "Campaign Against Sex Determination Tests," *Lokayan Bulletin*, 1990.

[77] Santanu Dutta, "Sale of Organs," *The Times of India*, November 18, 1985.

the life of a patient, then it's not unethical... When all avenues are exhausted, [only] then we consider a paid donor." Doctors were generally aware of the desperate situations of the donors, but those who engaged in the transplants argued that the practice was ethically sound when done on a "selective scale" as against a "massive scale".[78]

Propelled by heavy commercial stakes and supported by ethical ambiguities, the "kidney trade" flourished in major Indian cities in the late 1980s and early 1990s. In 1987 the Maharashtra Medical Council was investigating complaints against two doctors accused of "inducing the poor and needy to sell a kidney for a paltry sum to be transplanted to wealthy patients in Gulf countries for an exorbitant fee." Doctors in Kuwait were reported to complain that some of their patients who had received transplants in India were facing complications as the hospitals had not taken "due care" in matching the donor and recipient, with only a "perfunctory matching of blood groups" being done, as against more comprehensive matching.[79] By 1989, reports about India's kidney racket had become commonplace. The eminent surgeon L.H. Hiranandani wrote that "malpractice in kidney transplant surgery is now an open secret... It is no use blaming the agents when the main players in the sinister game are the doctors." He was disappointed that the Maharashtra Medical Council and the IMA were simply being "silent spectators."[80] Hiranandani's strong opinion on the pernicious role of doctors was at least partially corroborated by the ethnographic work of Lawrence Cohen, who a decade later wrote: "Doctors know that sellers have little to no access to hospital care, that they often have to work at strenuous labor, that they are undernourished, and that they

[78] Louis Berney, "India's Poor Sell Kidneys for Transplants," *The Boston Globe*, December 9, 1985.

[79] "Current Topics: Organ Donation," The Times of India, November 25, 1987.

[80] Apparently, the investigations being done by the MMC had not yielded any results

live in neighborhoods where infectious disease and alcohol are endemic. They know that much of the money passes quickly through the hands of sellers and goes to moneylenders."[81]

An important aspect of both these scandals is that even as there was outrage against these developments in the elite public discourse, doctors' closest collaborators were also from among the privileged public.[82] In a way, no sooner had private enterprise and commercialism begun to reshape Indian medical practice, than privileged communities found ways to exploit it for their own benefit.[83] However, despite this opportunistic partnership between doctors and a section of the elites, a considerable number of privileged Indians—especially from the growing middle class—were also undergoing unpleasant experiences with doctors and hospitals. While a doctor who might have overcharged, or prescribed unnecessary tonics or antibiotics, was still a relatively acceptable "devil that you know," a doctor who might potentially subject one's body to needless surgery or arrive late to check on a serious emergency had to be an undesirable "devil." At the same time, growing reports of medical negligence and surgeries gone awry[84] eroded confidence in the competence of doctors in general: a doctor who might cause injury or death out of incompetence and negligene was surely an unacceptable "devil."

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[81] Lawrence Cohen, "Where It Hurts: Indian Material for an Ethics of Organ Transplantation," *Daedalus* 128, no. 4 (1999): 142. Not long after, the Government of India passed a law regulating organ donation, and expressed hope that the law would help curb the exploitative trade in kidneys. Newspapers, however, continued to show that the trade had not been substantially affected. See Frontline. "Kidneys Still for Sale," December 13, 1997.

[82] In this case a broad division is evident among the elites, with more conservtive sections participating in these acts and more liberal ones opposing them.

[83] This trend continued in the 1990s with conservative Hindu elites demanding, and procuring, elective Cesarean deliveries on dates considered astrologically auspicious.

[84] Nergis Dalal, "Doctor, You're Not God," *The Times of India*, March 22, 1981.

In March 1978, the English-language magazine *Femina* carried a feature on medical negligence, which claimed that while negligence was a cognisable offense, "scores of injured patients do not sue the doctor concerned."[85] A few months later a *ToI* journalist wrote about the "nightmarish" experience she had with a private practitioner as well as doctors at a public hospital. Her narrative elicited a letter from a reader who wrote that the image of most medical specialists in Bombay was unsatisfactory: "... they demand excessively high fees from their clients, irrespective of their financial capacity, indulge in malpractices such as keeping their patients under observation for unreasonably long periods, which entail huge medical bills, or... refuse to attend to urgent home calls at night."[86] It is worth noting that a doctor, particularly a specialist, attending a patient at their home in the night would not have been a privilege available to most Indians. In many ways, hence, the dissatisfaction with doctors expressed by the elite public at this time can be read as a disappointment that an old trusted ally, the medical profession, was no longer a reliable social partner (a similar realization about doctors had dawned upon the Indian state in the post-Nehruvian period, as discussed in the previous chapter). The final line in the reader's letter made this sentiment more clear: "Such unethical conduct on the part of the doctors only besmirches the reputation of the medical profession built up over the years..." It was, after all, only the elite who could claim, in a narrative about personal experiences with doctors, that the medical profession had built up a more or less unblemished reputation over the years.

An episode from a popular television series in 1986 featured a similar narrative, wherein an elite social worker reprimands a doctor (and the medical profession) for allowing commercialism to thrive at the

[85] Issue of *Femina* for the fortnight 23 March - 7 April 1978, advertised in *The Times of India*. "Display Ad 14," March 17, 1978.

[86] Leslie Soccoro, "Heartless Doctors," *The Times of India*, November 19, 1978.

expense of patient welfare, but at the same time also sings paeans to doctors, the "messiahs of society." The TV series was *Rajani*, the highly popular fictional serial which featured a woman protagonist named Rajani ("a fiesty middle-class housewife") who took on the "daily injustices that plague modern Indian life."[87] This particular episode portrayed a wealthy, successful private practitioner who seemed to focus more on monetary gains than patient welfare, and who had "forgotten the oath taken when he first became a doctor." The episode also decried the tendency among the general public to value a doctor with "name and fame" more than other equally skilled doctors, and to offer to pay them extra fees to jump the line in the clinic while other relatively less privileged patients kept waiting for hours—and other doctors without "name and fame" were left waiting for patients. After a spirited admonition by Rajani, the doctor is shown to realize the folly of his ways, and promises to put patient welfare as his first and foremost responsibility.[88]

Over the 1970s and 1980s, thus, the image of the medical profession among the privileged public had suffered considerable deterioration, whether as a result of unpleasant personal experiences or by reading and watching about corrupt and negligent doctors in the popular media. Evidently, the changes in the culture and political economy of urban, especially private, biomedical practice which began in the 1960s (as described in the early sections of the chapter) had resulted in the elites of India also now approaching doctors with caution, skepticism, even trepidation—a privilege previously enjoyed only by the underprivileged public.

[87] Elisabeth Bumiller, "'Rajani,' TV's Star of India," *The Washington Post*, December 8, 1985.

[88] *Rajani Episode No - 07 | Doctor's Real Responsibilities*, https://www.youtube.com/watch?v=jzZdkKrK-Ko.

The Mobilization of the Elites

Negligence and callousness of doctors had been for decades a routine experience in the healthcare system encounters of underprivileged Indians. As I discussed earlier in the chapter, despite this lived experience, it was near impossible for them to demand accountability from doctors and hospitals. But with even the privileged now approaching doctors with caution and trepidation, and the medical profession now being taken to task in the (elite) public discourse, it was unsurprising that doctors began to be put in the dock. As the report by journalist Kagal (mentioned at the beginning of this chapter) showed, there was an increase in the number of lawsuits against doctors in the early 1980s. The failure of the profession's own regulatory bodies (the medical councils) to hold erring doctors accountable was an important reason behind people's decisions to file lawsuits, a path which they were aware required tremendous amounts of patience and expenses.[89] A shopping store owner who was operated upon by a neurosurgeon to treat "heaviness in left leg" and ended up with a paralysis of both lower limbs, shared his helplessness with the reporter. His relatives advised him that there was no point in filing a lawsuit, and that he would have to travel to the city a lot, which was difficult and expensive with his paralysis. However, Kagal wrote, others were beginning to look beyond "fatalism." While in the past the unexpected death of a patient under a doctor's care would have been attributed "either to 'God' or 'India'," people were now "demanding answers, determined to wait out the time it will take to get them." While her report acknowledged that perhaps a few of the lawsuits were intended more to "pull down" a doctor than to plead for justice, it also emphasized the sentiments of aggrieved patients who were choosing to embark on what seemed like a thankless, stressful, and prolonged endeavor: "We don't care what the judgment is. We just don't want the

[89] Again, there is a glaring lack of scholarly histories of the regulation of the biomedical profession, and specifically of the influential Medical Council of India.

doctor to believe that he can get away with what he has done."[90] It is indeed likely that for many of the early individuals and families who took doctors to court at great personal expense and trouble, the primary motivation was to hold the individual negligent doctor accountable (as against a desire for monetary compensation), and thereby also ensure that other patients did not have to undergo the same suffering as they did. A doctor-activist who had worked with such patients and families wrote in 1992 that the "attitude of the majority" of complainants was "not materialistic."[91]

This interest in standing up against corrupt and negligent persons in power seemed to be aligned with what contemporaneous commentators considered to be the dominant sentiments among the middle class elites in the 1980s: frustration with everyday corruption and malpractice, and with the arrogance of those in power. The above-mentioned TV serial *Rajani* was said to sympathetically portray these frustrations of the "common man." It must be noted, however, that while the "common man" was used in the elite public discourse as a shorthand for the "ordinary Indian," it commonly stood for the privileged urban Indian belonging mostly to the economic "middle class." As Satish Deshpande has perceptively argued, "by a remarkable feat of ideological condensation, this phrase/figure [common man] manages to convey a powerful sense of middle-class identity that claims to be 'common' both in the sense of something that is *shared* as well as something that is *widespread.*" He urges readers to remind themselves that despite contrary claims, the "common man" belongs to just the "top 10 or 15 percent of the income distribution."[92]

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[90] Kagal, "The Case of the Negligent Doctor."

[91] Arun Bal, "Letters: Docs' Defiance," *The Times of India*, June 11, 1992.

[92] Satish Deshpande, *Contemporary India: A Sociological View* (New Delhi: Penguin Viking, 2003), 130.

This elite middle-class, frustrated by corruption in daily life, organized and led a highly successful consumer movement in the 1970s and 1980s, which culminated in the passage of the Consumer Protection Act (CPA) by the Parliament of India in 1986. The Act mandated the establishment of Consumer Disputes Redressal Forums at the district level and similar bodies at the state and federal levels (often just called "consumer courts"), providing what lawmakers considered a more convenient and affordable alternative to the traditional judicial system for complaints involving deficiencies in goods and services. Even though the consumer movement of the 1970s and 1980s which culminated in this Act did not explicitly lobby for protection from negligent doctors,[93] people who intended to sue doctors realized that the new consumer courts offered a relatively more convenient option than conventional lawsuits. Soon, to the shock and dismay of the medical profession, a growing number of people began dragging doctors and hospitals to consumer courts. Between 1988 and 1994, the activists at the Bombay chapter of the organization Medico Friend Circle who assisted victims of medical malpractice were "literally flooded with cases, as if there was an explosion of public anger against a system substantially alienated from people's needs."[94]

Unfortunately, some aggrieved people who did not find the lawsuits or CPA option viable but were still intent on letting the doctor know that they could not "get away," chose the violent option of physical assault. Physical violence against doctors in India had antecedents prior to the 1990s. As early as in 1972, the IMA was receiving reports of assaults on doctors "from time to time from different parts of the

[93] The major issues which consumer activists emphasized were related to food items, housing and construction, municipal civic services, and pharmaceutical drugs. See: Joyeeta Gupta, "Consumerism: Emerging Challenges and Opportunities," *Vikalpa* 11, no. 2 (April 1, 1986): 149–58.

[94] Ravi Duggal, "MFC Reminisces - 30 Years of Health Dialogues," *Medico Friend Circle* (blog).

country," organizing seminars on the doctor-patient relationship, and mulling schemes under which doctors "could be insured against assaults and injury."[95] A perusal of reports in the *Times of India* indicates that assaults on doctors were not uncommon in the 1970s and 1980s. Extrapolating from just this single English-language news source, some patterns can be discerned in the various incidents of violence against doctors. Firstly, there were only a few incidents in which a lone, dissatisfied patient assaulted the doctor. In most cases the violence was committed by a group of people, mostly the relatives and friends of a patient, and was almost invariably catalyzed by the death of the patient. Commonly, (though not in all cases) the attacking group of persons was composed of individuals with some form of political or administrative privilege: for example, union members at a Calcutta company, orderlies at a Madurai hospital, Railway Protection Force (RPF) personnel in Begusarai, and associates of political parties in Calcutta and Bombay.[96] One of the more comprehensive reports on violence against doctors appeared in 1978, covering a strike by the Uttar Pradesh Provincial Medical Service (UPPMS), called because of governmental "apathy" toward doctors' demands for protection. There was "an alarming increase in the number of cases of assault on, and misbehaviour towards, government doctors by politicians, officials, and others during the last six months." The reporter reproduced examples from a list of incidents of violence furnished to

[95] J. Majumdar, "Association Notes: All India Protest Day - July 1 1969," *Journal of the Indian Medical Association* 52, no. 12 (June 1969): 579; "Branch Notes: Kamarhati Branch," *Journal of the Indian Medical Association* 58, no. 5 (March 1972): 192.

