2.1. Introduction

With the help of review of literatures, the conceptual framework of Quality of Work Life and Commitment is portrayed in this chapter. It includes origin of Quality of Work Life (QWL), meaning and concept of QWL, identification of factors for measuring QWL, QWL in India context, measures to improve QWL, Barriers of QWL origin of Organizational Commitment (OC), Meaning and concept of organizational commitment, identification of model for measuring Organizational Commitment and the relationship between QWL and OC. Further the nature and scope of a hospital along with its definition is also portrayed here in this chapter. Finally, organization profiles of the hospitals under study are also highlighted.

2.2. Origin of Quality of Work Life:

Origin of Quality of Work Life (QWL) is dated back in industrial revolution\(^1\) where higher production was the main concern. During this period, ordinary working people found increased opportunities for employment in the new mills and factories. But, strict working conditions with long hours of labor dominated by a pace set of machines exist. In the year 1930, the concern for QWL evolved during Hawthorne studies by George Elton Mayo where he studied the impact of level of workplace illumination on workers’ productivity-that workers are not motivated solely by pay but also by total work situation, psychological and social factors\(^2\). Also, one of the pioneering insights into the real study of human beings at work was F.W Taylor’s scientific management principles where it ignores the human element in production, social and ego needs of people\(^3\). It was followed by research into job satisfaction in 1935. In early 20\(^{th}\) century, legislation was enacted to protect employees from job-injury and to eliminate hazardous working conditions\(^4\). It was followed by unionization movement (1930-1940) where the main emphasis was job security due to the production process and economic gains for the workers. This is comparable to Abraham Maslow’s motivational theory of needs where basic needs like monetary benefits were the first priority followed by safety or security needs. During 1950’s and 1960’s, various theories were developed by psychologists suggesting a “positive relationship between morale and productivity” and the possibility that improvement in human relations would lead to enhancement of both\(^5\). This can be seen in Frederick Herzberg’s Motivation Hygiene Theory which indicates that employees’ satisfaction and motivation were influenced more by how employees felt about their
work than the specific attributes of their job, including pay and workplace surroundings. Many researches during this period show the relation between work and family life. Fluctuating work environment with competing job and family commitment negatively affects the employees in the form of reduced productivity, lowered morale, increased burnout and turnover. According to Walton, QWL is broader than these earlier developments and is something that must include ‘the values that were at the heart of these earlier reform movements’ and ‘human needs and aspirations’. Further development in the theories of motivation and leadership provided a sound base for the concept of QWL. During 1969 to 1974, a development in the interest on how to develop the quality of the individual through on-the-job experience can be seen in the works of a group of researchers, scholars, union leaders, and government personnel. Further, the United States department of health, education and welfare sponsored a study on the issue of Quality of Work Life, which led to the publication of work in America. At the same time, the pressure of inflation promoted the US Government to address on the issues of Quality of Work Life. As a result a Federal Productivity Commission was established. This commission sponsored several labor management QWL experiments which were jointly conducted by the University of Michigan quality of work programme and the newly-evolved National Quality of Work Centre.

The term “Quality of Work Life” appeared in research journals and press in USA only in 1970’s. The term was coined by Louis Davis. In 1972, the first International QWL conference was held in Toronto and in the same year, the international council for quality of work life was established. Since 1980, QWL is placed on employee-centric productivity program. In the mid 1990’s till today, the importance of workers as the main organizational resource is reflected in the QWL studies conducted during these period. QWL is reemerging where employees are seeking out more meanings where there are rising educational levels and occupational aspirations in today’s slow economic growth, rising concerns for career and personal life planning. The rising interest in the QWL issue can be seen in the second International Conference on QWL held in Toronto in 1980 where it attracted 1,500 participants. The International conference, besides attended by academicians, consultants and government officials, a good number of 200 unionist and 750 management people attended the conference.
Further, with all the concerns, developments so far, QWL has been gaining momentum in the following phases:

1. QWL as a variable (1959-1972)

2. QWL as an approach (1969-1975)

3. QWL as a method (1972-1975)

4. QWL as a movement (1975-1980)

5. QWL as everything (1979-1989)

1. QWL as a variable (1959-1972): It focused primarily on getting employees and the employers to work collaboratively to improve employees’ work experience.

2. QWL as an approach (1969-1975): It was defined as an approach as it became synonymous with certain approaches, which focused on the individual rather than organizational outcomes, but aimed at improving the outcomes of both the individual and the organization.

3. QWL as a method (1972-1975): It was defined as a method in terms of specific approaches, methods, and technologies used such as job enrichment, autonomous work group, and high involvement aimed at providing satisfaction and productivity of workers.

4. QWL as a movement (1975-1980): During this period, society considers QWL as a very important factor which directly or indirectly affects the job attitudes and behaviors of the people. Maintaining the already developed momentum was an important concern for a lot of people. Hence, QWL emerged as a movement.

5. QWL as everything (1979-1989): QWL covers all aspects of life that are seen as desirable by organizational members. It is not just providing job security, good working conditions, and adequate and fair compensation but everything to do with people at work.
2.3. Quality of Work Life: Meaning and concept

A) Review of literature on Concept of the terminology used

The term QWL has different meanings to different persons. To some it is just earning a basic pay or an industrial democracy where there is participation in decision making process. For others, it is an improvement in the socio-psychological aspects of work. Some might interpret as more promising sharing of profits, job security and healthy working conditions. Overall, QWL is a prescriptive concept where it attempts to design work environment for maximum concern for the welfare of humans in the workplace. It can also be defined as a goal and as well as a process. Quality of Work Life as a ‘goal’ is all about the creation of more involving, satisfying and effective jobs and work environment for people at all levels of the organization. As a process, QWL involves active participation of the employees to realize this goal. Thus QWL can be stated as a cooperative rather than authoritarian: evolutionary and open rather than static and rigid; informal rather than rule-bound; impersonal rather than mechanistic; mutual respect and trust rather than hatred for each other. According to Prasad (2003), QWL is concerned about the impact of work on people as well as the organization effectiveness and the idea of participation in organizational problem solving and decision making.

Keith (1989) defined QWL as the favorableness or unfavorableness of a job environment for people.

Khanka (2005) & Robbins (1989) refers QWL as a process by which an organization responds to employees’ needs in developing mechanisms to allow them to share fully in making the decisions that design their lives at work.

Ruchi (2008) refers QWL to a sum total of values which consist of both the material and non-material, attained by a worker throughout his career life. It includes aspects of work-related life which will bring about satisfaction of the workers such as wages and hours, work environment, benefits and services, career prospects, and human relations.
Walton (1975) defines Quality of Work Life as an organization’s ability to meet the individual essential needs. He further illustrates the eight dimensions of Quality of Work Life. They are

1. Adequate and fair compensation
2. Safe and healthy environment
3. Development of human capacities
4. Growth and security- the opportunity to achieve personal identity and self esteem
5. Social Integration in work environment
6. Constitutionalism- It is the degree to which a worker has rights and can protect it.
7. The total life space-It is the extent to which a person’s work has a balanced role in his or her life, so as not to disrupt leisure and family time.
8. Social relevance- It is the degree to which the worker views that the organization does as socially responsible and, therefore, sees his or her contribution to the organization as being of social value.

Jyothi & Venkatesh (2006) defined QWL as the favourableness or otherwise of the job environment to the people. It is the degree to which employees are able to meet their personal needs through their experience in the organization.

Laar et.al. (2007) indicates that QWL is that part of overall quality of Work Life which is influenced by work. It is the widest context in which an employee would evaluate the influence of work on their life.

