A Potential not Realized: (Isolated) Struggles by Medical Staff in Punjab, Pakistan

by

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Abstract

This thesis highlights the struggles of Young Doctors' Association (YDA), Young Nurses' Association (YNA) and Paramedical Staff Association (PSA) in Punjab as social movements making claims against the state to improve their professional/group situations along with the public healthcare system at large. Since the last decade, these associations have gained prominence and have received a lot of media attention because of their frequent strikes. The fact that the three associations struggle for similar basic demands and make claims against a common 'other', and that their members work in such close proximity both in terms of territorial space and work coordination, makes one wonder why they never come together to make integrated claims. Analyzing semi-structured interviews with members of the three associations, state health department officials, and public healthcare users, based in Lahore, the thesis will provide the reasons for a lack of coordination among the three associations. In a nutshell, it will reveal that the struggle of each group is different and has its particular logic and trajectory depending on the structural conditions it operates in. This results in different forms of reactions from each group that are somewhat irreconcilable. The structural dependencies and professional hierarchies also explain the differences in the extent to which each group goes beyond their group interest and makes claims for the improvement of healthcare system at large.

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List of Abbreviations

CM – Cabinet Member

CSS – Civil Superior Services

FCPS - Fellow of College of Physicians and Surgeons

HO – House Officer

MO – Medical Officer

OPD – Out Patient Department

PSA – Paramedical Staff Association

PG – Post-Graduate Trainee

PMA – Pakistan Medical Association

SAP – Structural Adjustment Program

YDA – Young Doctors' Association

YNA – Young Nurses Association

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Introduction – So Close Yet So Far

In 2007, in one of the oldest and biggest public-sector tertiary care hospitals in Pakistan, located in the city of Lahore, a young female doctor was assaulted by a patient's attendant and both got into a physical fight. Why did this happen? Because the biggest public hospital in Pakistan did not have the facilities to treat the patient in a timely manner. As she was the first person of contact, the attendant blamed her. The administration formed a committee to decide who was guilty in the conflict, and the doctor was suspended. Similar incidents of attendant and doctor fights were recurrent, but this one was the trigger point when the young doctors, those who have just completed their medical degree and are doing traineeships in hospitals, decided that something had to be done to curb such ill-treatment and disrespect of doctors. The young doctors protested against the reversal of suspension of the doctor and were successful. The power of collective action was realized, an organization to protect the rights of young doctors, Young Doctor's Association (YDA), was formed, and protests for pay raise and an improved service structure began. Since then, a Post Graduate (PG) trainee's pay has increased from $120/month to $700/month and public-sector young doctors at other levels have experienced similar significant pay increases over a short period of time. The struggle continues for a better service structure and now for better healthcare facilities for the patient. Seeing the successes of YDA, nurses were inspired. Aggrieved over the fact that countless nurses have not received promotions even after 15-20 years of service and that they are not paid what they deserve for their extremely hectic work, nurses organized to form Young Nurses Association (YNA). Through collective action, many were able to receive promotions and have pay raises. The struggle for better service structure still continues. The association of hospital staff, ranging from the technical staff that works in labs, dispensaries and operation theatres to manual workers such as hospital gardeners, sweepers and laundry workers, is called the Paramedical Staff Association (PSA). They also demand better pays and service structure.

Viewing these three separate struggles for the same basic demands and their proponents working in such close proximity both in terms of territorial space and work coordination, one wonders why they never come together to make integrated claims. Realizing the power of collective action in the form of occupational groupings, why do they not pool their resources to have even stronger collective power?

Student nurses and health workers take part in a demonstration | Carl Court/Getty

This picture is taken from a nation-wide strike of doctors in the UK in 2016 against certain proposed reforms in their pay structures. Although there were no demands that directly benefited the nurses, they joined the rallies to support the doctors under the banner of an overarching organization that bound them together - the National Health Service (NHS) (Collis 2016). In other instances doctors support nurses in their struggle: in a county in Kenya, doctors boycotted work and joined hundreds of nurses who had been protesting for three weeks demanding promotion and payment of delayed salaries among other demands ("Doctor and

Nurse Strikes"). In some instances, doctors and nurses have collaborative strikes. In Kenya, again, nurses and doctors had joint strikes in December 2016 for better pays and work conditions ("Kenya Doctors and Nurses strike" 2016). The instances of such and other forms of coalitions among various medical staff are numerous around the world. In Pakistan, however, such collaborations never happen. This thesis highlights the struggles of YDA, YNA and PSA in Punjab, Pakistan as social movements which lay their claims against the state, trying to improve their professional/group situations along with the public healthcare system at large. An exploration into the reason why they do not form coalitions will be undertaken in this thesis and will be helpful in explaining similar lack of coalitions in other places with comparable structural conditions. These separate but somewhat strong collective forces also have the potential to bring about significant betterment of the abysmal conditions the public healthcare system of Punjab is in, if they come under one overarching umbrella to make joint claims. An exploration into what prevents the formation of a coalition will also explain what limits the materialization of this potential for improvement of the system – an improvement that is direly needed.

In a nutshell, an exploration of the three associations reveals that that the struggle of each group is different and has its particular logic and trajectory depending on the structural conditions they operate in. This results in different forms of reactions from each group that are somewhat irreconcilable. Each struggles in isolation from others sometimes providing indirect support in the form of media statements and cover at the hospital when a group is on strike. The structural dependencies and professional hierarchies also explain the differences in the extent to which each group goes beyond their group interest and makes claims for the improvement of healthcare system at large.

Methodology

My research followed an inductive approach. I became interested in studying YDA and YNA because they are recently formed associations, formally organized in 2007 and 2010 respectively, and since then their strikes have been highlighted in the media. YDA in particular caught my interest because its strikes are massive and they have a notorious image: sometimes, as a last resort, they close down emergency service. During research I discovered that the paramedical staff also has an association which receives much less media attention. I had around 25 semi-structured interviews in total. My interviewees were YDA (Punjab) cabinet members (CM), YNA (Punjab) cabinet members and other doctors and nurses who are members of the associations. They were from three different tertiary care hospitals in Lahore, the capital of Punjab. I also interviewed the president of PSA (Punjab), an administrator of a hospital, some state officials from the state health department of Punjab, and two members of a leftist party in Punjab that supports the three organizations, particularly the PSA. I also interviewed a few people from lower socio-economic backgrounds who utilize the public healthcare because they cannot afford private healthcare. After the analysis of the initial few interviews, I geared the rest towards the direction of finding out if the professional hierarchy in the three groups translates into the demands they make and whether the three associations work together, if not then why.

It was impossible to comprehend the phenomenon on the national scale in the time and resources that I had, hence I focused on the associations in one province. Since all three associations have independent organizations in each province and since healthcare has been devolved to the provincial state level in 2010, taking the province as the unit of analysis made logical sense. I chose to base my research in Lahore, which has the largest percentage of tertiary care hospitals in Punjab where these associations are based. Moreover, many of the doctors I

interviewed were originally from other parts of Punjab who had come to Lahore to study medicine and had continued the training here or they had come for the training. Nurses from other parts of Punjab were fewer. They had come to Lahore after getting married and resumed their jobs here. These doctors and nurses were able to give me a glimpse of their associations' activities in other parts of Punjab also. Moreover, since Lahore is the capital of Punjab, the state offices are also located here. The young doctors that I interviewed were well spread out in terms of their professional ladder and included House Officers (HOs), Medical Officers (MOs) and Post Graduate trainees (PGs). The ages of nurses were well varied: they had been in the profession for at least seven and at most 25 years. Getting access to doctors, nurses and state officials was extremely hard. Because of their busy schedules some would simply refuse to be interviewed, others would make me wait for hours while some others would call me for an appointment and after hours of waiting ask me to return another day. Moreover, many of the doctors and nurses were initially very hesitant to speak up openly. Since the YDA and YNA members are in a constant conflict with the state and sometimes even receive threats from it, they were afraid that I might be affiliated somehow with the state. During the course of the interview they relaxed and opened up more. Some who had initially refused audio recording also gave me consent to record the interview half way through. Some information and incidents they shared were asked to keep confidential so I do not recount them here but refer to them in general terms.

Forthcoming

The professions and the social movements rarely meet in the literature as they are quite differently organized domains of collective actions, and sociology of profession has largely ignored the distinct forms of development of professions and their struggles in the post-colonial states. Terence Johnson wrote about their development in the former British colonies in 1972,

and the follow up has been scarce (Quah 1989; Gandhi 1983), certainly none in the case of Pakistan. And this already limited literature can only help understand the more developed professions such as those of doctors. The sub-professionals like nurses and paramedical staff in these regions – operating in completely different structural conditions compared to the industrialized nations – have been somewhat neglected in the literature and so have been their relations and interactions with each other. This is a gap that I seek to fill. Literature on social movements is very useful to explain the separate tracks of these 'professions'. An integration of these two distinct streams of literature will then be placed within the scalar analysis (Neil Brenner 1999; 2011). Combining the three rarely combined conceptual frames and filling the aforementioned gap in literature will be my contribution to the theory. With regards to practical contribution, an analysis of the three social movements with established platform having the potential to influence the public healthcare system of Punjab for the better, will help to see what is holding them back and whether they can let go of the differences to bring a positive change.

The thesis has four forthcoming chapters: Contextual Embedding, Theoretical Embedding, Analysis and Conclusion. In the next chapter, I will provide a brief overview of the healthcare system and conditions of Pakistan and how they affect different medical staff. I will then describe the composition, structure, objectives and activities of YDA, YNA and PSA. In the chapter on theoretical embedding, I will discuss the particular theoretical frame that I will be using to understand these associations – a connection of the conceptual frames of social movements with politics of professionalization embedded in the overarching frame of scalar analysis. The analytical chapter will discuss the three social movements as three different forms of struggle in three separate sections. This form is chosen to indicate how the three movements are separate struggles which cannot be analyzed together.

Chapter 1: Contextual Embedding – The Birth of the Associations

In a major tertiary care hospital in Lahore, a child not older than three or four years old requires a ventilator to survive. There is none available. A doctor inserts an artificial tube which is attached to a balloon into his lungs. His mother is asked to press the balloon continuously to save her child. She does it for three consecutive days, occasionally giving the responsibility to other family members, for if she stops, her child would die.

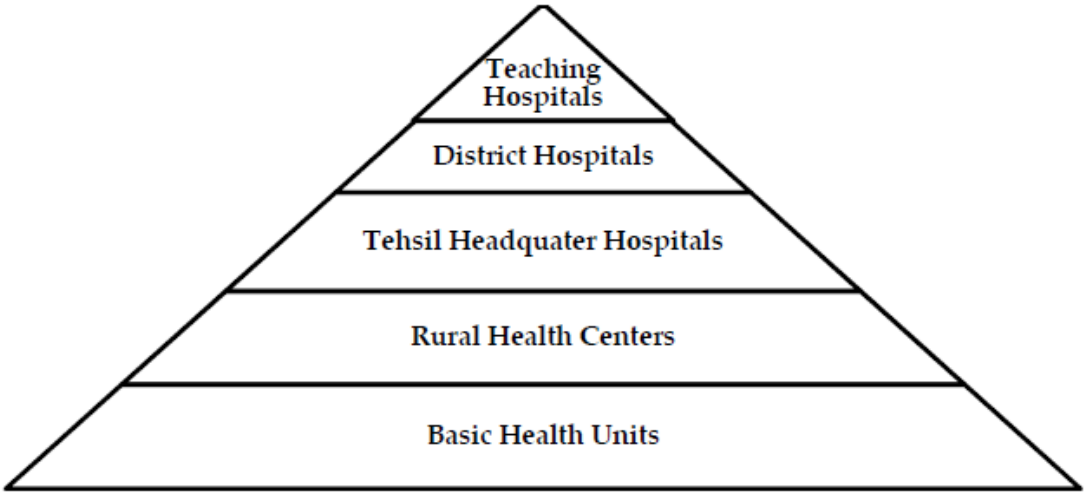
This chapter will describe the public healthcare system of Punjab highlighting its adverse conditions due to lack of funds and 'interest' by the government as a reaction to which the three associations develop. It will then discuss the status and conditions of different medical staff operating within this system and the objectives and structures of their associations.

