CHAPTER VII: ROLE-CONFLICT AND COPING MECHANISMS
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A. ROLE CONFLICT: ITS FOUR ELEMENTS

Role-conflict is a situation of contradiction and incompatibility of expectations between two roles and they cannot be expressed simultaneously. Thus, it requires certain mechanisms to control, to amend the ways and to help the actor in fulfilling two contradictory expectations. The present chapter deals with such issues.

In this chapter, we shall report on data concerning the role conflict experienced by our respondents, and also the coping mechanisms used by them to resolve the said conflict. In the theorem, we shall highlight some of the theoretically relevant propositions on the phenomenon of "coping mechanisms" and relate them specifically to our own data.

As discussed in chapter I, the four criteria of role-conflict are as follow:

(a) a situation between two contradictory normative behaviour patterns;

(b) a situation between prescribed behaviour patterns and perceived behaviour patterns;
(c) a situation between behaviour patterns and individual's own inadequacies of managing her/his own time, energy and resources, and

(d) a situation between the relationships of members in the role set.

(a) A Situation Between Two Contradictory Normative Behaviour Patterns

Social and professional roles are differently formulated from each other in the normative expectations. One binds woman to her husband, home and children, and the other requires her complete involvement with her patients, teaching and research work. These two aspects have been discussed in the chapters IV, V and VI at length. It has been observed that role expectations are interrelated with the age factor. The variation was clearly observed in the responses of physicians. Role-expectations are heavy at younger age and lower at older age. At younger age, both roles put a strain on woman physician. For example, in social roles, younger married woman is liable to adjust with a new environment (family set up), role-relationships, and responsibilities (household work, care and supervision, etc.) The mother role is also difficult at younger age than the older age. In the same way, junior physician in
professional work has to be on shift duty, night duty and emergency duty. She is also at learning stage, and at the first ladder of her career. Undoubtedly, she is hard pressed for time because of a series of expectations on both sides. Thus, role conflict is associated with the life cycles of women. Consequently, younger women were susceptible to role-conflict. Combining two roles, it was asked, "are you satisfied with your present position by playing two roles: social and professional?".

Out of 116 physicians (19%) faced high role conflict due to two roles. In this category more responses have been recorded in the younger and middle aged, particularly with small children, than older physicians, and inevitably dwelt on role-conflict. The second category of physicians observing medium role-conflict were a large number of respondents (47.4%). This category of physicians had, however, adjusted their two roles. Also their role-demands were lessened as they were married eight to ten years and had settled the family issues. They had also achieved professional excellence by practice and knowledge. Therefore, they were relaxed and role conflict was avoidable in that case. The last category of physicians (17.2%) were facing less or no conflict in their two roles. It suffices to remind that they were higher age group with grown up
children even married and settled (a few cases). They were also senior physicians with professional success and competence. The normative expectations are not heavy from them as are expected from younger age group or middle aged who started their family and professional life at later phase of life cycle. However, 16.4% did not answer this question.

(b) A Situation Between Prescribed Behaviour Patterns and Perceived Behaviour Patterns

It has been observed in chapter IV that more and more women physicians are now getting married than before. This trend is illustrative of the fact that female physicians were interested in carrying out their traditional model of a married woman with husband and children. Simultaneously, they had idealized the doctor role-model since childhood. Data indicate that out of 150 total number of physicians, 84 had credited them for becoming a doctor. Out of 84, 85.7% had shown their great desire to be a doctor since childhood. Apart from 84, considerably a large number 31 (20.7%) were motivated by their fathers, most of whom were doctors themselves. Remainder (23.3%) came to this profession through the instrumentality of mother, brother/sister, relatives and mass media. These two role models certainly pose a problem to physicians. On this issue
quantitative data suggest that their involvement in fulfilling the two different roles leads towards marital discord. The question was asked, "does your profession sometimes lead to marital discord?" In response to this question, out of 116 physicians, 38 (32.8%) faced the dilemma of roles. The reasons are given below with the age distribution.

