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Health, Development and 'The Sick Role' in *Putulnacher Itikatha* and *Arogyaniketan*

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Abstract:

'The Sick Role', a concept developed by Talcott Parsons constitutes a specific sociological concern regarding the diseased identity in society. In light of this approach, the doctor-patient relationship, ideally based on a paternal-authoritative model, needs to be viewed beyond its intersubjective nature, since the diseased and dependent body is not only that of an 'individual', but also a part of society. The involvement of the doctor, or the local administration, in health and development, makes the issue significant— in terms of Medical Humanities, seen through a literary-sociological perspective. This paper proposes to explore the notion of 'the sick role' with reference to two Bengali texts by Manik Bandyopadhyay and Tarasankar Bandyopadhyay, featuring the colonial and post-independent situations of healthcare and development in Bengal.

Keywords: Colonial, Development, Doctor-Patient relationship, Healthcare, Talcott Parsons, The Sick Role

1.0 Introduction:

In colonial India, the interaction between imperial health policies and indigenous medical traditions had been a critically fraught area of political, medical social and cultural negotiations. In opposition to David Arnold's *Colonising the Body*, Indian medical historians like Poonam Bala and Projit Bihari Mukharji have argued that alongside obvious conflicts, there had also been some kind of coexistence and interaction between the western and the indigenous cultures concerning health and development. This paper proposes to read such issues from a literary-sociological perspective, with close references to *Putulnacher Itikatha* (1936) by Manik Bandyopadhyay and *Arogyaniketan* (1953) by Tarashankar Bandyopadhyay, two cult-texts of colonial and postcolonial Bengali literature, dealing with issues of health, sickness and development. From a sociological point-of-view, this paper argues that the 'sick role' defined by Talcott Parsons, although critiqued by several scholars in the 1980s, functions as a way to read the doctor-patient relationship in a larger social and community-life concerning the holistic well-being of mankind – which is also one major aspect of societal development. Several studies and have been published in the West, with reference to this concept, but application of this theory to the vernacular literary texts in India, is yet to be done. Within the limited approach, the paper only proposes an offer a brief overview of the topic, with reference to two major texts found suitable for the study.

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2.0 Materials and Methods:

The present paper hails from a literary background, so materials are nothing more than primary and secondary texts (the novels as primary texts, and texts concerning theoretical and background studies as secondary). As to methodology, it uses a combination of Medical Sociology and Cultural Studies. The major point of reference is Talcott Parson's theory, so it is better to briefly introduce it theory at the outset. In his 1951 book *The Social System*, he introduced the concept of 'the sick role'. For Parsons, being 'ill' is a kind of 'sanctioned' deviant behaviour within society. Unable, or unwilling to fulfill their normative social duties, the sick people may pose a threat to the progress and productivity of society. In other words, the self-indulgent role of being 'sick' and 'dependent' is detrimental to social development. So, the sick role needs to be monitored and regulated by 'doctoring', which gives validity to the societal role of the doctor. Parsons devised a 'Sick role mechanism', where both the doctor and the patient should abide by some codes of 'rights' and 'obligations', in order to prevent the 'subculture of the sick'. It would be wrong to assume, however, that Parsons showed a lack of sympathy towards the 'sick', he is not against the rights the sick persons are supposed to enjoy. His theory proposes to monitor a negative mentality of 'sickness', a kind of affected 'role' which tends to cast a dysfunctional effect on the community.

3.0 Discussion:

Now, coming to the historical context of our selected texts, it can be said that the situation of colonial healthcare system deteriorated after the First World War. According to Mark Harrison's *Public Health in British India*, "The Montagu Chelmsford reforms of 1919, which made the provincial governments responsible to a majority of elected representatives" (233), led to a localization of the health-oriented reforms. Further, provincial governments continued to operate within financial restraints during the postwar depression of the early 1930s. Health officials became even more cynical after the institution of diarchy in 1919, which passed responsibility for certain subjects, including sanitation, to provincial and local Indian ministers while keeping subjects such as defense in the hands of British executive councilors. Before the Far Eastern Association of Tropical Medicine, J. D. Graham, India's Public Health Commissioner, remarked on the difficulties of disease control in India, as quoted in Sandhya L. Polu's (2012; p 98) *Infectious Diseases in Colonial India:*

> Municipal Government which, in these days of the reforms and local autonomy, is largely Indian and very often non-co-operative in tendency, the problem of prevention of disease on modern lines becomes at once surrounded by great difficulties. If we add to these the small numbers of qualified doctors, the ignorance of the population, their prejudices and superstitions, religious and otherwise, the want of a public health conscience in the community and the absence of driving force, it will be realized how difficult it is to promise or even to anticipate.

The Government of British India's Sanitary Commissioner thus painted a picture of public health in India, in which Indians were to be blamed for the abysmal state of health and disease, thus exonerating the government from responsibility for past, present, and future failed public health measures, while also justifying limited government attempts to ameliorate sanitary conditions. Officials displaced the Government of India's failure to address tropical diseases effectively onto local bodies governed by Indians.