Bhatia (2008) refers QWL to the favourableness or unfavourableness of a total job environment for people. QWL programs are another way in which organizations recognize their responsibility to develop jobs and working conditions that are excellent for people as well as for the economic health of the organization.
Further, it can be noted that there is no general definition of QWL. Rather it is an improvement in the organization climate by the practitioner or whatever that the researcher has concluded. According to the American Centre for Quality of Work Life (1977)¹⁸, Quality of work Life improvements are defined as any activity which takes place at every level of an organization which seeks greater organizational effectiveness through the enhancement of human dignity and growth...a process through which the stakeholders in the organization-management, unions and employees-learn how to work together better... to determine for themselves what actions, changes and improvements are desirable and workable in order to achieve the twin and simultaneous goals of an improved quality of life at work for all members of the organization and greater effectiveness for both the company and the unions.

B) Review of literature on previous work done by others:

Saraji & Dargahi (2006)¹⁹ aimed to provide insights into the positive and negative attitudes of Tehran University Medical Sciences hospital employees from their QWL. The sample includes nurses, supportive and paramedical staff. Questionnaire was designed based on the 14 factors- fair pay and autonomy, job security, reward system, training and career advancements, opportunities, participation in decision making, interesting and satisfying work, trust in senior management, recognition of efforts, health and safety standards at work, balance between time spent at work & with family and friends, amount of work to be done, level of stress experienced at work, occupational health & safety at work. The finding suggest that majority of the employees were dissatisfied with the occupational health and safety, intermediate and senior managers, their income, balance between time spent at work & with family and friends, and their work was not interesting and satisfying. It also concludes that factors that make work a positive experience were occupational health and safety, monetary compensation and support to employees by intermediate managers or supervisors.
Reddy & Reddy (2010) reviews the meaning of QWL, analyses the dimensions and practices of QWL and techniques for improving QWL in an organization. The dimensions include health and well-being, job security, job satisfaction, competence development and balance between work and non-work life. The practices followed in the organization are the Walton (1973) eight practices of QWL- adequate and fair compensation, safe and healthy working environment, immediate opportunity for use and development of human capacities, constitutionalism in the work organization, future opportunity for continued growth and security, work and the total life space, social integration in the work organization and the social relevance of work life. The techniques for improving QWL includes job redesign, career development, autonomous work group, flexible work schedule, participative management, job security and administrative justice.

Mona et.al. (2014) conducts a cross-sectional descriptive study to assess the nurses’ perceptions of the quality of work life in Ain Shams University specialized hospital. Sample consists of 265 staff nurse in various departments and ICU. Self administered questionnaire sheets was used which contains 3 sections. The first section was based on nurse’s socio demographic characteristics such as age, marital status, qualification, experience, previous attendance of the nurses. Second section was based on a standard scale used to assess the quality of nursing work life (Brooks, 2001) which consists of 42 questions categorized into four dimensions 1. Work/home life (7 items) such as balancing work and family needs, arranging child care while at work and hospital policy offering child care. 2. Work design (10 items) such as feeling job satisfaction, having enough time to do the job efficiently, having enough staff at work. 3. Work context (20 items) such as supervisor providing efficient supervision, opportunities for self development at work, communication with other care providers, having comfortable room for nurses and having chance to continue study through work. 4. Work World (5 items) such as salary being suitable to job, feeling own work influences patients’ lives and their families. The third section was based on priorities to improve the Quality of nursing work life. The findings indicate that the highest domain was that of work world (40%) while work context was the lowest (23%). As for improvement priorities, the highest was work/home life (55.8%) and the lowest was work world (39.2%). The perception of QWL was significantly higher with increasing age, experience and
attending training courses. Overall, they have low perception of QWL with higher perception of priorities for improvement especially the work-home dimension.

Almalki et al. (2012)\textsuperscript{22} assess the QWL among 585 primary health care nurses in the Jazan region, Saudi Arabia. Data were collected using Brooke’s survey of Quality of nursing work life and demographic questions. The questionnaire was a self-completion questionnaire with 24 items divided into four subscales: (a) work life/home life, (b) work design, (c) work context and (d) work world. Data analysis consists of descriptive statistics- t-test, one way analysis of variance (ANOVA). It concludes that the respondents were dissatisfied with their work life. Majority of the nurses perceived dissatisfaction with the work life/home work factors including family needs, working hours and energy left after work. In the work design dimension, shortage of nursing workforce and not getting autonomy of practice affects their perception towards their work lives. In the work content dimension, management practices like lack of supervision, feedback, participation in decision making and respect shown by the upper-level management are identified as one of the problem areas. Also, nurses were dissatisfied with the opportunity for professional development. In the work world dimension, nurses were not satisfied with the image developed about nursing profession, salary and financial incentives. However, it was found that their jobs are secure and there is no fear of losing them unexpectedly. Significant difference in the perceived QWL were found according to sex, age, marital status, dependent children, dependant adults, nationality, nursing tenure and organizational tenure, positional tenure and salary per month.

Dargahi et al. (2011)\textsuperscript{23} conducts a cross sectional, descriptive and analytical study among 250 radiologists at Tehran University of Medical Sciences Hospitals. A standard questionnaire was developed through a combination of modifying existing instruments which consist of 34 variables. Data analysis consist of descriptive statistics- T-test, one way analysis of variance (ANOVA) and Pearson statistical methods. It was found that the respondents were unsatisfied with the lack of job security, employees’ participation in decision making, job environment, employees’ retention, career advancement, monetary compensation/reward system, services training, environmental
and occupational health in the radiology department, unclear organizational goals and policies, work load and the job assessment system. QWL dissatisfaction increased with age- due to dissatisfaction in career advancement and monetary compensation and job environment. But QWL was not affected by respondents’ marriage, sex and academic degrees.

Greenberg & Baron (2008)\textsuperscript{24} indicates QWL as one of the Organizational development techniques which can improve organizational functioning by humanizing the workplace, making it more democratic and involving employees in decision making. He also adds that work restructuring; quality circles are some of the activities which can improve QWL.

Vaghaseyyedin et al. (2005)\textsuperscript{25} aimed to identify the predictors of the nurses’ QWL through an integrative review of literature and identified leadership and management style/decision making latitude, shift working, salary and fringe benefits, relationship with colleagues, demographics characteristics, and workload/job strain as predictors of nurses’ QWL.

Freyedon Ahmadi et. al. (2012)\textsuperscript{1} identifies Growth and development, Participation, Supervision, Pay and benefits, social integration, Work environment (Immediate, personal, Professional, Administrative, educational, community, social, economic, political environment) as important determinant of QWL.

Laar et al. (2007)\textsuperscript{2} used Work Related Quality of Work Life (WRQoWL) scale and found that Job & career satisfaction, Working conditions, general well being, Home-work interface, Stress at work, Control at work are the factors which need to be considered to study the QWL of the employees in a health care sector.
2.3.1. Identification of factors for measuring QWL

Different researchers have identified different parameters for measuring QWL. From the above review of literature, the factors and their corresponding items are identified and presented below.

1. General well being: Self respect life satisfaction, depression and anxiety.
2. Home work interface: Balance between time spent at work and with family & friends, total life space, social relevance of work, working hours, balance between work and non-work life, policy offering child care.
3. Job career satisfaction/ work design: Organizational goals and policies, Reward system, training and career advancement opportunities, recognition of efforts, immediate opportunity for use and development of human capacities, growth & security, job satisfaction, interesting & satisfying work, unclear organizational goals and policies, job assessment system, having enough time to do the work efficiently.
4. Control at work: Autonomy, participation in decision making.
5. Working conditions: Safe & healthy working environment, occupational health and safety at work.
6. Stress at work: Level of stress, amount of work to be done, job security, work load
7. Salary: Adequate and fair compensation, fair pay.
8. Social integration at workplace/ Social relevance of work life/ work context: Communication with other care providers, relationship with colleagues, trust in senior management, management practices: efficient supervision by the supervisor and feedback, respect from the upper level management.
9. Constitutionalisation or the degree to which a worker has rights and can protect it: financial incentives, image of the profession, retention policy.
10. Demographic details: Age, marital status, qualification, experience, attendance, organizational tenure.

