Chapter II

JOB SATISFACTION AMONG NURSES

Nursing as a Profession

Nursing has its own identity as a health profession. Due recognition needs to be given to the role and contribution of nursing personnel to health care services in the hospital and the community. In general, sociological (and other) studies of health work have focused on the development and contemporary role of the medical profession and have assumed that nursing and other health work 'fitted in' with this framework (Jones, 1994). Medical sociologists studied what doctors did and hardly noticed nurses. (Oakely, 1986) Chapman observes that the medical profession has traditionally regarded the nurse as a 'handmaiden'. Although doctors want an intelligent observer and a nurse capable of carrying out complicated technical skills in an efficient manner, most do not want a colleague in the true sense of the word (1988:13).

In a study of 1,022 doctors and nurses located in ten public hospitals of Delhi, Oomen (1978) reports that 84.2 per cent of the nurses felt that they did not get the respect they deserved (1978:59). According to them, the three main reasons which accounted for this lack of respect were as follows:

- They handled polluting objects
- They belonged to poor families.
They were misunderstood and considered immoral.

Oomen observes that the status deprivation felt by the nurses was rooted in their antecedent low economic status, incorrect societal perception of their sexual behaviour and the nature of work which they performed as nurses (1978:59).

The basis of professional authority is knowledge, and the nature and extent of knowledge that professionals command may influence their role-structure in the organisational system considerably. Doctors undergo long periods of training, they generate and apply knowledge, their activities are not supervised by purely administrative superiors, usually, their expertise is not questioned and their advice is almost invariably accepted by clients. All these factors may facilitate the maintenance if not the enhancement of professionalisation among the doctors even when they work in an organisation. In contrast, nurses have shorter periods of training, they usually do not generate knowledge, even when they apply knowledge, the decision as to what therapy is to be administered is made by the doctors and nurses are supervised by administrators or by full fledged professionals (doctors), and sometimes by both. These characteristics may lead to an inertia, even erosion of professionalism and a loss of work satisfaction upon their being employed in complex organisations such as hospitals. In fact, nurses invariably work in organisations whereas doctors work both in organisation and as independent practitioners.
The High Power Committee on Nursing and Nursing Profession appointed by the Ministry of Health and Family Welfare, Government of India in July, 1987 to review the roles, functions, status, preparation of nursing personnel and other issues relevant to the profession observes that “Nurses are generally not involved in making policies that govern their status and practice. They are invariably excluded from the governmental bodies that decide these policies. Most of the decisions concerning nursing care and nurses are made by other people usually physicians, without the benefit of professional input by nurses” 
*(cited in Indian Nursing Year Book, 1990-92:11)*

Today, nursing work is carried out in a wide range of settings and by many types of nurses. Even as students, nurses perform hands on care in hospitals and community settings. Within the hospital itself, “nursing” means different things for example, the duties and tasks carried out within an intensive care unit are different from those in an accident or emergency department or in a paediatric ward. While basic nursing care may remain the same, the types of interventions, the social character as well as the structuring and organisation of the work differ.

**Landmarks of The Nursing Profession in Maharashtra:**

The following information is gleaned from the Report of the Committee appointed by the Government to go into the question of improvement of nursing services and education in the state of Maharashtra (November, 1975).
Nursing services in Maharashtra and specially in the city of Mumbai started with the formation of nursing associations in the major hospitals of the city. (J.J. Hospital, G.T. Hospital, Cama and Albless Hospital and St. George's Hospital). These associations were independent bodies run by philanthropists and lay persons. They provided nursing services to government hospitals and carried out their training and education. Sir Ness Wadia started the earliest association at the J. J. Hospital in the year 1920s. The largest number of nurses then were from the religious order of nuns called the "All Saints Order". The first sister superior to work at the J. J. Hospital belonged to this order. The first Indian Matron to be employed in 1928 was Ms. T. K. Adranvala.

As the scope of the hospitals increased and activities expanded, the associations found themselves unable to handle the magnitude of the task and in 1945 the government of the erstwhile Bombay State took over all the nursing associations with their assets and liabilities. The State Nursing Services was formed in 1947. The post of a Superintendent of nursing services was also created in 1945 and the second incumbent to occupy the post was an Indian (Ms. M. Doctor).

