

# **Medico Friends Circle - Anecdotes from a journey of thirty five years (1977-2012)**

Ravi Narayan.

<b>Contents .....</b>	<b>1</b>
<b>1. An introduction.....</b>	<b>2</b>
<b>2. The Alternative value system: an ongoing commitment .....</b>	<b>3</b>
<b>3. A social analysis of Alternative Health Care Approaches.....</b>	<b>4</b>
<b>4. The National office comes to Bangalore.....</b>	<b>4</b>
<b>5. The Bhopal disaster and its aftermath.....</b>	<b>5</b>
<b>6. Reexamining Medical Education and beyond.....</b>	<b>8</b>
<b>7. Who is a Gandhian ? Who is a Marxists? Who is a liberal? – the identity debate.....</b>	<b>9</b>
<b>8. TB and Society : Constructing the social paradigm.....</b>	<b>11</b>
<b>9. Reviving and expanding the circle: A continuing challenge .....</b>	<b>12</b>
<b>10. mfc - a SWOT.....</b>	<b>13</b>

**References.**

**Appendices:**

<b>Appendix – 1 – Request to the mfc Convenor - 1984-85 (Patiala meeting paper-3).....</b>	<b>14</b>
<b>Appendix -2 Some questions and issues on the role of mfc –(Patiala meeting paper- 1).....</b>	<b>15</b>
<b>Appendix – 3 - Bouquets and brick-bats ( Patiala meeting paper -4) .....</b>	<b>20</b>
<b>Appendix – 4 - A review of the website for articles on mfc –organisational /personal.....</b>	<b>23</b>

## **Medico Friends Circle - Anecdotes from a journey of thirty five years (1977-2012)**

**Ravi Narayan**

### **1. An introduction:**

My association with the medico friends circle goes back thirty five years, when I was first introduced to the circle and invited to join it, by Anant Phadke, at a Science Policy workshop organized by the Society of Young Scientists (SYS), at the All India Institute of Medical Sciences in New Delhi, in 1977. I was then a post graduate student at the Centre for Community Medicine at AIIMS.

My 'baptism' into health activism had taken place through internship experience in an East Pakistan refugee camp in 1971, followed by an introduction to 'marxist dialectics' on the sidelines of postgraduate studies in public health and industrial health at the London school of Hygiene and Tropical Medicine from 1972-74.

From 1974, as a young faculty member at St. John's Medical College, I was deeply involved with early community health experimentation which included two field practice areas. The first was the Mallur Health Cooperative, selected later by ICMR in 1976, as one of the 14 alternative projects to the Primary Health Centre model in India. The second was by working towards Community Health Orientation in the tea plantation communities in South India, helping to evolve the Comprehensive Labour Welfare Scheme – both pre Alma Ata innovations in India. Apart from this I was also evolving as a social activist due to my close association with the 'social analysis and community development training' of the Indian Social Institute in Bangalore and participation in the SEARCH experiment in Bangalore. This experiment was to evolve the 'apprentice in development' concept supported by inside and outside learning which is well known through the book 'People in Development' by John Staley, SEARCH.

In all these initiatives, I seldom came across medical professionals involved in social/societal analysis or action and hence discovering a group like medico friends circle (not all medico's but a sizeable number of the initial core group had medical backgrounds) was an inspiring discovery. I felt a great sense of solidarity and generational collectivity. For 35 years since that encounter in 1977, mfc has remained a major link, influence, inspiration, point of reference, identity and most important a circle of friendship. (See blog in March, 2007 – "A roomful of friends". <http://narayanblog.blogspot.in>)

My association and linkage with mfc has also taken many forms over the last three decades. This broadly divides into an active phase (1977-1996) and a passive phase (1997–2012). During the active phase from 1977, I was also the national convenor from 1984-86 and bulletin editor at the same time – probably the only mfc member, who took on both the jobs simultaneously. This was possible because of the full support of Thelma and the CHC team, who saw our involvement and support as part of the CHC quest at that time. During this active phase, I also had the opportunity to play many roles- manager, campaigner, policy advocate, researcher, bulletin contributor, peace maker, fund raiser, agent provocateur, and active participant in discussion and dialogue. In the passive phase which started around 1997, I had got quite disillusioned by the 'thought current preoccupation' of mfc and its addiction to the 'discussion mode' with no concerted effort to shift into action mode – Bhopal and AIDAN not with standing. Therefore from 1998 along with SOCHARA members, friends and associates, we began to evolve an idea

that had been suggested in Thelma's doctoral thesis at the London School and later in our contribution to the VHAI report of the Independent Commission on Health in India (ICHI) which was as follows: (see box)

***Need for a Health Movement***

***"What is needed is a strong countervailing movement initiated by Health and Development activists, consumer and people's organizations that will bring health care and medical education and their right orientation high on the political agenda of the country. All those concerned about people's need and people's health will have to take on this emerging challenge as we approach the end of the millennium"***

- From CHC's contribution to ICHI report – VHAI -1998

This led to CHC/SOCHARA's deep involvement with first the International Poverty and Health Network (IPHN) and the health assemblies in Kolkatta and Savar; then People's Health Movement in India (JSA) and globally; International People's Health University; Global Health Watches; WHO watch; and the whole engagement with NRHM and WHR 2008 and WHO CSDH 2008. (A separate story).

While this was an inactive phase in terms of my own involvement with mfc, SOCHARA continued to promote the mfc linkage among all its teams and fellows, as part of an organizational commitment - encouraging them to read the bulletins, appreciate the collective analysis emerging out of mfc meetings, read the anthologies and attend mfc meetings. This ensured support and solidarity but in a more indirect way. It was also the phase of an inter-generational shift in SOCHARA, when the younger generation was taking over from the older folks and this gen-next including son and nephew were now active in mfc. Not surprisingly just 25 years after CHC hosted mfc, CHC team members – Rakhal, Sukanya, and Premdas took over as co-convenors for another period of CHC involvement.

In this reflection for the 40<sup>th</sup> milestone, I am presenting some anecdotes and some extracts from documents, just to give the present circle of members, glimpses of the past and a feel for some of the challenges and some unusual snippets from the previous years. These are drawn primarily from the active phase, particularly 1984 to 1987, when we were the national office of mfc. There is so much to share from the documents and the archives. This is just a small selection.

## **2. The Alternative value system: an ongoing commitment.**

The most inspiring characteristic of the mfc circle because of its roots in the J.P. movement of 1970's has been the commitment to build an alternative value system and to try and do it by "living it" rather than preaching it. The mat level simplicity of the Wardha meetings have always been an inspiring example and quite a contrast with the current pre occupation with five star meetings. Linked to this was the commitment to dialogue, plurality, non hierarchy, equity, marginalization, gender sensitivity etc and it was during the medical education anthology – chapter on alternative framework that we made an effort to list them out and link it to medical education in the future. (see box) In the older mfc manifesto's, a word about not accepting physicans samples from drug companies and not ragging juniors in colleges, was often included. The tradition of dropping 'Dr' from the names of medico's as a commitment to greater equality, were small traditions that were never preached but taught through example and passed on through oral tradition.