Section 1.1: Public Health System of Punjab

There are two parallel healthcare systems in place in Punjab: general-government (public) and private. The public health system is decentralized to the districts so the central government in Lahore has an administrative role (Callen et al. 2013). Additionally, there are three substructures that make up the public health system in Punjab: 1) service delivery – where the hospitals are organized at various levels; 2) administrative side – which largely includes bureaucrats working at the provincial, divisional, and district levels; and 3) a monitoring system for these health facilities – which operates outside the department (Callen et al. 2013).

The following chart depicts different health delivery centers according to geographical division of the province:

Figure 1: Hierarchy of public hospitals in Punjab



(Callen et al. 2013: 251).

Public healthcare centers have the following numbers in Punjab:

- 2,461 Basic Health Units (BHUs)
- 293 Rural Health Centers (RHCs)
- 88 Tehsil Headquarters Hospitals (THQs)
- 34 District Headquarter Hospitals (DHQs)
- 23 Teaching/ tertiary Care Hospitals ("Punjab Health Department Website")

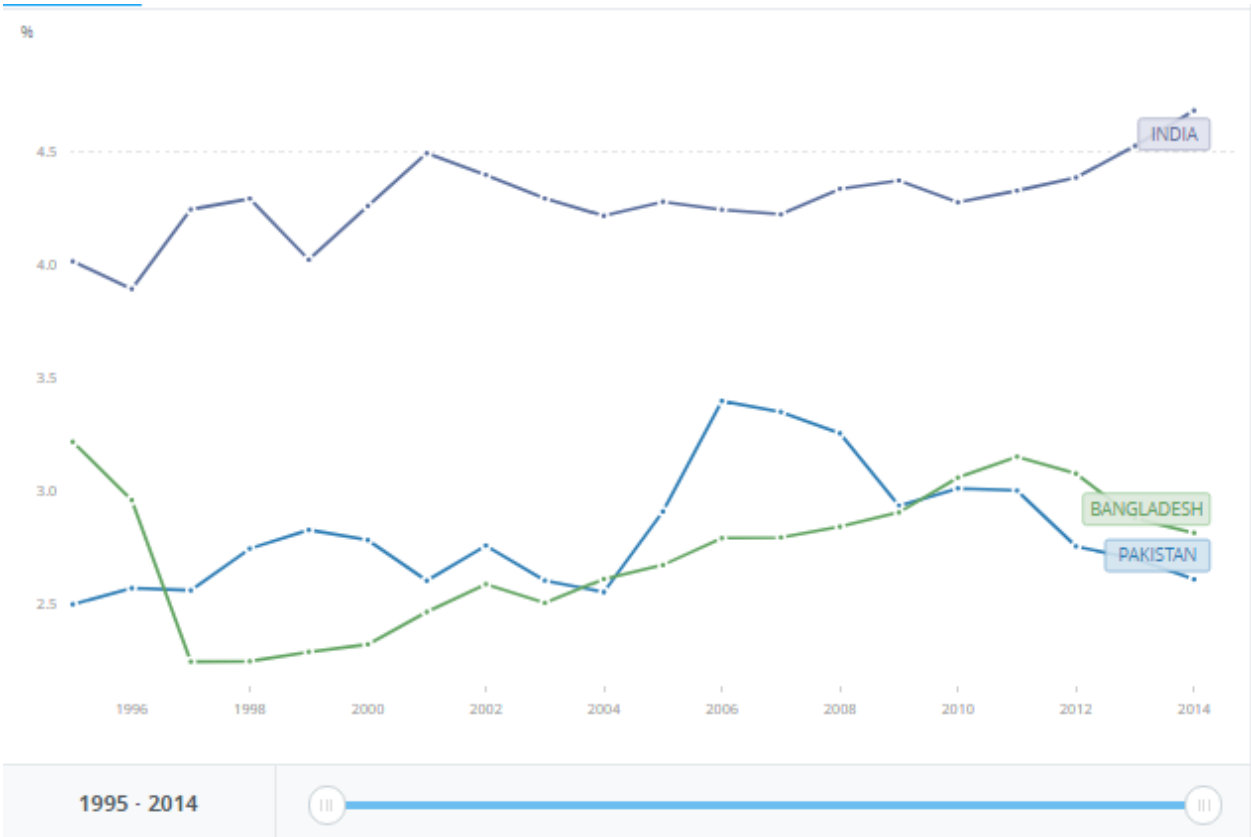
These health care centers charge a minimal token fee for consultation and in-patient services. Free medicines are provided in the emergency where the patients are not allowed to stay for more than a couple of hours. Patients have to pay themselves for medicines and medical tests.

Callen et al. (2013) highlight the limitations of the public healthcare system. As far as services are concerned, due to lack of facilities, poor service delivery and absenteeism at the Basic and Rural Health Units, the population from rural areas seeks healthcare from hospitals higher up in the hierarchy which are based mostly in the cities. The 23 major public teaching hospitals serve the best possible healthcare in the province and 11 of them are located in Lahore (the capital city of Punjab). These are especially overcrowded not only because of exponential

growth of urban population due to internal migration but also because people from rural areas specifically come to these hospitals seeking better quality healthcare.

In 2010, after the 18th amendment to the constitution of Pakistan, health was devolved to the provinces. Hence, all the major decisions with respect to healthcare education, planning and service delivery now come under the authority of the Punjab health department of the Punjab Civil Secretariat. To put the financial situation into perspective, in 2016 provincial budget totalling PKR 1681bn (around $16bn), PKR 43.8bn (around $ 4bn) were allocated to health. This makes 2.6% of the total budget of Punjab. Even out of this budget, the government spent some on the metro train project being constructed in Lahore (YDA CM 2; YDA CM3)

In order to get an overall picture of the health expenditure in Punjab, WHO figures for public expenditure on health for Pakistan and its two neighboring countries with comparable Human Development Index can be seen:



"Public expenditure on health is the total expenditure of all levels of government on health, presented as a proportion (%) of gross domestic product (GDP). It consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations) and social (or compulsory) health insurance funds. GDP is the value of all final goods and services produced within a nation in a given year" (WHO "Nutrition Landscape Information System"). Compared to Bangladesh with the public health expenditure of 2.8% of the total GDP and India with total health expenditure of 4.8%, Pakistan spends 2.6% of its total GDP on health and the percentage has been dropping since after 2006.

There are larger structural forces that prevent recommended expenditure on public healthcare in Pakistan. Privatization of the health sector in Pakistan was part of the project of privatization that began in the 1990s. The country carried out nuclear tests in 1998 and had to face economic sanctions. Moreover, it had a foreign exchange crisis because investment flows and bilateral and multilateral aid decreased sharply (Ravindran 2010). Loans were provided by International Monetary Fund (IMF), the World Bank and Asian Development Bank to help Pakistan out of the crisis and also to help in rescheduling bilateral and commercial loans. These international financial agencies granted loans on certain conditions – to Pakistan's adherence to structural adjustment programs designed to rectify fiscal imbalances. These programs require countries to become more free-market oriented, to adopt austerity measures and reduce public spending. Hence, the country is discouraged from spending too much on sectors like health and education (Zaidi 1994).

Apart from that, there has been an urban bias in the development of healthcare and an incapacity for rural practice whose origins can be traced within the British arrangement of medical training within large centralized hospitals (Johnson 1972). Apart from the urban bias,

there's preference to concentrate on curative rather than preventative healthcare, and both of these factors lead to extra burden on tertiary hospitals, especially in Lahore.

A woman from a lower socio-economic background from Lahore who frequently goes to a tertiary care hospital described the condition of the people who come from outside Lahore:

> The people who come from outside are more than the Lahori patients. Generally, with every patient who comes from outside Lahore, three to four people accompany them. One stays with the patient in the ward and the others camp outside the wards. They bring mattresses with them and sleep there. Security guards ask them to pick up their stuff before doctor come for rounds. The people who have come from afar, it's very difficult for them (Rashida)

Furthermore, there is lack of sufficient medical resources even within these large tertiary care hospitals:

> There are no medicines. There are basic medicines in the emergencies, but there are none for those admitted in wards. The government spends 9 dollars on people's healthcare and 50 are being paid by the public. YDA wants people to have free medicines (YDA CM 2)

> There are barely 10 ventilators in the hospital. If they had enough ventilators in every hospital, the mortality rate will come down 50%. A lot of times what happens is your patient is in a critical condition and you know if they have a ventilator, they will survive. You ask for a ventilator but the ones present are already in use. So the death rate is very high very high very high (YDA CM 1)

Showing me around the emergency ward of one of a hospitals that is considered one of the well-equipped ones in Lahore, YDA CM 2 said:

> It is morning now when the influx of patients is the least. Even at this time and you can see double occupancy on beds has begun. In peak hours – 2-5pm and 7-9pm, there will be 4 patients on one bed. You are supposed to keep infectious patients isolated. And in our case we have to put a person with paralysis and one with TB on the same bed. By the time they are discharged, the paralysis patient has caught TB.

Lack of human resource is also a critical issue. In 2014, Pakistan's physician density per 1000 population was 0.806 and nursing and midwifery personnel density was 0.604 per 1000 population (WHO. "GHO").

In such conditions – lack of medical facilities and ever increasing crowds of patients who have no other alternative to public healthcare since they cannot afford private care – the people who encounter these crowds of people are the nurses, paramedical staff and the young doctors under training (House Officers (HO), Medical Officers (MO) and Post Graduate Trainees (PGs)). These are the people who stand between the provider of services (the state) and the receiver of services. It is on them that the patients and their attendants take out their frustration due to lack of proper care and resources and it is to them that the administration instructs to "clear up the hordes of people" in the hospitals (YDA member 2).

Patients frequently complain of the negligence and rude behavior of the medical staff:

> There are numerous cases when the staff does not pay attention. During labor women are shouting to take them to the delivery room because they feel their child is about to be born and the nurses just say they will be there but take a lot of time to get there. I have seen several times when the child was born in the labor room without any medical staff" (Fatima, consumer)

> The doctors and nurses are very rude. They scold and even slap you on the face. I witnessed once that a girl in the gynecology ward was in a lot of pain. She was screaming and the doctor came and slapped her and asked her to keep quite. Some doctors are also nice and talk politely. Some are rude" (Rashida, consumer)

Doctors and nurses gave explanation for this behavior:

> The biggest disadvantage of shortage of doctors is that after a 24 hour duty in the OPD, I am so fed up and frustrated that I am rude with the patients. Public sector doctors are infamous for being impolite. Being overworked and dealing with frustrated and angry patients and attendants is the reason why. Not being able to save patients because of lack of equipment makes us depressed and frustrated. How can a normal human being be polite under such circumstances? I myself like that. What can the doctor do? (YDA member 2)

> For 80 patients there are 2 nurses. And just one if the other is on leave. She is overworked and depressed after seeing so many distressed, helpless patients. The doctors write down the prescription and ask the nurse to give the medicine in 5 minutes and they are able to give it after hours (YNA CM 1).
>
> If you have to see 2500 people in emergencies daily then you can't do one very important part of the treatment: counselling, during which you tell the patient about the ailment, give them reassurance, tell them the details of the treatment plan. And this is the biggest reason for the conflict. Doctors are distressed and the patients are dissatisfied so we fully understand that as time is passing, patient satisfaction and trust with the public hospitals in diminishing (YDA CM 2).

Apart from dealing with over-crowding, patient frustrations and work environment related issues, the young doctors, nurses and paramedical staff have other problems – they are not paid sufficiently and have no clear service structure. These are the grievances which lead to the formation of the three associations. The following section describes their objectives and demands.

Section 1.2: The Objectives and Structures of the Three Associations

Before I discuss the three associations, it is important to describe the service structure of state employment. The public sector employees in Pakistan, from Central Superior Service (CSS) officers, government school/university teachers or lawyers to gardeners and sweepers who work in state institutions, are employed on a grade system that ranges from grade 1-22. CSS officers are inducted in state departments at grade 17 and so are medical officers who have completed their one year house jobs after a five year medical degree. Nurses are hired on grade 16 or 17 (the latter grade is for administrative roles). And the paramedical staff is hired from grade 1-15 depending on their exact job.