This is precisely the situation in which Manik Bandyopadhyay has set his 1936 magnum opus, *Putulnacher Itikatha*. The young doctor-protagonist Sashi wants to introduce ideas of primary healthcare and sanitation in his native village, infested by malaria and cholera. But his own family members suspect him, saying: "Does he want to display his daktari knowledge at home?"[1]. In reality, for a large number of rural population, allopathic medicine was still regarded 'foreign' and even harmful to the indigenous body. The incident of Sendidi --Jamini Kaviraj's wife suffering

under wrong treatment in the hand of her own husband reveals the attitude of the old generation people towards modern healthcare. Jamini's wife has smallpox, but Jamini mistakes it for malaria and treats her with kaviraji medicine. When Sashi makes a proper diagnosis and starts his allopathic treatment, the patient recovers after a long struggle but loses her facial beauty and one of her eyes. Cured but not 'healed', suffering from an inferiority complex for her deformed face, Sendidi who once loved Sashi as her own son, now blames him all the time for not treating her with proper care. Thus the image of the never-satisfied, complaining patient, willing to depend on the doctor all the time and perpetually exercising what Talcott Parsons (1951) calls 'the sick role' remains a disturbing presence for the physician, and in society. Sendidi's plight of 'being sick' metaphorically gets reflected in the 'diseased' situation of the rural society as a whole. The stagnant, malaria-stricken, unhygienic environment of the village smacks of a stale and sickening existence, which needs to be handled by the doctor-figure. The case of Sendidi is only one instance; but many of Sashi's patients within his rural surrounding continue to haunt the doctor's developmental and reformist aspirations. His neighbour Paran who has a throat-soar, Bhuban Barujje's grandson whom he cannot save, and even his own sister Bindu whom he sought to rescue from her unhappy marriage, causing a complete physical and mental breakdown, in one way or another, directly or indirectly challenge the doctor's professional and personal commitments. It is against this perpetual presence of the 'sick role' in his family and society at large, that the doctor has to fight out his battle.

The issue of 'development' becomes evident in *Putulnacher Itikatha* with the foundation of the hospital. Just as medical historians like Mark Harrison and Sandhya L. Polu have shown, the shift to local self-government at this time reflected the decentralizing nature of the colonial government in the 1930s, losing much of his earlier supremacy in health administration. Sashi daktar has to deal with the local authorities, the president of the village union board and other influential people instead of the government officers, to get the permission granted and start the hospital. The funding comes from a man's will who in his lifetime was a rigid proponent of the ancient spiritual-philosophical system of *Suryavijnanam*[2], and a severe critique of modern medical science represented by Sashi. However, he expressed his wish that all his savings would be donated for the establishment of a local hospital. Thus the hospital itself figures out as a marking point where tradition and modernity, old beliefs and new notions of development seem to find a reconciliation. Sashi's private aspirations for love and happiness dry out, he become stagnant and caught up in a sort of existential dilemma, but on the other hand, he finds the worth of life in his work for the hospital. The more is Sashi's sense of dissatisfaction and disillusionment in his personal life, involving pain and loss in the lives of others around him, the more grows his attachment to public development – to the hospital. His attempt to leave the village and begin his life anew gets thwarted; now he must identify himself with the developmental project he himself started – the hospital. "What else would Sashi do, he cancelled all arrangements for going away… if he must stay in the village, how would he live without feeling the pulse of every patient in the hospital?" (*Putul Nacher Itikatha* 217) This also indicates the paradox inherent in the postmodern philosophy: 'development' takes shape as a social grand narrative at the cost of causing displacement and disruption among many a personal micronarratives.

The history of colonial medicine, in extension can be read as a chronicle of the assimilation of Western discursive practices in the otherwise impregnable opacity of Indian cultural practices. The progression from the dominant indigenous modes of treatment encompassing nature, namely Ayurveda, Unani, and a confounding gamut of religious practices to adopting Western medicine reflects an interconnected renaissance in the system of Indian history of ideas. This trend can be observed in Tarasankar Bandyopadhyay's *Arogya Niketan* where the transition from the old medicinal practices to the systematized Western modes of treating illness and the conflicting

intricacies are brought to the fore. The transition from the modes of Jeevan Mashay to those of Pradyot daktar apart from exposing a shift in trends of reception towards healthcare also reflects a change towards a materialist culture of healthcare introduced by the colonial administrators. The novel displays a transition in the perceived attitude towards death against the vast conception of eternal life, in which the ultimate cessation of being is moving into the realm of the absolute. However, against this philosophical backdrop of a perennial theme about the inevitability of death, the novel shows, on a realistic level, the transition of medical practice and healthcare from the colonial period to post-independence Bengal under Dr. Bidhan Chandra Roy, complying with the Central government's socialist objects of development. Tarashankar Bandyopadhyay has described in details how the village Devipur in the post-independence era emerges as a combined product of old rural cultures and new modes of social development through distributive justice, undertaken by the new government. The community project, the Nabagram medical co-operative and the new hospital – all these are significant of how development affects the rural life. The village people for whom Jeevanmashay's Ayurvedic treatment was the ultimate resort, are now getting introduced to surgery, X-ray, and antibiotics. But beneath the trumpeting of a progressive health administration, the social reality of sickness becomes evident when we see that some unscrupulous drug-sellers are dealing with adulterated or expired drugs, causing unfortunate deaths. Further, modern therapies are more commercialized than humanitarian, and so most of the poor population of the village find it difficult to enjoy the benefit of this 'development' which makes an economic demarcation between the well-off and the poor. The business-mentality of the young generation doctors pitted against the old kaviraj's fatherly and sympathetic attitude to patients appear to be a critique of development in ethical and sociological terms. This difference becomes evident when Rana Pathak cannot get any treatment from the hospital because of fees, he comes back to Jeevanmasai and says,

