

Transformation and Restructuring of Professions in Globalizing India

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Abstract

The present paper is an attempt to look into the growth and development of professions in pre-independence period and a detailed analysis of changes in medical profession right from the ancient Indian society through the development of Yunani system of medicine in medieval period and the advent of modern system of medicine during the colonial period. Finally, an attempt is made to examine the growth and development of medical professions in pre-globalized independent Indian society along with the transformation and restructuring of western based medicine system by the forces of globalization and the revival and transformation of the traditional system of medicine in the era of globalization.

Key words: Globalization, Medical profession, Ayurveda, Yunani medicine, Medical tourism, Stratification

Professions and professionalism have been important parameters to measure the growth and development in modern societies. The forces of globalization in last few decades are transforming and restructuring professions in both the developed and the developing societies. As professions expand their network beyond the boundaries of nation-states in order to develop the requisite skills needed to compete at global level, some new dimensions are added to the traditional notion of the profession and professionalism. The transnational flows of people, ideas and objects have repercussions for the professions and professionals located in different parts of the globe. Growth of new communication technologies and global environmental issues paved the way for the emergence of new professional groups and restructuring of the existing professions in the globalizing world. The multidimensional process of globalization has provided a new dynamicity to the professional groups in performing their roles as well as in maintaining the ethics of professionalism. Information and communication technology play a vital role not only in the task of performing their day to day professional role but also in updating professional knowledge and skills. The present paper is aimed to analyze the transformation and restructuring of the professions in India focusing on the medical profession only which is now passing through the process of globalization for last three

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decades. First of all, an attempt is made to look into the growth and development of professions in pre-independence period. Thereafter, a detailed analysis of changes in medical profession is made right from the ancient Indian society, covering the development of Yunani system of medicine in medieval period and the modern system of medicine during the colonial period. Finally, the growth and development of medical professions in pre-globalized independent Indian society are discussed along with the transformation of western based medicine system by the forces of globalization and the revival and transformation of the traditional system of medicine in the era of globalization.

I

Indian society has a long history. In ancient period, there is evidence of some institutions of higher learning and specialized professions based on the practice of specialized knowledge. Apart from learning of common sense knowledge through participation in everyday life and hereditary based transmission of skills from one generation to the other, there are numerous references of an ancient institution of education, namely, *ashram* – a specific place where education was imparted by a person called *rishi* (sage, one who is practicing the life of simplicity and renunciation) *who was the head of that ashram* and his associates called *Munis* (thinkers, having deep knowledge of both the physical and spiritual world). These residential institutions were located in the forests and had patronage of the various kings. These *rishis and munis* had specialization in different fields. There are also incidences when after completion of basic education in a particular *ashram*, a rishi referred his student to go to some other *rishi* for getting specialized training. The students were admitted in these *ashramas* at the age of 12 years through a ceremony called *Upnayan Sanskar or Diksha* (by putting a sacred thread by the rishi to be worn on the body all the time and has to be changed time to time following a particular method prescribed for it). Thereafter, the head of the institution became the *guru* (teacher) and the admitted child *shishya* (disciple) for the whole life-span. This *guru-shishya* tradition still continues in spiritual world even today. Later on, these *ashramas* were converted into *gurukuls* (traditional educational institutions where traditional form of knowledge both worldly and other worldly is imparted). The period of stay in these institutions was for a period of about 12 years. After completion of education in these institutions a student was supposed to return and engaged in an economic pursuit as per his specialized knowledge in a particular field. In every *ashrama* there were a number of specialized teachers imparting education and vocational training to the students as per their interest and capacity. These teachers were called *acharyas* (equivalent to a university professor of today). Apart from spiritual knowledge and guidance generally given by the *Brahmins*, there were certain specialized occupations like training of operating arms, war strategies mainly allocated to *Kshatriyas*, trade and commerce allocated to *Vaishyas* and various type of services allocated to *Shudras* which included artisans and other activities. Musicians, artistic occupations were open to persons of all the above mentioned groups. However, the agricultural occupation was common to the members of all these groups. *Grams* (Villages) were self-sufficient units and had functional ties with *nagaras* (city/town). However, the king had a control over the territory of his kingdom and all the land belonged to him, the cultivators were supposed to pay tax to the king. Thus, there was some sort of division of labour not only at the village level called *Jajmani system* (see Wiser 1936; 1963; Mandelbaum 1963).

