

**WOMEN DOCTORS AND NURSES IN INDIA :  
A STUDY IN SOCIOLOGY OF PROFESSIONS ✓**

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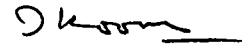
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CERTIFICATE

Certified that this dissertation entitled "Women Doctors and Nurses in India: A Study in the Sociology of Professions", by Miss. Nigar Fatima Abidi is an original work and has not been submitted previously by her for any degree to this or any other Universities. We recommended that the dissertation be placed before the examiners for evaluation.



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NIGAR FATIMA ARIDI

## PREFACE

The title of the present work spells out that it is an effort in understanding the Sociology of Profession -- an area of research, which is concerned with the attributes, emergence and growth of professions within society, their degree of professionalism and the power they wield in the overall socio-political system. There is, thus, a direct relationship between profession and social structure. Through the present study we are trying to develop some understanding along these lines in the context of medical profession in the Indian society. In more specific terms, our concern in the present study will be with the women professionals in the medical profession and those in nursing which may be recognised as a semi-profession conveniently. Medical sociology focusses its attention on two dimensions: (a) sociology of medicine, (b) sociology in medicine. Those who are interested in the former often explore the nature of medical setting, health and illness, to study such sociological phenomena as organisational role relationships, attitudes and values of persons involved in medicine. The institutional setting in which professional socialisation of the young recruits to the profession takes place, it is also covered under the field of Sociology of Medicine.

Sociology in medicine refers to studies that help to solve problems in medical sciences or to provide knowledge

about a political problem in medical practice, the allocation of health resources, operation of health facilities and services etc.

The present work is a study in sociology of medicine as it is concerned with women medical professionals and nursing professionals in an organisational context. Although doctors may work on their own, nurses work only in instrumental roles assisting the doctors either in their independent practice or in the hospital organisations.

Part of the objective in this work is to explore the apparent incongruity between the normative expectations associated with the role performance to serve of the doctors who take formal oath to serve the sick and the suffering on the one hand, and the commercial attitude they actually exhibit in their roles. These days, it is generally believed that professionals practice more often to make money and not to provide care and cure to the needy persons. This is a severe social problem. Although health care is a state responsibility but providing care and cure to the patients is of course a professional responsibility of doctors and other health professionals.

The published materials on women doctors and nurses are dismally inadequate. Even then, attempts have been made to utilize whatever material is available within the unavoidable

constraints. It is for that reason, no time sequence utilisation of the statistical data could be maintained. Therefore, there have been a few limitations in this study, namely: this study mainly focusses on the modern system of Allopathic medicine; it covers those professionals and semi-professionals which are engaged in organisations, i.e. government hospitals; and this said hospitals are located in urban areas.

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## Chapter I

### INTRODUCTION

A profession is defined as a vocation one professes with a sense of commitment, consistency and theoretical and scientific knowledge based on a prolonged specialised training of that particular work, which is derived from altruistic motive that occupations generally lack. However, occupations also specialize in certain skills. Pottery and weaving, blacksmithing etc. are illustrative of this but the major difference rests in their basic nature as occupations may be hereditary whereas professions are necessarily acquired. Also professions are institutional entities whereas occupations are essentially traditional. There is, therefore, a thin layer separating occupation from profession. In profession one enters after fulfilling essential qualifications while occupations never allow any outsider to come in.

A detached person may be inspired by only service motive to serve the people on the basis of objectivity of work. This is the key point in applying these two terms. On the other hand, professions are defined as modified forms of occupations. This is so because occupations are as old as society. It has always been a determining factor in each society whether it was a primitive or modern. We indeed know that occupations were found in many forms in the different phases of evolution of civilisations. As in pre-historic period, it was merely a

division of labour, while in the historic period, occupations were recognized in the form of certain skilled activities which were confined to the boundary of certain caste and class. "The increasing importance of profession in the occupational structure is the hallmark of modernizing and industrializing societies. This relationship between industrialization and professionalization was recognized as early as thirties in the comprehensive work on the sociology of professions" (Sarr, et.al, 1935). And has attracted attention even in Hage's (1963) paper published three decades later. The sociological explanations for the phenomenon of professionalization is given by Durkheim (1964) in his study of division of labour. According to him, increasing struggle for survival resulting from demographic complexities such as the growth in population and moral density, increase in social volume etc. leads to the development of division of labour as a strategy to increase productivity capacity. Improved productive capacity or industrialization of productive activity could then be regarded as a consequence of specialization. In response to generated social needs, this in turn causes emergence of specialized occupational groups (Gandhi, 1992, 8). This emergence influenced the entire social structure. A sharp mobilization came into existence, a major shift is seen from one job to the other because of two reasons: Availability of new jobs; and changing attitudes towards hereditary occupations.

In fact 17th century was the period of renaissance where the whole world awakened about the reality of life which provided the field to fight against the discrimination and atrocities against mankind. This was the base where intellectuals, artisans and more dominantly businessmen, traders and so forth, all had started raising the voice to get their right in the concerned field, to make policies, to protect the interests of that certain field. However, economic factor has always been a significant factor in each society. Thus, all persons were specifically attracted towards means of production. In that process classes emerged in different occupations also endeavoured to get the definition of their occupations clear and to make clear cut policies to save interest of their occupations. However, business class were far ahead of occupation else. In that they were organized in guilds designed to regulate process and to protect trading rights against the interference of Royal officials and landed magnates (Misra; 1970:7).

<sup>in</sup>  
 Therefore, the Western and the European countries a movement started with two objectives: ideal type occupations should be recognized as full-fledged professions. Those which lack one or the other characteristics of profession should be deemed as semi-professions. This could happen because of division and sub-division within an occupation or with the origin of new occupations. In India too, such professions were very much excited in the society. This is not the case that professions have migrated from the West to India. Even before the inception

of British rule, these professions were in their traditional forms. There is an evidence in Misra's view, "Indian artisans, industry occupations other specialisations were highly developed before the inception of British rule" (Misra; 1978;7). <sup>In fact</sup> what was new to the Indians was to learn an idea to establish these occupations into a well organised form and to create its safeguards against traditional business and crafts. In this process the development of professions is indeed lacked by British. Gandhi notes, "The growth of professions in India was caused not by the orthogenetic economic or technological compulsions of indigenous society, but was instead triggered by the inception and entrenchment of an exogenous rule in India" (Gandhi; 1983;4). Why so, because British attempted as a part of their educational policy to create a class comparable to their own so that it might assist them in the administration of the country and help in development of its internal resources, necessary for payment of increasing imports of British manufactures (Misra; 1978;11). Therefore, a new class emerged as a middle class. For that purpose, IES, IAS and other civil services came into being in India. Competitive examinations started just to protect the easy entrance into professions. Simultaneously, other fields like law, medicine, teaching etc. also started making a field with their boundary for non-professionals.

With the establishment of secular state, wider opportunities were opened throughout the country but there is still a low proportion of professionals. According to one estimate, the number of members in professional employment (employees in medical and health services, teachers, journalists and lawyers) in 1950s in India was 770 thousands, this increased by 1961 to 1220 thousands. Similarly, the category of administrators, executives and technicians (including clerks) increased from 2700 thousand in 1950s to 3100 thousand in 1961 (Rosen, 1966, 178). Compared to other Asian countries, however, the professional classes in India constitute a lower proportion of all workers. The professional employees per 10,000 of all workers in India is 171 as compared to 489 in Japan, 349 in China, 448 in Ceylon, 314 in Malaya and 249 in Philippines (Madan and Verma, 1971, 18). At the same time in the Asian countries the proportion of females is lower than males (Yogendra Singh, 1974, 365). This is quite clear that all the three censuses (1951, 1961 and 1971) reveal that males are more in number than females in professions and technical jobs. Although Article 15 of the Indian Constitution clearly says that women have equal right to work, but women sometime saged with the burden of social constraints and sometimes they rose up with stick to control the entire social structure. Stating the crude reality of Indian society, Balfour and Young noted, "Perhaps there is no country in the world where men and women live in different situations as in

India. The man has education, medical aid, the power to earn his living, the right to move freely and voice his grievances (Balfour and Young 1929:64).

History gives a positive proof that in the Aryan times, women appear to have held a good position in society, but it was not until later, as the Hindu women began to loose their original position of freedom like right to study, right to work etc. However, situation seems to have worsened in the medieval times with the invasions of foreign rulers — Muslims, Portuguese, French, Dutch and more so the British. Thus women lost their freedom, compelled to remain at home. In those days fear and fright were pervaded in the society. Hence Pardah, Satipratha, early marriages, unmatched marriages were the well known constraints devised to save woman's chastity. Due to fear of insecurity women were kept behind the bars like slaves until independence relieved them to move around. Then they entered into the man's world — employment market. They again suffered discrimination, inequality, injustice against them.

