

evidence could be used to consider the deletion of Section 5(ii) and Section 13, as these appear to be used in a gender-discriminatory manner. Their application is detrimental to the interests of women, and also does not fit with the modern understanding of mental illness and its curability or otherwise, taking into account the recent Supreme Court judgment (21). Further, it clearly violates the UN Convention on Rights of Persons with Disabilities, to which India is a signatory and is thus bound to implement the Convention in its domestic legislation. Third, the judiciary must be made aware of the need to adopt a more gender-sensitive approach to mental illness and divorce. Sensitisation activities should focus on the complex social, legal, cultural and medical factors that play a role in the use of mental illness as a ground for divorce in the Indian context. Finally, it would be interesting if future research could determine whether such patterns of the use of mental illness as a ground for divorce exist in other Family Courts in India, and even in South Asia. Data could be accumulated and fed into potential theoretical frameworks on mental illness and marriage (and divorce), thus strengthening the evidence that could then be used to facilitate advocacy and prompt an amendment to HMA.

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## Reflections on discrimination and health in India

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### Abstract

*This is a speculative paper on the structure of caste-based discrimination in India.*

*It sketches the field by a) proposing four empirical and historical examples of discrimination in different medical situations; b) suggesting an analytical framework composed of domain, register, temporality and intensity of discrimination;*

*c) proposing that in the Indian historical context, discrimination masks itself, hiding its character behind the veneer of secular ideas; d) arguing that discrimination is not some unfortunate residue of backwardness in modern society that will go away, but is the force of social hierarchy transforming itself into a fully modern capitalist culture. The paper then arrives at the understanding that discrimination is pandemic across India. The conclusion suggests that in India today, we need proposals,*

*hypotheses and arguments that help us establish the ethical framework for meaningful empirical research that sociological studies of medical ethics and the epidemiology of discrimination can pursue.*

*Its method is that of logical and speculative argument based on experience, with examples of different forms of discrimination to clarify the point being made.*

*No specific research was undertaken for this purpose since the paper is not empirically based.*

#### **Four scenarios of discrimination**

- In 2013, at a Medico Friend Circle meeting in Bhopal, I watched a 'sting' video of the treatment of a tribal woman in northern Chhattisgarh who went to a primary health centre (PHC) to deliver her stillborn child. The woman was made to deliver on the bare floor, empty beds in clear view. The placenta lay in a pool of blood beside the exhausted woman and the video covered several conversations between the functionaries, where they all refused to clean the floor. It was the woman's mother's task. Did the staff refuse because it wasn't their job, or because the woman belonged to an untouchable 'lower' community? Did they make her deliver on the floor because there wasn't a labour room, or because she couldn't be allowed to use the bed?
- The Musahar have been described as the most disadvantaged of the scheduled castes in Bihar and eastern Uttar Pradesh. This community has a disproportionately large percentage of cases of kala-azar in the country, and the disease is endemic to this territory (See Zachariah and Srivatsan, "What makes a disease marginal" in (1)). Kala-azar came into colonial Bengal from Assam, becoming a major killer in the wake of migration and the new settlements of indentured plantation labour in the nineteenth century. The hundred year history of modern epidemic forms of kala-azar is an example of a path of discrimination through research priorities, treatment options and a lack of interest in more effective methods of cure and control. What is the historical play of circumstances leading to the sustained neglect of this disease that has homed in on the most disenfranchised caste in this part of the country?
- In a preliminary investigation, my colleagues and I visited a local bone setting clinic in a small village called Kepal near Hyderabad. It was situated in a two bay garage that opens on to the road like a car service centre. Two doctors sat on stools in the bays amidst several patients milling around, waiting to see them. As we watched, a thin old woman (from an apparently agricultural labour background) with a damaged hip was helped towards the doctor. He carefully put his hand under the sari, and raised it all the way to the hip, palpated and then massaged the damaged area. The woman didn't mind the 'indignity' and she bore the pain of the massage. Some patients, when we probed them, said that as soon as their fracture was treated in a mainstream hospital and put in a cast, they came back to Kepal, had

the cast removed, the traumatised area massaged with an ointment and a crepe bandage put on. When we asked the doctor there why the patients did this, he said "Doctors in hospitals have good equipment and medicines but they treat without any human contact. The plaster cast also gets loose quickly and permits movement of the fractured bones, whereas the crepe bandage is regularly tightened." Another insight expressed by a colleague ran thus: "The patients distrust mainstream doctors and hate the treatment they get. Some say they would rather die than go to a hospital for any illness. They go to the Kepal doctor because he touches them, and shows interest in their problem, even though he rarely talks to the patient." Is the problem with the mainstream doctors described here one of discrimination against the lower caste, or is it rather a callousness toward the poor? Or is it due to the evolution of new imaging techniques that make touching unnecessary?

