REVIEW ARTICLE

The Roots of "Brown Sahib Medical Men's" Burden

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Abstract

Background: Bhore Committee was setup at a time of great capitalism crisis – the Second World War. In India, there was an acute emergence of the nationalist movements at that time. Indian people were being oppressed under the British colonial rule for more than 200 years and their socio-economic conditions were very poor. The health conditions of Indian people at that time were reflection of their socio-economic conditions and were very poor. India had a severe shortage of human resource for healthcare. Subsequently Bhore Committee and Sokhey Committee gave their recommendations which were further reviewed in 1959 by Mudaliar committee. **Aims and Objectives** - This review article aims to critically compare the strategies for developing human resource for health; proposed by the Bhore Committee, Sokhey Committee, and the Mudaliar Committee reports; and to discuss their implications. **Material and Methods**: Rigorous literature review was done to extract the information. Thematic analysis was done to generate main themes and sub-themes. The paper was then structured, analysed and concluded at the end. **Results and Conclusion**: The medical education today has become the privilege of English speaking, urban based, rich, upper class and caste students. On the other hand majority of downtrodden section of society got buried under the burden of "Brown Sahib medical men" such trends divide the society in to an upper class of English proficient intellectuals riding on the backs of lower class who can only sell its labour.

Key Words

Brown Englishmen, Brown Sahib's burden, Bhore Committee, Sokhey Committee, Mudaliar Committee

Introduction

The term social/community/preventive medicine have a common denominator i.e. medicine. It implies that, these disciplines are used as a subset of medicine. (1) These disciplines are also practised as a minor subdivision of medicine in terms of various parameters like finances, manpower, political influence and status. (1) On the other hand public health is an interdisciplinary concept which also studies how health of people gets influenced by their environment and the environment includes social, physical, economic and political environment. On the one hand clinical medicine deals with the treatment of individuals and on the other hand public health makes sure that all the individuals get access to preventive and curative treatment. Also the term Public Health emphasize on the word "health" instead of the word medicine. It concerns with complete health and well-being of public at large. It is a very wide concept and a holistic approach towards complete physical, mental and social well-being of community at large. Public health addresses health inequities by working at grass roots level and also at policy level. Public health considers medicine as its subdivision. Public health aims to provide an entire social system to people where they could live a healthy, happy and productive life. (2) It is an entire system and has overlapping boundaries with developmental systems, socio-economic and socio-political systems. (2) Public health view health in its totality. It is a dynamic system which constantly

interacts and influenced by its social and physical environment.

Aims & Objectives

To critically compare the strategies for developing human resource for health proposed by the Bhore Committee, Sokhey Committee and the Mudaliar Committee reports and to discuss their implications.

Material and Methods

Rigorous literature review was done to extract the information. Thematic analysis was done to generate main themes and sub-themes. The paper was then structured, analysed and concluded at the end.

Human Resource during British India – During 1940s, India had a severe shortage of human resource for healthcare (Table 1). At the time of Independence; for the entire population of 400 million; there were only 17,654 medical graduates, 29,870 licentiates, 7000 nurses, 750 health visitors, 5000 midwives, 75 pharmacists and about 1000 dentists. (3). Only one fourth of doctors were in government service and rest all had private practice in urban areas. There were only 70-80 women medical officers in total in public service in whole nation and that too purely in maternity and child welfare work. Although medical colleges were setup by British in 1835 at three presidency towns, their degrees had to gain recognition from the British Medical Council. As a consequence, the Medical Council of India accepted the British norms of medical education. The selected students used to go to Great Britain for higher medical education. (4) In this manner, Indian physicians got trained in a colonial value system of British rule and got encultured in British Modelled Indian Medical Colleges. (4)