Subsection 1.2.1 Young Doctors' Association

YDA is an organization of doctors who have completed their medical education and have entered the profession as House Officers for a year, and those who have completed their

house jobs and begun their specialization for five years (sometimes it takes longer): Medical Officers and Post Graduate Trainees. After completing this specialization, they take an exam and become consultants after which they are no longer an official part of YDA. In 2016 the organization decided on an age limit on the membership of YDA: anyone who is beyond 35 years cannot be a member. This rule has been formulated because YDA has become a very strong organization and those who were in prominent positions did not want to let go of their leadership roles and give chances to other people: "Although it is an apolitical organization, politics within the organization is quite prevalent" (YDA CM 1). Additionally, although there is almost an equal number of male and female doctors, council members of YDA are mostly male and generally, male doctors are more active in the activities of the association.

There is an independent association in every province and each has a very formal structure. Every tertiary hospital in the province has its own YDA cabinet referred to as a chapter which has a president, a vice president, a chairman, a media secretary and a few other members. There are regular elections for these positions. There is a general council of Punjab and every YDA chapter president is a member of the general council. The general council then selects the president of YDA at the provincial level. Whenever there is problem in any of the chapters, there is a meeting of the general council. The issue is discussed and the action to be taken is decided. YDA general council announces it and it is the responsibility of all YDA chapter presidents to implement it in their specific hospitals. For instance, if the general council decides that the YDA needs to shut down out-patient department (OPDs) then it's the president's duty to make sure that happen.

YDA struggles for five basic objectives:

- Pay Raise
- Service structure
- Security

- Induction of doctors
- Health facilities

Pay raise

When the organization was formed, an HO's pay was $60/month and PG's pay was $120/month. After several strikes, it was increased to $120/month and $180/month for HOs and PGs respectively. And the struggle went on:

> In 2017, the pay of a PG is around $ 700/month. This change is because YDA struggled very hard for it. It is also because of our struggle that senior doctors have also benefited – when our pays increased, theirs did too. The doctors used to think that we study more, work more hours and work in the most difficult conditions as compared to any other profession but other professions have more pays than us (YDA CM 1)

Secondly there is a large number of doctors in their training at public hospitals, who are mostly graduates of private institutions, who work without pays on honorary basis. These doctors have to practice/train and get a certificate to complete their specialization. The government exploits this factor. They are official employees who will get certificates after the completion of their training. They just are not paid. It is through the struggle of YDA that a significant number has begun to be paid now. So YDA is also working for private sector doctors indirectly to get them pays when they work in the public sector. Moreover, when the pay increases in the public sector, the private sector also has to increase the pay of doctors in their training.

Service structure

There is no proper service structure for promotions of doctors. "If you are inducted on grade 17, you might stay on that grade for the next 20 years. There are no rules regarding promotions. For instance, if a doctor passes the specialization examination then he/she will be promoted" (YDA CM 2). Promotions are granted on random factors. After completing a number of requirements, the doctors apply for a promotion and it is on the whim of the state

officer to grant it to him/her. Because there is no proper system and everything is random, connections and public relations play a huge role in determining promotions.

Security

YDA also struggles to ensure that the young doctors are able to practice in a secure environment and urge the government to make laws that ensure whoever ill-treats doctors is punished. Facebook page of the organization has frequent posts and pictures of physical violence inflicted on doctors by frustrated attendants.

> Attendants see that the patient has died because of lack of medical facilities. They end up slapping the doctors. If medicine is not there in the hospital, it's not the doctor's responsibility. It is the government's. The attendants are very frustrated people since their loved ones are sick and who do they take out their frustration on? Who is in front of them at the confrontation point? It is the doctors (YDA member 2)

Induction of more doctors

There are 32000 specialists out of which 40% have left Pakistan. For around 190m people of Pakistan, there are just around 20,000 specialists working in the public sector (YDA CM 1). Given the critical deficiency, the trainee doctors are an important human resource. YDA demands that the state induct more doctors:

> After you take FCPS part 1 exam you are eligible for induction as a Medical Officer. This January, there were 2500 people who took the exam in Punjab and there are only 400 seats for them. Where would 2100 people go? WHO recommends Pakistan to have at least 100,000 specialists. We just have 20,000. Why are you inducting so less if you have the resource available? The situation is so bad that there should be emergency induction of all the doctors that have passed the exam. But the state doesn't do it. Because they don't have budget for health. They invest $9/person on health. International recommendation is that you spend $60/person. (YDA CM 1)

Health facilities

YDA also struggles to improve hospital facilities for the patients and have demands like: one bed for one patient, free medicines, more machinery and more teaching hospitals. Moreover, the demand on which they stress the most is to have a doctor as a health secretary: "Our current health secretary is an engineer. How would he know about the problems of doctors and how they should be tackled?" (YDA CM 3). They want the appointment of somebody who has practiced medicine and has gone through the entire system to be able to understand its problems.

Subsection 1.2.2 Young Nurses' Association

YNA formally started around 2010 by nurses to have a platform to voice their issues which are mainly related to service structures and better pays. The initial reason for collectivizing was that a large number of very old nurses who should have been promoted 12-15 years ago were still working on the grade they were hired on. Moreover, the capacity of hospitals had increased (measured in the number of beds) but nurses were not being inducted accordingly: "there are two nurses for 80 patients and if one of them is absent, which a lot of time is the case, then one for 80 patients" (YNA cabinet member). Moreover, they now demand post-graduate study opportunity like the doctors. Like YDA, they are organized at the level of the province with cabinets at hospital level representing around 14000 nurses from various health establishments all over Punjab. They also have a hierarchy and chain of command similar to YDA.

"Young" as a descriptive label in the case of YNA is somewhat misleading. Although a cabinet member of YNA explained that like in the case of YDA, youngness is related to professional grade of employment rather than age, the label in its literal terms is still much far off from how it is being used. In the case of doctors, the variation of age within the grades that

defines youngness is not so much. In the case of nurses, however, the variation is vast and so while the main demands are related to the professional grades, issues pertaining to older nurses within the grades are also sometimes raised, for instance the demand to stop the night duties for older nurses.

Subsection 1.2.3 Paramedical Staff Associations

The paramedical staff, inspired by labor unions from other work spaces, organized themselves in the form of an association in 1972, much before the young doctors and nurses. The staff includes technical staff that works in labs, dispensaries and operation theatres (grade 9-15 who require a diploma after high school) as well as manual workers such as hospital gardeners, sweepers, laundry workers (grade 1-4). Around 15% of paramedical staff are females and very few of them are involved in association activities. Unlike single organizations representing young doctors and nurses, there are five different ones to represent the interests of medical staff belonging to grade 1 through 15. There was initially a single organization that kept splitting into factions over the years due to differences in viewpoints. The factions have a structure similar to YDA and YNA: there is a hospital level cabinet the presidents of which form the general council who then elect a president. These associations struggle for pay raise, risk allowance for the staff who the president of one faction claims has the most risky job among all levels of the medical staff. It was through the 6 year struggle of the association that the workers with technical jobs were able to secure grade 9-15. Earlier they were hired on grade 5. Moreover, the state has separated 1-4 grade category to be outsourced to private agencies against which the associations are now struggling. The association represents the staff from all grades unlike YDA and YNA who represent the interests of doctors and nurses from lower grade until the former become consultants and the latter gains position of seniority.

Towards An Understanding of Their Separation

The movements originate under the same overarching structural conditions of the health system as highlighted in this chapter. However, each in influenced by different aspects of those structural conditions. The kinds of demands that they make, as described in this chapter, depict these differences to some extent, however, to have an in-depth understanding of their separate struggles, some theoretical conceptualizations are required which will be provided in the next chapter.

Chapter 2: Theoretical Embedding – 'Professionals' Renegotiating Scales

This chapter builds the theoretical framework by combining three different strands of literature in order to meaningfully understand the struggles by various medical staff in Pakistan and to further position them in the sociological and anthropological literature. Scalar analysis will provide the overarching framework to understand the politics around the healthcare system of Punjab. Within the scalar analysis, negotiation between two scales – state (policy maker) and medical staff (having dual identity of policy implementer and receiver) – will be highlighted in their attempts to impact the healthcare system. To understand this negotiation or renegotiation of scales, literature on the politics of professionalization and social movements will be used and hopefully contributed to. Social movements and politics of professionalization rarely come together in literature, my aim is to combine the two streams in order to make sense of the case at hand.

Section 2.1: Scalar Analysis

A useful theoretical lens to understand the dynamics between the local, the global and everything in between in the context of health is the scalar analysis to help analyze different levels of governmentality. Since the globalization of 1990s, various disciplines have become interested in the "'scalar ontology' of a vertical local-subnational-national-regional-global hierarchy" (Stepputat and Larsen 2015: 15). A scalar analysis is especially relevant for global policies since jurisdictions, identities and other forms of material resources are bound to differ across different scales. Moreover, scales are "inherently part of the strategic and everyday engagements of policy makers (and breakers)" (Jonas 2006; Hay 2014 qtd. in Stepputat and Larsen 2015: 15). Stepputat and Larsen (2015) suggest that rather than discarding the conception of scales altogether or starting from straightforward ideas of local, regional,

national and global levels as hierarchical and progressively larger scales, social scientists should seek to take scale and scale making in the arena of policy studies as an object of analysis (Tsing 2000; Gupta and Ferguson 2002, qtd. in Stepputat and Larsen 2015). Through my exploration of the social movements by different medical staff against the state, I seek to analyze the role these social movements play in the scale making process within the domain of healthcare.

Neil Brenner (1999) presents his view of the multi-scalar conceptualization of geography, which can generally be applied to the conceptualization of space, in response to the two extreme approaches to understand geographical conceptualizations and their consequent impact on social, economic, political and cultural relations. On the one hand are state-centric approaches where states are seen as "self-enclosed geographical containers of socioeconomic and politico-cultural relations" (Brenner 1999:40). Such a view conceives territorialization as something static rather than a dialectical process that is in a constant state of flux. Recently, he argues, globalization researchers have been challenging such views and have been going beyond state-centric epistemologies. However, some have gone to the other extreme and argue that "state territoriality and even geography itself are shrinking, contracting, or dissolving as a consequence of processes of 'deterritorialization' which results in a placeless and borderless world society" (Brenner 1999: 41). Such viewpoints overlook "newly emergent, reterritorialized forms of state power and their associated political geographies" (Brenner 1999: 41). Moreover, "deterritorialization approaches bracket the various forms of spatial fixity, localization, and (re)territorialization upon which global flows are necessarily premised" (Brenner 1999: 62).

In response to the two extremes, Brenner presents an alternative analysis of the current round of globalization as a reterritorialization process that is multi-scalar and in which states

play a significant role. In this analysis, "[s]pace is not merely a physical container within which capitalist development unfolds, but one of its constitutive social dimensions, continually constructed, deconstructed, and reconstructed through an historically specific, multi-scalar dialectic of de- and reterritorialization" (Brenner 1999: 43). He further argues that "geographical scales – the discrete tiers or levels within interscalar hierarchies – are not static, fixed or permanent properties of political-economic institutions…. They are best understood, rather, as socially produced, and therefore malleable, dimensions of particular social processes – such as capitalist production, social reproduction, state regulation, and sociopolitical struggle" (Brenner 2011: 32).

Since the de and reterritorialization of scales (as envisioned by Brenner) is a contradictory and conflictual process that is in a constant state of flux, the role of actors comes to be really important in influencing change in these processes. In the field of health, the agency of various medical staff, both as targets and implementers of health policy, is important in such conflictual processes as they have the potential power to influence the course of the constant de and reterritorialization of scales in the healthcare system. Hence, I want to take Brenner's theoretical framework one step further by highlighting and focusing on the role of actors, in a detailed manner through ethnographic fieldwork, in this broad and somewhat abstract process of re and deterritorialization of scales in the field of health.