- Early March 2012, Anil Kumar Meena, an MBBS student committed suicide at the All India Institute of Medical Sciences (2). He was a tribal, with a good academic record, but had difficulty in understanding English. The teachers allegedly humiliated him instead of helping him. His performance dropped. He ultimately took his life. This was the second suicide in AIIMS in two years, and protesters said that nothing was done to improve circumstances. The administration denied that Anil was discriminated against because he was a tribal. The situation is worse than it appears. In 2007, the Thorat Committee Report (3) described extensive discrimination against SC/ST students in AIIMS, where 85% of the students reported that internal examiners wanted to know the caste of the students, and that they were blatantly discriminatory in awarding grades. The upper caste students too were openly aggressive against the reserved category. The opposition to such students is based on the conviction that they don't have merit (they didn't know enough English to understand the lectures and do the tests). As is well known, the phenomena of fatal discrimination and suicides in higher education extend far beyond AIIMS as an institute, and medicine as a discipline.

#### **Sketching a critical framework**

The scenarios described above don't exhaust the forms of discrimination that are encountered in India. I should also make it clear that I leave aside in this essay the large tract of discrimination that arises *due to* disease, as in leprosy, tuberculosis, AIDS and diabetes (for examples of such studies see 4, 5, 6, 7).

I argue here that discrimination is pandemic across India. It is a cultural trait that expresses itself in an infinite variety of forms. This is an attempt to grasp how discrimination operates in India.

#### **Domain, register, temporality and intensity**

What are the categories that would be useful to analyse discrimination? My first suggestions based on a reading of

the literature would be four: domain, register, temporality and intensity.

The term *domain* of discrimination could be used to account for the fact that there is a historical, social and/or structural dimension to the form of discrimination that gives it its specific character. To start with, in addition to caste and tribe described above, there are also the domains of discrimination on the basis of community (the Muslim community being an example *par excellence*), on the basis of gender, and on the basis of sexuality or sexual preference. I mention these domains here to open the terrain, but have not the resources to explore them. It would suffice, therefore, to say that they are marked as significant domains, and that the domain of caste and tribe are sketched out in this essay.

The term *register* of discrimination could be used to make a differentiation on the basis of whether discrimination is subjective, observed objectively by someone else, or measured as a statistic among samples of populations.

The term *temporality* could be used to denote the time span of the specific discriminatory practice as observed (8, 9). A sharply defined event of discrimination has an acute temporality. If it is continuously experienced, it is chronic. A historical temporality involves duration of decades if not centuries.

A useful fourth term would be the *intensity* of the experience – is it a pin prick, devastatingly hurtful, or even fatal? The intensity of discrimination can be experienced subjectively by an individual (public humiliation) and observed objectively in either an individual (lynching) or a population (demonstrated physiologically in disease, low birth weight, early death, or culturally in submissive conduct, clothing, etc.). This last is an expression of what Nancy Krieger (10) theorises as embodiment – the way the individual's body carries a history of the discrimination it has been subjected to.

In the case of kala-azar, the domain of caste discrimination is not seen or described in the register of a subjective personal experience, but may be measured in terms of population statistics. It has objective, measurable characteristics in the high percentage of cases of kala-azar among the Musahar. Its temporality is historical—over a century. Its intensity is sustained and complex, yet it is probably not understood as discrimination so much as fate and a lack of assistance from government.

The practice of the patients going to the bone setter is objectively observable, and can be interpreted as a subjective response to a chronic experience of discrimination in mainstream hospitals which results in an intractable distrust of modern medicine among a segment of the population. Both the poor and the middle classes go to the bone setter. However, the caste composition seems largely non upper-caste. There were some Muslim women too.