Bhore Committee and its recommendations regarding development of Human Resource – The British colonial authorities in India set up the "Health Survey and Development Committee (Bhore Committee) in 1943 to draw up the health services scheme for the newly emerging Independent India. Although the committee comprised of Sirs, Colonels, Khan Bahadurs and Dewan Bahadurs, it was greatly influenced by the aspirations of national movement and some of its members had been in the fore front of the struggle for independence. (5,6) The committee played a very pivotal role in the shaping of health services in Independent India. (5,6) The recommendations of committee got inspirations from the recommendations made by Dawson committee and the Beveridge Committee reports produced in England. (5,6,7) Just as these committees in England led to the formation of their National Health Service (NHS) Scheme, the Bhore Committee recommendations led to the development of health services system in India. (7)

Regarding the development of human resource, Bhore Committee was very comprehensive and recognized the importance of preventive medicine and preventive epidemiology. The committee visualized that role of a primary unit doctor does not confine to the medical treatment given by him but he should ensure necessary precautions to prevent the spread of infections and he should also look for the source of infection. (3) The committee gave importance to the field visits of doctors in the community and recommended that a major part of weekly programme of doctors at PHC will be outdoor duties and the attendance at dispensary only during forenoons on 3 days in the week. (3) The committee was very comprehensive regarding the development of human resource and gave due importance to social determinants of health. The committee recommended the appointment of Hospital Social Workers and nutrition workers at all the three levels (Primary, Secondary and Tertiary). The committee recommended development of School Health Services and CMO (Chief Medical Officer) of Ministry of Health should also be the CMO of board of education. The committee recommended that health functions of the school health services should be under the department of health and not under the education department. (3) It reflects on an interdisciplinary approach. Members of the Bhore Committee recognized "the great lack of doctors" at that time in India and recommended that resources may be put in the production of, "highly trained doctor". (3) The committee also elaborated on the kind of training, a basic doctor should receive. The committee recommended the establishment of a department of preventive and social medicine in medical colleges with 3 months of compulsory internship in this department. The committee showed a contemptuous attitude towards indigenous system of medicine and termed it as 'unscientific'. (3) The Ayurveda, Unani, Siddha and Homeopathy were very prevalent systems in India and had won the faith of millions of people in India. The Bhore committee was not having even a single representative of these indigenous systems on its board. (3)

Sokhey committee and its recommendations regarding development of Human Resource – The National Planning Committee was appointed in 1938 to develop a national plan with its chairman being Pandit Jawaharlal Nehru. The committee had various sub-committees to gather together some of the best brains in the several departments of our national life. Dr Sahib Singh Sokhey was the chairman of subcommittee on National Health (Sokhey Committee) and worked under difficult circumstances to release a report in 1948 with recommendations on poverty reduction, better hygiene, nutrition and healthcare. (8)

Sokhey committee recognized the lack of resources at that time to provide large scale medical services in the country. So the committee recommended the training of Health Workers from the community itself in auxiliary medical institutions. (8) In contradiction to the recommendations of Bhore committee regarding Indigenous systems of medicine, Sokhey committee (National Planning Committee) gave due recognition to the Vaids and Hakims, and proposed their training to mainstream them with the physicians or surgeons or gynaecologists and obstetricians. But regarding the type of training, the committee recommended, "the best scientific training in medicine in schools of a university standard". (8) The committee visualized to have one doctor per 1000 of population in the next 20 years and thus to produce 20,000 medical doctors each year. The committee encouraged women to come for medical training. (8) Regarding the medium of teaching and examination, the committee recommended the use of mother tongue with English words whenever necessary or English itself. The committee also recommended translation of medical books in mother tongue along with English version. The committee also emphasized on the medical research and development of a Medical Research Council. (8)

Mudaliar Committee and its recommendations regarding development of Human Resource - The Mudaliar Committee (Health Survey and Planning Committee) was set up at the end of second five year plan in 1959 to survey the progress made in health services since the submission of Bhore committee report and to make recommendations for future development and expansion of health services. The committee found that, quality of services provided by the primary health centres was inadequate and thus the committee advised strengthening of the existing primary health centres (PHCs) before establishing new PHCs. (9)