TABLE 7.1
Age of Female Physicians and Reasons for Martial Discord
(N=38)

<table>
<thead>
<tr>
<th>Age</th>
<th>Night Duty</th>
<th>Tired after coming from the Hospital</th>
<th>Do not like at times</th>
<th>Any other</th>
<th>Rows</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 30</td>
<td>6 (35.3)</td>
<td>7 (41.2)</td>
<td>2 (11.8)</td>
<td>2 (11.8)</td>
<td>17 (44.7)</td>
</tr>
<tr>
<td>31-45</td>
<td>4 (21.1)</td>
<td>12 (53.2)</td>
<td>3 (15.8)</td>
<td>0 (0.0)</td>
<td>19 (50.0)</td>
</tr>
<tr>
<td>46+</td>
<td>0 (0.0)</td>
<td>1 (50.0)</td>
<td>1 (50.0)</td>
<td>0 (0.0)</td>
<td>2 (5.3)</td>
</tr>
</tbody>
</table>

Columns
10 (26.3) 20 (52.6) 6 (15.8) 2 (5.3) 38 (100.0)

Figures in parentheses are the relative percentages of the columns.
Thus, professional requirements including night and shift duties, long hours of work put a strain on physicians not being able to meet both the demands. Focussing on the wife role, a question was asked "when both profession and your husband need you at the same time, how do you feel?" In answer to this question, out of 116, 40.5% were tense, 18.1% were frustrated or depressed and 10.3% were apprehensive. Rest of the physicians (23.3%) were indifferent, if they were put up in such a situation. A marginal number (7.8%) said that their husbands never ask for them when they are liable to go in for professional work. However, age does not have a bearing on marital discord.

Child care was another area of role-conflict where women tend to face problems. Despite putting emphasis on equal mother role and professional role, almost all had taken leave when their children were sick or any school function was to be attended. Out of 87 (physicians with children) 13.8% of physicians reported having ignored their children 'frequently' and 'faced high role-conflict'. Others (2.0%) mentioned having ignored their children 'occasionally' and experienced medium role conflict. A large number of physicians (59.7%) said that their children were 'rarely' ignored. This is plausible as their children had crossed the age of infancy and had entered into
adolescence. Thus, they did not require attention all the time and were looked after by strong social supportive network (see chapter V). The remainant (5.7%) did not reply this question. However, when women physicians leave professional demands for the sake of children, they did not have much gratification out of optimum child care. A considerably large number of respondents (51.7%) felt sad or were depressed, having to withdraw home from professional duty for child care. There were some (20.7) who have not bother about profession, when they had taken leave for the sake of children or others (27.6%) were happy in order to give full attention to child care. This was perhaps the reason, why a majority of physicians (79.3%) did not consider 'children as major source of conflict in their profession'. Only 20.7% were of the opposite view.

On their professional side, married women physicians though gave weightage to their profession (faculty members mostly got married at later 28-35 years of age after the completion of MD). Also, they delayed their family plan as most of middle aged 31-45 years had children in prep to class 5. Youngsters also wanted to have baby after MD course and permanent job, yet their performance was less evident in professional roles. The married ones were more happy than the single physicians in treating the same kind
of diseases. They were routinized in their prescription and guidance. Though difficult to generalize, all responses 'react angrily' in the case of guidance was recorded in the column 'married' than single physicians. Married Physicians preferred to do scheduled job than showing a humanitarian attitude by attending last minute serious case. In comparison to married, single physicians were more dissatisfied with the prescription and ventured to prescribe new medicines and injections. Also, they were more helpful in guidance, but they were facing high conflict being exploited by their colleagues. It has been mentioned that they had been put up in odd duties, held up in last minute case, granted less leave, thought of free all the time. In their social side those who were not living with the extended family set up, had no social life because of their extra work involvements.

Academic role was less affected by married women's social roles. They had published papers, had association memberships etc. However, attending conference was difficult for married physicians. A significant number of them (57.5%) did not have time, another (14.2%) were not interested in attending conferences for enhancing their professional knowledge. Physicians did not show conflictual attitudes towards teaching work. This is plausible due to
three reasons: first, it had a set schedule, second, it had direct advantage in their career, and third, it was an academic work, placing them at intellectual's position. To sum up the second proposition of role-conflict -- a situation between prescribed and perceived behaviour patterns, we argue that most of the physicians had idealized both the role models. These must have prepared them to perform their roles in the process of socialization. But physicians were either less instrumental or they experienced role-conflict in the performance of their two roles. This is because of a gap between the prescribed and perceived expectations. To validate the statement two conclusions have been drawn:

(1) Traditional role at home and professional role (technical job) at hospital,
(2) Modern role at home and professional role (ideal medical profession) at hospital.