## **An Anthology of Ideas- from Medical Examination Re Examined – 1991**

***“8.9c- Analysis of values of hierarchy, expertise, individualism, professionalism, glorification of technology, respect for money and status and other such values which are integral part of the existing curriculum ethos, and medical practice....***

***8.9d – Exploration of alternative values like collective work, democracy , demystification of medical knowledge and technology, transfer of skills to other health workers, autonomy and so on..”.***

In 1982, Thelma and I spent six months of the year on a Bharat Darshan in which we visited many of the mfc core group members in their own villages /projects and this has remained one of the most inspiring impressions and foundational experiences before we began the journey from medical college into SOCHARA. We visited Wardha, Sevagram, Mangrol, Ahmedabad, and met Ullas, Abhay, Rani, Anil, Daksha, Ashok, Nimita, Ashvin, Hanif, and many others of the core group and most important learning was this commitment to an alternative value system. Even today while many of us in mfc may not be necessarily exemplary in our practice of these elements of a alternative value systems, what is significant is the effort by many members and the circle in general to live by this values inspite of social /societal pressures at individual and institutional level to do the contrary. While gender sensitivity and gender equality are part of this commitment I some time have a doubt that an inadvertent patriarchy continues. (Perhaps a survey of mfc spouses may not be bad idea.)

### **3. A social analysis of Alternative Health Care Approaches**

In the early years of my involvement, I found the commitment of mfc members to understand the deeper social context and political economy of community health action including the analysis of well known projects and experiments - a great learning experience. The meetings in Jamkhed- Ahmednagar; RUHSA-Vellore; CMSS - Hoshangabad; and others were very insightful and the interaction with the initiators/innovators was a very serious and committed affair dialogue. Learning from this sort of ‘visiting seeing and dialogue’ was a very welcome engagement. Many of these initiators became supporters or contacts of mfc as well. Since my interest was in alternative health care approaches, I found this questioning, learning, from action and perspective development process very satisfying. One of the best debates about this issue is Chapter 18, of the mfc anthology – Health care which way to go? . This chapter is also entitled - Medico friends circle which way to go. I have enjoyed reading it several times and it also helped us in SOCHARA to understand the dialectics of alternative health care strategy versus alternative socio political change. Quoting from one of this articles, we have always appreciated this diversity and tried to internalize it in the balance of our action reflection process within our work. In the box there is a quote which from our red book taken from an mfc source. ( See box)

#### **THE ROLE OF THE COMMUNITY HEALTH MOVEMENT**

***“a movement towards community health can therefore be a bridge between the ill founded euphoria of the alternative health care project enthusiasts and the inactive cynicism of the socio-political activist, building a new common and more mutually supportive process”***

#### **4. The National office comes to Bangalore**

The story of how we became the national office of mfc handling both convenorship and editorship in January 1984, is an interesting one. Thelma and I had just left our faculty jobs from St. John's Medical College in December 1983 and were planning to attend the mfc annual meet on Medical Education in Calcutta in January 1984. Having been teachers in a community oriented medical college, we had participated in the preparation of background papers and some of the pre-meet discussions. We could however not attend due to some sudden local constraints. At Calcutta meeting both Anant Phadke, the convenor and Kamala Jaya Rao, the editor conveyed their decision to complete their term (probably at the end of their tether, not unusual with mfc responsibilities!) In a very unusual development, we were unanimously selected (in our absence) as two mfc members currently unemployed who could take over these responsibilities and we have always believed that Anant was part and parcel of this unusual decision. We were thus informed that the core group had agreed to our unanimous nomination. We were a bit overwhelmed by this sudden collective recognition and while we were beginning to evolve the CHC agenda, four weeks after we had co-initiated it, it is true that mfc hijacked the CHC team for two years from January, 1984 till January, 1986. I took over somewhat reluctantly as a convenor- editor and Thelma agreed to be publisher of the bulletin and our team members agreed to be committed supporters of a national network office!!

Members can peruse bulletin No 97-119 and 2 additional unofficial news letters of Dec 1985, and Jan- March 1986, to get some understanding of the phase when CHC became national mfc office as well. The bulletins reflect the shift our team tried to infuse into the 'thought current' by focusing on action, interactive dialogue, news from the field, keeping track of publications, placements available, etc to make mfc more 'alive and networking and engaging and acting'. The Bhopal involvement, the birth of AIDAN, the TB dialogue, Medical Education engagement and Environmental health dialogue were all actions that got a boost during this phase. Some participatory reflection on roles and responsibilities especially the Patiala discussion also took place in this phase. The table taken from the background paper of the Patiala discussions gives an overview of the wide range of roles, that a thought current was beginning to think about. ( see also appendix -1)

#### **POTENTIAL ROLES FOR MFC (The Patiala Discussion – 1985)**

- a) Evolving /evaluating alternative health care strategist at field level.
- b) Critical evaluation and analysis of national health programmes and health care approaches.
- c) Acting as a forum for raising health issues and organizing campaigns.
- d) Monitoring health policies and playing a watch dog roles.
- e) Influencing health policy by lobbying and legal action.
- f) Medical activism which would include organizing people around health issues.
- g) Investigative research with a critical social perspective.
- h) Documentation, collection, review and dissemination
- i) Participating /linking with other groups in a health action network.
- j) Consultancy/support work for community health projects.
- k) Organising field orientation for medicos and others to sensitize them to broader social issues in health.
- l) Building stronger links with members through sharing of experience and evolving common perspectives.

## 5. The Bhopal disaster and its aftermath

The Bhopal disaster was in some ways, a major existential experience for mfc because it precipitated a strong action response in a thought current that had resisted such active responses in the earlier phase. While we were discussing 'TB and society' in Bangalore during the annual meet in January 1985, at Indian Social Institute, facilitated by the Bangalore team we received a urgent telegram from some ngo friends in Bhopal who were missing the meeting because they were involved with acute relief and disaster response effort. The Bhopal disaster, one of the worst environmental health disasters in history had taken place on 3<sup>rd</sup> of December 1984. The telegram was sent 7-8 weeks later when relief workers were still not clear what they were dealing with and the government was bungling through the challenge. While ICMR and others had mounted some field study to understand the local health challenge the government had imposed the official secrecy act on the researchers since this was also a major medico legal problem, involving corporate culpability. The relief workers had no idea of what the initial research findings were and the telegram requested mfc to send a research team to help bring some clarity in the relief operations. What followed has been reported in two bulletins - 109 – **The Bhopal Disaster** and 112- **Medical Research in Bhopal – are we forgetting the people?**. Smaller reports and news is available in all the bulletins of that phase after the Bhopal involvement began.

It was an unusual experience for mfc and included – initial visits by Abhay, Rani, Mira, Sadgopal and others; followed by a planned research study under the leadership of Anil Patel, (the first in mfc history); studies on women's health by Satyamala and others; the Eklavya/ mfc Hindi comic based on the research study (probably one of the best examples of people oriented knowledge translation efforts of our times)- all this is part of our published research history.

The Bangalore team had another set of challenges which included - raising funds for mfc research team (ultimately from the science movement in Kanpur); bringing together a team of mfc researchers from all over the country, mostly women to Bhopal; handling police surveillance and CBI questioning due to a mischievous report by the opposition linked to Union Carbide that we were terrorist creating trouble in the slums; letters to prime minister and chief minister using public interest litigation strategies to get mfc members released from police stations lock ups – arrested because they gave thiosulphate injections on the recommendations of ICMR to ameliorate the sufferings of the people of Bhopal!; secretly negotiating support from ICMR leadership and scientists to support our study including an unofficial visit to ICMR head quarters to present study findings and get their support; handling the concurrent tensions during and after the Patiala meeting when this surveillance became somewhat challenging including being followed by IB officials during our public bus rides and so many more interesting challenges when the state suspects its own citizens! This is all part of unwritten history and oral tradition waiting to be documented. Any volunteers!

