CHAPTER V.

CONCLUSION.

It may be useful to restate the principal findings of the investigation in a summary form. All nurses are aware of the normatively ideal role to be performed by the professional nurses. This is an indication of socialization because this awareness must be based on some instruction and experience in course of socialization common to all the nurses. Judged in the light of such a normative standard, the nurses concede that their actual role performance falls far short of the ideal, and this has nothing to do with variations in the socio-economic status of the nurses. Such a capacity for self-evaluation based on an objective understanding of the quality of nursing is a pointer to the critical ability of self-examination by the professional nurses. This must also be a function of socialization in course of occupational experience or otherwise. In the formation of the awareness of the normative demands of the occupation and in the development of certain commitment to meet the normative demands, socialization by certain specific structures and group formations have evidently played their role. The hospital authority and the trade unions are the structured agents which, in the nurses' eyes, have played such a part. For obvious reasons the hospital authority has stood out as the
The co-workers have played a somewhat inefficacious role mainly due to a lack of internal solidarity among them. Interestingly, the process of normative socialization directed towards development of capacity and commitment to perform a nurse's tasks, has met with contradictory influences generated very often by the same structures and the same are associated with the original spell of socialization. The organization of work sets limits to a nurse's ability to act out according to the normative ideal. The overall social conception of nursing and the public image of the nurses have reduced the occupational self-esteem. This combines with lack of autonomy typical of a profession. The result is that what is learned in original socialization remains unutilizable due to factors present in the organization of work and in the larger social and political milieu. We have found as if the making and the unmaking of the nurses are under the auspices of the same structures and groups.

II

Like any professional individual the nurse in India is "made". The organization of her self is a function of socializing instructions and experiences. It sometimes appears that a nurse makes herself through imitation or through self-socialization
in the correct sense of the term, but even then the models imitated and the experiences in which self-socialization is based are not the nurse’s creation. These are socially available — it may not be incorrect to say that these are socially made available. With this understanding of the socializing process we have come to notice that the nurses in India are made in the sense that they display the capacity to learn, to internalize the role ideally expected of them.

Learning of the ideal role has a touch of being anticipatory socialization because the nurse learns the ideal usually before becoming an adequately operative nurse. When the nurse undergoes a range of stable experiences, a different kind socialization takes over — more specifically occupational socialization — that is learning while functioning. This is another level of making of the nurse (one may even argue, the unmaking of the nurse in good measure). While in occupation, the nurse is ‘compelled to deviate’ from the ideal that is the nurse is exposed to contradictory socialization. The structures, the processes and the experiences — the anticipations and the apprehensions these generate — are also socializing in nature.

A professional self exposed to contradictory socialization naturally suffers from an internal contradiction. It is
remarkable that the same socializing structures indulge in contradictory socialization either as a matter of deliberate policy or unknowingly. Take the example of hospital authority. It is the principal structure which inculcates most effectively the concept of ideal role in the nurses. But it is the same structure which through its organizational peculiarity produces severe limitations to materialization of the ideal in nurses' actual role performance. Take a second example of highly politicised trade unions of nurses and other hospital employees. A union or an association of identical political partisan affiliations but representing hierarchically different hospital employees like nurses and class IV employees, create situations for the nurses in which the nurses find that their role is re-defined to incorporate duties peculiar to a lower stratum of hospital employees. Take a third example of sister tutors — the socializers in occupational culture per se — they have been insistent on locating themselves as a category of nurses different from and hierarchically higher than the ordinary nurses. They want to give u, the standard outfit of the nurses, as if to symbolically redefine their professional appearance, but this is setting up a contradiction again. If this is so, we should be directed to a more fundamental contradiction which has mediated the three elements we have noted above. This is
the contradiction between the posture of a welfare state and state policies which somehow fails/does not formulate the appropriate policy.

One may point out that at a more basic level, there is a contradiction between society's need for services rendered in ideal proportion by the nurses and a generally pejorative conception of nursing as a profession and the nurses as persons; and every nurse knows about it.

The contradictions over existing arrangements concerning allocation of financial resources and distribution of authority within the hospital organisation involves implicit conflict as Coser postulated (1957, p. 203). The normative dimensions of a nurse's role accompanied by disagreement in a nurse's role-set, limited opportunities and constraining factors reveal imbalances, tensions and conflicts of interests among various interrelated parts.

