THE PROBLEM AND ITS CONTEXT

Medical Sociology, barely forty years old as a distinct field, is one of Sociology's most active sub-specialities today. It emerged as an identifiable field only after World War II in the West. In India it is still an upcoming field where there is still a lot of scope to fill in the gaps in sociological theory as well as its applied aspect to improve the health system. Medical Sociology did not develop out of attempts to explore conditions of health and disease as had been the case with Pathology or Bio-chemistry. Like Physiology, it arose in an effort to describe human functioning in a social group rather than in the individual organism. It has been attempting to develop concepts, knowledge and skills which appear applicable to the investigation of many problems in medicine.

We are today carrying the banner of "Health care for all by 2000 A.D." Only a little has been achieved yet and a lot still has to be done in this field. The failure in the area of modern medicine to attain complete or optimum physical, mental and social wellbeing necessitates the planners, doctors, nurses and the social scientists to analyse the health care system and to find out discrepancies which effect the working of the system.

In India the current processes of urbanisation,
westernisation, industrialization, modernisation and population explosion have aggravated diseases. One of the major assets of any nation is the health and well-being of its population. Hence the role of modern hospitals is of prime importance in the developing and under-developed countries. They are the pivotal institutions of modern medicine which have the responsibility of attaining greater degree of efficiency and effectiveness in order to attain their goals. The present study falls under this field of sociological enquiry.

1.1 STATEMENT OF THE PROBLEM

The modern hospital, as we all know, is a complex social world with a multiplicity of goals, complexity of personnel and elaborate division of labour. Patients in the hospitals are like business clients and a study of their behaviour is of paramount importance in the modern times. A smooth running of the hospital depends upon the interpersonal relationship within the organisation and its administrative hierarchy. The most important means to achieve this objective is through good doctor-nurse-patient relationships. Most of the hospitals in large cities are not able to achieve the objective of good patient care because of inefficient management and faulty doctor-nurse-patient relationships.

There are three levels of communication among them - on emotional, cultural and intellectual planes. The doctor and the nurse who are able to communicate with the patient on all
the three planes may give maximum psychological satisfaction to the patient. Patient care by doctors and nurses involves interaction at three different or conflicting orientations which include the orientation of doctors, orientation of the hospital organisation or the hospital administration, and the orientation of the patients towards the hospital organisation and the doctors and nurses.

Most of the hospitals in India have a number of good specialized and superspecialized departments. Among them, the gynaecology and obstetric department is one which is always flooded with patients.

It may be observed that many of the problems which concern our society are related to the discipline of gynaecology and obstetrics. We are all concerned with both the quantity of the population explosion and the quality of the next generation. The mounting social, economic and medical problems posed by population explosion demand serious consideration. Pregnancy is a normal life crisis like adolescence and old age. Patients who attend the pre-natal wards seem more emotionally disturbed than other patients. Thus the role of the doctor and the nurse in these wards has a greater element of responsibility for this may have a marked effect on the future and well-being of the mother and the child. Relationship between a patient and gynaecologist or an obstetrician may have certain quantitative differences as compared to the relations between other physicians
and their patients. At one end the doctor must retain the objectivity so necessary for surgical performance; at the other end she must be sensitive to the perception of the highly emotional situations of patients in dealing with their problems. If there is a delay on the part of the doctor or the nurse in treating the patient, there may arise the danger of development of non-adaptive neurotic and psycho-somatic symptom-formation at times becoming chronic disability.

The relationship between the doctor, the nurse and the patient in this ward affects the patient, since the patient is subordinate both to the doctor and the nurse, in the sense that she is dependant on them for her recovery. A good relationship will reinforce the positive effects of medical care and also possibly contribute to expediting recovery. Similarly, a bad relationship will definitely prove damaging in the long run as regards the delivery and acceptance of medical care because the anxieties and fears of gynaecology and obstetric patients are different from those of other patients.

In this scientific and nuclear age, the relationships are perceived differently by the doctors, nurses and the patients. The doctor and the nurse look at medical technology with a mechanical and professional perspective. Whereas the patient looks at it from a different angle of receiving the necessary service because this mechanisation and professionalism leads to
an 'impersonal' attitude and the loss of personalized care by the doctor and the nurse. It is thus necessary to study the differences in their perceptions in order to understand their relationships.

In this present study an attempt has been made to analyse the socio-economic background of doctors, nurses and patients alongside their perceptions on hospital setting has been studied. Besides this, the perceptions of the doctors, nurses and patients have been studied in terms of behaviour, professional, emergency and commercial components.

The role perceptions of doctors towards nurses and patients, of nurses towards doctors and patients and of patients towards nurses and doctors have been studied in terms of role-expectation and role-performance; and their satisfactions and dissatisfactions have been considered. Further their perceptions towards commercialization in the gynaecology and obstetric wards of the selected government hospitals and nursing homes of Andhra Pradesh and Uttar Pradesh have been studied to know their role relationships.

1.2 OBJECTIVES OF STUDY

The objectives of the present study are as follows:

1) to analyse the social structure of government hospitals and nursing homes;
ii) to determine the social composition of doctors, nurses and patients in gynaecology and obstetric wards;

iii) to analyse the role perceptions, role expectation, role performance and role relations of the doctors, the nurses and the patients and their consequent satisfaction and dissatisfaction; and lastly

iv) to explain the commercialisation in gynaecology and obstetric wards of government hospitals and nursing homes.

1.3 REVIEW OF LITERATURE

Sociology deals with the dynamic networks of changing social relationships within particular spheres of social life or in a social life as a whole. Some among its key areas of concern are social groups, the internal structures, their functioning processes, social actions and interactions within and between groups that tend to maintain or change the given organisational forms and the associative and dissociative processes involved. It is with some of these that we are more directly concerned as a part of medical sociology.

Medical Sociology is a subspeciality of sociology and deals with the interface between the providers and consumers of health and medical care systems. Some of its major concerns are social facets of health and illness, the social functions of health institutions and organisations, the relationship of the system of health care delivery to other systems besides the social behaviour of health personnel and those who are
consumers of health care.