The questionnaire, Work Related Quality of Work Life (WRQoWL) developed by Van Laar, J. & Edwards, S. (2007) contains most of the factors discussed above and it is based on a health care workers dataset. However, it doesn’t include work-based factors
such as Salary and Social integration. So by adding two additional items along with 24 items, WRQoWL questionnaire consisting of 26 items on six factors are used to explain the individuals quality of Work Life for the present study. The six factors are:

1. Job and Career Satisfaction, JCS: It is said to reflect an employee’s feelings about, or evaluation of, their satisfaction or contentment with their job and career and the training they receive to do it. Within the WRQoL measure, JCS is reflected by questions asking how satisfied people feel about their work. It has been proposed that this Positive Job Satisfaction factor is influenced by various issues including clarity of goals and role ambiguity, appraisal, recognition and reward, personal development career benefits and enhancement and training needs.

2. Working Conditions, WC: It assesses the extent to which the employee is satisfied with the fundamental resources, working conditions and security necessary to do their job effectively. Physical working conditions influence employee health and safety and thus employee Quality of working life.

3. General Well Being, GWB: It aims to assess the extent to which an individual feels good or content in themselves, in a way which may be independent of their work situation. It is suggested that general well-being both influences, and is influenced by work. Mental health problems, predominantly depression and anxiety disorders, are common, and may have a major impact on the general well-being of the employees. It assesses issues of mood, depression and anxiety, life satisfaction, general quality of life, optimism and happiness.

4. Stress at Work, SAW: It reflects the extent to which an individual perceives they have excessive pressures, and feel stressed at work. It is assessed through items dealing with demand and perception of stress and actual demand overload.

5. Control at Work, CAW: It addresses how much employees feel they can control their work through the freedom to express their opinions and being involved in decisions at work. It is assessed by communication at work, decision making and decision control.
6. Home-Work Interface, HWI: It measures the extent to which an employer is perceived to support the family and home life of employees. This factor explores the interrelationship between home and work life domains. Issues that appear to influence employee HWI include adequate facilities at work, flexible working hours and the understanding of managers.

2.4. QWL in Indian Context

In India, the concept of QWL emerged in the mid 1970’s. Indian Philosophy advocates self-actualization as a goal of life and work as a way of life instrumental in achieving the ultimate goal. According to the Indian, Work Life is viewed as a spiritual discipline. The process of refinement to realize this objective or the identity of the self is Yoga or Work. According to traditional teaching, the workplace is a temple and work is worship. The basic philosophy, the central theme of Gita is Karma Yoga. It means action, duty or work and is concerned with multifarious development. Karma Yoga means action, duty or work, which is not performed with a selfish motive but with the object of surviving humanity. To perform one’s duty is to worship the Lord himself as mentioned in the Gita.

Nishkama Karma proclaims the philosophy of performing one’s duty without the desire for reward. Work in itself is considered as a reward. The Indian industrial work culture is influenced by an agrarian culture, a culture in which agriculture is the primary means of subsistence. The workplace and home are located near to each other in an agrarian culture. This culture provides time to take care of the family and the children, and to maintain healthy social relations. Festival and celebrations were related to harvests which enabled the people to relax and enjoy the outcome of their hard work. While in an industrialized society, sometimes the worker has to leave behind his home or even village to reach the workplace. The industrialized society also demands a discipline which is new to the people.
On the other side, QWL emerged as a movement. Some of the important factors that led to the QWL movement in our country are given below.

1. Firstly, a remarkable change in the profile of the Indian worker is one factor where there is a change from the illiterate to the educated, from rural to urban, etc. These changes have made the individuals more concerned with their own hopes and aspirations.

2. Secondly, workers, unlike other factors of production like machinery, land and capital, are an asset with feelings and emotions, trustworthy and capable of making valuable contributions. This has made the organizations realize the importance of workers and contribute their best for the welfare of their workers. Also, the establishment of a separate Ministry of Human Resource Development by the Government of India is a testimony of such realization.

3. Thirdly, around 10 per cent of workers in organized sectors are unionized. Historically, it is evident that the unionized work force has been much vocal for demands of one type or the other.

4. Fourthly, human behavior is very complex and unpredictable where it changes from time to time. Therefore, the need for the study arises as a very important area in the field of Organizational Behavior. It helps in understanding the nature and behavior of the employees and the employers in the workplace. And hence, the study of QWL has become very important in the field of Organizational Behavior in a continuous search for finding the true meaning of the work he/she undertakes.

Further, in many organizations, the QWL is practiced through a variety of operational systems such as workers participation, job enrichment, Quality Circles, etc.
2.5. Measures to improve Quality of Work Life

Some of the important ways of improving QWL are given as follows:

1. QWL through Employee Involvement (EI):
2. Quality Circles
3. Socio- Technical Systems
4. Autonomous work group
5. Job redesign
6. Flexible work schedule
7. Job security
8. Administrative justice

2.5.1. Barriers to QWL

1. Resistance to change: As it is a human tendency to resist, the resistance can be from both the management and the employees. In order to bring a change in the organization, it is very necessary to identify the barriers and to develop certain strategies to overcome the barriers.

2. Perception of the organization that the implementation of the QWL programmes is a costly affair.

3. Barriers in India Are highlighted as follows:\textsuperscript{12}:

   - Widespread unhappiness due to unhealthy comparison with colleagues
   - Skepticism about the performance appraisal system and promotion criteria
   - Division into camps and cliques, hampering fruitful communication
iv) Frequent fits of anger of top-level officials

v) Regional prejudice

vi) Glorification of speed and excitement as against serenity

vii) Unreasonable personal expectation

viii) Limitless addiction to lower-order material needs

2.6. Origin of Organizational Commitment

The subject of organizational commitment in the organizational behavior literature emerged in the sixties. Before this, the relationship between an organization and its employees has been studied primarily in the form of job involvement, loyalty, motivation etc. in social systems in order to formulate constructs, definitions and interpretations of commitment of an employee in the industrial scenario (Singh et al, 2008). The concept of commitment has been defined in different ways in the literatures by various researchers. In sixties and seventies, a broader concept of commitment emerged where it was not only the commitment to the norms but also to other social systems. During the eighties and nineties, organizational commitment was classified into attitudinal and behavioral commitments. And currently it is studies as a psychological frame of reference of employees’ characteristics and their relationship with organizational factors leading to commitment.

During the period from 1951 to 1960: In this decade commitment is viewed as more relevant to industries than to other social systems. Becker (1960) defined organizational commitment in terms of exchange considerations and presented side bets theory. According to him, organizational commitment came into being when a person, by making a side bet links extraneous interest with a consistent line of activity. Side bets are defined as the benefits which an employee deems as valuable, such as pensions, seniority,
vacation, money and organizational relationships which are rewards offered by the organization.

During the period from 1961 to 1970: In this decade, the concept of commitment is broader whereby different aspects of social system were also considered. Grusky (1966) suggest that high rewards from an organization create a positive commitment to the organization. He further states that the greater the obstacle the individual had to overcome to obtain the reward, the greater will be the commitment. Kanter (1968) on the other hand view organization commitment from the social integration in the work place aspects. He proposed three forms of commitment: Continuance, Cohesion and control. Continuance commitment refers to the employees’ recognition of an advantage associated with not leaving the organization. Cohesion commitment refers to the commitment loyalty to the group or a set of social relationships. Control commitment refers to the Commitment to the group authority and an agreement to uphold the norms of the group.

