

The chronicle of caste and the medical profession in India

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Abstract: Caste has always been an important feature of Indian society. Historically it has determined the occupational pattern and allotted social positions to individuals differentially. The divisive system of caste was cleverly used by the colonizers to rule the vast Indian land. The modern development that took place during colonial period should have reoriented the production relations as in the west. In India it could not escape the caste connections and the caste organization maintain the prevailing production relations in the society. The new modern professions accepted by the changing Indian society has caste attributes to act as a social closure for downtrodden castes. Medical profession being highly rewarding remained in the hands of social elite in these developments.

Keywords: Caste, Governmentality, Medical profession, Modernity, Social closure

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I. INTRODUCTION

Technology played an important part in establishing the western rule over colonies [1]. Modern technology was the tool of British Empire, which helped them to demonstrate their power and their ability to rule the colonies. However with technology alone such rule could not be established. British cleverly used the existing social stratification to govern. They disarmed peasantry, created and consolidated rural elites from dominant castes and incorporated the fighter or military castes in their military to consolidate military power[2]. British could rule this country for a long time because they succeeded in using the existing system of castes such as *Zamindars* and *Baniyas* which very well suited for generating revenue, fighter castes for military and English educated elite for bureaucracy and governance [2][3][4]. The British used the complex blend of existing unequal system of social order, modern technology and apparatus of modern state to rule such a vast land and geographically and culturally diverse population.

This rule was justified by claim of bringing new civilization in the form of modernity. But it is also true that the form of modernity British brought to India was distinct from the modernity of west. This form of modernity was devoid of the universal reason and was focused on technology for better governance. GyanPraksh observed that colonial form of modernity was fundamentally distinct from the modernity in West. According to him:

“(Colonial modernity was) never simply a tropicalization of the Western form but its fundamental displacement, its essential violation. Utilitarian theorists from Jeremy Bentham to Fitzjames Stephen, including James and John Stuart Mill, had maintained that British rule in India must necessarily violate the metropolitan norm: only despotic rule could institute good government in India; only a Leviathan unhindered by a Demos could introduce and sustain the rule of law in the colony”[3].

This project of modernity for the colonies was an agenda to hegemonise, to establish power and rule. This was a specially tailored package of modern ideas which complimented the governmentality. This ideological conception shaped development of various forms of science in colonial India. Medicine was among the prominent tool used by colonizers in establishing this hegemony [1]. This colonial modernity shaped the development that happened in all sectors. Health being very crucial to the modern development was no exception. In this context this paper will discuss the selective modernity for east, use of social elites as part of governmentality by the colonizers to rule India and its social repercussions on the health profession in India.

II. THE BACKGROUND

The industrialization in West had strong underpinning of belief in the scientific knowledge, technology and utilitarian logic. For the growing satisfaction of human need, state projects were launched for expansion of production and rational design of the social order. Society became an object for experimentation with scientific rationality[6][7]. The rationality of these projects was control and mastery over nature. The outcome of the logic

of modernity was pride in the scientific knowledge. The scientifically organized social order was considered to be superior to the traditional one. With this pride, the structures of past collapsed, which were supposed to be non-modern, based on the foundations of religious prejudices. Technical solutions were proposed to reorganize societies. Invariably technical solutions to the problem in the all fields of human activity were forced by the reason of the utilitarian state. Scott in his analysis observed;

“The point of the Enlightenment view of legal codes was less to mirror the distinctive customs and practices of a people than to create a cultural community by codifying and generalizing the most rational of those customs and suppressing the more obscure and barbaric ones” [4, p. 90].

This radical modernization assumed authoritarian power to bring desired social order. Public health action in colonial India typically progressed on these underlining principles. Emergence of new social order with demolition of old by introducing despotic technological projects went at odd with the modern democratic principle. Scott observed this phenomenon of technical project to establish new social order as High Modernity [4]. There are ample examples of this from the West such as Haussmann’s plan of reconstruction of Paris[6][7].

The functionalist would understand modernity as ‘the ideas and institutions which tends to produce societies similar to those of the modern West’[5]. This replication of the West includes creations and operationalization of modern institutions which did happen in India. In classical ‘Marxian’ or ‘Weberian’ understanding, India was supposed to go through some distinct features of modernity such as change of production relations from feudal to capitalist and industrial mode of production, growth of modern state institutions, reorganization of social power and emergence of democracy along with decline of community and emergence of individuality[5]. However the reorganization of the society never took place as the state claiming to modernize used the old social order for the purpose of governance. The whole machinery of the state was running through the high level of bureaucratic system. But it failed to obtain modern social order. It could not break the power of social structures. The people in India remained member of a specific caste group and individuality remained a way far. The shift from society to individuality never took place. In reality in this transformation the modern democratic rights of people in colonies were undermined on account of utilitarian state.