Robert Straus (1957), classified Medical Sociology into two separate but closely interrelated areas - 'sociology in medicine' and 'sociology of medicine'. 'Sociology in medicine' deals with application of sociological concepts, knowledge and techniques. It deals with questions regarding etiology and ecology of disease, variation in attitude and behaviour regarding health and illness. 'Sociology of medicine' is concerned with questions regarding recruitment and training of physician, relations of physician in role set, medical organisations and hospitals and development of community health. Here emphasis is on organisation relationships, norms, values and beliefs of medical practice.

According to Mehta (1982), in the first category the sociologist as a member of team collaborates with the physician and other health personnel in studying social factors relevant to health disorders, whereas in the second emphasis is on role relationships as form of human behaviour. This distinction suggested by Straus (1957), becomes meaningless in view of the complexity of health and disease behaviour since this involves interaction of physical, biological, psychological, social, cultural, political, geographical, technological and economic factors in different combinations and permutations. Therefore a sociologist studying 'sociology of medicine' should be
adequately equipped with knowledge of 'sociology in medicine'.

The present study broadly belongs to the field of 'sociology of medicine' although the distinction as mentioned above seems arbitrary. The present review of literature, for the sake of convenience, has been divided into three parts:

1) General Studies in Medical Sociology done Abroad.
2) General Studies in Medical Sociology done in India.
3) Specific studies done in Gynaecology and Obstetrics both Abroad and in India.

1.3.1 General Studies on Medical Sociology Done Abroad

Against the background of diversity and rapid expansion of medical sociology abroad any attempt to review the full scope of activity would be impossible. Fortunately excellent reviews have been sprouted throughout its history, (Caudill 1953, Clausen 1956, Freeman and Reeder 1957, Reader and Goss 1959, Reader 1963, Suchman 1964, Graham 1964, Bloom 1965, Hyman 1967, Kendall and Reader 1979, McKinley 1972, Mechanic 1975 and Fox 1976).

Our approach here is limited to -

a) Hospital based studies.
b) Studies on Interpersonal relationships in hospitals amongst the doctors, nurses and the patients.
1.3.1.1 Hospital based studies

Hospitals are an important element of the system of medical care and health services. According to Gouldner (1954), sometimes hospital rules are not followed but are ignored. Merton (1957), is of the opinion that formal rules and regulations can both have functional and dysfunctional consequences. Sometimes conformity to the rules interferes with the achievement of the purposes of the organisation.

Goss (1963), Perrow (1963, 1965), Rosengren (1969), Hydebrand (1973), focus on the internal structure of hospital technology. Technology is seen as a major deterrent of behaviour depersonalization and alienation.

According to Georgopoulos and Mann (1967), "The community general hospital is an organisation that mobilises the skills and efforts of a number of widely divergent groups of professionals, semi-professional and non-professional personnel to provide a highly personalized service to individual patients through collaborative activity." They have suggested that hospitals low tolerance for error and concern for maximum efficiency and high rate of performance tends to make the authoritarian control patterns more functional. They ascertain relations among internal organisational variables such as cohesiveness, communication, coordination and effectiveness.

Becker and Duncan (1975), in study of hospital organisation
found that rules and efficiency are negatively related while efficiency and results are positively related.

Mumford (1976), shows a high degree of significance for the physicians in hospitals according to the orientation of their major reward system. Mechanic (1976), Naveero (1976), and Taylor (1979) describe that indifferent attitude of personnel in the hospital is related to the organisational characteristics of hospital. Robert Presthus (1979), is of the opinion that specialists disturb the equilibrium of the organisation by fighting amongst themselves for resources and recognition.

1.3.1.2 Studies on interpersonal relationships in the hospitals amongst the doctors, nurses and patients

The studies on interpersonal relations in hospitals amongst doctors, nurses and patients have been divided into three sub-categories:

a) doctor-patient relationships;
b) doctor-nurse relationships and
c) nurse-patient relationships.

1.3.1.3 Studies on doctor-patient relationships

The scope of studies on doctor and patient is very wide. These have been studied by Parson (1951), M.Balint (1964), Merton (1957), Coser (1969), Mechanic (1968), Duff and Hollingshead (1968), Coe (1970), Friedson(1970), Bloom and Wilson (1972),
A. Shiloh (1972), Cartwright (1974), D. Tuckett (1976), Szasz and Hollander (1979), Denton (1973), Kisch and Reader (1973), Quint (1973), Leonard and Skipper (1979), Anderson and Helm (1979), Svardal (1979), Tagliacozzo and Mauksh (1979). For example -

Horton (1957) represents values governing the doctor-patient relations. These values relate to doctors emotional detachment, preferences for patients confidence, diagnosis, medical care, time, psychological and social circumstances.

Szasz and Hollander (1966), distinguished between three types of doctor-patient relationships - activity-passivity; where the doctor is active and patient passive, guidance-cooperation; in which the patient is capable of taking instructions from doctor and exercising his own judgement, mutual participation; in which the treatment programme is carried on by the patient with occasional instruction from the doctor. Friedson (1971), added some other categories to the above like mutual-cooperation, passivity-activity and mutual passivity. Tuckett (1976) agrees with Friedson but maintains that these three type of relationships are the relationships which the doctors wish to create with patients suffering from different conditions.

Michael Balint (1957), argued that more harm is done to patients through treating physical symptoms alone without recognising their emotions. Wolf (1959) suggests that one
third of the success of any drug or procedure depends on the patients belief that something is being done for him. Zola (1963), suggests that failure to recognise the non-medical element leads to drop out treatment. Friedman (1963) and Egbert (1964), remarked how pre-operative encouragement and proper instruction of patients can dramatically improve treatment.

There are a number of studies that analyse the negotiation and bargaining that can occur between the doctors and the patients and the strategies each one uses to advance their point of view (Roth, 1963; Davis, 1963; Glaser and Strauss, 1963; Garnow, 1967 and Goffman, 1963).

Friedson (1970), points out that the institutional arrangement will influence the doctors power to carry out his wishes regardless of patients culture.

Cartwright (1975), found that doctors spent longer time talking with middle class patients as compared with working classes patients. Doctors are more satisfied where discussions are kept short and where they are in complete control of the situation. A good general practitioner can train his patients not to make unnecessary or unreasonable demands.

According to Tuckett (1976), the relative power of doctor and patient depends upon the needs of both. The patient likes
and more nurses hold a baccalaureate degree and increasing number are taking masters and doctoral degrees. Ashley (1976) expresses that good nurses like doctors are born, not made that the nurse exists to be a doctors helper and that overeducation and not undereducation is the greatest threat to the performance of the nurse.

