CHAPTER VI

SUMMARY AND CONCLUSIONS
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1. Introduction

1.1 The Problem of Research

In the hospital setting, the role of a nurse as a health functionary is of great relevance and her unique position of having continuing contact with the patient and as a catalyst in promoting personal relation between a patient and a physician make her contribution to the total patient care as rather indispensable.

In the wake of rapid technological change, nursing has become more technical as hospital has become increasingly more complex bureaucratic professional organisation, providing work location for the majority of the nurses. Their conditions of work are largely controlled by the organisational climate and the working relations are relatively impersonal. As semi-professionals, nurses are responsible for providing professional care to patients under their charge. They are, at the same time, agents of supervising physicians in carrying out orders for treatment and patient care. Finally, nurses are members of the hospital staff and must involve themselves with the day to day
administration of the patient care unit. As a result, while a strong sense of responsibility and discipline are felt to be necessary for the welfare of the patients, a considerable number of nursing tasks are those which have no direct connection with the care of patients.

Besides, nurses as semi-professionals are predominantly women. Their position in the society as well as in professional hierarchy is ambiguous. Their role performance is affected by different set of role expectations from various members of the health team as well as patients in addition to their own role perception. This is precisely what forms the base of this study.

1.2 Objectives of the study

The main objectives of the study are:

1. To analyse the socio-cultural and economic characteristics of the nurses.

2. To delineate the role perception and performance of the nurses and relate these to some of their socio-cultural characteristics.

3. To analyse the expectations of patients and nursing supervisors (supervisory nurses and doctors) towards their role performance.
4. To analyse the sources of conflict in the role of the nurses.

1.3 Hypotheses of the study

The study largely being an exploratory one, some of the general hypotheses pertaining to it are:

1. Different emphasis on various job expectations by two sets of supervisors holding different positions in the hospital set-up may lead to role conflict thus affecting the role performance of nurses.

2. Lack of clarity in expectations on the part of 'others' as well as incongruency in the perception of nurses and expectations of 'others' on certain aspects of nursing may lead to inadequate performance of nurses.

3. Lack of facilities and rewards in the hospital set-up may result into inadequate performance of nurses.

4. As a consequence of conflict between occupational and familial role of nurses, their role performance tends to get affected.
5. In general hospitals, patients being generally from lower socio-economic strata have a low expectation and feel satisfied with whatever services are rendered by the nurses.

1.4 Methods of the study

The study was carried out in Medical College, Rohtak in the State of Haryana. For nurses, a two stage sampling was done. At first, some wards were selected and in the second stage, all the nurses in these wards were interviewed with the help of an interview schedule. The main focus was on eliciting their responses pertaining to their socio-economic background, their attitudes towards their profession, their role perception, the expectations patients and supervisors had of their role and their own satisfaction with the role they performed. As regards patients, a twenty per cent random sample was drawn from the same wards from which the nurses were taken. They too were interviewed with the help of an interview schedule consisting of questions pertaining to patients' socio-economic background, their level of satisfaction with the general and nursing services provided by the hospital organisation.

All the ward sisters, matrons, nursing superintendents and
registrars in these wards were interviewed with the help of an interview schedule in order to have an assessment of various organisational aspects, their expectations of and satisfaction with the role of nurses in the hospital. In order to supplement the data thus obtained, non-participant observation was also carried out in different ward situations.

The data collected were analysed through ratios, proportions, measures of central tendency, ranking and correlation, wherever found suitable.

1.5 Limitations of the study

Some of the main limitations in carrying out this study are as follows:

1. As the nurses have been studied in only one hospital, the study may not be representative of the other hospitals in India. As such, it is necessary to test the validity of the present findings in other geographical and cultural areas before further generalizations in regard to the role of nurses may be deduced.

2. Though there were fifteen specialities in the hospital, only four were chosen due to shortage of time and
resources. It is assumed that these four specialities will reflect the hospital social structure and problems associated with it in general.

3. The data were obtained through a subjective reporting method. All the intrinsic limitations of this method, therefore, would be valid for this study as well.

4. While constructing the family social status index, which is built up of variables like education, occupation and income, it has been assumed that each one of the variables contributes equally towards socio-economic status, though this may not be true. However, it is a methodological attempt to group the families into different socio-economic strata, and this has significant influence in the role performance of nurses.

5. Though the analysis is mostly based on methods of classification and cross tabulation, statistical treatment has been given to the data, wherever possible. In order to apply the test of significance, the data in certain categories had to be combined due to a small number of respondents in these categories.
2. **Demographic, socio-cultural and economic profile of nurses:**

2.1 An overwhelming majority (97.5 per cent) of the nurses were below the age of 30 years.

2.2 The majority of the nurses were Hindus (88.33 per cent), Sikhs and Christians were marginally represented, their percentages being 9.17 per cent and 2.5 per cent respectively.