[96] "Doctor Succumbs to Injury: Attack by Patient," *ToI*, August 17, 1962; "Doctors on Strike in Tamil Nadu Govt Hospitals," *ToI*, January 29, 1973; "RPF Men Assault Doctors after Colleague's Death," *ToI*, September 7, 1977.

them by the UPPMS: doctors "abused and maltreated by some rowdy elements," "manhandled by an MLA[97] and some local officials," and "brutally assaulted by an MLA and his associates."[98]

Most of these newspaper reports make no mention of any punitive action taken against the persons who engaged in assault. At the same time, politicians and administrators occasionally took doctors to task for "negligence" or reprimanded them when they struck work in protest against an incident of assault. In response to the strike call by the UPPMS, the state's Chief Minister was reported to have "warned that if the doctors resorted to direct action, they would be dealt with." In the incident involving the RPF personnel, who alleged that one of their colleagues had died because of the negligence of doctors, a senior administrator with the Indian Railways "assured the angry jawans [soldiers] that an enquiry would be held into their allegations" and that the concerned doctors had already been suspended from duty. When the resident doctors at a Maharashtra government hospital went on strike to protest an assault on one of their colleagues, the state government took disciplinary action against them.[99]

The lawsuit option and the assault option (so to say) were available primarily, though not exclusively, to persons and groups with some form of social, economic or political privilege. For the underprivileged in India, neither was particularly viable. The kidney trade episode, wherein doctors and privileged patients together risked the lives of marginalized individuals with impunity, symbolized the immense power asymmetries involved in the relationship between the medical profession and the underprivileged. While for many of them, especially those who lived in rural and tribal areas, doctors

[97] Member of the Legislative Assembly, i.e., an elected representative at the state level

[98] "UP Doctors Go on Strike, Seeking Protection," *ToI*, January 19, 1978.

[99] "Resident Doctors to Go on Strike," *The Times of India*, December 10, 1983.

continued to remain only rarely-used providers of care, many others, like low-income city-dwellers, were occasionally left with no option other than to solicit care in public hospitals. Throughout the 1980s, there were regular media reports of patients dying in public hospitals due to systemic negligence or more individual medical negligence.[100] However, there is little evidence that such deaths were followed by assaults or vandalism, or by successful lawsuits and punishments. As a journalist wrote (somewhat patronizingly) about underprivileged Calcutta families who lost their kids at a public hospital: "The dazed parents walking away from the hospital with their dead infants in their arms could not comprehend the possibility of poor people like themselves having the wherewithal or even the audacity to take on the state."[101] Or—it is important to add—to take on the doctor *sahab*.

Conclusion: Reddy's Story and Rakku's Story

In January 1980, after an interlude of only around three years, Indira Gandhi was back as Prime Minister. This time over, "a different path of development was being sought from that which had been followed in the early 1970s." Among the major differences was the emphasis on "freeing the private sector in industry from the regime of tight government control."[102] One of the most important beneficiaries of these policy changes was the cardiologist Prathap Chandra Reddy who, along with a group of US-based doctors of Indian origin, was "concerned about the lack of adequate medical facilities for our people in India," including the "strain on the families not only financially but also emotionally" who had been going

[100] Dalal, "Doctor, You're Not God"; "Civic Chief Denies Negligence: Kids' Deaths," *ToI*, October 8, 1983.

[101] Bachi J. Karkaria, "Patients Suffering in Augean Wards," *The Times of India*, August 16, 1989.

[102] Partha Chatterjee, ed., *State and Politics in India* (Delhi ; New York: Oxford University Press, 1997), 31.

to the United States for advanced medical treatment.[103] Their solution to these issues plaguing the Indian elites was the establishment of a new, for-profit multi-speciality hospital which would provide advanced medical treatment within India, although in their framing, this was going to serve all the people of India: "a hospital must be created which would provide care that was not available for *our people* [emphasis added]".[104] The welcoming approach of the Gandhi government toward the private sector worked to the favor of Reddy and his associates, and in early 1984 they were able to begin operations in their new "hospital-cum-hotel complex" (as described by a newspaper report) based in the city of Madras, with preparations for another one in Hyderabad already underway.[105] Under the enabling influence of the state, the Indian medical profession's historical commitment to private enterprise had earned another feather in its cap, this time in the form of a hospital managed as a public limited company. Years later, in the early 2010s, Reddy approvingly talked about the state's openness to his ideas and suggestions, and how he was "very grateful" to "the great lady... Iron lady, then Prime Minister of India."[106]

In Chapter 3, I discussed how, after the Indira Gandhi government decided to put aside many of the guiding principles of the Bhore report in 1970s, the relationship between the state and the medical profession came to be characterized by a combination of collaboration and confrontation. The establishment of the Apollo Hospitals in the 1980s represents a striking example of collaboration between these two entities. At the same time, as a swanky hospital complex built primarily for Indians who

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[103] "Unique Hospital to Be Built in Madras," *India - West*, July 18, 1980, Ethnic NewsWatch.

[104] Interview with Prathap Reddy, interviewed by Tarun Khanna, April 29, 2014, Creating Emerging Markets Oral History Collection, Harvard Business School.

[105]"Hospital-Cum-Hotel Complex in Madras," *The Times of India*, April 15, 1982.

[106] Interview with Prathap Reddy, interviewed by Tarun Khanna.

previously chose to go abroad for treatment (and those who could avail of commercial insurance and elite government insurance schemes like the Central Government Health Scheme), Apollo more specifically represented a collaboration between the medical profession and the privileged public of India. Many of the elite had apparently made peace with the demise of the family doctor and were now demanding, and receiving, the "best" and the "latest" in medicine, just as they had done in the 1960s and 70s.

Even as elites were reshaping the healthcare system in India, they were also reshaping the "public image" of the medical profession. It was only after this section of the Indian population began to increasingly experience unpleasant encounters with doctors, that discussions on the pattern of *God's representatives on earth are losing their sanctity* became more common in mainstream conversations. But as I showed in Chapter 2, in the lives of other groups of Indians, such encounters had been common for decades. For example, commenting on how doctors behaved with Dalit patients in the early 1900s, Bhimrao Ambedkar had observed that they felt "no qualms of conscience in setting aside the code of conduct" which was binding on their profession. While *Rajani*, the "feisty middle-class housewife," found reason to admonish doctors for valuing monetary gains over the ethics of healing only in the 1980s, subaltern people had already been asking such questions for over a century, with one of them writing in an 1855 essay: "Was there ever any doctor among you [Brahmins] who was human enough to treat [impoverished] people free of charge?"[107] The privilege of Rajani meant that all she had to remind the erring doctor of was his oath; but in the case of the underprivileged who routinely faced disrespect and dehumanization, doctors had to be reminded of patients' humanity in the first place.

[107] See Chapter 2 for context

In 1984, just as Apollo Madras was beginning to admit patients, Canadian doctor-researcher Sheila Zurbrigg published a book titled "Rakku's Story," which helps us better understand the stark differences in the healthcare experiences of India's elites and the underprivileged. Zurbrigg mentioned a community health workers program in a southern Indian village, not far from Madras. This program had helped improve the health of many families, but these improvements had been short-lived, particularly since the villagers' "dependency and powerlessness to confront established power structures in society had not changed."[108] What took center-stage in this important book on ill-health and the structures of policymaking in India was the lived experience of a Dalit woman, Rakku, whose story reflected "the obstacles which confront most of the labouring poor who seek health care in rural India."[109]

When Rakku's child developed diarrhea, all she could afford on her own, that too barely, was five-paise worth of "powder medicine" from a local shop. Five paise is one-twentieth of a rupee. When the powder medicine did not work, Rakku was forced to see the "injectionist" in the small town fifteen kilometers away. His fees, in addition to the bus fare to and fro, would cost four to five rupees, which was a "lot of money." So much that she had to borrow some from the good midwife. (Rakku and other villagers preferred going to this injectionist instead of the government dispensary in the same town, because most often it was either out of medicine or handing over the "same yellow pills" for everything, and also because the "doctor was young, and often spoke harshly.") When even the injection did not help, the trusted midwife told Rakku that the only option was to go to the big city hospital, forty kilometers away. This was beyond Rakku's financial capacity, and now she feared the imminent death of her child. In her mind she

[108] Sheila Zurbrigg, *Rakku's Story: Structures of Ill-Health and the Source of Change* (Bangalore: Centre for Social Action, 1984), 14.

[109] Zurbrigg, *Rakku's Story*, 13.

also "relived a similar struggle to save her third child, and the pain of its death a week after its birth." Rakku's husband had accepted the child's dismal fate. But for some reason she felt an urge "to fight for this child." And a sense of anger. "Anger for what?... She wouldn't have been able to say exactly, though she well knew that there were some village mothers who could afford to take their children for treatment when they needed it."

Rakku did fight. She bravely took the child to the city hospital all on her own, and took the brusque comments of the doctors there in stride. But, tragically, her child did not live.[110]

Through this gut-wrenching story and a sensitive analysis, Zurbrigg revealed how "issues of health and socio-economic justice are concretely inseparable."[111] But in a public discourse dominated by the stories of the Sambus, the Rajanis, and now Dr Reddy, Rakku's story (both in the form of her experiences, and also in the form of the book based on those experiences) was painfully conspicuous by its absence.[112] The space in the policy discourse left empty by the absence of hundreds of millions of Rakkus was, as the case of Apollo Hospitals shows, crowded out by the bloated influence of a small number of elites. While India's elites were already transitioning to high-technology medical care in the comfortable setting of a "hospital-cum-hotel complex," the experiences of people and families like Rakku's continued to be marked by both an absence of care and by the presence of disrespectful, dehumanized, "catastrophic"[113] care. In a display of the elites of India not only being blind to the experiences and lives of the underprivileged, but

[110] Zurbrigg, *Rakku's Story*, 19-41.

[111] Zurbrigg, *Rakku's Story*, 15.

[112] With respect to the absence of the book: I never came across it in my medical or public health training. A Google Scholar search for it gives only 29 results. A search in HOLLIS (Harvard University's library system) returns only seven results.

[113] In the public health literature, it is customary to denote massive, impoverishing healthcare expenses as "catastrophic expenditure."

also assuming their experiences and beliefs to be those of all people of India (something which Deshpande describes as "moral privileging" by the elites[114]), Dr Reddy and his partners constantly claimed their goals to be making medical care accessible and affordable to "our people in India" (as discussed above).

As early as in 1956, a perceptive writer had acknowledged this vast discrepancy between the lives and experiences of elite Indians and of the rest of India. They were writing about the tendency of the Indian press to provide wide coverage to foreign news: "other people's affairs receive greater attention than our own." An important reason, they argued, was that if reporters and journalists talked about "filthy" Calcutta streets or said that the "affairs in the University have room for improvement," that would mean "to accuse, first, one's friends, and then, oneself... This is never a pleasant process, and to invite the unpleasant when it can be avoided" was not something which the popular press preferred. This active neglect of "unpleasant" affairs in one's own backyard extended to the state of medical care: "We know nothing about it until we ourselves, or our friends, or some individual with a newspaper at his disposal, is the victim." The darker corners of life in West Bengal [and India], they wrote, "which are many in number, are seen only in lightning."[115]

Later, when a few such dark corners of medical services did swell and began to appear in the fringes of the lives of the privileged, they quickly mobilized to minimize the potential damage. Relentless advocacy in the popular press and media, the use of lawsuits and consumer courts, and even violence, were some of the ways in which Indians with privilege dealt with the challenges of a profiteering medical profession which had forgotten its "oath" and ethics. The appearance of a public discourse which regularly critiqued

[114] Deshpande, *Contemporary India*, 143.

[115] Flibbertigibbet, "A Profession Under Fire."

the practices of the medical profession and discussed how people were "losing trust" in doctors, was another consequence of this elite mobilization. However, the present chapter makes it clear that this "break" in the trajectory of public trust in doctors (that is, high levels of trust pre-1980s, and decreasing trust after that) is an insubstantial one. With respect to the experiences and perceptions of the privileged public (10 to 15% of India's population, as Deshpande would put it), it might well represent an actual transition, but it certainly cannot be generalized to other Indians. For the majority of the people of India, like for Rakku, the relationship with doctors was mostly defined by power, not trust.