The first category of physicians were experiencing high role conflict in social roles. The second category of physicians were experiencing high role conflict in professional roles. Both the roles were reciprocal for a married physician. There was a causal relationship between the two roles. The performance of one role is affected by the other role while it caused the previous role.
Role-conflict may also emerge due to individual's own inadequacies of managing her/his own time, energy and resources. Quantitative data has given a positive side of women physicians that they had successfully utilized the time, energy and resources. The qualitative data, however, has provided enough evidence that how women physicians had to work round the clock. Physicians completed most of domestic tasks in the early mornings, evenings, nights, weekends and holidays. They were certainly hard pressed for time and faced conflictual situation in fulfilling their two roles. It has been noted that expectation of a role is closely associated with life cycles of a woman. Thus, role-conflict is higher at lower level due to shortage of time and loss of energy. Data indicate that out of almost all physicians (20.7%) who had small children, perceived children as a source of conflict. They were also caught in the guilt syndrome that they ignored their children. Case studies clearly give an idea that newly married women were unable to fulfill their marital demands due to their own inadequacies of balancing their two roles. Situation would have been more critical, if they did not have good resources.
In order to highlight social support system, a question was asked, "are you carrying out all household work yourself?" It was an open ended type of question. Therefore, yes/no responses were again questioned in this way, "if yes, why?, if not, is it because you have a maid servant/your daughter helps you/your mother/mother-in-law helps you/any other help/specify". Out of 116, 87.9% had some alternative like maid, servant, mother-in-law, mother relatives, etc. Focussing on husband's help, it was asked, "how often does your husband help you?" It is interesting to note that husband's help was evident (38.6%) in domestic work. Not only they were quite resourceful in obtaining man-power skills, but they themselves were intelligent assertive, manipulative, and had scientific attitude towards life and social milieu. Also, their self-realization in having worked in the medical colleges of Delhi hospitals, capital city of India, had helped in settling down half of their psychological problems. Combining their two roles, younger and middle aged married physicians had their eyes set on their watches more than the elderly and single physicians. It has been noted in chapter VI that head of the units and head of departments stayed on till 6 p.m. They also visited hospital in off times, if necessary. Case studies reveal that most of the physicians aspired to go higher in academic work, but lagged behind
their colleagues due to family responsibilities. There were few, who managed to go abroad leaving their child/children with mother-in-law, while others had cancelled their trip.

(d) A Situation Between the Relationships of Members in the Role-Set

Physicians in their wife and mother roles had three relational functions in respect of their husbands, parents-in-law, and children. Most of the physicians had harmonious relationships, less tensions on sexual side and high frequency of recreational activities. Also, data show the high acceptance of wife's physician role by their husbands (see chapter V). Thus, physicians were helped by their husbands in their plans. Simultaneously, most of the physicians (77.6%) lived in nuclear families and 22.4% lived in complex families. Thus, there were more parents-in-law who came to Delhi and lived with their sons and physician daughters-in-law. In other cases, parents-in-law were living separately in their traditional way and physicians were living with their husbands in complex families. In both the cases, parents-in-law, and mothers-in-law in particular, were aware that their daughters-in-law were physicians and adjusted to the new situation. This was largely perceived by women physicians in their case studies.
Case Studies also reveal that physicians living in nuclear families had visited each other on occasions, and had treated each other as guests. The behavior of guest mothers-in-law and host mothers-in-law was clearly brought out in the discussions during case studies. But physicians were troubled in most cases. In former case, it was a transitory period and that was adjusted by physicians by some mechanisms, but in latter case, it was the major source of conflict. Though, mothers-in-law had supported physicians in most of domestic tasks and child care, yet physicians were facing problems in their performance of social roles. Thus, status of mother-in-law was a decisive factor in building up a relationship in their role set. Unlike husbands, physicians had good relations with their children, data indicate that most of physicians looked upon children 'not as a source of conflict' except in case of small children. Physicians also perceived that their children felt pride in having physician mothers. However, children could not be interviewed due to paucity of resources. But physicians were positive in case of children's "problems, studies and recreational activities etc." Therefore, the relationship of the members in the role sets was overall cordial which eased their conflict in the performance of two roles.
Physicians in their professional roles were confronted with colleagues, heads, semi-professionals and patients. Quantitative data suggest a positive relationship between these members and physicians. Conversely, qualitative data gives enough evidence (see chapter VI) that the relationship between two professionals was not good. However, a distinction can be made between two types of relationships. The relationship was worse between two units than two individuals per se. Since physicians worked as a team forming a unit. Thus, they were haunted and challenged by each other's unit. But the professional environment got polluted by favours, manipulations and face value. As a result, relationship between units deteriorated. This was reflected in patient care, duty schedules and academic work. Clearly physicians faced conflict due to poor communication between units. As has been written in chapter VI, the duty politics manifested at lower levels and patient care was at senior levels. Academic work also suffered due to poor relationships (see Chapter VI).