1.3.1.5 studies on nurse-patient relationships

The studies on nurse patient relations are as few as nurse doctor relations. A few that need mention are Brown (1936), Schulman (1953), Glaser (1950), Javoe (1963), Martin (1957), Miller (1958), Benn and Dennis (1970), Bates (1970), Stein (1971), Glelend (1971), Lamb (1973), Karol (1975), Halton (1975). For example -

Schulman (1958) coined the happy phrase "Mother Surrogate" to describe the ideal, bedside, ministering stereotype of the nurse's role. He finds this role to be feminine, characterized by affection, intimacy, physical proximity and identification with and protective care of patient. According to Strauss (1966) the nurses must justify their activity in terms of ultimate benefit to patients. Schulman (1972), "There is no doubt that professional nursing has left the patient beside and that a majority of professional nurses have resolved the "mother surrogate" healer role conflict by abandoning, circumventing
or sublimating the mothering functions of the nurse's role."

Hatton (1975) puts it "that in order to advance in the hierarchy nurses had to take up administrative posts withdrawing them away from patients. This situation often left the patients without optimum nursing care."

The general studies on medical sociology abroad are handicapped to some extent in not having formulations regarding the consultation process in terms of social interactions within this field. Most of their formulations seem to be more psychological in content than sociological. They are dynamic in nature as they describe processes at work rather than the more fixed entities, such as social status or health beliefs. They are more concerned with why and how the patient behaves rather than what the others do for the patient in the health system.

1.3.2 General Studies on Medical Sociology Done in India

Medical sociology is comparatively a new development in India. Anita Ahluwalia (1974) in her trend report on sociology of medicine outlined the needed areas of research and suggested priorities in certain areas. She classified the work in this field under heads -

1) Traditional system of medicine.
2) Modern system of medicine.
3) The medical profession.
4) The institutional structures of modern medicine.
5) Medical knowledge and technology and
6) Medicine health and community.

S.R. Mehta (1982) critically analysed studies on providers of health and medical care which include health organisations and institutions, health professionals like doctors, the nurses, indigenous medical practitioners, aids and folk medicine and found that the focus should be on community which has larger clientele with the providers of health service. According to his patient oriented studies should be given preference to organisational studies, and doctor-patient relationship in different studies should constitute the core to build studies around.

In a later attempt under IASSR S.L. Sharma published (1995) in his trend report on the study of professions in India has reviewed the medical profession including professionals and professional organisations and provided critical analysis of some of those studies.

The review of studies done in medical sociology have been divided into two parts -

1) studies in rural India.
2) studies in urban India.
2.1 Studies in rural India

Eminent social scientists from abroad and India have conducted studies in rural India. Harriot (1958), Elvin (1968), Gould (1957), Opler (1962), Fisch (1964), Carstair (1965), Leslie (1967) from abroad and Prasad (1961), Millon (1963), Khare (1963), Hasan (1967), Shatia (1973), Sakhair (1976) and Shatnagar (1978) from India drew attention to basic cultural and social factors which work against the acceptance of modern medical practices in the mostly traditional bound, caste ridden, rigidly hierarchical, illiterate and superstitious rural communities of India. It is impossible to mention in detail all the studies. Two such studies are being mentioned for they reflect certain ideas which can be adopted, and modified by modern medical practitioners.

Harriot (1958), in a study of western medicine in a village of north India has highlighted cultural aspects of medical role like trust, responsibility, charity, power and respect which are responsible for interpersonal relations. It is found that number of conflicts between the role assumed by the indigenous and the western medical practitioners has resulted in obstacles to the acceptability of western medicine.

Carstair (1965), in a study of rural Rajasthan gives importance to 'faith and assurance'. He refers to importance
of confident prognosis in the patient that traditional system establishes which perhaps the modern medicine is lacking.

The studies mentioned above and many more conducted by eminent social scientists are based on observations and lack variability in methodology (Ahluwalia, 1974).

According to S.R. Mehta (1962), they are primarily exploratory and to some extent diagnostic in nature. Most of these are sketchy in nature and provide gaps to be filled in regard to knowledge, belief and practice, status of people related to causation, curation and prevention of diseases. They have thrown up a number of hypotheses which need to be validated in different geographical and cultural regions of the country.

1.3.2.3 Studies in urban India

The review of studies in urban India is based on the objectives taken for study. They include:

1) Studies on hospital as a social organisation.

2) Studies on socio-economic background on doctors and nurses.

3) Studies on role relations of the doctors, nurses and the patients.

4) Studies on commercialization in medical profession.

1.3.2.3 Studies on hospital as a social organisation

Hospitals were started in India by the British Colonials
during nineteenth century. There number increased from 3 to 1794, to 2810 in 1912 (Jaggi, 1979). There were 8600 hospitals in 1946 which increased to 15000 in 1975 (CBHI, 1982). There are different types of hospitals from organisational point of view. There are government, private and semi-government (aided) service hospitals in contrast to private business hospitals (nursing homes).

Srivastava (1979), observed that the bureaucratic structure and process influences the performance of personnel working in it. This in turn is influenced by socio-cultural demands of the patients. He observed that conflicts in the hospital organisation arise due to excessive bureaucratic control and non-recognition of the professional competence of hospital personnel. 70% of the medical respondents observed that decisions are mostly taken by senior organisers and administrators.

Every hospital organisation has certain norms and behaviour and it prescribes rules of conduct for professionals, semi-professionals, paramedical and non-professionals in the hospital. It is generally found that the professionals and semi-professionals in the hospital are not strict in conforming to some rules (Srivastava, 1979; Venkatraman 1979 and Kirkpatrick, 1981).

1.3.2.4 Studies on socio-economic background on doctors and nurses

Much of the research on health professionals in urban India
has focussed on allopathic doctors. There are studies on private practitioners (Nadan, 1972), doctors in public hospitals (Advani, 1975; Mathur, 1975; Drivastava, 1979), of health professionals in organisations (Oomen, 1973), of doctors in elite institutions (Nadan, 1977) and above all comparative studies of institutional doctors and private practitioners (Nadan, 1972; Chandani, 1977; Rameshram and Ramakokie, 1973). Studies on medical students are by (Sharadaram and Parvathamam 1968), and Jayaram (1977) and Rao T.V. (1976).