5. ELITE WITHOUT BLEMISH

In mid-December 2014, the massive promotion drive for the upcoming Hindi-Urdu film *P.K.* brought its protagonist, actor Aamir Khan, to the western Indian city of Ahmedabad. At the promotional event there he was greeted with a strange question-cum-comment from an audience member, Dr. Shah, who introduced himself as a general surgeon. Shah started by telling the actor that "there have been lots of comments against you on our [doctors'] Whatsapp groups." He was referring to an episode of a talk show hosted by Khan, which had created a sensation in the country with its exposé of unethical practices and corruption in medical services. (The tagline for the episode on the show's YouTube channel read: "People trust medical practitioners, believing that they are equipped with the knowledge and skills to safeguard their health. But when this knowledge is misused to exploit this trust, medical care becomes a nightmare.") Doctors believed, Shah told Khan, that what had been represented on his show was not the full picture, and that by showcasing only those doctors who were "badly practicing," Khan's show had given a "wrong message to the society." There sure were malpractices among doctors, but "we feel, there are two percent nonsense people are there practicing in medical also, and everywhere [sic]." Apparently unperturbed by a protracted comment unrelated to the event and the film in question, Khan responded: "I am afraid I disagree with you.. Because in our finding.. what you are saying *na* 2-3 percent people are there who are not good.. it is the *oolta* [opposite]." The claims made in his show were backed by the "very thorough research" which the show's team had done, Khan said, revealing that what they had shown on the show was "even less.. We did not want to show more because you will be *shocked* with the stories that came in front of us.. *Shocked*.. [emphasis original and thespian]."[1]

[1] BollywoodHungama.com, *Aamir Khan Meets Doctor Who Had Reservations With An Episode Of "Satyamev Jayate,"* 2014, https://www.youtube.com/watch?v=8OmHDXsEaSA.

The episode which Shah was referring to was aired in May 2012, a full two and a half years prior to his interaction with Khan.[2] That doctors were still discussing the show in and outside of Whatsapp groups, and nurtured resentment against the actor, indicates that the biomedical community in India had been unusually disturbed by its content.[3] Prior to this time, such nationally widespread discontent and discomfort among doctors had been seen in the early 1990s, when, as mentioned in the preceding chapter, people had begun to put doctors in the dock in unprecedented numbers, especially following the passage of the Consumer Protection Act (CPA). Many doctors relentlessly wrote and talked about how the CPA would damage the patient-doctor relationship. Others—the "dissenting doctors"—argued differently and welcomed the CPA.

This is the final full chapter of the dissertation, and in it I attempt to excavate the origins of the present-day dominant narratives in India's mainstream medical discourse vis-a-vis public attitudes toward doctors. As I explained in the Introduction chapter, it is these narratives, used by doctors to explain why the patient-doctor relationship in India had "deteriorated" since the 1990s and 2000s, that set me on the path to the research behind this dissertation. I argue that the fundamental themes and frames of those narratives originated in the early 1990s as doctors struggled to make sense of the post-CPA world. In this chapter I will discuss and analyze the rhetoric that doctors employed in the 1990s and 2000s, as they went

[2] Satyamev Jayate, *Satyamev Jayate S1 | Episode 4 | Every Life Is Precious | Full Episode (Hindi)*, 2012, https://www.youtube.com/watch?v=5vOgh011FJs.

[3] In the months after its release, the show generated much debate, with mainstream doctors largely criticizing it for being "sensationalist" and dissenting doctors largely commending it for catalyzing a national debate on important challenges in Indian healthcare. See "Physicians, Heal Thy System!," *Economic and Political Weekly* 47, no. 25 (2012): 4–5; Nitin Kekre, "Should Mr. Aamir Khan Apologize - Medical Professionalism in Crisis," *Indian Journal of Urology* 28, no. 2 (2012): 121–121. Doctors were still resentfully mentioning Khan and his show as late as in 2020: Swati Kedia Gupta and Sudhir Khandelwal, "The 'Good, Bad, and Ugly:' Challenges for the Health-Care Professionals in Wake of the COVID-19 Pandemic," *Indian Journal of Social Psychiatry* 36, no. 5 (October 2020): 181–86.

about processing the changes afoot in the public discourse during this time, paying special attention to the narratives they were constructing about the profession's history. What follows is a critical exploration of these narratives, and thus a peek into the self-perceptions and received wisdom of India's doctors themselves.

Patients as "Doubting Thomases"

The most striking element of doctors' narratives in the early 1990s was the almost complete absence of an acknowledgement of the longstanding and widespread presence of profiteering and malpractice in medical services, even as these two phenomena were receiving the most fire from consumer activists and journalists. The occasional reluctant acknowledgment of the existence of unethical practices was almost invariably accompanied by the caveat that these were uncommon and were the work of "a few black sheep." Articles in the *Journal of the Indian Medical Association* (JIMA), for example, went to great lengths to make the case that private medical practice was more a humanistic public service than a commercial business. In October 1992 the Honorary General Secretary of the IMA, N.K. Grover, wrote that there was, "generally, a lot of human feeling and approach in the doctor-patient relationship" and treating it "as a mere commercial service prevalent between a trader and a consumer is to malign the profession of its nobility." In an admission uncharacteristic for IMA leaders, he also said that "even if the profession is not all that noble as it used to be or as it is expected to be, it has still not generally speaking, ceased to be a profession as against a trade or a business." If the application of the CPA to the medical profession became a permanent fixture,[4] he appeared to warn, the profession of medicine "might convert

[4] The IMA and other doctors' organizations were legally contesting the CPA during this time, as discussed later in the chapter.

into a trade/business, making treatment much costlier." Grover's commentary, however, erased the fact that medical practice in India had been a highly commercialized phenomenon for decades, as I have shown in the previous chapters. He also ignored the existing widespread prevalence of medically unnecessary investigations and procedures. He write that in apprehension of lawsuits and legal challenges, doctors would begin to "resort to overinvestigations which otherwise may not have been considered necessary," and medical ethics would then be "seriously eroded."[5] Such claims obfuscated the situation on the ground, where overtreatment had been common for decades. Nevertheless many other doctors also made similar claims: that the CPA would *lead to* medical practice turning into a business and to doctors prescribing unnecessary investigations as a "defensive" practice.[6]

A former president of the IMA, P.K. Choudhuri, argued that the CPA would lead to an "inevitable deterioration of the doctor-patient relationship and involvement of high cost of the treatment due to superfluous investigations doctors are likely to advise for their safeguards." Interestingly, he wrote that there was "already a tendency of commercialisation by the intervention of the industrialists in the field of medical service," and that CPA would intensify such commercialization.[7] The medical care landscape in metropolitan India had indeed undergone major changes through the late 1980s and early 1990s, mainly with the growing presence of for-profit multi-speciality hospitals and diagnostic centers. So Choudhuri probably was reacting to these developments and making an implicit claim that prior to these,

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[5] N. K. Grover, "Consumer Protection Act and Medical Profession," *Journal of the Indian Medical Association* 90, no. 10 (October 1992): 277–79.

[6] "Letters to the Editor: Applicability of the Consumer Protection Act to the Medical Profession," *JIMA* 91, no. 7 (July 1993): 193.

[7] P. K. Choudhuri, "Medical Profession and Consumer Protection Act," *Journal of the Indian Medical Association* 91, no. 7 (July 1993): 168–69.

commercialism was an insignificant element in medical practice. His claims, however, display substantial amnesia. His own predecessor in 1946, the IMA President P.B. Mukerjee, had made an impassioned appeal against socialized medical services and in favor of preserving what was considered by his generation of doctors to be the profession's "most valued privilege and cherished right" of private practice.[8] Doctors after Mukerjee had so enthusiastically followed this cherished right that as early as in the 1960s and 1970s, patients and journalists were critiquing the presence not just of commercialism but even of profiteering and "excessive fees." As a senior doctor and former IMA president, Chaudhuri's failure to account for these developments, to almost all of which he probably was a first-hand witness, is puzzling. One possible (and still only partial) explanation of his claims is that small-scale entrepreneurialism by doctors—for example, the running of clinics and nursing homes—was so historically inherent to the profession and intimate to how the majority of Indian doctors practiced medicine, that many of them perhaps believed such "traditional" forms of providing medical care (as opposed to the more recent "intervention of the industrialists in the field of medical service") could not be classified as "commercial." Nevertheless, narratives like Choudhuri's worked to blur the nature and extent of commercialism in medical services and to provide and propagate a misleading history of its origins.

Such claims regarding commercialism were invariably accompanied by denial, even deliberate obfuscation, of the presence of malpractices. The "few black sheep" argument was widely employed, especially after newspapers began reporting in earnest about medical negligence in the 1980s. In response to the 1985 report on medical negligence by Ayesha Kagal, discussed in the preceding chapter, two doctors wrote a letter to the paper arguing that "isolated instances of malpractice and medical negligence are bound

[8] I discussed Mukerjee's speech in Chapter 1.

to occur, but these are exceptions rather than the rule and should not be blown out of proportion."[9] (Three decades later, as discussed in the introductory paragraphs, Dr. Shah would say something similar: just 2-3% of doctors in India were "nonsense.") The depiction of commercialism in the 1986 *Rajani* show was also greeted by some doctors with obfuscation: "... such programmes should not be shown, though there could be *some* instances of misbehaviour on the part of the GPs" [emphasis added].[10] Later when a prominent businessperson said in a speech that doctors were "fleecing" patients, some doctors protested by demanding he apologize to the medical profession "in general" and to "a large majority of dedicated, honest, hard-working doctors in particular."[11]

Although most doctors probably found it embarrassing to acknowledge the presence of malpractice and negligence, or perhaps even had normalized it, they were also aware that such incidents were regularly making it to the public discourse. Doctors had to thus reconcile the increasingly negative public image of the profession with what they considered—or wished to project—as a relatively blemish-free past (and even present). This reconciliation attempt led to doctors selectively singling out certain aspects of their recent history as important causes behind the "deterioration" in the patient-doctor relationship. Thus, apart from the intrusion by industrialists as cited by Chaudhuri above, blame was assigned to the proliferation of private medical colleges, the "reduction" in the quality of medical training, and the intrusion of a "corporate culture."[12] Frequently, these commentaries invoked nostalgic remembrances of a past era of medical practice which supposedly was untainted, or minimally tainted, by

[9] Lalit Kapoor and Mahendra Sheth, "Doctor 'Do Little'?," *The Times of India*, December 29, 1985.

[10] "Doctors Assail 'Rajani' Show," *The Times of India*, February 16, 1986.

[11] Atul Garud, S.S. Joshi, and A.N. Nathwani, "Doctors' Protest," *The Times of India*, February 22, 1991.

[12] Ramesh Potdar, "Consumer Protection Law and the Pediatrician," *Indian Pediatrics* 34, no. 4 (April 1, 1997): 283–86.

commercialism and ethical transgressions. In 1994, a doctor with the Indian Railways wrote: "After nearly two decades in the medical profession, I have come to realize that it is affected by serious maladies… Previously, doctors used to have an almost god-like status, because medicine had not become commercialized. Now the incoming entrants into the profession are interested in only one aspect of the job—making money. This may be understandable because their medical education may have been obtained after paying a huge donation [i.e., capitation fees], so what else can we expect! To survive in the rat race the young doctors follow the examples of their seniors who are no longer shining examples of virtue."[13]

An editorial by Ramesh Potdar in *Indian Pediatrics*, titled "Consumer Protection Law and the Paediatrician," also constructed a similar narrative. At the same time, it revealed a lack of self-introspection and a tendency among some doctors to assign much of the blame for commercialism and consumerism to patients and the "society." Potdar completely disregarded the widespread presence of unethical practices, and instead blamed rising general education levels and public "awareness" on health as the enabling conditions under which the "good old patient was bound to convert himself sooner or later into a consumer of medical services and seek protection under the Consumer Protection Act." This statement indicates that some doctors were annoyed with "educated" and "aware" patients who had decided to become "consumers." There is almost an implicit acknowledgement here that in the absence of education, awareness, and consumerism, it was possible for medical malpractices and negligence to not be recognized by patients as such, and to simply stay under the public radar. Potdar's rough timeline of the trajectory of medical practice in India deserves special mention: "deteriorating standards of medical college admissions

[13] Atul K. Agrawal, "Correspondence: Medical Maladies," *The National Medical Journal of India* 7, no. 6 (1994): 305.

and education, maldistribution of medical personnel in rural urban divide, commercialization of the vocation as an inevitable sequel of capitation fee phenomenon, lowering of value systems in society and impersonalization of medical services due to corporate culture taking roots in private health sector." Under such circumstances the patient-doctor relationship had, he wrote, changed "from all patients having full trust and blind faith in doctors to doubting Thomases who would expect a doctor to cure everyone and cry hoarse in cases of some deficiency or even unavoidable failures."[14] Potdar's disdain for the accountability-seeking patient is obvious in the language he uses, and serves as a testament to the privilege and entitlement which the biomedical profession had been enjoying for decades—and, apparently with underprivileged patients who were not "educated" and "aware," continued to enjoy.

