CHAPTER - I

INTRODUCTION
1. The Problem of Research:

Nursing as a profession has assumed a significant role in providing patient care. The nurses have become almost indispensable for the welfare of the patients. To a very large extent, the accomplishment of goals of medical system depends on the way they perform their role and the manner in which they interact both with doctors and patients.

In modern hospitals, work of a nurse revolves around both scientific knowledge and technical apparatus. Over the years, one also finds that certain changes in hospital organisation have occurred. This trend has introduced fundamental shifts in the nurse's occupational role. The growing complexity of the organisation of health and medical care delivery system has necessitated a team work approach in which the nurse has assumed a subservient role to the doctor. Nursing functions, now-a-days, are predominantly medical orders translated into action and these hardly get evolved from the needs of the patients.

In practice, the role of nurse in the hospital setting has become increasingly removed from the traditional activity at the bedside of the patient (cf. Burling et. al. ¹, Davis et. al. ², Reissman & Rohrer ³, Saunders ⁴). The ever present shortage of qualified nurses and the utilisation of them for administrative work has created a division of
labour in the hospital characterised by increasing specialisation of task assignment. In the process, other medical personnel have assumed many of the nurse's traditional tasks. However, at the level of belief and ideology, both the public and many of the other members of the profession still maintain that the real task of the nurse remains that of administering directly to the patient as the angel of mercy or mother surrogate (Benne & Bennis, Simpson).

This conflict between practice and ideology has created among practitioners and public what Benne & Bennis have described as a 'blurred self image'. In this image, the value system of the profession continues to emphasise the ultimate relationship between the nurse and the patient while the reward system and the actual practice context, place greater emphasis on the removal of the patient from the direct care of the nurse (cf. Benne & Bennis, Reissman & Rohrer, Saunders, Vaillot). On the one hand, a nurse has to bear the full and concentrated impact of stress arising from patient care, and on the other, she is expected to conform to the rigidities and inflexibilities of professional bureaucratic structure of the hospital, while dealing with the specific problems. As a result, her role performance is affected by different set of role expectations from various members of the health team within the hospital as well as from patients, in addition to her own perception of the role, she is expected to perform.
Taking all these aspects of nursing into consideration, the present study is an attempt at exploration of role analysis of nurses in a hospital setting.

2. Development of Nursing as a profession:

A nurse has been considered as a person qualified and authorised to provide the most responsible service of nursing nature, for the promotion of health, prevention of illness and care of the sick. The origin of nursing is traced back to the contributions made by church in taking care of the sick and poor people. Prior to the 19th century, nursing under the auspices of the Roman Catholic Church was regarded as a means of achieving the spiritual salvation by helping the less fortunate persons. Hence, the original concept of nursing was not as a female occupation with its own body of knowledge and specialised training procedures, rather its primary focus was religious activity for spiritual consideration.

Nursing as a profession assumed significance much later when during war, Florence Nightingale demonstrated her ability and ingenuity in providing care to the sick and wounded soldiers. In the later part of 19th century, particularly in England and the United States, nurses took the major lead in organising themselves professionally. At the same time, nursing schools aided in the development of an increasingly autonomous nursing profession. Thus nursing as an occupation
has evolved from being an informal exercise of charity into a formal occupational role subordinate to the authority and control of the physician. However, nurses have continually struggled to achieve formal colleague-ship with the physician.

Unlike a nurse of a few decades ago, today's nurse works with other nurses in an institution where there is a rigid division of labour. The place and the conditions of work are controlled by the organisational climate and working relations are relatively impersonal. With the advent of varied medical therapies and growing complexity of hospitals, the new trends are emerging in nursing that are likely to continue for many decades and significantly affect staff relationships in hospitals. The scientific and technological developments have demanded technical competence, application of facts and principles in the day to day nursing care of the patients. Nurse's role in the health team in the hospitals and in the community is becoming increasingly accepted and recognised.

Presently, nursing as a profession is in a state of ferment, reflecting not only the changing nature of health tasks but also large scale changes in the society including the women's movements, modifications in sex roles and a new professional militancy in the nursing profession itself.

According to Goode's analysis of the features of a profession, the two core characteristics of a profession are those of a service.
orientation and control over a specialised body of abstract knowledge. Nursing, of course, has had traditionally a service orientation, which is inherent in the mother surrogate role. But the claim of nursing to be having a specialised body of knowledge does not seem to be justified in the light of physician defined and created practices. Goode, in fact, excluded nursing from consideration as profession because he believed nursing training was nothing more than a lower level medical education. This same type of reasoning has prompted Freidson to describe nursing as a paramedical occupation.