Vedic literature has been a rich source of spirituality in Indian society since Vedic period (c. 1500 – c. 600 BCE). In post-Vedic period (600–323 BCE) witnessed the rise of large, urbanized states as well as of *shramana* movements - Jainism and Buddhism - which challenged the Vedic

orthodoxy. All the knowledge that we have of the post-Vedic period comes from the Buddhist literature and the Hindu Epics. One can say post-Vedic period is Buddhist Period, and *Smriti* and *Epic* Period when other religious traditions –Jainism, Buddhism, Charvak-emerged and spread in the Indian sub-continent. These intellectual traditions gave rise to a class of profession i. e. intelligentsia, who has expert knowledge of the Vedic literature and the literature of other indigenous religions. The Mauryan period (322 – 185 B.C.E.) was ‘extremely rich in terms of literary resources of information, the most important being Kautilya’s *Arthasastra*, the Buddhist texts and travel accounts. During this period, city administration was well developed. The administration was done through six committees, each one headed by an officer called *adhyaksha* or superintendent appointed by the ruler for supervising the functioning of committees related to ‘factories; foreigners; birth and death records; markets, weights and measures; inspection of manufacturing goods; and sales tax’ (Ramachandran 1989: 41). The city legal system consisted of courts at three levels: the locality, the caste and the clan level. In addition to these courts, the various occupational guilds also settled disputes among their members. The city was also a ‘centre of the manufacturing industry’ usually ‘surrounded by craft villages (more or less homogeneous in terms of occupation and specialization in some activities)’. Within the city it had ‘a number of sixty odd industries.... grouped into 11 categories:

‘(1) textiles, (2) carpentry and woodwork, (3) metal work including smiths and jewelers, (4) stone work; (5) glass industry, (6) bone and ivory work, (7) perfumery, (8) liquor and oil manufacture, (9) leather industry, (10) clay works including pottery, terracotta figure making, modeling and brick making, and (11) other miscellaneous industries such as making garlands, combs, baskets, musical instruments, and painting’ (Ramachandran 1989: 41-42).

Advanced level of guilds of industrial labour and merchants were in existence. Occupation wise major sections of society were:

‘the king and his higher administrative and military officials, priests, lower administrative and military officials, independent professionals such as physicians, scribes, accountants and teachers, the mercantile community, artisans and craftsmen, public entertainers such as musicians, dancers, actors and prostitutes, and persons performing a variety of services, such as washer man, barbers and domestic servants’ (Ramachandran 1989: 42).

By that time three international universities- *Nalanda Vishwavidyalaya*, located in the present state of Bihar (India), a famous Buddhist educational institution whose curriculum included subjects such as the *Vedas*, logic, Sanskrit grammar, medicine and *Samkhya*; *Takshashila Vishwavidyalaya*, located in the Rawalpindi District of the Punjab, now in Pakistan; and *Vikramshilla Vishwavidyalaya* located near Bhagalpur in Bihar, came into existence. Takshashila’s famous researchers and teachers include: *Panini* (the great grammarian of Sanskrit); *Kautilya*, also known as Chanakya (king-maker, astute political advisor, and author of *ArthaShastra*, c. 300 BCE); *Charaka* (the distinguished physician, whose research on the region’s flora and fauna described in his *Charaka Samhita* strengthened the development of Ayurveda); and *Jivaka* (the great physician to Gautama Buddha).

It suggests that during the Mauryan period the urban society in north India was occupationally diversified and some sort of professions were also in existence. Similar patterns of urbanization and industrialization took place in south India as well. However, due to invasion and continuous

warfare between kings resulted into decline of economic and professional activities which was further accelerated during the invasion of *Hunas*, who entertained anti-Buddhist sentiments, resulted into deliberate destruction of many Buddhist centres in north-western India and Gangetic plains. This process continues even in the Mughal period particularly in the period of Khilji dynasty. Although, some efforts were made by Emperor SherShah Suri for the first time to promote trade and commerce, followed to a great extent by emperor Akbar and his descendants (Mukherjee 2011). It is important to note that rural areas were connected with the urban centres and had economic ties with urban based industrial units but at the same time maintained their autonomy during the period of various rulers focusing mainly on agricultural activities and craftsmanship. However, urban centres had high level of prosperity through trade and commerce became the victim of invaders and cruel rulers who insisted on conversion of the local population in order to strengthen their administration and military power. But these indigenous industries continued to survive even in adverse conditions and engaged in trade and commerce activities not only within the country but also abroad particularly in the middle-east and Europe (through silk route) came into existence during the Maurya Empire.