The box item shares is a wonderful piece by Shiv Viswanathan and Rajni Kothari in the Lokayan bulletin which is probably the only piece of scholarship that has recorded not only the work of mfc but the anthropological significance of the mfc approach. The full article – "The imagination of a disaster" in Lokayan bulletin – volume 3-4 – On Survival – 1985-86 is a must, must read!

## SANE AND COMPASSIONATE SCHOLARSHIP - THE MFC STUDY:

**“Between the muteness of the victim and the propagandistic erasure of the state stands the voluntary organization.**

Voluntarism attempts to create an ethical space, an ecological niche where the victim as survivor marked by the stigma of the disaster can grieve, mourn remember and recover. But the voluntarist is more than a mourner. He realizes that the victim becomes in the aftermath of a catastrophe, the focus of a grid, the huge apparatus of health and social welfare seeking to diagnose, survey and map him out. He seeks humanize and even alter the structure of such an expertise. One example of such an attempt is the effort to alter the relation between doctor and victim in Bhopal. The voluntarist realizes that much of the formal language of medical expertise is caught in the mechanics of cause and effect. He seeks to transform the idea of a clinical gaze, where the patient is spread out like a table of symptoms, into speech with its more encompassing concern for signs, symbols, and symptoms. Through this he hopes to articulate the victim's conception of his own pain. One strategy adopted in Bhopal was to move the site of analysis from a formal organization like a hospital into the bastee itself. In the hospital the patients is an isolated unit. Now he is a part of the community. Rather than being based on a formal reading of symptoms, cure and relief now become part of the socio- drama of a community. The doctor listens while the patient enacts out his pain amidst a chorus of familiar actors. Typical of such a strategy is the work of Medico Friends Circle (MFC) Its report completed in May 1985, is **probably the most sane, compassionate piece of scholarship on the problems of relief in Bhopal.**

The MFC describes itself as a circle of health interested professionals united by the belief that the medical system in skewed in preference for the rich. It seeks to demystify medical expertise. *decommercilaize medicine, emphasizing community orientation of health care.* Its basic survey was undertaken between 19-25 March 1985. Its aim was three fold. It sought to uphold the idea of an expert as trustee, of science as publically available knowledge. It articulated the pain of the victim and his/her idea of relief into a more integrated plan for medical rehabilitation. Thirdly with true anthropological reflectivenss, it shows how conceptions of the patient, ideas of cause and effect, diagnoses and cure form an integrated consciousness, a gestalt as it were.....

....The MFC and other groups thus challenging the restrictive notion of health articulated by the government. The latter seemed to read the disaster in mere physical terms. What it refuse to see was the psycho – social dimension of the disaster. “ Thousands of people have experienced mass death, mass morbidity, mass migrations, disruption of family and social life, and escalation into an acute socio- economic financial crises and literally a loss of moorings in society. Such an experience is bound to manifest itself in psychological, somatic and psycho- social morbidity whose long term management will probably be more crucial than treatment of physical ill health and disability”!.....

.... It is this anthropology of gestalts that is fascinating about the report. What is offered were two clusters which deserve further explanation.

1. Patient as a analytical grid	Patient as Person
2. Clinical gaze of the doctors	Victims speech aids diagnosis
3. Focus of diagnosis is the hospital	Focus of diagnosis is the community
4. Diagnoses as mechanics of cause and effect	Diagnosis as an analysis of inter- relations
5. Pulmonary Model	Cyanogen Pool Model
6. Anti Thiosulphate	Use of Sodium Thiosulphate as a critical tool

- *Shiv Viswanathan with Rajni Kothari, Lokayan Bulletin, 85-86*

An interesting development not known to mfc members is the intellectual challenge that Bhopal presented to mfc members, who were involved with the disaster responses. Four members were inspired by the Bhopal disaster involvement to train in Epidemiology. Thelma, Satyamala, Ashwin, and Karuna went to London School in sequence to get an M.Sc Epidemiology degree. The LSHTM was the only institution then, offering a full time course in this discipline. Thelma went one stage further and made a political statement with her M.Sc thesis on Bhopal, being published with the help of Padma in the Economic and Political Weekly rather than in an international peer reviewed epidemiology journal, so that science and activism could converge and SOCHARA's commitment to 'scholar activists and activist professionals emerge'.

#### 6. **Re-examining Medical Education and beyond .**

In the early 1980's the mfc decided to explore medical education with the idea of evolving a more relevant curriculum for the country. In the initial discussions there was some despair that with the Medical Council of India was not open to alternative curricula and hence this exercise may be a dead-end one. Zafrullah of GK project, Bangladesh, then invited mfc friends to do this homework with a promise that they would seriously consider the alternative curriculum, if GK's plan for an alternative medical school evolved. He also planned a conference inviting many mfc members to present papers. mfc began the exercise – which led to a series of six papers by mfc members for the GK meeting; reflections by many other mfc members; and a very interactive and participatory meeting in Calcutta in 1984, involving many junior doctors and interns as well. All these efforts and papers then led to the evolution of the fourth Anthology of mfc entitled – '**Medical Education Re- Examined**'.

Just as the anthology was being put together, Ulhas, Thelma, and I – the only three medical college teachers in the core group suggested that the anthology would remain just a set of provocative reflections if we did not evolve a final composite piece that medical college faculty could reflect upon and consider as a definitive 'alternative curriculum'. We then studied the current MCI guidelines -1992 and evolved the **chapter- 13 – An anthology of Ideas**. This chapter used the same headings and subheadings as the MCI guidelines and extracted from all the papers- ideas, and suggestions under the following themes - preamble, objectives, admission criteria, duration, medical curriculum, design, selection of teacher, examination, internships etc. To supplement this effort- one more **chapter -14 - Recent initiatives** towards alternative highlighting fourteen other innovative initiative and experiment were included to create the context and enthusiasm for change. Unlike the three previous anthologies, the Medical Education one was probably the first and only one in mfc history that offered the main stream a clear alternative that could be immediately acted upon.

These two final chapters – 13 &14 proved to be, as expected, the most read chapters by deans and faculty, when 125 copies of the anthology were sent to then 125 deans of medical college as a follow up initiative by SOCHARA. The deans were able to grasp quickly the major difference and paradigm shifts suggested by mfc, leading to three medical schools inviting us to operationalise these ideas. This is a story we have shared in the bulletin 264-265 in 1999. (<http://www.mfcindia.org/mfcpdfs/MFC264-265.pdf>).