However, despite their lack of control over a unique body of specialised knowledge, nurses have continued to strive for a true professional identity within the status and work hierarchy of medicine. This has brought some changes in the work role of nursing. More and more nurses have sought a career in hospital administration because it allows them to be less subordinate to physicians. Thus they have acquired the status of semi-professionals and not full-fledged professionals. But, in the context of the present study we have used the term occupation, profession and semiprofession as interchangeable.

3. Historical background of nurses in India:

The status of nurses has always been greatly affected by the prevalent status of women in a society. In a society like ours, which
believes in the subordination of women, the introduction of a role with attitudes at variance to the prevailing cultural norms is bound to evoke opposition. This is precisely what happened nearly a century ago in India, when the new role of the professional nurse was introduced for the first time. To start with, the nurses were recruited from Europe and America. A number of training centres were established but the recruitment was limited to Anglo-Indian and Christian communities. Organisations such as Seva Sadan in Poona encouraged young women to undergo training in nursing and midwifery.

In 1908, the formation of the 'Trained Nurses Association of India' gave the nurses an opportunity for pooling their experiences and ideas. This association helped to promote the standard and status of nursing profession. The most important development took place during the period 1940-47, when the shortage of nurses became markedly significant due to the demand for nurses in the military hospitals and also because of the expansion of civil hospitals. An 'Auxiliary Nursing Service' was created in 1942 to meet this shortage. During this period, 'The School of Nursing Administration' was established in Delhi for giving courses in Nursing administration and teaching. This subsequently led to the course for the Bachelor of Science degree in nursing. Such courses were established at Vellore, Post Graduate Institute of Medicine, Chandigarh and recently at Hyderabad, Indore, Bombay and Jaipur.
The 'Indian Nursing Council Act' was passed on 31st December, 1947. Since the enforcement of this act, there has been a considerable development in the nursing profession. Another major development took place when in 1954, the Government of India appointed a committee consisting of ministers of health of the different States of the Union of India to review the conditions of service and emoluments of nurses. This Committee submitted its report in 1955, recommending various measures for improving the nursing profession and the service conditions of the nurses. Nursing in India has benefitted a great deal by the help received from the international agencies such as World Health Organisation, United Nations International Children Emergency Fund, United States Aid for International Development etc.

Today there are three hundred schools imparting training in nursing. These schools are basically attached to hospitals and about six thousand nurses qualify every year. These nurses mainly meet the hospital manpower needs. Apart from the certificate courses in nursing, there are twenty one colleges affiliated to various Universities in the country which award Bachelor of Science degree in nursing and four colleges which prepare nurses at Masters' level with specialization in community nursing, medical surgical nursing, pediatric and psychiatric nursing. These nurses mainly meet the teaching requirements for various nursing schools. India today is one of the leading centres in nursing education in South East Asia.
The curriculum of nursing has been revised from time to time in order to meet the health needs of the community especially with reference to the Alma Ata Declaration to provide 'Health for All by the year 2000'. It has been recommended by the Indian Nursing Council that for giving quality care, the ratio of nurses and patients in the teaching institutions should be 1:3, in service hospitals, 1:5, in specialised units that is burn, intensive care, intensive coronary care, recovery, 1:1. But so far this has not been accomplished.

4. Review of Studies:

In the context of the present context, it is imperative to take cognizance of some of the studies carried out on nurses earlier.

Davis and Olesen\(^1\) have noted that many nursing students anticipated that nursing school would provide them with an opportunity to meet the physicians, medical students and other young men and they found difficulty in adjusting to their categorisation as nurses rather than as pretty, attractive nurses.

Psathas\(^1\) noted that many fresh nursing students came to join nursing with the expectation of meeting and marrying a physician.

The research by Warnecke\(^1\) showed that a lack of commitment to the nursing role was the major non intellectual factor of attrition for collegiate nursing programmes.

Davis\(^1\) has shown that among student nurses who graduate, there is often a lack of commitment to the actual practice of nursing.
The nursing degree thus becomes an end in itself rather than the basis for a life long career and this lack of professional commitment remains the most serious problem for the future development of nursing.

Hughes, Hughes and Deutscher\textsuperscript{18} while summarising several studies of nurses, conclude that few nurses choose specialities because of intrinsic preference for them. Nurses take whatever jobs are most readily available regardless of what nursing specialities these may be or they select jobs for consideration of money, hours of work, easy journey to work and the like.