The discontinuities in the understanding needs of the healthcare system between service providers (medical staff) and policy/program developers (state), and the reactions and practice of the service providers amidst these discontinuities are significant processes in the negotiation of scales. These scales are constantly in a state of flux, and hierarchies being renegotiated as different actors interact with each other and are influenced by a plethora of external influencing factors that guide their action (such as ideologies and media). Like Brenner argues, the idea is not merely to recognize that this area of inquiry is scale differentiated but to explore "the social

dynamics through which the scaled political-economic configurations are actively produced and continuously transformed during the course of capitalist geohistorical development" and "to trace the ways in which such scaled political-economic orders structure (i.e. at once constrain *and* enable) social relations of power, domination, exploitation, and struggle" (1999: 35).

Although I discuss the interaction between two scales only, a scalar conceptualization of the healthcare system being influenced by different actors on each scale and by their interactions between scales, is important for my case to be able to point out (in the last chapter) the limitation of the social movements at this stage as they only target the sub-national and national scales but not the ultimate global scale.

Section 2.2: Politics of Professionalization

Analysis of professions has historically connected to broader sociological issues such as occupational closure, social stratification, formation of state and the development of capitalistic order. An important dimension of this stream of literature is about the concept of professionalization. Noordegraaf (2011) provides the definition of professionalization by considering the work of various sociologists of profession (Abbott 1988; Burrage and Torstendahl 1990; Evetts 2003; Freidson 1994, 2001; Hall 1968; Larson 1977; Wilensky 1964) "as the collective demarcation and institutionalization of occupational practices, acknowledged but not controlled by outsiders" (2011: 467). This means that professions have authority over different aspects of their occupation ranging from issues related to education, employment and career development.

Professionalization has to do with the strategic agency of professions and the way various groups follow their collective interests in broader socioeconomic and political domains (Abbott 1988; Larson 1977). Also referred to as the 'professional project', it is about the

systematic effort to convert limited cultural and technical resources into institutionalized and secure system of financial and social benefits (Larson 1977). The professional project involves processes of educational and legal closure (MacDonald 1995; Murphy 1988; Parkin 1979) where the 'professional' group tries to control entry to the labor market and competition within it and tries to maintain 'institutional autonomy' (Evetts 2002) to regulate their affairs (qtd. in Muzio and Kirkpatrick 2011: 391).

Noordegraaf (2011) argues that although occupational control and legitimacy may seem obvious, particularly in highly institutionalized fields such as medical services, they do not occur naturally and a conscious effort is required to organize them. Cultural and political perspectives (Larson 1977; Evetts 2003; Hodgson and Cicmil 2007;) indicate that professionalization is a matter of sociopolitical construction (Noordegraaf 2007).

According to Abbot (1991), "professionalism is generally, but not always, under the control of either the professionals as a corporate body or of an elite drawn from them" (27). However, there are some exceptions to this generalization in the case where the states are particularly strong, where professionals work for an organization and their professionalism is influenced by the employers and when professions can come under the control of third parties where third parties provide the payments for services, like in the case of American medicine (Abbot 1991). The case at hand is among the exceptions, albeit of a specific kind influenced by particular political structural developments (which will be further explained later on in the chapter).

Broad trends in the form of changes in the capitalistic markets, technologies, state regulation and management in the neoliberal era are taking away the authority from professions to control their occupations – they are leading to de-professionalization.

Being employed by large, bureaucratic workplaces takes away the authority of the professionals to have control over their own profession (Abbot 1991) and they are exposed to "external sources of power and managerial authority, subordinating the criteria and values of their profession to the rules and objectives of their employer" (Muzio and Kirkpatrick 2011: 394). Under such circumstances professionals lose their autonomy relating to the terms and conditions of work and to defining, executing and evaluating their own occupational activities (Aronowitz 1973 qtd. in Muzio and Kirkpatrick 2011: 394). Managerialism and commercialism replace professionalism (Freidson 2001). These developments also replace professional logic of social trusteeship with logics of expertise having a commercial spirit (Brint 1994; Hanlon 1998; Leicht and Fennell 2001; Reed 2007, qtd in Muzio and Kirkpatrick 2011).

Brint (2014) argues that there has been a move towards "expert professionalism"– the concentration on the value of specialized skills that require higher education, highlighting technical achievements and internal affairs of the profession – and a move away from "trustee professionalism" under which civilizational functions are highlighted. The social trusteeship in case of professions is best described by Tawney (1948):

> [Professionals] may, as in the case of the successful doctor, grow rich; but the meaning of their profession, both for themselves and for the public, is not they they make money, but that they make health, or safety, or knowledge, or good government, or good law…[Professions uphold] as the criterion of success the end for which the profession, whatever it may be, is carried on, and [subordinate] the inclination, appetites, and ambition of individuals to the rules of an organization which has as its object to promote the performance of function (qtd. in Brint 2014: 5).

Due to the decline of professional self-regulation/deprofessionalization, trustee professionalism also began to decline by 1960s (Brint 2014: 8). The ideology of social trustee professionalism continues to some degree in some human service sectors like general care medicine. However, the more specific concern to serve those who are underserved due to poverty and disadvantage are related with the struggle for symbolic status by "a subordinate

fraction of the professional-managerial stratum" which mostly includes those working in social welfare sectors of the government and non-profit sector (Brint 2014: 11). The professional communities, on the other hand, are mostly interested in technical skill building and civilizational project than in the underserviced. These disadvantageous groups are mostly helped by the aforementioned service sector (Brint 2014). However, it will be illustrated that among the young doctors of Pakistan, not only the ideology of the social trusteeship continues with its civilizational project and humanitarian purposes, it is combined with the need to serve the underserved. This however has only been possible because of the achievement of YDA to establish a platform to voice its group interests and by then making use of this established platform to struggle for the underserved. First, however, it is important to explain the structural conditions that led to the establishment of the associations itself.

As Ritzer (1977) argues, the perceived power of professions differs across groups in society and across time and geographical areas (qtd. in Quah 1989). It also varies across different socio-economic and political structures of societies (Quah 1989). In this sense, neither professionalization, nor managerialism are relevant to understand the development of medical profession in the Pakistani case.

Johnson (1972) argues that the theory of professionalization cannot sufficiently explain "the character of those occupations we conventionally refer to as professions" as they have developed in the post British colonies (285). He suggests that the professions in the 'new state' went through a process of historical development which is fundamentally different from that experienced by occupations in the industrialized world (Johnson 1972). The social structures and power relations out of which the professions emerged and are embedded in, in the British Commonwealth are significantly different from those in the metropolitan country. These differences are the result of the specificity of the relationship of professions with the colonial

administration, and after the independence, with the post-colonial state (Johnson 1972: 285). Under colonialism, there was an institutionalized form of occupational control in the form of corporate patronage which is the reverse of professionalization since it is "the client – a powerful, corporate, client – which regulates the profession rather than the profession itself" (Johnson 1972: 285). Corporate patronage is an occupational control which is linked to the phenomenon of bureaucratic colonialism and which continues to effect professional practice in the underdeveloped, new Commonwealth countries today (Johnson 1972).

By taking Johnson's theory forward, I will argue how in the case of Pakistan, and potentially other countries with similar socio-economic and political structural developments, the progress cycle of professions has been different from what the aforementioned theorists argue. It doesn't have the path of professionalization followed by deprofessionalization in the neoliberal era. In Pakistan the deprofessionalization as has been described does not occur, as the country has not been through professionalization in the first place as understood in the literature. It is in this context that the social movement by doctors originate and evolve, carving their unique paths to professionalization against a colonialism influenced, centralized bureaucratic state. The particularity of their struggle differentiates them from social movements by other staff and prevents collaboration. Concepts deriving from the social movement literature (highlighted in the next section) will be helpful in analyzing how and why this exactly occurs.

The political struggle of nurses with regards to their profession cannot be understood in terms of professionalization in the post-colonial professional development. That discussion is more relevant for more 'developed' professions with standardized forms of education such as those of doctors. Nurses have not reached that stage in Pakistan yet hence theirs, at this stage, is a struggle to gain professional status rather than claim professionalization in terms of

increased control of their profession. Many social theorists have described and explained the claims to attaining a professional status for nurses and the difficulties associated with it. Historically, nursing as a vocation referred to by some as 'nightingalism' (Grand 1971 qtd. in Briskin 2012) along with the discursive construction of caring as an inherent female trait are differentiated from the educated practices of curing undertaken by doctors. These have created barriers to attaining a professional status (Briskin 2012: 288). Over the years, nurses have sought for a professional status by focusing on "self-regulating profession with workplace autonomy, which emphasizes their knowledge, expertise, skill and responsibility" (McDonald 2010 qtd. in Briskin 2012). These are ways to dissociate nursing work from domestic association and inherent female traits and from any connections to its roots as a working class trade which are the reasons for devaluing nursing work (Kealey 2010). Briskin (2012) uses the concept 'politicization of caring' which refers the prevalent mobilization of nurses who are involved in care-work who frame their struggle in terms of a collective responsibility for caring and the impact of adverse conditions of nursing work on the quality of care and demand for a revaluation of care-work (Briskin 2012: 291). Bickley (1997) points to nurses acting 'as a buffer between consumers and the large-scale structural changes' (304). This suggests that the politicization of caring is both about the professional interests of nurses and about better patient services (Briskin 2012).

The struggle of public sector nurses in Punjab is somewhat different owing to the particular nature of their work that results from shortage of staff and overflow of patients in these hospitals. Their struggle is about revaluation of nursing as an occupation – and consequent demand for an increased salary and better service structures – rather than nursing as care-work because providing care to patients is not what they actually do. The politicization of caring as a concept does not apply in the case of nurses in Punjab and is perhaps also one of the reasons why the struggle is not framed in terms of better patient care and services. Lack of

politicization of caring and concentrating solely on professional interests due to structural dependencies is a hindrance in coalition formations with the young doctors.

Section 2.3: Process Approach to Social Movements

According to Tilly (2008), contentious politics includes confrontations between actors who make claims bearing on other actors' interests. In these confrontations, governments are either the actor who makes the claim, are targets of the claim or are third parties. "Contentious politics thus brings together three familiar features of social life: contention, collective action, and politics" (Tilly 2008: 5). Collective action is the coordination of efforts for shared interests (Tilly 2008: 6). Social movements are a particular type of practicing contentious politics/ claim-making performances that involve the formation of "special-purpose associations, public meetings, petition drives, street demonstrations, and a few more" (Tilly 2008: 7). Hence, dense formal/informal networks and distinct collective identities are essential features of this type of collective action (Diani 1992; 2003; 2004; Diani and Bison 2004 qtd. in Della Porta and Diani 2006).

McAdam, Tarrow and Tilly (1996) identify three approaches that developed in the social movement literature to understand the post 1960s movements: structural, rationalist and cultural. Each, they claim, if considered in isolation, would provide a partial and even deceptive account of a social movement as it is the interaction and mutual reinforcement of all three factors that holistically explains a social movement. Hence, a synthesis of the three in important and will be used in the thesis.

Structural approaches tried to understand the macro/structuralist origins of social movements coming up with the concept of 'political opportunity structure' (Tilly 1975; Tarrow 1983; Kitschelt 1986; Knesi et al. 1995) which in its simplest terms refers to political structures that are conducive to the development of social movements. A different kind of structuralism

was post- Marxism (Touraine 1971) which inferred a new class basis for social movements through an analysis of the student movements of the late 1960s (McAdam et al. 1996). Theorists like Habermas (1981) and Offe (1885) used structuralism as the study of objective life-chance coalitions. These theories all together came to be known as the "new social movement approach". This approach included a variety of macro structuralism that was not preoccupied with class like the classical Marxist approaches (McAdam et al. 1996).

The rational theorists, in their earlier writings at least, ((Zald and Ash 1966; McCarthy and Zald 1987), Anthony Oberschall (1973; 1980), and Charles Tilly (1978) considered social movements as "rational, purposeful, and organized actions" (Della Porta and Diani 2006: 14). They argued that collective action derives from a cost-benefit analysis in the presence of resources – especially organization – by "strategic interactions" that are necessary for a social movement's development (Della Porta and Diani 2006: 14). They argued that the existence of structural tensions was not enough and a study of factors that enable the transformation of discontent into mobilization is important. This potential to mobilize depends on material and non-material resources.