In the preamble of the alternative curriculum evolved by mfc , we have described the community oriented primary health care doctor and I have always found this section 1.6 very inspiring and courageous in its positioning. (see box)

#### **THE MFC DOCTOR**

*“The community oriented, Primary Health Care doctor is by no means a ‘basic’, second rate , or low –skill doctor as is made out by the protagonist of the conventional curriculum. She /He needs greater competence and capability to work in the community and has to develop multidisciplinary skills, knowledge and attitudes far beyond conventional medical boundaries. Her/His specialist colleague, while certainly being necessary for delivering highly technical, medical services, has the disadvantage that she/he can function only at secondary and tertiary levels with an array of infrastructural and technological and senior peer group support. But in the present system she/he is at best a glorified technician . This shift of emphasis is basic to the development of the community oriented doctor.”*

#### **7. Who is a Gandhian ? Who is a Marxists? Who is a liberal? – An identity debate.**

In 1985 a group of mfc friends who had stronger commitment to a more orthodox framework of Marxist analysis in health and who were also very active and supportive core members of the mfc as well as members of the editorial board of the bulletin informed me as convenor that they wish to start another journal with a more orthodox Marxist social analysis, to reach out to other progressive sections of health activists, who felt the orientation of the mfc and its bulletin was somewhat more centric and perhaps too plural. Their serious and very genuine communication to all of us as they explored this idea led to a heated debate in the mfc about the relevance of such an initiative. Some members interpreted it as a potential crisis – between the Gandhian’s and Marxists in the group

These two ideologies were the main groups from which most of the mfc members of those days emerged. While most members appreciated the plurality of the group this initiative caused strong reactions. Some felt it was the beginning of a split, a common feature in many social movements; others thought it seemed impractical since many members of this group were also member of the mfc bulletins- seeing conflicts of interest between the bulletin and the journal etc. As convenor during this phase, I was challenged to try and sort this matter out amicably. I could see no threat, or conspiracy and not even incongruence – infact I saw it as a healthy and creative challenge. In the dialogue process there was some some light but mostly heat and the July 1983 meeting in hot Hoshangabad became hotter. I still remember taking the philosophical position- who is a Gandhian? Who is a Marxist?, who is a liberal? An exercise was planned asking all members to describe each other member on a slip of paper - Gandhian or liberal or Marxist. All sorts of interesting combinations emerged. As convenor I got equal number of slips with mfc colleagues describing me as a marxist, also Gandhian, also a liberal. This exercise carried the day and all of us realized the meaninglessness of such labels or labeling

#### **WHAT IS MFC?**

*Mfc is a progressive broad front between socially conscious medicos of all kinds- from Gandhians to Marxists. We come together with a certain minimum understanding and stick to the common perspectives during our discussions. Each one has to keep his/her own ideology/jargon a bit more to one self and operate, discuss within the parameters of the common framework of medico friend circle. It is through this tradition of restricting oneself to the common perspectives and language during discussion that mfc has been able to hold together politically diverse elements on a common platform. Admittedly this does reduce the sharpness of analysis to a certain extent. But bringing together medicos fundamentally critical about the medical system of India is today a very important task that some organization must take up. Mfc has evolved as such a kind of organization.*

*FIRSTLY, we feel that persons from different (but basically pro-people) background scan together for a meaningful discussion if all of us observe certain norms. If every body completely sticks to his/her framework and political language then different people would talk in different language and a meaningful discussion would become almost impossible.*

*SECONDLY though almost all members of mfc are socio-politically oriented, we have kept directly political issues out of our discussion and confine it to the politics of medical care only. As we go nearer to the directly political question, differences, emerge sharply and a common consensus cannot emerge. It would therefore be better to refer to general political issues only if they are directly related to the point being discussed. Within a broad pro-people consensus, there are bound to be difference of opinion and they are indirectly linked to politics. But if different groups/individuals coming together start 'exposing' each other politics, then the purpose of mfc meeting would be defeated; there would be political polemics and not a discussion on the topic. AS an organizers of such discussion, we are concerned to see that these discussions are fruitful and the above lines may please be read in that context.*

*From a letter written to all socially conscious medico in West Bengal – Anant Phadke, October, 1983*

The group was allowed to evolve the Socialist Health Review (SHR), which ran for 5-6 years and then after a break metamorphosed into the Radical Journal of Health (RJH) and ran for a few more years, till it wound up on its own. mfc had survived its one and only serious potential split with the consensus decision that the mfc bulletin could live in peace with the Socialist Health Review! I have always felt that this firmly established the Gandhian 'yin' and the Marxist 'yang' of mfc.

In the box item above, Anant Phadke's note on the role of mfc sent to a group of students in West Bengal in 1983 preparing them to host and participate in an mfc meeting, shares this very succinctly. In the box item below there are extracts from SHR and RJH sharing their objectives.

#### **SOCIALIST HEALTH REVIEW**

" This periodical is a collective effort of many individuals active or interested in the field of health or interested in health issues. The chief aim of the journal is to provide a forum for exchange of ideas and for generating a debate on practical and theoretical issues in health from a radical or marxist perspective. We believe that only through such interaction can coherent radical and marxist critique of health and health care be evolved".

#### **RADICAL JOURNAL OF HEALTH**

" The Radical Journal of Health is an interdisciplinary social sciences quarterly on medicine, health, and related areas published by the Socialist Health Review Trust. It features research contribution in the fields of sociology, anthropology, economics, history, philosophy, psychology, management, technology, and other emerging disciplines. Well researched analysis of current developments in health care and medicine, critical comments on topical events, debates and policy issues, will also be published. RJH began publication as Socialist Health Review in June 1984 and continue to be brought out till 1988".

## **8. TB and Society : Constructing the social paradigm**

TB and Society was the theme evolved for the annual meeting in Bangalore in 2005. Apart from a series of background papers – a staple feature of mfc discussions and dialogue - a new idea was experimented with. Many of us felt that mfc was always talking to itself – to other activists and to those who thought similarly. There was need to talk to the mainstream and to policy makers as well. There was a need for a policy engagement. To operationalize this we initiated a dialogue with the National Tuberculosis Institute and the Ministry of Health and invited some of them to join the dialogue. It was heartening to record that NTI and MOH sent experts to the dialogue. This created a positive image of mfc as a sort of constructive group which had moved beyond the process of criticism and critique to helping evolve concrete alternative proposals and framework. The NTI folks have never forgotten this dialogue and several NTI directors through a process of oral history have had very positive opinions about mfc and hence NTI is the only government institution which agreed to provide facilities to host an mfc meeting later ( the meeting on Public Health in 2006).

The dialogue identified four groups of factors while understanding causes of TB-patient related, doctor related, drug related, and society related and four types of action including system development, community involvement, new partnerships and tackling social determinants of health. In a SOCHARA paper by Thelma and myself published in the Imperial college book - Tuberculosis – An Interdisciplinary Perspective, we have constructed a social paradigm using the mfc meeting and Mira Sadgopal's summary as our starting point. This paper often referred to as the DOTS to COTS' paper, owes its inspiration to the mfc dialogue further strengthened by Thelma's doctoral thesis on policy analysis of TB control in India. In the box this social paradigm is highlighted.

### ***The Social Paradigm***

***“it was evident at this meeting that if the factors responsible for the occurrence, spread and maintains of the disease were social and societal then the responses needed to be social /societal as well. This shift of emphasis would not only change the frame work of the tuberculosis control but would lead to a broader frame work of educational effort to support action towards control..... The sustained success of our efforts will however, be determined by the extent to which we understand and respond to the challenge of the social paradigm and the creative nature of our supportive educational response. The way forward is a paradigm shift from ‘Directly Observed Therapy Short Course’ (DOTS) to ‘Community Orientated Tuberculosis Service’ (COTS)”***

This experience of understanding TB and its social paradigm helped SOCHARA in its subsequent search for understanding social paradigms and the role of social determinants in communicable diseases- Malaria, Vector Borne diseases, HIV-AIDS, Diarrhoea, ARI- Arthropod

related viruses, NCD's and other health challenges moving beyond the bio-medical model. Later we applied this to women's health, substance abuse, and occupational and environmental health. During one of the more recent phases of mfc when it was led by the triumvirate of Prabir, Madhukar and Anand we supported them during this phase, to particularly continue this search for social determinants in communicable and other diseases. mfc had showed the way!