Nursing services continued to be largely urban, hospital based except for a few hospitals at Thane, Nashik and Dhule. In 1955, the Public Health Department of the government and the Superintendent of Nursing services began to work together to evolve the training of Auxiliary nurse midwives to work in rural areas. The post of the Assistant Director (Public Health) was created in 1966. The first graduate college of nursing in a public hospital began in 1960 in
Bombay. It is called the Institute of Nursing Education, and is located at the J.J. College of Nursing. It began a graduate programme of Nursing (Earlier nurses from Maharashtra had to go to Delhi, Vellore or Trivandrum for higher education). In 1952, the Srimati Nathibhai Damodar Thakersey (SNDT) University began a Department for Nursing education. The department evolved into a full fledged college in 1964 and its BSc Programme was recognised by the Maharashtra Nursing Council in 1965, by the state government Council in 1969. In 1976, it began its Master’s programme in Nursing.

Meanwhile, consecutive moves also took place at the all India level. The Trained Nurses Association of India (TNAI) began in 1908 and was initially known as Association of Nursing Superintendents. The TNAI membership stands at 71,205 (September 1998). The Association has affiliation fora for student nurses (Student Nurses Association) as well as for the different categories of nursing personnel such as Midwives and Auxiliary Nurse Midwives Association and Lady Health Visitor’s League. A significant achievement of the Association which is the only national organisation of nurse practitioners at all levels is the passage of the Indian Nursing Council Act in 1957. The Council is the apex body governing the policy matters on professional issues. Yet another important step which followed was the setting up of the state level Nursing Registration Councils. These are instrumental in the regulation of examinations and registration of all nursing personnel to monitor standards of nursing practice in different states.
The Indian Nursing Council allows entry into nursing at two levels at the end of schooling (that is, 10 years of formal education) and at the Higher Secondary level (that is, 12 years of formal education). The former enroll for a two year course which leads to their becoming an Auxiliary Nurse Midwife (ANM) and the latter join for a three year programme leading to the qualification of General Nursing and Midwifery. Both categories are required to register themselves with the state level Nursing council to be able to practice or take up a job. The total number of persons registered up to December, 1996 with the Maharashtra Nursing Council was 82,008 while active registration (that is those who have renewed their registration) is 46,304. These figures probably indicate the gap between the number who have been trained as nurses and those who continue to work. Hardly two per cent of the total registered nurses are male.

Typically in Maharashtra State, female personnel varying in age from 21 to over 55 years predominantly carry out nursing care. Their duties are performed according to the shift system. The various chores, which constitute patient care and hospital duties deal with human, emotional and psychological problems apart from the obvious health or medical problem under treatment. On an average, nursing duties can be more taxing than similar work at a desk in an office or in other business or industrial establishments. The work conditions and duty obligations make the nurse’s role very different from other working women not only in the place of work but also in the social and domestic sphere.
Defining Nursing

Diers (1994) stated that despite extensive effort, the debate to define nursing is far from over. “At the heart of the search for definition in nursing is the woeful recognition that nursing is so badly understood by the public, policy makers, professional colleagues and health care administrators—what we ache for is not definition it is description—what the work is and what it is like to do it”. (1994:11) To Diers “Nursing is two things: the care of the sick, or the potentially sick, and the tending of the entire environment within which care happens”. (1994:11)

The underpinning of today’s search for appropriate definitions lies in the definitions of Florence Nightingale as well as Virginia Henderson. In Notes on Nursing: what it is and what it is not, Nightingale writes:

It (nursing) has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air light, warmth, cleanliness, quiet and the proper selection and administration of diet all at the least expense of vital power to the patient.

(Nightingale, 1859/1946)

Virginia Henderson’s definition is of the unique function of the nurse, which she deliberately calls not a definition but a “personal concept”. “The unique
function of the nurse is to assist the individual sick or well in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible". (Henderson, 1961). At this point she cautions the nurse about not stepping into the doctor's realm by "not diagnosing, prescribing treatment for disease or making a prognosis; for these are the physicians functions". Reflecting on this thirty years later, Henderson revised her emphasis

I recognise now, as I think the majority of health care providers recognise that registered nurses or obstetrical nurses or midwives have been universally recognised worldwide as the providers of primary care for mothers and new borns. They diagnose and treat as well as care.

(Henderson, 1991).

Apart from Nightingale's and Henderson's definitions which focus on what nursing does (rather than what it is) there are two other sources which have attempted to define nursing. The first of these is what Diers (1994) terms as the explosion of words and terms trying to give nursing a theory of its own and the second source is the expansion of nursing roles in keeping with social and technological changes affecting health work. The purpose of the former was to develop the academic part of the discipline and to provide structure to research. However, the attempt to make these conceptual models resemble those from other disciplines was futile because other disciplines did not have the practice component which nursing did. Dickoff and James (1968) recognised this when
they said that since nursing was a practice discipline, nursing theory had to encompass things such as values and goals.