In the last few decades the issue 'educated woman in employment' received much attention not only from the male sociologists but also increasingly by female sociologists. A few of them are running women organisations in India. Available literature on women can be divided into two parts. One deals with the status of Hindu women and Muslim women,



traditional life, constraints and legal rights which are known against them. The other deals with the studies on problems of working women. It is true that working woman concept is itself new. Working class <sup>Women</sup> ~~men~~ grew more and more because of modern education, urbanism and scarcity of means. No doubt these already existed a female laboratory engaged in agriculture, construction, mines and industry, but because of these factors even the educated women were drawn into the employment fields. Further, because of decaying certain traditional occupations owing to technological tools and scientific applications in every walk of life, villagers were forced to seek employment in cities. As rightly Merton writes, "Through the enforced obsolescence of skills, labour saving technology produces an acute psychological and social problem for the worker. The difficulty does not lie exclusively in the need for learning new routines of work. The need for discarding acquired skills and, often the accompanying denotion of status destroys the positive self image of the worker, stemming out from the confidence use of those skills (Merton, 1938, 618). Thus after loosing the grip over traditional occupations, villagers moved to the cities with their families in hope of finding job opportunities. At the same time, middle class men who left their lands, moved to cities to seek professional employment instead of becoming cultivators or land supervisors

or sharecroppers. Simultaneously, it gave them opportunity to educate these females. This trend is termed by Andre Beteille who also joined hands with their male counterparts in professions and other services.

A third group of higher class women moved into the professions owing to the power deprivation motive rather than economic necessities.

The study of "working women" and "women in profession" both are concerned with women problems but there is a distinction between the study of problems of working women and women in profession. First is involved with the general problems of working women; physical, familial or conjugal, which results due to dual role performances, male-female relationship within the work setting. On the other hand, when we talk of women's status and women in profession, we mean, job satisfaction, professional autonomy within the professional context, more over professional commitment, degree of professionalism are studied.

Having made the concepts of working women and women in profession, it will be necessary to focus on Indian women's participation in Medieval and Nursing Professions. For this purpose it will be fruitful to have a look in order to understand Indian studies, surveys and censuses.

In India, according, to ILO study, 1970, 17 percent of the total labour force were women professionals and technical

workers, of which three fourth were teachers. The Directorate-General of Employment and Training's data show that there are selected professions in public and private sectors which identify teaching, medical and health personnel, clerical and related workers and telephone operators as the four occupations where the largest concentration of women workers are found (Government of India, Towards Equality, 1974, 206).

According to manpower survey of 1967-68, the existing medical work force comprised 12,000 women doctors. Out of a total of 1,20,000. According to 1971 Census the ratio of woman physician and surgeon is only 6.1 per hundred men - a total of 23.7 thousand women to 398.5 thousand men. The number of qualified woman doctor is however about 25 per 100 men doctors (Ibid, 206-7).

Regarding the other categories of medical personnel, there is an increase in the number of nurses, midwives and health visitors during the last two decades. Nurses and midwives constitute the largest of these groups. According to the Census of 1971, the total number of women in all category of para-medical personnel amounted to 1.95 lakhs, of which 9 lakhs were concentrated in urban areas.

### Study Design and Methodology

This study is related to women medical and nursing professionals in the organisational setting (hospitals) in

India. It is our assumption that comparatively more women than men are engaged in government organisations than in their private practice. Further they are mostly located in urban areas than in rural areas. And finally, women in medical profession are ranked lower than men. Keeping these considerations in view, we have formulated the following objectives of the study:

- 1) What is the level of participation of women in medical and nursing professions?
- 2) Why medical women are found in much larger proportions in urban areas than in rural areas?
- 3) What is the nature of role performance of women doctors and nurses in the hospitals?
- 4) What is the position of women doctors and nurses in the professional community?

#### Methods:

This study is not confined to any particular state or any particular area, but gives a picture of women doctors and nurses in the overall Indian society. Data is used in an integrated form at all-India level. Further, attributes like participation, socio-economic background and professional socialisation, attitudes and role setting will be treated as the independent variables through which influence on women's

position in the medical and nursing professions will be considered.

The present study is based mainly on the secondary sources of data such as books and articles, reports, journals, working papers (published or unpublished), theses, newspapers and for statistical data census and statistical registers or reports published by related organisations. Although such materials do not provide a comprehensive picture of the contemporary and dynamic position of women doctors and nurses in India, yet, they help to construct a general profile of professionals and semi-professionals in the country.

Chapterisation

Chapterisation scheme in the present study will be as follows;

- Chapters: I --- Introduction
- II --- Meaning of Profession and Professional Evaluation
- III --- Women Doctors and Nurses in the Context of India: A Sociological Profile
  - (A) Part One: Socio-cultural background and professional participation of women doctors and nurses
  - (B) Part Two: Socialisation and Attitudes of <sup>Women</sup> Doctors and Nurses

**(C) Part Three: Role Setting of Women Doctors  
and Nurses**

**(D) Part Four: Position of Women Doctors and  
Nurses in Professional Community**

**IV -- Women Doctors and Nurses in India;**

**A Statistical Profile**

**V -- Conclusion**

## Chapter II

### MEANING OF PROFESSION AND PROFESSIONAL EVALUATION

#### The Meaning of Work: Different Perspectives

The concept of work is as old as society. Generally, the work is used to describe the set of activities of man. Historically, the meaning of work was related to religion. As Sigmund Nešow "William H. Form argued, "In the primitive society religious activities were expected to give meaning to work" (Nešow, et.al., 1962: 11).

So let us analyse the religious meaning of work. In the light of Christian, Hindu and Muslim religions. According to Catholic tradition work is considered 'sin'. As Adriano Tilgher indicates that work for the Greeks was a curse and nothing else. According to Homer, the Gods hate mankind and out of spite condemn men to toil. Xenophone called "work the painful price the gods charge for the gods of life (Ibid, 11). According to protestant, ethic work means charity. It means that in protestant theology, work gains a positive value. In Hinduism and Islam, work is supposed to help man in his search for salvation. For instance, a Hindu does believe that if he does work which his religion demands from you, he will be in a better position in his next birth. On the other hand, in Islam work determines the position of men in the cosmic world.

Traditionally, work comprises of a set of activities hereditarily prescribed to an individual, that provides him a particular position in the society. But in modern society the meaning of work is entirely different. In the industrial era work is nothing but 'paid labour'. The joint study of Nancy G. Morse and R.S. Weiss indicates, "With the increasing complexity and industrialisation of society, work has become more and more simple a means toward the end of earning a living" (Ibid, 29).

As we see, more and more people tend to move towards the better jobs through which they can raise their standards of living. This study is concerned with the study of profession. The meaning of work has been used in terms of 'paid labour' where personnel come together in a specific profession. It is so because, each profession has its safeguards and professional interests.

### Attributes of Profession

A number of sociologists and non-sociologists have endeavoured to identify some basic attributes of profession in order to find out how a profession differs from an occupation. This is done by them in two ways. Firstly, by defining certain discriminatory characteristics of some of the well established professions such as law, medicine, engineering, teaching etc. Secondly, by explaining the developmental sequences through which an occupation becomes profession. It is so because, some professions are ideal type professions while others are



deemed-to-be profession. Thus, in order to have a clear understanding we can easily make a distinction between an occupation and a profession through some fundamental definitions.

### First Approach

Most of the sociologists have recognized some discriminatory characteristics of profession in isolating profession from an occupation. The term 'profession' as Hughes writes, "originally meant the act or fact of professing. It comes to mean, the occupation which one professes to be skilled in and to follow a vocation in which professed knowledge of some branch of learning is based in its application to the affairs of others or in the practice of an art based upon it (Hughes, 1933, 656).

It means, a profession as an art is based upon some theoretical knowledge acquired by those who are committed to its practice. It is interesting that this definition is more or less similar to that expressed in Oxford English Dictionary which defines profession as, "A vocation in which a professed knowledge of some department of learning or science is used in its application to the affairs of others or in the practice of an art founded upon it." (O.E.D., 1970, 1427).