#### **9. Reviving and expanding the circle: A continuing challenge**

mfc has always had a dialectic tension about its initial formulation as a thought current. While all of us have appreciated the need for serious reflection, listening to many points of view and evolving a comprehensive critique of a health problem or health challenge of our times, there has been a continuous sense of dissatisfaction about the resistance to action which often leads to debate, dialogue, some times even dissension. This has been going on for a long time and I particularly remember the build up to the Patiala discussions in 1985, which was provoked by papers by Anant and Ashvin and responses by Abhay and others on questions such as - Why are we discussing role?; What are the questions and issues before us?; What are the roles we would like to play?; and what are the alternative strategies and experiments?; and what could be the role of the bulletin?. In the appendix 2 we share the compilation of the questions and issues before the Patiala meeting in 1985. Have these issues and questions changed or are they still relevant?. During each of these moments of review and reflection mfc would get a series of bouquets and brick bats from members and all those who participated in the discussions. Appendix -3 is one such collation before Patiala which includes some feedback from elders like Prof. Banerji,(JNU); Prof. George Joseph (AIIMS) Prof. K. Ramachandran, (also AIIMS and later ICMR) and from newer members Sanjay Nagral, Brahmaputran, Kelkar, and a strong brickbat from Newton as well. All this makes very interesting reading. Some times the issues are the same!

#### **10. mfc - a SWOT**

The linkage with mfc has been a significant component of my personal journey in community health and also in the journey of SOCHARA and many of its members. I have shared just a few anecdotes with some documents or extracts from them. There is a lot more? If the 40<sup>th</sup> year reflections are spread over the whole year- perhaps one could share some more anecdotes and notes at a later date.

I would like to end this reflection with a personal assessment of what I feel has been some of mfc's strengths and weaknesses. Also in today's situation what are some of its opportunities. For it to be a sustainable and viable group – what are the threats? **(These are only my personal view and not a collective view in SOCHARA)**

**Strengths:**

mfc's key strengths are its commitment to open, transparent, serious dialogue and its culture of friendship which helps people to hear other voices which are different, dissenting or with opposing views.

The friends circle ethos is also exemplified by the gentle, peer pressure, camaraderie and non hierarchical style, in which all those who breach these boundaries and etiquette of communication between friends are handled. The email dialogue of 2012, saw two such breaches of communication between mfc members, handled with collective solidarity, sensitivity and humaneness.

Interestingly whenever two or three members with mfc links are invited into a larger government or ngo committee then this friends circle ethos takes over and the committee experiences greater openness and dialogue. It has to be seen to be believed!

**Weaknesses:**

While a 'thought' current is a very significant concept and the serious dialogue without the frills and diversions of current conferences, result in some very significant background papers, critiques, and position papers, the tendency to just enjoy a really good discussion and dialogue and most often not plan to do anything with the output – proceedings or declaration or statements seems an increasingly self defeating objective.

Are we just talking to ourselves? Are we just satisfied with perhaps reaching mfc or EPW? (Both of which have a selective readership). Should there not be a concerted effort to reach out to policy makers, opinion leaders, younger generation of health professionals, and health activists, etc more pro-actively. I have often found this attitude very problematic. Sometimes the focus is on critique without suggesting concrete alternatives. Very often you come across younger members or recruits who find this predilection for non action quite demotivating. I think mfc should ensure that atleast some follow up is done after every meeting and the proceedings and background papers are distributed more actively and some forms of advocacy and knowledge translation to many more fora is planned for proactively with a small committee of members wherever possible to facilitate such engagement.

Another weakness due to this resistance to action perhaps is the lack of any effort to learn from the action of individual members of mfc, who are deeply involved with field action or engaged with health policy and programming. A large number of mfc members are linked to the task forces of NRHM; many have participated as experts of the Health and AYUSH steering groups of the Planning Commission or are advisors at National and state level or engaged in other capacities. Many facilitate training and research initiatives and many facilitate networks and social initiatives. If mfc learning from them was possible in some proactive way, even if perhaps just through a website or a special e-group of policy and or action engagers it would add a further credibility to mfc and root its discussions and perspectives with field and policy making reality- thus enhancing relevance and context.

As the 12<sup>th</sup> plan health document was being evolved many mfc members were participants of special working groups and steering groups. It is interesting to note that a mfc member became the global coordination of the People's Health Movement secretariat in 2003 and a few weeks ago, a mfc member became the co-chair of the Global Coordination committee of People's Health Movement. Are we tapping all this rich experience?

### **Opportunities:**

The recent engagement of mfc with the whole national pre-occupation with universal health coverage and its active engagement with members of the High Level Expert Group ( HLEG) of the Planning Commission and its output of over 20 papers or more, has been an opportunity very well used and greatly enhanced mfc's credibility at many levels. The involvement in Bhopal and medical education was responsive but not sustained.

In the last decade there has been a national revival of interest and commitment to public health education and inspite of an annual meeting on this theme there has been little follow up in the mfc circle and there by missing many opportunities. In the last few years there has been efforts to define 'public health' for the Indian context; evolve lists of public health skills and competencies; many MPH courses and diploma courses have evolved in new and older schools of public health and medical colleges; civil society sector learning programs like Public Health Resource Network (PHRN) and the Community Health Fellowship of SOCHARA and others have evolved but the mfc committee set up to evolve an alternative public health curriculum has been not functional. A major missed opportunity even though some mfc members had been involved in other capacities.

I hope the involvement with UHC will be long standing, strategic and a sustained one with advocacy and campaign to promote the UHC model and approach we feel is relevant to the country. Linking our thinking with action at different levels is urgently required. Simplistic formulations by different sections of civil society and the sensational contributions of media not rooted in multidisciplinary evidence, are reasons for mfc's role to take the UHC debate to a campaign stage. Critical and strategic analysis becomes even more relevant and necessary.

### **Threats:**

There is a sort of revival of spirit in mfc ever since the UHC process began and the recent planning and writing of background papers for Hyderabad conclave has also been very significant. However whether we are really engaging with multi-sectoral experience, multistate realities, and with a new generation of younger health activist who seek action and not only perspective, or we are still caught up in an old paradigm of reflection without concerted action- only time will tell. The 40<sup>th</sup> milestone can be a time for nostalgia, celebration and reflective documentation of history. It can also be the beginning of a new realism and a commitment to reflective action.

### **In conclusion:**

What ever is decided or happens to mfc after Hyderabad it is important to endorse at the 40<sup>th</sup> milestone, that a friends circle, that could keep friends connected over four decades and continuously add younger and younger friends, has been a great experiment in inter-generational knowledge and inspiration transfer. Long live mfc!!

**(References to be added later)**

## Appendix-1

### REQUEST TO THE MFC CONVENOR 1984-85

The role of mfc can be discussed in abstract. It can also be seen in the context of the sorts of requests that come to the mfc convenor from different people, groups, organizations. The following is a list of request that came to the mfc office in 1984 and 1985. It gives some idea of the expectations of people who contact mfc for support, advice, action and solidarity. (Can we respond to all these? Do we have the collective technical know- how, organizational base or shared perspective to respond to these?)