Finally, it is the expanding role of nursing that has allowed the definition debate to continue. Nurses, in their work in the community as well as in their role as midwives and anaesthetists had already expanded their role beyond primary care. In community health nursing, nurses had long functioned independently and had managed illness alone. The growth of intensive care in hospitals quickly legitimised what nurses had been doing when doctors were not available. Research showed that nurses could clearly do the work (Schulman and Wood, 1972 and Spitzer et al, 1974, cited in Diers, 1994) and over time evidence accumulated to show that the work of nurse practitioners was equal to that of physicians (Office of Technology Assessment, 1986).

The debate today is whether this advanced practice as it has come to be called is delegated medical functions or within nursing’s boundaries. The definitional question however is a political and a legal one, not a conceptual one, and it is increasingly becoming an economic question as well.

The Social Position of Nursing

The above three sources have influenced the definitional debate namely, the attempts to give nursing a theory of its own; the expansion of nursing roles in keeping with social and technological changes and the evolution of Advanced Nursing practice indicate the need to understand nursing in all its complexity as
a practice discipline. Diers (1994) indicated a direction when she says that what nursing is will not be resolved through research and conceptual thinking alone. It will be resolved if at all by recognising that nursing changes very fast for all kinds of reasons and that those changes redefine the field.

Diers is supported in this assertion by Lesley Doyal (1979) in his comment that class, race and gender divisions characterise the contemporary health service reproducing the class, sexual and racial divisions in the wider society. Feminist theorists have highlighted nursing as gendered work in which stereotypes of what is natural and normal combine together to delineate women's role. Medical sociology has been preoccupied with the role of doctors and has paid less attention to the work of nurses. Nursing has been seen as confined to assisting doctors. Nurses and other health workers are not seen as being in a position of control, but are seen to be in a position of subordination (Friedson 1970)

Jones (1994) asserted that the medical profession has controlled the place of nursing in health work. The relationship of dominance of a doctor over a nurse is both patriarchal as well as technological. This relationship has become rooted in status differences, the position of women in society, differences in education and remuneration and the tendency of nursing to be an adjunct to medicine (Dingwall and McIntosh 1978, cited in Jones 1994: 486) (See Jones, 1994, 460-503).

Apart from the above, there are certain social and organisational issues which
are peculiar to the situation of nurses in Indian society. The foremost amongst these is the role which nurses at all levels in the hierarchy are expected to conform to as handmaidens or assistants to the medical profession. This situation has prompted progressive nurse practitioners to point out that nurses are primarily meant to assist patients to recover from ill health and not to assist doctors in serving patients. The Trained Nurses Association of India (established in 1908) in its policy statement has asserted that:

Nursing has its own identity as a health profession, hence the recognition needs to be given to the role and contribution of nursing personnel to health care services in the hospital and the community

(Indian Nursing Year Book 1990-1992 : 6)

The major social issue affecting the nursing profession is its low occupational status. While the old stigma and bias towards it has been eroded gradually it is yet to receive the recognition that it deserves. The elevation of nursing education to the university level, the need for Indian women to work in the face of economic pressures and the relatively high salaries (along with job security) of nurses in the government services are some factors which have helped the profession to grow in the eyes of society. However, even today, the general view towards the profession is either mixed or against it.

These as well as several other issues have been noted by successive committees set up by the Government of India as well as by the State of Maharashtra. The State Government’s report of 1975 to go into the question of improvement of
nursing services and nursing education in the state of Maharashtra has made pertinent recommendations. These include improvement in the quality of education, training, clean hospital atmosphere with adequate supplies, elimination or drastic reduction of all non-nursing duties, and emphasis on the psychological satisfaction of the nurse through appropriate work distribution and recognition of the nursing service as an indispensable respected wing of the medical sciences. With respect to the organisational role, the report recommends that a well defined set-up of nursing administration be instituted with clear cut delegation of administration powers for prompt attention to issues of every nursing personnel. With regard to the social bias towards the profession, the report suggests the need to strengthen the public image of the nurse through mass education, use of electronic media, information about the role of a nurse in school text books, recognition of outstanding performances at the hospital and the community level, government nominations to serve on committees and selection of nursing professionals to serve as special executive magistrates. The report asserts that notwithstanding all the above, the recognition of the nurse as an indispensable member of the medical team and due respect given to her by a doctor in the wards and the administrators in the hierarchy would go a long way in establishing the status which the profession deserves.

Despite the above clear-cut observations, the High Power Committee appointed by the Government of India in 1987 (almost twelve years later) has been forced to observe that compared to other professionals, nurses have a low salary and poor status.
The Committee states:

- Nurses are generally not involved in making policies that govern their status and practice.

- Decisions concerning nursing are made by administrators who are generally physicians.