The conflict between the nurses and the state is over the distribution of source resources. The nurses in the medical organisation are not entitled to a separate budget. The investment and expenditure on health is just a part, negligible at that, of a composite budget on medical organisations, family welfare, public health, sanitation and water
supply of nursing services is included under the medical organization. Nursing service is granted a fraction of 5.02% of the agreed outlay during the sixth five year plan (1980-85) under State Plan Expenditure (P - 5.1). This explains the steady underdevelopment of medical services. To identify one specific problem, paucity of funds means that the number of nurses cannot be increased to match the demands of an ever-rising population, which is increasingly turning to the state for medical services. The result is that the nurses are not in proper proportion to the population. The standard set for nurse-population ratio is 1:5000 whereas in India it has an estimated shortfall of no less than 35,000 nurses (Lascoo, 1987, p. 14). Lack of funds means not only lack of infrastructural growth, but also decay of the existing infrastructure. This has a feedback on the quality of services rendered by the nurses. Improper distribution of available resources sets limits to the nurses' capacity to conform to the ideal role conception. The more the nurses have been questioning the legitimacy of the existing distribution of scarce resources, the more they have been initiating conflict. More they engage in preparation for conflict or in conflict in a complex political arena of a third world modernizing state, they find their political ambitions competing with the requirements of their duty in a service sector for time and attention. This has adverse effect on their desire to reach the standard for ideal nursing.
### Table 5.1

#### State Plan Expenditure by Major Heads of Development in West Bengal

Medical, Family Welfare, Public Health, Sanitation and Water Supply (Rs. in crores).

<table>
<thead>
<tr>
<th>Year</th>
<th>Sixth Five Year Plan (1980-85) Agreed Outlay</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-81</td>
<td>24.90 (5.54)</td>
</tr>
<tr>
<td>1981-82</td>
<td>26.97 (5.94)</td>
</tr>
<tr>
<td>1982-83</td>
<td>24.74 (5.25)</td>
</tr>
<tr>
<td>1983-84</td>
<td>27.55 (5.14)</td>
</tr>
</tbody>
</table>

Note: Figures in bracket indicate percentage to total.

It is notable that their attempt to be in a position to influence, if not controlled, the relevant policy concerning the size and the distribution of resources is mixed with numerous difficulties. First, their ability to represent themselves at the level of hospital authority is governed by the discretion of the hospital authority. More often than not, they find themselves unrepresented or severely underrepresented. Similar is the situation in overall health administration. This is combined with a situation in which the nurses find themselves represented only at the local committee levels of the nursing unions. They have no place in the sense of committee of the political parties to which the nurses' unions are affiliated. The nurses are compelled to develop political ambitions; they are also 'prevented' from belonging to the relevant power structure also. As a result the institutional channels for articulating and redressing ever increasing grievances are not available to the nurses. This must have negative consequences for their role performance.

The situation is further complicated by a feeling of deprivation in terms of opportunities as the nurses in best Bengal Government run hospitals compare themselves with the nurses employed by the central government. Further the state government hospital nurses are made at par with state government clerks. The normative dimensions of the nurses' role...
differ conspicuously from normative dimension of clerks' role, the opportunities are the same, but the role imperatives are not. In addition, the nurses are to perform against a patterned set of expectations arising from the partners of the nurses' role-set. The nurses thus feel unrewarded in comparison to other central government hospital nurses as well as the state government clerks. The deprivation of the nurses are transformed from absolute to relative, creating again the potentiality of conflict.

In view of the dysfunctional consequences of unequal distribution of resources, of fewer channels for expressing grievances and of relative deprivation, the withdrawal of legitimacy of existing arrangements on the part of the nurses is very likely. However, because of the absence of other facilitating conditions, this is unlikely to develop into violent conflict as theoretically anticipated by Coser (1966, pp. 45-60). The resultant feeling of suffocation can undo whatever work ethics the nurses might have been socialized into. What is more, being persistently excluded from the relevant power structure, the nurses are deflected from realistic issues and from the conflictual path to realize them. In such a situation they have started seeking compromises over the means to realize their interests, the real issue is how to establish
and maintain congruence between normative standards defining a nurse's role on the one hand and expectation of role partners in her role set and the quality of rewards on the other. Unable to do this the nurses have become increasingly engaged in collective attempts to get a salary increase from time to time. This reduces the possibility of violence in conflict but this leaves unresolved the fundamental issues.