The reactions against the rationalist/resource mobilization approach led to the development of a constructivist perspective that gave importance "to political culture and the construction of new collective identities through collective action" (Melucci 1989 qtd. in McAdam et al. 1996: N.p). Against essentialism, this perspective argued that actor grievances and identities were not natural (Somers and Gibson 1994 qtd. in McAdam et al. 1996). Injustices had to be identified and attributed to antagonistic others, and positive symbols around which ordinary people could come together had to be formulated. Reality had to be shaped for potential supporters by social movement activists (Gamson 1988; Brysk 1995 qtd. in McAdam et al. 1996). McAdam et al. (1996) argue that in the absence of either a political opportunity

(structuralist approach) or a mobilizing structure (rationalist approach), there will be an incomplete account of a collective action. Moreover, shared meanings that people bring to their situations (cultural approach) mediate between opportunity, organization and action (McAdam et al. 1996). Actors need to feel aggrieved about an issue and optimistic that collective action will solve that issue. If either or both of these perceptions is lacking, a mobilization is unlikely even if an opportunity is available. "Conditioning the presence or absence of these perceptions is that complex of social-psychological dynamics -- collective attribution and social construction -- that David Snow and various of his colleagues have referred to as framing processes" (McAdam et al 1996: N.p).

A way to integrate the three strands of literature, and their differences in giving importance to either structure, mobilization or culture, is through the process approach – "a dynamic approach to processes of contention" (McAdam et al. 1996). It is only through an intersection of these approaches in the form of a "process approach" that a social movement can be explained holistically. Moreover, all the three classes of factors highlighted above are mutually reinforcing at each phase of a movement and so one cannot identify a particular set of variable with a particular phase of the movement (McAdam et al. 1996). The process approach calls for understanding all phases of a movement cycle to all three sets of factors: political, cultural and organizational (McAdam et al. 1996). For the analysis of the three social movements and their various forms of politics for professionalization in the backdrop of negotiation of scales, a process approach will be used in order to holistically understand all factors that affect the trajectories of the movements and influence their lack of cooperation.

In the case at hand, structural conditions in which the movements originate are explained (previously) as embedded in the particular development of professions in the colonial influenced centralized state system and cultural notions about the status of doctors, in the case of doctors; and structural dependencies influenced by the nature of work and societal religious

and cultural perceptions with respect to gender in the case of nurses; and structural dependencies influenced by socio-economic class in the case of paramedical staff. To understand the movements holistically, the thesis will further address how these structural conditions are responded to by the actors, concentrating on collective identity formations (constructivist analysis) and on how these identities are made exclusive or inclusive depending on what will be most resourceful for the success of a movement (rationalist analysis).

Various social theorists have underscored the importance of the relationship between identity and collective action **(**Pizzorno 1978; Cohen 1985; Melucci 1989; Calhoun 1991 ; Mach 1993; Stryker, Owen, and Whyte, 2000;Horton 2004; Hunt and Benford 2004, qtd. in Della Porta and Diani 2006). When they speak of identity, they do not refer to an independent object or a trait of social actors. Identity is rather seen as the *process* through which social actors recognize themselves as part of a larger group to which they form emotional attachment and give meaning to the system of relations in which they are embedded (Melucci 1989, 1996; Polletta and Jasper 2001; Goodwin et al. 2001 qtd. in Della Porta and Diani 2006). It is also the process through which they come to be recognized by others. Identity formation is a complex phenomenon: on one hand "it evokes the continuity and the solidity of allegiances over time" and on the other, it is "open to constant redefinitions" (Della Porta and Diani 2006: 94).

According to Della Porta and Diani (2006), a social movement is not a sum of protests on particular issues but a process during which collective identities develop which "go beyond specific events and initiatives" (21). Collective identity creates connectedness between a group (Pizzorno 1996 qtd. in Della Porta and Diani 2006) and binds the groups under a common purpose. This commitment to a common cause may also enable separate organizations to relate to one another and "regard themselves as inextricably linked to other actors, not necessarily

identical but surely compatible, in a broader collective mobilization" (Touraine 1981 qtd. in Della Porta and Diani 2006: 21).

Some social theorists argue that a collective identity forms the basis for the development of informal communication networks, interaction and support which are important replacements for dearth of organizational resources. Moreover, "identifying themselves – and being identified – as part of a movement also means being able to count on help and solidarity from its activists" (Gerlach and Hine 1970; Gerlach 1971, qtd. in Della Porta and Diani, 94). The presence of the feeling of solidarity that steps from a collective identity, makes it easier for social movement actors to take risks that are associated with collective action. In this way, collective identity serves as a resource for the success of social movements and this factor links the conceptualizations of resource mobilization theorists with those of constructivist theorists in the understanding of social movements. Moreover, identities may be inclusive when actors feel close to multiple types of collectivities. And they may also be exclusive and not support certain other forms of recognitions (Della Porta and Diani 2006).

Informal networks of collective actions, such as coalitions elucidate why collective identities are critical features of social movements. "In coalition dynamics, collective actors are densely connected to each other in terms of alliances, and identify explicit opponents, but those links are not necessarily backed by strong identity links" (Della Porta and Diani 2006: 25).

Hence, the coalitions among groups of actors on shared goals are of a purely instrumental nature. Resource mobilization and campaigning is carried out through joint resources of the groups. However, the actors derive their main identity from the group rather than the network. "Actors instrumentally share resources in order to achieve specific goals, yet do not develop any particular sense of belonging and of a common future during the process" (Della Porta and Diani 2006: 25). Once, a battle has been fought, they may go their separate

ways and not try to connect "the specific campaign in a broader framework" (Della Porta and Diani 2006: 25). In the case of the groups of various medical staff in Punjab though, a joint campaign under a broader framework is not hard to imagine since in terms of work coordination and territorial space they are so closely knit. However, what is puzzling is that not only do they not collectively struggle in a broader framework, but they don't even form coalitions of instrumental nature.

The next (analytical) chapter will elaborate on why this is the case highlighting on differences in the identities of each group and a maintenance of exclusivity by doctors. These differences in collective identities and lack of coalition formation are due to each group struggling for something completely different. Moreover structural dependencies and professional hierarchies strengthened by differences in habitus in which each group operates also prevent coalitions.

Chapter 3: Three Different Struggles, Three Separate Movements

Tensions among various types of identification have to do, first, with the fact that the motivations and expectations behind individuals participating in social movements are, in fact, much richer and more diversified than the public images of those movements, as produced by their leaders, would suggest (Della Porta and Diani 2006: 98).

The chapter discusses the structural conditions under which the social movements of young doctors, young nurses and paramedical staff operate. These determine the particular forms the movements take and the opponent they target. It will combine this discussion with the role of collective identity formations and how maintaining particular identities influences the structural power of the groups in their bargaining position against the state. The first three sections explain social movements of each medical staff separately and highlight how they are fundamentally struggling for different objectives. The fourth section discusses how these unobvious differences in their movements are combined with obvious frictions among the group to create unbridgeable differences.

Section 3.1: YDA – A Reclamation of the Messiah Status

I grew up reading the proverb: Read and Write, a Nawaab you shall be. Now I often say: 'Burn the books that said: Read and Write, a Nawaab you shall be' – YDA CM 1

Nawaab is an honorific title that the Mughal Emperors bestowed upon the Muslim princes of the semi-autonomous states in South Asia during the reign of the Mughal Empire. Used in this proverb, it refers to an honorable person of high status which the proverb indicates can be achieved through education. The alteration of the proverb by YDA CM illustrates how he has become disillusioned with the idea because even after "studying so much, [he] could not become a Nawaab". One of the major reasons to aspire to become a doctor in Pakistan, to gain higher levels of educational capital, is to acquire symbolic capital due to the prestige associated with the profession:

> Why does anyone get educated? So that they would have respect and prestige in society. There is no other reason for getting educated. I also became a doctor so that I would be a respected member of society. That is why most parents also want their kids to become doctors. Because there is a perception that this profession leads to most prestige. But if a regular member of society can slap you so easily and you have no way to protect yourself… you have no self-respect. This happens quite frequently in public sector hospitals, even with the lady doctors. When there is no respect, then nothing matters for you (YDA member).

By ordinary members, the young doctor refers to the patients and attendants who verbally and physically harass doctors (due to reasons described in Chapter 1). In continuation of explaining his alteration of the 'Nawaab' proverb, the young doctor indicated 'the other', against whom the social movement of YDA is targeted against. "We are on roads, struggling so much for our rights, while those who are much less educated [the government and state officials] are the Nawaabs deciding our destiny" (YDA CM 1). Power-centered approaches to understand professional dynamics have distinguished classic or "status" professionalism from other types of professionalisms which are considered less pure such as bureaucratic professionalism (Larson 1977; Noordegraaf 2007). One important element disguised within this renegotiation of scales in the healthcare system is also a competition between two types of professions – state officials and doctors – for symbolic capital. The specificity of this dialectical relation between the state and medical professionals in Pakistan is embedded in the development of professions within the British system of corporate patronage.

The bureaucracy in post-colonial societies cannot be understood in the classical marxist view – as instrument of a *single* ruling class. "The specific nature of structural alignments created by the colonial relationship and re-alignments which have developed in the post-colonial situation have rendered the relationship between the state and the social classes more complex" (Alavi 1972: 61). Unlike in the western society where the nation-state was created by an indigenous bourgeoisie to provide the infrastructure for capitalist relation of production, the bourgeoisie revolution – the establishment of a bourgeois state and the legal and

institutional structure to support it – takes place by the metropolitan bourgeoisie with the imposition of the colonial rule. The metropolitan bourgeois could not simply replicate the superstructure of the state which it had established in the metropolitan country, it had to create a state apparatus through which it could "exercise dominion over *all* the indigenous social classes in the colony" (Alavi 1972: 61). Hence, the superstructure in the colony is overdeveloped relative to the one in the metropolis and has a powerful bureaucratic and military apparatus along with "mechanisms of government which enable it through its routine operations to subordinate the native social classes" (Alavi 1972: 61). This system is inherited by the post-colonial state and several social classes find themselves "enmeshed in bureaucratic controls by which those at the top of the hierarchy of the bureaucratic-military apparatus of the state are able to maintain and even extend their dominant power in society, being freed from direct metropolitan control" (Alavi 1972 61). The over-developed state in Pakistan has been one of the major constraints in the development of professionalization.

Although, the British colonial policy was to recruit professionals from the metropolis for their colonies, the colonial administration was still in constant conflict with the metropolitan professional associations. This clash of interest represented the "inherent tensions existing between the demands of professionalism" and the emerging system of "corporate patronage of professional occupations" (Johnson 1972: 288). During colonialism, professional occupations were "subject to the patronage of the colonial administration and were dependent on its distribution of social and economic rewards" and so there was no secure foundation for the development of professionalization as a form of occupational control (Johnson 1972: 289). Hence, the technically-based authority of the professions was subjugated to "extra-professional sources of power" (Johnson 1972: 289). In the new states that inherited the colonial structure, the professions continued to be subjugated to the control of a centralized bureaucratic state – a legacy of the colonial system.

The social organization of the colonial bureaucracy signifies the historical conjunction of two cultures – the culture of the colonized and that of the colonizers – while encouraging the subordination of one by the other (Johnson 1972). The struggle for independence was, to a great extent, about gaining political control of this bureaucratic structure "with all its potentialities for economic management, nation-state formation and political patronage" (Johnson 1972: 295). After independence, the transfer of power involved the transfer of these organizational resources to a new class within the new states "which has generally sought to maintain and develop what have become the mediating institutions of state power in order to both develop and distribute the surplus which it has at its command" (Johnson 1972: 295). The post-independence growth of the state warranted that a significant component of this redistribution has been for the benefit of the "functionaries and beneficiaries of the patron state itself" (Johnson 1972: 295). Although the position of the professions has been somewhat changed due to new forms of political relationships in each of the new states, professions retain their characteristics that developed under colonialism and fundamentally remain dependent on the corporate patronage of the state. The development of professionalization as a form of control was able to develop in Britain as it allowed a more market oriented and flexible development of professions at home (Quah 1989). While in the case of its colonies, such a development was hindered by systems of control of professions by centralized bureaucratic states, the systems later inherited by the new states. Since the new states have had no past of professionalization, Johnson (1972) argues that "their present and their future are likely to exhibit very different forms of organization and practice" (306).