On nurses there are studies by N.Kumar (1973), Haroi (1974), Reid's R.I.D. Project (1969), Oommen (1973) and Venkatraman (1979). In India the medical profession is predominantly a male occupation and nursing a female occupation (Oommen, 1973).

The ratio of doctors from rural urban background was found to be 40:60 (Nadan, 1977). Majority of the doctors come from an urban middle class elitist background (Oommen, 1973).

S.N.Dubey (1975) finds that more doctors than any other professionals are drawn from white collar families and constitute the most prosperous class among the professionals.

According to Oommen (1973), doctors form a 'socially insulated occupational category' in that there exists a social
closure in the process of recruitment into these occupations which limits the entry of individuals from certain social categories such as lower castes, rural backgrounds and poor families. Compared to the doctors, the nurses are drawn from lower castes, rural backgrounds, poor families and predominantly Christian communities and from middle class families. According to Cormack (1953), and Bendix (1960) the lower status of the nurse has to be understood in terms of many factors which include handling of bed-pans, blood and other body emissions.

1.3.2.5 Studies on role relationships of doctors, nurses and patients

There are several studies dealing with doctors, nurses, patients and their relationships. Studies which need mention are Advani (1975), Dubey (1975), Indu Mathur (1975), Chandani (1977), Oommen (1973), Ramaiahmas and Bambavale (1973), Srivastava (1979) and Venkatratnam (1979).

These relationships be described under three heads -

a) Doctor-patient relationship.
b) Nurse-patient relationship and
c) Doctor-nurse relationship.

doctor-patient relationship

There are many factors influencing the doctor-patient relationship. Madan (1972), in his study dealing with role
perceptions of doctors reveals that doctors harbour a 'patient and disease oriented' rather than a 'person and health oriented' self definition of their role. In his AIDMS study (1977), he points out that doctors perceive their role primarily as the healer. This has been supported by Oommen (1973) study.

Oommen (1973), finds that most of the doctors, view the patient not as a person but a 'bundle of clinical symptoms'. According to him most of the doctors do not consider the welfare of the patients as their most important role obligation. Madan finds in his study of AIDMS, the apex institute (1977) that doctors want to spend more time on research than on patient care.

As regards role relationship it was found that doctors subscribe to Parson's 'affective-neutrality' prescription, (Mathur, 1975; Advani, 1975; Chandani, 1977; Ramanamma and Bambawale, 1978). Some studies suggest discriminatory dealing with patients on account of kinship considerations, patients socio-economic status, power and position, (Mathur, 1975; Oommen, 1978; Srivastava, 1979). Some doctors complain of excessive work load and excessive demands by patients and attendants (Madan, 1977), (Chandani, 1977) and (Oommen, 1978).

According to Oommen (1978), doctor-patient relationship depends excessively on the size of the hospital. In medium size hospital the doctor patient relationship is more equalitarian
closure in the process of recruitment into these occupations which limits the entry of individuals from certain social categories such as lower castes, rural backgrounds and poor families. Compared to the doctors, the nurses are drawn from lower castes, rural backgrounds, poor families and predominantly Christian communities and from middle class families. According to Cormack (1953), and Bendix (1960) the lower status of the nurse has to be understood in terms of many factors which include handling of bed-pans, blood and other body emissions.

1.3.2.6 Studies on role relationships of doctors, nurses and patients

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doctor-patient relationship

There are many factors influencing the doctor-patient relationship. Madan (1972), in his study dealing with role
readily met by the nurse. In large hospitals the performance of nurses is rated to be poor. Resourceful patients use influence for obtaining better care in the hospital, (Advani, 1975; Srivastava, 1979 and Kirkpatrick, 1981).

C. Rajagopalan (1963) is of the opinion that social stigma attached to their jobs tends to spoil their marriage prospects. According to Hale (1969) the nursing is characterised by overwork and helplessness. In the editorial comment in the 'Time of India' 15th April, 1963 he wrote, "The general failure on the part of hospital administration all over the country to provide their nursing staff with proper accommodation is a cause of serious concern."

Prashant K. Nandi (1974) agrees with Hale (1969) and adds that the argument is not that Indians under rate conservation of life, alleviation of suffering, and promotion of health - the three basic tenets of nursing ethics. It is that those who are trained for and charged with these responsibilities are at the same time denied a decent working and living condition and their work is looked down upon. The nurses' lack of professional status, her low and unattractive salary, inadequate recognition of her services by the community, little incentive is responsible for deteriorating standards in serving the patients.

**Doctor-nurse relationship**

According to Oommen (1973), the nurses dislike the authoritarian attitude of the doctors and thus their relations are
a little hostile.

Hamananma and Bambawale (1978) are of the opinion that doctor-nurse relationship is mostly on a professional footing. Doctors diagnose and settle the treatment and the nurses carry out the treatment advised by the doctor. They maintain the required distance for their is a senior junior interaction in their relationship.

Venkatratnam (1979), found that the difference in role expectation and role performance of doctor and nurse is due to difference in professional and organisational requirement. The role conflict in both cases is due to personal and social situations in which they are placed. As regards role conflict it is found that doctors are more committed to their profession than nurses.

1.3.2.6 Commercialization

Doctors wish to hold various office (President, Secretary, Editor). It is a matter of professional pride (Commun, 1973; Madan, 1980). Venkatratnam (1979) found that many doctors in the hospital are not members of any professional body except I.M.A. Doctors basically look upon their profession in terms of making a successful living. Madan (1980) calls this as 'acquisitive achievement'.

The main attractions of private practice are independence, stability of domicile and a good income (Madan, 1972). It is
found that doctors mostly considered their role performance to be better in private practice and the reason given for this is that there is no external control of work, also because of competition and better image in the market the private doctors try to improve their performance (Madan, 1972; Nagla, 1982). Doctors consider their performance better in private practice because it helps better checking and personal attention (Indu Mathur, 1975; Srivastava, 1979). Colleagual relations amongst doctors are least professional (Madan, 1972; Chaudri, 1977 and Conner, 1978).

Rama P. (1985) in her unpublished M.Phil dissertation found that 71% of the doctors in government hospitals are involved in private practice and most of them run moderate to high, successful practice. She found that doctors often use the hospital for their private patients thereby depriving proper care to patients coming to hospitals directly. 56% of the doctors in her study felt that private practice does adversely affect the working of the hospital. Some doctors use their position and authority in government hospital for promoting and protecting their private gains to the detriment of other patients.