Note: The classification is adhoc and does not represent any priorities. The list is also not complete.

#### 1. PARTICIPATION IN SEMINARS/WORKSHOPS.

Popularization of science ( KSSP, Trivandrum)

Science, Teaching and Education Policy (Eklavya, Bhopal)

Protecting the child consumer (Indian Academy of Pediatrics and CGSI, Gorakhpur)

Ten years after Hathi Commission (KSSP, Trivandrum)

Bhopal never again ( Consumer protection board and IOCU, New Delhi)

The Drugging of Asia : Pharmaceuticals and the poor ( IOCU, VHAI, ACHAN in Madras)

Peoples Science , Environmental protection and Democratic rights groups convention ( ZGKSM, Bhopal)

People for Drugs or Drugs for People ( Welfare organization, Jalpaiguri)

Health Workshop (TN Theological seminary, Madurai)

+Many meetings related to Bhopal and issues arising out of disaster ( various city networks)

#### 2. SUPPORT TO RESEARCH ( MAINLY INFORMATION, REFERENCES ETC)

Govt of India's Policy towards Drug industry (Research student)

Study of occupational injury among orthopedic patients in an ESI Hospital ( Medico Social worker)

Ayurveda and ancient medicine ( French Postgraduate)

Health Education in India ( German Research Student)

Medical Education in Bombay presidency (Medical College Professor, Bombay)

Appropriate technology in water supply and sanitation in India ( Geography Postgraduate, UK)

Drugs availability /marketing in the third world ( Oxfam researchers)

Occupational hazards of radiation in a factory ( Researcher from Kerala)

Drugs, Pesticides, Dams and Deforestations ( Oxfam campaign researchers)

#### 3. COMMUNITY HEALTH INTERVENTIONS

Planning Health Education programme in Urban slums ( Chetan, Delhi)

Support to trainers of Community Health Workers ( A NGO, Madras)

Course for school teachers and mothers ( mfc members, Calcutta)

Training of village Health Workers ( A NGO, Dharwar)

Survey of Tuberculosis in slums ( mfc members, Calcutta)

#### 4. SUPPORT TO MEDICAL/NON MEDICAL STUDENT INITIATIVES.

6 month special elective in community health, final year medico, CMC Vellore- (this was Prabir)

Community Health Project tour in Karnataka , Tamilnadu and Kerala ( Medical students group from AIIMS, New Delhi- This was Yogesh and friends who became the JSS group)

Community Health Development Project tour in South India ( Post graduate and friend, Karnataka)

Elective with mfc to get broader understanding of medicine (US students before joining medical school)

Public Health Committee of All India Medical Students Association requesting for ideas for action by Medicos.

Exhibition on Alternatives- including Jamkhed, Astra Medical Student group, Calicut

Medical Students Debate on Health issues ( students group, AIIMS, New Delhi)  
Permission to print mfc articles in student union magazines ( Several medical colleges in Kerala)  
Voluntary placement in mfc related hospital or rural projects ( Psychology student, US)  
Elective in Mental Health ( Psychology postgraduate, Chandigarh)  
Study tour of NGO's in Health Education in South India ( French Students)  
Lecture discussion by mfc members for medical students group, New Delhi.

**5. MISCELLANEOUS/UNUSUAL:**

Discussion on social movement at rural level, Drugs and environmental issues (representative of French India solidarity group)  
Education Foundation in Gujarat requests for mfc members to give lectures at community science centre in Saurashtra.  
Technical support requested from medical group working with refugees from Srilanka.  
Information for All India Science and Technology- Directory.  
Requests for initiating National Dialogue on building rural health delivery systems and comprehensive assistance for low income rural mother and children ( preliminary reports from an NGO in Gujarat)  
Charitable Trusts requesting for contacts with groups in Rural Health Education ( a UK registered Charity and a family trust in Bombay)  
Members in State govt. Health Services requesting for ideas to tackle the system  
A doctor couple ( both ophthalmologists) interested in voluntary social work – request for ideas.  
Support to People's Health Forum in Madurai formed as a result of inspiration from mfc.  
Pediatrician asking for thought provoking articles on Community Health for his Department staff (Medical College Aurangabad)  
Material on Tuberculosis for continuing education of church related medical coordinating agency.  
Solidarity with Third World Action network for information dissemination.  
Request from consumer group to study baby food, sale practices, ( Consumer Guidance Society, Bombay)  
Request from German Drug action group in drug campaign against German multinationals.

**6. MFC LINKED ACTION/CAMPAIGN/INITIATIVES:**

Writ petition against import of injectable contraceptives  
Epidemiological and Socio Medical study of Bhopal Gas victims  
Rationality study on Antidiarrhoeals  
Study of pregnancy outcome in Bhopal  
Rationality study of Analgesics and antipyretics  
Circulation of a note on communication strategy on health issues in Bhopal  
Participation in the evolution of a comprehensive medical care strategy in Bhopal  
Technical support to NGO's and action groups in Bhopal  
Circulation of note on Health Services in tribal regions to get collective response  
Circulation of WHO document on government and voluntary agency participation to get collective feedback  
Technical handout on Sodium Thio-sulfate treatment for doctors and NGO's in Bhopal  
Health Education pamphlet and comic for gas disaster victims in Bhopal  
Anthology of articles related to medical education generated by mfc sources  
Fact finding report on medical relief and research in Bhopal.

## **Appendix – 2**

### **SOME QUESTIONS AND ISSUES ON THE ROLE OF MFC**

Notes on the discussion at Patiala – July 1985.

The discussion in Patiala was an opportunity to reflect on and discuss together the papers of ANANT PHADKE and ASHVIN PATEL which were featured in the special mfc bulletin nos 100-1 in April – May 1984 and to consider the issues raised by ABHAY BANG in a recent letter which had been circulated before the Patiala meeting. A short report of these discussions was featured in mfc bulletin 116-7 ( Aug-Sept 1985). The following minute is an attempt to highlight the questions/issues/comments raised during the discussion so that a dialogue /discussion initiated so that a dialogue/discussion initiated in Patiala can continue.

To help learn from past debates on some of the issues, it was decided that old timers would support in current debate by reporting on earlier debates as and when they became necessary.

#### **PART-I: WHY ARE WE DISCUSSING ROLE?**

##### **SOME PROBLEMS:**

A problem we face is that mfc core group members are too busy with their local pre-occupation and do not respond as actively as they could /should to common organizational/action issues. Bhopal has been an exceptional example but even here the question of how much we should get involved and how organized are we for such interventions come up. Another problem is that we are geographically too dispersed to effectively take up common action. A third problem is that we are also members of other organization many of which are involved in action.

##### **SOME QUESTIONS/ISSUES:**

- i) Should all our expectations are priority interest be met from mfc?
- ii) We should look at which other organizations or networks similar to mfc are doing and indentify either clear or specific role for ourselves. Is this more realistic?
- iii) The pamphlet gives a very broad perspective and it is expected that each of us are promoting this perspective through discussion and action in our local areas. Is This really happening?
- iv) An individual we may be doing it on our own. But can we do some of this collectively?
- v) We feel the need for a near full time convenor but are not willing to give more time organizationally to support a common endeavor. Is this realistic?
- vi) To ask what we can do as a group or agency... may be pos-ing a model that creates problems. But should it is be posed?
- vii) If the core group remains as pass, we as passive as it is at present ( exception of Bhopal intervention) then should be seriously decide what we can/cannot in the future?
- viii) Role identification is not just a convenor's headache it is necessary for all of us to reflect on this and share these ideas so that common priorities can evolve. How to do this?
- ix) Are we joining mfc because we think it has a role to play in health today or we joining it because we are already doing what mfc stands for?
- x) How many of us are really interested or are willing to give time for collective action? Without such collectivity how will the organization grow?
- xi) Should we look at the reality of health situation and identify a role in that context? Or should we put down our limitations and derive a role in that context.