Malone et. al.\textsuperscript{19} have indicated a basic paradox in nursing. According to them, the kind of activities, student nurses see as essential to the fulfilment of their role are not the kind of activities, they see rewarded. Their role concept reflects those aspects of nursing emphasised as most central to the role by the profession and yet they are aware that the accountments of success go to those nurses who are not performing according to this concept.

Malone\textsuperscript{20} has noted that nurses showed evidence of organised demands taking precedence over professional values when these were in conflict.

Skipper\textsuperscript{21} found the conception of the role given by nursing students, to be much closer to that of providing the expressive function in which persons would be treated as persons rather than cases. Warm
and cordial relationships were approved.

Hebenstein and Christ\textsuperscript{22} have observed that baccalaurate nurses were more likely to seek tasks that gave them supervision over others and greater autonomy. The other nurses having a utilitarian orientation to their work tended to view nursing as a means to supplementing their family income and also considered it as secondary to their primary role as wife and mother.

Segal\textsuperscript{23} in a study of nurses and patients found that anxiety pertaining to the status was at least partially responsible for the tendency of certain respondents to display ritualistic attitudes which emphasise the significance of their own hospital position as an end in itself rather than as a means for establishing affective ties with patients.

Kurtz and Flaming\textsuperscript{24} in a study of short term general hospitals found that as many as 42 per cent nurses indicated that the best way to improve nursing would be to clarify the responsibilities and tasks involved. They further conclude that nurses were content to remain subordinate to other occupations in the institution. In response to a question, whether nurses should have more authority, two third replied in the negative.

Bates\textsuperscript{25} has noted that the full development of the nursing role has been limited both by pressures from without (physician) and by timidity from within. In her review of literature, Bates has observed that few nurses have openly rebelled against physicians' authoritarianism.
and most have accepted a position of deference towards them.

Roth while analysing nurse-patient relationship found that nurses have persisted in seeing affective qualities in their relationship with the patients, while the patients in these same relationships have seen the nurses as rigid authoritarian types.

Most of the above mentioned studies have focussed on the commitment of nurses to the profession and have found the same lacking in them. A few studies show that nurses, while defining their own role, approve of affectiveness in their relationship to the patient.

Besides the studies reviewed above, some of the Indian scholars have also analysed the nurses' role.

Rajagopalan in his study 'Social Change: An analysis of Role Conflict & Deviation' has drawn attention to the basic conflict between the occupational role of nurses and their desire to get married. This conflict is accentuated among other things by a social stigma attached to their job which tends to spoil their marriage prospects. The study sheds more light on stresses and strains introduced by social change aspects in role relationships and consequently inconsistencies and conflicts engendered into them, than on the 'role' of nurses as such.

Seth's analysis reveals that the new role of a professional nurse conflicts with the normal domestic role of the female in our society. They are on the crossroads for a choice between the
professional role of a nurse and the domestic role of a wife and mother. According to him, role conflict is but an expression of a basic conflict between the norms. This role conflict in the case of a female nurse is largely due to the absence of a change in the old cultural norms, defining the female role in general as well as to the existence of two incompatible norms in particular.

Venkataratnam in his work 'Medical Sociology in an Indian setting' has given the operational definition of the concepts 'Status' and 'Role'. According to him, 'Status' is a specific position accompanied by its rights and duties, created to carry out specific tasks in the organisation which are directed towards the fulfilment of the organisational goals. 'Role' is the expected behaviour of an occupant of a status in the organisation including the rights and duties in relation to an alter in the organisation. Applying these concepts he has tried to consider the different role expectation models of doctors and nurses about their own and of each other's roles in the organisational contexts as held by them. Both in expectation and in performance, nurses accept their subordinate position to the doctors and claim they carry out all the orders of doctors in respect of professional matters. On the whole, actual role performance showed that there was role conflict in terms of expectation and performance not only due to disparate professional and organisational requirements but also due to the personal and social situation in which they played their role in the hospital.
A study conducted by Srivastava about the nature of interaction among nurses and patients provides an insight into the functioning of nursing profession in India. According to him, if doctor's behaviour towards nurses is not sympathetic, the doctor patient relationship is affected to the detriment of the patient's welfare and mal-functioning in the hospital organisation. The repercussion of relationship between the doctor and nurse affects the treatment and care pattern of the patient. The observation made by the author during the course of his investigation testifies the fact that there exists a gap in the expected and the actual role performance of the nurses. Their professional role is often subservient in the social and personal consideration. The low socio-economic background of the nurses, their high aspirations and the key position occupied by them in the hospital organisation are the important factors which have contributed to the careless and callous attitude towards the patients, according to him.