Devi Saran Sharma (Ph.D. thesis approved 1986) found that most senior doctors are busy in private practice and the services including diagnostic tasks are performed by junior doctors who lack the skill and experience to deal with patients in hospitals.

Review of the general sociological studies in urban India
reveals the fact that most of them seem to be concerned with occupational roles of doctors, nurses and patients rather than professional roles. Studies of Madan (1972, 1977) and Gommen (1973) are exceptions, but they too seem to be less effective. Madan's study is based on a small number of respondents. Gommen depends upon his M.A. students for collection of data. Another drawback in Gommen's study is in relation to the operationalization of some variables. The measures used by him are general indicators of occupational commitment but not professional commitment. The studies by some other sociologists have a more or less similar methodology and are mostly descriptive. They comment on the routine role of doctors, nurses and patients in general at one place of study and therefore lack comparison in different settings.

1.3.3 Specific Sociological Studies in Gynaecology and Obstetrics Both Abroad and In India

It is evident that many of the problems which concern our society are related to the field of gynaecology and obstetrics. Gynaecology is the study of female diseases and obstetrics is the science of pregnancy and its disorders. Park and Park (1962) calls it social obstetrics and defines it as interaction between the environment and human reproduction. Sociological studies on the above ward are not many, a few shall be mentioned.

Menderson (1953) in studies of patient population in
Canada and North Scotland found that patients with maternity
and reproductive diseases come more promptly if there has been
established a positive confident relationship with the
physician.

A study by Rainwater, Lee (1960) indicates the strains
and stresses faced by pregnant women. The expectant mothers
becomes more self involved and critical and totally confides
in the doctor.

Taylor (1961) focuses on the fact that population increase
is one of the great social and health problems. According to
him the pregnant female who is carrying a normal and defective
foetus has the right if not the obligation to inquire about
the child and self.

Rosengran and Devault (1963) observes that in one maternity
hospital the staff attempts to maintain a definite spatial and
temporal organisation of its work irrespective of individual
variations in condition. The staff tolerates the expression
of pain only in the labour room, elsewhere it is deprecated
and ridiculed.

Skipper and Leonard (1963) shows how a particular sort of
social interaction providing emotional support can reduce
mothers experience of stress and help in social, physiological
and psychological responses to hospitalization and recovery.
Rita Seinder Miller, Brooklyn, College Cuny in studies in symbolic interaction (1978) found that in acquiring the pregnancy identity physical signs are transformed into evidence of social pregnancy through typically informal, invisible process of social construction. The pregnant women tentatively recognizes their new identities but waits further confirmation of their new status before they acknowledge their identities as fully real.

Sandra Klein Danziger (1980) in the case of pregnancy care found that patients lose more than they gain from patienthood. Alienation may occur when the physician exercises unchecked reign over patients' life. The patient is excessively depends on the medical care system. Individual physicians who regret the illusions the patients have of their power are likely to make little effort to alter their interactional processing procedures to reduce their promotion of medical social control.

Wertz, Dorothy C. (1932) found that growing technology gave the regular doctors (MD's) some of their first claim to legitimacy and enables them to eliminate other practitioners including mid-wives. In taking over births MDs not only improve their economic status but become moral authorities and personal confidants to women. It is now a surgical event which has accustomed families to the use of hospital. This has provided MDs with many professional advantages.
Pamela S. (1983) found that in US the childbirth usually takes place by the MD. Decision that MD takes, is not only controlled by patients condition but also by factors like state of medical knowledge available to them, the structural constraints of the hospital, MDs own practice and the extent of medical ideology about actual childbirth management. Variation in style of deliveries are found to be due to difference in medical knowledge, training and pressures such as malpractices, ways of handling medical uncertainties and the belief of new technology, their impact on infant health and on childbirth itself.

Joanna Kirkpatrick conducted a case study of gynaecology ward in an Indian mission hospital in Punjab in the year 1965, 66. Micro situations involving the patients, hospital staff and their social interaction in terms of role expectations, unofficial behaviour are analysed from the perspective of symbolic interactionism. The microsituations include reference to illness definitions, concepts of hospital, diet and its complications, ritual and secular status of ward, the role of patients, nurses, doctors. Both staff and patients share notions of the moral etiology of illness. Staff views stress personal and individual responsibility. Patients and staff views of hospital coincide with the superiority of mission hospital in cleanliness, service and care. Diet is a source of controversy. Patients often experience considerable dissonance about blood. This view is shared by (Carstairs, 1967; Wyon and Gordon, 1971). She also found that there are conflicts between culture and
structural situations.

In a study of mothers admitted in maternity wards by Tewari, Aggarwal and M. Kaur (1982) it is found that poverty, illiteracy, lack of knowledge about child-bearing, social belief, customs and practices affect child birth.

It is evident from the review of literature in gynaecology and obstetrics that more work has been done abroad than in India. The studies abroad in this field appear to be psychological studies rather than sociological. They focus on one or more aspect but fail to look at the ward as a unit.

The present study on 'Doctor-Nurse-Patient relationship in gynaecology and obstetric wards of government hospitals and nursing homes of U.P. and A.P.', is a humble attempt to study the ward as a sub-system of the hospital.

1.4 CONCEPTUAL FRAMEWORK

The study revolves around such concepts as organisation, social structure, goal, role, behavioural component, professional component, emergency component and commercial component. These have been conceptualized as follows:

1. Organisation

The elements of an organisation are human beings or social groups interacting with each other in a patterned way. When their interactions are directed towards the fulfilment of certain shared goals, there is
an ordered relationship between them and they interact for facilitating the functioning of their respective counterparts.

2. **Social Structure**

An organisation has a structure of various components arranged in a particular order where in the force and functional relationship of the components is based on certain patterns. In other words the social structure of an organisation is composed of the patterned interaction of its members. It is constituted by the interaction of a plurality of individual actors whose relations to each other are mutually oriented through the definition and mediation of pattern of the given structured and shared symbols and expectations. Hospital is thus an organisation with a social structure of its own.

3. **Goal**

The goal of any hospital is to provide proper medical care. The role performance of the doctors and the nurses is giving proper medical care which is directly related to patients' satisfaction. The work environment is determined by including variables like criticism, harassment, trust and appreciation along with reputation of the hospital, clarity of rules, working hours and group guidance.