2.3 The sample of nurses was dominated by Khatri/Arora caste group (68.38 per cent), Jats were fairly represented whereas Brahmins, Banias, Kayasthas, and Scheduled Castes were marginally represented.

2.4 There was a preponderance (79.17 per cent) of nurses from towns and cities.

2.5 More than half (58.34 per cent) of the nurses were married. Out of unmarried, 96 per cent expressed a desire to get married.

2.6 The academic qualification of most of the nurses was matriculate/higher secondary but graduates were also fairly represented (16.67 per cent). Those who were graduates/
post graduates had completed their respective education after taking up nursing as a job.

2.7 With regard to parents' education, occupation and income, a majority of the nurses (65 per cent) had fathers educated up to school level. Most of them were following medium prestige occupations like shopkeeping and low administrative govt. jobs and were earning between Rs. 750/- to Rs. 1000/- monthly. The mothers of the majority of the nurses were either illiterate (60.83 per cent) or educated up to middle level (26.67 per cent) and none of them was employed anywhere.

2.8 The data regarding respondents' husbands revealed that more than 50 per cent of them were college/university educated, a large proportion engaged in business or government jobs and majority of them earned either up to Rs. 1000 or between Rs. 1000 to Rs. 1500 monthly though those earning above Rs. 1750 were well represented. As compared to parents, the husbands of nurses were better placed in life.

2.9 In a nutshell, the analysis of socio-economic background of nurses reveals that they are mainly drawn from lower middle class families. It seems, there has not been much change in
our society's attitudes towards nursing. Those who are needy and cannot go in for higher education are the ones who are drawn towards this occupation rather than those who are genuinely interested in nursing. The people who are in an occupation due to economic consideration only may give a performance which is just of average level.

3. Professional socialisation of the nurses and organisational milieu

3.1 The mean age at which nurses in the sample entered this profession was 17.72 years, the range varying between 17 and 28 years.

3.2 As many as 35 per cent nurses had their relatives in the nursing occupation.

3.3 The majority (70.83 per cent) of nurses did not have interest in any other occupation before taking up nursing. Those who had initially some other occupation in mind were interested mainly in teaching, clerical jobs, and as telephone operators. Monetary rewards and guarantee of job were the major considerations for them to take up this occupation instead of any other occupation.
3.4 The prime motivating factors to join nursing for the majority of the nurses were: (a) desire to serve humanity, (b) liking for nursing, and (c) easy availability of the job.

3.5 As many as 70.83 per cent nurses had no regrets at having joined this occupation. The feeling of regret, however, showed a uniform increase with rise in family social status index of the nurses ($\chi^2 = 7.02$, df = 2, $p < .05$). The main reason for this feeling of regret was their dissatisfaction with the status accorded to nurses by the society.

3.6 More than 60 per cent of the nurses expressed that the society recognised their services in some respects. There was a fall in the perceived recognition of nursing as an occupation with a rise in the socio-economic background of nurses. The main reasons advanced for low or no recognition of nursing were (a) stigmatized connotations attached to nursing, and, (b) direct contact of nurses with male patients.

3.7 As regards supervisors, 19 out of 34 supervisory nurses and 18 out of 28 doctors found the status of nursing low. More supervisory nurses than doctors felt that the services of nurses
were definitely recognized. The supervisory nurses attributed this low recognition of the occupations mainly to the stigma attached to nursing and a status quo being maintained by the hospital authorities by not giving an uplift to this occupation whereas doctors attributed it to the poor quality of nursing in the wards and the faulty training of nurses.

3.8 While ranking the various hospital personnel in terms of the status enjoyed by each category, nurses placed themselves second in hierarchy, next only to doctors.

3.9 An overwhelming majority (93.33 per cent) of nurses considered themselves to be important for society.

3.10 A little less than 50 per cent nurses disliked one or the other job in nursing. The most disliked jobs were: (a) to attend to the male patients, (51.72 per cent), (b) control of visitors (31.03 per cent), (c) making beds (6.90 per cent) and (d) record keeping (6.90 per cent).

3.11 The analysis in regard to extent of satisfaction of the nurses with their job revealed that, the mean score value (3.77) fell between satisfied and fairly satisfied categories, and more
towards fairly satisfied response, suggesting thereby that the satisfaction of nurses with their job was fairly substantial. It was further revealed that as compared to unmarried nurses, married nurses were more satisfied and also those with a longer period of working experience showed a higher satisfaction level than those with a shorter period. By relating the level of job satisfaction and family social status index of nurses, it was found that the nurses with relatively lower socio-economic background showed higher satisfaction with the job.

3.12 As regards leisure time, a two-third of the nurses found sufficient time to follow their leisure time pursuits. The most common activities engaged in by the nurses were; light reading, household chores and going to movies or listening to radio. The study of perceived adequacy of leisure time and marital status of nurses indicated that unmarried nurses had more leisure time at their disposal than the married nurses.

