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HOLISTIC AND HUMANISTIC: AN ANALYSIS OF WOMEN HEALTH NARRATIVES IN RURAL INDIA

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ABSTRACT

A female's physical and psychological being is structured around the roles of belief systems and shared culture. The stigma around women's health in India incorporates many factors, concepts, and theories. A woman's diagnosis is seen as biologically biased and the medicine in itself is gender biased in practice. The reductionist approach explains an illness through the biological lens and is not very favourable to women. Therefore, a holistic and humanistic approach recognises human illness as a whole concept with social, cultural, political, and personal factors. Medical humanities works around the social discourse, humanistic, and cultural dimensions of health. This paper studies two case studies out of rural India that speak comprehensively of possible prejudice and practices in the health sector. The research draws upon a conceptual study through a medical humanities approach. In Conclusion, the structures of biomedical discourses will be examined on how they can affect the agency of women's bodies and being, as well as how gender and illness coalesce to reflect upon a woman's suffering.

Keywords: Health, Medical Bias, Suffering, Medical Humanities

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1. INTRODUCTION

The experience of health and illness is not just a social phenomenon but also an innate connection to the body and self. It is a subjective experience of illness that builds the territory of physical discomfort under a medical practice, giving voice to the stories and suffering. "The stories that ill people tell come out of their bodies. The body sets in motion the need for new stories when its disease disrupts the old stories. These embodied stories have two sides, one personal and the other social," (Frank, 1997). Telling stories about illness reveals the psychic disruption a person faces in the medical brief process; it confronts a previously neglected physical and psychic self during the process of the event.

The art of medicine deals with the hopes and fears of humanity. Medicine approaches a wound with a specific treatment, thereby finding a cure for a disease to turn it into a story of illness. Every wound has a story; even the symbol of medicine narrates a story. The recognition of humaneness lies in an empathetic approach to patient-centred care which includes understanding their hope and fears, their social, cultural, economic and spiritual factors ascertaining their stories, not just knowing the medical symptoms and behaviour.

In the last few decades, there has been a paradigm shift in how diagnosis, prognosis, and therapy are understood, which calls for reconsidering the role of humanities in medicine. Theoretical reflections on medicine are lagging with the advancements in biomedical sciences. The healthcare sector has sparked concerns from academics, practitioners, and citizens about its overall direction and shortcomings. There was very little transparency about women's health a quarter of a century ago. Still, today it is a focal point with very self-evident questions concerning the body, narrative, illness experience, gender differences and the whole mapping of its genetics medically. The exploration to understand and improve women's health has been a complex mechanism in medical history. It has been subjected to various stereotypes and sexist and phallogocentric bases of medicine.

2. HOLISM AND REDUCTIONISM

The reductionism approach explains human illness through the biological concept that prioritises the role of science technology and pathologies in the medical experience. For instance, the birthing mother will be viewed as a patient who is completely under the authority of a professional obstetrician and his use of biomedicine, or anaesthesia. The trials and tribulations of a diagnosis seek a non-formidable response from a caregiver and doctor. There is a sense of reliability and trust that an individual seeks from medical grounds that form the base for any doctor-patient relationship and foremost humanity.

According to Smuts, "A whole is a synthesis or unity of parts, so close that it affects the activities and interactions of those parts, impressing on them a special character. . . . It is a new structure of those parts, with the altered activities and functions which flow from this structure" (Lefkaditou and Stamou, 2006).

On the other hand, Holism strives for wholeness in medical theory and practice; considering an individual's mental and social well-being. It perceives human behaviour beyond the biomedical discourse of action and framework. It believes in acknowledging all factors affecting an individual, which are psychological, physical, cultural, intellectual, social, and political, thereby transcending the one-dimensional list of follow-ups in a reductionist approach. The art of medicine involves humane encounters in a clinical setup, thereby reinforcing the importance of care and advocacy for patients.