During the period from 1971 to 1980: During this decade, organizational commitment emerged as a key factor of the relationship between individual and the organization. Great strides in the construct clarity and definition of Organizational Commitment were observed. Also distinction between attitudinal and behavioral commitments exists. Sheldon (1971) describes commitment as an investment orientation within an organization. He defined commitment as attitudes towards the organization which attach the identity of the person to the organization and found that social involvement increase the commitment to the organization, reinforcing the affects of investments. Buchanan (1974) in his study viewed commitment as an affective attachment towards the goals and values of the organization for its own sake, apart from its purely instrumental worth. Mowday et al. (1974) defined commitment as strength of an individual identification with and involvement in a particular organization. Salancik (1977) made further distinction of commitment by dividing into two aspects: attitudinal and behavioral commitments (figure 1). Attitudinal commitment is the employee’s identification with the goals and values of the organization and the strong desire to remain membership of the organization. Behavioral commitment refers to the process by which individuals become locked into an organization and how they deal with the problem.
During the period from 1981 to 1990: Development can be seen in industrial approach to job, profession and organizational climate factors and psychological approach concentrating on normative and instrumental beliefs. Facet analysis of work commitment and concept of different foci of commitments were the important developments. Since the mid 1980’s there has been considerable interest in the idea that firms can improve their performance by harnessing the commitment of the employees through human resource management practices. HRD mechanism namely role analysis and potential appraisal were found to have significant impact on commitment (Kumar & Krishnaveni, 2008)\(^1\). Sharma (1987)\(^2\) found significant correlation of OC with recognition and appreciation, safety and security, training and education, scope of advancement, grievance handling and participative management.
During the period from 1991 to till date: Organizational Commitment is further described as a multi-dimensional construct. It plays a key role in the formation of an integrated human function in the organization and it is reflected in many management studies. Meyer and Allen (1991) developed three component models of OC- affective, normative and continuance. Employees with a strong affective commitment remain with the organization because they want to, those with a strong continuance commitment remain because they need to, and those with strong normative commitment remain because they feel they ought to do so. Their view reflects the evolution of thought on their three component model of organizational commitment.

2.7. Organizational Commitment: Meaning and Concept

A) Review of literature on Concept of the terminology used

Armstrong M. (1977) defines Organizational commitment as
a) A strong desire to remain a member of a particular organization;
b) A willingness to exert high level of effort on behalf of the organization; and
c) A definite belief in and acceptance of the values and goals of the organization.

Stephen et. al. (2007) refers Organizational Commitment to the employee’s emotional attachment to, identification with, and involvement in a particular organization. It consists of three themes: Affective commitment, Continuance commitment and Normative commitment. Employees with a strong affective commitment remain with the organization because they want to, those with a strong continuance commitment remain because they need to, and those with strong normative commitment remain because they feel they ought to do so.

Bhatia (2008) defines Organizational Commitment as the extent to which an individual identifies with a particular organization, its goals and wishes to remain a member of that organization.
B) Review of literature on previous work done by others:

Han et al. (1995) studied a causal model of organizational commitment developed on data collected from Western Societies in a hospital in South Korea. The model to be estimated is grounded in expectancy theory. Basic to this theory is the idea that employees enter work organizations with expectations and values, and if these expectations and values are met, the employees will likely be satisfied with their jobs and be committed to the organization. The model assumes an exchange of benefits between the organization and its employees. The model includes four individual variables: met expectations, work involvement, positive affectivity, and negative affectivity. The model has two environmental variables, opportunity and kinship involvement. The model has eleven structural variables: autonomy, role ambiguity, role conflict, workload, coworker support, supervisory support, organizational support, routinization, distributive justice, promotional chances, and pay. Role ambiguity, role conflict, and workload are dimensions of job stress, whereas coworker support, supervisory support, and organizational support are dimensions of social support. The model has one intervening, endogenous variable, job satisfaction. Five demographic variables — age, tenure, gender, education, and union membership — are used. Sample consists of 511 hospital employees and represents all occupational categories in the hospital (physicians, nurses, administrative/clerical workers, technicians, and manual workers). A four-item index selected from Porter and his colleagues Organizational Commitment Questionnaire (Porter, Steers, Mowday and Boulian, 1974) was used to measure commitment. Satisfaction was measured by a six-item index selected from Brayfield and Rothe (1951). Data are analyzed with LISREL maximum likelihood method. Despite the great differences between Western societies and South Korea, the model works quite well in the latter. Ten variables are important in explaining organizational commitment: job satisfaction and the nine exogenous variables representing three types of determinants: environmental (opportunity), individual (met expectations, work involvement, positive affectivity, and negative affectivity), and structural (autonomy, role conflict, supervisory support, and distributive justice). The model explains eighty-five percent of variance in organizational commitment.
Coskuner and Yartutan (2009) carried out the study among the housekeeping staff employed by the private company to work in the hospitals, affiliated to the Ministry of Health, central district of Ankara Province. From a population of 2749 housekeeping staff, 337 housekeeping employees including managers and service providers were included in the study. All the housekeeping managers of each hospital were included in the study while the service provider was selected by simple random sampling method. The survey form consists of two parts. First part included questions aimed at collecting general information about housekeeping employees and the second part comprises the questions relating to organizational commitment. The Organizational Commitment scale developed by Wasti (1999) consisting of 3 factors—affective commitment, continuance commitment and normative commitment and 18 items were used by translating into Turkish and adding some unique cultural elements. Findings suggest that there organizational commitment of the employees does not differ by the employees’ gender, marital status, educational background, title/position, while it differs according to age, tenure in the firm and the profession.

Vanitha et al. (2006) studied the sex impact of Organizational Commitment and stress among Information technology professionals and found that there is no significant difference between male and female IT professionals.

Steers (1977): suggest a preliminary model that incorporates both antecedents and outcomes of organizational commitment. It reveals six antecedent variables significantly associated with commitment: Personal Characteristic—need for achievement, education; Job Characteristics—task identity; Work experiences—group attitudes towards the organization, organizational dependability, and personal importance to the organization. As outcomes, commitment is found to be related to both desire to remain and intent to remain with the organization. Also commitment is significantly and inversely related to employee turnover and therefore a stable workforce is one of the most significant outcomes of increased commitment. Personal characteristics included age, education and tenure, plus the need strength of achievement, affiliation, autonomy, and dominance. Need strengths were measured using the Manifest Needs Questionnaire (MNQ)
developed by Steers and Braunstein (1976), *Job characteristics* included autonomy, variety, feedback, task identity, opportunity for social interaction. It was measured using the scaled developed by Hackman and Lawler (1971). Work Experience was measured using an instrument developed by Buchanan (1974). The experiences include 1. Group attitudes towards the organization, 2. The extent to which subjects’ expectations were met by the realities of the job, 3. Feelings of personal importance to the organization based upon the actions of the organizations over time, and 4. The extent to which the organization was seen as being dependent in carrying out its commitments to employees. Organizational commitment was measured using a questionnaire developed by Porter (Porter et al., 1974). Job performance was measured on four related performance dimensions: overall performance, quality of work, quantity of work, and promotion readiness. Attendance was measured as the number of days absent from work and employee turnover data was collected were collected for a period of one year in the hospital sample.

Mowday et al. (1979) measured organizational commitment based on the three factors namely: 1. A strong belief in and acceptance of the organization’s goals and values, 2. A willingness to exert considerable effort on behalf of the organization, and 3. A strong desire to maintain membership in the organization. The sample consist of public employees (custodial hospitals, social service budgetary, licensing agencies), classified university employees, hospital employees, bank employees, telephone company employees, scientists and engineers, auto company engineers, psychiatric technicians and retail management trainees. The analysis was carried on the following psychometric properties: 1. Means and standard deviations, 2. Internal consistency Reliability, 3. Test-Retest Reliability, 4. Evidence of convergent Validity, 5. Evidence of Discriminant Validity, 6. Evidence of Predictive Validity. Compared to other measures, the items of the Organizational Commitment Questionnaire (OCQ) were found to be reasonably homogeneous and the result suggests that the overall measure of organizational commitment was relatively stable over short periods of time. OCQ possesses acceptable, although far from perfect, levels of convergent and discriminant validity. Further he suggests that employee behavior in organizations is determined by a complex set of factors and not just commitment in the organization.
Misra (2007) examines the dimensions of organizational effectiveness and organizational commitment (OC) among group of managers in a joint venture. The study involved two phases for collecting data- interview and ratings on specific indicators of OC. The thematic analysis of the interview protocols obtained from the managers revealed that the important component constituting commitment involve three domains of orientation i.e. work orientation, affective orientation ad continuance orientation. Work orientation was manifested in terms of expressions such as working hard and undertaking efforts for the organization. Affective orientation took many forms- having pride in being part of the organization, experiencing pleasure while working. Continuance orientation was expressed in terms of not only personal willingness to continue in the organization but to see that colleagues too continue in the organization. It was found that the highest rating is for recommending others to join the organization and experiencing pleasure in working for the organization. Thus continuance and affective orientation were prominent. Feelings of pride, concern for hard work were also clearly emphasized. The themes and ratings both tend to suggest that commitment is two dimensional. On the one hand, it inspires positivity in the person and on the other it involves some kind of investment towards the organization. Further, effectiveness is more social process involving group life and integration with the larger entity of organization while commitment is predominantly individual level process.