Doctors as Dissenters

While many doctors thus ended up displacing the reasons for public distrust to factors external to medical practice and doctor's own behavior (like private medical colleges and overly alert consumer-patients), some did call out the disingenuity involved in this exercise. For example, at the same time as the *JIMA* was engaged in arguing that the CPA would end up converting medical practice into a business, the journal *Medical Ethics* (which later became the *Indian Journal of Medical Ethics* or *IJME*) published commentaries which were vastly different to what mainstream doctors were proclaiming. V. Murlidhar asserted that "nearly 80% of private health practice is based on the nexus of commission and cuts between the G.P. and the consultant. They go to any lengths to earn their bread, butter and jam."[15] Another doctor

[14] Potdar, "Consumer Protection Law and the Pediatrician."

[15] V. Murlidhar, "Problems in the Health Care System - A Brief Appraisal," *Medical Ethics* 1, no. 2 (November 1993): 1–2.

took the IMA and the larger medical community to task for their reactions to the CPA, interspersed with a healthy dose of sarcasm:[16]

> We were shocked and angry. How could any one even think of accountability from us? How could we be taken to task? Meetings were called. Talks were arranged.... The entire medical community revolted, albeit orally... Did we stop to look at the situation through the eyes of... the common man? Our panic reactions, in fact, provide the strongest justification for the CPA.

He dismissed the outrage of doctors over being supposedly equated with "traders", saying that doctors were "conveniently" ignoring the commercialization which had "crept into" the profession. The *IJME* also made a commentary on the prevalence of over-treatment and over-investigations through a telling cartoon, in which we see (seemingly) a radiologist X-raying a patient, and exclaiming, after eyeing the wallet in the patient's trousers, that he can "finally see something that needs removal!"[17]

Indian Journal of Medical Ethics 2, no. 4 (1994)

[16] Mangesh Jalgaonkar, "Consumer Protection Act - an Introspection by a General Practitioner," *Indian Journal of Medical Ethics* 2, no. 4 (1994): 12–13.

[17] *Indian Journal of Medical Ethics* 2, no. 4 (1994): 15. https://ijme.in/wp-content/uploads/2016/11/251-5.pdf

Other journals and dissenting doctors also contributed to the discourse. Long-time dissenter Sunil Pandya wittily remarked in 1992: *'There are black sheep in the profession', they confess sheepishly*, referring to the fact that people's experiences of malpractice had become so rampant that doctors could now no longer depend upon flat denial and were hence conceding some reluctant acknowledgements of unethical behavior. He revealed that "enquiries show that kickbacks are expected by over 70% of general practitioners in parts of this city [Bombay]. Indeed, the system has been perfected to the extent that aspiring consultants deposit several thousand rupees with the general practitioner who deducts a sum per patient referred to the consultant."[18] Arun Bal, a practicing surgeon and a vocal advocate of patients' rights, believed that doctors were "solely responsible for destroying" public trust in the medical profession, and they couldn't deny that they "indulge in various rackets and extract 'commissions' from each other."[19] Sanjay Nagral called out the implicit claims of some doctors that the CPA was the major reason behind lawsuits against doctors, reminding them that there had been a "steady rise of cases both in the medical council as well as civil courts on matters of medical negligence in the last few years." Like Bal and other dissenting doctors, he entreated the profession to introspect and to own up for a mostly self-inflicted "degradation." Sure, the "crass commercialization" in the profession had gone hand in hand with the "overall commercialisation of society," but this was at best "an explanation and not a justification."[20]

The use of the CPA by patients and families in the late 1980s and early 1990s had thus led to a proliferation of commentaries in medical journals on the patient-doctor relationship and medical practice.

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[18] Sunil K. Pandya, "Letter From Bombay," *The National Medical Journal of India* 5, no. 5 (1992): 243–44.

[19] Arun Bal, "Consumer Protection Act and Medical Profession," *Economic and Political Weekly* 28, no. 11 (1993): 432–35.

[20] Sanjay Nagral, "The Consumer Protection Act," *Journal of Postgraduate Medicine* 38, no. 4 (December 1992): 214–15.

Considering the intensity of public interest in the topic, commentaries invariably spilled over into the popular press and other journals, where the basic patterns and themes, including the fundamental duality of a mainstream profession opposing the CPA and dissenting doctors favoring it, were retained.[21] One short commentary by a doctor, in a letter to the *ToI*, is remarkable (like Potdar's commentary above) for its contemptuous language, and perhaps well represented the private feelings of many mainstream doctors at the time. He contended that the CPA would "open floodgates" of litigation against doctors: "A doctor cannot treat a patient as if the patient is a time-bomb, ready to go off in the hand any moment." He further wrote:[22]

> Despite the advances in the medical field and the best efforts of doctors, people are going to die of illnesses. They are going to develop complications, preventable or not. Even God cannot guarantee a human being perfect in body and mind. The doctor is not God. He is not perfect... If people do not have faith in the doctors, they may try the post office or the railway station the next time they are ill.

As opposed to such commentaries, dissenting doctors, like Arun Bal, used the platform of the popular press to express their support for the "progressive" CPA legislation, and at the same time to critique its practical workings and suggest remedial measures. An important challenge which arose soon after people began to use the CPA was the pile-up of cases in the consumer courts. Bal urged that the government should not "rest on its laurels" and must continue to work on improving the various "lacunae" which were plaguing the courts. He also urged the press to not indulge in "sensational coverage," citing an

[21] There probably were a number of doctors who would not have considered themselves as part of either "camp."

[22] Vivek Gharpure, "Trust in Doctors," *The Times of India*, May 26, 1992.

example of "unfair" reporting against a doctor, wherein the reportage was "contradictory to the facts of the case."[23]

The opposition of the mainstream profession to the CPA was not just confined to medical journals and other public forums. Throughout the early 1990s, the applicability of the CPA to the patient-doctor encounter was challenged in several courts including the Supreme Court of India (SC). In the SC case ("Indian Medical Association vs V.P. Shantha & Ors"), the court was primarily adjudicating "whether and, if so, in what circumstances, a medical practitioner can be regarded as rendering 'service' under... the Consumer Protection Act, 1986." Some of the claims made by lawyers representing the medical profession were that the CPA referred to only "occupational" services and not "professional" services, that its language implied that the lawmakers had not intended for the law to be applied to the medical profession, and that the peculiar nature of doctors' services meant that ordinary norms of evaluating "deficiency" in service (which the CPA supposedly relied on) could not be applied to doctors. In a judgment delivered in November 1995, the SC rejected most of the arguments of the medical profession and held that the provisions of the Consumer Protection Act were indeed applicable to "deficiency in service rendered by medical practitioners and hospitals" (with certain exceptions).[24] Calling it a verdict of far-reaching consequences, the *Times of India* carried news of the judgment on its front page with the headline "SC Ruling Brings Doctors Under Consumer Act."[25] A top IMA official said that while they "respected" the court's decision, the organization had "mixed feelings" about the judgment. Dissenting doctors welcomed

[23] Arun Bal, "Correct the Lacunae," *The Times of India*, October 9, 1992.

[24] *Indian Medical Association vs V.P. Shantha & Ors* (1995); 1996 AIR 550, 1995 SCC (6) 651; Accessed on IndianKanoon.

[25] "SC Ruling Brings Doctors under Consumer Act," *ToI*, November 14, 1995.

the decision. Arun Bal, for example, said that the "historic judgment should motivate physicians and their organisations to introspect deeply on every aspect of the medical profession in India."[26]

It is clear that in the wake of public critiques and people's use of the CPA in the 1980s and 1990s, the Indian biomedical profession was experiencing an unprecedented crisis. Not surprisingly, different doctors reacted differently to the crisis, and two broad groups emerged, which I have called the mainstream profession and the dissenting doctors. These groups had vastly different approaches to the CPA and to the nature and presence of malpractices and corruption in medical practice: in the rhetoric of the former, we encounter an obfuscation of the realities of corruption and malpractice in medical services, and the latter chiefly leaned toward transparency and corrective action. However, in terms of explaining how the profession had come to such a point where there was considerable (elite) public anger and distrust in doctors, there were more similarities than differences in the narratives of both these groups, as the next section will show.

Doctors as Amateur Historians

The mainstream profession, as discussed above, considered the rise of private medical colleges and of hospitals and diagnostic centers run with corporate business ethics, as the most important factors leading to public distrust in doctors.[27] Interestingly, the historical narratives created by many dissenting doctors also contained several of these elements. At the same time, the much longer history of

[26] Joaquim P. Menezes, "SC Ruling on Doctors Pleases Consumer Activists, Forums," *TOI*, November 15, 1995.

[27] It is worth noting that with time, newer generations of doctors — more and more of whom would come to overwhelmingly depend upon corporate hospitals for their careers — would begin to assign less blame to corporate hospitals and more to other factors, including "entitlement" in patients and patients' use of the Internet.

commercialism, profiteering, and "callous" attitudes of doctors remained unaccounted for in most of the narratives from either side.

D. Banerji, prominent doctor-sociologist, wrote about the "crisis in the medical profession" in 1989. Discussing the "sharp decline" in the ethical standards of medical practice, he emphasized "the widespread trend towards commodification of medicine over the past several years," saying that medical practice was "now" becoming a commercial activity.[28] V. Murlidhar contrasted the nature of medical practice in an undefined past with that of more recent times. He emphasized the profit orientation of modern health services, with the influence of pharma companies and the capital-intensive diagnostic and therapeutic centers which "have been set up by businessmen." In the past, he wrote, the option of working in state and municipal hospitals, particularly as honorary staff, was "very attractive" and the "cream of the profession" served there with "devotion and sincerity." But in recent times, instead of working in public hospitals, "fine young doctors... were following the pipes played by those" in the top management of new "five-star" medical care centers.[29] For George Thomas the deterioration in ethical standards was "part and parcel of the new social ethos where everything is judged by the yardstick of monetary wealth."[30] At a workshop on the CPA in 1992, a consumer activist claimed that in their experience, doctors who had graduated from private colleges after paying capitation fees were "the ones who exploit patients."[31] In 1995 an *IJME* editorial expressed concern that health was "now" a matter of commerce, with concern for profits

[28] Debabar Banerji, "Crisis in the Medical Profession in India," *Economic and Political Weekly* 24, no. 20 (1989): 1091–92.

[29] Murlidhar, "Problems in the Health Care System - A Brief Appraisal."

[30] George Thomas, "Correspondence - The Worship of Mammon," *Medical Ethics* 5, no. 2 (April 1995): 29.

[31] Madhukar Pai, "Workshop on 'Patients, Doctors and the Law': A Report," *Medico Friend Circle Bulletin*, no. 184–5 (August 1992).

overshadowing all other considerations and with the "new economic policies, liberalising the 'health market' without effective and meaningful regulation," amplifying the suffering of patients.[32]

As the material discussed in previous chapters shows, there are many historical inaccuracies in these narratives. For example, doctors neither found honorary professorships in government hospitals universally "attractive," nor is there evidence that honorary physicians and surgeons were generally sincere and devoted in their jobs, and nor was economic exploitation of patients by doctors dependent on the rise of capitation fee-based private colleges. Considering that the dissenting doctors who were writing these narratives were generally committed to transparency and did not have any obvious reason to obfuscate the history of the profession, it is clear that they genuinely believed in these evaluations of the past. In fact they shared many elements of this understanding of the past with their mainstream counterparts. In the following paragraphs, I attempt to explain why and how so many doctors during this time came to propose these partial and often misleading narratives of the history of their own profession.

One of the most significant aspects of these narratives is the centrality of the events of the 1980s-90s, which seem to almost completely overwhelm the events of the prior decades. An important reason for that lies in the historical momentousness of this period for Indian policy in general and healthcare in particular. It was the period of economic liberalization in India (alluded to in the 1995 *IJME* editorial above), with accompanying major transformations in how the state conceptualized its role in the healthcare system.[33] The elite public discourse was marked by intense debates on these changes, which included gradual disinvestment of the state from several forms of medical and healthcare services. Many dissenting

[32] Anil Pilgaonkar, "Ethics of Professional Bodies," *Medical Ethics* 3, no. 1 (January 1995): 1–2.

[33] See for example, Mohan Rao, ed., *Disinvesting in Health: The World Bank's Prescriptions for Health* (SAGE Publications, 1999).

doctors considered these policy shifts to be detrimental for public welfare, and vehemently opposed them. The two most feared and most debated consequences of liberalization were commercialization (also sometimes termed "commodification") and privatization of healthcare services. Some doctors, for example, participated in demonstrations against the introduction of user fees in government hospitals.[34] Others unsuccessfully opposed the increasing dominance of corporate business ethics in healthcare.[35] The "scandals" of sex-selective abortions and the kidney trade, considered among the most antisocial manifestations of commercialized medicine, were fresh in public memory. Many doctors feared that liberalization, especially without adequate accompanying regulation, would end up amplifying such unethical practices. All these developments were indeed recent in origin and contemporaneous for the doctors who were actively engaged in the public discourse and activism during this time. Even private medical colleges, despite their long-standing origins, had witnessed a major proliferation phase in the 1980s.[36] It is unsurprising, then, that a cursory assessment of the state of affairs and an urgent need to articulate a working history of the medical profession and the patient-doctor relationship would have led doctors to these temporal low-hanging fruits.