To conclude, these four propositions of role-conflict have been tested in the light of empirical reality and have been found to be the major arenas of role-conflict in the performance of social and professional roles.
B. COPING MECHANISMS

First of all, we propose to have a brief glance at the theories and concepts having a bearing on the phenomenon of coping mechanisms. Coping mechanisms are the reverse of but reciprocal to role-conflict. On the one hand, role-conflict is a situation between two incompatible expectations, and therefore, results in a hindrance, disruption, upsetting the balance and causing an individual a strained situation in the performance of their dual roles. On the other hand, coping mechanisms are processes which serve the function of a checkpost, a suggestion box and a control room.

Mechanisms operate in both ways, preventive and curative, and serve the purpose of keeping a balance between two well-defined roles or whenever ego (an individual) is facing a crisis. Mechanism is a counter reaction to role conflict. Whenever ego is motivated by its own actions (alienative need dispositions) to attain its goal, the alter, through mechanisms, lends a hand to direct ego towards the right path. There is, however, little difference between social mechanisms and coping mechanisms. We have discussed the difference between social conflict and role-conflict in chapter one. In the same fashion social mechanisms provide the means of social control: an integration of role systems of all individuals or to
maintain equilibrium of social system as a whole. Whereas coping mechanisms give solutions to individuals for maintaining own control upon the situation of role-conflict. Parsons in his discussion on "deviant behaviour and social control" stressed on the social mechanisms to operate in one of two fundamental ways. The first is to 'nip in the bud' the incipient tendencies towards deviance so as to prevent the building up of a vicious circle. The second is to 'break through' the vicious circle."¹ According to Parsons, role conflict occurs between allocation of claims of different role expectations. This allocation or order should be made by priority of scales by occasion e.g. time and place and by distribution among alters. He also devised some social mechanisms as support, psychotherapy, religion etc. Parsons' attempt to define coping mechanisms is, however, restricted to role-system (ego-alter interaction) as was his main focus of discussion in the genesis of role-conflict.

In the same vein, Merton has seen coping mechanisms within the role set. He described role sets both as genesis of conflict and mechanisms to control. For example, his second mechanism 'difference in power distribution among

role set' may pose a real threat to instability of role set, but different members of power positions may deliberately or unwittingly come into terms of coalition of power, an alliance of power hierarchy and may fulfil expectations of different statuses. The other mechanisms are: observability of the individual's role activities, observability of conflicting role demands of others in the role set and support by observability of similar status and similar difficulties of the members of the role set. Merton's mechanisms for the articulation of roles in the role set clearly direct us to put forth two major coping mechanisms, (a) compromise between different activities and (b) referenced behaviour of members in the role set to resolve role-conflict.

For this, Goode has given a special emphasis in describing coping mechanisms. He has developed two main sets of techniques for reducing individual role strain. First is the ego's manipulation of his role-structure, and second settling or carrying out the terms of the role relationship. To his first technique, ego has to manipulate between different roles by compartmentalization


of activities (ignoring the consistency of expectations). This mainly works by (a) location and context and (b) situational urgency or crisis. Ego (an individual) may also delegate an alternative. Ego may also either eliminate the relationship or may extend his role membership by his engagements in other activities. This is to note that the first technique for reducing role-strain determines whether an individual will have a role relationship with another or not, but it is not effective in case of individual's performance in reality. The second technique is related to the latter problem. By this technique, the structure of role-relationship must be viewed as a transaction. Individual evaluates the role cost or performance cost at a minimum and may even apply some rationality to the felt strain in his role set. Individual may also decide the role price due to interaction between supply and demand factors. This, in his view, affects both ego and alter. The ego's performance is dependent on alter's attempt to reward ego well, and if so, ego will perform adequately. The third aspect of the second technique is the mediation of third parties, which either affects ego or alter or both and make a bargain towards their motto. Goode's attempt is welcome and more suitable to the needs of modern values. His work is a combination of theories in economics and sociology.
Focussing on coping mechanisms, two studies have been carried out by a team of researchers. In first study Gross, et. al. have maintained the individual's own definition of situation as reducing technique. They have divided individual's situation in three categories; moral orientation, expedient and moral expedient. In first situation, individual (person) may adopt three ways. He either conforms to the legitimate expectations and rejects illegitimate expectations. If he feels both the expectations are legitimate, he may compromise between two expectations. If he perceives both as illegitimate, he may adopt some kind of avoidance behaviour. In the second category, 'expedient', individual gives value to sanctions than own moral values. He will always care about the sanctions held by others. He may internalize sanctions in the same three ways as does perceive in case of moral perception. The third and the last category 'moral expedient', is the combination of both types of individuals. This type of persons pay equal weightage to both perceptions, their own moral perceptions as well as other's sanctioned perceptions. Thus, in their views, role-conflict is, to a large extent, based on individual's own situation