Pooja and Renu (2009) aims to examine the effect of psychological wellbeing on the commitment of employees and the result indicates that all the dimensions (Self-acceptance, Personal growth, Purpose of life, Environmental mastery, positive relations with others) of psychological wellbeing are significantly positively related to organizational commitment (OC), except autonomy which had low correlation with commitment. Here, the sample consists of 100 respondents working in different organizations-banking, manufacturing industries and automobile industries. OC is measured by using 15-item Organizational Commitment Questionnaire (OCQ) developed by Mowday et al.(1979) and Psychological wellbeing was measured by using 54 item scale with 6-point response category developed by Ryff (1989).
Kumar and Giri (2009) in their study on impact of age and experience of employees on job satisfaction and organizational commitment revealed that job satisfaction and organizational commitment differed significantly across the different career stages of employees. It was further observed that aged employees had higher job satisfaction and organizational commitment. Higher the work experience, higher was the job satisfaction and organizational commitment. Data was collected from 380 employees mostly from banking and telecom sectors. Job satisfaction was measured using 28-item “Job Satisfaction Survey” scale developed by Spector (1985) and Organizational commitment was measured using 15-item “Organizational Commitment Questionnaire” developed by Mowday et al.(1979).

2.7.1. Identification of model for measuring Organizational Commitment

From the above review of literature, it is evident that Organizational Commitment, its concept, its measurement scales and its theoretical basis have all differed over the past. And no full agreement has been reached about its definition and measurement (Price et al., 1997; Bergman, 2006).

Hence, of the entire existing model, the model which dominates the rest is the one developed by the team of Allen and Meyer. This stated with the concept that commitment is an attitude (Mowday, Steers and Porter, 1979) and calculative commitment (Becker, 1960).

Commitment as an attitude is characterized by i) Belief in and acceptance of the organization’s goals and values, ii) Willingness to exert considerable effort on behalf of the organization, and iii) Desire to remain membership in the organization.

Commitment as calculative commitment is characterized by cost associated with leaving the organization. Therefore, in the present study, for measuring Commitment for hospital
employees, Organizational Commitment scale developed by Mowday, Steers, and Porter (1979) will be used. This scale consists of three factors:

i) Belief in and acceptance of the organization’s goals and values,

ii) Willingness to exert considerable effort on behalf of the organization,

iii) Desire to remain membership in the organization.

The fifteen items corresponding to these three factors and two additional items are considered for measuring commitment.

2.8. Relationship between QWL and Organizational commitment

Freyedon Ahmadi et. al. (2012) measured QWL on a 28 item Questionnaire developed by Walton (1975) to represent the 7 dimensions of the QWL and to measure Organizational Commitment; a 20 item questionnaire developed by Allen and Meyer was used. Supervision, growth & development, social integration contributed highly to their QWL. After analysis of the factors of QWL on the four dimensions of Commitment it was found that participation, supervision, pay & benefits, growth & development, social integration have positive relationship with affective, continuance (alternatives). Continuance (cost) and normative commitment. Further it shows that QWL and Commitment is a multidimensional construct and is a product of one’s work place.

Kalayanee et al. (2007) found that QWL is a significant determinant of Organizational Commitment and QWL affects job related outcomes i.e. job satisfaction, Organizational Commitment and team spirit. A 16- item QWL scale developed by Sirgy et. al. (2001) and Organizational commitment scale developed by Jaworski and Kohli (1993) were used.

Daud (2010) aims to investigate the relationship between the Quality of Work Life and Organizational Commitment among 500 employees of Malaysian firm who were in the supervisory and executives levels. A 28 items questionnaire derived and adopted
from an earlier QWL study by Walton (1975) and modified by Mohd. Hanefah et. al (2003) and Mat Zin (2004) were used to represent the seven dimensions of QWL-Growth and Development, participation, physical environment, supervision, pay and benefits, social relevance and work place integration. Organizational Commitment was measured using the questionnaire, developed by Allen and Meyer, which consist of 20 items to measure affective, normative and continuance commitment. The result showed that there was a relationship between QWL and Organizational Commitment. Growth and Development have significant positive relationship with affective, normative, continuance (Alternatives), continuance (Cost) commitments. Participation has significant relationship with Affective, continuance (Alternatives), continuance (Cost) commitments. Supervision has significant relationship with continuance (Alternatives), continuance (Cost) commitments. Pay & benefits and social integration have significant positive relationship with Affective, normative and continuance (Alternatives) commitments. Further it shows that QWL and OC are a multidimensional construct and is a product of the evaluations of one’s work place.

Smith et al. (2000)\textsuperscript{14} indicates that perceived QWL of the nurses was higher with increasing age and experience in their profession. This might be explained by the fact that, as they get older and gain more years of experience, they advance in their career and have higher job status, which is a positive reflection on the Quality of Work Life. This ultimately brings about greater job satisfaction, productivity and organizational commitment.

Bhatia (2005)\textsuperscript{15} refers QWL as the level of satisfaction, motivation, involvement and commitment. And the prominent activities needed to create such conditions are fair pay, fair treatment of employees, safe working conditions and other specific employee needs.
Lees et. al. (2005)\textsuperscript{16} measured commitment of the employees to the organization as one of the parameters relating to QWL. Due to negative perceived QWL, the nurses and the physicians are less committed to the organization.

Sajjad and Abbasi (2014)\textsuperscript{1} conducted a descriptive correlation study to investigate the relationship between Quality of Work Life and Organizational Commitment amongst 196 customs employees of Iran Province. Quality of Work Life is measured using Walton QWL and Organizational Commitment is measured using Mayer and Allen OCQ. The result proved that there is a positive and meaningful relationship between the QWL and its dimensions including safe and healthy environment, development of human capacities, constitutionalism, social integration and the total life space with the organizational commitment.

Permarupan et al. (2013)\textsuperscript{18} studied the relationship between the QWL, employee’s job involvement and affective commitment among the employees of the public and private sector organizations in Malaysia. A sample of 334 middle management level employees was included in the study. QWL (modified from Walton, 1974) was measured with five dimensions- fair and appropriate salary, working conditions, capacities at work, opportunities at work and organization climate. And partial implication of the Allen and Meyer (1997) dimension of OC were adapted by focusing on affective commitment of the employees towards the organization. The result indicates that working conditions, opportunities at work and climate organization had a relatively higher impact on job involvement and affective commitment.

2.9. Summary and Conclusions

It can be concluded that there is no general definition of QWL. Rather it is an improvement in the organization climate by the practitioner or whatever that the researcher has concluded. As for the present study, QWL is the overall impact of work on people, a favorableness or unfavorableness work environment that designs their
lives at work. It is influenced by various aspects of life which is desired by the organization members. It aims to seek balance between the human, technological, organizational and the societal demands. Fulfilling these employees needs is contradictory and conflicting and above all a challenge for the organization to attract and retain the best employees. Commitment on the other hand, can be categorised as Attitudinal commitment- employee’s identification with the goals and values of the organization and the strong desire to remain membership of the organization; Behavioral commitment- individuals become locked into an organization and how they deal with the problem and calculative commitment- cost associated with leaving the organization.