Mishra (1961) discussed at a length the growth of Indian middle classes and argued that it can be divided into two: Old middle class and new middle class. By old middle class, he means, urban based indigenous occupational groups emerged, developed and survived in India prior to advent of East India Company and British Empire. However, New Middle Class originated as a result of colonial experience for a period of about 200 years. Thus, with the growth of modern professions, old professional groups either vanished or subjugated by the forces of westernization. The growth of professions, namely, law, medicine, teaching, and engineering was relatively low. Of these, medicine remained by far the most important, second only to law. The following table is based on the data presented by Mishra (1961:332) which gives a comparative picture of the trends in each of them in pre-independence period:

In independent India, the growth of professions took place at a faster rate and a number of institutions to impart professional education were established. As a result a sizable number of professionals (Doctors, Engineers, University Teachers, Journalists, Lawyers, etc.) emerged in post-independence period. In 1990s, India adopted the policy of Globalization, Privatization and Liberalization moving away from the model of mixed economy and introduced a number of structural reforms to cope with the process of globalization. These changes led to not only in transformation and restructuring of existing professions but also to the emergence of some new professions such as IT professionals, Environment Impact Assessment Professionals in India. Information and Communication Technology has brought information revolution in India. There has been tremendous increase in flow of information through internet based devices. The digitalization of government records and use of information services by the professionals in their everyday role performance has changed the patterns of their work organization and helping them not only in performing their professional roles more effectively but also in updating their professional knowledge by regular use of internet. For example, High Courts and Supreme Courts now upload their day-to-day orders and judgments on their websites.

The advent of multinational companies in post-globalization era has brought new opportunities not only to the urban based middle class families but also educated families of rural areas and opened the ladder of professional jobs to the youth of the diverse socio-economic background. In last three decades, the growth of professional educational institutions (mainly privately owned) has increased at a faster rate. It has motivated even parents of lower middle class and rural peasants to

admit their wards in these institutions after 12 years of schooling. The number of girl students in professional courses is now more than the boys. Five-year integrated courses of law in the Indian universities and colleges are meant to prepare a new class of law professionals mainly absorbed in the globally operating corporate sector. These changes reflect the nature of transformation and restructuring of professions in globalizing India. Due to lack of space, we shall focus only on the restructuring and transformation of medical profession in India.



Medical Profession

The history of medicine and medical profession in India can be traced back in ancient Vedic literature, *Rig Veda*, 'data of which may mostly be referred to the latter part of the second millennium B.C.' (Basham 1977: 11). In *Rig Veda* the word '*Bhisaj*' is used which is more or less synonymous with *Vaidya*, still a standard Indian term used for the doctor of traditional type. The *bhisaj* is referred to in one passage of *Rig Veda* 'as desiring, a break, a fracture (*rutam*), in order to gain wealth, indicating that he was originally a bone-setter' (*ibid.* 11) (in contemporary Indian society the technique of bone-setting by a local specialist is still in practice but the term *bhisaj* has been disappeared in due course of time for such persons). In another hymn, he is referred as 'to as conversant with healing herbs' (*ibid.* 18). Later on another term '*cikitsaka*' (*chikitsak*) was used to refer for the person who was engaged in the profession of medicine. "By far the most common term for a medical practitioner in Kaumilya's *Arthauâstra*, however, is *cikitsaka*. This term was probably the most generic, as it covered the 'king's own physician' (*KAS* 1.19.23), various kinds of itinerant healers, army medics (10.3.47), and even veterinarians" (Olivelle 20: 1). Thus in ancient Indian society, there were three types of persons engaged in the pursuit of medicine, *Vaidya*, *Cikitsaka* and *Bhisaj*. However, the first two nomenclatures are still in existence but the third one is either disappeared or its nomenclature is changed.