3.13 With regard to their value orientations, patient orientation was ranked highest by the nurses in both the general idealised set of statements provided to them and in the real life situation. However, it was observed that more nurses subscribed to
professional orientation, in general set of statements provided to them whereas in real life situation, more of them conformed to the views which classified them as 'bureaucratically oriented.

The data further revealed that the nurses with a shorter length of working experience scored high on patient orientation and those with a longer experience scored more on bureaucratic orientation. The chi square value was found to be highly significant showing an association between value orientation and the length of experience ($\chi^2 = 11.41$, df = 2, $p < .05$).

3.14 The analysis in regard to the satisfaction of supervisors with the organisational set up brought out that most of the doctors and supervisory nurses were not satisfied with the organisational set up of the hospital. The major factors responsible for their dissatisfaction as identified by them were; inadequate staff-patient ratio, lack of incentives provided to the staff and lack of co-ordination between the members of the organisation.

3.15 Whereas most (30 out of 34) of the supervisory nurses were satisfied with the willingness of staff to assist each other, 18 out of 28 doctors were not satisfied.

3.16 As regards the possibility of exchange of information within their own department was concerned, the majority of
supervisory nurses found it easy to exchange information within their own department but with regard to other departments in the hospital more than 50 per cent of them expressed that exchange of information was not easy. On the other hand all the doctors found it easy to exchange information with their own as well as with the other departments.

3.17 The analysis in regard to the relationship between doctors and nurses showed that most of the doctors treated nurses as their subordinates in work situation. Referring to their personal life, most of the doctors tried to maintain courteous relationship, some of them did not like to keep any association with the nurses, and a few of them treated nurses as subordinates, suggesting thereby that the doctors did not like to mix up much with the nurses. Further probing showed that by becoming informal with nurses, doctors were afraid of jeopardising the discipline of the organisation as well as the performance of the professional role. More than 80 per cent of the supervisory nurses also expressed that the doctors and nurses either did not associate or rarely associated in personal life.

3.18 With regard to their reaction at the annoying behaviour of staff nurses, both the categories of supervisors preferred to discuss
the matter with the person concerned and educate her as to correct behaviour. While with most of the doctors, the situation never got out of hand, a very large number of supervisory nurses reported the matter to the authorities or gave adverse remarks in their confidential reports in extreme cases.

3.19 In regard to analysis on communication between nurses and doctors, only 14.17 per cent nurses expressed that it was direct whereas 48.33 per cent stated that only in serious cases, they were directly informed, by the doctor. As many as 37.50 per cent nurses opined that the communication between themselves and doctors was always indirect, be it ordinary or serious patients.

3.20 A little less than 75 per cent nurses emphasised that difference of opinion did crop up with the doctors over the treatment of patients. The nurses with comparatively higher family social status index showed a greater tendency to have a difference of opinion with the doctors \( (\chi^2 = 10.09, \text{df} = 2, p < .05) \). Out of those who had some difference of opinion with the doctor, only one fourth made sure to express it, and the rest,
expressed their views only sometimes or not at all. Those not expressing themselves at all showed a constant decline with a rise in their socio-economic background of the nurses. More than 50 per cent of the nurses who expressed themselves, did so either very tactfully or weighed the situation and acted accordingly. Those with a comparatively higher socio-economic background tried to influence the doctors more than those with a lower socio-economic background.

3.21 As regards the reaction of doctors towards the opinion expressed by the nurses, 58.03 per cent nurses reported that doctors listened and co-operated with them. Sometimes they even tried to explain things to the nurses, if they were wrong. Those who thought doctors were not that co-operative disclosed that some doctors listened, some did not (27.16 per cent), they did not do anything in front of nurses (6.17 per cent), got annoyed (6.17 per cent) or tried to evade (2.47 per cent).

3.22 In order to have a rough idea of motivation, morale and job attitude of nurses, their extent of agreement on certain general statements and their satisfaction with working conditions was elicited. An analysis of intrinsic factors related to their role performance showed that the nurses felt more strongly about
the low prestige and autonomy attached to nursing, expectations and indifference of the patients, as compared to the situational factors like physical surroundings, disobedience of class IV etc. Among extrinsic factors; leave rules, salary, medical facilities were considered to be more satisfactory than orientation/training facilities and departmental support. They were least satisfied with incentives and promotion/transfer prospects.

3.23 Briefly, some inferences can be drawn from the above analysis. The professional socialisation of nurses brings out that they are largely patient-oriented and bureaucratic-oriented in the day to day ward situation. Their substantial satisfaction with their job, their humanitarian/patient orientation, perceived adequacy of leisure time and their interest in the occupation, are likely to make them well adjusted and socialised in this occupation. But along with this, they are conscious of their importance and the low recognition accorded to them by the society. A few of them also showed a feeling of regret at having joined this occupation. So far as this perceived low recognition and feeling of regret emanates from societal values and norms, there is a likelihood of their role commitment being instrumental and consequently affecting their role performance.
Most of them who joined this occupation instead of other occupations of their choice did so due to economic consideration and guarantee of job. This once again substantiates our observation in the previous chapter on socio-economic background of nurses that people from lower socio-economic background who can not afford higher education are attracted largely to this profession.