Concerning nurse's attitude towards patient care, Oomen in his study 'Doctors and Nurses' reports that more nurses reveal a humanitarian perspective in contrast to doctors who show an instrumental orientation. Nurse's relations with doctors are marked by an undercurrent of hostility primarily due to an authoritarian and overbearing attitude of doctors which is resented by the nurses. Contrary to popular impression, the majority of doctors and nurses are found not to experience intense
conflict. Nevertheless, some evidence of role conflict arising from the contrasting demand of occupational and familial role is reported by Oomen.

Jayalakshmi in her study 'Nurses' role performance' has tried to analyse the role performance of nurses to find out the reasons for inadequate services rendered by large institutions. It is found by her that the role performance of nurses is influenced by three factors, mainly: role demands, role perception and role facilities. She concludes that the inadequate role performance of nurses is mainly due to the defective policies (role demands) and lack of role facilities in the organisation. Though the main objective of the hospital is to provide comprehensive nursing care to the patient, the policies of the organisation are such that the nursing practice is mainly geared towards the service needs of the patient rather than the patient's psychological needs.

Kakar et al. indicate that the role performance of nurses as stated by the nurses themselves is mainly affected by i) lesser professional advancement, ii) nurses being bored with routine work, iii) less cooperation of the society, iv) getting bored being ordered by doctors, v) inadequate salaries of nurses. By way of conclusion, the authors highlight that in the hospital setting, the role of a nurse as a health functionary is of singular importance. For this, she needs to develop her skills to the fullest extent so that she can communicate...
effectively with patients, representing widely varying socio-economic backgrounds as these too have a great influence not only on their disease but also on their hospitalisation.

Sharma in her study 'Socio-economic correlates of professional satisfaction among nurses' finds that although majority of the nurses noted improvement in the social status and felt professionally satisfied, many nurses were voicing dissatisfaction with the status quo in health care. They deplore the effect of hospital bureaucracy on their standard of professional care and their sense of professional autonomy. She has stressed the need for visualising nursing as an entity in itself and redefining the professional norms.

Ramanamma and Bambawala have tried to analyse Doctor-Nurse-Patient relationship in a government hospital. They find that while doctors are more in contact with outpatients, nurses are in constant interaction with patients in wards. The doctor-patient relationship was found to be cordial and differential, while the nurse-patient relationship was more or less on the footing of a person in authority in the wards and those who have to obey them. They further find that doctor-nurse relationship is on a professional footing. In the hierarchical order of the hospital system they are lower down the ladder than doctors and psychologically they are aware of their position and their attitude to doctors generally is of maintaining the required social distance.
On the basis of above studies, it is clear that there exists a gap between role expectations and role performance. In addition to conflicting professional and organisational requirements, defective policies of the hospital bureaucracy, and certain personal and socio-cultural factors affecting the role performance of nurses have also been analysed in the studies reported here.

The main lacuna in most of these studies is that they have analysed the role performance of the nurses without taking into account either patients or nursing supervisors. The role of the nurse needs to be analysed by taking into account, both the expectations of patients and as well as those of her supervisors, in addition to her own perception of what is required of her. Thus the major focus of this study is to analyse the nurse's role in the light of expectations and evaluation of both these categories of people.

5. 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, nursing supervisors (including doctors) towards nurses' role performance.

4. To analyse the sources of conflict in the role of the nurses.

6. Theoretical framework

In order to understand the research problem in proper perspective, it is important to take into account some theoretical considerations.

The notion of social role has a long pre-scientific history as a way of describing and interpreting social conduct in everyday life. Novelists, dramatists and other astute observers of the human scene have noted that behaviour is often determined less by the characteristics of the person than by the part he or she is assigned to play. In the contemporary times, role has become a central concept in social sciences. Sociologists, as yet, do not have much consensus on the definition of role.

Linton was perhaps the first to give the notion of role, a central place in any of the social sciences. According to him, status and role represent a conceptual elaboration of the ideal pattern which control reciprocal behaviour. By status, Linton meant a position in a social system occupied by designated individual and by role, the
behavioural enacting of the patterned expectations, attributed to that position. Thus role, according to him, is the dynamic aspect of status. Consequently, the content of the role is the sum total of the culture patterns associated with a particular status. Though he acknowledged that a person could have many statuses, he failed to realise that a particular status may involve a whole range of associated roles.

This refinement was brought about by Merton in the concepts of role set and status set. To him, a role set is that complement of role relationship which a person may have by virtue of occupying a particular status. Similarly, a complement of social statuses occupied by an individual is his status set. To provide for the dynamic aspect of functional analysis, Merton introduced the concept, status sequence, which refers to the successive statuses which an actor occupies in the course of time, provided that the succession is patterned. Similarly, role sequence refers to the succession of role performances of an actor with a specific status.