For these reasons, the professional associations in the new state are weak compared to those in the metropolis. "There is no direct relationship between registration and autonomous occupational control of practice as state regulation is maintained through the official representatives on the registration boards (Johnson 1972, 305). Moreover entry to the

profession is hardly ever controlled by the professional association and the educational institutions that train professionals are also responsible to the state (Johnson 1972, 305). Such is the case in Pakistan with regards to the medical association. The state health department has authority over the medical education system, doctor induction processes and career development. Moreover, unlike an institutionalized medical association, such as the British Medical Association (BMA), in the UK, Pakistan Medical Association (PMA) is not representative of the doctor interests against the state. PMA is mostly geared towards arranging conferences and planning research. The young doctors realize that PMA, or for that matter, hospital administrations and managements have no real authority (they have never been professionalized), since they are controlled by senior doctors who are put into those positions by the state officials and who consequently do not question the state activities. Hence, the junior doctors have taken it upon themselves to collectivize in form of a social movement against the state. Their struggle is an attempt at professionalization – with a competition for symbolic capital as its main feature – of a field which never got a chance to professionalize due to its particular historical origin embedded in colonialism and the British policy of corporate patronage of professionals.

Although the young doctors, like other medical staff, have basic demands pertaining to the service structure, pay raise, and getting the state to pay for those doctors who are working on honorary basis (see Chapter 1), they frame their grievances more in terms of status improvement and struggle to acquire the prestige promised to them by the general perception of society – that medicine is the highest status profession in Pakistan – a promise on which they had aspired to join the profession. When they graduated medical school and entered the profession, they were paid "less than a 'mediocre' police constable" and were bullied by state officials much less educated than themselves and were harassed by 'uneducated' patients and attendants from the lowest statuses and socio-economic background: "The admin humiliates

us. Politicians mistreat us. Attendants slap us and go out freely. We don't have any security. Because of all these factors, doctors feel protected by YDA… that makes us united and powerful" (YDA CM 3). Although the public sector senior doctors had similar experiences in the initial phases of their careers, they never organized themselves and now they do not feel the need to. Once their training is complete and they achieve the position of a consultant, they get the perks associated with government jobs, the respect due to their position of seniority and the money coming in from private sector practice. As YDA CM 2 pointed out:

> The *poor* senior doctors are helpless. They have spent their entire lives studying and then suffering through the system like we do now, after which they have achieved this position. Now they want to stay in the position and maintain the system as it is. When they confront the state or come on the media talk shows, they never address the shortcomings of the system.

Hence, the movement is a struggle of young doctors only one of whom voices his grievances:

> My biggest concern was that when I become a trainee I will come under the authority of the health secretariat. If I want a leave or something, I have to go to the secretariat and deal with a state clerk much less educated than I am. I tell him the reason for my visit and he teases me on purpose sometimes sending me to different officials, sometimes asking me to wait for hours and other times telling me to come back another time. He just exploits his position. I didn't become a doctor or my parents didn't make me a doctor so a high-school graduate clerk could treat me this way. I don't mean to disrespect him. But this is not fair that he treats such an educated person this way. They tease us on purpose and delay our work so that they get money out of us. I became a doctor so wherever I go, I would be respected. I should be treated how a *messiah* is treated– with respect (YDA CM 1).

Apart from a feeling that the state officials exploit their position to show their symbolic capital and gain extra benefits from the doctors like they do with everyone else, some doctors also felt that there is an outright competition between the two professions – a struggle to be recognized as the most prestigious profession in the nation. While claiming that the hospital administration is actually on the side of the doctors, a hospital administrator shared their views in the following quote which represents the general feelings of the doctors:

> This movement by young doctors is actually against the state bureaucratic officials. Actually there's a lot of difference between the treatment of doctors and bureaucratic officials – between their pays and privileges. The state/government facilitates the bureaucratic officials so much more. You know these people are mostly the ones who didn't get admission in medical colleges so there is professional jealousy involved. They couldn't become doctors and when we become doctors after so much hard work and go to the state health department for jobs, they treat us very badly. Not even a clerk gives us a seat and asks us to sit down even if we are grade 20 doctors. Then naturally this causes aggression and motivation among doctors who believe they are the cream of nation. Us seniors didn't react too much to these injustices. In our era we used to just do our work, get pays and take care of our family and kids and wouldn't participate in such activities. But now there is a new generation and it is a new era. This generation doctors compete with the bureaucracy. They think that they deserve the same facilities as the bureaucracy, if not more. When the state doesn't do equality and where there is unfairness then there will emerge organizations.

Because of this outright competition between the two professions to attain the highest level of prestige, YDA CM 3 stated that their demand to have doctors inducted on grade 18 (since they have 18 years of education) instead of 17 have not been met because "it will pain" the state to approve of this demand because their own officials join the Civil Superior Services at grade 17 and they would not want the doctors to join on a higher grade.

Apart from status over symbolic struggle that are disguised forms of a fight for professionalization, there are also very obvious attempts to have some control over their profession. YDA demands for less bureaucratic involvement in the hospitals and more autonomy of the profession. Additionally it wants YDA members to be consulted when health policy and programs are devised. Although the health secretariat has doctors to advise it on these matters, YDA feels that these doctors are essentially "yes-men" who never criticize the state in order to maintain their positions. Moreover, "it is the young doctors who experience the *real* state of health and healthcare conditions, [they] see the misery of people and [they] are at the forefront managing the crowds of patients every day. The senior doctors only handle the complicated cases" (YDA CM 2). So the young doctors want more voice, agency and control over their work environment and occupation. The demand for a technocrat as a health secretary

(see Chapter 1)is also a part of this struggle, the exact specifications of whom were described by one of the YDA CMs (2):

> We want a Health Secretary who is a doctor. Not just any doctor who merely has a medical degree and who later passed the Civil Superior Examinations [CSS] and became a bureaucrat. We want someone who has experienced our system. Someone who has been beaten up by attendants, who has interacted with other doctors, who knows about the suffering of patients and the grievances of doctors. Someone who knows that if there is a bungle related to medicines then at what level it can be happening. Someone who knows that if doctors skip duties and cheat the system, how exactly they do it. Someone who knows how much work exactly does a junior doctor do and how much does a senior doctor do. The health secretary has no idea about this stuff and he makes policies. He was initially serving in the agricultural department making policies for better wheat growth and then he comes here and devises measures to control TB [gave a hypothetical example]. These bureaucrats think they are perfect. By writing an essay in English in the CSS exam they feel that they can do no wrong now.

Banners placed in front of the admin office of a public sector hospital. The purple banner reads "Our Demand: A Doctor as Secretary Health"

The doctors aspire to work at public hospitals rather than private as state employment in Pakistan gives more economic and symbolic capital (Alavi 1972). "Economically, the government jobs are well protected. They are not very well paid… but they do have a lot of privileges and perks: after retirement you get a handsome sum of money. Socially also there is a perception that the government jobs are much better" (YDA CM 3). The social perception

about public sector jobs being better has to do with the ideology of trustee professionalism coupled with serving the underserved (as discussed in Chapter 2). This ideology has not been replaced by expert professionalism is the case of Pakistan perhaps because it has not gone through the same course of professionalization and de-professionalization as experienced in more developed countries. The social prestige in the profession has not only to do with the ideology of trustee professionalism alone but more to do with the idea that they are servicing the underserved:

> Doctors give a lot of comfort to human beings and so I thought I should become one. Secondly, my parents also really wanted me to become one because they thought that you can serve humanity through this profession (YDA CM 3).

> I believe that working at a public hospital is a great thing because the patients who come here can't afford to pay for healthcare. When you solve the problems of non-affording patients then you feel contentment and happiness because they are grateful and pray for your wellbeing (YDA CM 4).

The ideology of social trusteeship was not associated with working at a private sector hospital indicating that social trusteeship in this case is heavily dependent on serving the poor. Muzio and Kirkpatrick (2011) argued that the plight to serve the underserved is not taken by the professionals anymore and it's the job of the "activists". Here we see otherwise:

> In private hospitals the patient is paying so you are working for the money. You treat them for their money. There is no sensitivity or emotions involved in the whole thing. Although they are your patients and you have an understanding and a communication with them, but those patients sometimes misbehave with you and say that we have paid you why aren't you doing this or that. But in public hospitals, more than 90 percent of the patients are from rural areas and poor parts of Lahore. And when they come with a hope and you address that hope and they are grateful to you then internally you feel contentment and happiness. (YDA CM 4).

This combination also gives them the status of *messiah* and they have internalized this role hence, they don't just serve the poor through their 'professional' services but also by fighting for patients' rights. Following the ideology of social trusteeship coupled with the duty to serve

the poor and thus internalizing the *messiah* identity is also something that differentiates the social movement of YDA from those of other medical staff and prevents a resonance with them.

Section 3.2: YNA – A Struggle for Professional Status minus the Status

The nurses are not high-school graduates anymore as the doctors and the others claim. They have a bachelor's degree and a year of training before they join the profession… earlier our professional grade was much lower, it was due to the struggle of YNA that is was increased to 14 some years ago, and further struggles led to an increased grade of 16 [with salary increase according to the scale]. Recently we have received a risk allowance of PKR 9000 [$90] and the nurses who hadn't been promoted for years have also been promoted….I think YNA has done what it aimed to achieve. If other issues come up in the future, the nurses will stand collectively for their rights again.

One of the CMs of YNA summed up the struggle of nurses of the public sector hospitals of Punjab. These could have easily been the words of all the nurses that I interviewed. Everyone stressed on the struggle for salary increases, risk allowance, and the overdue promotions (see Chapter 1). They spoke of the increased level of education of nurses now (unlike before) and how their work should be revalued accordingly. Apart from revaluation of work based on increased level of education, a revaluation was also demanded because the nurses felt the hospital cannot function without them since they do not do only their own, but "other staff's work".

Although they have a very strong professional identity which derives fuel from the label 'nurse' and their uniforms and binds them together, their actions cannot be understood in terms of a struggle for professionalization of the same nature as the doctors since none of their demands are about an increased control of their profession and they do not frame their grievances as strongly against the state officials as the doctors do. They have accepted that they come under the authority of state officials at the state department of health. They have a semi-professional status in the sense that they are perceived as 'just any other employees' who have been hired by the state. Moreover, the requirements for their educational background have been

flexible and have only recently been standardized and that adds to their semi-professional status.

Their struggle is about attaining a professional status, however, just for the improvement in economic position associated with it and not for the increase of prestige unlike doctors, who repeatedly pointed out how given their position they should not be mistreated by the state officials or by 'regular' people. Nurses did not mention anything of the sort. They felt that they were respected by doctors, the admin and patients. In fact it was the doctors who revealed that nurses too are physically abused by attendants due to shortage of facilities or lack of medical attention given. So the nurses do not frame their grievances in terms of status struggle. Theirs's is mostly a form of class struggle with the professional 'nurse' identity used as a resource for mobilization.

An important factor about the kind of work that they actually do in hospitals helps to explain the particularity of their struggle in relation to social movements by nurses discussed in literature (see Chapter 2). In general perception – not only globally but even among the Punjabi society and healthcare system – nursing is associated with the provision of care in a hospital setting. The following picture from a nurse protest in 2016 in Minnesota depicts just that:

("nursesstrike_laborday3")

Moreover, some of the doctors I interviewed expressed their beliefs about nursing being care-work which can only be provided by females:

> The actual concept of nurse is that of a female. *Allah* has made females of a caring nature. They are mothers and sisters and wives. Females have a greater tendency to love and care and keeping that in mind, females are hired as nurses and that's a good thing. (YDA CM 2)

> A nurse's job is to care for the patient and a woman is caring by nature. *Allah* has put in her nature the element of care. So women can do this job best. And the first nurse was also a woman. Men are by nature of a harder temperament. I believe they find it difficult to do such duties all night long or spend the night sitting by a patient's side and counsel them. They find it hard (Hospital Administrator).