2.10. Hospital and its classification

Every society needs the institution called “Hospital”. It is not only an institution for the care, cure and treatment of the sick and the wounded but with technology advancement in medical sciences and complexity of modern hospitals, it is also an educational and training centre, a research centre. In this chapter, the nature and scope of a hospital, its definition and the classification of modern hospital will be highlighted.

2.10.1. Nature and Scope of a Hospital

People make a society and healthy people make a healthy society. But society is not free from illness, disease. It is evident from the past how an individual afflicted by a disease or wound were left to suffer without and assistance and care by a healthy person. Rather, it was believed to be a curse by evil spirits or a punishment for one’s misdeed and so, the ill person was left in complete isolation from society. No cures for the ailments existed. With civilization, the need for common responsibility for the welfare of his fellow- beings arises. Thus, there comes the need for medical treatment, nursing care and shelter. The hospital is one such institution catering to such needs of the sick.
2.10.2. Hospital: Definition

The word ‘hospital’ is derived from the Latin word *hospitalis* which comes from *hospes*, meaning a host. The English word ‘hospital’ comes from the French word *hospitale*, as do the words ‘hostel’ and ‘hotel’. The three words, hospital, hostel and hotel, although derived from the same source, are used with different meanings. The term ‘hospital’ means an establishment for temporary occupation by the sick and the injured\(^9\). According to Dorland (1961)\(^{20}\), a hospital is an institution suitably located, constructed, organized, staffed to supply scientifically, economically, efficiently and unhindered, all or any recognized part of the complex requirements for the prevention, diagnosis and treatment of physical, mental and the medical aspects of social ills; with functioning facilities for training new workers in many special professional, technical and economical fields, essential to the discharge of its proper functions, and with adequate contacts with physicians, other hospitals, medical schools and all accredited health agencies in the better-health programme.

A hospital is defined as an institution for the care, cure and treatment of the sick and wounded, for the study of diseases and for the training of doctors and nurses. (Steadman medical dictionary, 1961)\(^{21}\).

A hospital is defined as an institution for medical treatment facility primarily intended, approximately staffed and equipped to provide diagnostic and therapeutic services in general medicine and surgery or in some circumscribed field or fields of restorative medical care, together with bed care, nursing care and dietetic service to patients requiring such care and treatment. (Blackisto’s New Gould Medical Dictionary, 1956)\(^{22}\).

According to the Directory of Hospitals in India (1988)\(^1\), a hospital is an institution which is operated for the medical, surgical and/or obstetrical care of in-patients and which is treated as a hospitally a Central/ state government/ local body/ private and licensed by the appropriate authority.
2.10.3. Modern Hospital: Classification

The modern hospital is one of the complex organizations. Within the organization, there is a wide diversity of objectives and goals for different departments and different personnel. The personnel range from highly skilled to unskilled employees.

Modern hospital can be classified in many ways. The commonly accepted criteria for the classification are given below:

1. Length of stay of patients: According to the length of stay of patients, a hospital can be a long term or a short term. A patient stays for a short term in a hospital for the treatment of diseases like appendicitis, gastroenteritis, etc. Patient stays for a long term in the hospital for treatment of diseases like cancer, tuberculosis, etc.

2. Clinical basis: The classification of hospital on the basis of clinical classification can be general hospital and specialized hospital. In a general hospital, patients are treated for all kinds of diseases such as fever, typhoid, etc. but in a specialized hospital, patients are treated only for those diseases for which that hospital has been set up, such as, tuberculosis, heart disease, cancer, maternity, etc.

3. Ownership control basis: On the basis of ownership or control, hospital can be divided into four categories. They are:

   i) Public hospitals: Public hospitals are those run by the central government or local bodies on non-commercial lines. These hospitals can be a general or specialized or both.

   ii) Voluntary hospitals: Those hospital which are established and incorporated under the Societies registration Act, 1860 or Public Trust Act, 1882 or any other appropriate Act of the Central or State government.

   iii) Private nursing homes: Hospital owned by an individual doctor or a group of doctors where out-of-home care services are rendered. They are run on a commercial basis.

   iv) Corporate hospitals: They are public limited companies formed under the companies act and run on a commercial basis.
2.11. Organization Profiles of the Hospitals

The profiles of the organization under study namely, Shija Hospitals & Research Institute Pvt. Ltd, a private hospital and District hospital, Thoubal khangabok, a public hospital are highlighted in the following.

2.11.1. Profile of Shija Hospitals and Research Institute (SHRI)

Shija Hospitals and Research Institute (SHRI) is an ISO 9001 - 2008 certified, 200 bedded multispecialty hospital with 21 specialties including super-specialty at eco-friendly Langol, outskirts of Imphal, Manipur, providing secondary and tertiary healthcare in the region with more than 670 dedicated trained staff.

The journey started in May 29, 1985. Dr. Palin Khundongbam, the moving spirit behind Shija and path finder, Plastic Surgeon by profession, conceived the idea of SHRI. From a mono-practice clinic “Shija Clinic” to the first ever ISO certified hospital, Shija Hospitals and Research Institute has had a meaningful journey and looks forward to a remarkable future ahead by adding cardiac science, kidney and cornea transplantation, infertility treatment, joint replacement surgery, Wellness Park etc.

In 1985, Shija Clinic at Paona Bazar, Imphal, Manipur, started with a consultation chamber with a minor operation facility attached to a pharmacy. It is the first centre in the Northeast India to start cryofreezing a non-operative treatment of piles in 1986. On 3rd October, 1988, it was shifted to RIMS road near Regional Institute of Medical Sciences with 9 beds and a major operation theatre facility. It was further expanded to 24 bedded clinic with new OPD complex in November 1996. On December 18, 1998, the name Shija Clinic was changed to Shija Clinic Private Limited, after converting from partnership to Private Limited Company. On 29th March 2001, SHRI got its present name Shija Hospitals and research Institute Private Limited. As recognition to deliver the best services increases, public demands for SHRI increases. And, hence it was again
shifted to Langol, where the present HRI stands, an eco-friendly, spacious environment and outskirts of Imphal. In 2003, the hospital has set a Guinness World Record for successful excision of the largest neck tumour in the world from a 12 year old baby. The tumour constituted 40% of the total body weight. As the public demand increases, the hospital, felt the need for further expansion. Thus, three more were added with other additional facilities. At present the hospital has around 600 employees. The hospital received ISO certification in 2006. Further, the Hospital has been preparing for the NABH accreditation. Currently, the hospital is managed by a team under the leadership of Dr. Palin Khundongbam, Chairman (CMD) and Managing Director of the hospital.

SALIENT FEATURES OF SHRI

- Environment friendly location
- Modern hospital architect
- G+4 hospital building
- 200 bedded health Care Centre
- Three Modern Operation Theatres
- Well Equipped Intensive Care Unit
- 24 hours Emergency Medicine
- Minimally Invasive Surgery Training Institute
- 25 Kh/hr incinerator
- Nursing Institute
- Paramedics training Institute
- Computerised Management by professionals
2.11.2. Vision of Shija Hospitals & Research Institute Pvt. Ltd.

The organization has a clear vision formulated. It is stated under the following lines.

“To be a premium and leading brand in health care services in the South East Asia, recognized by our customers for our holistic approach, personal touch and technological advancement”

2.11.3. Mission of Shija Hospitals & Research Institute Pvt. Ltd.

The mission statement of SHRI is stated below.

We are dedicated in providing high quality and customer focused healthcare services. We will achieve this by focus on:

- Customer needs - being sensitive to our customers
- Research and Development - improving our services through constant research and skill development
- Quality system - continuing to be highly systematic and organised in our services delivery and quality control
- Networking - building up our local and international network with our partners in healthcare
- People Development - caring and grooming our people to set higher goals
2.11.4. Values of Shija Hospital & Research Institute Pvt. Ltd.

The organizational culture and priorities of SHRI are set with the following values:

“Integrity, Agility, Passion for Excellence”

2.11.5. Quality policy and Quality Objectives of Shija Hospital & Research Institute Pvt. Ltd.

The quality policy of SHRI is stated as follows.