Therefore, by applying knowledge alongwith service orientation a vocation gains professional rank. But as we find in one of the earliest sociological writings such as Flexner who noted that the term 'profession' should be used to

oppose the business or handicraft because it is a title of a peculiar distinction coveted by many persons. He further adds six criteria for distinguishing profession from other kinds of work, "Professional activity was basically intellectual, carrying with it great personal responsibility, it was learned, being based on great knowledge and not merely routine; it was practical, rather than academic or theoretic; its techniques could be taught, this being the basis of professional education; it is strongly organized eternally; and it was motivated by altruism, the professionals viewing themselves as working for some aspect of the good of the society" (Fleener quoted in Becker, 1970, 88).

Fleener's attempt was not the last, but at least the above cited characteristics are apparently revealed in the works of Carr, Saunders and Wilson, Goody, Barber, Greenwood, Tyler and others. Some of these points will be illustrated here. Carr Saunders recognizes profession as a vocation founded upon prolonged and specialized intellectual training which enables a particular service to be rendered. That is a chief distinguishing characteristic of a profession. In the same way, Tyler provides two basic attributes of a true profession to be the 'existence of a generally recognized code of ethics supported by the group discipline and professional functions are based on general principles rather than rules of thumb or routine skills (Ibid, 89). Greenwood also sums up some of the

attributes in this way 'profession seems to possess: (1) Systematic theory (2) Authority (3) Community Sanction (4) Ethical code (5) Culture' (Ibid,89).

In all we find two core characteristics, namely, a prolonged specialised training with an abstract body of knowledge, a collectivity or service orientation. It means professionals use specialised theoretical knowledge in discharging their functions and also they have a sense of collectivity which provides them safeguards and service ideal.

Second Approach

With the second approach through the developmental sequences by which an occupation becomes profession. This approach may be called processual approach as Turner and Hodge explain "the main issue is in the study of professions and professionalisation centers around the problems of distinguishing a profession from non-profession and the discerning process of professionalisation" (Jackson,1970,23).

Thus, this approach provides some useful insight in the exploration of general problems associated with studies of profession and professionalisation. That is why, Turner and Hodge (1970) have suggested four main areas of analysis; that

1. the degree of substantive theory and technique in the practising of professional or semi-professional activities;

- 2. the degree of monopoly over claimed professional or semi-professional activities;
- 3. the degree of external recognition of a profession or semi-profession;
- 4. the degree of organization of a profession or semi-profession (Gandhi, 1982; 10).

Therefore, it should be evident from the said areas that a profession rests on to what extent an occupation has professional knowledge, autonomy, ethics and professional association. Professional associat<sup>C</sup>ion is a chief distinguishing characteristic of a profession. And also the fact, that these attributes may affect the degree of professionalisation which could be understood in the context of a movement popular in America and other Western countries, while several occupations and occupational associations are trying to claim a professional rank.

In all sociological writings we find a common consensus about professional's motive. Professionals have service motive rather than to earn profit. Parsons comments on this "professional men have been thought of as standing above these sordid considerations, devoting their lives to service of their fellow men (Parsons, 1975; 43). According to him, both professions and business are equally 'acquisitive' and 'altruistic'. Parsons provides three basic characteristics which are necessary for a profession: rationality, functional specificity, universal standard.

This is the only reason, Etzioni has defined profession in the organisational form in which professionals usually work. As noted earlier, the degree of an organisation is a core characteristic of a profession. Therefore, Etzioni divides into three types;

1. Professional Organisation; This itself is divided into two sub-types;

a) Full-fledged professional organisation in which knowledge is produced, applied, prescribed, preserved or communicated, which recruits a large number of professionals on their staff in which professionals have superior authority in influencing the objectives and activities of the organisations.

b) Semi-professional organisations which employ professionals having a shorter training and less theoretical knowledge.

2. Service organisations in which the professionals are provided with the infrastructural facilities and auxiliary staff required for their work, however, they are neither employed by the organisation nor subordinated to its administrators.

3. Non-professional organisations in which the professionals are assigned to special division or positions which depend upon the situation (Etzioni, 1969, xiii-xiii).

This typology may be useful as a first step to categorize the organisational context of professional work.

In an organisation, professionals are rated by the degree of monopoly and professional status. An organisation includes both the professionals employed in fullfledged professions and semi-professions. We are interested in women professionals in the medical and nursing professions.

### Medical Profession and Social System

Medical profession is considered as intellectual or gentlemen's occupation; it gets a prestigious niche in the social hierarchy. It is so because, medical professionals in any socio-cultural setting perform one of the core functions for the perpetuation of social system. They maintain, within their limitations, public health and welfare. Of course, health problem is a state responsibility. As Coomans has explained it in this way, "health is no more a mere private worry of an individual, it is a public issue to be tackled by the state" (Coomans, 1978, 2). Thus, professionals, particularly medical professionals, get prestigious status in any society whether it is a primitive or a modern one. While nurses are considered as helpers or subordinate members although they contribute their share to the treatment process as much as the doctors do. This is so because nurses do not generate knowledge and they have a less 'say' in the diagnosis and prescribing drugs and so on.

Theoretically, one can argue that high prestige of an occupation rests on its specific functions through which one acquires power, control and wealth etc. Therefore, to understand the prestige of an occupation, it is important to know the meaning of professionals who are figured in this study. In this context we can discuss the view of Ala Schumpeter and Ben David according to them, 'professionals could be viewed as a pressure group commanding considerable resources and prestige in society'. (Schumpeter, et.al., quoted in Commen; 1978, 12). On the other hand, Parsons comments on this, "the professional man is not thought of as engaged in the pursuit of his personal profit but in performing services to his patients and clients or to impersonal values like the advancement of science" (Parsons; 1975, 55).

According to Denton, "members of a profession may come to think of themselves as professionals and act in terms of the self concept of a professional which is culturally-defined image" (Denton; 1978, 188). In the same way Vollmer and Mills write, "professionals themselves are those who are considered by their colleagues to be member of a professional group (Vollmer, et.al; 1988, 29). It is necessary to know that what professionals themselves think about their prestige and professional status. In this context Commen has done a very important study. He provides the study of relationship between

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medical profession and social system. In doing so, he has discovered three dimensions in which professional measure himself "a set of socio-economic attributes of professionals, self rating by them vis-a-vis the wider community and self rating by them in the occupational hierarchy within the organisation" (Cooman, 1978, 63).

Western and Indian studies of profession show that most of the doctors belong to middle or upper middle class families, their fathers are college educated professionals or administrators. The nurses mostly belong to lower class families. Their fathers or husbands are mostly less educated and are in semi-skilled or manual work. Thus those who belong to higher or middle class families, perceive their social rank as the highest rank but they experience power and income deprivation. Those who belong to lower class families as nurses are, mostly perceive their social status as higher but their deprivation is cultural one.

There is a tendency of self rating by professionals in the organisational context for example, what position he/she gets into the hierarchy of an organisation or in which he/she employed. In other words, professional's status is determined by the size and nature of the hospital and whether hospital is a private or a public organisation, rural or urban, state hospital or central hospital, government or semi-government hospital.



Thus in the social system not only medical professionals but all professionals' position is an important factor which determines an individual's prestige and allocation of social privileges. In this context we can apply the 'socio-economic scale' introduced by Beckman in order to measure an individual's rank in a society. As he emphasises, the rank of an occupation rests on the level of intelligence, capacity or skill, education and training, require for its pursuit. (Beckman, quoted in Caplow, 1970, 34 ).

This scale is very helpful to understand medical professionals. As we have mentioned, medical professionals are characterized by some attributes like that long period of training (five years') specialised theoretical knowledge, which is based on intellectual techniques. In fulfilled profession, knowledge is produced, applied, reserved or communicated. This is the reason why medicine professionals are considered to be respected and have a measure of high esteem in the social system. On the other hand nurses do not generate knowledge they provide only their help in the treatment process. Their training is also short and have less theoretical value. These factors are responsible for their rank as semi-professionals.

#### Evolution of Women Doctors and Nurses: An Indian Context

In all ancient professions, medical profession is one of the oldest because, whenever and wherever man first began to

care and cure for the injured, the sick, the wounded then medicine and nursing began. In order to understand the evolutionary pattern of women doctors and nurses we can go through the history of medical profession.

### Indian Context:

Like Western countries, in India too, the medical profession was associated with religion. The religious leaders, *Cojha*, were expected to cure patient. It was due to the belief, sickness is a n outcome of some evils or 'invisible' reasons and not because of physical disorders. But nursing profession was a female profession. In some earlier writings we find references to the midwives in the form of nursing profession. Altkar has noted two established professions like teaching and medicine and some semi-profession like midwives and nursing. However, on the entrance of women into these professions he emphasizes that medical profession was opened to women in the higher sections of society. But, lady doctors in the past like those in the modern age seem to be usually specializing in midwifery (Altkar, 1958).