Corresponding to the compromise referred above is another game the nurses play, which eventually undermines their ability to render the services expected of them. The various partners in the nurse's role-set are differentially involved in the relationship with the nurse, and consequently address demands and expectations towards the nurses with differing intensity. The nurses face stronger demands from hospital authority and trade-unions than from patients and patient's relations. Conversely, for the nurses the expectations of hospital authority and trade-unions are more significant than those of the expectations of patients and patient's relations because these two have immense control over their career. Thus, the nurses cope with the possible role-conflict by paying differential attention to the expectations originating in her role-set, with more and effective attention to the expectations and demands of 'more' significant others. The impact upon the
nurses of "diverse expectations of appropriate behaviour among those in their role-set can be structurally mitigated only by differentials of involvement in the relationship among those constituting their role-set" (Merton, 1968, p. 426).

The various partners in the nurses' role-set have 'differential power' with respect to the nurses, owing to the fact that different role-partner's social position is located at different levels of power hierarchies. "As a consequence of social stratification the members of a role-set are not apt to be equally powerful in shaping the behaviour of status occupants" (Sexton, 1968, p. 426). The 'structural circumstances' of the medical organization indicates that the hospital authority, and trade-unions have more enduring power over the nurses than have patients and patient's relations. The necessity to subject herself to the expectations of hospital authority or trade unions who are more powerful in the nurses' role-set, works to resolve the role-conflict.

The nurses in recent times have succeeded, though in no remarkable degree, in informing through movements, media and personal contacts, the partners of the role-set of the conflicting and mutually incompatible expectations, thereby reducing the pressure to some extent, as various role-partners became aware of her insoluble predicament. "When it becomes plain that the
demands of some are in full contradiction with the demands of others, it becomes, in part, the task of members of the role-set, rather than that of status-occupant to resolve these contradictions either by a struggle for exclusive power or by some degree of compromise (Norton, 1968, pp. 430-431). In view of the organizational constraints and absence of role-specificity, the nurses make aware the partners of her role-set of the difficulty in actualizing the normative dimensions required of a nurse. The partners e.g. hospital authority and trade-unions resolve the conflict by compromising the conflicting demands made of a nurse. The compromises are in the form of adherence to hospital rules and regulations. The norm to take care of individual patients is replaced by treating patients at par. The compromise is conceded because of the cognizance of the fact that other responsibilities not related to nursing are carried out by the nurses.

Thus, to cope with the conflicts in role-set the nurses seek to find structural arrangements that provide social mechanisms for the reduction of structural strain (Sztompka, 1986, p. 203). These mechanisms are structurally facilitated by organized collectivities. But adaptation of these mechanisms result in 'displacement of goals'. Adherence to the rules originally conceived as a means becomes transformed into an
end-in-itself. Analyzing the medical organization along bureaucratic structure defined by Merton it is seen that hospital nurses develop patterns of ritualistic overconformity to institutional means; bureaucratic discipline leads to ‘a transference of the sentiments from the aim of the organization onto the particular details of behaviour required by the rules. The medical organization as a bureaucratic structure demands reliability of response and strict devotion to regulation. Such devotion to the rules leads to their transformation into absolutes. They are no longer conceived as relative to a set of purposes. Thus, the extreme embodiment of the resulting inflexibility is the bureaucratic virtuoso who never forgets a single rule binding her action and hence is unable to assist many of her clients’ (Sztompka, 1980, p. 195). The medical organization produces personality traits among the nurses that work counter to its avowed goals.