According to Parsons, the role is that organised sector of an actor's orientation which constitutes and defines his participation in an interactive process. It involves a set of complementary expectations concerning his own actions and those of others with whom he interacts. The role, he holds, is status translated into action, the role being the processual aspect of status, as status is the positional aspect of the role.
Davis defines role as the manner in which a person actually carries out the requirements of his position while Parsons uses the term performance.

Nadel differs from Linton and Parsons in that, he neither considers status as being static or positional nor role as being dynamic or processual. According to him, status is quasi role and thereby he means 'set of rights and obligations embodied in a piece of knowledge within a norm or prescription, conceived by people as relevant to a position in the social structure'. The role, according to him, is the execution of these rights and obligations. In short, it is like a rule and its application. Nadel has further talked of recruitment roles, the recruitment being any antecedent condition, upon which the assumption of all the other role attributes depends. The qualities which lead to the recruitment will be expected to last through the lifetime of the role, whereas role performance, that is, the externalisation of the role takes place as a consequence of the rights and obligations assumed in the group, that is, the internalisation of the role.

Banton has defined role as a set of rights and obligations, that is, an abstraction to which the behaviour of people will conform in varying degree. According to him, role is the pattern of expected behaviour reinforced by a structure of rewards and penalties which induces individual to conform to the pattern.

Benett and Tumin define a role as what the society expects of
an individual occupying a given status. This implies that any status is functionally defined by the role attached to it.

Newcomb\textsuperscript{43} brought the concept of role from Anthropology to Social Psychology. According to him, it refers to expected or appropriate behaviour and is distinguished from the manner in which the role is actually enacted in a specific situation which is role behaviour or role performance.

Sarbin\textsuperscript{44} defines role as a patterned sequence of learned actions or deeds performed by a person in an interaction situation. He deals with non normative stimuli and responses. The action of one actor is a stimulus to another actor, whose response becomes a stimulus for the first actor and so on.

In addition to structural-functional and social psychological perspectives on role, another school of thought, symbolic interactionism, looks at the individual as a creative thinking organism who is able to choose his or her behaviour and the role as member’s orientation or conception of the part he or she is to play in the social setting. The chief exponents of this approach are Mead\textsuperscript{45} and Cooley\textsuperscript{46}. Goffman\textsuperscript{47} has introduced a further sophistication to this approach. According to him, role consists of the activity, the incumbent would engage in, were he to act solely in terms of the normative demands made upon some one in his position. Role in this normative sense is to be distinguished from
role enactment, which is the actual conduct of a particular individual while on duty in his position. One can see in the writings of Goffman \(^{48}\) the creative possibilities of the interplay of self and role as a conceptual tool for the analysis of social behaviour. He noted that when an individual performer plays the same part to the same audience on different occasions, a social relationship is likely to emerge.

All the above definitions may appear to be somewhat confusing but they clearly reflect a common core. Almost all the authors cited, assume an elementary category of sociological analysis that is defined by 'expected patterns of behaviour'. According to role theory, social behaviour is not random and meaningless, rather behaviour tends to be patterned. In other words, it is predictable, meaningful and consequential for the participants. It does not imply accepting a static view of social behaviour. On the contrary, it is a dynamic perspective which allows a considerable range of variability among individuals enacting the same role (Sarbin & Allen \(^{49}\), Turner \(^{50}\)). People's behaviour is influenced, to some extent, by their own expectations, those of others in the group and that of the society in which they participate. Therefore, the concept, if it is to be used as an evaluative standard, must be understood in terms of perception, expectation and performance of incumbents in positions in different settings in the social system.
The perceived role is that set of behaviour, the occupant of the position believes he should enact. The role performer through socialisation gets an estimate of the way his rights and duties are defined by others. The perception of individuals differs according to their mental and personality make-up, needs, motives and previous experiences. In addition, the sensory factors, that is, psychological events occurring in the nervous system of the individual in direct reaction to the stimulation by the physical objects, also affect one's perception. Thus, perceived role may not correspond exactly to the expected role, but a person's knowledge of others' role expectation for him facilitates interaction with them, regardless of whether his own conception of role coincides with them, or not.

Further, role expectations are comprised of rights and privileges, the duties and obligations of any occupant of a social position in relation to persons occupying other positions in a social structure. The constraining force of role expectations is due to the availability of sanctions, measures by which society can enforce conformity with its prescription. Thus, role expectations are norms, institutionalised and governed by the value standards of society.