But men have continued to study the diagnosis, etiology and treatment. The teaching of these systems was based on the writings of Charaka, Sushruta in Sanskrit, Avicenna, Al-Arabi and Al-Frabi in Arabic. In the Buddhist age, medical profession itself has enhanced its standard. In this context, Malik and

Hurallah have stated in a joint study that this profession had elevated its standard of education in the Buddhist period. They went on to show the history of professional education. According to them, "the Buddhist system of education had emphasized professional and industrial education. It includes medical studies too. Takshila was the most renowned center of medical education in the country (Haik and Hurallah, 1945)

With the establishment of the Muslim rule in India, a new system was introduced, called Unani system of medicine and medical professionals were known as Hakeems. There is no evidence that females were ever involved in medical profession. For the teaching of Unani system, some medical colleges were opened with Urdu as a medium of instruction. Although these systems were well developed with the general scientific knowledge, but they became stagnant due to failure of advancement of other sciences as in the West. Since renaissance, the experiments and observations of animals were introduced in the study of natural sciences instead of following the old techniques as before. When the Europeans established trading centres and settlements in different parts of India, they brought medical men, trained in western system of medicine from their own country to look after the health of their men. When the East India Company was established their authority became more confirmed in India and assumed the government functions, the need for maintaining

a large number of civil officers, mostly British, because became absolutely necessary to look after the medical needs for which hospitals and dispensaries were established in large numbers under British surgeons and physicians. These British doctors trained some Indians to assist them as dressers, compounders or medical orderlies.

Impressed by the skill and enthusiasm of these Indian assistants, some of the British surgeons instructed them on the general aspects of diseases and the principles of treatment. The government recognised these trained men as "native Doctors" for employment on a higher rank than the dresser and compounders provided, they passed a qualifying examination. This was the beginning of medical education on modern lines. But there was no system for selecting the candidates for the medical education (Chatterjee: 1981, 91). A Medical Board consisting of British medical officers was formed by the government, to consider the question of providing a more regular and systematic method of medical education to train "native doctors". On the recommendations of this Board, the first medical institution was established in Calcutta in 1824. Teaching was imparted through Sanskrit and Urdu languages and classes were held in Calcutta Sanskrit College and Calcutta Madrasah. Along with the study of translated texts from English medical books, the students had to study the works of Charaka, Sushruta and Avicenna. It was thus an integrated

system. The course was of three years duration and clinical teaching was given in the Native hospital, the general hospital and the Hon'ble Company's dispensaries at Colingah and Gurnahatta in Calcutta. The students were paid and had to serve the government for 15 years after qualifying the course (Ibid, 92).

Whereas women entered the medical schools seventy one years after men medical students did, the first medical schools for women was established in 1805 in Louisiana, but before this school was established a few women sailed to America for medical education. In India Madras Medical College opened its doors to women in 1875 and was followed in 1883 by the Bombay College. These were the first co-educational medical colleges. In those days, Hindu women were not allowed to go for higher education and into co-educational institutions. Thus, "Parsee women were the first to attend a complete medical course at the Universities of Calcutta, Bombay and Madras for the M.B.B.S. degree (Kapur, 1975:68).

Nathan provides a table showing state-wise distribution of women students in medical colleges and medical schools during 1901-1902 (See p.28 for Table-1).

Thus, by that time girl students had enrollment in almost all the states. Similarly health policy makers enhanced the standard medical education and opened new medical schools and medical colleges all over the country to provide better facilities for girls. The main objectives behind the health

**Table-1**

|         | Madras | Bombay | Bengal | U.P. | Punjab | Total |
|---------|--------|--------|--------|------|--------|-------|
| College | 6      | 45     | 15     | -    | 12     | 78    |
| School  | 20     | 5      | 45     | 92   | 46     | 208   |
| Total   | 26     | 50     | 56     | 92   | 58     | 242   |

Source: Nathan, 1964, Vol.2.

education policy, one was to allow women to enter the existing medical schools, the second was to found separate schools for women. The progress that was made can be assessed from the fact that within the period of 1901 to 1950, 42 medical colleges were opened which were estimated in the First Five Years Plan. Fifteen medical colleges were added during Second Plan. Following this trend of growing number of medical colleges, 30 more medical colleges were opened in the Third Plan. However, Fourth Plan could not see much increase, only 18 medical colleges were added to the total number of 87. Hence, during 1969 to 1977, total number was 105. The Fifth Plan showed a poor increase as only one medical college was opened. Since then no improvement has been made. Today we have 106 hospitals all over the country. The progress during the last six Five Year Plans in the number of hospitals is shown in Table-2;2.

Since Independence, not only medical colleges have increased in number but the courses also expanded. Some of the

**Table 2.2****Achievements in Different Plan Periods  
(Medical Colleges)**

| Plan Period (position at the end of) | Medical Colleges         |                                     |
|--------------------------------------|--------------------------|-------------------------------------|
|                                      | Total in each plan phase | Progress made during the plan phase |
| 1st Plan (1951-56)                   | 42                       | -                                   |
| 2nd Plan (1956-61)                   | 57                       | 15                                  |
| 3rd Plan (1961-66)                   | 57                       | 30                                  |
| 4th Plan (1969-74)                   | 105                      | 18                                  |
| 5th Plan (1974-78)                   | 106                      | 1                                   |
| 6th Plan (1978-79)                   | 106                      | -                                   |
| Likely achievements (1979-80)        | 106                      | -                                   |

Source: Health Statistics of India, Central Bureau of Health Intelligence, Directorate of Health & Family Welfare, Govt. of India, New Delhi, p.95. 1981

courses were abolished on the recommendations of Bhore Committee, such as licentiate in medicine in order to make medicine more skilled and intellectual work. At present, the courses are as follows: Graduation, Post-Graduation, research, diploma, and certificate courses. However, there is no evidence of separating women from any field. Hence women are also sharing the same room in medical departments.

### History of Nursing in India

History proves the fact that nursing has been recognized as an essential part of medical treatment since time is immemorial. Sushruta does mention of four feet of medicine, namely, the physician, the patient, the medicine, and the nurse, upon which a cure must rest (Wilkinson, 1958, 15]. <sup>Quoted in IAMR, Report No. 4/1966</sup> Charaka also describes the qualifications of a nurse who should, according to him, "possesses knowledge of the manner of preparing drugs or of compounding them, cleverness-devotedness to the patients, purity of mind and body" (DGHS, 1947-48, 387). Thus, the nursing work has a reference even in ancient times. In the field of medicine, Buddhist dynasty helped it to become a systematic profession, similarly, in the field of nursing also Ashoka established a large number of hospitals and defined the role of nursing. "After this should be secured body of attendants of good behaviour distinguished for purity and cleanliness of habits, possessed of cleverness and skill, endued with kindness, competent to cook food and carries, clever in rubbing or pressing the limbs, raising a patient or helping him to walk, well skilled in making or cleaning beds, able to compound drugs, always ready to serve the patient, skilful to wait upon who is ailing and, never unwilling to do what is commanded by the physician (IAMR, Report No. 4, 1966, 3).

Nursing as an occupation was first established with Army hospitals, basically for their soldiers. However, the fact is



that those who were carrying out the orders of the doctors were in the category of 'nurses'. There was a long gap of many years until the name of Florence Nightingale, famous as 'The Lady with the Lamp' became known all over the world for introducing several reforms in Army nursing during the Crimean war in the year 1854. She laid the foundation of modern nursing system. Since then upto 1910, developments of nursing education had been taking place. The period 1920-40 was one in which many developments in nursing education were taking place abroad, and nurses and in India were also aspiring towards a wider scope for nursing and opportunities for higher education. In the beginning of the present century a few schools giving training in nursing of the present century a few schools giving training in nursing and midwifery were in existence. But, during the period 1900 to 1940, 102 training schools were recognised, and other 37 were added to this list during the period of 1941-46. After independence and before the <sup>First</sup> Five Year Plan, 34 more training schools were recognised. Thus, bringing the total number of recognised training schools to 175, 67 training schools were recognised during the First Plan period, and 150 new schools were added during the Second Plan period, 46 were added during the period of 1961 to 1963 to the field of nursing education (IAEP, Report No.4, 1966, 21). Within a span of eleven years nursing institutions for the four recognised courses in 1974, rose from 458 to 606 (Government of India, 1976, 78). The four

courses remained the same since 1950s. These are; general nursing senior or A-grade, midwifery senior or A grade, auxiliary nurse midwife course, health visitor course.