"Medicine has never enjoyed full monopoly or police powers, and most healing, like charity, begins at home. The upshot is that doctors traditionally had to remember that he who paid the piper called the tune" (Porter, 1985). The healthcare sector had been bred with an attitude of working to make a patient survive. The basic structure of a survival instinct doesn't consider pain and a process in hand. It's quite direct and robotic. For instance, promising a painless delivery to a woman sounds like a mechanic and marketing approach that promises something that would seem practically impossible. Still, the in-depth acknowledgement of the whole process varies in reality. Research around gender and pain has escalated in recent decades. The pain severity has been researched concerning biological and psychological mechanisms and the studies conclude gender biases in pain treatments with several underlying factors. So, what can lead to a better prognosis among women and the self-reflexivity of their sexuality and illness?

3. ANALYSIS OF HEALTH NARRATIVES

Shella and Lata, are the two female Sugarcane workers from Beed, Maharashtra, who underwent hysterectomies, Struggling with post-surgery anxiety, depression, physical health, and Jyoti Prabha Kispotta, an RMP in Pashchimi Singhbhum district of Jharkhand. These two case studies deal with contrasting discourses that reveal the complexity of the medical practice and a derelict healthcare system that foregrounds its foundational challenges in rural India. The hopes and fears; of a female cane-cutting worker silently coping with post–surgery ailments of hysterectomy and a Rural Medical Practitioner (neither a qualified doctor nor a trained nurse) trying to save a sick woman who has been waiting to reach her for two days.

Sheela Waghmare, a 33-year-old woman lives in the suburbs of Rajuri Godhka village in Maharashtra's Beed district. She lives with her husband Maanik and their 3 children. Sheela has always complained of having insomnia accompanied by constant pain and crying. She says, "I always feel sad, anxious. After a pause, she sounds irritated. It all started after my *pishvi* [uterus] was removed. It changed my life forever" (Shiloni, 2022). A 20-year-old went through a hysterectomy in 2008 and since then; she has been suffering from constant pain, irritation, and pain that persists for a long period. Post-hysterectomy ailments are not scant in this part of Maharashtra. A hysterectomy done before the age of 45 years can lead to a risk of non-communicable diseases. This relevant data on a detailed inspection of hysterectomies among women is displayed below:

"The prevalence of hysterectomy among women >=45 years was 11.4 (95% CI: 10.3, 12.6), with higher odds among urban women (aOR: 1.39; 1.17, 1.64) and higher economic status (highest compared to lowest quintile: aOR: 1.95; 1.44, 2.63). Hysterectomy history was associated with four chronic conditions: hypertension (aOR: 1.51; 95% CI: 1.28, 1.79), high cholesterol (aOR: 1.43; 1.04, 1.97), diabetes (aOR: 1.69; 1.28, 2.24), and bone/joint disease (aOR: 1.54; 1.20, 1.97) and higher odds of any hospitalisation in the past year (aOR: 1.69; 1.36, 2.09)" (Desai and et al., 2023).

Hysterectomy is a complicated procedure with adverse short and long-term consequences. After undergoing a hysterectomy, hormonal imbalances may lead to depression and anxiety in addition to physical symptoms. Sheela travels to western Maharashtra to harvest sugar cane for approximately 16 to 18 hours a day following the surgical procedure. She said, "Working during *paali* (menstruation) was difficult, I would change the cloth pads at the end of the day's work and fully soaked, blood would be dripping from it" (Shiloni, 2022).

No mandatory tests were done before surgery, like blood tests or biopsy and her uterus was said to have holes in it. She was told in a straightforward manner that she had only 6 months to live due to cancer. Sheela reluctantly consented to undergo surgery that very day. The hysterectomy was performed without adequate scanning or tests. Hysterectomy, the removal of the uterus, is a complicated procedure; its prognosis varies differently for different women, depending upon their age group and personal history. This requires attention that brings humanities practice into medical procedures to work and understand the well-being of a patient beyond a lethal list of diagnoses and treatments of the medical sector. "The (re)conceptualization and (re)presentation of healthcare needs an outlook on the social position of public health. Social position shapes individuals' unequal experiences of the social determinants of health" (Olstad and Mclntyre, 2019). Relevant factors concerned with a certain subgroup's biological and behavioural patterns in a social position have varied risk factors working differently at different levels. Sheela socially lives and works in a community where they migrate daily. "The medicine does not help with the emotional upheaval. *Asa sagla traas aslyavar ka mhanun jagaava vatel* ? [With all these troubles, why would I feel life is worth living?]" (Shiloni, 2022). Infections from poor menstrual hygiene are common, and treatable with simple medications. Opting for a hysterectomy is a last resort in case of cancer, uterine prolapse or fibroids.