There is another important reason behind the absence of the longer histories of commercialism and malpractice in these narratives of doctors: hand-in-hand with the looming presence of recent liberalization and privatization, was the disproportionate influence of personal experience. A vast majority

[34] "Fees in Public Hospitals Opposed," *The Times of India*, April 12, 1988. See also reminiscences by Nagral in Sanjay Nagral, "To the Indian Medical Association, Here's Why I Am Not Marching with You Today," *Scroll* (June 6, 2017).

[35] K.S. Sanjivi, "Hospitals of the Future - Letters to the Editor," *Business India*, January 14, 1985.

[36] Sanjay Kumar, "India: Curbs on Private Medical Colleges," *The Lancet* 341, no. 8844 (February 27, 1993): 549; Vikash Ranjan Keshri, Veena Sriram, and Rama Baru, "Reforming the Regulation of Medical Education, Professionals and Practice in India," *BMJ Global Health* 5, no. 8 (August 1, 2020): e002765.

of the doctors participating in the public discourse and constructing histories of their profession at this time—whether dissenting or otherwise—were from privileged castes and communities, many whose parents or other family members also were doctors. The discourse in their family networks and social networks would have been similar to the discourse among privileged Indians discussed in the preceding chapter, with the sentiments of caution, skepticism and trepidation vis-a-vis the medical profession entering their healthcare encounters only in more recent times, if at all. For example, in the narratives of doctors, as in those of other elite Indians, we see the invocation of a supposedly kinder and nobler past when doctors were committed to service and practice was hardly influenced by commercial concerns. Thus, for a large number of doctors, it so happened that the experiences and perceptions of members of their social circles also emphasized the temporal low-hanging fruits of liberalization and the recent rise of corporate hospitals and private medical colleges. To paraphrase Satish Deshpande, "given that most [doctors] were from upper-caste backgrounds, they could not call upon the accidental resources of personal experience to overcome the powerful consensual [perceptions of medical practice] in the past."[37]

In summary, even as doctors were pondering over and responding to the growing (elite) public anger and distrust in the early 1990s, they were also charting a trajectory of the history of medical practice. The claims they arrived at, while not always historically accurate, reveal their anxieties and concerns, and tell us what they chose to believe, in the historical moment, to be the main causes of the "deteriorating" patient-doctor relationship. Nevertheless, the narratives they constructed then, which reduced the longer and chaotic histories of commercialism and malpractice in medicine to a truncated and streamlined post-

[37] Deshpande's original statement was about the failure of Indian sociologists to acknowledge the persistence of caste in "modern" society in India: "Given that most sociologists (and other academics) were from upper-caste backgrounds, they could not call upon the accidental resources of personal experience to overcome the powerful consensual positioning of caste in the past." Satish Deshpande, *Contemporary India: A Sociological View* (New Delhi: Penguin Viking, 2003), 124.

1980s timeline, and largely left unacknowledged the continued presence of disrespectful and dehumanizing behavior toward marginalized patients, remained uncontested and have since assumed the cloak of truth in medical as well as the public discourse.

This was apparent, for example, in 2012 when doctors were contributing to the massive public discourse catalyzed by Aamir Khan's talk show *Satyamev Jayate*, mentioned in the introductory paragraphs. Much of the commentary from that time incorporated elements of the narratives created by doctors in the early 1990s. Urologist Nitin Kekre, for example, blamed private medical colleges and corporate hospitals for what he considered a more recent deterioration in the patient-doctor relationship. According to him, it was the pressures of the "new medical industrial complex which... coupled with insufficient training [in private medical colleges] and imperfect skills are seriously compromising the moral and ethical fabric of this noble profession."[38] Members of the Medico Friend Circle (MFC) wrote an open letter to the IMA, which had apparently demanded an apology from Aamir Khan for supposedly showing the medical profession in poor light. They argued that doctors were "increasingly forced to become hard-nosed businessmen - often in order to repay large loans - to ensure their practice, and to remain 'in the system' despite the fact that many would not have liked to depart from their principles. In this situation, the increasing numbers of 'black sheep' - and much larger numbers of 'grey sheep' - are the inevitable products of this system."[39] George Thomas surmised that cut practice and kickbacks appeared in medical practice some time in the late 1980s and early 1990s when many for-profit players entered medical services, including in hospital services and diagnostic imaging: "It appears that relative overcapacity rapidly

[38] Nitin S. Kekre, "Should Mr. Aamir Khan Apologize - Medical Professionalism in Crisis," *Indian Journal of Urology* 28, no. 2 (April-June 2012): 121–22.

[39] "Physicians, Heal Thy System!," *Economic and Political Weekly* 47, no. 25 (2012): 4–5.

developed and this was the start of competition among the players for patients, which led to offering kickbacks to doctors for referring patients. This has now become established practice."[40] [However, as I showed in Chapter 4, these malpractices existed as early as in the 1960s, and were even showcased in a popular Bollywood film in 1971.] Similar narratives, in which the longer history of commercialism and malpractices is missing, were seen in 2015 and after, when incidents of violence against doctors witnessed a substantial spike, spurring doctors, journalists, and social scientists to analyze what they claimed to be worsening public anger and loss of trust in the biomedical profession.[41]

Conclusion: Setting the Historical Record Straight

The histories which doctors constructed in the early 1990s have not only proven persistent, but also adaptable. For example, with time, the supposed effects of the liberalization phase of the Indian economy (which was only in its preliminary stage in the early 1990s) came to assume a larger role in the genesis of the loss of public trust in doctors. Analyses by doctors and social scientists in recent years have indeed largely focused on liberalization. M.S. Valiathan wrote in 2018 that though "petty corruption" in healthcare had long existed in India, the "growth of corruption in the post-1991 liberalization era has startled Indian citizens who are bombarded continually by reports of needless hospitalization and costly diagnostic tests, unnecessary medical and surgical intervention, the physician–industry nexus, medical insurance frauds, and profiteering in medical treatment."[42] In an influential 2018 book on the state of

[40] Thomas, "Satyam or Sensationalism?"

[41] For example, see Meharban Singh, "Intolerance and Violence Against Doctors," *Indian Journal of Pediatrics* 84, no. 10 (October 2017): 768–73.

[42] M.S. Valiathan, "Corruption in Healthcare - A Technology Perspective," in *Healers or Predators?: Healthcare Corruption in India*, ed. Samiran Nundy, Keshav Desiraju, and Sanjay Nagral (Oxford University Press, 2018).

healthcare services in India, several chapters, written by doctors and social scientists, primarily blamed liberalization and the resulting privatization and commercialization, for the rise in corruption in medical services and the consequent loss of public trust in doctors.[43]

While liberalization has indeed been a crucial factor, I argue that its role is not originatory but acceleratory: it accelerated the preexisting processes of privatization and commercialization of healthcare services, as well as expanded the already available field for profiteering and malpractices. As my research shows, the origins of public distrust in doctors, and of commercialism and corruption in medical practice, predate the liberalization era by several decades. In attributing the rise and proliferation of these phenomena chiefly to the changes brought about by a political economic event (liberalization), there is a risk of missing the central role played by the human agency of the medical profession and individual doctors who, with their commitment to private enterprise, had normalized and institutionalized corruption and unethical practices long before the faceless behemoth of the Indian economy set its eyes on liberalization. In recent years, historian Amrita Bagchi has also argued about the need to take seriously the pre-liberalization origins of privatized healthcare services in India.[44]

In an interesting coincidence, a similar misinterpretation of chronology has been observed in the conventional narrative of the history of large multi-speciality hospitals in India. Historian Sarah Hodges observes that the Apollo Hospitals are believed to represent "the beginning of a new chapter in the history of healthcare in India: the rise of the corporate hospital alongside the unfolding of liberalisation in the

[43] Samiran Nundy, Keshav Desiraju, and Sanjay Nagral, *Healers or Predators?: Healthcare Corruption in India* (Oxford University Press, 2018).

[44] Amrita Bagchi, *Health Care in Post-Independence India: Kolkata and the Crisis of Private Health Care Services* (London: Routledge, 2022).

country." But she found that those narratives were "based on assumptions and assertions that crumble under even the most basic historical scrutiny." For example, she commonly encountered assertions that corporate multi-speciality hospitals marked an unprecedented innovation in the delivery of healthcare, and that the broad range of high-quality medical services they offered in the late 1980s became a template for future healthcare delivery in the country. Analyzing these claims, she writes: "Surely, I thought to myself, the concept that one hospital could treat an entire range of ailments was the foundational idea of hospital medicine, as it emerged in the late eighteenth and early nineteenth centuries." What corporate multispeciality hospitals provided was not something new, but "simply a shinier imitation of the government and charitable institutions which were already in existence and which, too, were based on a long-standing model of comprehensive clinical investigation and treatment." When people attribute the rise and dominance of large multispeciality hospitals in India chiefly to Apollo and its founder Prathap Reddy, Hodges argues that they end up obscuring "a set of broader historical processes that both precede and go beyond any results that can be attributed" to a single historical moment or person.[45]

I believe that a similar blurring of reality occurs with the persistence of claims which maintain that commercialism, profiteering, and malpractice in medical services are primarily a result of the abstract process of economic liberalization, as against of the decades-long institutionalization of these entities executed by India's doctors and medical organizations like the IMA, frequently in collaboration with other elites. My dissertation has been, thus, an attempt to intervene in the contemporary narratives on the history of the biomedical profession in India in three major ways. I have highlighted the central role which doctors themselves played in the development of commercialism and corruption in medical practice; I have shown

[45] Sarah Hodges, "'It All Changed after Apollo': Healthcare Myths and Their Making in Contemporary India," *Indian Journal of Medical Ethics* 10, no. 4 (2013).

that these phenomena long predated the liberalization decades; and I have argued that while the elite discourse around a "deteriorating" patient-doctor relationship and "loss of trust" in doctors indeed intensified in the 1980s, for a large number of other Indians throughout the post-independence period, biomedical doctors rarely were trusted healers in the first place.

The incomplete and flawed historical narratives about the medical profession and the patient-doctor relationship which were constructed by doctors in the early 1990s, in the heady years of the CPA debates, are thus amenable to correction and revision. However, and unfortunately, it is somewhat beyond the historian's skill to work to address the denial and obfuscation of reality which some doctors resorted to during the CPA debates, and which, unfortunately, persist to this day. The claim by Dr Shah mentioned at the beginning of the chapter—of only 2-3 percent doctors being "nonsense," by which he meant those who indulge in unethical practices—is a telling example. It is extremely difficult to believe that a practicing senior doctor in a large Indian city, in 2014, would be unaware of the obvious speciousness of that statement. Still, it is common to hear such claims from doctors even today. As dissenting doctors experienced during their advocacy against sex-selective abortions in the 1980s and during the CPA debates (discussed in Chapter 4), an honest assessment of the state of affairs, and acknowledgment of unpleasant realities, have for long been sorely missing elements in the discourse of the mainstream biomedical profession in India. This absence of honest introspection applies to the profession's privileged-caste origins and ideologies too. In fact the longstanding failure of most doctors to engage in any serious discussion on caste-based privilege and casteism within the profession, and their regular insistence that "there is no caste

discrimination in Indian medical field,"[46] point to the enormous challenges involved in setting the record straight with respect to the substantial history of the Indian medical profession.[47]

I believe, on the one hand, that the historical analysis of people's perceptions of and attitudes toward doctors which I have laid out in this dissertation will be found useful by many doctors to better understand the genesis of current public attitudes toward them, and to acknowledge the role which doctors themselves have played in shaping those attitudes. But at the same time, I am aware of the unfortunate possibility that many other doctors will continue to disregard scholarly histories and to place their faith in the dominant narratives they learned as received wisdom during their training, which in recent years, as the allusion to Whatsapp messages by Dr Shah makes clear, are also being furiously propagated through social media.

[46] Anoo Bhuyan, "IMA Vaguely Acknowledges Caste Discrimination in Medical Education," *The Wire*, June 3, 2019.

[47] Sylvia Karpagam, "Caste-Washing the Healthcare System Will Do Little to Address Its Discriminatory Practices," *Indian Journal of Medical Ethics* VI, no. 1 (March 2021): 1–4; Kiran Kumbhar, "The Medical Profession Must Urgently Act on Caste-Based Discrimination and Harassment in Their Midst," *Indian Journal of Medical Ethics* VI, no. 1 (March 2021): 1–5.