The encounter of western medical practitioners and Indian population primarily occurred in the context of wars. In the middle of the eighteenth century, continuous wars between British, French, Maratha’s and Mysore led to recruitment of surgeons from England [6]. These doctors were recruited for the military purpose although they entered in the civilian practice, but their orientation was military. The first of its kind a medical institute in India was outcome of the war against French i.e. Royal Naval Hospital Madras. The second medical institute came after conquest of Bengal by the British. Following the 1857 revolt, the configuration of army changed and number of British soldiers increased. Maintaining health of these soldiers was imperative. The inquiry of health of the army was by ‘Royal Commission on the Health of The Army’ in 1859-63 and the action taken to reform military hygiene in India was the first attempt in organized health action[6]. In England, the subject of health emerged as the consequences of the industrialization and in India it emerged as consequence of 1857 revolt. The subject of interest for health action was poor and working class in the West where in India it was soldiers and Europeans. The goal of the health action was to mitigate crises and to maintain empire¹.

‘Although the production relations were changed up to some extent. But this was due to diversity dilution of existing job market by opening new opportunities for rigid caste based occupational structure. However this new production relations failed in reorganizing power structures’[3][4].

This failure of modernity in the east can be attributed to the governmentality of the colonial state and very organization of structured Indian society. In the time of consolidation of Raj the system of caste and the feudal landlords were used for military, agricultural production, trade and revenue by the state. In doing so it consolidated the old feudal lords and made them powerful². In this structure, those who were at the top accessed these new ideas and started following them. Also the new liberal ideas were accessed through western form of education. This education was available to few Indians; it was not for masses. These western educated elites later turned out to be leaders of nation. They inherited the ideas of modernity from the West and imparted in the planning of new India. Naturally they were the one who had power in the previous system and this power remained with them. The ideas changed but the structure remained the same. Power remained with the same elites [3][4].

¹The 1857 revolt was a crisis in itself for British Raj. The sepoy rebel taught a lesson that in order to control and keep check on any militancy in future from the Indian soldiers’ the government needs to reduce the Indian soldiers and increase the numbers of the white soldiers in the army. At the time of 1857 the composition of the military was 1 white soldier to 6 Indian soldiers.

²Zamindarisystem is good example

III. CASTED AND THE MEDICAL PROFESSION IN INDIA

The development of science and emergence of modern institutes the occupation got consolidated in nineteenth century in England. The occupation of healing also got modernized by the process of professionalization³. The medical profession acquired status and was fetching economic and social rewards for the practitioners of medicine. These professions also came to the colonies with the modern agenda of the state. From 1885 the admissions in the medical field were opened to Indians. Soon the medical field became popular among the Indian elites who could afford to go and take the exams in England[10, pp. 34-52]. Bombay Medical Act in 1912, later in 1914 in Bengal and in Madras government introduction of similar Act progressed in to organizing medical profession. General Medical council (GMC) started recognising Indian degrees from 1892 [11, pp. 301-26]. The developments in the field attracted more and more Indians to take up this profession. Moreover these jobs provided good opportunity to earn money as every surgeon was paid for treating each patient above his salaries. The result was that an increasing number of Indians entered in the medical colleges. Commenting on this, Anil Seal observed said;

“It is interesting that in this profession, where the new training with its emphasis on anatomy and surgery would seem to have offended against high caste prejudices, the higher castes of Bengal established a dominant position. For example, of 244 students at the Dacca Medical College in 1875-6 only six were low caste men, while there were seventy Brahmins, one hundred and twenty-eight *Kayasths* and thirty-six *Baidyas*” cited in[12, p. 120].

Similar on the line of development in West from the mid eighteenth century the practitioners of medicine started claiming higher status and some of them who were non- *Bramhin* declared themselves to be *Brahmin*[13]. In the beginning of 20th century high caste Hindus outnumbered Christians and other religions in adopting skills in western medicine.

Table 1 Students at Medical Colleges by Religious Origin (in per cent)

Medical Students	1901-02	1906-7	1911-12	1916-17
European/Eurasian Christian	13	10	12	4
Native Christian	8	8	3	6
Brahman Hindu	17	23	24	25
Non-Brahman Hindu	44	37	47	50
Muhammedan	4	4	4	7
Parsi	12	16	9	6
Other	--	1	2	3
Total (in numbers)	1466	1542	1656	2511

Source: *Quinquennial Review of the Progress of Education in India* (Recognizing India's Doctors: The Institutionalization of Medical Dependency, 1918-39, cited in[11, p. 303])