- xii) Except for Bhopal mfc has not played a collective role actively. We have not reacted collectively to policy issues like drug policy, health for all by 2000. National health policy etc why is that?
- xiii) Many of our new members contacts and more recently form organization have great expectations from us. The pamphlet and the bulletin creates this aura. How do we size up to this expectation?
- xiv) There is a tendency to remember mfc only at meetings and forget it after we go from the meetings. Why is that ?
- xv) There is bound to be constant conflict between individual priorities and interests and organizational priorities and interest. How are we going to face this dichotomy?
- xvi) A key outstations is are we just a discussion group, a thi or an organization with a perspective beyond discussion to action also. This also means can there be an mfc organizational stand emerging by consensus? Or is there no mfc's but individual stands which have some degree of collectivity?
- xvii) Those of us who have felt that mfc should react/respond to certain issues why did they not react when they felt we needed to?
- xviii) If e ach of us are responding to issues in health care in our own ways, writing, lobbying, mobilizing etc is this not also a type of collectivity?
- xix) When each of us individually initiates some action around an issue even it is local, it is also mfc effort? How do we decide what is and what is not?
- xx) When we work in coordination with other groups or notice networks, there is often a degree of urgency in arriving at an mfc common stand. How does one go about getting this in a specific situation?

**PART II: KEEPING ABHAY'S LIST IN MIND COMPONENTS OF ROLE WERE IDENTIFIED:**

- a) Evolving /evaluating alternative health care strategist at field level.
- b) Critical evaluation and analysis of national health programmes and health care approaches.
- c) Acting as a forum for raising health issues and organizing campaigns.
- d) Monitoring health policies and playing a watch dog roles.
- e) Influencing health policy by lobbying and legal action.
- f) Medical activism which would include organizing people around health issues.
- g) Investigative research with a critical social perspective.
- h) Documentation, collection, review and dissemination
- i) Participating /linking with other groups in a health action network.
- j) Consultancy/support work for community health projects.
- k) Organising field orientation for medicos and others to sensitize them to broader social issues in health.
- l) Building stronger links with members through sharing of experience and evolving common perspectives.

**WHAT DO WE MEAN BY ALTERNATIVE STRATEGIES OR EXPERIMENTS?**

Do we mean those strategies or attempts that help us in our overall goal a more people oriented the health system which we set ourselves?

We need to identify problems and gaps in these strategies, formulate research programs to get over these problems, look at how such ideas can be practiced on a wider level; communicate our critique to sensitive sections primarily medicos and decision maker in health care and thus try to influence health care policy. A critical study is not enough. We must communicate our findings to sensitive sections for it to have real morning.

Medical education is a good example. What has concretely emerged from the discussion? Do we have an alternative medical education policy worked out if only in outline? If so how can we communicate to it?

- a) How do we critically evaluate existing policies or programs? Review of literature, case studies and our small field studies? Is it possible to anticipate changes in policy and lobby against it before it is finalized/formulated?

From (a) and (b) the important issues which arise are:

- i) What can the role of the bulletin be? Could we write about our critical findings? Should it be the only forum through which we communicate our reflections?
- ii) Who are the key groups to which communication should be directed apart from members and subscribers? Should we send it to key decision makers? Should we keep health activist groups informed /updated?
- iii) This basically means that whenever we take up an issue we should identify the important target groups and evolve a specific COMMUNICATION STRATEGY. We have never done this specifically in the past. (Recently, however, the Bangalore team has done it with Bhopal reports, Bhopal issues of mfc etc. In Narmada problem influencing bureaucrats did help. Some lobbying with Inj. Contraceptives and TB issues of mfcb has also been done. In oral contraceptive issue senior politicians were useful, in the nuclear fuel complex issue letter to the Prime Minister was useful. From our own experiences, therefore communication/lobbying is important /useful.)
- iv) Writing reports is not enough. We need to write different types of report, for different groups so that our arguments are demystified and available in the form to stimulate action.
- v) Another important policy issue will be the need for action/intervention meetings not just discussion. Just sensing out information is not enough. Bringing groups together to discuss findings so that sections by different groups together to discuss findings so that actions by different groups can merge is also an important task.
- vi) Should there be a greater result orientation in our efforts eg. Should we ask ourselves what critical information have we added to health activist groups in a year?
- vii) Another important question is regarding the "Critical Analysis" word that we use often. For whom is this analysis? Is it just intellectual stimulation or luxury? Do we suggest social relevant alternatives? Should critical analysis be an end by itself?

**FROM ALL THE DISCUSSIONS FIVE ROLES EMERGED AS OF GREATER PRIORITY:**

1. Critical analysis of policies and programmes
2. Evolving alternative strategies of health care
3. Lobbying /communicating with intention of changing policies etc
4. Support /sharing ideas/consultancy for community health interventions
5. Investigative field research.

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### **Appendix – 3**

#### **Bouquets and Brick bats**

I am getting more and more convinced that progress in community medicine is likely to come from the work of devoted individuals rather than employees of the system.

- **K. Ramachandran, Professor, Biostatistics, AIIMS**

At the outset let me congratulate the mfc team for their singular, contribution. You have once again proved what the voluntary sector can contribute and that too, in a crucial area where the public sector has not come upto this expectation.

The way the whole problem has been handled by those responsible including the administrators and the leaders of the medical profession does not leave the impression that their sections were guided by the true gravity of the situation and a real concern for the lives of these affected. The mfc report owes credit, more than anything else, for bringing this out. Yours is not an armchair critique but based on a serious, in depth on the spot community enquiry.

It behoves the scientific community at large and the medical profession in particular in their role as custodians of the health and wholeness of the community to exercise greater prudence of their stewardship.

Thanks once again to the mfc team and its leadership.

-**George Joseph, Ex Professor Community Medicine, AIIMS**

I too am deeply concerned why even the concerned community physicians have not succeeded in developing the sort of thinking which could be developed for NTP. I am hoping that people in mfc will be able to ponder over this issue and as a result of the deliberations we will have creative thinking from mfc which will influence health service development concepts and hopefully practices in India and abroad

( Jan 85)

My complaint with the study is that while giving so much of importance to the controversy on the cyangoen theory the mfc group has unwittingly drawn attention away from much more important aspects of the tragedy, even in conventional public health terms, besides of course there are very critical political economical and social dimensions. (June 85)

**D. Banerji, Professor Community Health and Social Medicine, JNU**

This letter comes after repeated readings published in different papers and EPW about your activities ..... I believe that you are also helping to strengthen the organizations which at present are putting unresisting struggles against the savage oppression of the state machinery. I express my solidarity with you in your fight against these oppressions and social evils prevailing in the present Indian Society.... I am a health worker residing in one of the remotest villages of Uttar Pradesh and while writing to you, hesitate a bit to ask you, whether you keep

yourself confined to only MBBS degree holders or not? I hope you will be friendly enough to make this communication two way.