The case of the tribal student committing suicide at AIIMS and the problem of systematic discrimination unearthed

there demonstrate three important features. One, in this case discrimination occurs not in access to medical care, but in access to medical education; two, it is not at the fringes of society, but at the core of society in an exemplary educational institution; three, it shows how constitutional measures of inclusive policy through reservations are negated fatally through structural discrimination that occurs in society. In fact, I would argue that this kind of discrimination is a critical clue to the structure and function of discrimination in India.

In every case, discrimination is ultimately structural. As Krieger puts it, “random acts of unfair treatment do not constitute discrimination. Instead, discrimination is a socially structured and sanctioned phenomenon, justified by ideology and expressed in interactions, among and between individuals and institutions, intended to maintain privileges for members of dominant groups at the cost of deprivation for others” (10: p 301). This structural discrimination finds its way into an institution through the functionaries and habitants (students, co-workers, teachers, managers, employers, administrators, doctors) who carry out its deadly project, negating law and policy. As Harriss-White and Prakash (11: p 17) argue usefully, elite administrators mirror the wider social structure. “They are not prevented from expressing their ideological beliefs to colour their official actions and hence may deliberately act against the interests of dalits, adivasis, and minorities. Policies directed towards disadvantaged social groups may be neglected, under-funded, selectively implemented or completely sabotaged.”

The different domains of discrimination (caste, tribe, community, gender, sexuality) cannot be simply added or subtracted. Therefore the discrimination that may occur between an upper caste woman and a dalit man, a Hindu man and a Christian woman, or a Muslim man and a Hindu woman, needs to be qualitatively investigated in each case with an eye to its historical determinants and effects. As importantly, when one person suffers discrimination which can be attributed to more than one domain effect (for example the tribal woman who was forced to deliver on the floor in my first example) the discriminative result cannot be added arithmetically (tribal + woman). It has to be assessed in its actual complexity.

### Discrimination masks itself

In all but the worst instances, discrimination *masks* itself, sometimes as a logical and ethical expression of liberal thinking and, at other times, even as modern science. Thus,

- a) Discrimination against the “lower” castes in hospitals is explained away as the inverse of respect towards fee paying patients and is also criticised as secular callousness toward the poor. One, most often the poor belong to the “lower” castes. Two, these “free” patients are unquestioning subjects on whom young doctors improve their practical medical skills in government hospitals –again a form of discrimination.
- b) Doctors not wanting to touch “poor” (actually “lower” caste) patients may explain their behaviour as not

discriminatory by arguing that touch is rendered obsolete by modern medical imaging techniques.

- c) Discrimination against reserved category (SC/ST) students in medicine, as in other disciplines, is explained as the unacceptability of a "lack of merit" among them.
- d) Specific ailments (kala-azar is one of them, poisoning and snake bite are other examples) that do not affect the elite are marooned in the history of medicine (12). Victims who come from (labouring) 'lower' caste backgrounds are left with inappropriate forms of medical care and the secular explanation given is that research into appropriate forms of treatment is "not commercially viable."

Masking is not always cynical – it is often the way in which ethically unacceptable forms of conduct are ideologically justified. Masking becomes necessary because of what I will call the secular and universal promise of equality among all citizens in any modern democracy (see Habermas (13) for a discussion of the history of intolerance, discrimination and democracy in Europe). Independence and the adoption of the Constitution mark the watershed of democracy in India. On the one side, there is the internalisation and acceptance of the principles of democracy which challenge the individual to think according to the ethics of egalitarianism. On the other side, there is the complex history of discrimination according to the domains of caste, community, gender and sexuality. The masking of discrimination screens the failure of the promise of equality by providing secular reasons for exclusion such as poverty, lack of capability, etc. Masking is a sign of the gap between what one would feel urged to do ethically and what one does uncritically due to habit and culture.

### **Discrimination, wealth and power**

It is important to understand that discrimination in India is fully woven into political power, economic capability and social dominance. In other words, it is not some defunct residue in modern Indian society. Discrimination is the means by which a living hierarchy forces its "will" on society. As such it will inexorably survive and transform itself as it will also transform the character of Indian democracy. Forms of discrimination as we see them are actually caste Hindu elite strategies to ensure that they control and capture benefits of development and capitalist growth. These efforts, rather than be seen as some specific evil person's intentions, should be seen as the method by which the dominant castes on the whole maintain their privilege in modern capitalism in India.