In the medieval period, with the advent of foreign invaders and later on establishment of Mughal Saltanat in India, Yunani/Unani System of Medicine came into existence (Basham 1977). The Muslim physician (*tabib*) became known generally as a *hakim* ("a learned man"). 'Since his system looks back to classical Europe, the Muslim hakim in India practices Yunani (often spelled Unani)-i.e., Greek medicine, as a distinct from Ayurveda, or a hybrid Muslim-Hindu system known as *Tibb*' (Basham 1977: 39). This system of medicine flourished in medieval period under the protection of the Mughal emperors. There is no mention in Hindu texts and scriptures for the existence of a fully developed system of hospitals. On the other hand, hospitals were essential aspects of the Muslim medical system and the *tabib* is advised to visit hospitals regularly. One important feature of Muslim medicine was the development of surgery in *Tibb* system. The surgeon was called *Jirah* (phlebotomist). Thus, under the protection of the Saltanat a number of hospitals were established to provide treatment to the patients. However, *ayurvedic* medicine system also persisted in the society parallel to the *Yunani* or *Tibb* system of medicine. Much before the Mughals and British stepped into India, residential universities like Takshashila and Nalanda provided organized institutionalized training in medicine. Students were trained in both theoretical and practical aspects under the guidance of a *guru called acharya*. In the 16 century, it was the Portuguese who first introduced Western medicine into India.

In 1600, East India Company brought some medical officers who were trained doctors in western medicine. Initially, medical departments, with surgeons, were setup to provide medical

relief to the troops and employees of the East India Company. In 1785, The Company set up Medical departments in Bengal, Madras, and Bombay presidencies to look after both the military personnel and the British civilians (Mushtaq 2009). After the Mutiny of 1857 the British government took over the rule of India from the East India Company and took several initiatives for the improvement of health services such as the Indian Medical Service, the Central and Provincial Medical Services, and the Subordinate Medical Services. A public health commissioner and a statistical officer were also appointed to the Government of India (Mushtaq 2009) and opened a number of hospitals in different parts of the country, Madras (1679), Calcutta (1796), Calcutta Medical College (1835), Lahore (1860). Afterwards, a network of hospitals was set up throughout India. A nursing school in Delhi was established in 1918 and the All-India Institute of Hygiene and Public Health was established in Calcutta in 1930 (Mushtaq 2009). As for as the status of locally rooted Ayurvedic and Yunani system of medicine during the British period is concerned, Panikkar (2009) and the following observations of Anshu, Supe are relevant:

However, during the colonial period, there was a clash of cultures where the East was seen as weak against the powerful knowledge of the West. Both groups tried to differentiate their own set of ideas from those of the other. In the East, medicine was largely pluralistic and there was awareness and acceptance of alternative traditions. Medicine was not viewed simply as a biological phenomenon and emphasis was given to a patient's societal standing, environment, and relation with the therapist. As colonial arteries hardened, claims of the Western superiority and scientific authority isolated Western medicine. Allopathic practitioners saw themselves as modernizers and often treated their indigenous counterparts with contempt for their "inferior knowledge." Local knowledge was labeled unscientific or irrational. While Western medicine was accorded the status of official medicine, the state turned discriminatory and hostile toward the other systems (Anshu and Supu 2016: 2).

The above observations reveal that there was a clash of culture between the western system of medicine and the locally rooted system of medicine during colonial period. As a result both the local system of medicines struggled for their survival in adverse political climate which continued even in post-independence period as well.

In first three decades after independence, most of the doctors were either engaged in private practice or were employed in government hospitals or educators in state owned medical colleges. In this period, the medical profession had a very high prestige and was most preferable profession in the society. As a result, the demand of science and biology stream increased at the secondary level education. The admission in medical college became highly competitive and most of the medical institutions started entrance test for admission in early 1970s. Majority of the doctors belong to the new middle class and were employed mostly in the public sector institutions. It is only with increasing commercialization of medical care that a significant proportion of doctors chose to work in the private sector.

Studies on the social background of doctors before independence reveal that most of them either belong to the old middle class or upper middle class and caste (Jeffery 1988). However, by the 1970s, the social background of doctors presented a much more mixed background, especially with affirmative policies for marginalized sections. In addition, the growth of private colleges in the western and southern states resulted in large sections of the new middle class gaining access to medical education. It also witnessed the rise of middle order castes that have acquired wealth

through commercialization of agriculture or petty business, investing in medial and other professional education in the private sector. A contrast can be seen between the doctors in terms of their salaries and working conditions. The higher salaries and easier conditions in case of doctors in private hospitals in contrast to their overworked and comparatively less-well paid counterparts in public hospitals (Baru 1998).