Mudaliar committee emphasized on the continuation of then current short-term course as a minimum qualification for a basic doctor and rejected the ideas of revising this course. (9) The committee also opined that English should continue to be the medium of instructions in medical colleges. Also the committee was not in favour of any reservations for scheduled castes and backward communities and argued that such reservations act as a deterrent for well-qualified candidates being admitted to colleges. (9) The committee recommended involving private medical practitioners to overcome the shortage of human resource for health in public sector. At the same time committee prohibit private practice by government medical officer. Instead he should be given non-practising allowance along with residential accommodation. (9) To meet the shortage of doctors in tribal areas, the committee recommended training the students from tribal area itself in medical colleges with the condition that they will serve in tribal community itself. (9) The committee emphasized on training of multipurpose technicians, auxiliary health workers, paramedical personnel and hospital architects. Just like Sokhey committee, the mudaliar committee emphasized the need for giving a degree qualification in modern medicine to the students qualified in Ayurveda. (9) The committee, like earlier committees, prioritized the modern medicine by asserting that national health services should be based on modern medicine and its persons should be adequately trained in modern medicine to be comparable to international standards. (9)

After independence, as a result of recommendations made by Bhore Committee, the departments of preventive and social medicine were created and upgraded in medical colleges and the emphasis was to bring about social orientation of medical education in India. (10) But the paradox was that in the prestige hierarchy of disciplines, discipline of preventive and social medicine came at the bottom and only those students were filled in to it, who could not get admission to higher disciplines.(11)

The present always have its roots deeply buried in the past. The colonial mind-sets reflected in the recommendations of Bhore and Mudaliar Committees who opined that English should continue to be the medium of instructions in medical colleges. (12) As a consequence of such mind-sets of

policy makers, the medical education today has become the privilege of English speaking, urban based, rich, upper class and caste students. On the other hand majority of downtrodden section of society got buried under the burden of "Brown Sahib medical men" Such trends divide the society in to an upper class of English proficient intellectuals riding on the backs of lower class who can only sell its labour. Dr Bajpai referred to this situation as, "White Man's burden turned in to the Brown Sahib's burden". (12) There was a need for social health physicians within the community, who could understand the community needs and work with a broader social perspective.

Another succession of Bhore committee's report was abolishment of Indian Medical Services in August 1947, along with women's medical service and the medical research department. (13) It leads to centrifugal approach and a certain measure of co-ordination between centre and state. A central council of health was established with health ministers of states as members. Then the establishment of planning commission in 1950 with its five year plans followed. The first five-year health plan (1951-56) had a health budget of Rs 140 Crores. (14) Although in the first two five year plans, there was huge investment in the development of teaching hospitals, medical colleges, general hospitals, dispensaries and other medical care facilities; the PHCs so developed had severe shortage of staff as compared to the recommendations of Bhore Committee and even today we are lagging far behind the "irreducible minimum" requirements of Bhore committee. One major reason for this shortfall, was, a wide gap between the understandings of community people and medical men. (15) The community was unable to accept the foreign system of medicine and doctors trained in such system. There was a preference for local healers over the medical doctors in the community and this trend continues even today. The medical doctors were not willing to practice in rural areas, due to their inability to adapt to local conditions. Even in urban areas, doctors preferred private practice instead of a government service. (16)

After conducting its Survey of health situation in country in 1960-61, the Mudaliar Committee recommended several policy methods to overcome the shortfall. One of the recommendations was to involve private medical practitioners. Even today i.e. 55 years after Mudaliar committee, the policy makers resort to public-private partnership as a solution to health crisis in the country. Public-Private partnership, at the end, only increases the "Brown Sahib Medical Men's Burden". (13)

At one point, Mudaliar committee stated that, "Enough maternity beds must be provided in teaching hospitals to allow each under-graduate to do the normal quota of 20 cases……..". (9) This statement reflects the chauvinism of committee members and the disrespect they had for patients. The purpose of whole medical structure was not to serve the patients but to use them as an object of experimentation in the learning process. It dilutes the whole vision for the existence of public healthcare system or teaching hospitals.