However, providing care is not what the public sector nurses in Punjab get to do. The work that they actually do have no feminine connotations to it as generally associated with care-work. In the case of public hospitals in Punjab nurses are overworked and each is responsible for around 40 patients in a 6 hour shift, they rarely get to perform their main role of caring for the patient and providing a nurturing environment in the hospital. They mostly go from patient to patient administering medicines prescribed by the doctor. In other times they are carrying out duties that are not officially theirs: that of a pharmacist and sometimes those of a doctor as they claim putting injections is not officially part of their duty. Moreover, they also manage the subordinate employees like plumbers, electricians, laundry workers and pharmacists and oversee their functions, and claim that the hospital system cannot function without them. Since nursing is dissociated from care-work in the case of Punjab, nurses struggle not for the revaluation of care-work as the literature on nurse strikes suggests but simply for their professional cum labor rights. Perhaps this is also why their struggle is not framed in terms of gender like many other nurse movements. Briskin (2011) argues that: "Resistance to patriarchal practices and gendered subordination has provided a foundation for solidaristic alliances with the community-based and union movements of women, with nurses based on gender, and with other women workers" (289). Since collective identity based on gender is not highlighted by

them, no collaboration with any women rights' movements takes place. It is the other medical staff that highlight the collective identity of nurses in terms of their gender: "If there are any super women, it's the nurses. A few days ago the government was celebrating Women's Day but they didn't highlight nurses or lady doctors in their ceremony" (YDA CM 2). Nurses themselves don't make any references to it. The occupational and professional identity is the only one highlighted in the struggle to gain solidarity.

The Janus face of gender – gender as a resource

Although they don't highlight the gender factor, it however plays a paradoxical part in their struggle – it is both a resource and a constraint. Despite being a weaker association in terms of its structure and organization, owing to the structural dependencies of nurses, YNA has been able to achieve significant successes. This is not only because of the rise of consciousness about women's rights but also because of cultural and religious perceptions of the society regarding women. Although the nurses themselves did not mention these factors, they were highlighted by YDA members, and state officials.

A female state official from the health department spoke of the rise in consciousness about women empowerment and how that benefits the nurses:

> These days there's a lot of talk about women empowerment in our society that makes the voice of the nurses louder [they are heard more]. Females get more edge now and they use this position to their benefit. Females are given more respect in the department. Working women are pampered more in our society because they work and they also take care of the house.

Some highlighted how in Islam it is not righteous for women to come out in a public space and "stand on the roads and protest" and if they do, then they get a lot of attention: "If females protest, it creates more hype, they are listened to more in our society" (YDA member). Others

claimed that their protests are effective because media gives a lot of attention to female protests and females generally have more public sympathy:

> Obviously the media gives more attention to nurses … because they are female and because it's rare for females in a society like ours to come out, stand on the roads and protest. It makes for a bigger story. Secondly in Pakistani society, the women can build more pressure since they have greater sympathy from society overall so the government fears more when they come on the roads (YDA CM 3).

Some state officials spoke of the importance of chivalry: "What puts nurses in a better bargaining position with the state is the female factor – females are given more regard by the state" (Health Department Official 1). Another claimed that since we are brought up in a society where females are treated with chivalry and respected because our religion requires those things, the state agrees to demands during female protests more readily. "With men, there are a lot of ways to stop them when they confront the state. Police aggression, etc. with women, you can't do these things" (Health Department Official 2).

Nurses themselves however did not highlight any effects of their gender as a resource benefitting their social movement. They generally believed that despite having a somewhat weaker association, they were able to achieve their demands because they were more integral members of the hospital staff without whom the hospital could not function. Moreover, whenever specifically asked about issues related to gender, they spoke of it as an inhibiting factor rather than an enabling one.

The Janus face of gender – gender as a constraint

No one likes to come on the roads especially women. Being a female coming on roads is very hard. Firstly, our society doesn't accept it and secondly, females have to balance both work and home.

Gender dependencies related to work-personal life balance and societal non-acceptance of 'women on roads' were the reasons highlighted for a weaker, less active association by nurses

when asked if and how gender impacted their movement. The most important factor nurses not being able to devote their times and energies to association activities was surely that they had to give time to their families, particularly to their husbands and kids which was not so much a consideration for YDA, whose active members are mostly males.

> YDA is more active since it is an all- male organization. Moreover doctors can spare more time. They can even protest for longer periods. We can't take much time off work and we also have to give time to our families (YNA CM 1).

> We are always worried about our kids. If we are on the roads, who will take care of them… their life gets disturbed. The last time we had a strike back in the summer, it was their exam period and we had to think about that too. (YNA member 1)

Some YNA members explained how they had to quit the cabinet membership after their marriage because of increased pressure to devote more time and energy to the family:

> I was involved with the union but then I dropped out because I got married and the union takes up a lot of time. They call you for a meeting sometimes at night also which is hard. Sometimes we go in the morning and come back late. In strikes too you have to sit day and night (YNA member 2)

> It is not much of a problem before marriage. Because you are single. But later you have to give time to your profession, your in-laws, husbands, do some house-work and when you have kids, you have to look after them also. It's quite difficult but I feel it's not specific to our profession, every working woman has to face these issues (YNA member 2)

Some doctors also expressed that being politically active as a female is much harder than as a male because these activities require a lot of risk taking and getting oneself into dangerous situations which women in the Pakistani society are not trained to do:

> We are males and we can take higher risks. We don't disclose this but our life is perpetually on risk. We receive threat calls. On every protest these politicians and state officials, who are in power and have local stakes, send their men who threaten to get us killed. Then poor nurses are female and they have family pressures and they endure too much. You can't imagine the ways in which they are blackmailed (YDA CM 2).

Other YDA members also mentioned the difficulty for women to organize politically due to other distractions, the perceived 'Islamic' idea for women to remain within the house, and due to family duties and pressures:

> We [YDA] have females but most active members are male who are more motivated to go on strikes. Females are not as motivated. Most of our council is also male. Being an all-female association makes YNA weak. A lot of nurses don't even know when some of their strikes are supposed to happen because they are caught up with their own issues (YDA CM 1).

> Since we belong to a Muslim society, in our societies the families of females have a problem with them getting involved in protest activities and sometimes they have problems themselves. Sometimes they are harassed so they try not be on the forefront. Secondly, they have other family issues. They have to give time to their husbands and kids so they cannot give as much time to association activities. Some even have to leave their jobs after they get married (YDA CM 4).

Due to such family responsibilities and other aforementioned reasons, nurses thought not having male nurses was a serious hindrance to the strength of the association. "Like male doctors in YDA, male nurses could be at the forefront representing our interests. It is easier for males" YNA member(5) exclaimed. Nurses sometimes have to call the paramedical staff during sit-ins at night for protection against harassment by "hooligans sent by the state".

The constraining effect of structural dependencies related to gender is one of the reasons why nurses feel they do not have the time to collaborate with doctors or other staff or strike for causes related to improvement of public health. "We don't have time for ourselves, where will we get time for others" YNA member (2) shared. One of the YNA CMs (1) mentioned that "in our meetings with the health department officials, when we talk about our own issues, we also talk about healthcare problems in general. We tell them that there is just one teaching hospital in our area and there are too many patients – more patients than there are beds. Then there are medicine issues. The patients cannot afford them. Not enough stretchers and sterilization issues. No one keeps a check on the hospital's quality of service". When I asked if they ever

thought of going on a strike for such issues she said that YNA had never thought of doing that: "it is a big deal for us to solve our own issues. We hardly have time to do anything else". She also explained that unless you strike, no one pays any attention to the suggestions they make during table talks. "That is just a process that we have to go through before we go on the actual strike". These structural dependencies are also why nurses "fold easily and compromise on demands" in the words of a doctor, "whereas the doctors never compromise". "They easily become happy with whatever they get. This is one of the reasons we can't work together with nurses" (YDA CM 3).

Section 3.3: PSA – Just Another Workers Movement

When we strike, other labor unions come to support us, like the carpet industry association and the textile industry association. We also go to their protests. It's a mutual relationship – PSA member

The social movement of the paramedical staff in the public sector hospitals in Pakistan is a labor struggle for class interests within the domain of public healthcare system using healthcare specific frames to voice their grievances. They argue that theirs is the riskiest job among the medical staff: "Ward attendants attend patients in whatever position they come. They put them on beds and change the beddings etc. They come in direct contact with their germs" and so they should be compensated accordingly (PSA President). Since it is an amalgamation of different types of jobs within the hospital domain – ranging from technical staff working in labs, dispensaries and operation theatres to manual workers like hospital sweepers and laundry staff – there is no strong occupational identity that binds this group together, like the identity of being a nurse in YNA and that of being a young doctor in the case of YDA. The range of state employee grades that the associations cover are also very widespread, preventing solidarity. Moreover, the state has separated employee grades 1-4 and outsourced their employment to private agencies. These employees are now hired on daily wages through agencies so they are not entitled to any benefits like before and they have no

regular employment. This leads to a division of objectives of the social movement. Although these associations are struggling for the reversal of privatization of grade 1-4 employees, the detour from its original objectives undermines the strength of the movement. Moreover, the major factor of its weakness is that the social movement has become divided into 5 different factions. The president of one of the five associations told me that this happened because "the state bought off some of the members who then create their own organization which is not that critical of the state or which compromises easily" and this is easier to do among the paramedical staff because "they are from lower classes and they are lured easily into such schemes of the state" and "that is why it is easier to divide them".

The 'labor' identity is more prominent among them than any identity drawing its energy from the work space and this is why they do not resonate as much with YNA and YDA as they do with labor unions from other work spaces. Moreover due to weakness of their association and the inability to have their current group-interest demands fulfilled, they do not consider struggling for any improvement of healthcare system. However, like nurses, they also raise issues about the betterment of facilities in the hospital: "We tell our administration that there should be places for attendants to live or to sit down on something respectful. They camp on the floors" the PSA president claimed. And he continued: "we noticed that people who come from afar to get treatment done are mugged by people who live around here". However these issues are just discussed with the admin of hospitals who have no real authority and are limited to table talks.

Section 3.4: Professional Hierarchies and Group Habitus Preventing Collaboration

When a doctor, after 18 years of education is hired on grade 17 and a matric pass nurse is hired on grade 16 and paramedic has grade 15, then you feel a social pressure - YDA CM 3

Apart from the fact that the three different associations have completely different forms of struggles due to a complicated intermingling of structural factors with identity formations,

there are obvious frictions between the three groups due to similar reasons based on professional and socio-economic hierarchies. These also hinder coalition. The aforementioned quote highlights the sentiments of some of the doctors who see the nurses and the paramedics as much lower in the professional hierarchy than themselves. Although now the education requirements of nurses have been increased and standardized, doctors still refer to them as "matric pass" (high school graduate). This is perhaps because the increase in educational requirements is a recent development and a great number of nurses who form YNA and whose grades have also been increased to 16 are in fact high school graduates. When I asked a doctor if the demands of YNA were justified he answered:

> Their demands about the improvement in service structure are justified. If you talk about the pay [He took a long pause] then I feel they take pay that is almost equal to ours (medical officers). The government just gave them a PKR 9000 [$90] health allowance. They didn't give us that. Now we have demanded for PKR 20,000 [$200]. We used to get risk allowance but not health allowance. Nurses got it and doctors didn't [stated in disbelief]. This is *totally* unfair. We are more educated and our duty hours are harsher. They do 6 hours duty in the emergency ward and we do 12 hours. (YDA CM 1)

The doctors want to maintain a position of significantly higher status than the other medical staff. Some YNA members shared that they felt doctors were not happy about so many nurses getting promoted at once due to struggles of YNA. "What they don't realize is that our promotions have been stopped since 1985. Doctors feel that we have received promotions in huge numbers and a lot of nurses have been promoted to grade 17. What they don't realize is that promotions have been overdue" (YNA CM 1). Moreover, the president of one of the paramedical staff associations believed that if all three medical staffs collaborate, then they will become "an unstoppable force". However, when paramedical staff approaches YDA and YNA for collaboration, they are not interested. "Doctors mostly think that their status is much higher than ours and this also angers the paramedical staff and they think if doctors don't

consider us worthy of collaboration, we don't consider them worthy either" claimed the president.