and it may be resolved by their own perceptions. In another study, Kahn et al. framed coping mechanism in two ways: direct ways and indirect ways. Individual in his role-relationship must either adjust by compliance with the expectations or persuade role senders to modify incompatible demands. Indirect attempts may be utilized either to avoid the sources of stress or by using defence mechanisms which distort the reality of a conflictual or ambiguous situation in order to relieve the anxiety of the undistorted experience.

Pridham has also attempted a theoretical formulation of individual's mechanisms and group moves to resolve stress. To formulate the proposition, she has worked on Bion's two modes of activity in a problem solving group: (1) work involving rational and scientific behaviour; and (2) basic assumption culture activity expressed in the acting out of a tacit, non rationality held belief or assumption about the purpose of the group. This is apparent from these two modes of activity that purpose of a group is fulfilled as


long as members of a group hold work expectations in a rational and scientific manner, but, when members of a group are in a state of basic assumption culture activity, they are likely to be dissatisfied with the group. Bion, quoted by Pridham, identified three basic assumptions, each of which constitutes a belief about the group's purpose in meeting: dependency, fight and pairing. The third assumption is, however, formed by Bion as coping mechanism in the process of resolving stress. He observed the acts of turning members to resolving mechanisms in a group behaviour. First, two individuals had separate talks with a therapist, then these two learned and experienced men talked to each other, and then initiated talks with members of the group in a man to man conversation. Finally, the leaders who initiated the first talks, changed the group atmosphere. This change was posited by Bion as 'manipulation of the group'. Therefore, actions taken to establish pair relationship had functioned as a mechanism to manipulate the group. In the final diagnosis, Pridham has maintained that (1) these acts of turning are viewed as stress resolving moves to change the group condition just as are those acts of warning in which the intention is to locomote the group.


8. Ibid. p. 797.
to work, and (2) when the group's condition is work and individual turns to an agency as if with an intention of locomoting the group to basic assumption culture activity. Thus, the basic postulation is to change the situation of the group in either way.

Hartmann's theory of adaptation mentions two types: (1) autoplastic, consisting of changes in the organisms as a result of the transaction of the organism and environment, or (2) alloplastic, referring to processes which organisms use to shape their environment.

To conclude, it is rather safe to divide the discussed theories in three categories to put forth the coping mechanisms in their right perspective. It has been mentioned that Parsons and Merton have suggested social mechanisms for (a) articulation of social behaviour, and (b) for providing means of social control. Their scheme of thought is less on the processes of individual's moves towards the problem, and more on the total individual's resolution processes.

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The second category of theorists like Kahn et al. and Pridham in particular have conceptualized the problem in a group situation. There is, however, the third category of theorists like Goode and Gross et al. who have formulated the individual's perceptions and actions as resolving mechanisms. Thus, focusing on the individual's processes to cope with one's experience of conflict, we have built up three processes of coping mechanisms. These are: conformity, compromise and avoidance behavior. Conformity response initiated by Parsons is actualized in most of later theories. It is clear that ego (an individual) wants to conform to the call given by the alter, only if ego may deviate from the norm. When ego does not find the gratification out of given call, even if there is a difference in status and power among the members in the role set, ego tries to conform the call either by making an alliance or by observing the same difficulties of other members and tends towards work by consoling and counseling mechanisms. Ego is, however, independent to choose between legitimate and illegitimate expectations, but tries to conform. This has also been established in two studies done by a team of researchers (discussed earlier).

Compromise is the most sought after resolution in the discussed theories. Parsons stressed on making a priority
scale of activities by giving more value to one expectation and less to others. Merton also focussed on the compromise in his role set. His suggested mechanism for articulation in role set, is basically manifested towards compromise. Goode's work is explicitly based on making a compromise by compartmentalization of activities (ignoring the consistency of the expectation) or by engaging him in other activities, etc. Ego must make a priority of preferences not only by emotional judgments but by considering the monetary cost of role performance as well.