The fact that the nurses with a comparatively better socio-economic background have shown more consciousness about their lack of recognition and status, have exhibited a higher tendency to feel regret at having joined this occupation and have felt less satisfied with nursing lead one to believe that their expectations regarding their career are high, as they may be seeking rewards in terms of prestige and power along with the material rewards.

An analysis of the organisational milieu in the hospital brings out that the facilities and rewards provided to the nurses are insufficient. Nurses are highly dissatisfied with the conditions of their employment and the incentives provided to them. It is also supported by the responses of the supervisors.
role which is neither provided with adequate facilities nor sufficiently rewarded may generate ambivalance in the incumbent towards meeting its expectations.

3.27 Besides, the low coordination of various units of the hospital and unwillingness of staff to assist each other as revealed by the superiors can lead to low morale of the employees.

3.28 The relationship between doctors and nurses revealed that it was more authoritarian than collegial. The communication between the two categories of personnel who are mainly responsible for patient cure and care is limited mainly to written orders. It is not easy for the nurses to put forward their own opinion about patients' treatment though they are with the patients more than the doctors. It seems that the doctors mostly treat nurses as subordinates to them and therefore there is a communication gap. This kind of treatment at the hands of doctors may generate a sense of inferiority complex in the nurses and thus block the communication between the two. Simultaneously, it can also lead to an apathy towards the job as far as nurses are concerned.
4. Role perception, expectation, performance and effectiveness

4.1 Role performance of nurses has been done from two perspectives. The first is role definers' perspective which throws light on their expectations and the second is that of nurses dealing with their perception of their own role. In their role expectations of nurses, supervisory nurses put emphasis on punctuality and discipline among the nurses, their cooperation with other staff and on record keeping. It was found that the main emphasis of supervisory nurses was on instrumental role and that too on the ritualisation of various activities carried out by the nurses, that is, on the bureaucratic role. They certainly attached lesser importance to expressive role of nurses. As regards doctors' expectations, they put more emphasis on professional and expressive role of nurses as compared to supervisory nurses. They emphasised activities like empathy with the patients, personally checking the linen, diet, and activities which involved direct contact with the patients. Besides, they felt it was essential for the nurses to carry out supervisors' orders without questioning them.

4.2 Both the sets of supervisors attached lesser importance to the expectations like 'inform the doctor about patients' problems'.
'keep away from emotional involvement, educate patients about their disease.'

4.3 The main emphasis of patients' expectations was on technical care. All the patients expected the nurses to give them technical care. General care was expected by 42 per cent patients. As many as 40 per cent patients expected the nurses to carry out doctors' orders. Besides this 35 per cent patients wanted some kind of sympathetic behaviour from nurses.

4.4 The role perception of nurses showed that the supervisory nurses largely expected them to carry out technical and general care of patients. It seemed from their responses that the main emphasis of supervisory nurses was on the bureaucratic role of nurses, their stress being on 'ward management,' 'routine work,' 'duty,' 'punctuality' and 'discipline.'

4.5 According to nurses, doctors too mainly expected them to carry out technical and general care of patients. In addition to this, they expected them to carry out their orders and cooperate, and assist them in various functions. Male doctors also expected them to cultivate social relationship with them.
4.6 The most common expectation of patients as stated by the nurses was technical and general care. More than 70 per cent nurses felt that patients expected sympathy/consolation from the nurses.

4.7 A comparison of doctors', supervisory nurses' and patients' expectations showed that, some of the expectations of all these categories were similar but their emphasis on various job expectations was quite different. Whereas doctors were more concerned with the professional role of nurses, supervisory nurses stressed the bureaucratic role of nurses. The supervisory nurses certainly attached more importance to rules and procedures of the hospital, while the doctors emphasised those activities which involved contact with the patients. The patients more than anything else were concerned with the condition of sickness and expected nurses to dispense technical care only.

4.8 As regards nurses, 37.50 per cent of them felt that there was difference in emphasis on various activities expected by doctors and supervisory nurses. Out of those who found this difference in emphasis, more than 75 per cent reported that the main
emphasis of doctors was on patient care. The other activities to which doctors attached importance were, their orders to be carried out, and nurses' assistance to them. On the other hand, the activities emphasised by the supervisory nurses were, ward management, punctuality, work according to procedure, and complete written records.

4.9 The study further revealed that this different emphasis by two sets of supervisors often led to a conflict in the nurses in regard to priorities to be accorded to different jobs, thus affecting their performance. This provides support to our hypothesis, 'Different emphasis on various job expectations by two sets of supervisors holding different positions in hospital set up may lead to role conflict, thus affecting the role performance of nurses', to a certain extent.