Again, roles are always enacted by individuals, though they are socially defined patterns or delimitations within which much variation is possible. Even when the role demands are not difficult, they are sometimes
required at particular time and place. Moreover, all individuals take part in many different role relationships, for each of which there will be somewhat different obligation. The role of an individual is also influenced by the role performance of other individuals in the interactional process. Considerable variation among individuals in their enactment of the same role is possible and acceptable. Acts that exceed the latitude of acceptable behaviour will, however, result in evaluation of invalid and unacceptable role enactment (Gross et al. 51). In other words, when enacted role departs too much from the expected role, the role will change or the occupant will be evicted. The extent of agreement between role and actual behaviour and between norm and opinion is an index of social stability and disagreement indicates the presence of conflict and thus the possibility and likely direction of change.

According to Parsons 52, if roles are to be enacted in a way that fits the needs of the social system, persons have to be motivated to act according to role prescription. Thus roles become contingent upon the rewards, and sanctions that pass between actor and others. The exchange theory (Homans 53, Blau 54) also argues that once a person has found it rewarding to behave in a certain way, he tends to settle on that form of behaviour in that situation. For any activity there is a reward and a cost. No exchange continues to take place between people unless both persons or all persons in the relationship are making a profit. Whether it is in terms of psychic gratification or some other reward, some kind of
motivation seems to be necessary for role enactment.

7. Hypotheses of the Study:

In the background of above analysis, we have observed four main perspectives namely (i) structural - functional, with its stress on 'expected patterns of behaviour', (ii) social psychological, emphasising individual's perception in an interactional situation, (iii) Symbolic interactionism, highlighting interplay of self and actor's orientation of the part he is to play, (iv) Exchange theory, focussing on the importance of rewards in a given relationship. All these have a close bearing on the role analysis of incumbents within a social system. We will make an attempt to operationalise these concepts in the hospital organisational setting where the role of nurse permeates as well as mediates.

Nurse, as a member of the health team, acts as an intermediary between the doctor and the patient. Within a health team, the responsibility for the total patient care rests with the nurse. In other words, the nurse in a hospital setting is a liaison between a patient, his family, the hospital and the health team.

We do know that nursing service in the hospital is a semi-autonomous one. Nurses are responsible to the physician on the one hand and to the supervisory nurses and to other upper echelons of the hospital administration on the other. The work norm of profession emphasises
more freedom and self determination while the administration favours the efficient coordination of the hospital activities through formal rules. This simultaneous occurrence of two different sets of expectations is such that compliance with one might make the other difficult.

It has been observed that in terms of 'expected patterns of behaviour', the intermediate position of the nurse leads to lack of clarity in expectations associated with her role. She is expected to discharge the responsibilities of categories above and below her in the hospital. Nurse on duty is usually considered as a watchman for everything that is happening in the ward. This lack of clarity in expectations from others may affect her role performance.

Along with the others' expectations, the nurse herself has a conception of her rights and duties. This perceived role may or may not correspond to the expected role, since the latter depends on the perception of others, in the organisational setting. In addition to occupational role, she has certain other social and psychological roles. The attitudes and feelings associated with these roles may interfere with the smooth functioning of the organisation. For example, the role of nurse may conflict with her role as a wife and mother which was the only role that was ever permitted to a woman a few decades ago, and this may affect her role performance.
Furthermore, the role performance of nurses may also be influenced by certain organisational and occupational constraints or facilities. The shortage of equipment, non-nursing jobs and low nurse-patient ratio are some of the problems encountered by them in general hospitals. Besides, the training period is long and the requirement is of high standard but nurses tend to be poorly rewarded and inadequately appreciated. In other words, they are persistently paid low and there is lack of opportunity for advancement to the higher level, policy making positions. This lack of role facilities and rewards may also lead to their inadequate performance.

In addition to this, the nurses are directly involved in the welfare of the patients. The situation of illness generally presents the patient and those close to him with complex problems of emotional adjustment. Right type of attitudes on the part of nurses towards the patient and families go a long way to alleviate their sufferings. But it has been observed that in our setting, the patients in general hospitals are mostly drawn from lower socio-economic strata. They, as such, do not have much expectation from the nurses. They feel satisfied more easily with whatever services are provided to them.

Since the focus of the study is on 'exploration' of role analysis of nurses, the study largely remains an exploratory one. Consequently, no specific hypotheses or assumptions could be formulated. Some of the
'general' hypotheses pertaining to it, on the basis of the above discussion are as follows:

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 expectation of 'others' on certain aspects of nursing may lead to inadequate performance of nurses.

3. As a consequence of conflict between occupational and familial role of nurses, their role performance tends to get affected.