CONCLUSION: CARING FOR AND ABOUT RAKKU

In December 2013, a young biomedical graduate, Varun Patel, penned an impassioned blog post about his internship experiences.[1] Conveying emotions of deep disillusionment and betrayal, he wrote: "This year was the best so far in terms of learning medicine, but it was also worst ethically and has left a deep impact somewhere deep down in my conscience."[2] His write-up belonged to the whistle-blowing tradition seen in the 1970s with the writings of Arun Limaye and Anil Awachat (discussed in Chapter 4). Patel boldly wrote about the many irregularities and malpractices he witnessed in the conduct of many doctors around him, as well as about their disrespectful and dehumanizing behavior toward patients. What seemed to have affected him most was how his colleagues and seniors behaved with women in the labor ward (as this was a government hospital, almost all the admitted women belonged to underprivileged communities). He wrote:

> In an Indian government hospital giving birth to a child is not a unit less than suffering the third degree torture in jails. Pregnant women are beaten like anything and, worst of all, the doctors feel it as justified... It's discernible that the woman will be in pain and would shout out of pain but the thing you find implausible is when the doctor hits her and asks her to keep her mouth shut. Unreasonable usage of Buscopan and Drotaverine to speed up the labour and unwanted episiotomies with accompanying fundal pressure manoeuvres (which are contraindicated) leave you baffled. You decide at that very moment that none of your loved ones will ever deliver in a government hospital hereafter. It's better to be childless than making a woman go through such crucifixion.

[1] During "internship" in the Indian biomedical education system, fresh MBBS graduates are expected to spend a few weeks to months at a time in major departments at a host hospital, working as apprentices under supervision, to eventually learn basic clinical skills before they are formally registered as medical practitioners.

[2] Varun Patel, "A Year as a Doctor's Apprentice," *India Medical Times*, December 2, 2013, WayBack Machine, https://web.archive.org/web/20131216074311/http://www.indiamedicaltimes.com/2013/12/02/guest-article-a-year-as-a-doctors-apprentice-by-dr-varun-patel/.

Patel's host hospital was the magisterial Sassoon Hospital of Pune. It is where I completed my own medical training. As an intern, I had indeed witnessed the abusive treatment meted out to women in labor by many doctors, even as others worked to be humane care providers despite the challenging context of heavy workload and toxic work ethics.[3] Hitting and slapping women in labor, and yelling at them even as the latter scream in intense agony, are particularly cruel activities common in many Indian hospitals.[4] This cruelty is often made worse by doctors defiantly justifying their violent acts, often even claiming them to be for the benefit of the women themselves ("If I am not stern, she will give up pushing"[5]). It is worth noting that the doctors who receive their training in government hospitals are considered among the best and brightest medical students, and it is thus many of these best and brightest who perpetrate such violence against patients.

Clearly, the dehumanization which has been a characteristic of patient-doctor interactions in India throughout the post-independence period, as I discussed in the preceding chapters, continues to the present day. Disrespect toward and abuse of women in labor is a powerful example of that, although, as seen throughout the dissertation, there are many other examples of the everyday humiliation of patients in

[3] I also remember, at that moment, having a mixed reaction to Patel's article and being annoyed that my alma mater had received such bad press, although with time I realized that was an inappropriate reaction from my end.

[4] Shreeporna Bhattacharya and T. K. Sundari Ravindran, "Silent Voices: Institutional Disrespect and Abuse during Delivery among Women of Varanasi District, Northern India," *BMC Pregnancy and Childbirth* 18, no. 1 (December 2018): 1–8; Neha Madhiwalla et al., "Identifying Disrespect and Abuse in Organisational Culture: A Study of Two Hospitals in Mumbai, India," *Reproductive Health Matters* 26, no. 53 (August 27, 2018): 36–47

[5] I remember this explanation provided by an ob-gyn resident doctor in a conversation around 2014-15.

India's healthcare spaces. Such disrespectful experiences were, and continue to be, borne almost exclusively by persons from underprivileged castes and communities.[6]

This everyday state of affairs in India's medical care system, however, remains for the most part under-acknowledged in the mainstream public and medical discourse. The responses to Patel's article are instructive. All of the 108 accessible comments on his blog post, whether critical or sympathetic, focus on the corruption, malpractices, lack of state investment in healthcare, and related issues which he mentioned, and almost no comment discusses in any detail the everyday nature and the normalization of the abusive treatment of women in labor.[7] Senior doctor-administrators at Patel's hospital, when approached by journalists, assumed an aggressive stance toward him, and provided no indication that they were serious about working to make the hospital spaces more humane. Following are some of their responses: "He has absolutely no right to defame the institution that has produced some of the finest doctors in the country."; "He was interning in 2011 [two years ago], so why did he not raise the issue or give us feedback regarding any irregularities."; "If he did see something so alarming [in the labor rooms], why did he not report the issue then [instead of blogging about it now]?"[8] More importantly, even as such disrespect and abuse has been documented in the media and by social scientists for at least a decade now, there seems to have been no organized and institutional effort on the part of the Indian medical profession to address and mitigate such incidents: a concerted search for published guidelines or symposia organized on the topic, either by

[6] Sanghmitra S. Acharya and Stephen Christopher, eds., *Caste, COVID-19, and Inequalities of Care: Lessons from South Asia* (Singapore: Springer, 2022); Sobin George, "Caste and Care: Is Indian Healthcare Delivery System Favourable for Dalits?," *Working Papers* (Institute for Social and Economic Change, Bangalore, 2015); Rosina Nasir, "Muslim Self-Exclusion and Public Health Services in Delhi," *South Asia Research* 34, no. 1 (February 1, 2014): 65–86.

[7] Patel, "A Year as a Doctor's Apprentice."

[8] "Ex-Intern's Blog Has Docs Fuming, Sassoon May Move Court," *The Indian Express*, December 6, 2013.

the Indian Medical Association or the Federation of Obstetric and Gynecological Societies of India, yielded no results (I also complemented this search by informally enquiring with an Indian ob-gyn for any available resources).

Even as commercialization, malpractice, and negligence in medicine have taken center stage in the public discourse including in medical journals and conferences, it is evident that the everyday dehumanization and humiliation of patients from underprivileged castes and communities continue to be rarely acknowledged, and never comprehensively analyzed. This state of affairs is tragically in alignment with the history I have discussed in the preceding chapters: the power asymmetry between the medical profession and underprivileged communities is so deep that the profession has neither felt compelled to acknowledge the challenges involved in the relationship, nor faced accountability for normalizing their dehumanization. At the same time, elite Indians, through their socioeconomic power and privilege including control over the mainstream discourse, have succeeded in monopolizing the public critique of the biomedical profession and in narrowing that critique to issues that reflect primarily their experiences. These experiences, while genuine and important in the broader context of healthcare in India, are—as I have argued in the dissertation—far from the full picture.

As it stands today, the discourse on the patient-doctor relationship, and on the relationship between the profession and the larger society, seems to be wedged firmly between the (elite) public's critiques of corruption and negligence in biomedical practice, and the profession's critique of violence against doctors.[9] The marginalized and the underprivileged do not find any representation of note in this discourse, and have been denied the power to shape its content and direction. They continue to be

[9] "IMA to Hold Nationwide Protest against Assault on Doctors," *Hindustan Times*, June 12, 2021.

routinely exploited in healthcare settings, frequently under the supervision of biomedical doctors. Prominent examples include unnecessary and harmful hysterectomies of young women for commercial gain, and the exploitation of clinical trial participants.[10] While researchers have generally been able to gain direct access to the perceptions and attitudes of the elite toward doctors, through their writings and reflections preserved in the mainstream discourse, it continues to be extremely difficult to gain access to how the underprivileged experience their biomedical encounters and what they think of doctors, except filtered through journalists and social scientists. No Dalit woman who was tricked into undergoing a hysterectomy, or physically harmed Adivasi clinical trial participant, for example, is seen writing an op-ed or publishing a memoir about their experiences.

My dissertation shows that for a proper understanding of public perceptions of and public distrust in doctors, we need to take into account the vast gaps in the conception of the "public" in India, and acknowledge that mainstream public discourse has mostly been reflective only of the ideas, beliefs, and experiences of socioeconomically privileged individuals and groups. As a result, commercialism has occupied an overwhelmingly larger space in the public discourse than the routine disrespect, discrimination, and dehumanization rampant in medical care. It is true that commercialism exerts considerable adverse influence on people's encounters with doctors and the healthcare system. However, the disproportionate focus on that phenomenon leads to the neglect of other phenomena, including the caste-based power asymmetries between most doctors and patients, which also exert a significant influence

[10] Patralekha Chatterjee, "Hysterectomies in Beed District Raise Questions for India," *The Lancet* 394, no. 10194 (July 20, 2019): 202; Roli Srivastava, "Missing Wombs: The Health Scandal Enslaving Families in Rural India," *Reuters*, May 8, 2019; Anant Bhan, "Clinical Trial Ethics in India: One Step Forward, Two Steps Back," *Journal of Pharmacology & Pharmacotherapeutics* 3, no. 2 (2012): 95–97; "India: Doctors Call for Investigation into Allegations of Ethical Abuse in Covid-19 Vaccine Trial," *BMJ* 372 (January 14, 2021): n131.

on how patients are treated and how they experience those encounters. Addressing the unbridled commercialism in medicine in India is indeed likely to reduce the incidence of malpractice and corruption, especially if, as many reformist doctors have argued, India institutes a comprehensive, general taxation-funded universal healthcare model.[11] But I argue that in the absence of a simultaneous redressal of the power asymmetries between doctors and underprivileged patients (and, more broadly, between social groups in India), even such a "reformed" arrangement is unlikely to humanize the encounters and experiences of the latter. Despite its universalizing claims, such a future healthcare model will reproduce existing asymmetries and become another hierarchical arrangement, only with a potentially reduced influence of commercial for-profit firms. To employ the metaphors I used in Chapter 4: even if the righteous Rajani triumphs over Dr Reddy, Rakku's story will continue to remain unheard or be ignored.[12]

[11] Arun Gadre and Abhay Shukla, *Dissenting Diagnosis* (Random House, 2016); Samiran Nundy, Keshav Desiraju, and Sanjay Nagral, *Healers or Predators?: Healthcare Corruption in India* (Oxford University Press, 2018).

[12] In Chapter 4, I used the stories and metaphors of Rajani, Rakku, and Dr. Reddy to denote India's middle-class elite public, underprivileged public, and the mainstream biomedical profession respectively.

BIBLIOGRAPHY

Archival repositories

Dr. Ambedkar Foundation, Ministry of Social Justice & Empowerment, Govt. of India (online)

The Asiatic Society of Mumbai, Mumbai

Central Secretariat Library, New Delhi (online)

Community Health Library & Resources at SOCHARA, Bengaluru

Dhananjayrao Gadgil Library, Gokhale Institute of Politics & Economics, Pune (online)

The Francis A. Countway Library of Medicine, Boston

Google News Archive (online)

Granth Sanjeevani, Asiatic Society of Mumbai (online)

Harry Elkins Widener Memorial Library, Harvard University, Cambridge

HathiTrust Digital Library (online)

India Office Records and Private Papers at the British Library, London

The Internet Archive (online)

JSTOR Digital Library (online)

Library of Congress, Washington, D.C.

Maharashtra State Archives, Mumbai

The Medical Humanities Department, Seth G.S. Medical College, Mumbai

Medico-Friend Circle Archive (online)

National Archives of India, New Delhi

National Medical Library, New Delhi

Nehru Memorial Museum & Library, New Delhi

Parliament of India Digital Library (online)

Prasar Bharati Archives (online)

Press Information Bureau (PIB) India Archives (online)

ProQuest Historical Newspapers (online)

PubMed Central (PMC), U.S. National Library of Medicine (online)

Shodhganga: a reservoir of Indian theses (online)

SL Bhatia History of Medicine Museum, Library & Archives

South Asia Open Archives (online)

Wellcome Collection Library, London

World Health Organization Institutional Repository for Information Sharing (IRIS) (online)

Select references

Ahluwalia, Sanjam. *Reproductive Restraints: Birth Control in India, 1877-1947*. University of Illinois Press, 2010.

Alam, Eram. "Cold War Crises: Foreign Medical Graduates Respond to US Doctor Shortages, 1965–1975." *Social History of Medicine*, March 8, 2018.

Alavi, Seema. *Islam and Healing: Loss and Recovery of an Indo-Muslim Medical Tradition, 1600-1900*. Palgrave Macmillan, 2008.

Allsop, Judith. "Regaining Trust in Medicine: Professional and State Strategies." *Current Sociology* 54, no. 4 (July 1, 2006): 621–36.

Ambedkar, Bhimrao Ramji. *Untouchables Or the Children of India's Ghetto*. Amazon Digital Services LLC - KDP Print US, 2018

———. "The Annihilation of Caste (An Undelivered Speech)." 1936. https://ccnmtl.columbia.edu/projects/mmt/ambedkar/web/readings/aoc_print_2004.pdf

———. *Dr Babasaheb Ambedkar: Writings and Speeches*. Dr. Ambedkar Foundation, Ministry of Social Justice & Empowerment, Govt. of India, 2014.

Amrith, Sunil. "Political Culture of Health in India: A Historical Perspective." *Economic and Political Weekly* 42, no. 2 (2007): 114–21.
———. *Decolonizing International Health: India and Southeast Asia, 1930-65*. Palgrave Macmillan, 2006.

Antia, Noshir H. *A Life of Change: The Autobiography of a Doctor*. New Delhi, India: Penguin Books, 2009.

Antoniello, Patricia. *For the Public Good: Women, Health, and Equity in Rural India*. Nashville: Vanderbilt University Press, 2020.