The growth of large private hospitals is a phenomenon appeared on the scenario in mid-1980s as a shift in the policy of the government to provide subsidies in procuring land and reduction in import duties for purchasing technologically advanced medical equipment etc., as well as exemption in taxes for promoting research and development activities. It facilitated the growth of corporate hospital as a number of national and regional business groups readily invested in these institutions with an active involvement of non-resident Indian (NRI) doctors particularly from the United States (Baru 1998). At the same time, small and medium size nursing homes were also established at the initiative of local capitalists with an involvement of local doctors serving privately as well as in public sector medial institutions on part-time basis. Prior to this most of the hospitals and nursing homes were opened by some industrial houses and trusts for charity purpose without having any objective of profit to serve the common man with limited surgical facilities. The rise of the private sector hospitals and nursing homes of different size 'altered the dynamics within the private sector and resulted in a considerable amount of competition and also pushed up the cost of medical treatment during the 1990s. These private hospitals and nursing homes attracted the upper-middle and middle classes patients who were highly dissatisfied with the hygienic condition, poor services and low reputation in the society. Even the rural and lower class patients began to prefer private nursing homes for the treatment of complicated diseases and surgical operations by the well-known specialists of different private and public sector institutions. This has given rise to a shift in the attitude and values of the general public towards medical care and they preferred good quality medical care over the poor medical care and services offered in government hospitals. Thus, a kind of consumerism has emerged in the field of medicine as the forces of globalization paved the way for the growth of private sector in health services in India. The transnational flow of the capital and doctors helped in establishing world-class medical facilities in different metropolitan centers. Consequently, a number of super and multi-specialist hospitals started to dominate in medical and health services and begin to attract the patients not only from the different remote corners of the country but also from the abroad.

Another important phenomenon in the field of medicine was the revival of the Ayurveda system of medicine. In first four decades after the independence, two locally rooted systems of medicine, namely, *Unani* and *Ayurveda* struggled for their survival against the popularity of the western system of medicine. *Hamdard* and *Tibbia* were the leading pharmacies representing the *Unani* system, while *Dabur*, *Baidyanath*, *Jhandu* and many other local pharmacies representing the *ayurvedic* system of medicine. However, they could not get much success in the decades of 1950s, 60s and 70s as they continue to rely on their traditional techniques and organizational structure.

With the phenomenon of globalization there was an unprecedented growth of information and communication technologies in India. The Indian television transformed into global television. At this juncture, a young *sanyasi* (a Hindu religious person) Ramdev founded the Divya Yog Mandir Trust in 1995 and in 1997, a new ayurvedic pharmacy-"Patanjali Ayurveda Limited (PAL)- established in the name of an ancient sage 'Maharishi Patanjali' who was one of the founders of Yoga and

Ayurveda in ancient period. The founders of this company were two youth- Ramdev (a sanyasi) and Balkrishna. Both of them studied Yoga and Ayurveda in *Kalwa* Gurukul in *Jind* district of Haryana, (a *gurukul* is a traditional form of educational institution reestablished in 19th century by Swami Dayanad Sarswati, a religious reformer and founder of Arya Samaj). Ramdev offered free yoga training to the villagers. Then both of them moved to Haridwar in Uttarakhand, where they practiced self-discipline and meditation, and spent several years to study ancient Indian scriptures at *Gurukul Kangri Vishwavidyalaya*, Haridwar (a university established by another Arya Samaj saint Swami Shradhdhanad to promote research and training in Ayurveda and Yoga in 1902). In 2003, *Aastha* TV began featuring Ramdev as a *yog guru* in its morning *yoga* slot. There, he proved to be telegenic and gained a large following, while Balkrishna appeared as an *Acharya* (equivalent to a university professor) who has an in-depth knowledge of herbs and herbal medicines in his TV show. As a result, a large number of people, celebrities from India and abroad began to attend Ramdev's Yoga camps in various towns and cities of the country. He opened a number of centres of yoga training in different parts of India and developed a large number of followers who donated liberally for the promotion of yoga and ayurved in India and abroad. Some of his yoga exercises became very popular (*Pranayama* and *Kapal bhati*) in these sessions of yoga. His popularity in media attracted many celebrities not only in India but also in foreign countries including Britain, the US and Japan across the religion. He established Patanjali Yogpeeth (a university of Yoga and Ayurveda) in 2006 at Bahadurabad, near Haridwar. They opened many dispensaries, shops and franchises in every small and big town of the country and also appointed '*baidyas*' (traditional Ayurvedic doctor) in his own established dispensaries to give free consultation regarding the herbal medicines. Later on, he also led '*swadeshi* movement' and started to produce consumer goods like toothpaste, shampoo and other cosmetic items and biscuits to noodles, and now apparel and footwear and posed a big challenge to a number of multinational companies— the likes of Unilever, Proctor & Gamble, Nestle, Hindustan Liver, Colgate - Palmolive, Johnson & Johnson. No other indigenous company has built such a well-diversified product portfolio. It has grown more than ten times in revenue in last one decade. The company has extensive sales channel including Future Group, Reliance Retail, Hyper City and Star Bazaar as well as leading e-commerce platforms.