An elementary assumption about modern capitalism in general is that the liberty of the market will eliminate the deeply entrenched social inequalities and ensure equality of opportunity. However, what is forgotten is that liberal capitalism too has a long tradition of discriminating against those who acquire any form of wealth or property they are not "entitled" to. In a market economy, the term property covers not only land, but also moveable forms of wealth such as durables and consumables. Even more, with the ferocious privatisation of education and healthcare, these too begin

to function as forms of property – you can only buy the education or healthcare you can afford with your own wealth. Taxing wealth or property and redistributing it in the name of welfare is equivalent to thievery in extreme forms of liberal capital and its cultures. The great resentment against those who benefit from welfare in the United States is an instance of this intolerance toward those who depend on the State for their well being.

In India, this form of liberal capitalist thinking marries happily with caste Hindu elitism, doubling and masking the latter's intolerance of equality. In the transition to modern forms of capitalist society, embracing liberal principles of the market means opposing anything the State does to help the poor survive (the poor are, of course, largely not the upper castes). Three examples: one, the attempt to provide food security is opposed in the name of market freedom. However, even the imagination of what food security should be, masks a caste cultural definition of what the "poor" (read "lower" caste) deserve: low quality PDS grain and nothing else. Two, the State's constitutional agenda to provide the Scheduled Castes and Scheduled Tribes specific help to cross the barriers of privilege is strongly opposed. Thus the upper caste resentment against reservations for SCs and STs in premier institutions becomes a call to battle against what is secularly called "the failure of merit." Three, it is for this reason too that patients who come for free treatment to public hospitals are treated with disrespect. The elite have over the past three decades moved away from public hospitals toward corporate hospitals which charge a fee that is unaffordable to all but their kind. When a governmental insurance (*Aarogyasri*) programme in erstwhile Andhra Pradesh sought to provide corporate healthcare to the poor, these hospitals immediately opened "*Aarogyasri* wards" so that the "fee paying" patients and the "free" patients were separated. Thus in different ways, well being becomes a property one is "entitled to", and a hybrid (both liberal capitalist and modern caste) form of discrimination works against the acquisition of well being if one doesn't already have it through caste privilege.

Discrimination causes uncharted damage to mental and physical health. It is common experience that discrimination affects those who escape its deadliest traps by burdening their already fragile bodies with illnesses (such as diabetes, hypertension) that are triggered and sustained by the chronic stress of facing a humiliating social environment. This effect is described as *allostatic load* (9, 14).

### **Conclusion: some directions for critical debate**

It should be clear by now what I mean by the proposition that discrimination is pandemic across India (see UNICEF Report (15) for a discussion of the extensive spread of discrimination). In this field of pandemic discrimination, it is futile to initiate empirical studies that try to establish whether discrimination exists. I say this with much respect for Indian studies such as Acharya (16), which tries to measure the extent of discrimination faced by dalit children in Rajasthan and Gujarat.

I have discussed this study elsewhere (17).

Immanuel Kant in his monumental contribution to modern philosophy separated the Critique of Pure Reason (about the domain and limits of knowledge and fact) from the Critique of Practical Reason (about God and the domain of faith, ethics and conduct, ie values). He argued that critical ethics and internal autonomy of an individual had to decide what the right thing to do was. The notion of God, spirit and faith were transformed into the modern secular ethics of conduct, in part due to the force of Kant's critiques. Philosophers today argue that it is impossible to find factual, empirical proof of failure of values from "unbiased" observation of facts (18). This is because our understanding of what is a fact is embedded in conventions and theories that carry implicit values. Specifically in our case, discrimination is the failure of the values embedded in the constitutional promises of equality and fraternity. The conviction that something is not as it ought to be gives rise to an ethical criticism. The decision to interpret a phenomenon in terms of an atrocity or outrage, ie, as a *form of injustice*, is fundamentally ethical. It can never be proven unless the ethical axiom underlying it, of what constitutes justice, is accepted. Therein lies the impasse – in the Indian context, the spirit of democratic equality and fraternity on the one hand and the culture of caste elitism on the other militate against each other. It is very difficult to get a consensus about a value when the field of caste power is against it. This is why in many cases an interpretation of discrimination is simply ignored as not based in "fact". At this ambiguous point in our history, we need studies of discrimination that come logically prior to the current investigations that follow empirical methods adapted from the biomedical sciences and epidemiology. We require explorations in the medical humanities that examine the ambiguities and masks that we use to hide discrimination from ourselves in specific expressions and cases.

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