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

5. In the 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.
8. Methodology:

(a) Research Site

This study is an extension of the study 'Role Analysis of Nurses in a Hospital Setting' conducted by the researcher in Medical College, Rohtak in Haryana. This institute is the only one of its kind in Haryana, combining teaching and treatment facilities together. It has got all the modern facilities for treatment and is having following post graduate courses along with M.B., B.S. course (1) M.D. (2) M.S. (3) Ph.D. (4) Diploma courses for doctors (5) M.Sc.

It is also having paramedical courses, including Diploma in Pharmacy, Multipurpose Health Workers' Training, General Nursing Training, Midwifery Training Course and Radiographer's Course. It is a modern large-scale professional bureaucratic type of organisation having a network of personnel in a graded hierarchy with various responsibilities in their sphere of activity.

Besides, being located at a district headquarter, it could reflect the general hospital management problems more clearly than an institution of this type in a metropolitan city of India. It provides somewhat different kind of setting for analysing nurses' role also, since both

* A single site has been chosen in order to delve an intensive analysis of the role of nurses.
nurses and patients are likely to be drawn in from rural as well as from urban areas. Moreover, the researcher being a resident of Haryana had some contacts there and this helped her in establishing easy and good rapport with the hospital authorities.

The population of the hospital consists of the resident and non-resident patients, and the staff working over there. The resident or indoor patients are those who are admitted into wards based on the nature of disease, the sex of patients, the age of patients or the seriousness of the cases. Thus, the ward is the basic unit where the treatment is carried out.

The other component of the hospital is its staff. There are four categories of staff. 1) doctors (2) nursing staff (3) class IV staff* (4) administrative staff or office staff. The Medical College Hospital is administratively controlled by Director-Principal who coordinates all the activities with the assistance of medical superintendent, deputy medical superintendent and with their subordinates.

In the hospital sphere, there are 15 departments namely medicine, pediatrics, surgery, psychiatry, skin and V.D., obstetrics and gynaecology, T.B. and chest,

* Class IV includes auxiliary workers in the ward i.e., ward boys, ayahs (orderlies), sweepers etc.
E.N.T., orthopaedics, blood bank, anaesthesia, radiology, dental, eye and casualty. There is another wing housing some of the specialities attached to general medicine namely, neurology, nephrology, urology, burn unit, coronary and cardiology.

Each department is independent in its functioning and is headed by a professor. It is further divided into units for an added division of labour. A unit consists of a professor, reader, lecturer, tutor, registrars, one or two house surgeons, full time post graduates and rotatory interns.

Incharge of the nursing services in a ward or a unit is a nursing sister or a ward sister who controls the routine business of the ward and supervises nurses' work. In addition to this, there are class IV employees who assist in the wards but perform no core nursing tasks.

(b) Nursing service

The nursing service in the hospital is a semi-autonomous service being professionally subordinate to medical services but administratively almost independent.
Organisation Chart of Nursing Services

Director Principal

Medical Superintendent

Principal Tutor

Sister Tutor

Class IV Driver Steno typist Student Nurses

Nursing Superintendent

Clerk Matron House Keeper

Nursing Sisters Staff Nurses

Class IV
The nursing superintendent is the senior-most and chief nurse in the hospital who is the administrative head of the wards and supervises the working of incharge of the wards. Matron is also a senior and executive nurse who has certain specified areas under her supervision.

The head nurse of a single ward is ward sister. She is incharge of the ward, controls the routine of the ward, supervises the nursing and non-technical work and is responsible for providing adequate supplies round the clock.

A trained nurse who works under the ward sister is staff nurse. She is the pivot around whom the whole patient care revolves. She is responsible for administering nursing care to the patients and thus is in immediate contact with all the patients in the ward.

Student nurses help the staff nurses in various tasks involved in patient care and also attend the classes.

The nursing staff of Medical College hospital consisted of 2 nursing superintendents, 3 matrons, 68 nursing sisters and 331 staff nurses at the time this study was conducted.

The School of Nursing in the Medical College consisted of one principal tutor, 9 sister tutors and 76 students.
As mentioned earlier, in the hospital, there were 15 departments but in view of the limited time and resources, only four specialities were chosen. These are medicine, surgery, orthopaedics and gynaecology. Outpatient departments were excluded and only in-wards were taken as it was here that patients were kept for a longer period and were in constant interaction with the nurses.

The four specialities chosen consisted of the heaviest wards in the hospital. They were selected with an assumption that they would reflect the true picture of general hospitals in India today admitting the maximum number of patients everyday. Besides, patients in these wards, stay for a period which is sufficient to develop interactional patterns between the patients and the staff.