4.10 On the basis of analysis of role perception and expectation, and evaluation of role performance by the supervisors some ambiguity in the work role of nurses was identified. This ambiguity was found to be operating on two levels. First, role expectations held by specific 'others' were vague and indefinite and second there was incongruity in role perception
of nurses and expectation of 'others'. The doctors as well as supervisory nurses showed contradictory expectations. On one hand doctors wanted nurses to carry out their orders without questioning them and on the other hand, they expected them to use their own discretion and make decisions. Similarly, supervisory nurses were also unclear about their expectations. Although they themselves admitted that the empathy with the patients did not form a part of nurses' duty, yet in their evaluation of nurses' performance, the most important factor for their dissatisfaction with the nurses was nurses' inability to empathize with the patients. Nurses also felt that they were evaluated negatively for spending time with the patients, though it formed a part of supervisors' expectations.

With regard to ambiguity in terms of overlapping responsibilities it was found that as many as 81.67 per cent nurses felt that they had overlapping responsibilities in the wards with other personnel. Out of these, 28.57 per cent expressed that it hampered their performance. Functions which required contact with the patients were either delayed or not performed at all, in such a case.
4.12 The analysis further revealed that 44.17 per cent nurses perceived a gap in their training and job expected or performed by them in the wards. According to them while at the training time, emphasis was put on patient care, in the wards, the emphasis was shifted to management of wards and written records. As a result patient care which was their prime duty often suffered. The above findings lend support to our hypothesis, 'Lack of clarity in expectations on the part of 'others' as well as incongruency in the perception of nurses and expectation of 'others' on certain aspects of nursing may lead to inadequate performance of nurses.'

4.13 The analysis in regard to role performance of nurses revealed that most (27 out of 34) of the supervisory nurses did not find the performance of nurses to be matching with their expectations. The main causes of their dissatisfaction with the nurses were; 'nurses do not empathise with the patients', 'do assigned duty in a reluctant manner', 'never use their own judgement and constantly depend upon the supervisors', and 'are poor in educating patients about their disease'. As regards doctors, 24 out of 28 doctors were not satisfied with the performance of nurses. Their dissatisfaction with the nurses' performance
to a very large extent was due to the inability of nurses to use their own discretion at the time of emergency, and their carelessness in imparting technical care. Nurses' lack of cooperation with the supervisors and their lack of interest in educating patients about their disease contributed to doctors' dissatisfaction to some extent.

4.14 There was a close agreement between patients' expectations and their evaluation of nurses' performance as far as technical care and carrying out doctors' orders were concerned. There was some discrepancy with regard to activities like 'general nursing care,' 'sympathy with the patients', and 'educating patients about their disease.'

4.15 As far as the inadequate performance of nurses was concerned it was mainly attributed to organisational problems of the hospital, by the senior nurses. 'Non compliance of orderlies', 'paucity of incentives provided to the nurses', 'low nurse-patient ratio' were the main factors identified, leading to inadequate performance of nurses by the supervisory nurses. On the other hand, according to doctors, 'faulty training of nurses', 'lack of aptitude for nursing', 'lack of effective communication between the nurses and patients', which again
is caused by faulty training of nurses on socio emotional aspects of illness were mainly responsible for the inadequate performance of the nurses.

4.16 More than 90 per cent nurses were of the view that hospital setup hindered them in discharging their duties. Out of these, an overwhelming majority (92.86 per cent) was troubled by equipment shortage in the hospital. After this, the main organisational problems experienced were; non-compliance of orderlies (51.79 per cent), lack of cooperation from hospital authorities (46.43 per cent), non-nursing jobs (44.64 per cent). Similar organisational problems were identified by supervisory nurses in the previous analysis thus giving ample support to our hypothesis. 'Lack of facilities and rewards in the hospital setup may result into inadequate performance of nurses'.

4.17 As far as conflict between occupational and familial role is concerned, more than 50 per cent of the married nurses felt that marriage and its responsibilities interfered with the performance of their job in the hospital. Likewise, occupational role interfered with their familial role. 'Night duty', professional restrictions', 'disreputation' were considered to be interfering with their personal life. As a result, they
were forced to make tremendous personal sacrifices. More than 50 per cent of the unmarried nurses also felt that once they got married, it was going to affect their performance. The above findings do lend support to our hypothesis 'As a consequence of conflict between occupational and familial role of nurses, their role performance tends to get affected' to some extent.