When the country got independence few at the top of the hierarchy, the *Brahmins* and *Baniya* were holding the positions of economic opportunities, whether administrative positions in the state system or the role of a capitalist in the market economy [7]. Post-independence policies of the Indian government aided the capitalist and the high caste. Import substitution policy and infrastructure projects promoted in-house capitalist and led to expansion of the public sector[15]. With the expansion of the public and private sector, high caste Hindus got opportunity to grasp occupations of importance and grew into middle class with a remarkable pace. The middle class group included members of prosperous farming families, as well as the primarily urban-based professional, administrative, and business elites who benefited from government protection and training[8]. Gradually they emerged as an important political class by the end of 1970. Members of this class were high caste Hindus who had migrated from rural areas and were absorbed in the urban public service sector and the market economy. Kinship and caste provided a social framework for migration. Their alliances played a vital role in securing jobs and maintaining a power position not only among the working classes but also in business; all this reflected the traditional rural ties[17]. This class, inherently is a strong believer and practitioner of caste and thereby has always enjoyed a power position in the rural society and economy. In the new urban space, an easy way to acquire and maintain higher social status was to appropriate the high rewarding occupation. This was not difficult for the high caste Hindus who had easy access to English education and had the resources to invest in education. Brahmins were the first to have English education in western as well as in southern part of India. For almost 30 years, from the 1890's, more than 65 percent of the students were Brahmin in Madras presidency[7]. The professions such as law, engineering, and medicine continued opening up avenues for this class to mobilize

³ The process through which occupations excel into professions. Exclusive right in the domain of profession is associated with moral responsibility to act in the interest of society.

towards positions of importance. The social capital of this class helped in the emergence of a range of professionals, including doctors who were ready to cater to the needs of this class in the early 90's[8].

The trend continued while the middle class retained opportunities to enter professional carriers leaving lower castes with limited scope [18]. However, by advantage of population and land ownership intermediate castes such as Marathas and Patidar made their presence felt in the political and economic sphere[7].

During 20th century while the Indian society mutated and metamorphosed in a new avatar, between modernity and tradition, it kept the essence of the original hierarchy based division intact[18]. In an agrarian economy the ownership of the land was in the hand of upper castes and the labor was provided by the members of the lower castes. In the new modern era of the service economy, capturing the occupations of social importance was essential for these castes to maintain their hierarchical position[19]. According to Damodaran, "Scribal castes (Brahmins, Khattris, Kayasthas, and the Bengali *bhadralok*) that have historically dominated the bureaucracy and various white collar professions"[7, p. 4]. Not to mention that the profession of medicine is socially important white collar profession which eventually also became the domain of upper caste.

This control of the upper caste on medical profession was principally gained to maintain the ascribed social status of caste. In India the class which was entering in this profession was already having higher social status by virtue of their caste. They were getting into this profession to maintain that status in the changing economic and political conditions. Exclusion and restriction of the lower section of the society from the profession although is not unique to development of the profession in India, the social closure was also observed in west in case of medical profession[20][11]. However the caste factor is unique to India. The upper castes kept a strong hold over the profession of medicine.

The data from 2001 census confirms that till now the lower caste are yet to make a significant presence in the medical profession, whether it is allopathy or indigenous form of medicine. Tribal community is least represented in this profession. The interesting point to note is combined population of SC and ST during 2011 census was 24.4 percent. The data shows how poorly the marginalized section is represented in the medical profession (see table 2below).

Table 2 Percentage Share of Marginalized Section among Health Professionals

Occup. Code	Health Professionals	Person	Caste Category (in percent)		
			SC	ST	Other
2220	Health Professionals (except nursing)	947433	7.49	1.87	90.63
2221	Physicians and Surgeons, Allopathic	617619	7.49	1.5	91.01
2222	Physicians and Surgeons, Ayurvedic	107346	5.49	1.23	93.28
2223	Physicians and Surgeons, Homeopathic	64567	5.42	0.54	94.03
2224	Physicians and Surgeons, Unani	10020	3.96	0.49	95.55
2225	Dental Specialists	21261	6	1.17	92.83

Source: Census 2001, cited in [12].

IV. CONCLUSION

In colonial times when the society was encountering modern education, institutions and ideas of modernity, the governmentality to rule the Indian state did not open the new economic opportunities for downtrodden. The policy of of the colonial regime to rule with the help of social and political elite, using traditional social power structures became the politics of the governance. This gave opportunity to the social elites to capture the status professions. Thus an important economically and socially rewarding medical profession was captured by the high caste. In the governmentality of colonial time there was dim possibility in the context of graded social for change in production relations and emergence of a new equitable social order. Thereby assimilation of the lower caste in status professions such as medicine. Post-independence also the social structure of graded inequality remained a major hindrance for the *Shudra* and erstwhile untouchable castes to get assimilated in the medical profession. There are systemic and social closures that automatically excludes the downtrodden from entering the medical profession. 'Studies have pointed out the absence of the deprived sections from the prestigious profession and have advocated drastic measures in favor of the deprived to create opportunities for them. This absence is on account of policy failures' [13].

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