In addition to the four courses dealt with earlier, there is a degree course, B.Sc (Nursing), a number of post-certificate courses, post graduate courses are opened to qualified nurses with some practical experience.

### CHAPTER III

#### WOMEN DOCTORS AND NURSES IN THE CONTEXT OF INDIA:

##### A SOCIOLOGICAL PROFILE

There are different systems of medicine practiced in the world but Allopathic Medical System is prevalent in almost all the countries. In India, there are different kinds of medical systems. For instances, four kinds of medicines are available to people such as Ayurvedic, Unani, Homeopathy, Sidha and Naturopathy. Although these systems have their roots in tradition, but the Allopathic medicine has gained currency in Indian Society due to its scientific applications to health care and treatment process, and also sent down the other indigeneous system to a lower position. This deteriorating situation was seen felt by the Health Planners and policy makers, The first education policy says that all systems of medicine - Allopathic, Ayurvedic, Unani, Sidha and Yega, Naturopathy and Homeopathy - "must draw strength and inspiration from each other. The ideological differences among different systems of medicine need to be bridged". (Indian Express, 28 April, 1979).

After independence, consistent attempts have been made in this direction; the Sixth Five Year Plan, 1980-85 has made an allocation of Rs. 270 million for the development of

these systems (Planning Commission, Sixth Plan, 370). The objectives are to improve the quality of education, promote research programmes based primarily on their respective philosophies, planned production of herbal and other medicines on a large scale and their standardization - all this with a view to minimize the gap in existing services in urban and rural areas to achieve the goal of health for all by 2000 A.D. (Banerji: 1983: 483). In order to make a balanced health policy, the idea of integration of all systems of medicine is encouraged by the planners, as recommended by the National Conference on Medical Health and Education. Not only today but before independence also, the Shore Committee recommended upgrading the medical relief, in the form of a short- and long-term plan, built upon an integrated curative and preventive services, manned by whole time salaried staff. But this idea was then and now totally opposed by the IMA and doctors in general. Indian Medical Association has been fighting to oppose any sort of integration and wanted to separate Allopathic medicine from other systems. Even the Janata regime headed by Prime Minister Morarji Desai opposed any kind of integration. He spoke at a joint conference of Central Council of Health & Family Planning, "the system of medicine could not be mixed up because they were different. If this was done, the system would be neither here nor there." (Indian Express, 28th April, 1979). Therefore, the medical

system as it is today rests upon three different poles: Health policy makers, Health Personnel and Government. The ideological differences give birth to a net of complicated situations and force medical professionals to go abroad and look for a job. At present, India is the largest exporter of doctors in the world. This constitutes a staggering drain of the cream of the country as scientific talent. For the rest, the vast majority of doctors on the medical registers are located in the more affluent sections of urban India, mostly in Metrocities, rural India gets scant medical attention (Indian Express, June, 1982), where the 60 per cent of the population lives. Jeffery writes "This is the unbalanced distribution of doctors in the country; between 67-80 per cent of the doctors are estimated to be serving the 20 per cent of the population in towns (Jeffery: 1978: 105). This trend remains the same since 1946, when the Bhere Committee came with findings; In 1946 there were 16 medical colleges, 19 medical schools training out nearly 1000 students, annually. Today we have seven times more medical colleges admitting nearly 13,000 students, annually. Even with such a gigantic increase, the rural areas remain devoid of trained medical men. Ahmad finds two reasons behind this trend. One is that, India has continued, over the last two decades, to be the major donor country in terms of medical skills to the undeveloped countries of the third world and

developed nations of the West. The second reason is, that the trained medical men, by remaining in India, do not find congenial working conditions and chances for self-realization and development. On many an occasion their total life time earnings are not even commensurate to the investments they made in receiving the medical training (Ahwad: NS: 12-13). We have already pointed out that there is a conflict between these three poles. Hence, doctors claim that, in rural areas Government has not provided even the basic facilities required by them to impart medical attention to needy patients. The arguments are as follows :

1. There are only broken down instruments to work with, medicine is hardly available to suit the needs of the patients;
2. There are no schools for children, no entertainment for wives (Patriot, 11 July, 1982).

This attitude needless, does not encourage doctors to go to villages. On the other hand, health policy makers are trying hard to increase Allopathic Medical manpower in rural areas. To achieve this such recommendations as this was made "After medical graduation, internship should be abolished and young doctors should work for two years in rural areas. This was a vital condition for eligibility for government services as well as entry for Post-Graduate courses. Another idea was proposed that in a four years' course in MD/MS of which two years should be spent in rural

areas (The Times of India, 29 August, 1979). Jeffery describes the hopeless situation in this field, "in spite of National Service Act of 1972 which empowered government to demand three years service from all doctors after graduation, the doctors have remained free from the direction of their labour (Jeffery: 1978: 105). These situations have made the sociologists and medical policy makers, terribly anxious because they are trying to provide a good health care system by 2000 A.D.

However, in the field of Nursing such conflicts do not take place. Because of bare necessities, nurses with or without hesitation, are serving in rural areas too.

After having discussed the general problems of the medical systems in India, it will be appropriate to discuss the profile of women doctors and nurses.

#### PART ONE

### SOCIO-CULTURAL BACKGROUND AND PROFESSIONAL PARTITION OF CIPA WOMEN DOCTORS AND NURSES

#### Socio-Cultural Background of Women Doctors and Nurses:

The doctors and nurses may come from different socio-cultural background and, consequently their behaviour may well be quite different. Also they may belong to different classes and with diverse demographic attributes. Therefore,

their social background must be adequately understood, which is studied in almost all the sociological studies. First of all, let us see, why all these attributes such as religion, caste, class, state of domicile, age, education and marital status are important into the consideration. This is so because, firstly these attributes are the determinants in the individual's participation in the professions and jobs secondly, these attributes influence the behaviour of professionals in their role performance. Hence these attributes are studied by a number of sociologists, i.e., S.V. Dubey (1975), T.N. Madan (1972, 1980), T.K. Oommen (1978), Ramananna Bombavale (1978), Venkataratnam (1979), Māshu Nagla (1980) and others. For some useful insight, we will discuss the general impression of these studies.

A very interesting point which needs special mention that mostly the doctors are drawn from the Hindus, It is followed by the Sikhs, the Muslim and the Christian accordingly. Apart from the general demographic factor that the Hindus, by virtue of their majority in the population preponderate in this profession too, there may very many socio-economic factors also. But owing to the paucity of resources, no observation could be highlighted to that effect without empirical data at micro-level.

Secondly, it has also been observed that among the doctors, the great majority hails from the upper sections



of the society, i.e., upper caste people from Hindus as well as from Muslims. The lower percentage of scheduled castes as well as backward classes of Muslims in this profession is only because of the gracious governmental policies towards these sections of the society. The reason is obvious, which needs further elaboration. Madan gives a special mention "medical education is very expensive and, therefore, involves a commitment on the part of whole family to invest systematically" (Madan: 1980: 52). This requirement certainly refrain lower class people sending their sons and daughters for medical education.

Thirdly, urban people, by virtue of their better accessibility to better academic institutions and other facilities have invariably edged over the rural people. This is consequent upon the factor that mostly the doctors have urban backgrounds. The doctors were found such young compared to their counterparts in any other profession. It is mainly because of the fact that as soon as they complete their MBBS degree, they start practicing. It has been found that higher studies are not pursued by the majority of the doctors, which is clear from the surveys and general observation. Owing to their better accessibility to earning their participation in higher studies declines. Finally, doctors were found married rather than unmarried.

Having an idea about the background of men doctors, it is easy to understand sociocultural background of women doctors too. A survey has been conducted by the IAMR, on women doctors in Punjab. These findings of the survey almost confirmed the factors as in the case of male doctors. From the sociological point of view, the context of marital status and their social relevance needs specific attention. In the survey, it was stated, "majority was found married that is 82.2 per cent, 11.4 percent were unmarried while 0.4 per cent were widow" (IAMR: Paper No. 1/1978: 5-8). This is also shown in Madan's study of Ghaziabad where except one female all were married. However, Venkata Ratnam (1979: 33) gives a negative picture of marital status of women doctors. Among doctors more women (74 per cent) remain single than men (26 per cent). The reasons that he gave was that the cultural values probably affected their being singles. For instance, people in Tamil Nadu generally do not prefer highly qualified women as wives as they would not be able to look after their families in a proper way. In contrast women prefer to marry men who are equally or more qualified than themselves. The preference of women for husbands from the same occupation is noted by Madhu Nagla in her dissertation. She notes that out of a total sample of 43, all three women were found to be married to men doctors, whereas only nine males preferred to marry with women doctors (Nagla: 1980)48)

This gives a negative attitude of men doctors and men in general that men prefer to marry women with lesser qualifications and under certain circumstances equally qualified women but under no circumstances they are prepared to marry women with higher qualifications. This may be a factor responsible in withdrawal of women from higher studies.