4.18 The suggestions to make the role of nurses more effective were invited from nurses, supervisory nurses, and doctors. While the junior nurses' stress was mainly on organisational aspects, supervisors put more emphasis on professional aspect of nursing. All the categories interviewed favoured more fund allocation for equipment, improvement in nurse-patient ratio, relieving nurses of some of the non-nursing jobs. However, both the sets of supervisors felt that the posting of nurses in various wards should be based on their aptitude, type of patients and condition of patients. On professional front, better training facilities for nurses, a clearly defined line of authority, some role in health care policies, and revision of professional status of nurses were the main factors identified to bring about role effectiveness.
4.19 On the basis of analysis of role perception, expectations and performance, it is possible to suggest that the performance of nurses differs substantially from the expectations, their supervisors and the patients have of them. They do their job in a routine manner, carrying out technical activities and those too mechanically. The behavioural part of treatment is altogether neglected by them. Their performance is determined mainly by organisationally given demands for which they are accountable to the hospital authorities. It is also influenced by their role perception to some extent. The jobs which they do not perceive to be expected by their supervisors like 'being sympathetic to the patients' are performed occasionally and even hardly, though these are expected by the patients.

4.20 The major factors identified for the inadequate role performance of the nurses are (a) role ambiguity, (b) role conflict, and (c) lack of role facilities and rewards.

(a) Role ambiguity: The work role of a nurse suffers from an ambiguity in expectations held by others. Being present in the ward all the time, she is expected to discharge the responsibilities of categories above and below her.
Supervisors themselves do not seem to be very clear in their expectation of nurses' role. This tends to affect nurses' perception also, to a great extent. When expectations are unclear, incumbent of a position becomes uncertain about what is expected of him or her and what role behaviour is appropriate at a particular time.

(b) Role conflict: Two types of role conflicts are identified; intra role conflict and inter role conflict. On one hand, a nurse is under an obligation to carry out supervisory nurses' orders and on the other hand, those of doctors. Both the categories, emphasize different activities which involve incompatible demands, making the conflict most evident between the professional and bureaucratic conceptions of role. Moreover, certain expectations of nurses' role are also found to be in conflict with each other. Though at the time of training, emphasis is placed on personalised care, yet in the wards she is rewarded more for administrative jobs. As a result, she performs only those functions which result in strongest negative sanctions if she fails to comply and thus she imparts only technical care to patients.
Alongside intra role conflict, inter role conflict, that is, between familial and occupational role is also found to be operating. This conflict is more pronounced in the case of nurses due to some peculiar characteristics of nursing which often call for personal sacrifices on the part of nurses thereby affecting their role performance.

(c) Lack of role facilities and rewards: It is found that the role of nurses has neither adequate role facilities nor it is sufficiently rewarded. Equipment shortage, non-compliance of class IV employees, inadequate training facilities, unsatisfactory working conditions, paucity of incentives, lack of autonomy and recognition, low status accorded to nurses are some of the factors which discourage them to perform their role adequately.

5. Role relationships between patients and nurses

5.1 An analysis of socio-economic background of patients revealed that male and female patients were equally represented in the sample and more than 50 per cent patients fell in the age group of 21-40 years. The sample mainly consisted of the Hindus (89 per cent) belonging mostly to Jat (54 per cent) and Khatri/Arora (31 per cent) caste groups. There was a
preponderance of patients from rural areas (69 per cent). As many as 40 per cent patients were illiterate and the rest with the exception of 3 per cent, were educated up to school level. A majority of the patients were engaged in agricultural occupation. Petty businessmen, those engaged in low and medium government jobs, and labourers were equally represented in the sample. A majority of them earned between Rs. 2001 to Rs. 6000 per annum. The average family size of the patients was 5.65 members and the average number of earners in a family was found to be 1.32 members. An overall view of socio-economic background of patients suggests that most of them belonged to lower socio-economic strata of the society.

5.2 Most of the patients got themselves admitted to the hospital on local doctors' recommendations.

5.3 The study has shown a trend on the part of lower class people as well as those from rural areas to utilize allopathic treatment in the first instance.

5.4 As regards difficulties faced by the patients in the hospital, most of the problems indicated by the patients were of structural nature (e.g. linen, diet, equipment etc.) rather than those
5.5 A comparison of jobs expected by the patients from the nurses and their evaluation of nurses' performance showed a considerable agreement between the two, as far as technical care and 'carrying out doctors' orders' were concerned. Some discrepancy in the performance and expectations with regard to general care, educating patients about their disease, and arrival of nurses when called by the patients, was found.

5.6 The communication between the nurses and patients was found to be extremely limited. Only 38 per cent patients made an attempt to talk to the nurses. The study further revealed that more female patients than male patients tried to talk to the nurses. The strength of this relationship between the two variables was proved by the highly significant Chi-square value ($\chi^2 = 9.24$, df = 1, $p < .05$). Besides, the patients' attempt to talk to the nurses was also found to be influenced by their length of stay. There was a uniform increase in the percentage of patients who made an attempt to talk to the nurses with an increase in length of stay of the patients ($\chi^2 = 8.17$, df = 3, $p < .05$).
The patients, who made an attempt to talk to the nurses, generally talked about their disease thus confining their communication only to the field of disease. The nurses on the other hand mostly put them off and told them to ask the doctor showing that the communication between patients and nurses was almost negligible. As regards reservations on part of the patients while talking to the nurses, more male than female patients, ($\chi^2 = 5.68$, df = 1, $p < .05$), more patients with lower educational level than those with comparatively higher educational level ($\chi^2 = 8.37$, df = 2, $p < .05$) and those having lower income level as compared to those with higher income level felt hesitant. The two main reasons for hesitation of patients in communicating with the nurses were "nurses' business like manner" and 'patients were scared of them'.