Arnold, David. *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, 241. Berkeley: University of California Press, 1993.
———. *Science, Technology and Medicine in Colonial India*. Cambridge University Press, 2000.
———. "The Rise of Western Medicine in India." *The Lancet* 348, no. 9034 (October 19, 1996): 1075–78.

Arole Mabelle, and Arole Rajanikant. "A comprehensive rural health project in Jamkhed (India)." In *Health by the people*, edited by Newell Kenneth W., 70–90. Geneva: World Health Organization, 1975.

Bagchi, Amrita. "Health Care in Crisis: The Changing Pattern of Private Health Care in Post Independence Kolkata." Jadavpur University, 2010. Shodhganga: A reservoir of Indian theses.

Bal, Arun. "Consumer Protection Act and Medical Profession." *Economic and Political Weekly* 28, no. 11 (1993): 432–35.

Banerjee, Dwaipayan. *Enduring Cancer: Life, Death, and Diagnosis in Delhi*. Durham: Duke University Press Books, 2020.

Banerji, D. *Family Planning in India: A Critique and a Perspective*. People's Publishing House, 1971.
———. "Health Behaviour of Rural Populations: Impact of Rural Health Services." *Economic and Political Weekly* 8, no. 51 (1973): 2261–68.
———. "Social and Cultural Foundations of Health Services Systems." *Economic and Political Weekly* 9, no. 32/34 (1974): 1333–46.

Baru, Rama. *Private Health Care in India: Social Characteristics and Trends*. SAGE Publications, 1998
———. "Privatisation and Corporatisation." *Seminar*, no. 489 (May 2000).
———. "The Bhore Committee and Recent Debates." *Seminar*, no. 714 (February 2019).

Bhardwaj, S. M. "Attitude-toward Different Systems of Medicine: A Survey of Four Villages in the Punjab-India." *Social Science & Medicine* 9, no. 11–12 (December 1975): 603–12.

Bhattacharya, Sanjoy. *Expunging Variola: The Control and Eradication of Smallpox in India, 1947-1977*. Sangam Books Limited, 2006.

Bhore, Joseph *et al*. *Report of the Health Survey and Development Committee*. Vols. 1-4. New Delhi: Manager of Publications, 1946.

Bhuyan, Anoo. "IMA Vaguely Acknowledges Caste Discrimination in Medical Education." *The Wire*, June 3, 2019.

Bose, Ashish, and P.B. Desai. *Studies in Social Dynamics of Primary Health Care*. Studies in Economic Development and Plannin No. 29. Delhi: Hindustan Publishing Corporation, 1983.

Bradfield, Major-General E.W.C. "Medical Schools." In *An Indian Medical Review*, 98. Delhi: Manager of Publications, 1938.

Brandt, Allan, and Martha Gardner. "The Golden Age of Medicine?" In *Companion to Medicine in the Twentieth Century*, edited by Roger Cooter and John Pickstone, 21–37. Routledge, 2000.

Brass, Paul R. "The Politics of Ayurvedic Education: A Case Study of Revivalism and Modernization in India." In *Education and Politics in India: Studies in Organization, Society and Policy*, edited by Susanne Hoeber Rudolph and Lloyd I. Rudolph. Cambridge: Harvard University Press, 1972.

Brimnes, Niels. *Languished Hopes: Tuberculosis, the State, and International Assistance in Twentieth-Century India*. Orient BlackSwan, 2016.

Carstairs, G. Morris. "Medicine and Faith in Rural Rajasthan." In *Health, Culture, and Community*, edited by Benjamin D. Paul. Russell Sage Foundation, 1955.

Cerulli, Anthony. "Politicking Ayurvedic Education." *Asian Medicine* 13, no. 1–2 (September 10, 2018): 298–334.

Chakrabarti, Uma. *Gendering Caste Through a Feminist Lens*. Popular Prakashan, 2003.

Chatterjee, Partha. *State and Politics in India*, edited by Partha Chatterjee. Delhi ; New York: Oxford University Press, 1997

Chopra, Col. R.N., A. Lakshmipathi, Balkrishna Lagu, and B.A. Pathak. *Report of the Committee on Indigenous Systems of Medicine: Vol 1 - Report and Recommendations*. New Delhi: Ministry of Health, Government of India, 1948.

Coffey, Dean Spears and Diane. *Where India Goes: Abandoned Toilets, Stunted Development and the Costs of Caste*. Noida, Uttar Pradesh ; New York, NY, 2017.

Cohen, Lawrence. "The Other Kidney: Biopolitics Beyond Recognition." *Body & Society* 7, no. 2–3 (September 2001): 9–29.
———. "Where It Hurts: Indian Material for an Ethics of Organ Transplantation." *Daedalus* 128, no. 4 (1999): 135–65.

De, Rohit. "Constitutional Antecedents." In *The Oxford Handbook of the Indian Constitution*, edited by Sujit Choudhry, Madhav Khosla, and Pratap Bhanu Mehta. Oxford ; New York: Oxford University Press, 2016.

Deshpande, Satish. "Caste and Castelessness: Towards a Biography of the 'General Category.'" *Economic and Political Weekly* 48, no. 15 (2013): 32–39.
———. *Contemporary India: A Sociological View*. New Delhi: Penguin Viking, 2003.

Djurfeldt, Goran, and Staffan Lindberg. *Pills Against Poverty: A Study of the Introduction of Western Medicine in a Tamil Village.* Curzon Press, 1975.

Dube, S.C. *Indian Village*. London: Routledge and Kegan Paul Ltd., 1955.

Dwyer, Rachel. *Bollywood's India: Hindi Cinema as a Guide to Contemporary India*. London: Reaktion Books, 2014.

Forbes, Geraldine Hancock. *Women in Colonial India: Essays on Politics, Medicine, and Historiography*. New Delhi: Orient Blackswan, 2005.

Gadre, Arun, and Abhay Shukla. *Dissenting Diagnosis*. Random House, 2016.

Gandhi, M.K. *The Story of My Experiments with Truth*, 1927.

George, Sobin. "Caste and Care: Is Indian Healthcare Delivery System Favourable for Dalits?" *Working Papers*. Working Papers. Institute for Social and Economic Change, Bangalore, 2015.
———. "Reconciliations of Caste and Medical Power in Rural Public Health Services." *Economic and Political Weekly* 54, no. 40 (October 5, 2019): 43–50.

Gokhale (Ranade), Leela. *माझी गोष्ट [My Story]*. Mumbai: Mouj Prakashan, 2019.

Guha, Ambalika. "The 'Masculine' Female: The Rise of Women Doctors in Colonial India, c. 1870–1940." *Social Scientist* 44, no. 5/6 (2016): 49–64.

Hardiman, David. *Missionaries and Their Medicine: A Christian Modernity for Tribal India*, 139–46. Manchester: Manchester University Press, 2008.

Hardiman, David, and Projit Bihari Mukharji. *Medical Marginality in South Asia: Situating Subaltern Therapeutics*. Routledge, 2013.

Harrison, Mark. "A Global Perspective: Reframing the History of Health, Medicine, and Disease." *Bulletin of the History of Medicine* 89, no. 4 (December 28, 2015): 639–89.
———. *Public Health in British India: Anglo-Indian Preventive Medicine*. Cambridge: Cambridge University Press, 1994.

Hodges, Sarah. "'It All Changed after Apollo': Healthcare Myths and Their Making in Contemporary India." *Indian Journal of Medical Ethics* 10, no. 4 (2013).
———. "South Asia's Eugenic Past." In *The Oxford Handbook of the History of Eugenics*, edited by Alison Bashford and Philippa Levine. Oxford: Oxford University Press, 2010.

Hollen, Cecilia Van. *Birth on the Threshold: Childbirth and Modernity in South India*. University of California Press, 2003.

Ilaiah, Kancha. *Post-Hindu India: A Discourse in Dalit-Bahujan, Socio-Spiritual and Scientific Revolution*. New Delhi, India: SAGE, 2009.

Imber, Jonathan B. *Trusting Doctors: The Decline of Moral Authority in American Medicine*. Princeton, NJ: Princeton University Press, 2008.

Jalgaonkar, Mangesh. "Consumer Protection Act - an Introspection by a General Practitioner." *Indian Journal of Medical Ethics* 2, no. 4 (1994): 12–13.

Jaya Rao, Kamala S. "Why an Alternative Health Policy." *Medico Friend Circle Bulletin*, no. MFC025 (January 1978): 7–8.

Jeffery, Roger. "Allopathic Medicine in India: A Case of Deprofessionalization?" *Social Science & Medicine* 11, no. 10 (July 1977): 561–73.
———. "Doctors and Congress: The Role of Medical Men and Medical Politics in Indian Nationalism." In *The Indian National Congress and the Political Economy of India*, edited by Mike Shepperdson and Colin Simmons. Avebury, 1988.
———. "Estimates of Doctors in Delhi: A Note." *Economic and Political Weekly* 12, no. 5 (1977): 132–35.
———. "Migration of Doctors from India." *Economic and Political Weekly* 11, no. 13 (1976): 502–7.
———. "Recognizing India's Doctors: The Institutionalization of Medical Dependency, 1918-39." *Modern Asian Studies* 13, no. 2 (1979): 301–26.
———. *The Politics of Health in India*. Berkeley: University of California Press, 1988.

Jhirad, J. "Readers' Views: Women Doctors." *The Times of India*, January 30, 1953. ProQuest Historical Newspapers.

Jones, David, and Kavita Sivaramakrishnan. "Making Heart-Lung Machines Work in India: Imports, Indigenous Innovation and the Challenge of Replicating Cardiac Surgery in Bombay, 1952-1962." *Social Studies of Science* 48, no. 4 (August 1, 2018): 507–39

———. "Transplant Buccaneers: P.K. Sen and India's First Heart Transplant, February 1968." *Journal of the History of Medicine and Allied Sciences* 73, no. 3 (July 1, 2018): 303–32.

Kagal, Ayesha. "The Case of the Negligent Doctor." *The Times of India*, November 24, 1985. ProQuest Historical Newspapers.

Kariyanna, Pramod Theetha. "The Caste System Is Thriving in Medicine in the U.S." *KevinMD.Com* (blog), June 4, 2018.

Karpagam, Sylvia. "Caste-Washing the Healthcare System Will Do Little to Address Its Discriminatory Practices." *Indian Journal of Medical Ethics* VI, no. 1 (March 2021): 1–4.

Kaur, Rajkumari Amrit. *Selected Speeches and Writings of Rajkumari Amrit Kaur*, edited by G. Borkar, 278–82. Archer Publications, 1961.

Kaviraj, Sudipta. "Modernity and Politics in India." *Daedalus* 129, no. 1 (2000): 137–62.

———. *The Imaginary Institution of India: Politics and Ideas*. Columbia University Press, 2010.

Keshri, Vikash Ranjan, Veena Sriram, and Rama Baru. "Reforming the Regulation of Medical Education, Professionals and Practice in India." *BMJ Global Health* 5, no. 8 (August 1, 2020): e002765.

Khaleeli, Z. "Harmony or Hegemony? The Rise and Fall of the Native Medical Institution, Calcutta, 1822-35." *South Asia Research* 21, no. 1 (2001): 77–104.

Khan, M.E., and V. Chandra. "Some Observations on Kanpur Urban Mass Vasectomy Camp: Back to Square One." In *Problems and Prospects of Family Planning in India*, edited by Hem Sanwal and S.N. Agarwala. Lucknow: Population Centre, India Population Project, 1975.

Khare, R. S. "Folk Medicine in a North Indian Village." *Human Organization* 22, no. 1 (1963): 36–40.

Khilnani, Sunil. *The Idea of India*. New Delhi: Penguin Books India, 1997.

Kothari, Manu L., and Lopa A. Mehta. "Violence in Modern Medicine." In *Science, Hegemony and Violence: A Requiem for Modernity*, edited by Ashis Nandy. Delhi ; New York : Tokyo, Japan: Oxford University Press, 1989.

Kothari, Rajni. "Alternatives in Development: Perspective on Alternative Development Strategies for India." *ICSSR Newsletter* 9, no. 3–4 (1979): 1–14.

———. "Alternatives in Development: Towards a Conceptual Framework." *ICSSR Newsletter* 9, no. 1–2 (1979): 1–10.

Kumar, Awanish. “Caste and Public Health.” *Frontline*, May 22, 2020.

Lal, Maneesha. “The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin’s Fund, 1885-1888.” *Bulletin of the History of Medicine* 68, no. 1 (1994): 29–66.

Leslie, Charles. “What Caused India’s Massive Community Health Workers Scheme: A Sociology of Knowledge.” *Social Science & Medicine (1982)* 21, no. 8 (1985): 923–30.
———. *Paths to Asian Medical Knowledge*, edited by Charles Leslie and Allan Young. University of California Press, 1992.
———. *Asian Medical Systems: A Comparative Study*, edited by Charles Leslie. University of California Press, 1976.