4. **Roles**

The study looks into the role played by parts in maintaining the organisation of the gynaecology and obstetric wards of the hospital. Role and status are related concepts. According to Linton "Status is a polar position and is a collection of rights and
duties". Role, according to him is the dynamic aspect of status. Merton modified it and gave the concepts of "role set" and "status set" because one social status may involve more than one role and vice-versa.

4.1 Role Expectation and Role Performance

Role expectation means the expectation by society from an individual to perform his duty according to a definite status while role performance is his actual conducting or conduct on duty. When there is a lot of gap between role expectation and role performance there arises a situation of conflict.

4.2 Role Commitment

Occupational role commitment means a consistent pattern of behaviour from the choice of occupation to the determination to stay in it. Becker noted - "A person remaining in the same occupation may engage in many kinds of activity in course of his career. He sees several alternatives open to him but chooses one which best serves his purpose. Another aspect of role commitment is that it restricts the choice of the professional and thus, he becomes located into a position and coerced into living up to the promises and sacrifices built into it." A person is committed only to a role he regularly performs. The occupational role commitment is one of the purposes of this study.

Human beings at some time or the other seek the help of doctors and nurses. This relationship of the ill person or patient with doctor and nurse is considered important and has become an area of investigation by social scientists. Although it is
not possible to analyse all the factors which effect doctor-nurse-patient relationships, yet an attempt has been made to study behavioural professional, emergency and commercial factors which affect these relationships.

5. **Behavioural Component**

Traindis and Traindis (1964) believe that the behavioural component of interpersonal attitudes is multidimensional. This has been empirically observed and also confirmed in cross-cultural studies of generalisability of behavioural component. This behaviour component for the study includes two factors - illness and emotional needs.

6. **Professional Component**

This component deals with effective medical care and professional ethics. It is multidimensional and consists of five factors - treatment, prevention, physical tests, non-verbal situation and interference.

7. **Emergency Component**

This component deals with crisis situations in which the doctors, nurses and the patients have to act. This involves good behaviour and proper professional ethics. In such a situation relaxation is not permissible.

8. **Commercial Component**

Commercial component deals with monetary gains, rewards, promotions and appreciations. Professionals may be working either as private practitioners or as professional employees. They have to demonstrate skill to attract clients. In the case of independent medical
practitioners it means more rewards and fame, but doctors working in public hospitals work for specific hours in very crowded situations. They are likely to face role conflicts. This adversely affects the working of the hospital.

1.6 COVERAGE

1.6.1 Locale of Study

The study pertains to gynaecology and obstetric wards of the selected government hospitals and nursing homes in Andhra Pradesh and Uttar Pradesh. Hyderabad-Secunderabad in Andhra Pradesh and Meerut in Uttar Pradesh have been selected as specific locale of study as both the cities have quite many nursing homes and large government hospitals which cater to the needs of people coming from different settings and statuses. Both have a significantly cosmopolitan environment and in both the places the nurses and doctors are drawn from different parts of the entire country. The gynaecology and the obstetric wards look after patients belonging to different age groups, statuses and family backgrounds.

1.6.1.1 Hyderabad

Hyderabad is the capital of Andhra Pradesh and is famous for its cosmopolitan environment. It is well known for its Charminar, Salarjung museum, Hussain Sagar, Birla temple and Nehru Zoological park. It has a large number of industries and
educational institutions. The study has been conducted in one teaching government hospital called Osmania Maternity Hospital affiliated to Osmania Medical College which was established in 1906 by the Nizam of Hyderabad. This hospital is situated in Ameen Bagh near Salarjung Museum and is a 420 bed hospital.

The nursing home selected for conducting the study is St. Therese's hospital in Sanathnagar started in 1974. It is a 224 bed hospital set up and run by missionaries who are well known for efficient and selfless service.

1.5.1.2 Meerut

Meerut is a city situated approximately 73 kilometers away from Delhi. It is famous for sports goods and handlooms, besides many other industries. It has innumerable educational institutions. In Meerut the study has been conducted in Lala Lajpat Rai Medical College on the Garh road situated beyond Tajgarhi in a suburban area. It is a teaching government hospital and caters to a large number of patients coming from the rural areas.

The nursing home selected for the study is Sushila Jasswan Hospital situated in the civil lines near Nawan bus stand and is approximately 3 kilometers from the city. It is a 100 bed hospital.
1.5.2 Universe of Study

The doctors, nurses and patients in gynaecology and obstetric wards of government hospitals and nursing homes in Hyderabad (Andhra Pradesh) and Meerut (Uttar Pradesh) constitute the universe of the study. Some features of the universe are as under -

1.5.2.1 Gynaecology and Obstetric wards in the two govt. hospitals

<table>
<thead>
<tr>
<th>A.I.P.</th>
<th>U.P.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No. of beds = 420</td>
<td>Total Number of beds = 165</td>
</tr>
<tr>
<td>Total No. Professors = 06</td>
<td>Total No. of prof. = 03+2</td>
</tr>
<tr>
<td>Total No. of Asst. professors. = 13</td>
<td>Total No. of Asst. professors. = 04</td>
</tr>
<tr>
<td>Civil Surgeon = 01</td>
<td>Junior doctors = 24</td>
</tr>
<tr>
<td>Deputy civil surgeon = 03</td>
<td>Sisters = 03</td>
</tr>
<tr>
<td>Junior doctors = 30</td>
<td>Staff nurses = 03</td>
</tr>
<tr>
<td>Head nurses = 08</td>
<td>Students nurses = 10</td>
</tr>
<tr>
<td>Total staff nurses = 81</td>
<td></td>
</tr>
<tr>
<td>Tutor grade II = 01</td>
<td></td>
</tr>
<tr>
<td>Student nurses = 50</td>
<td></td>
</tr>
<tr>
<td>VIP Room = 01</td>
<td></td>
</tr>
<tr>
<td>Special VIP Room = 01</td>
<td></td>
</tr>
<tr>
<td>Paying rooms = 12</td>
<td></td>
</tr>
</tbody>
</table>
1.5.2.2 Gynaecology and Obstetric wards in the two nursing homes

<table>
<thead>
<tr>
<th></th>
<th>A.P.</th>
<th>U.P.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No. of beds</td>
<td>35</td>
<td>100</td>
</tr>
<tr>
<td>Special rooms</td>
<td>04</td>
<td></td>
</tr>
<tr>
<td>Private rooms</td>
<td>07</td>
<td></td>
</tr>
<tr>
<td>Doctors</td>
<td>04</td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>05</td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>09</td>
<td></td>
</tr>
<tr>
<td>Total No. of doctors</td>
<td></td>
<td>03</td>
</tr>
<tr>
<td>Total Nurses</td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

1.5.3 Sampling Procedure

1.5.3.1 The Sample of States

Andhra Pradesh and Uttar Pradesh are the two states which have maximum number of hospitals. They are respectively first and second as far as the number of hospitals and their bed strength is concerned in the country.