III

It is seen that there is normative incompatibility between the ideal role as envisaged by the recipients of nurse’s service and the actual role performance by a nurse. There is the need to negate at least drastically reduce the gap between the ideal and the actual. The need is for two reasons. The nurses represent roughly a half of health personnel resources. Nursing
is the occupational group best placed to realize the social goal of health for all (Maglaoaa, 1988, p. 25). So the nursing occupation needs to produce leaders who can motivate and mobilize others, and who can help to orient health care system towards health promotion and sickness prevention, while at the same time achieving a balance between institution and community. To achieve the balance between the institution where the nurses are to function and the recipients of the nursing service, the public expectations from the nurses should be realistic, that is, based on a correct understanding of constraints which reduce the nurses' capacity. The present incompatibility between the ideal and the actual on the other hand lowers the image of the nurses in the public eye. Not taking into account the dysfunctional modes of organization of activities and resources in the hospital, the members of the public turn towards the nurses, thereby nurses' social acceptability is injured. The nurses are regarded as violators of basic values as the nursing service relates to human life. To increase the social status of nurses, it is needed to reduce the gap between the ideal and the actual. If this can be done, the nurses would not be psychologically handicapped by their knowledge of low or none public esteem for them. It is not unlikely that some nurses may legitimize their low
performance by assuming or arguing that better performance would not receive public praise because the public perception of the nurses has become hardened in the meantime. So that public expectations from the nurses can be realistically drawn up, the public must be kept continuously informed about the various constraints on appropriate level of role performance. The media, the trade unions, even the state have an important role to play in this process.

In view of the constraints in actualizing the ideal, it is logical that the nursing authority has a set of recommendations regarding how to reduce the gap between the ideal and the actual. The Directorate of Health Services submits from time to time charter of demands for improving the state of nursing (Interview with Deputy Director of Health Services, Government of West Bengal, July 1989). These demands are:

1. Increasing the strength of nursing so that nurse patient ratio can be functional,
2. Dissociation of school of nursing from medical colleges so that the nursing school will have a separate budget by means of which the infrastructure needed for nursing training can be set up and continuously improved. In the present set up of hospital structure, the nursing superintendent is placed below the medical superintendent. Consequently, the nursing superintendent does not have adequate
power to provide requirements needed for imparting nursing education, (3) higher nursing service cadre in the form of representation of nurses in the relevant secretariat cadre so that the constraints unique to nursing can be taken care of, (4) composition of an independent Directorate of Nursing. Presently nursing is under the Directorate of Health. The resources allocated for nursing are included within the health budget. Establishment of separate Directorate would call for separate allocation of resources.

One feels that the recommendations are designed to have a better share of administrative power than to reorganize the nursing services. Excepting the demand for increasing the number of nurses there is no demand for increasing opportunities, redefinition of nursing role norms and restructuring of nurse-community relationships.

Keeping in view of the intervening factors (viz., moderate perceived opportunity, feeling of relative deprivation, low occupational commitment) responsible for the gap between the ideal and the actual, the following recommendations are made. Much of this is in keeping with those by International Labour Organisation (ILO, 1977, pp. 86-87, see Note 1).

The nurses' opportunities as are available now are at
par with other state government employees in the category of clerks, but the nature of job and role norms are significantly different. The arduous nature of the duties which include night work and relatively low scales of pay still constitute handicaps for women in this profession (Committee on the Status of Women in India, 1974, p. 307). The low status, poor working conditions and low wages of nurses severely constrain proper development of the nursing profession (Chatterjee, 1988, p. 76).

In view of this, it is recommended that effort should be made to eliminate the existing cadre rules and there should be compatibility between opportunities and role norms. Existing cadre rules make the nurses of state-run hospitals as clerks of state government offices belonging to same cadre.

If there is a public focus on the negligent yet unconcerned nurses in state-run hospitals, a significant part of it is unwarranted. For inadequate role performance by the nurses, the nurses should not be always held responsible. The nurses are to perform roles some of which are not related to nursing.

It is recommended that the hospital administrators undertake more comprehensive means for remedying existing absence of nurses' role definition. The medical staff organization within each hospital should assume responsibility for obtaining the co-operation of its members with regard to nurses' role definition.
The division of functions in medical organisation should be in such a way that the nurses can utilize their conception of their role in ideal terms as well as their professional training.

The general objectives of the General Nursing Midwifery course (the course meant for staff nurses) are to equip the nurses with relevant knowledge from the humanities, biological, behavioural and physical sciences and to apply these in carrying out health care and nursing activities and functions. Though the aspect of sensitivity and skill in human relationship are included in the syllabus these occupy a minor place in the total education as is evident from the time allotted to these aspects. Total hours allotted for instruction and clinical/field experience is 4500 hours (1185 hours for instruction + 3335 hours for clinical/field experiences). For education in how to establish human relationship (with patients, their relations) only 140 hour is allotted. Moreover, the clinical areas for practising what the nurses are learning do not include areas meant for establishing communication with hospital patients (Details are shown in Appendix - II).