Limaye, Arun. *क्लोरोफॉर्म [Chloroform]*. Mumbai: Granthali, 1978.

Madan, T. N. “Doctors in a North Indian City: Recruitment, Role Perception, and Role Performance.” In *Beyond the Village: Sociological Explorations*. Simla: Indian Institute of Advanced Study, 1972.
———. “Who Chooses Modern Medicine and Why.” *Economic and Political Weekly* 4, no. 37 (1969): 1475–84.

Madhiwalla, Neha, Rakhi Ghoshal, Padmaja Mavani, and Nobhojit Roy. “Identifying Disrespect and Abuse in Organisational Culture: A Study of Two Hospitals in Mumbai, India.” *Reproductive Health Matters* 26, no. 53 (August 27, 2018): 36–47.

Mahalanobis, P. C. “Next Steps in Planning.” *Sankhyā: The Indian Journal of Statistics (1933-1960)* 22, no. 1/2 (1960): 143–72.

Mamdani, Mahmood. *The Myth of Population Control: Family, Caste, and Class in an Indian Village*. Monthly Review Press, 1972.

Mani, M. K. *Yamaraja’s Brother: The Autobiography of Dr. M.K. Mani.* Bombay: Bharatiya Vidya Bhavan, 1989.

Marathe, Shweta, Benjamin M. Hunter, Indira Chakravarthi, Abhay Shukla, and Susan F. Murray. “The Impacts of Corporatisation of Healthcare on Medical Practice and Professionals in Maharashtra, India.” *BMJ Global Health* 5, no. 2 (2020): e002026.

Marriot, McKim. “Western Medicine in a Village of Northern India.” In *Health, Culture, and Community*, edited by Benjamin D. Paul. Russell Sage Foundation, 1955.

Minocha, Aneeta A. “The Medical Profession in India: Elite without Power.” In *Power Elite in India*, edited by Khadija Ansari Gupta. Vikas Pub. House, 1989.

Mudaliar, A. Lakshmanaswami, *et al*. *Report of the Health Survey and Planning Committee*. New Delhi: Government of India Ministry of Health, 1962.

Mukharji, Projit Bihari. *Nationalizing the Body: The Medical Market, Print and Daktari Medicine*. London: Anthem Press, 2009.

———. "Structuring Plurality: Locality, Caste, Class and Ethnicity in Nineteenth-Century Bengali Dispensaries." *Health and History* 9, no. 1 (2007): 80–105.

Mukherjee, Sujata. "Medical Education and Emergence of Women Medics in Colonial Bengal." In *Gender, Medicine, and Society in Colonial India: Women's Health Care in Nineteenth- and Early Twentieth-Century Bengal*. Delhi: Oxford University Press, 2017.

Murlidhar, V. "Problems in the Health Care System - A Brief Appraisal." *Medical Ethics* 1, no. 2 (November 1993): 1–2.

Nagral, Sanjay. "The Consumer Protection Act." *Journal of Postgraduate Medicine* 38, no. 4 (December 1992): 214–15.

———. "To the Indian Medical Association, Here's Why I Am Not Marching with You Today." *Scroll*, June 6, 2017.

Naik, J.P. "An Alternative System of Health Care Services in India: Some General Considerations." *Bulletin of the I.I.E.*, 1977

Narayan, R.K. "Second Opinion." *The New Yorker*, March 30, 1981.

Nasir, Rosina. "Muslim Self-Exclusion and Public Health Services in Delhi." *South Asia Research* 34, no. 1 (February 1, 2014): 65–86

National Health (Report of the Sub-Committee, National Planning Committee Series). Bombay: Vora and Co. Publishers Ltd, 1948.

Nehru, Jawaharlal. *Jawaharlal Nehru on Science and Society: A Collection of His Writings and Speeches*, edited by Baldev Singh, 52. New Delhi: NMML, 1988.

Neumann, Alfred K., J. C. Bhatia, S. Andrews, and A. K. S. Murphy. "Role of the Indigenous Medicine Practitioner in Two Areas of India—Report of a Study." *Social Science & Medicine (1967)* 5, no. 2 (April 1, 1971): 137–49.

Nicholson, M. A. "The Medical Profession in India and Its Education." *The Indian Medical Gazette* 80, no. 1 (January 1945): 57–58.

Nundy, Samiran, Keshav Desiraju, and Sanjay Nagral. *Healers or Predators?: Healthcare Corruption in India*. Oxford University Press, 2018.

Paik, Shailaja. "Dalit Feminist Thought." *Economic and Political Weekly* 56, no. 25 (June 19, 2021).

Pandya, Shubhada. "An Outlier in Public Health History in India: A.T.W. Simeons's Scheme for Rural Medical Relief, Kolhapur, 1943–47." *The National Medical Journal of India* 30, no. 2 (2017): 103–7.

Pandya, Sunil. "Letter From Bombay." *The National Medical Journal of India* 5, no. 5 (1992): 243–44.
———. "Turning Points In My Medical Career." *Mens Sana Monographs* 4, no. 1 (2006): 154–65.

Patel, Ashvin. "Ten Years with MFC: My Personal View." *Medico Friend Circle Bulletin*, no. 100–1 (May 1984).

Pati, Biswamoy, and Mark Harrison, eds. *Society, Medicine and Politics in Colonial India*. Routledge India, 2018.

Phule, Jotirao. "गुलामगिरी [Slavery]." In *महात्मा फुले समग्र वाङ्मय [Collected Works of Mahatma Phule]*, edited by Dhananjay Keer and S.G. Malshe

Pinto, Sarah. "Development without Institutions: Ersatz Medicine and the Politics of Everyday Life in Rural North India." *Cultural Anthropology* 19, no. 3 (August 1, 2004): 337–64
———. *Where There Is No Midwife: Birth and Loss in Rural India*. Berghahn Books, 2008.

Porter, Roy. "The Patient's View: Doing Medical History from Below." *Theory and Society* 14, no. 2 (1985): 175–98.

Prakash, Gyan. *Another Reason: Science and the Imagination of Modern India*. Princeton, N.J: Princeton University Press, 1999.
———. *Emergency Chronicles: Indira Gandhi and Democracy's Turning Point*. Princeton, New Jersey: Princeton University Press, 2019.

Prasad, Purendra, and Amar Jesani, eds. *Equity and Access: Health Care Studies in India*. New Delhi, India: Oxford University Press, 2018.

Qadeer, Imrana. "Health Planning in India: Some Lessons from the Past." *Social Scientist* 36, no. 5/6 (2008): 51–75.

Rajan, Rajeswari Sunder. *The Scandal of the State: Women, Law, and Citizenship in Postcolonial India*. 2003rd edition. Durham: Duke University Press Books, 2003.

Ramalingaswami, V., R.S. Arole, B.J. Coyaji, N.S. Deodhar, and N. Jungalwalla. "Health For All: An Alternative Strategy." Delhi: ICMR and ICSSR, 1981.

Ramanna, Mridula. *Health Care in Bombay Presidency, 1896-1930*. Primus Books, 2012.
———. *Western Medicine and Public Health in Colonial Bombay, 1845-1895*. Orient Blackswan, 2002.
———. "Women Physicians as Vital Intermediaries in Colonial Bombay." *Economic and Political Weekly* 43, no. 12/13 (2008): 71–78.

Rao, Mohan, ed. *Disinvesting in Health: The World Bank's Prescriptions for Health*. SAGE Publications, 1999.
———. *From Population Control To Reproductive Health: Malthusian Arithmetic*. New Delhi: SAGE Publications, 2005.

Rao, U. B. Narayan. "Problems of Rural Medical Relief in India. Poverty Amidst Plenty." *The Indian Medical Gazette* 86, no. 3 (March 1951): 105–10.

Rawat, Ramnarayan S., and K. Satyanarayana, eds. *Dalit Studies*. Durham: Duke University Press Books, 2016.

Reagan, Leslie J., Nancy Tomes, and Paula A. Treichler. *Medicine's Moving Pictures: Medicine, Health, and Bodies in American Film and Television*. University of Rochester Press, 2007.

Reddy, S. Muthulakshmi. *Autobiography of Dr. (Mrs.) S. Muthulakshmi Reddy*. Madras: M.L.J. Press, 1965.

Renu, Phanishwar Nath. *मैला आंचल (Maila Anchal)*, 1954.

Rosenberg, Tina. "Necessary Angels." *National Geographic* 214, no. 6 (December 2008): 66,68,70-74,76-81,83-85.

Rosner, David, and Susan Reverby, eds. "Beyond 'the Great Doctors.'" In *Health Care in America: Essays in Social History*, 3–16. Philadelphia: Temple Univ Press, 1979.

Ruddock, Anna. *Special Treatment: Student Doctors at the All India Institute of Medical Sciences*. 1st edition. Stanford, California: Stanford University Press, 2021.

Sarcar, Aprajita. "Mythical Families: The Small Family Norm and Everyday Governance of Population in India, 1954-1977," 2020.

Sehrawat, Samiksha. "Feminising Empire: The Association of Medical Women in India and the Campaign to Found a Women's Medical Service." *Social Scientist* 41, no. 5/6 (2013): 65–81.

Selden, Menefee. *The Pais of Manipal*. New York: Asia Publishing House, 1969.

Shrivastav et al, J. B. *Health Services and Medical Education: A Programme for Immediate Action: Report of the Group on Medical Education and Support Manpower.* Alternatives in Development. Health. New Delhi: Ministry of Health and Family Planning, Govt. of India, 1975.

Singh et al, Kartar. "Report of the Committee on Multipurpose Workers," 1973.

Singh, Meharban. "Intolerance and Violence Against Doctors." *Indian Journal of Pediatrics* 84, no. 10 (October 2017): 768–73.

Sivaramakrishnan, Kavita. "An Irritable State: The Contingent Politics of Science and Suffering in Anti-Cancer Campaigns in South India (1940–1960)." *BioSocieties*, July 20, 2019.

Subramanian, Ajantha. *The Caste of Merit: Engineering Education in India*. Harvard University Press, 2019.

Suntharalingam, R. *Politics and Nationalist Awakening in South India, 1852-1891*. University of Arizona Press, 1974.

Supe, Avinash. "Violence against Doctors Cannot Be Tolerated." *BMJ Opinion*, March 29, 2017.

Sur, Abha. *Dispersed Radiance: Caste, Gender, and Modern Science in India*. New Delhi: Navayana, 2011.

Swaminathan, Padmini. "Women's Education in Colonial Tamil Nadu, 1900-1930: The Coalescence of Patriarchy and Colonialism." *Indian Journal of Gender Studies* 6, no. 1 (March 1, 1999): 21–42.

Taylor, Carl. "The Doctor's Role in Rural Health Care." *International Journal of Health Services* 6, no. 2 (April 1, 1976): 219–30.

———. *Doctors for the Villages: Study of Rural Internships in Seven Indian Medical Colleges*. Asia Publishing House, 1976.

Teltumbde, Anand. *Republic Of Caste: Thinking Equality in the Time Of Neoliberal Hindutva*. New Delhi: Navayana Publishing Pvt Ltd, 2018.

Thirumal, P., and Carmel Christy. "Why Indian Universities Are Places Where Savarnas Get Affection and Dalit-Bahujans Experience Distance." *Economic and Political Weekly* 53, no. 5 (February 3, 2018): 7–8.

Tomes, Nancy. *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers*. Chapel Hill: The University of North Carolina Press, 2016.

Tremblay, Reeta Chowdhari. "Representation and Reflection of Self and Society in the Bombay Cinema." *Contemporary South Asia* 5, no. 3 (November 1, 1996): 303–18.

Venkatesh, Archana. "The Home and the Nation: An Oral History of Indian Women Doctors, National Development and Domestic Worlds." *Oral History* 47, no. 2 (2019): 43–54.

———. "Women, Medicine and Nation-Building: The `Lady Doctor' and Development in 20th Century South India." The Ohio State University, 2020.

Vicziany, Marika. "Coercion in a Soft State: The Family-Planning Program of India: Part I: The Myth of Voluntarism." *Pacific Affairs* 55, no. 3 (1982): 373–402

Virdi, Jyotika. *The Cinematic Imagination: Indian Popular Films As Social History*. New Brunswick, N.J: Rutgers University Press, 2003.

Wilson, Caroline. "Dis-Embedding Health Care: Marketisation and the Rising Cost of Medicine in Kerala, South India." *Journal of South Asian Development* 4, no. 1 (April 1, 2009): 83–101.

Wujastyk, Dominik. "The Evolution of Indian Government Policy on Ayurveda in the Twentieth Century." In *Modern and Global Ayurveda: Pluralism and Paradigms*, edited by Dagmar Wujastyk and Frederick M. Smith, 45. SUNY Press, 2013.

Wyatt, H. V. "The Popularity of Injections in the Third World: Origins and Consequences for Poliomyelitis." *Social Science & Medicine (1982)* 19, no. 9 (1984): 911–15.

Zurbrigg, Sheila. *Rakku's Story: Structures of Ill-Health and the Source of Change*. Bangalore: Centre for Social Action, 1984.