- Nearly 97 per cent of nurses are in Group “C” category and their status in the Health Directorate is quite low.

- By and large along with their poor status, they are plagued with some chronic problems such as long working hours, inadequate work place (duty station), lack of supplies and equipment and performance of inappropriate non-nursing duties.

(In Indian Nursing Yearbook 1990-92 : 11-14)

A significant issue which has not received sufficient attention is the exodus of the best trained nurses from India to countries of the Middle East and to the West. Low salaries, poor working conditions and the low social status accorded to nurses in India are the major dissuading factors which act as incentives for them to actively pursue job opportunities outside India, even at the cost of social alienation in a foreign land. And this immigration of nurses persists in the
face of a health manpower scenario where for every three trained medical doctors, only one trained nurse is available to the country's population.

In these circumstances, it is important to understand the job satisfaction of nurses who continue to serve the profession. While many nurse academicians and senior nurses feel that nursing should never become a job, but should always be considered as a service, the thinking of the nurse practitioner on this issue is probably different. The work of the doctor, the nurse and that of the paramedical are all equally important for the recovery of the patient. In today's context, it is therefore teamwork where every member of the team deserves respect for his/her own contribution. When such recognition is not forthcoming nursing continues to be regarded as a subordinate profession. This may lead to job dissatisfaction and consequently the patient will suffer, if the dissatisfied nurse fails to deliver quality care. Further, the nurse herself will experience discontent which will affect other areas of her life too.

Review of Literature on Job Satisfaction amongst Nurses

Nursing is an inherently demanding profession. In common with other human service professionals, the focus is on the client rather than the career. However, it is a personal as well as a management goal in every profession to maximise job satisfaction. Redfern commented that there was little research on job satisfaction of nurses in comparison with other occupational groups. Since then, several articles on the subject have been published. (Seybolt et al 1978; Stember et al 1978; Slavitt et al 1979; Walker and Bronstein, 1981; Nichols et al 1981;

Improving job satisfaction and increasing understanding of how the concept relates to several variables such as turnover, absenteeism, performance, leadership styles, mobility, autonomy and burnout has been attempted through these studies.

**Absenteeism and Turnover**

Seybolt *et al* (1978) substantiated the belief that job satisfaction and employment longevity are correlated. A relationship between turnover and dissatisfaction with content or type of work has been demonstrated in student nurses (Saleh, 1965). Matrunola (1996) in a study of stress and burnout in hospital nurses explored factors which affect job satisfaction and the relationship between these absence rates. While the results did not indicate a positive relationship between job satisfaction and absenteeism, they did point to the use of job satisfaction questionnaires as a useful diagnostic tool in screening those at risk of burnout. Jones *et al* (1981) found that only thirty per cent of the nurses working in a burn unit changed jobs because of job related dissatisfaction. Classical literature on organisations also tell us that other factors such as family situation, educational opportunities, mobility or social values strongly affect the decision to retain a job (March and Simon 1958). Myrtle and Robertson (1979) also concluded that job satisfaction is only one of several factors that contribute to absenteeism and turnover.
Further it has been found that the same factor may have a varying effect on an individual’s job satisfaction, the effects depending upon the employee’s expectations and the importance he/she places on that factor. That is, a raise in pay may bring satisfaction primarily as a result of a factor such as perceived equity of the increase rather than the amount itself (expectations) but the additional amount will bring little satisfaction if money per se is of little value to the individual (importance) (Porter and Steers, 1973).

Literature on job satisfaction in nurses also indicates directions in which strategies can be formulated to decrease staff turnover. Redfern (1980) reported that nurses who stayed in their jobs were more satisfied with certain extrinsic satisfiers such as hospital policies, working conditions, pay and advancement opportunities than their counterparts who left. Her findings also revealed that among those who quit or remained, no differences were to be found in certain intrinsic factors such as autonomy, security, use of ability, achievement and responsibility - factors that have been identified by others such as Jones et al., (1981) Myrtle and Robertson, Allen and Kraft (1981) Sorensen and Sorensen (1974) and Alexander et al (1982) as important job satisfiers. In conclusion, it may be said that though evidence points to a strong correlation between job satisfaction of nurses and job retention, other factors such as autonomy, mobility, educational qualifications, hospital policies and working conditions also play an important role. Furthermore, the degree and direction of change in job satisfaction are heavily influenced by the individual’s expectation as well as the level of importance attached to particular factors.
Quality of Care

Joiner et al (1981) and Kent and Larson (1983) through their studies indicated that while it seems reasonable to assume that a satisfied nurse will deliver better patient care, it is found in fact that quality of care and nurse satisfaction may well be independent of each other. Larson, Brown and Shore (1984) indicate that a probable reason could be the factor of “burn-out”. That is, a satisfied nurse, if under conditions of stress or fatigue due to the demands of the job, may mete out poor quality care. However, it is also found that it is not always that nurses in high stress jobs are less satisfied. Nichols et al (1978) reported that these units often attracted highly motivated and enthusiastic nurses whose satisfaction is enhanced by the high demand situation. Thus the propensity to deliver high quality care could be a personality characteristic or an ethical decision.