Let us now try to findout the socio-cultural background of nurses. Although not much studies are available on this topic. A few studies have been done by Gemen (1976), Venkataratnam (1979), Shayamasingh (1981) and others. In the same manner, we are stating below the general findings of these studies.

Majority of the nurses came from Christian community. Secondly, among Hindus, the majority of nurses belonged to middle order castes. From all the communities, most of the nurses did not belong to the higher income group. The reason is obvious, that nursing education is not expensive. Moreover, matriculation is the minimum requirement for entrance in nursing education.

Thirdly, the majority of nurses came from the state of Kerala. Shyama Singh stated in her study of Lucknow, "it is interesting to note that a distant place like Kerala

accounts for as high as 35.5 per cent of the nurses in the hospitals of Lucknow" (Shayama Singh, 1981: 17).

Despite the fact that Kerala is largely inhabited with Christian community, Besides, Kerala in general is educationally advanced state of India. Therefore, Kerala women in general, and Christian women in particular took up this profession in large numbers all over the country. And also, most of the nurses hailed mainly from the urban areas. This difference brings into focus how the rural society is still reluctant to send women into this profession.

Fourthly, majority of nurses were found to be within 25-30 years of age group. For Nurses, it is not surprising as the minimum requirement is of low level for entrance into nursing profession. However, it can be thought that once nurses are settled in jobs, not much interest is seen for higher education as is observed among women doctors too.

Finally, wherever data could reveal, it was found that majority of nurses were unmarried. Venkataratnam notes "they were holding a strong view that their occupation is a positive handicap for their marriage" (Venkataratnam: 1979: 34). The reasons for this handicap seems to be:

- (1) Low-ranked job;
- (2) Arduous working hours;

(3) Night calls; (4) Social inter-mixing with both the sexes; (5) Economic constraints, and (6) Religion.

Among the married, the nurses showed a preference for the same occupational background of their husbands. The reason that they felt was that economic advantages were far greater than the minor physical and occupational disadvantages that might occur if both husband and wife happen to be nurses (Venkataratnam: 1979: 34).

Thus, we can safely say that socio-cultural background have a decisive influence upon an individual to choose a particular profession.

1. Participation of Pioneering Women Doctors and Nurses

The participation of Indian women in medical profession can be traced only in late 18th century. It was 1882 when Dr. Ananthi Bai, at the tender age of seventeen left the shores of India, for America to receive medical education and 1886 was the golden year in the history of medicine when first Indian woman became medical professional to serve Indians.

The trend of women participation can be analysed in these dimensions :

1. Participation of pioneering women doctors and nurses;

- 2. Statewise participation of women doctor and nurses, urban-rural differences in the participation of women, doctors, and
- 3. Participation of women doctors and nurses by level of education and by area of specialization.

The above mentioned points will be discussed here in some detail. Anathi Bai came forward to join medicine because of her personal interest, when her own child died soon after birth and she could not get the proper care due to absence of women medical professionals. Another pioneering woman was Dr. Moti Bai Kapadia who joined the great medical college Bombay in 1884, and passed the LRCP examination in 1887 (Kapoor: 1975: 68). Moti Bai was the first trained native woman doctor who could achieve the medical degree. In those days, even in urban areas, the education of women was not encouraged. However, the social resistance could not refrain some women seeking medical education. Another woman, who rebelled against Indian traditional values to study medicine, was Dr. Rukhmabai. "She was bitterly criticized for refusing to live with her husband who filed a case against her, leading to a six month imprisonment term. A compromise was finally reached when she paid a large sum of money to him and got rid of him " (Kapoor: 1975: 69). She was the one who had obtained LRCP and MRCP degrees from

London and MD from Brussels, especially when it was difficult to women to seek admission in Medicine. When she came back to India, worked tirelessly for women and children. The environment was such that even for government scholarship advertisement such as qualifications were attached to, as women need not apply. But such women like Dr. Jeursha Jhired had courage, secured Tata Loan and went abroad (Valladares: 1969: VI: 5). Another pioneering women was Dr. Emeline De Cunha D'Costa who passed in 1902 as a Bachelor of Hygiene from the University of Durham with honours, winning the Luke Armstrong Prize in Bacteriology.

#### In the Twentieth Century:

By that time third and fourth generations of medical women entered the profession, they had become a powerful social force in Indian society. Mathula L Reddi who completed her professional course with distinction in 1907, specializing in gynaecology and child welfare, became the first female surgeon in the government hospital of Madras. Many Lakose was the first woman to be appointed as acting head of the Medical Department of Travancore State. She introduced training in hospital for delivery and tackled the problem of training midwives, organized a separate ward for children and organized child welfare schemes in the slums (Kapeer: 1975: 69). It is visible that all these

women fought against the many prejudices and social customs prevalent in their orthodox societies, with undaunted courage to give direction to a movement which at that time was in an embryonic state. This process consumed all their energy, both physical and mental, they had to pay the price in terms of loss of life or family life and very frequently, social and religious ostracism. They sowed the seed for the 20th century women leaders so that they can forge ahead and fulfil their vital roles in the medicine. Today, practically, all the doors are open to women and they are found holding a variety of posts and positions in the medical departments.

Tara Ali Beg has depicted how medical women have served India in time of war, "In the Army Medical Services, there are a large number of women of high military rank now in service such as Col. Matilda Butt and Brigadier (Miss) G.A. Ram, Matron-in-Chief of Army Headquarters, serving on the same terms and conditions as men. Major Farida Rehana, for instance, was in service with her Army surgeon husband in Bangladesh and in 1971 was with Pakistan. Farida Rehana has the added distinction of being a paratrooper and the only woman to take part in the sky-diving and para-display in the Paratroop reunion in Agra, November 1975". (Beg: 1976: 197-98).



The participation of nurses also goes back to many years, but modern nursing began only with military nursing when the influence of Florence Nightingale was widely spread in India. For many years, only government and Municipal hospitals offered training in nursing to Anglo-Indian and European girls. It was the mission hospitals again, that pioneered the training of Indian nurses. Nursing as a profession started with Kashi Bai Ganpat, who was the first woman to be trained as a nurse in 1881 in Bombay, but women were started being taken nurses on a large scale since 1910 when Bombay Presidency Nursing Association was formed (Shayama Singh: 1981: 3).

In 1907 Sat Ranade made a start in this direction by founding a Sewa Sadan Society in Poona. At first, some thirty five Hindu widows (ranging from babies to old women) lived in Mrs Ranade's house and received a thorough education. Many among them were trained professionally as nurses by qualified nursing sisters in the Sassoon Hospital. The Cama and Apley Hospitals in Bombay were also among the first few hospitals to persuade young widows to take some training in nursing. Even as late as in 1929, when Dr. J. Jhirad took over as the medical officer at this hospital, all the ward sisters were widows. Dr. Jhirad's work in the medical field has been outstanding. Miss Lavinia Mewa and Miss Maula

Bukhsa were the first two nurses trained in England through the Lady Reading Funds in 1923. Smt. S. Pathak was the first Indian nurse to win a League of Red Cross Scholarship, in 1925 (Kapoor: 1975: 70).

From the above discussion, two points are clear: one, is that western zone had a participation of nurses, second is, that most of them were widows. However, after Independence, both the trends got reversed. Today, the participation of nurses is found in all states with a distinction of high rank in southern zone and women from all the communities are engaged in nursing. A relevant study was recently made by WHO, New Delhi (Regional Office) about the participation of nurses. The findings are mentioned below:

- 1) the number of active nurses in 1975 is 1250 or one nurse per 4000 population;
- 2) currently the number of new graduates annually is 200;
- 3) the number of graduates could not be increased before 1980;
- 4) each year 10% of the active nurse leave the profession and this conditions is not expected to change in the foreseeable future (WHO: 1974: 2).