The latter works of Gross et al., Kahn et al. and Pridham have devised compromise by an analysis of the situation. Not only they, but Bion's 'manipulation of the group' and Hartmann's 'alloplastic adaptation' also point in this direction. Finally, the avoidance mechanism has also its roots in the discussed theories. Parsons's term 'ordering' is the indication of the avoidance behaviour. He defines ordering in this way, "there is an establishment of a time schedule so that different times are 'set aside' for different activities with different people. 'Time off' from occupational obligations on sundays, holidays, vacations etc is the example". 11 Although he stated that these provisions are provided in the system but it is implied by individuals

as well. Whenever ego finds it in predicament and fails to adopt both the mechanisms of conformity and compromise, it escapes and avoids the situation. Avoidance behaviour is visibly seen in the works of Goode, Gross et al. and Kahn et al. Avoidance behaviour is also well depicted in the literature in the form of proverbs, slangs, words and facial expressions.

As things stand, these three coping mechanisms will be highlighted in the light of empirical data how women physicians responded to the proposed coping mechanisms in the performance of major functions of social roles.

Table 7.2
Social Roles and Coping Mechanisms

<table>
<thead>
<tr>
<th>Social Roles</th>
<th>Conformity</th>
<th>Compromise</th>
<th>Avoidance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Happiness</td>
<td>29 (25.0)</td>
<td>73 (62.9)</td>
<td>5 (4.3)</td>
<td>107*</td>
</tr>
<tr>
<td>Household work</td>
<td>14 (12.1)</td>
<td>14 (12.1)</td>
<td>88 (75.9)</td>
<td>116</td>
</tr>
<tr>
<td>Salary Giving pattern</td>
<td>42 (36.2)</td>
<td>28 (24.1)</td>
<td>46 (39.7)</td>
<td>116</td>
</tr>
<tr>
<td>Child care</td>
<td>67 (77.0)</td>
<td>4 (4.6)</td>
<td>16 (18.4)</td>
<td>87**</td>
</tr>
<tr>
<td>Socialization of the child</td>
<td>67 (77.0)</td>
<td>-</td>
<td>20 (22.9)</td>
<td>87</td>
</tr>
</tbody>
</table>

*Total does not add up to 116 due to those physicians who never faced situational crisis (see chapter V).
**Total shows the number of physicians with children (see chapter V).
physicians responding towards coping mechanisms. To maintain marital happiness, it was asked, "if your husband is furious over your negligence towards his needs, how do you respond?" The responses clearly show a preference for compromise mechanism. However, a significant number of physicians conformed to the needs of their husbands in keeping marital harmony. In case of household work, physicians had adopted the avoidance mechanism as they did not do household work. The question was asked, "are you carrying all household work yourself?" In response to this question, data indicate that majority had a maid (For discussion see Chapter V). In view of Goode's theoretical proposition, physicians delegated household work. Therefore, they were a little free from the main housewife role.

It is noteworthy that significant number of physicians reported having given their salaries to their husbands either to conform to the tradition (head or the husband is the incharge of household income) or to maintain peace and also to share the family responsibilities. The question was asked, "do you give your salary to your husband, if not, then is it because your husband gets handsome salary; your husband has advised you to save money for the future; you
have a common pool; or you manage the whole budget for the month?" Physicians had compromised in one of three ways: They either had a common pool or managed the whole budget for one month or saved money for the future on the advise of their husbands. A considerably large number of physicians neither conformed nor compromised, but did not bother to give their salary to husbands.

The issue of child care projects the traditional image of women physicians as mothers mostly conformed to the norms. Since child care is the major responsibility of a mother, it was enquired, "do you ignore your children?" As it has been noted in the earlier section of this chapter, there were 21.8% physicians who felt guilty of ignoring their children, adopting avoidance behaviour. Since compromise device was not a handy solution to the problem of childcare.

To highlight the coping mechanisms adopted by physicians in their performance of professional roles, Table 7.3 is given below:
Table 7.3

Professional Roles and Coping Mechanisms

<table>
<thead>
<tr>
<th>Professional Roles</th>
<th>Conformity</th>
<th>Compromise</th>
<th>Avoidance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional work</td>
<td>23 (19.8)</td>
<td>86 (74.1)</td>
<td>7 (6.03)</td>
<td>116 (99.93)</td>
</tr>
<tr>
<td>Duty Adjustment</td>
<td>123 (81.3)</td>
<td>20 (13.0)</td>
<td>3 (2.7)</td>
<td>146*</td>
</tr>
<tr>
<td>Academic work</td>
<td>42 (28.0)</td>
<td>8 (5.3)</td>
<td>97 (64.7)</td>
<td>147**</td>
</tr>
<tr>
<td>Academic Rewards</td>
<td>71 (47.3)</td>
<td>60 (40.0)</td>
<td>3 (2.0)</td>
<td>134 (89.3)</td>
</tr>
</tbody>
</table>

* **Total does not add up to 150 due to non-response.