**Amitava Choudhury, UP**

This is just to inform you that I would like to stop receiving the mfc bulletin and to explain why. There are so many reasons actually. But it boils down to this, that very few people can go through books like Health Care in India and mfc Still persist in having faith in radical socialism of any type. What penetrates throughout is the hatred of the human race, so cleverly disguised as the love of suffering humanity... It was Russel who applied the test to those who would destroy the present system.. to find out if they are creative or destructive.. find out whether they have a practical alternative or merely mouth slogans.

The world is divided into angels and devils, good men and bad. Everything is black and white, the rainbow is a mirage Human beings are tools towards a Marxist heaven, ruled by a (Marxist) intellectual criche, governed by the power of fear, hatred and propaganda.

Forgive my trito statement but I do not believe that good can come out of evil, that pestism and hatred can be creative. There is plenty that needs to be done.... So like so many before me, I too leaving the negative atmosphere.

**Newton Luis, Muvattupuzha, Kerala**

I recently read a handbook entitled 'Health Care which way to Go' published by mfc. I found several of the articles quite on grossing. The appendix related to the genesis of the group was to me specially significant. Being a superintendent of a 30 bedded hospital in a backward district.....

I am becoming increasingly aware of the limits of the therapeutic approach to health care. Additionally a constant entanglement with administrative problems and a growing alienation with actual clinical work (and thus the challenge of Diagnosis) is rapidly leading to a prone fossilization of my thought processes. Naturally I would like to avoid such a state of affairs..... therefore would request you to let me know something about your organization and just how I could participate in it atleast passively if not actively.

**-Ambar Kumar Gupte, Islampur, West Bengal**

Reactionary ideas and wretched trends are becoming powerful in the medical profession. A sense of inevitability and helplessness as regards the corruption is growing. Organisations like the mfc can actively be in the forefront of a struggle by the progressive sections amongst medicos to resist these trends. And this can only be done by actively taking part in struggles both inside and outside the profession for a more just and rational medical system.

We are trying our best to mould MARD into one such organization. With the help of friends like you all and magazines like MFCB and SHR we hope to do so.

**-Sanjay Nagral, SHO, Bombay**

Ours is neither a formal organization nor even a group. It is just a gathering of some 10-20 students moulded unconsciously to a common awareness just by living together in a hostel for 2-3 years.

Some six months ago an idea came into our common talk to think of some practical forms of activity which we can adopt in our future medical practice. And we decided without breaking the informality of our gathering to reprint relevant articles regarding health issues and to distribute it inside the whole campus. It was at this time that we got the mfc manifesto which we published in Nov 1983.

Regarding Fran ideas and suggestions- we hope that at least for few coming years we would be having nothing to suggest to mfc but to adopt from you and transform our awareness.

**Brahmaputhran, Calicut Medical College, Kerala.**

I am happy for having get acquainted with so many people who have shown an inspiring disregard for greed, for money affluence and power etc., I know these things to be not as absolutely rare as thought generally but meeting them was a pleasure if not something very astonishing.

I want to also convey my wish that I will be willing to undertake some sort of specific task for mfc. My own subjects of interest, work and some elementary research I am doing and some experiences ( other than with the Tibetan settlements) I will be willing to share when they become sufficiently worthy of being shared.

**-S.K. Kelkar, CMO of a Pvt Hospital, Madikeri, Karnataka.**

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**Appendix- 4**  
**Some Articles from past bulletins on mfc organizational issues and personal experiences**

**1973**

MFC: Learning experience

**1975**

Proceedings of the second all – India meet of Medico Friend Circle held at Sevagram on 27<sup>th</sup>, 28<sup>th</sup>, & 29<sup>th</sup> December **1975**. MFC Bulletin, January – February 1976. Issue No. 1-2, P5-6, 12.

**1977**

Proceedings of the Third All India Meet on MFC which held at Rasulia, Near Hoshangabad on December 25 – 27, **1976**. MFC Bulletin, January **1977**. p4-6

**1978**

Proceedings of the Fourth All India Meet of MFC held in Sewa Mandir Post Basic School, Kerala from 29<sup>th</sup> to 31<sup>st</sup> of December **1976**. MFC Bulletin, Feb. 1978. P4-6

**Ravi Duggal. Politics of III Health and Health Care. EPW,**

**1979**

Proceedings of Fifth Annual meet of MFC held in 26<sup>th</sup> – 28<sup>th</sup>, 1979 in School of Social Work – Kashi Vidyapeeth. MFC Bulletin, February **1979**. P4-5

Revitalisation of MFC: hard introspection – crucial decisions. MFC Bulletin, September **1979**-P3-6  
Changing emphasis of MFC. MFC Bulletin, September **1979**. P6-8

**1980**

VI All India Annual Meet of MFC at JAMKHED, 24<sup>TH</sup> – 27<sup>TH</sup> January 1980. MFC Bulletin, April **1980**. P5-8, 12

Proceedings of MFC General Body meeting held on 27-1-80 at Jamkhed and the core group on the next day. MFC Bulletin, April **1980**. p9-10

**1981**

VII Annual MFC meet held in RUHSA near Vellore from 30<sup>th</sup> jan. to 2<sup>nd</sup> February 1981. MFC Bulletin, March **1981**. P5-6

The Biannual Executive Committee Meet at Hyderabad from 26<sup>th</sup> – 28<sup>th</sup> June. MFC Bulletin, August **1981**. P3

**1982**

VIII MFC Annual Meet held at Yusuf Meherally Centre, Tara, near Bombay from 23<sup>rd</sup> to 25<sup>th</sup> January 1982. MFC Bulletin, December **1981**. P10

Mid – Annual Executive Committee Meeting held in Tilonia, Rjasthan from 29<sup>th</sup> to 31<sup>st</sup> August. MFC Bulletin, October 1982. P5-8

**1983**

The IXth annual meet of the Medico Friend Circle will take place at Anand, near Baroda Gujarath from 29<sup>th</sup> to 31<sup>st</sup> January 1983.

**1984**

1. Patel, A.J. *Ten years with mfc: My personal view*. Medico friend Circle Bulletin **1984**; 100-1:1-3. 10. Available from <http://www.mfcindia.org/mfcpdfs/MFC100-101.pdf>, Accessed on 27<sup>th</sup> October 2012.

Phadke, A. *Looking Ahead*. Medico friend Circle Bulletin **1984**; 100-1:4-5. Available from <http://www.mfcindia.org/mfcpdfs/MFC100-101.pdf>, Accessed on 27<sup>th</sup> October 2012.

Narayan R, Narayan T. *At the Hundredth Milestone*. Medico friend Circle Bulletin **1984**; 100-1:6-10. Available from <http://www.mfcindia.org/mfcpdfs/MFC100-101.pdf>, Accessed on 27<sup>th</sup> October 2012.

Organizational Development of Medico Friend Circle – A brief overview – (**Jun' 88**)  
X MFC Annual Meet held in CINI, Calcutta from 27<sup>th</sup> to 29<sup>th</sup> Jan. 1984

## **1985**

Notes on the discussion at Patiala. Background Paper I. July **1985**

Requests to the MFC convenor **1984-85**. Background Paper III

From letter to MFC. Background Paper IV

Role of mfc: on the ethos of mfc discussion..... Background Paper V

## **1989**

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