> [Modern] Doctors are very rude, you see – they do not consider us as human beings. You used to practise in old days – … now these doctors earn more, because they take too much money. But they cannot have that kind of popular demand. You [old-day kavirajas] treated patients as if you were their own relations. (Bandyopadhyay, 1975, p. 170)

What strikes one is the curious fact that when Parsons was writing on the sick role in 1951 in America, Tarashankar Bandyopadhyay sitting in West Bengal, India was composing such a novel as *Arogya Niketan*, which contains so many revealing observations on social and moral pathology, closely related to medical ethics and healthcare. The 'sick role' operates in a different way in *Arogya Niketan*. The patients show chiefly three modes of dealing with sickness: some of them accept death as the ultimate truth in life and resign calmly; the second group fights the disease heroically and sometimes get cured, sometimes do not, but celebrate the vital force of life before death. And the third category behaves like cowards. They invite death into their body by wrong living habits, and remain unproductive and morally weak in their social roles, both in life and death. A doctor's experience gains validity from all these kinds of connections, and he has to view life, health and mortality, development and its anomalies– all in a holistic way. Such multifaceted aspects of negotiating 'sickness' can be read as a critique of the Parsonian argument that sickness always creates a problematic group of people withdrawing from social demands and expectations, and constantly seeking dependence on doctors, thus defining the doctor's curative social role in turn. Criticisms against Parson's theory contend that his definition of the 'sick role' assumes a preconceived notion that a doctor *can* help the socially deviant sick person 'recover' and lead him back to normal life. This does not apply to acute or chronic illness, or to different levels and experiences of illness within a complex social structure. Elliot Friedson's thesis has sought to overcome the limits within Parsons' approach, holding that reactions to illness and the

expectations of the sick people are variable; different groups in society may look at it differently. However, in his later writings, Parsons modified some of his earlier stances, saying:

> The position was taken that the author never had meant to confine the category of illness to deviant behavior, though its negative valuation should not be forgotten. Nor had he con fined it to cases of acute illness, omitting consideration of chronic and other types. The most important issue, however, concerned the structure of the relation between physician and patient. Though insisting that interaction between them is two-way, not one-way, the author insisted that the relation is basically asymmetrical because of the physician's expertise in health matters, gained through training and experience, and his special fiduciary responsibility for the care of the sick. (Parsons, 1975, p. 257)

It is interesting to note in this context that the physician's role in monitoring the socially deviant, weak and suffering people and thereby confirming his own importance in society has an obvious parallel with the policies of governance. The medical administration offered by the British authorities sought to make the 'diseased' and weak populace subject to their palliative measures for healthcare. But sometimes, the 'sick role' of the colonized people became subversive and threatening to their imperial power. Healthcare and development are now largely considered among bioethics, in which sociology and literature also intersect. A sociological perspective on literary texts portraying the doctor-patient relationship can thus open up new avenues in bioethics, and trace its development across the colonial and post-colonial situations.

4.0 Conclusion:

In conclusion, coming back from the social philosophy of doctor-patient relationship to historical realities, it can be said that healthcare and medical facilities provided by the British government also served as an instrument for ensuring the colonised population's dependence on the masters. However, after the First World War the British power lost much of its invincibility, and the government's policy was now to appease the masses by allowing them self-governance in local health-administration and other matters as well. This shift from absolute control to decentralisation of power marked not only a historical change in public health policies; it also marked the fact that the image of a 'caring' yet 'flexible' government was all that was required for running the administration. The nature of government policies changed after India's independence, the colonial policy was manipulated and converted into a nationalist political agenda in the post-independence period. The Nehruvian government in independent India also sought to showcase 'development' as a positive measure of healthcare facilities, and the image of modern India and Bengal represented through the impressive hospital-building and its accessories comes to the fore Though texts like *Putulnacher Itikatha* and *Arogya Nikentan* do not deal with contemporary politics directly, they indeed reflect the issues of health and development and their subtle connection with social and economic changes. Dropped mortality rates and a marked improvement in the quality of life would suggest a process of development across the colonial and postcolonial times, which is not only to be viewed in terms of economic and social history, but also to be understood in the light of interdisciplinary humanities, highlighting health and sickness as modes of a moral, cultural and practical way of human resource management.

Notes:

1. Translations from the Bengali original are mine.
2. A traditional astronomical branch of knowledge, semi-mystical and semi-scientific.

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