Sociocultural beliefs about femininity and masculinity also appear to be an important determinant of pain responses among the sexes as pain expression is in general more socially acceptable among women, an effect that may lead to biased reporting of pain. In a study by Robinson and colleagues, both men and women believed that men are less willing to report pain than the typical woman and such gender role expectations may contribute to sex differences in experimental pain (Bartley and Fillingim, 2013).

Ashok Tangde, a social activist from Beed, revealed the majority of these surgical procedures are conducted at private hospitals and says that "it is inhuman how doctors perform a serious surgery like hysterectomy without any medical reason" (Shiloni, 2022). This reductionist approach to medicine leads to a pathological medically oriented diagnosis which is not compatible with cultural psychologically oriented illness. Illness is different from a disease, disease focuses on the biomedical process of the body i.e. bodily discomfort whereas illness focuses on the 'subjective perceptions', giving symbolic meaning and identity thereby connecting the whole process to the body, society and self.

Lata Waghamre, who lives just six kilometres away from Sheela's home, shares the same story. Lata says, "I don't feel like living", "I don't feel like working, I just feel like sitting and doing nothing, "Sometimes I keep milk or *sabji* on the stove, and even if it's overflowing or burning, I don't react." Lata is a 32-year-old woman, she got her hysterectomy done at the age of 20 and her post-surgery ailment resulted in a Lata who seems more obscure, grumpy, moody and abstaining from any sexual overtures. The women who are working as sugarcane cutters in the Beed district have common problems and diseases to share.

Another case of a Rural Medical Practitioner (RMP) in Jharkhand is written by a famous poet and activist Jacinta Kerketta. This drives us deeper into a holistic approach to women's health making 'health a matter of faith'. Jyoti Prabha Kispotta has been providing healthcare services for 10 years in Paschimi Singhbhum district of Jharkhand. "She is neither a qualified doctor nor a trained nurse. Regional surveys indicate that over 70 per cent of healthcare providers in rural areas in India do not have proper medical training" (Pulla, 2016).

Scoffingly RMP is referred to as *jhola chhaap* or (quack) doctors. These unqualified Practitioners are labelled as 'quacks' and uncertain in academic and government policies. Graci Ekka, one of Jyoti's patients expresses her reliability on Jyoti over a government nurse in the Primary health care centre. She said "It was 2009 and I was pregnant with my first child. The baby was born at midnight. The only woman with me at that time, apart from my old mother-in-law, was Jyoti. I had severe diarrhoea after childbirth and was feeling weak. I had lost consciousness. Jyoti was the one who took care of me all through" (Kerketta 2022). The nurse at a Primary Healthcare Centre (PHC) sits once a week and it offers basic facilities where normal patients having a fever are checked. "Pregnant women do not visit the PHC. They seek Jyoti's help to give birth at home" (Kerketta, 2022). Sheela and Lata too received no medical advice on the possible side effects. "I became free from periods, but I am living the worst life now" Sheela says (Shiloni, 2022). So the question is what has a medical treatment solved for women like Lata and Sheela? It keeps them alive in a world where they don't want to live anymore. The Economic Survey (2013-14) by the Department of Finance of Jharkhand government reflects upon the data of Primary Healthcare Centre, that shows the fall clearly:

The situation has not changed for a decade now. The Jharkhand Economic Survey 2013-14 noted a shortfall of over 65 per cent in the number of Primary Healthcare Centers (PHCs), 35 per cent in sub-centres and 22 per cent in CHCs. The lack of specialist medical officers is one of the most alarming issues, the report said. Over 80 to 90 per cent deficit was noted among obstetricians, gynaecologists and paediatricians at CHCs, confirmed (Jharkhand Economic Survey, 2014).