There were eight wards in total, three* each of medicine and surgery, one each of orthopaedics and

* Along with medicine ward three other small wards, coronary care, cardiology and neurology were attached and with surgery - urology, nephrology and the burn unit were attached. The nurses, patients and sisters of these small wards were also taken into account though the number of patients was small in these wards.
gynaecology. All the staff nurses in these wards were taken into the design of the study. There were 12-13 nurses in each of the wards of medicine and surgery sometimes even 16 when the ward consisted of two units. In orthopaedics and gynaecology, there were 14 and 18 nurses respectively at the time of study. There were 126 nurses in all in these wards, out of which the responses of 120 nurses could be obtained. The remaining nurses either refused to cooperate or were on leave at the time, this study was carried out.

All the ward sisters in these wards (29), matrons (3) and nursing superintendents (2) were interviewed.

All the registrars who are the immediate medical supervisors of nurses in these wards were also contacted for interviews. Out of thirty one, some twenty eight could be interviewed and the remaining three could not be contacted due to their changing duties. For patients' evaluation in view of the limited time at the disposal of the researcher, a 20 per cent random sample of patients in these wards was taken. The number of beds in the selected wards ranged from 64 to 74. The total number of patients interviewed was 100. These were selected out of a total number of 526 beds spread over eight wards chosen for study purposes. Six of the wards, each consisting of 64 beds, had beds, one of which was confined to male patients. The remaining four wards had 74 beds each, one of which was used for child patients. The total sample included 100 patients.
Instruments of data collection

The nurses were interviewed with the help of an interview-schedule. The first part of the interview schedule consisted of questions pertaining to nurses' socio-economic background mainly. The second part had questions relating to their attitudes towards their profession, perception of their role in the hospital and their satisfaction with the roles they performed. The interview schedule consisted of both close and open-end questions. A large number of open-end questions were included to elicit a frank and original response in addition to close-end questions where rating scales were also used. The schedule was pre-tested and with necessary changes finalised. Each interview took about one and a half hour. During interview, free discussions with the respondents about their difficulties and problems were held, the main guiding source being the interview schedule. Proper rapport was established before coming to desired information. At first, the respondents were very reluctant to give the necessary information, partly because they said they were very busy and partly because they were unable to comprehend the meaning of this...
research study. But when they were given a clear idea about the problem under study, they were willing to cooperate. Due to their busy work schedules and immediate job commitments sometimes the interviews had to be completed in two sittings. Those nurses who were on night duty were contacted and interviewed either in their hostel or homes.

Similarly for patients, an interview schedule was prepared. This consisted of both close and open-end questions. Questions pertaining to patients' socio-economic background, their stay at the hospital, the way they dealt with the illness initially, their expectation and evaluation of nurses' role were included. This schedule was also pre-tested and was found to be tapping the information needed. Each interview took about 45 minutes. Patients were also reluctant to part with the information required of them but on convincing that the researcher was not one of the hospital employees and thus not in any way likely to let this information out, they provided the necessary information.

The ward sisters, matrons, nursing superintendents and registrars were interviewed with the help of an
interview schedule. These interviews were open, unstructured or semi-structured, where the researcher tried to know the expectation of these people and also how they evaluated nurse's performance, being her supervisors. The time taken to conduct these interviews varied between an hour or two sometimes. Prior appointments from the supervisors had to be taken so that the interviews could proceed uninterrupted. During the course of discussions, some light was also thrown on certain technical, administrative and organisational problems of nurses and more insight was provided on certain other facets of nursing.

All the interviews were conducted personally after an extensive contact to have uniformity in the collection of data. To supplement the data collected with the aid of interview schedules, an attempt was also made to make non-participant observations in different ward situations where nurse-patient, nurse-doctor interaction took place. These observations provided greater insight into the processes of interaction between them. It took the researcher three full months from January to March 1984 to complete data collection.

In the months of January and February, information was obtained from the nurses and the nursing supervisors, whereas in March all the patients were interviewed.
(e) Analysis of data

When the data were collected, a thorough scrutiny was done. Schedules were numbered and the whole information was transferred on the code cards with the help of code design. The data were analysed by making simple and cross tables. Simple statistical techniques were used, wherever possible, for the purposes of interpretation and generalisation.

9. Limitations of the study:

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

1. As the nurses in only one hospital have been studied, 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 areas before further generalisations in regard to the role of nurses can 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.

The fourteen specialities selected were found to be similar in their organisational set up.
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. (Seltiz, Festinger).

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 on 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.
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