In view of the undermining of the need of inculcating communicative role of the nurses with patients and patients' relations, it is recommended that the course content need
restructuring. The training programme should place adequate emphasis upon nurses' communicative roles. Effort should be made to develop the student nurses' rapport with patients and encouraging the self-actualization of the individual nurse.

The trade unions or associations of the nursing community from time to time submit charter of demands to reduce nurses' role-strain. These demands include increased allowance and increased number of nurses. The trade unions for the sake of political interest have never demanded enforced division of labour in the medical organization and change in the existing cadre policy, which has made the staff nurses at par with the state government clerks. Again, there have been cases of nepotism in recruiting nurses as indicated by cases of use of forged marksheets in enrolment into General Nursing Midwifery course (Staff reporter, 1989). But still now, no trade union has criticized those responsible for the corrupt practice. For restructuring of nursing service the trade unions do not have any policy or programme. This is one of the reasons which explains nurses' marginal relationship with the trade unions. In view of the nurses' low involvement in the trade unions' activities due to trade unions' reluctance to restructure the nursing service the following recommendations are made.

In recognition of the factors that there has been cases...
of recruitment of the nurses who have allegedly submitted fake
certificates and who have allegiance to a political party, it
is recommended that the political parties should not demand
potential loyalty to their organization at the cost of nursing
service. The trade unions should rise above the sectarian
political interest in enforcing effective division of labour
in the medical organization so that the nurses can utilize
their training. In view of the fact that the role of a nurse
is significantly different from that of a clerk, the trade
unions should demand for a change in the existing cadre policy.

To change nurses' occupational self-direction from
polyvalent hospital duties to primarily patient care needs
representation of nurses at political level. The Indian nurses
are not represented in the political party to which their
unions are affiliated. It is very probable that the political
parties are not aware of the specific constraints related to
nursing. The Indian nurses can take a lead from the global
situation. In a backward continent like Africa, nurses are
emerging to play a political and executive role in the health
system. In another country Deputy Minister of Health is a
nurse and in still another the Assistant Chief Planning Officer
of the Ministry of Health is a nurse. In several countries
nurses are members of National Assembly, while at district level
in many countries the nurse is frequently the senior health official working in harmony with the community to form the backbone of the health system (Bailey & Barton, 1978, p. 9). In United Kingdom nurses hold positions at every level of health care management from the clinical situation where direct patient care is given, to the highest level of policy making at government level (Quinn, 1982, p. 27). For participation in policy making decisions regarding nursing service, the nurses should be adequately represented at both political and administrative levels.

The marginal character of nurses' in-group solidarity prevents the nurses from organizing themselves against various onslaughts. The marginal solidarity is reflected in the sister tutors' attempt to identify themselves as a separate nursing category from the staff nurses by abandoning the nursing uniform meant for the entire nursing personnel. The demand for a separate nursing category may not improve the nurses' social acceptability, but on the other hand, the staff nurses may suffer from low self-esteem.

In view of the internal contradiction between staff nurses and sister tutors, it is recommended that the nursing community irrespective of nursing hierarchy should unite themselves against experienced constraints. Solidarity among the
nurses may help the nurses to counter various on-the-job onslaughts, thereby facilitating cultural acceptance of the nurses by the society.

The above mentioned recommendations — restructuring of opportunities, revising nursing cadre policy, proper functional differentiation, representation of nurses in decision-making at the hospital level as well as at the state level, coworkers' solidarity — require reorganization of policy priorities on the part of the state.

The reorganization of policy priorities on the part of the state is in the form of changing the recruitment policy. Most nurses are women and many nurses are also wives and mothers. The combination of these two positions with all the demands they make on women in this society, has many implications for the nursing occupation as well as for the individual woman who tries to meet both the demands of a spouse and a mother on the one hand and of a nurse on the other. If there is significant shift in recruitment of males into nursing there would also be some eventual alteration in attributes associated with the structure position of nurse — for example such attributes as compliant, gentle, nurturing might come to be less often associated with 'nurse'. 
The reorganisation of policy priorities on the part of the state health policy needs political will in the form of allotment of a higher percentage of revenue. Now there is no separate allotment for the nursing service. It is seen from Table 5.2 that the health sector has an allocation of 1.4% of total resource in 1980-80 plan outlays. So the expenses on nursing service comprises only a segment of total health expenditure. Only a fraction of total allotment for health services is spent on nursing. To realize the goal health for all, health services need more attention. The nurses constitute a major part of the health services and are the best placed personnel to realize the goal. The political will of the state is the fundamental need for the restructuring of the nursing occupation.