The first ever success of an indigenous company in the field of yoga and Ayurveda has revived the age old system of indigenous knowledge and practices of medicine having roots in ancient Vedic literature, neglected for centuries for various reasons. Information and communication technologies play a vital role in the revival and steady growth of such establishment. People's cultural values and beliefs also play an important role in this process. Use of modern technology in processing and packaging the ayurvedic products tremendously helped not only in popularizing these products but also enabled to compete with MNC's products in the globalized Indian market. It coincided with the rise of cultural nationalism led by conservative political party of India and telecast of mythological soap operas on national TV followed by flood of religious channels in the very first decade of 21st century and his admirers in media houses prepared the favorable ground for the success of his ventures. Thus, the forces of globalization created competition in different systems of medicines in India in terms of developing a high degree of professionalism and quality in services and products in the field of medicine in India. Thus, Manuel Castells (2000) argument that global economy has capacity to connect or include in its system all those things which are valued seems to be true in this particular case, even the elements of a traditional cultural system.

In the second half of the 20th century, the medical services and care in the public sector as well as in the private sector were not up to international standards. As a result, many

affluent patients and politicians preferred to go abroad particularly USA for their treatment. However, in the era of globalization, tremendous development took place and the Apollo group promoted by Pratap C. Reddy during the late 1980s, has emerged as the largest private health care Corporation in Asia. In December 1999, the company expanded its operations by mobilizing capital from European, American and Japanese medical manufacturers to finance new ventures (Baru 2000). Thus, "The establishment of Apollo marked the entry of non-resident Indian doctors into medical care and signaled a recognition of a hospital as a corporate enterprise" (Baru 2000). It marked a transformation in the organizational structure of private investment in health care as well as the shift from single owner enterprises and nursing homes to corporate enterprises.

The tremendous development in medical profession of India made India today a home to host of top facilities, 'many of which also act as medical tourism facilities, attracting patients from all over the world" (Ansari and Khan 2014:65). Medical tourism in India is one of the best options available to the patients across the globe. A large number of patients visit every year for their treatment combined with the tourism in India conceptually termed as 'medical tourism'. "India now provides world class medical facilities in corporate hospitals specialized in multi-specialty health centres providing their expertise in areas of cosmetic surgery, dental care, heart surgery, coronary by-pass, heart check-up, valve replacements, knee replacements, eye surgeries, Indian traditional treatments like *ayurvedic* therapies" (Ansari and Khan 2014: 65). Health care is one of the India's largest sector in terms of revenue and employment, is expanding rapidly. One of the major factors for this phenomenon is low cost of medical treatment by world class doctors and smooth communication in English language as well as low cost of medicines, accessories and residential accommodation in hospital premise.