“Our quality policy is to achieve customer delight by providing customer centric, cost-effective, timely and ethical medical care with diligence, consideration of the applicable legal and other requirements.

We are committed towards continual improvement of our Quality Manual Service with active participation of all members of our organization, customers, and other related parties.”

The corporate quality objectives of SHRI are as follows:

- To maximise patient satisfaction with regards to medical care and hospitality services provided
- To ensure maximum patient safety
- To ensure Zero defect in medical care
- To adhere strongly to the ethical clinical practices
- To ensure continual human resource development
- To continually improve productivity

Besides Corporate quality objectives, SHRI have drawn different quality objectives for various departments of clinical and non-clinical areas like Housekeeping, Human Resource Department, Purchase and Stores, etc.

Quality objective of clinical functions are as follows:
• To ensure maximum patient safety
• To ensure Zero Defect in medical care
• To adhere strongly to the ethical clinical practices
• To continually improve productivity

Quality objective for housekeeping department are as follows:

• To maximise patient satisfaction with regards to hospitality services provided
• To ensure maximum patient safety
• To continually improve productivity

Quality objectives for Purchase and Store department are as follows:

• To continually improve productivity

Quality objectives for Human Resource department are as follows:

• To ensure continual human resource developments
2.11.6. Organizational Structure of Shija Hospitals & Research Institute Pvt. Ltd.

The Organizational structure of Shija Hospitals & Research Institute Pvt. Ltd. is presented in figure no. 2.2.

Figure no. 2.2: Organizational Chart of Shija Hospitals & Research Institute Pvt. Ltd.
As indicated in the figure no. 2.2, SHRI adopts hierarchical lines of authority and departmentalization. On topmost is the shareholders, being a private limited company, followed by the board of directors. The overall functions of the hospital are carried out under the leadership of the Managing Director who is also the executive head of the hospital. The Director Administration, Chief Executive Officer (CEO) and the Medical Superintendent reports to him. The organization is divided into medical and non-medical departments. The head of the medical department is the Medical Superintendent. Consultants, Resident Medical Officers (RMOs), Nursing, Medical record Department (MRD) and Pharmacy functions under the control of the Medical Superintendent. Under the non-medical departments are the Finance and the Material department which is under the control of the Chief Executive Officer. Another non-medical department is the General Administration which is further divided into Business Development (Marketing), Operation and Human Resource Department.

2.11.7. Clinical Departments at Shija Hospitals & Research Institute Pvt. Ltd.

- Anaesthesiology and Critical care
- Plastic and reconstructive Surgery
- Shija Super-speciality Dental Centre
- Emergency, Trauma & Burn Unit
- Surgical Gastroenterology
- LASER & Cosmetic Clinic
- Shija Blood Bank & Transfusion Services
- Clinical Pathology
- Microbiology
- Nephrology
- Dermatology
- Urology
- Paediatric Surgery
- Biochemistry
- Neurosurgery
- ENT
- Orthopaedics
- Ophthalmology
- General Medicine
- Shija Heart Beat
- Audiology & Speech Pathology
- Radiology & Imaging Science
- Physiotherapy & Rehabilitation
- Obstetrics & Gynaecology
- General Surgery & MAS
- Dietetics & Nutrition
2.11.8. Armamentarium at Shija Hospitals & Research Institute Pvt. Ltd.

In order to provide world-class services, SHRI uses high end technology.

- Computerised hospital
- Laparoscopic Gynaecology
- FESS for Sinus Problem
- Oculoplasty
- Phototherapy for vitiligo
- Reconstructive including re-implantation
- Microsurgery for ear drum perforation
- Biliary & oesophageal metal stenting
- Harmonic scalpel for bloodless surgery
- Green LASER for treatment of diabetic retinopathy
- QS Nd Yag LASER for tattoo and scar removal
- EEG, EMG, NCV, etc. to rule out neuro-physiological disorder
- 24x7 pharmacy, diagnostic and ambulance services
- Carl Zeiss visu 160 microscope, Germany for retinal surgery
- SILS (Single Incision Laparoscopic Surgery)
- ESWL, PCNL, CLT, URS, TURP, TURBT for urinary stones
- Alcon Laureate World Phaco System (cold Phaco), Alcon’s Infiniti Vision system with Alcon’s Accurus High Brightness Illuminator for advanced Cataract and Vitreoretinal surgeries
- Shija Health Check- a comprehensive health check up programme
➢ New Hermonic Focus instrument for bloodless open surgery

➢ DGHAL, Germany (Doppler Guided Haemorrhoidal Artery Ligation)- the latest non cutting treatment technology of piles.

➢ Endoscopy- both diagnostic and therapeutic including ERCP

➢ C-Arm for foreign body removal, ERCP, pacemaker placement, PCNL, URS & Advanced bone fracture management

➢ IRC, USA for Piles

➢ Thoracoscopy

➢ Spirometry

➢ Intensive Care Unit

➢ Multislice Spiral CT Scan

➢ IPL (Intense Pulse Light)

➢ Tread Mill Test

➢ VITROS 250 – fully automated biochemical analyzer which can perform 250 tests in one hour

➢ VITROS – ECI – fully automated biochemical analyzer based on dry chemistry & HBV within one week of infection

➢ Colour fundus photography & Fundus fluorescien angiography machine for Carl Zeiss, Germany to document changes in optic nerve fibre

➢ HD (High Definition) camera with LED Light source of Stryker, USA – highly advanced medical video technology used in Minimal Access Surgery (MAS)

➢ Digital Colposcope with Cervical Cryotherapy machine for early detection of cervical malignancy
Datex Ohmeda (Aspire View), USA, with Savoflurane Anaesthesia – ideal for general anaesthesia

Accurus Vitrectomy System – highly advanced surgical technology for the posterior segment of the eye.

Holmium Laser and flexible uretero-renoscope, KARL STORZ. Germany—most advanced non cutting treatment technology for kidney, ureter and bladder stones.

MOCROAIRE Power Assisted Liposuction, USA, for improving the body shape by removing excess or unwanted fat cells

8 bedded ICCU with Alura FC Cathlab, Philips.

Aphresis for separation of the whole blood components

NAAT (Nucleic acid amplification test), for ensuring the safest blood to the recipient.

2.11.9. Major landmark achievements of Shija Hospitals & Research Institute Pvt. Ltd.

The major achievements of SHRI are arranged in chronological order in the following:

First Measles Vaccination in Manipur - 1986

1st Cyrofreezing for Piles in eastern India - 1986

1st free Flap surgery for sole defect in N.E. India - 1995

1st to perform full fledged Laparoscopic surgery in Manipur - 1996

1st to perform puppetry key hole surgery for gall bladder With just 2 tiny holes in Eastern India - 1997

1st to install Harmonic Scalpel (for bloodless surgery) in Indian sub-continent - 1997
➢ 1st to install diagnostic and therapeutic video-endoscopy with ERCP, in Manipur - 1998

➢ 1st to launch private ambulance service in Manipur - 1999

➢ 1st to re-implant an amputated thumb in N.E. India - 2000

➢ Guinness record for removal of the largest neck tumour in the world - 2003

➢ 1st to perform breast implant surgery in Manipur - 2003

➢ Full fledged endourology facilities (PCNL, URS, ESWL, CLT, TURP, TURBT, etc) for the 1st time in Manipur - 2003