For the political will shapes the health policy of the state is evident from Vietnam's experience. "In 1972, this country had been listed by the World Bank among the 26 least favoured nations in the world from the point of view of their gross national product (GNP). WHO and UNICEF are making common cause with all the world's governments to ensure that by the year 2000 essential care will be accessible to all the population of our planet. The aim is to offer to everyone, especially in the Third World, a 'basic minimum of health'. This stage has long ago been passed in the northern provinces of Vietnam,"
## Table 5.2.

### Pattern of Investment on Health.

<table>
<thead>
<tr>
<th>Period</th>
<th>Total Plan Investment outlays (all heads of development)</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. First Plan (1951-61) actuals</td>
<td>1960.0 (100)</td>
<td>65.2 (3.3)</td>
</tr>
<tr>
<td>2. Second Plan (1956-61) actuals</td>
<td>4672.0 (100)</td>
<td>140.8 (3.0)</td>
</tr>
<tr>
<td>3. Third Plan (1961-65) actuals</td>
<td>8576.5 (100)</td>
<td>220.9 (3.8)</td>
</tr>
<tr>
<td>4. Annual Plan (1960-65) actuals</td>
<td>6625.4 (100)</td>
<td>140.2 (2.1)</td>
</tr>
<tr>
<td>5. Fourth Plan (1969-74) actuals</td>
<td>15778.8 (100)</td>
<td>335.5 (3.1)</td>
</tr>
</tbody>
</table>
central regions of the country are close to it, and in the south it will have been attained within a few years. The problem of guaranteeing a reasonable expectation of life has been solved, and it has been shown that even a country with a struggling economy can hope to make positive improvements in the quality of its people's life" (Remy, 1978, p. 12).

Development in health care is essentially political. Health in the public sense requires an ideological resolve with a commitment to structural changes and a redistribution of resources (Alubo, 1985, p. 331). Central control over resource allocation allows political decisions to be made so that public expenditures on the National Health Service can be related to the state of the economy and other perceived needs (Starr & Immergut, 1987, p. 242). Within the federal government, decisions previously left to civil servants are now more likely to be politically directed. Increasing political control of civil servants dealing in questions of birth control, consumerism, medical care, environment, energy, transportation, civil rights, and so on — provide a legitimate justification for a much greater political interest in civil service decisions (Belo, 1975, p. 88).

In India, the allocation of resources in the hands of the state allows political control over the health sector.
Being a democratic and welfare state where equality is a more significant aim, Indian nurses are subjected to be dominated by socio-political pressure. The social pressure is in the form of marginal social acceptability. The political pressure is in the form of not being able to organize themselves against the hazards they face in their day-to-day functioning. The social unacceptability can be mitigated by allocating a fair percentage of resources. The increased resource allocation on the other hand demand political will on the part of the state. If necessary, the state should be induced to develop such a political will. In order to do so the nurses should join the mainstream of working class movements.

The above mentioned recommendations, needless to emphasize, are underlined by a concern for better nurses can be made. The focus has been on restructuring of various components external to the nurse as a person. This does not mean that we do not recognize the need for an appropriate change in the personality of a nurse. We have only suggested that restructuring of the organizational and policy levels should proceed restructuring of personality.

Note......
1. Participation.

"Measures should be taken to promote the participation of nursing personnel in the planning and decisions concerning them, at all levels, in a manner appropriate to national conditions. Representatives of nursing personnel should be assured the protection provided for in the Workers' Representatives Convention and Recommendation, 1971" (ILO, 1977, p. 85).

Remuneration.

"Remuneration of nursing personnel should be according to — Qualifications, Responsibilities, Duties & Experience, Needs, Constraints & Hazards, Similar Other Profession to the cost of Living and rises in the national standard of living, fixed by collective agreement." (ILO, 1977, p. 87).

Rest periods.

"Where nursing personnel are entitled to less than 48 hours of continuous weekly rest, steps should be taken to bring their weekly rest to that level. The weekly rest of nursing personnel should in no case be less than 36 hours uninterrupted hours." (Ibid., p. 87).