It shows that ancient Indian society had some sort of professions who had specialized knowledge and a specific educational institution called *ashram* to impart certain professional skills under the guidance of *rishis* and *munis*. In every field of knowledge there are references of some specific *rishis* in ancient *vedic* literature. These institutions were having liberal royal patronage from different rulers spread over in the whole Indian Territory and had very respectable status in the society. In the field of medical profession, solid evidence emerged out of Kautilya's *Arthashastra* where the reference of physicians is mentioned very clearly along with other professions. However, in post-Maurya period there has been decline in the profession due to continuous warfare between rulers of different Indian kingdoms. Later on with the advent of invaders the progress of indigenous knowledge and professional skills in ayurvedic system of medicine were hindered and the universities were destroyed. In the Mughal period, the Muslim medicine system, based on Yunani system, was promoted by rulers as a parallel system of medicine and hospitals were also established for the treatment of the patients. The major functionary was a hakim (physician). However, in long run, both the system of medicine developed harmonious relationship and exchanged their knowledge. During, the colonial period, western system of medicine was brought and established in India. This gave rise to a cultural clash between the locally rooted systems of medicines and the western system of medicine which considered as modernizer and looked local medicine systems unscientific and inferior. As a result, modern system of medicine progressed in colonial India and local systems of medicine gradually decline due to lack of protection but not totally vanished. After independence, the government preferred to promote modern system of medicine rather than indigenous medicine. However, some efforts in private sector helped the survival of Ayurvedic and Yunani systems due to their cultural roots in two major communities of India, namely, the Hindus and the Muslims respectively, who still have some faith in these systems of medicine. The medical profession in

India, thus became stratified, the modern doctors having a very high prestige and status and the traditional *vaidyas* and *hakims* having relatively inferior status in the society. The modern doctors who were mainly employed in public sector or practiced in private clinics maintained high professional standards. Therefore, a steady growth of modern medical profession can be observed in the colonial as well as in the post-independence period. However, the medical profession in India was not well equipped with advanced techniques and equipment due to lack of funds and political will as well as organization bottlenecks in the public sector. The efficient manpower of doctors migrated to the developed countries, a phenomenon called 'brain drain'.

In mid-1980s the growth of private sector took a new turn when world-class super and multi-specialty hospitals started to establish with corporate structure as result of the shift in economic policies of the country. The NRI doctors were instrumental in establishing such hospitals in collaboration with the local capitalist class. The adoption of the policy of globalization helped in import of highly advanced medical equipment and technology in this sector. The establishment of pharmaceutical hubs in different parts of India made the the cost of treatment relatively cheaper without compromising the quality. This high standard of professionalism in medical profession reversed the trend of medical tourism. Earlier the rich patients and the politicians used to visit foreign countries for their treatment but in the era of globalization patients from abroad began to visit these super and multi-specialty hospitals for their treatment. Thus, globalization has contributed significantly in achieving high standards of professionalism in private sector of medical profession. The medical facilities even in the small and medium level private nursing home and hospitals have improved tremendously in post-globalization period. These developments contribute in the high growth of Indian economy in last two decades. However, the two sectors of medical profession in India – the public and the private- have been fragmented and stratified. The private sector has developed and providing medical facilities to the rich section of the society, while the public sector medical institutions are now meant for the poor and marginalized sections of the rural and urban areas. The public sector institutions are gradually on the decline while the private sector institutions are on the rise. Therefore, the medical profession in India has on the one hand a group of doctor having high salaries and world-class infrastructural facilities and easy working conditions, while on the other, are the public sector doctors who are relatively less-paid and have hard working conditions affecting their professional commitment adversely. Another important consequence of the globalization and communication revolution in India is revival and a steady growth of an Ayurvedic company which succeeded in competing with established MNCs of foreign origin by transforming its technology and packaging techniques and using the faith belief of the local population in Ayurveda and yoga on the one hand and aggressive media advertising strategies on the other.

It is now clear from the above discussion that the medical profession in India has passed through various stages and now is restructuring and transforming itself affected by the process of globalization. Globalization has positive consequences for the professionals working in private sector hospitals and developing high standard of professionalism among them. Simultaneously, it has adverse impact on the working conditions of the doctors serving in public hospitals thereby generating low level of professional commitment among them. Theoretically, it supports the observation of Giddens (1998) that globalization may have positive consequences for one sector but negative consequences for another sector. Manuel Castells (2000) observation that global economy has the capacity to simultaneously include and exclude the people and places is also relevant in this context. The revival of traditional system of medicine through the process of globalization is an example not only of the process of inclusion of traditional medicine system in

global economy but also succeeding in a steady growth in its turnover. Thus, globalization does not essentially promote the forces of modernization but may also help in popularity and revival of traditions, if they are valuable for the growth of global economy. Moreover, globalization can also lead to stratification within a profession by having differential consequences as in case of public and private sector of medical profession in India.

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