(b) Urban-Rural Differences - Statewise Participation  
of Women Doctors and Nurses

In order to have a clear understanding about the participation of women doctors and nurses, a valuable study is made by IAMR, New Delhi, on stock of Allopathic doctors in India, which shed light on the distribution of urban-rural participation in different states.

Table 3.4

MEN-WOMEN RATIO OF DOCTORS - 1961

Number of women doctors per 100 men doctors

| State           | Urban     | Rural    | Total    |
|-----------------|-----------|----------|----------|
| Andhra          | 11.5 (10) | 0.5 (18) | 10.5 (6) |
| Assam           | 6.3 (17)  | 1.0 (16) | 2.2 (19) |
| Bihar           | 7.4 (16)  | 1.5 (15) | 4.3 (17) |
| Gujrat          | 10.2 (12) | 2.0 (13) | 15.01(4) |
| Jammu & Kashmir | 18.0 (6)  | 3.2 (9)  | 15.0 (4) |
| Kerala          | 25.6 (1)  | 9.5 (3)  | 15.0 (4) |
| Madhya Pradesh  | 12.3 (8)  | 3.1 (10) | 9.5 (7)  |
| Madras          | 25.4 (8)  | 14.0 (2) | 23.7 (1) |
| Maharashtra     | 20.0 (5)  | 4.5 (7)  | 17.6 (3) |
| Mysore          | 11.7 (9)  | 2.6 (12) | 8.9 (8)  |
| Orissa          | 18.0 (6)  | 5.7 (5)  | 11.7 (5) |
| Punjab          | 9.2 (14)  | 3.5 (8)  | 6.6 (15) |
| Rajasthan       | 10.2 (12) | 2.7 (11) | 8.2 (10) |
| Uttar Pradesh   | 11.1 (11) | 5.2 (6)  | 8.3 (9)  |
| West Bengal     | 4.5 (19)  | 1.8 (14) | 3.5 (18) |
| Delhi           | 20.5 (4)  | -        | 20.5 (2) |

contd.....

Table contd...

| State                   | Urban     | Rural    | Total    |
|-------------------------|-----------|----------|----------|
| Himachal Pradesh        | 13.7 (7)  | 3.2 (9)  | 5.6 (16) |
| Tripura                 | 2.5 (20)  | 0.7 (17) | 1.1 (20) |
| Pondichery              | 5.3 (18)  | 27.7 (1) | 8.0 (12) |
| Nagaland                | 25.0 (3)  | 0.0 (19) | 8.1 (12) |
| Other Union Territories | 10.0 (13) | 7.9 (4)  | 8.2 (10) |

Figures in brackets are the ranks of the States.

Source: IANR (Report No.2/1966), Stock of Allopathic Doctors in India, Manpower Survey (Health and Manpower), New Delhi.

This table shows the distribution of the number of women doctors per 100 men doctors. In 1961, there were 9-7 women doctors for every hundred men doctors at the all-India level. The highest number of women doctors for every 100 men doctors was in Madras (24) followed by Delhi (21), Maharashtra (18) and Jammu & Kashmir (15). There were 12 women doctors for every hundred men doctors in Orissa and 8 in Pondichery. The lowest number of women doctors per 100 men doctors was in Assam (2) and Tripura (1). West Bengal with highest number of doctors had only 3.5 women doctors every hundred men doctors, Jammu & Kashmir (15.0), Madras (23.7), Maharashtra (17.6), Kerala (15.0), Orissa (11.7) and Andhra (10.5) had a woman doctor ratio which was higher than the all-India level.

Urban areas of Kerala (25.6), Madras (25.4), Maharashtra (20.0), Orissa (18.0) and Jammu & Kashmir (18.0) show a higher women doctors ratio than the All India level.

Rural areas of Madras (14.0), Kerala (9.5), Orissa (5.7), Uttar Pradesh (5.1) and Maharashtra (4.5) had more women doctors per hundred men doctors than at the All India level. The urban areas of Union territories of Delhi (20.5), Nagaland (25.0) and Himachal Pradesh (13.7), had higher women doctors ratio than the all-India average. Only the rural areas of Pondichery (27.7) had the women doctor ratio higher than the all-India level. The lowest women doctor ratio are found in the group of Eastern states - Bihar, West Bengal and Assam (Ibid, 23-24).

The distribution of nurses is also estimated by IANR in a report on 'Stock of Nursing Personnel in India', which provides an insight into statewide participation in India. For a better understanding we are stating table below :

Table 3.2

Distribution of Nursing Personnel in India by States as  
at the end of 1964

| States               | Number | Percentage |
|----------------------|--------|------------|
| 1. Andhra            | 4,112  | 9.1        |
| 2. Assam             | 1,271  | 2.8        |
| 3. Bihar             | 1,988  | 4.4        |
| 4. Gujrat            | 1,419  | 3.1        |
| 5. Jammu & Kashmir   | 73     | 0.2        |
| 6. Kerala            | 1,008  | 2.2        |
| 7. Madras            | 6,543  | 14.4       |
| 8. Maharashtra       | 10,511 | 23.2       |
| 9. Nagaland          | 61     | 0.1        |
| 10. Orissa           | 699    | 1.5        |
| 11. Punjab           | 1,915  | 4.2        |
| 12. Uttar Pradesh    | 3,344  | 7.4        |
| 13. West Bengal      | 5,088  | 11.2       |
| 14. Rajasthan        | 1,903  | 4.2        |
| 15. Madhya Pradesh   | 2,016  | 4.4        |
| 16. Mysore           | 2,680  | 5.9        |
| 17. Delhi            | 635    | 1.4        |
| 18. Himachal Pradesh | 52     | 0.1        |
| 19. Tripura          | -      | -          |
| 20. Manipur          | -      | -          |
| 21. Pondichery       | 34     | 0.1        |
| 22. NEFA             | -      | -          |
| 23. Sikkim           | -      | -          |
| 24. Andaman          | -      | -          |
| 25. Dadra            | -      | -          |
| 26. Lakshdweep       | -      | -          |
| 27. Goa, Daman, Diu  | 35     | 0.1        |

Note: Dash indicates 'Not Known' and 'not Nil'

Source: IAMR (Report No.3/1966), Stock of Nursing Personnel in India, Manpower Survey Health and Medical manpower, New Delhi, p.61.

A few lines are needed on the above mentioned table. This table shows that West Bengal and Maharashtra (the two industrially advanced states) account for over one third (34.4%) of the stock of nurses. The states of Andhra, Madras and Uttar Pradesh account for a little less than one third (30.9%) of the stock of nurses. The remaining one third of the stock of nurses is distributed in the States of Assam, Bihar, Gujrat, Jammu and Kashmir, Kerala, Orissa, Punjab, Rajasthan, Madhya Pradesh, Mysore and Delhi.

Urban rural differences in nurses' participation in the profession is given in table below :

Table 3.5

Urban-Rural Distribution

| Category  | Urban | Rural | All India |
|---|-------|-------|-----------|
| Nurses  | 61.8  | 38.2  | 100.00    |
| Midwives, Auxiliary Nurse<br>midwives and Health Visitors | 33.6  | 66.4  | 100.00    |
| T o t a l   | 50.9  | 49.1  | 100.00    |

Source: Ibid.

The table shows that 62% of the nurses are in urban India and 38% in rural India. This is an indication of the fact that majority of the nurses are in urban areas.

The trend of participation from both the tables confirms this fact that both women doctors and nurses are over concentrated in urban India. Many sociologists have tried to identify some attributes leading to this fact why health and medical personnel are in urban areas. The basic attributes are:

1. Urban background
2. Education
3. Professional Opportunity
4. Social Mobility
5. Modernization.

Needless to write that these attributes make the favourable conditions for doctors to be centred in urban areas.

### 3. Participation of Women Doctors and Nurses by Level of Education and Area of Specialization

The participation of women doctor and nurses by level of education and area of specialization will be discussed in Chapter IV in the light of statistical analyses. Here for some useful insight we are giving an estimate made by IADR. This report shows that in 1964, 27.3 per cent women were licentiates, 70.6 per cent were Graduates and 2.1 per cent post-graduates. Thus, majority belongs to graduation



level. Most of that women join medical profession after graduation and higher studies are not pursued by many women.

Table 3.7

Distribution of Registered Women Doctors by Qualification  
1964

| Category      | No           | %             |
|---------------|--------------|---------------|
| Licentiatees  | 2744         | 27.3          |
| Graduates     | 7090         | 70.6          |
| Postgraduates | 213          | 2.1           |
| <b>Total</b>  | <b>10047</b> | <b>100.00</b> |

Source: IANR (Report No.2/1966), Stock of Allopathic Doctors in India, Manpower Survey (Health and Medical Manpower Survey), New Delhi, p. 62.