Difficulties in professional roles have been mostly highlighted through case studies and observations based on the fieldwork. Thus, the present table is a kind of feedback to the problem which needs exploration. It is apparently visible that physicians responded poorly to the questions in the professional context. However, when married physicians were confronted between social and professional roles, majority compromised between two roles. They were asked, "if you are put up in such a situation when both profession and husband need you at the same time, how do you adjust in such a situation?" The answer was, 'they
analyze the situation and react accordingly or manipulate and resolve the conflict. A small number of physicians had utilized the avoidance coping mechanism. It is encouraging that there were some who were committed to their profession and conformed to their profession even when they were in the crisis.

On the issue of duty adjustments, it was asked "if you have some personal work, how do you adjust your emergency duty?" Four alternatives were put forth: (i) adjust with your colleagues; (ii) request your in charge to change the duty; (iii) just leave your work; (iv) any other way. Data indicate that majority of physicians had adjusted with their colleagues, was a traditional way of adjustment. There were some who requested duty in charge to compromise in their duties. This is coherent with the Kahn's theoretical proposition 'to persuade role senders to modify the incompatible role demands' and with Hartmann's alloplastic adjustments. There were a negligible number who enjoyed avoidance behaviour by leaving the work just like that or giving an application and facing the consequences later on.

Academic work was mainly carried out by faculty members and specialists. Non-faculty members had shown a negative attitude in terms of paper publications, attending
conferences etc. Thus, when confronted with two expectations, majority of the respondents adopted avoidance behaviour. This falls in the line with the postulation of Gross et al. that "feeling illegitimate may adopt some kind of avoidance behavior". Non-teaching staff was aware that they were recruited for patient care and will not have to perform academic work in that situation. Physicians resolved their conflict through avoidance behaviour. It is important to note that out of 49.3% (faculty members and specialists) only 28% conformed academic work despite difficulties, while a negligible percentage compromised on this issue. Remainders were moved by avoidance behaviour.

Finally, a question was asked, "If you are more qualified as compared to other physician but you are not getting due credit, how do you adjust yourself in that situation?" Majority of the physicians were sad, but conformed to the work rules. Others consoled themselves by self diagnosis, by pointing out shortcomings or by observing difficulties of their colleagues as Merton argued in his role set discussion.

To illustrate these mechanisms in the lives of physicians, three typical examples of conformity, compromise and avoidance have been selected from our case studies.
Conformity Mechanisms

One divorcee mentioned:

"When I was left all alone, I was about to die, but a sudden thought struck me "why should I? I will not die on account of this man. I read Quran (she is Muslim) till early morning. The other day, I looked forward to my profession, and it really worked as an asylum".

Consequently, she concentrated all her energies on the profession. She forgot sadness in her life in ameliorating patient's miseries and pain and searched the new rainbows in her professional work. Apart from her, a large number of physicians were of the view that professional work is a great mechanism in solving so many family problems.

A married physician narrated,

"Our work is a big shelter for us to shed our fears, anxieties and tensions. No professional work is as caution prone as ours. If I am operating, have to be accurate in handling instruments, and if I get disturbed by a tiny thing, I may make mistake and that would lead to disaster".

Since the medical work needs complete involvement, it helps the incumbent to avoid other problems. Thus, conforming to work was perceived as a great coping mechanism.
Compromise Mechanism

Compromise between two expectations is not an instant judgement but it requires lots of thinking and consideration of monetary and emotional pros and cons regarding the issue.

Another married physician disclosed,

"If we fight over small issues, I avoid the situation and involve myself in washing, cleaning etc. If it is for big issue, I involve myself in professional work, come early to hospital and stay late in the hospital. If situation worsens and I feel it is going out of hand, I compromise. After all, we are husband and wife and maintain together a family and social life".

When probed whether she was ever requested by the husband to make a compromise, she conceded. However, she strongly rejected the idea of any third person interceding in the family crisis.