1.5.3.2 The Sample of Cities

In the two states of Andhra Pradesh and Uttar Pradesh the study is confined to Hyderabad and Meerut. Hyderabad has a cosmopolitan environment and has two medical colleges and several private and public hospitals and nursing homes. Meerut also has a cosmopolitan environment and has one medical college and several nursing homes. The two hospitals are chosen by the process of random sampling.
3.3 The Sample Government Hospitals

Since Meerut has only one medical college it was taken for the purpose of study. In Hyderabad out of the two medical colleges one was chosen by the method of random sampling.

1.5.3.4 The Sample Nursing Homes

Nursing homes run by one doctor have not been taken into consideration for they are very small. A list of private hospitals and nursing homes run by trusts and missionary hospitals has been made and two hospitals, one from Meerut and another from Hyderabad, have been chosen by the method of random sampling.

1.5.3.5 Sampling of Doctors in Gynaecology and Obstetric wards in Govt. Hospitals of Andhra Pradesh and Uttar Pradesh

In the medical college hospital of Hyderabad, there are 50 doctors out of which 20 are senior and 30 are junior. By junior doctors the researcher means the doctors who are doing their house surgery and post graduation and are not employed by the hospital. Out of them 25% samples of junior and senior doctors respectively are taken at random. In the government medical college of Meerut the total number of doctors are 31 out of which 7 are senior and 24 are junior. Since the number was nearly half of the above 50% of the sample of junior and senior doctors has been taken.
1.5.3.6 **Sampling of Doctors in Nursing Homes of Andhra Pradesh and Uttar Pradesh**

Since both the hospitals have 3 doctors each all the doctors from both the hospitals are covered.

1.5.3.7 **Sampling of Nurses in Gynaecology and Obstetric Wards of Government Hospitals of Andhra Pradesh and Uttar Pradesh**

The Medical college hospital of Hyderabad has 120 nurses out of whom 90 are senior nurses and 30 are junior nurses. By junior nurses the researcher means the girls who are studying in their 1st, 2nd, 3rd or 4th year of nursing training. 25% of the junior and senior nurses respectively have been taken at random for the purpose of study.

Medical college hospital of Meerut has 16 nurses. Out of which 6 are senior and 10 are junior. Since the number is small 50% of the sample respectively of junior and senior nurses have been taken at random for the purpose of study.

1.5.3.8 **Sampling of Nurses in Nursing Homes of Andhra Pradesh and Uttar Pradesh**

In the nursing home of Hyderabad chosen for the purpose of study, there are 14 nurses. Since there is not much distinction between junior and senior nurses 50% of the sample at random have been chosen. In the nursing home of Uttar Pradesh, there are 20 nurses 50% of them have been chosen for the purpose of study.
1.5.3.9 Sampling of Patients

10% of the total bed strength of the hospital has been taken from both government hospitals and nursing homes. Care has been taken for a heterogenous sample in prenatal, post-natal, pre-operative and post-operative which is inclusive of gynaecology cases. A stratified random sampling of patients in all the four hospitals has been taken.

1.6 TOOLS, DATA COLLECTION AND DATA PROCESSING

Such an inquiry requires both primary and secondary data. Since there are three categories of respondents, one common interview schedule has been prepared for the doctors and the nurses, and a separate one for the patients. The information is also supplemented by participant observation and informal talks. Secondary data has been collected through available records and documents.

1.6.1 The Interview Schedules

Two types of interview schedules have been prepared, one for the doctors and the nurses and second for the other patients. Both the schedules have been divided into four main parts based on the objectives of study which include identification data questions, questions on hospital settings and questions on the behavioural professional, emergency and lastly questions on commercial components.
1.6.1.1 Identification Data

The first part of the schedule deals with questions relating to the socio-economic background of the doctors, the nurses and the patients like sex, age, religious category, family background, marital status, type of family, education, rank, salary and experience.

1.6.1.2 Hospital Setting

The second part deals with questions relating to the perceptions of the doctors, nurses and patients concerning the hospital setting like admission procedures, beds, drugs, equipment, hygiene and sanitation water and electricity facilities for attendants, class four employees and coordination between departments. It also includes questions on personal and professional goals, as well as administrative rules.

1.6.1.3 Role Perceptions

The third part deals with the perceptions of the doctors, nurses and patients concerning three important components namely behavioural, professional and emergency. Each of the components consists of sets of questions whose answers would indicate the satisfactions and dissatisfactions of the doctors, nurses and patients working in all the hospitals under study.

1.6.1.4 Commercialisation

The fourth part of the schedule consists of perceptions of the doctors, nurses and patients towards commercialisation.
The aspect of private practice has also been included.

1.6.2 Participant Observation

During field work, observation of different activities in the wards has been made and in-depth informal talks have been held with the doctors, nurses, and patients. The information collected has been used in the course of discussion to make the study more objective.

1.7 DATA PROCESSING

The data has been subjected to hand tabulation. The four main parts of the schedule, consisting of a set of questions on identification data, hospital setting, perceptions on behavioral professional emergency components and commercialization, components. These have been assessed on a three-point scale. Perceptions of the doctors, nurses, and patients on hospital setting have been assessed on a three-point scale - not satisfied, satisfied, and very satisfied. Perceptions of the doctors and the nurses about patients on behavioral, professional and emergency components have also been assessed on a three-point scale - never, sometimes, and always.

Perceptions of the patients about the doctors and the nurses on behavioral, professional, and emergency components are again assessed on a three-point scale - not satisfied, satisfied, and very satisfied. Similarly, the perceptions of the doctors, nurses, and patients on the commercial component
have been put on a three point scale - never, sometimes and always.