These social distances based on professional hierarchies are strengthened by the differences in socio-economic classes of the three groups and the habitus each operates in.

> Nurses come from much lower socio-economic backgrounds compared to the doctors. We are more educated – we are doctors, we are messiahs. They are nurses – their class is much lower than ours. A doctor thinks of a nurse as a 3rd class woman [somebody who does not evoke respect]. Not just the doctors but also generally people in our society feel this way. Poor them, because of how they are perceived, they are not valued. The government also plays on that. They know that this group is greedy, they can be placated easily. They play one group of nurses against the other (YDA CM1).

A hospital administrator had to say the following about the mannerisms of the nurses:

> The low extent to which the nursing cadre can go to get their demands fulfilled, us doctors can't go. Socio-economic background of a group really defines who they are and how they act…They get their demands fulfilled through their crude language, lack of decency and misbehavior. Doctors are not like that.

YDA CM 3 shared his views on the behavior of nurses:

> I feel that the admin is scared more of the nurses. Nurses are ruder and disrespectful and they misbehave a lot and use foul language. Doctors among us also do that but nurses go to a different level altogether. Moreover, if a girl is abusing me in public then I would feel much worse than if a guy is doing it. I might be able to take my anger out by slapping him. With females I can't do that. In our society we can't use physical violence to curb the women so you eventually have to agree to their demands.

These tactics, demeanor and behavior was something that the doctors did not want to be associated with to maintain their symbolic capital. Hence, occupational differences are strengthened by habitus differences. Noordegraaf and Schinkel (2011) argue that within a profession, the professionals are not only educated in a technical sense, but are also socialized into their group as members and become "a professional in an embodied sense" (104). With time, they develop "a socially constituted capacity to act and acquire a professional *habitus"* which is a set of dispositions that effects how they think and act (Noordegraaf and Schinkel

2011: 104). This embodiment of capital is influenced by "objective social structures, not only within a (professional) field but also in society, such as class, family and (earlier) education" (Noordegraaf and Schinkel 2011: 104). Acquiring specific habitus influenced by their socio-economic backgrounds, education and the professional group they have been socialized into, the three groups grow distant and even working in close proximity is unable to bridge the distances.

Exclusivity of collective identities

Although the associations were originally formed to represent the collective interests of each group from all over Punjab against the state, the collective identities of each has solidified and has become somewhat exclusive so that the associations are now also used to voice the interest of groups against each other. This, however, happens at hospital level where YDA, YNA and PSA hospital chapters sometimes come in conflict with each other. If there is a conflict between a doctor and a nurse then the YDA protects the doctor and the YNA protects the nurse. "Some time ago a doctor had verbally abused a nurse so we all stood in solidarity and demanded that the doctor apologize to the nurse. YDA personally told us that they knew the doctor was in the wrong but since he has the label "doctor" attached to his name, they needed to protect him. In the end we took pity on the doctor because he just had 4 months left of his training period and we did not want to ruin his career. After all, such matters have to end somewhere" (YNA CM 1).

Wrapping Up

The chapter has highlighted how the particularity of structural conditions in Punjab lead to doctor and nurse struggles which are very different from the kind of struggles highlighted in literature studying industrialized nations. Rather than experiencing de-professionalization – since they were not professionalized in the first place due to the legacy

of colonial systems of state patronage – and associated move to expert professionalism in the neoliberal era, the doctors in Punjab are struggling for unique forms of professionalization in the form of social movement making claims against the state to gain control over their profession. Moreover, unlike other nurse movements that demand for revaluation of care-work, the nurse movement in Punjab (owing to particularity of their work that is influenced by the structural conditions they operate in) demand a revaluation of their professional status, in terms of increased compensation, due to recent standardization of their education and the fact that they do not do only their own but other staff's work.

Overall, the chapter discussed that the particularity of the structural conditions have resulted in unique and separate forms of struggles by each medical staff group that prevents a lack of coalition among them. Doctors struggle for professionalization, nurses for a professional status (in terms of an economic improvement) and paramedical staff for labor rights. The separation between them is further enhanced by professional hierarchies and difference in habitus. This separation also curbs the potentiality of the medical staff to make significant improvements in the healthcare system at large – it leads to *a potential not realized*

Conclusion: Upscaling the Negotiation

The contemporary era in professional development is referred by some as the era of expertise, where professionals have "strong interests in marketable knowledge and weaker concerns about relationships between community and authority" (Brint 1993 qtd. in Noordegraaf and Schinkel 2011: 102). In this era the "coherence of professional middle class as a force in political life" has reduced (Noordegraaf and Schinkel 2011: 102). Among the public sector doctors in Punjab, these trends have not emerged owing to the lack of the context of professionalization and de-professionalization, typical for industrialized countries. In Punjab and generally in Pakistan, the doctors are politically challenging the state and government not only for their own interests, but for the interests of the community. Having already established platforms through which to get their voices heard, the sub-professional classes such as nurses and paramedical staff have the potential to add to the resources of the doctors in their struggle for the betterment of the healthcare system.

The particularity of the struggle of each group stems from the broader structural socio-political and historical developments: a lack of professionalization due to systems of state patronage that originated in Pakistan's colonial history for the case of doctors; specificity of the kind of work nurses do (or the care-work that they don't do) due to lack of human resource in the hospital and the structural dependencies related to their gender for the case of nurses; and the socio-economic dependencies for the case of paramedical staff. Owing to the differences in the structural conditions, each group reacts in very different ways with regards to framing their grievances, forming particular collective identities and making them exclusive (YDA and YNA) or inclusive (PSA resonating with other labor movements) in order to use them as a resource for mobilization, depending on what they believe will be the best strategy for success in the movement. These differences in structural conditions, coupled with the

differences in habitus that each group belongs to, also maintains distances among these groups of collective actors. A combination of all three factors – different structural conditions under which the three groups operate, the consequent differences in the reaction of each group to those structural conditions in ways that they deem most resourceful, and their professional hierarchies intermingled with the vastly variable habitus that each group operates in – inhibit coalition for a collective struggle. A coalition that, if established, has the potential to become a strong force in the improvement of healthcare system.

Since all three groups have already established platforms to voice their demands and have been successful to varying degrees, the combined force of the three separate movements might have more power to influence the state. Once a common platform is established with the combined resources of all three, it might be able to successfully push not only for satisfying their group interests but also for improving the public healthcare system on a broader level. All three groups already understand the issues with the healthcare system. Seeing these issues close up and experiencing them on a daily basis, they believe their recommendations are worth heeding, but what they require is a stronger platform to get themselves heard. This platform could derive its strength from combined foundations of the three separate ones.

Now that the nurses have standardized and higher forms of education, and they are voicing this factor to make doctors realize that the distance in their professional hierarchy is not as vast as it used to be, the perception of doctors about nurses might change. Moreover, as time passes and less educated nurses retire and the more educated ones take their places, the distance between the two professions is likely to reduce. Additionally, a state official in the health department shared that there are talks of increasing the minimum education level of nurses to be able to practice in public sector hospitals, to a post-graduate degree. If this policy is implemented, professional hierarchies will further reduce. Once the distances are bridged, a

collaboration is likely. If that happens, the problems that nurses face in their struggle due to lack of males will be overcome and they might stand with the doctors not only when professional interests are concerned but also for the betterment of health system at large. Right now, a collaboration of doctors and nurses with the paramedical staff seems somewhat more difficult owing to the latter's much lower position in the professional hierarchy, and the weakness of their own association due to divisions and the vast range of occupations they represent. However, if the doctors and nurses support them in their struggle then a mutual relationship might follow. As a doctor stated "when you protect someone they become obligated to repay by supporting you and joining you in all the association activities that you take part in".

Conceptualizing and theorizing struggles by professional associations in the form of social movements is rare in literature, and this paper has attempted to do just that – combine the literature on politics of professionalization and social movements to analyze the struggle of young doctors, young nurses and paramedical staff in the context of Punjab. The concepts of social movement literature such as structural conditions of their emergence, collective identity formations and resource mobilization really help to understand the plight of these professions. Moreover, embedding this combination of two distinct streams of literature in the overarching framework of scalar analysis helps a more holistic conceptualization of the social problem at hand. This conceptual/theoretical framework can be used to view other similar struggles by professional groups, not only those operating in similar structural conditions but overall. Such scalar visualization of healthcare systems and teasing out the details of how negotiation and renegotiation between different scales takes place through ethnographic analysis can prove useful for those trying to understand the problems with the healthcare systems in an in-depth and holistic manner and for those devising solutions to those problems.

The envisioning of the healthcare system on a scalar level also makes us realize that these actors are struggling to have more voice by renegotiating scales between two levels only as they simply target the state. However, a struggle for the renegotiation of scales one level up – at the global-level does not take place. The social movements do not question or frame their grievances against the supra-national forces that influence the healthcare system of Pakistan to be in the condition that it is. However, a renegotiation of scales at the level of state and medical staff depends heavily on the renegotiation of scales at the global level. As highlighted in the Chapter 2, the current state of the healthcare system has as much to do with neoliberal conditions preventing significant expenditure on health as it has to do with the disinterest of the state to spend on health facilities due to governmental preferences to spend on transport developments and because of bureaucratic-military oligarchy in Pakistan that results in more expenditure on defense compared to social development (Alavi 1972).

Scaling up on the demands requires the social movements to question the neoliberal forces and share the sentiments of those that protest against these – the proponents of the global justice movement. This will involve making claims against the international financial institutions such as International Monetary Fund (IMF) and the World Bank for their imposition of Structural Adjustment Programs (SAPs) that have adversely affected the social development in Asia, Africa, Latin America and the post-communist countries (Narruzaman 2007). SAPs, which work on the principles of economic liberalization and the privatization of economic activities are considered one of the major reasons for destabilizing public health systems in developing countries (Nuruzzaman 2007). The unrestrained expansion of private medical services contributes to lack of government attention to the public healthcare system. In Pakistan, the private medical sector outperforms the public significantly (Nuruzzaman 2007; Zaidi 2001).

Upscaling the claim making in this form will also resonate with other social movements which protest against the withdrawal of the state from social development in the neoliberal era, creating a more inclusive collective identity that questions the fundamental problems of the system. The doctors indicated how they see private hospitals as a "mafia" destroying the public health system. Further research into the structural conditions regarding conflict of interests between private and public healthcare systems in Punjab and more generally in Pakistan, and their consequent effect on collective actions of professional actors may help uncover the potential upscaling of such movements.

Such a scaling up, however, might be too utopian. At the current levels the movements have a clear 'other' that is close and approachable which they can target and mobilize against, and that is one major reason for their strength. If it was against a global scale then it would lose the clear other and perhaps its efficacy. "Some have raised doubts about the global justice movement's capacity to mobilize its constituency beyond the most visible events on very similar grounds" (Tarrow 2005 qtd. in Della Porta and Diani). The distance, unapproachability, and ambiguity of the global 'other' may not resonate with many and may prevent the development of a strong collective identity. It may further prevent the horizontal cooperation capacities of the three social movements.

At a more immediate and realistic level, the social movements may scale up by demanding a voice in how the development loans and donations that come in for the healthcare system are spent. With the weakening of the state in the neo-liberal era, funding for many social services in developing countries including healthcare is increasingly provided through bilateral donor schemes and managed through aid agencies. Which healthcare facilities get the highlighted, depends significantly on the donors, and this may result in the focusing on those health issues that have global relevance at the expense of those that are locally relevant. Under

these conditions, a demand to have a say in the expenditure of funds on what they understand as locally relevant issues could be a way to participate in the renegotiation of scales not only between two but three levels. The proponents of these social movements, who claim they are most aware of the ground realities of the health conditions could demand to be consulted as advisors on how these funds are spent. This would require making claims not just against the state but also against aid agencies that manage the expenditures.

Upscaling of claim making processes and formation of coalitions among different medical staff has great potential to bring about significant changes in the healthcare system of Punjab and in extension Pakistan. The platforms are established, the potential is yet to be realized.

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