The most prestigious and powerful healthcare organizations are dominated by clinicians. (1) Further most of the important and leadership positions in healthcare organizations are occupied by clinical specialists. US Surgeon General, directors of national health services and ministers of health are appointed from clinical specialists. (1) Similarly educational institutions of public health have their faculty trained in medicine with little or no training in social issues. The public health institutions function as a subset of medical schools and are oriented towards teachings of community/ preventive medicine. As a result, medical care is skewed to secondary and tertiary care while little emphasis is given to primary prevention. Further health promotion component of primary prevention is totally left out. Similarly, rehabilitation services are oriented towards only medical rehabilitation. Little or almost no emphasis is given to vocational and social rehabilitation. The new training programmes like clinical epidemiology produces clinical scholars which are replacing public health scholars. These clinical scholars conduct clinical trials and work at individual level while the field of epidemiology was meant to study populations especially in developing countries where social conditions are not conducive to health. Funding for primary care is very less and these services are generally neglected. No effort is being done to improve socio-economic conditions of people which are major determinants of health.

Conclusion

To conclude, the hindsight shows us that our policy makers had a bipolar framework of action. On one side they had welfare schemes, and on the other side, their policies were favouring the capitalist and

semifeudal forces in our country. Their policies were constantly influenced by Globalisation and emerging superpower nations. Instead, there was a need to develop healthcare system and health manpower, sensitive to community needs and who could relate with the community. The community should also be able to relate with the health personnel as someone amongst them only. The barefoot doctors of China are examples of community sensitive health personnel and they proved to be successful in improving health conditions of rural China. Similarly, there is a need to train a cadre of rural doctors in India, chosen amongst the rural community, trained in Indian Systems of Medicine, along with training in emergency care, surgical care, Gynaecology & Obstetrics etc. to serve in their own rural communities. Also there is a need to improve the living conditions in rural areas. There is a need for rural development and to provide water, electricity, schools, colleges, dispensaries and connectivity in rural areas. One, as social determinants of health, it will improve the health of community and second, it will encourage the health personnel to work in rural areas and to live there with their families.

For this paper, I would like to limit my discussion to only these three committees. But actually it is a very long story. Lots of other committees gave their recommendations from time to time. Chaddah committee, Kartar singh committee, Srivastava Committee, Jungalwala Committee, Alma Ata declaration, National Health Policy, National Population Policy; all led to constant shaping of our healthcare system and led to several health reforms. As a tragic ending to the story, all we have today is commercialization of medical field, denial of treatment by private hospitals and deaths due to fever at the doorstep of hospitals. As public health leaders, we need to write a second part of this story, to make it a happier experience for all human beings because health is a basic human right.

Limitation of the study

The limitation of this study is that it is a review article based on available secondary literature and no field study was conducted to collect primary data.

Relevance of the study

The study is relevant for policy makers, MCI (Medical Council of India), public health leaders and public health teaching institutions. There is a need to generate a cadre of socialized medical men and public health professionals who can imbibe social dimensions of medicine along with technical competence.

Authors Contribution

RR: Conceptualized this article, did literature review of existing studies and various reports, comprehends them, build an argument, draw a conclusion, wrote the article, revised it and finalized it.

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Tables

TABLE 1 HUMAN RESOURCE AND HEALTH SERVICES SYSTEM DURING BRITISH INDIA (1942)

Indicators	Value
Doctor: Population	1:6,300
Nurse: Population	1:43,000
Health visitor: Population	1:4,00,000
Midwife: Population	1:60,000
Bed: Population	0.24:1000
Hospitals/ Dispensaries: Population	1:40,000
PHC (Primary Health Centres)	Nil