Avoidance Mechanism

Many physicians stressed on adopting avoidance behaviour. They particularly talked in terms of family matters and with family members. An interesting example of adjustment was cited by one widow physician,

"When my husband was alive, we never had long tensions with my husband nor a third person was needed to resolve the tension. Actually, my husband was a tidy person. So when he used to enter his room, always
looked around if anybody had upset his room, it was dirty, he used to get angry. I always avoided and went to my garden looking after the plants (she won prizes for roses in flower show), while husband had settled downing his room."

Apart from three mechanisms 'support' was the most sought after mechanism for physicians, one head of the department said.

An elderly physician responded,

"Well, I can recall only two times when no speaking term was practised. But my children are a major source of resolution. If I am angry, I start doing washing, scrubbing, etc. I will stick to my room with a novel. I will involve myself in professional work to show my non-cooperation. My children (grownup) would guess 'mummy is angry'. They will first try to make me cool and laugh or they will cut jokes and make fun specially when all of us (including husband and children) would sit together either in the morning or at dinner time. Both of us shed our anger and resolve the problem".

Thus, coping mechanisms are the essential feature in an individual's life. These provide solutions and ways to sort out the problem.

C. SUMMING UP

Role-conflict and coping mechanisms are contrary but interlinked to each other. Role conflict has to be replaced by some sort of alternative device. This chapter was based on these issues. The four major propositions of role-conflict were experienced by women physicians in
their performance of social and professional roles. To be specific on this aspect, physicians were confronted due to a difference in normative expectations of two roles. However, the experience of role-conflict was determined by age and professional hierarchy. It has been observed that the role expectations are inevitably associated with the life cycles of woman. It is for this reason as the life cycle of woman progresses, the intensity of role conflict decreases.

The second proposition of role-conflict was also tested in the light of empirical findings. Most of the physicians had idealized both the role models: married woman with husband and children and as physician since childhood. Thus, they perceived conflict in the performance of two roles causing a gap between the prescribed and perceived expectations. Perceived role expectations of physicians were observed in two ways:

(1) Traditional role at home and professional role (technical job) at hospital.

(2) Modern role at home and professional role (ideal medical profession) at hospital.

Thus, physicians felt conflict in their respective categories due to reinforcement of prescribed expectations of them.
Experience of role-conflict due to one's "own inadequacies of balancing two roles is lessened with countervailing resources, as seen in the case of physicians in this study. Physicians were not only resourceful, but they were also intelligent, assertive, manipulative and had a scientific attitude towards life and social milieu. However, resources could not eliminate the conflict since physicians completed their domestic tasks in the morning, evenings, weekends and holidays. They were also restricted to scheduled work in professional roles due to paucity of time and want of energy. Role-conflict faced by members in the role-relationship was less evident in case of physicians, as most of the physicians lived in nuclear families and parents-in-law, particularly mothers-in-law visited physicians on occasions and had treated each other as guest. Thus the difficulties and tensions arising from status and roles of other members were absent or little. It is for this reason, type of family was a decisive factor in the perception of role-conflict. However, physicians in their professional roles were troubled by members in the role relationships, and therefore, physicians did face problems in their roles.

To conclude, four theoretical propositions of role-conflict were in consonance with the four statistical
variables: age, professional hierarchy, martial status and type of family. Having summarized the role-conflict, it is necessary to give a brief account of coping mechanisms adopted by physicians in this study. The coping mechanisms have their origins in social mechanisms. This is why the typology of coping mechanisms applied in this work are also developed on the existing theoretical sets of mechanisms. They were categorized in three forms. First category of theoretical inferences have laid an emphasis on mechanisms adaptable to all individuals in wider situations. The second category of ideological inputs has attempted mechanisms to work out in a group situation. The third and the last category of mechanisms was based on individual's situation of crisis. All theoretical inferences focus on three types of mechanisms. Thus, we have built up three coping mechanisms: Conformity, compromise and avoidance mechanism, which were tested in this study and were found valuable in terms of making the roles viable. Physicians resolved their conflictual situations with the help of these mechanisms. As has been noted, physicians were intelligent and manipulative. Compromise mechanism worked as most handy mechanism to the physicians. Avoidance behaviour was a wise attempt to sort out many problems. Conformity mechanism was adopted on specific occasions. Whereas compromise and avoidance mechanisms can be utilized in all situations of
crisis, the adaptation of a particular mechanism was determined by moral perception, situations, and type of activity.

To conclude, role-conflict may arise due to contradictory expectations of two roles which can be resolved through conformity, compromise and avoidance coping mechanisms.

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