1.7.1 Statistical Techniques

For the first and second parts of the schedule (which consists of questions on identification data of the doctors, nurses and patients, and on hospital setting) simple percentage analysis has been done.

For the third and fourth parts of the schedule (which consists of questions on perceptions of the doctors, nurses and patients on behavioural, professional, emergency and commercial components) two types of analysis (% and Chi-square) have been done. Four broad categories have been formed on behavioural, professional, emergency and commercial component -

a) Doctors' perception towards nurses and patients.
b) Nurses' perception towards doctors and patients.
c) Patients' perception towards doctors and nurses.
d) Doctors', nurses' and patients' perception towards commercialization.

Two types of statistical analysis done on the above four broad categories thus formed are -

a) % analysis
b) Chi-square analysis
1.7.1.1 Percentage Analysis

Percentage Analysis on all the four broad categories mentioned above has been done. Simple analysis on each item of the components have been presented in the form of a table for the government hospitals and nursing homes in Andhra Pradesh and Uttar Pradesh under our study.

1.7.1.2 Chi-square Analysis

The chi-square is one of the simplest and most widely used non-parametric tests in statistical work. The Greek letter $X^2$ was first used by Karl Pearson in the year 1900. The quantity $X^2$ describes the magnitude of the discrepancy between theory and observation. It is defined as:

$$X^2 = \frac{(O - E)^2}{E}$$

Where, $O$ refers to the observed frequencies and $E$ refers to the expected frequencies.

Steps

To determine the value of $X^2$, the steps required are:

1) calculate the expected frequencies,

ii) take the difference between observed and expected frequencies and obtain the squares of these differences, i.e., obtain the values of $(O-E)^2$.

iii) divide the value of $(O-E)^2$ obtained in step (ii) by the respective expected frequency and obtain the total
This gives the value of \( X^2 \) which can range from zero to infinity. If \( X^2 \) is zero it means that the observed and expected frequencies completely coincide. The greater the discrepancy between the observed and expected frequencies, the greater shall be the value of \( X^2 \).

The calculated value of \( X^2 \) is compared with the table value of \( X^2 \) for given degrees of freedom at a certain specified level of significance. If at the stated level (generally 5% level is selected) the calculated value of \( X^2 \) is more than the table value of \( X^2 \) the difference between theory and observation is considered to be significant, i.e., it could not have arisen due to fluctuations of simple sampling. If, on the other hand, the calculated value of \( X^2 \) is less than the table value, the difference between theory and observation is not considered as significant, i.e., it is regarded as due to fluctuations of simple sampling and hence ignored.

**Degrees of Freedom**

While comparing the calculated value of \( X^2 \) with the table value we have to determine the degrees of freedom. By degrees of freedom we mean the number of classes to which the values can be assigned arbitrarily or at will without violating the restrictions or limitations placed.

In a 2x2 table where the cell frequencies and marginal totals are as below -
\[ a \quad b \quad (a+b) \]
\[ c \quad d \quad (c+d) \]
\[ (a+c) \quad (b+d) \]

\( N \) is the total frequency and \( ad \) the larger cross-product, the value of \( X^2 \) can easily be obtained by the following formula:

\[ X^2 = \frac{(ad - bc)^2 N}{(a+c)(b+d)(c+d)(a+b)} \]

or

with Yate's correction -

\[ X^2 = \frac{(ad - bc - 1/2)^2 N}{(a+c)(b+d)(c+d)(a+b)} \]

The Yate’s correction, also called Yate’s correction for continuity is introduced because the theoretical chi-square distribution is continuous whereas the tabulated values are based on the distribution of discrete \( X^2 \) statistic. The correction has the effect of reducing the calculated value of \( X^2 \) as compared to the corresponding value without correction. It is used when the cell frequency is less than 10.

Four level comparisons have been made after taking the views of each of the doctors, nurses and the patients on various components. The three point scale used has been coded. Chi-square analysis has been done to know the significance of
the comparisons for grouping of hospitals. The grouping of hospitals where chi-square has been used is given below:


b) M.H.A.P. and M.H.U.P. (Nursing home of Andhra Pradesh and Nursing home of Uttar Pradesh).

c) G.H.(A.P. + U.P.) and M.H.(A.P. + U.P.) (Government hospitals of Andhra Pradesh and Uttar Pradesh with Nursing Homes of Andhra Pradesh and Uttar Pradesh).

d) A.P.(G.H. + M.H.) and U.P.(G.H. + M.H.) (Government hospital and nursing home of Andhra Pradesh with Government hospital and nursing home of Uttar Pradesh).

With the help of \( \chi^2 \) test we can find out whether two types of grouping of hospitals are associated or not.

1.8 Importance of the Study

The present study is a humble attempt to analyse sociologically the doctor-nurse-patient relationships in the gynaecology and the obstetric wards of the government hospitals and the nursing homes in the states of Uttar Pradesh and Andhra Pradesh. Majority of the earlier studies deal with the role performance of either the doctors, the doctors and the nurses or the doctors and the patients. They do not provide a complete picture of the doctor-nurse-patient relationships. The present study, thus, provides a holistic view of the doctor-nurse-patient
relationships and fulfills the long felt need in this area of research.

In this study the focus has been on the doctors and the nurses who are the providers of medical care on the one hand, and patients, who are the 'consumers' of it on the other, at different levels and settings. It has been found that the doctor-nurse relationship is mostly on a professional footing, at least in the wards. There is more of the junior-senior interaction pattern between them. The doctors are the diagnosticians who chalk out the treatment while the nurses carry out their instructions in a hospital setting. It is evident that one cannot function without the other. The nurse-patient relationship is more or less on a footing of a person in authority in the wards and those who have to obey them. The study will show us to how the social structure of the hospitals affects the doctor-nurse-patient relationships, whose functioning is better - that of the nursing homes or that of the government hospitals, where the doctor-nurse-patient relationship is better - in A.P. or in U.P., and the reasons for these effects and differences like small size, better administration, socio-cultural or organisational climate. The study will also reveal the reasons for the commercialisation mainly among the doctors and the undesirable consequence of this commercialisation like deterioration of moral considerations and affect on professional character.
Thus this comparative study would give a comprehensive view of the inter-relationships amongst the doctors, nurses and patients in the gynaecology and the obstetric wards of the government hospitals and the nursing homes in the states of Andhra Pradesh and Uttar Pradesh.