Autonomy

Some studies have found that nurse decision autonomy is a major determinant of job satisfaction (Slavit et al, 1978; Alexander et al 1982, Butler and Parsons 1989) McLaney and Hurrel (1988) studied the effects of four domains of control – task, decision, resource and physical environment – on the job satisfaction of Canadian nurses. The study revealed that increased task control, resource control and physical environment were positively correlated with job satisfaction. However, decision control was not. This finding was attributed to the nurses not having the decision making power in patient management inherent in a hospital hierarchy. Blegen and Mueller (1987) however found that
autonomy barely affected job satisfaction in their study of North American nurses from five different hospitals. Collins and Henderson (1991) found that nurses thought they were expected to perform autonomously but received little support for doing so. They concluded that levels of autonomy had not changed in fifteen years from a similar study done by Prankratz and Prankratz (1974). Overall, it may be said that conflicting results have been reported with respect to the role which autonomy plays as a predictor of job satisfaction (Weisman et al, 1981, Roedel and Nystrom 1988, Blegen and Mueller, 1987, Dwyer et al 1992). The study by Dwyer et al argue that individuals have different needs for autonomy which, in turn, influence job satisfaction. Thereby, it is understood that increased decision or work autonomy is a determinant of increased job satisfaction only when desired by the nurse, otherwise dissatisfaction, may result. Dwyer’s analysis is supported in the findings of Boumans and Landeweard (1993) in their study of nurses from 16 general hospitals in the Netherlands. The authors found that nurses are most satisfied if the head nurse pays much attention to both dimensions of leadership that is consideration and initiating structure, but it is clear that nurses with a higher need for autonomy prefer a different type of leadership from nurses with lesser need for autonomy.

Leadership Styles

McNeese-Smith (1995) studied leadership behaviours of department managers in two different hospitals. The findings revealed modest but statistically significant correlations between the manager’s use of leadership behaviour and job
satisfaction, productivity and organisational commitment of the nurses.

A doctoral study by Krietzer (1990) at the University of Minnesota found evidence to substantiate that participation in decision making and the congruence between preferred and actual level of involvement is related to job satisfaction and organisational commitment. Interestingly, the study revealed that demographic variables such as age, education and experience were generally non contributory in explaining variance in the dependent variables.

Study of the relationship of headnurse leadership style to staff nurse job satisfaction carried out by Medley and Larochelle (1997) in four hospitals in Florida showed a significant, positive relationship between those headnurses exhibiting a transformational leadership style and job satisfaction of their staff nurses. A further exploration of transformational and transactional leadership styles could lead to a better understanding of the components of effective nursing leadership further leading to subordinates with higher job satisfaction.

In a dissertation related to reward strategies for the retention of professional nurses carried out by Bruce, 1990 at the University of Massachusetts, the significant findings were:

1) Salary was the most influential reward strategy for attracting or retaining nurses;

2) The component “professional status” provided the most job satisfaction regardless of education or time in the job, “autonomy” and “interaction” provided some satisfaction while the components, “pay”, “task
requirements" and organisational policies" did not;

3) Nurses who worked in primary nursing settings were more satisfied with their jobs than those who did not and finally;

4) Nurses who worked in settings with a clinical ladder were more satisfied with their jobs than those who did not.

The above review of literature on job satisfaction amongst nurses in hospitals enables an understanding of:

- The independent variables that have been popularly studied i.e absenteeism, turnover, quality of care, decision-making and autonomy, organisational commitment, demographic variables such as age, experience and educational levels, leadership/supervision styles, extrinsic factors such as salary and organisation policies and intrinsic factors such as achievement and responsibility.

- That the degree and direction of change in job satisfaction are heavily influenced by the individual's expectation as well as the level of importance (value attached to particular factors).

- That when the several factors that could lead to job satisfaction are multiplied by the individual's expectations and the value placed on each factor, it is seen that a single non-dimensional measure of job satisfaction is at best superficial and at worst meaningless or misleading.
Hence a multi-faceted approach which can deal creatively with the issue of job satisfaction is required if the staff nurse, the patient and the hospital are all going to benefit.