An acute understanding of the current healthcare system, according to Carson and Cloe, is of utmost importance to make Medical Humanities a sustainable supporting tool for the medicine's culture and practices. The commercialisation of the healthcare sector led to "dehumanising tendencies . . . not enough time to see patients; technology that shifts attention to machines rather than patients; growing incentives to put profits above patients; a biomedical reductionism that attends to pain but not suffering and to disease but not an illness" (Carson and Thomas and Cloe, 2014).

It isn't any more a debate about reductionism vs. holism. It is about the feeling as Ron Miller notes, "To be a person is to be a complex whole which is greater than the sum of its parts or roles." Theorising and defending are not enough, a patient's case should be considered concerning larger humanistic concepts that give meaning to his or her life and medical experience such as his/her culture, beliefs, social status, family, and community. Attention (selecting and integrating sensory input from the external and internal environments) plays a major role in the experience of pain. A cardinal characteristic of pain is that it has a unique ability to captivate and hold one's attention. The patient who has suffered a significant injury or disease and fears a recurrence of the pathology may be constantly on the alert for any physical signs or pains associated with the feared disorder. Another curious property of pain is that attention directed to it typically exaggerates its aversiveness (Pennebaker and Epstein, 1983).

An illness is a behaviour whose symptoms are perceived before its assessment and action by the person who feels and acknowledges some discomfort in their well-being. This behaviour is influenced by social patterns and belief systems which form an arrangement with concepts such as, "shopping" (trying multiple sources of medical care); "fragmentation of care" (treated by a variety of medical practitioners at a single source of medical care); "procrastination" (delay in seeking care following recognition of symptoms); "self-medication" (repeated attempts at self-treatment and home remedies); "discontinuity" (lapses in treatment or interruption of care). (Young, 2004)

Therefore, the question arises, why does medicine still come up desperately short when dealing with pain in women? A combination of systems, unconscious bias, a lack of research as well as a failure to acknowledge biological differences in how women process pain has led to pain being dismissed, misdiagnosed or underrated leading to lethal consequences despite advances in healthcare. Women were diagnosed significantly later across over 700 diseases and in some cases waiting up to 10 years for the right diagnosis, for instance in conditions like endometriosis. Sometimes women's pain is often wrongly attributed to psychological causes; it was only in 1980 that the term hysteria was removed from the American Psychiatric Association's DSM classification conditions that primarily affect women including pain. Focused research is less likely to be studied in clinical trials which makes effective treatments difficult to find, even medical products used only by women like the oral contraceptive pill are based on male bodies and male hormones to this day. We don't know how women metabolise and react to various pain medications and how women experience or manifest

pain, the efficacy, dosage, and side effects of many analgesic medications were never tested on women leading to drug dose, and gender gaps for various painkillers. Interestingly there's evidence suggesting that estrogen alters the pain perception and response to painkillers. This means there are sex differences in the way women perceive pain, so it's imperative that we treat the pain the patient has and not the pain that we think the patient should have.

4. CONCLUSION

In the World Economic Forum 2021 report, India's gender disparity rank is 140 out of 156 countries. This ranking reflects the country's performance in areas such as health and survival, economic opportunity and participation, academic achievement, and political empowerment. Rural healthcare in India is less developed compared to urban areas, leading to higher health risks for women, including high-risk pregnancies, menstrual-related issues, anemia, and UTIs. "For instance, in India only 22.3% of women participate in the labour market, translating to a gender gap of 72%" (World Economic Forum, 2021). The events recorded in history reveal what has been alive, recovered, will perished but will never quantify it. Sir William Osler says "To serve the art of medicine, as it should be served, we must first love our fellow man." Primarily the ending matters, in every story, no matter the journey, if the end seems happy the question of the journey never arises. A woman's journey through the whole treatment will not even matter if the results seem to be of a disease being cured successfully. Its aftermath is never a question or even put through a statement for say, the measure of its pain.

CONFLICT OF INTERESTS

None.

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