Only 47 per cent of the patients mentioned that they called a nurse to their bedside at some time or the other.

5.7 As regards importance of nurses in patient care, 97 per cent patients felt that the nurses played an important part in providing care to patients. This importance was mainly attributed to nurses’ ability to give technical as well as 'round the clock care' to the patients.
5.8 The analysis of data with regard to satisfaction of patients with the services rendered by the nurses showed that the patients were fairly satisfied with their services. There were only 12 per cent patients who were dissatisfied. Though no significant association between rural-urban background and satisfaction level of patients was found, literacy and income level of patients were found to be affecting the satisfaction level of patients negatively showing that patients with a higher socio-economic background were less satisfied with the services provided by the nurses. As such, our data in general lent support to our hypothesis 'Patients in general hospitals being mostly from lower socio-economic strata have a low expectation and feel satisfied with whatever services are rendered by the nurses.'

5.9 Patient's observation of relationship between doctors and nurses revealed that nurses invariably carried out doctors' orders. Only 20 per cent patients expressed that they saw doctors and nurses arguing in the wards and that too very rarely. But as far as the relationship between nurses and class IV was concerned, more than 35 per cent patients stated that the class IV functionaries never came on time and often disobeyed nurses.
With regard to a match between expectations of patients and the performance of nurses, a little more than 50 per cent nurses themselves felt that their performance was not in keeping with patients' expectations. The three main reasons sighted by nurses for this incompatibility were: 'equipment shortage', 'high expectation of patients' and 'shortage of time'.

The study in regard to problems faced by nurses in communicating with the patients showed that more than 60 per cent nurses had no such problems. As compared to nurses from rural areas, more nurses from urban areas faced difficulties while discussing the details of treatment with the patients ($\chi^2 = 5.19, df = 1, p < .05$). The main difficulties encountered by the nurses were, 'low educational level of patients', 'inability of nurses to translate medical concepts', 'language problem', 'difference in social status of nurses and patients'.

Ninety nine out of 120 nurses found the behaviour of patients annoying at one time or the other. As many as 86.87 per cent nurses expressed that when annoyed, they tried to discuss calmly and make the patients understand things.
5.13 The responses of nurses on some value orientations showed that the nurse-patient relationship was not completely characterized by the action pattern variables of 'universalism', 'functional specificity' and 'affective neutrality'.

5.14 An overall view of relationship between nurses and patients brings out that the patients do not expect much from nurses. They themselves ask for technical tasks as many of them may not be knowing what they should expect. The expectations of patients with a comparatively higher socio-economic background are high; making evident that with better education and income level, people are becoming aware of their rights as patients. Though the patients are facing many problems in the hospital, yet they seem to be fairly satisfied with whatever they get in the hospital. They see the role of a nurse limited to the field of health only and similarly nurses also hardly communicate with the patients maintaining 'affective neutrality in their relation with the patients. Their interaction with the patients is 'disease-oriented only'. The relationship between nurses and patients appears to be essentially 'functionally specific', 'affectively neutral' and 'universalistic' in nature. Though ideally nurses do approve of cordial
relation with the patients, in practical ward situations, they act in a very indifferent manner. This indifference on part of nurses appears to discourage patients to open up in front of nurses which in extreme cases may lead patients to hold back certain vital information about their disease, condition, symptoms, etc.

**RESUME**

A major concern underlying the research reported here was whether the nurses in hospitals perform their role in patient care as expected of them by their supervisors and clients and if not, to identify factors which affect their performance, be it positive or negative. An attempt has also been made to draw attention to some of the common phenomena, processes and problems which are prevalent in nursing as an occupation.

It is important to note that the adjustment of nursing to medical culture is still incomplete. With advances in medical sciences and technology, she had to take up newer functions, however, she could not at the same time give up many of her traditional functions. This leads
to overwork, making her less efficient, less organised and less energetic.

Shortage of nurses results as much from poor utilization as from a shortage of numbers. It is the responsibility of organised medicine and of hospital administration to ensure that the nurse is freed from those activities which do not directly contribute to patient care. The physician can help by inducting the nurse as a valuable copartner in new and more direct ways. She can be further freed for patient contact by proper scheduling of rounds and procedures.

Further, it is not enough to specify an expanded range of clinical responsibilities for hospital nurses without providing the organisational structure to support these new responsibilities. On the one hand, the broad array of diagnostic and therapeutic techniques performed in the hospital suggests that control of such operations be decentralized to the level of the professional group. On the other, this operational complexity demands that a greater proportion of hospital resources be allocated to coordinate and integrate these activities. A proper allocation of funds for medicines and equipment and their better utilization in patient care is the need of the hour in the general hospitals. At the same time, there is an urgent need to revise the professional status of nurses, to improve their working conditions, giving them some place in health care policies and autonomy in order to
make them secure in their profession. The discrepancy between the concept of the nursing role and the situation in which they work should be reduced.