➢ Upgradation of Hospital Information System (HIS) - 2005

➢ Nursing School (Shija Academy of Nursing) - 2006

➢ 1st to perform laparoscopic nephrectomy in Manipur - 2006

➢ 1st ISO 9001:2000 certified hospital in Manipur - 2006

➢ Recognized as Smile Train partnered hospital by Smile Train Inc., USA - 2006

➢ 1st to install Green LASER in Manipur - 2007

➢ Inauguration of Shija Emergency, Trauma & Burn Centre - 2008

➢ 1st private sector in Manipur to install 25kh/hr incinerator - 2008

➢ 1st to install Accurus Vitrectomy system in Manipur - 2008

➢ 1st to install Alcon LaureatenWorld Phaco System (cold phaco) in Manipur - 2008
- 1st to install DGHAL (Doppler Guided Haemorrhoidal Arteries Ligation) in Manipur - 2009
- Installation of QS Ned yag LASER - 2009
- Installation of Intense Pulse Light (IPL) - 2009
- 1st to install Stryker’s HD (High Definition) camera with LED Light source in Manipur - 2010
- 1st to install Alcon’s Infiniti Vision System in Manipur - 2010
- 1st to install Digital Colposcope in Manipur - 2010
- Installation of Dialog* Haemodialysis machine (B/Braun) - 2010
- 1st to install Datex Ohmeda (Aspire View) anaesthesia workstation machine in Manipur - 2010
- Installation of Holmium LASER & Flexible ureteo-renoscope, Karl STORZ, Germany for the 1st time in Manipur - 2011
- Inauguration of Shija Blood Bank and transfusion Services with high end facilities like NAAT (Nucleic Acid Amplification Test) for the 1st time in Eastern India & Apheresis for the 1st time in Manipur - 2012
- Inauguration of Shija Heart Beat, an advanced cardiac care center - 2012
- Installation of MICROAIRE Power Assisted Liposuction, USA for the 1st time in N.E. India - 2012
Besides the above achievement, the Emergency and Trauma Care supported by 21 clinical departments and diagnostics services ensures that all critical cases are given immediate and adequate care. There are 32 critical care beds with staff trained specifically for intensive care and round the clock anaesthetists.

SHRI being the 1st private hospital to install 25Khr/hr incinerator in Manipur strictly follows the system of segregation of bio-medical waste at source and ultimately appropriate treatment and disposal of waste through incinerator, shredder, sharps pit, deep burial etc for the safety of environment. Shija Bio-Medical Waste Management is now recognized by the Manipur Pollution Control Board as the common facility for the entire state.

State of the art Shija Blood Bank & Transfusion Services is a Public Private Partnership initiative, funded by North East Council, Shillong and Planning Department, Govt. of Manipur. This is the only licensed blood bank accredited by the National Accreditation Board of Hospitals & Healthcare Providers (NABH) in North Eastern states. It is equipped with Nucleic Acid Amplification Test (NAAT) facility to screen HIV, Hepatitis B & C Virus which is the first installation in the entire Eastern India.

The Shija Academy of Nursing is one of the leading nursing institutes in the state. SHRI also trains paramedics and is recognized for Post-graduate DNB courses in General Surgery, Anaesthesia and Plastic Surgery. Under Shija Overseas Training Program, SHRI in collaboration with AMASI (Association of Minimal Access Surgeons of India), took up the initiative of providing free training to two surgeons and four nurses from Monywa General Hospital, Myanmar for three months in the areas of Laparoscopic surgery, Operation Theatre Technology and critical care.

Over 3500 cleft lip and palate patients have been operated free of cost and given smiles on their faces under Smile Train Shija Cleft Project not only in Manipur but also in the neighbouring states of Nagaland, Assam, Mizoram and also the neighbouring country of Myanmar.
In its contribution towards the neighboring country, SHRI started the venture of Mission Myanmar in May 2013 with a firm belief to bring the two nations together. So far, three successful missions were ventured in continuation of its service wherein 134 cleft lip and palate, 179 cataract blindness and 32 key hole surgeries were performed for free.

The Shija Eye Care Foundation conducts various community based peripheral outreach camps in rural and tribal areas. More than 7000 patients with cataract blindness have undergone free surgeries in the last 4 years.

SHRI have also successfully performed 7 re-implantations of totally amputated hands and fingers for the first time in North Eastern India.

“Future belongs to those who believe in the beauties of their dreams.” With India’s Look East Policy, Manipur’s favourable location bordering with Myanmar, meeting point of two superpower nations, China and India, huge tourism potentials of the state especially in war, ecology, sports and cultural arenas. SHRI strongly believe that Manipur, one day, will become one of the healthcare destinations of South East Asia.

2.11.10. Empanelled Organization of Shija Hospitals & Research Institute Pvt. Ltd.

SHRI is empanelled by:

- Central Silk Board (CSB)
- Airport Authority of India (AAI)
- Government of Nagaland
- Indian Oil Limited (IOL)
- Central Agriculture University (CAU)
- CRPF
• United Healthcare India Medicare
• Power Grid Corporation of India Ltd.
• Regional Institute of Medical Sciences (RIMS)
• National Hydro-electric Power Corporation (NHPC)
• Ex-Serviceman Contributory Health Scheme (ECHS)
• Manipur State RSBY Society
• Govt. Of Mizoram
• HUDCO
• Government of Manipur
• Manipur University
• Navodaya Vidyalaya Samiti

2.11.11. Social Services

• Gujarat earthquake- A team of 12 sick and injured doctors from SHRI spent 1 week at Bhachao to help the sick and the injured

• Contributed Rs. 30,000/- to Tsunami Victims

• Blood donation camps – annually donating 80 to 90 units to the blood bank in JN Hospital, Imphal

• Health awareness programs in print and electronic media

• Regular active participation in Pulse Polio Immunization

• Contribution Rs. 1 Lac to IMA building construction

• Smile Train Shija Cleft Project rendering free corrective surgical treatment facilities to cleft lip & cleft palate patients
• Shija Mission for Vision – a joint initiative of SHRI and MSBCS to provide free cataract treatment

• Annual free medical camps

2.12. Profile of District Hospital, Thoubal Khangabok

District Hospital, Thoubal is a 100 bedded Government hospital providing healthcare services in the region by more than 250 dedicated trained staff. It was implemented by MAHUD with funding from Urban Development Ministry. The hospital was inaugurated in 2011. Before the construction of the new building, the hospital was functioning in the old CHC building located at Thoubal Bazar. The actual bed strength of the hospital was 20 when the then CHC Thoubal was upgraded to hospital during April 1998.

The hospital is located at Khangabok, Thoubal district, one of the nine districts of Manipur state in northeastern India. Khangabok is one of the largest village in Manipur in terms of area and population.

The component of the hospital consist of-

1. Main Hospital Building

2. 1 Type- V Quarter

3. 5 Type- IV Quarter

4. 5 Type- III Quarter and

5. 12- LS Quarter

The main hospital building comprises of OPD block, Maternity and OT block, Pathology block and Ward block.
Besides the new modern equipments procured, Solar power plant and a dedicated underground pump system is an important feature of this hospital.

District Hospital, Thoubal Khangabok had installed 25Kg/hr incinerator which strictly follows the system of segregation of bio-medical waste at source and ultimately appropriate treatment and disposal of waste through incinerator, shredder, sharps pit, deep burial etc for the safety of environment.

Blood Bank & Transfusion Services Unit was granted license in 2014 for collection, storage and processing of whole human blood, I.

The hospital has been providing free training to the nursing institutes in various parts of Manipur. They are trained in the different departments of the hospitals for gaining exposure and hand-on experience in the field.

The hospital impart various training programmes, refresher courses, workshops, conferences, etc. in both the clinical and non-clinical areas.

### 2.12.1. Clinical Departments at District Hospital, Thoubal

- Anaesthesiology
- Dental
- Emergency
- Blood Bank & Transfusion Services
- Clinical Pathology
- Dermatology
- Paediatric
- Biochemistry
- ENT
- Orthopaedics
- Ophthalmology
- General Medicine
- Radiology & Imaging Science
- Physiotherapy & Rehabilitation
- Obstetrics & Gynaecology
- General Surgery

2.12.2. Social Services

- Health awareness programs in print and electronic media
- Regular active participation in Pulse Polio Immunisation
- Free services for treatment like Rabies and Hepatitis B vaccine
- A training centre for various nursing institutes of Manipur.
REFERENCES (for chapter 2):