Rewards should not mean that the individual must necessarily move out of her present work situation. Those nurses who prefer to give direct care to patients should not be forced to give this up in order to get more salary or status.

The need to develop right type of attitudes on the part of nurses is equally important.

The nurse should be able to balance her own professional standards with individual physician's orders and the need to manage an aggregation of activities in an administratively acceptable manner. She must try to understand and carry out the doctor's orders to the best of her ability and must constantly be on the alert for anything that might aid the doctor in his care of the patient. Besides, the nursing profession has the responsibility to attract those candidates who would genuinely be willing to take up nursing. It has the responsibility to produce nurses with depth of scientific understanding, ability to think and reason, professional skill, judgement and character.
In the light of what is known today about the impact of society and culture on illness, a scientific approach to human behaviour should be a part of nurses' armamentarium also. The increasing importance of emotional and cultural factors in disease is widely accepted and acclaimed, yet the precise, discriminating and overall application of this information is still some way in the future. The focus of medical and nursing personnel is still upon the individual as a social isolate than as a person in the context of his social environment. While concern is centered on the disease, the attitudes and reactions of the patients are viewed as having little relevance. The modern nurse, must understand the basic principles of the social sciences as they apply to the ill and be able to take them into account in her communication with patients and physicians. This study suggests a drastic change in the training and educational system of health personnel.

In the above backdrop, if health personnel are to deal adequately with the socio-psychological and cultural aspects of illness, physicians and nurses must not only share a common body of knowledge but they must have the form of relationship that derives from a deeper appreciation of and respect towards each other as allies working towards the same goal. This type of relationship, however, would require the bridging of certain gaps that exist between a substantial number of members in related professions. They need to make concerted efforts to understand each
other, to be objective, to get rid of biases and prejudices towards one another.

Although the nurse works under the physician's supervision, she has well defined area of responsibility involving judgement and evaluation. She accepts the physician's leadership but recognises the value of her role in implementing his plan. The doctor must recognize the fact that the nurse is with the patient more than he is and that there is a possibility that she might very well find something that would help him to do a better job.

The need for doctors and nurses to work in unison and to understand each other is far greater than it was ever before, both because of the growing concept of comprehensive medicine and total patient care and because of the team work approach to patient care in the hospital as well as in the public health practice as a part of social epidemiological research.

It is up to the nursing profession to identify the activities needed to be performed by the nursing-personnel in relation to the objectives of the health service, assess what is presently being performed by them and the gap between what is needed and being provided, determine what plan of action should be taken, reduce the
gap and to get it approved by the top level authorities and initiate its implementation based on our conditions, limitations and potentialities.

Nursing leaders, do talk a great deal about being professionals, and their objective is to give nursing a full fledged professional status. But they should not lose sight of the fact that the legitimacy of professional guardianship to a body of knowledge depends not only on having a distinct body of knowledge, but on acceptance of the guardianship by those beyond as well as within the ranks. In the case of the nurse, the outside acceptance would have to come from the physicians and other medical personnel and would probably require drastic rearrangement of social role in the hospital set-up.

It is equally valid to point out here that though the provisional services of nurses are recognised, yet the attitude of the society towards the nurse, is quite negative in general. The low status ascribed to the nurses and the nursing profession in the past was due to the fact that it was associated with the low castes or poor widows. Though nursing now-a-days is drawing personnel from all sections of society to some extent, yet a greater proportion of nurses still seem to be coming from lower strata of the society. All this testifies to the fact that the attitudes of society still remain largely unchanged towards the nurses.
There is an inherent conflict between the societal values on the one side and that of the interests of nursing personnel on the other. It is evident from the deprivations from which the nurses suffer and the sacrifices they make in their personal and social life. They are conscious of the fact that their personal interests are not being fulfilled because of their profession being subjugated and subordinated by certain vested interests which in turn affects their role performance. The image of nursing needs to be changed in our society. What is asked for is a fuller realisation of the potential value of the nursing profession by the society. So long as the prevailing attitudes of men and women about nursing profession remain essentially as they are now, this basic situation seems unlikely to change. A greater change needs to be brought about in the attitudes of physicians who are at the helm of the organisation of health care services.

A brief discussion presented above throws up certain critical factors, hitherto also analysed in the study, which affect the role performance of a nurse in a hospital setting. A diagramatic presentation of these key variables does reflect that in addition to societal and environmental factors of the external system, and organisational climate of the hospital representing the internal system.
the personal characteristics and training of nurses, expectations and attitudes of supervisors and also those of patients, do affect the role performance of nurses. In the management of hospital care, a judicious consideration of these sets of factors may go a long way in making the role of a nurse more effective.