At the same time, participation of women doctors by activity states also shows more or less the same picture :

Table 3.8

Distribution of Doctors by Activity States, 1961

|                                  | Women        | Total        |
|----------------------------------|--------------|--------------|
| 1. Professional                  | 96.5         | 92.2         |
| 2. Administrators and Executives | 2.0          | 4.4          |
| 3. Others                        | 1.5          | 3.4          |
| <b>Total</b>                     | <b>100.0</b> | <b>100.0</b> |

Source: Ibid, 41.

If we look at carefully, in all the aspects of medical fields, we find less orientation or low participation of women doctors. Either they will be in traditional areas or in routinized jobs. S. Padmasvati gives a very elaborate picture of medical women and their area of specialization in medicine, "the subjects chosen in order of preference among women for specialization are obstetrics and Gynaecology, Pediatrics followed by para-clinical subjects such as Anatomy, Pathology, Physiology, Pharmacology and preventive and social medicine. An increasing number of women prefer pre- and para-clinical sciences because of the regular hours of work and absence of night calls which enable them to combine family life with a professional career."(Padmasvati 1975: 256). Probably, it is true that due to dual role and family responsibility women opt these areas of specialization. However, this situation needs to further research. In the absence of empirical data, we are handicapped to produce any valuable results.

The participation of women in nursing by level of education and area of specialization can be seen from the table below.

Table 3.6

**Enrolment of Students for Degree and Post-graduate Courses  
in Nursing**

| <b>Name of the course</b>  | <b>1961</b> | <b>1962</b> | <b>1963</b> | <b>1964</b> |
|--|-------------|-------------|-------------|-------------|
| <b>A- Post-Graduate<br/>Master of Nursing</b>                    | <b>6</b>    | <b>9</b>    | <b>5</b>    | <b>11</b>   |
| <b>B- B.Sc Nursing</b>   | <b>235</b>  | <b>312</b>  | <b>339</b>  | <b>378</b>  |
| <b>C- <u>Post-Certificate</u></b>                                |             |             |             |             |
| 1. Nursing Administration  | 12          | 18          | 22          | 24          |
| 2. Sister Tutor  | 67          | 74          | 82          | 100         |
| 3. Midwifery tutor   | 10          | 12          | 12          | 13          |
| 4. Ward Sister   | 110         | 153         | 204         | 225         |
| 5. Public Health Nursing   | 69          | 95          | 104         | 101         |
| 6. Psychiatric Nursing   | 20          | 20          | 18          | 28          |
| 7. Paediatric Nursing  | -           | 8           | 8           | 10          |
| 8. Public Health Nursing<br>Supervision                          | 12          | 12          | 12          | 13          |
| 9. Post Basic for B.Sc<br>Nursing Teaching and<br>Administration | -           | -           | 10          | 27          |
| <b>Degree courses</b>  | <b>235</b>  | <b>308</b>  | <b>339</b>  | <b>378</b>  |
| <b>Postgraduate courses</b>                                      | <b>306</b>  | <b>401</b>  | <b>477</b>  | <b>552</b>  |

**Source:** IAMR (Report No.4/1966), Development of Nursing Education in India, Manpower Survey (Health and Medical Manpower), New Delhi, p. 48.

This table shows the growing trend of enrolment of women students and a net increase is found in B.Sc nursing between the period of 1961-64. Similarly, in other post-certificate courses, the enrolment has followed more or less an increasing trend. The enrolment of students for Masters of Nursing courses in 1963 have fallen with respect to the previous year. At the same time, most of the nurses preferred ward sister course which has a higher participation. However, Nursing administration, sister tutor and public health nursing also have a considerable participation.

Oommen has detected some attributes in order to highlight the educational level of nurses and their professional rank in a hospital, For this purpose, he has used a sample of 545 nurses.

Table 3.70

| <u>Attributes</u> | <u>Background of nurses</u> |                     |              |                  |                 |
|-------------------|-----------------------------|---------------------|--------------|------------------|-----------------|
|                   | <u>Only certificate</u>     | <u>Diploma</u>      |              | <u>Graduate</u>  |                 |
| Nursing Education | 304                         | 230                 |              | 4 B Sc           |                 |
| Length of Service | <u>Upto 5 years</u>         | <u>5-9</u>          | <u>10-14</u> | <u>15-20</u>     | <u>above 20</u> |
|                   | 311                         | 141                 | 53           | 17               | 23              |
| Professional rank | <u>Matron</u>               | <u>Asstt Matron</u> |              | <u>Deptt Sic</u> |                 |
|                   | 5                           | 8                   |              | 5                |                 |

Source: Oommen: 1978: 41.

These figures confirm the previous results that most of the nurses have only certificates while higher studies are negligible. We should keep in mind, this study deals Delhi

based Nurses working in hospitals. We can assume what will be the level of participation in rural areas is a matter of speculation.

## PART TWO

### PROFESSIONAL SOCIALIZATION AND ATTITUDES OF WOMEN DOCTORS AND NURSES

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#### Professional Socialization of Women Doctors and Nurses

One point is accepted in all sociological studies which defines profession, that is, prolonged specialized technical training by which a professional can be distinguished from other professionals. Thus, for the medicine and nursing professions medical schools and nursing schools are crucial elements in the process of professional training. Because they represent the institutional context in which initial socialization takes place. In this manner, a medical school is a socializing agent. This is so, because it is not only the setting in which knowledge and skills, habits, attitudes, values are transmitted, but it is also the means by which member of profession is controlled by their colleagues and the standards of training are set. It is for these reasons that the structure and functioning of medical schools are presented here in some detail.

**(a) Development of Medical and Nursing Schools**

In the modern time medical care is a state problem, the development of schools is also a state responsibility. Regarding the development of medical schools Gee delineates two trends, pointed out by Evans, which provide the rationale for contemporary medical education. "One trend is the continued expansion and development of medical knowledge and techniques, the second is the emergence of the modern University as the appropriate institutional setting for transmitting and furthering the development of knowledge and technology" (Gee: 1978: 213).

For centuries, the development of medical knowledge and technology was basically a bare necessity in medicine, observation and classification of symptoms, invention of instruments and explorations in Anatomy, Physiology and the related medical sciences were accomplished through the efforts of the individuals, often working alone, and driven by a desire to find answers to questions arising in the conduct of medical practice. Such efforts not only caused development in medical education, but also worked for nursing education. As the studies reveal, in the Nineteenth Century, either nurses were untrained or had little training. But now, nursing professional training has increased by size and nature, three-fold than what was in 19th century. Nursing schools are carrying three years Diploma, two years

associate degree programme and four years bachelor's degree programme and the Post-graduate programme, successfully.

Now schools are more equipped with scientific knowledge and professional training than ever before. As the fund of knowledge grew the focus of medical education shifted to the University centres.

**(b) Institutional Context of Medicine and Nursing Training**

The process of acquiring specific knowledge and techniques and acquiring skills, attitude and values, characteristics of medical profession take place primarily in specialized institutions, with a specific selection process, programmes of study, and, syllabi are initially considered important decisions. These attributes of educational institutions are presented here in some detail.

**(1) Selection Process**

Technically speaking, the initial institutional process is the selection of school by the students and selection of students by the school (Gee: 1978: 215).

Therefore, the selection of school is made early by the students, as most of them are attracted to this profession at an early age, 15 years or so. That is why they opt for science in under-graduation and finally apply to medical schools. The second aspect of the selection process is

that some of the applicants are admitted and some are rejected. In this regard Rodney explains why the admission process is restrictive in the medical schools. This is so because the selection of prospective students are aimed at developing criteria to predict success or failure in medical schools (ibid, 217).

In medical schools, several methods are used to obtain information on applicants, including aptitude and psychological tests, personal interviews and even the application form. Admission committees tend to depend mostly upon grades and the pre-medical test (PMT), especially, the science score. Medical colleges also test the applicant's verbal and quantitative skills and their general knowledge in non-medical subjects. Only after the successful completion of these processes, students are given admission to the medical school.

Needless to say that the admission process is same for nursing also. But the preference of women who choose the nursing as a career, do not take decision at an early age. Most of them join nursing due to bare economic necessities and not because of any kind of lure, in expectation of high rewards, as medical students do.



(b) Programmes of Study

The important decisions are required to be taken by the medical institutions at an early stage of professional training. For example, the most divisive issue is the nursing education. Today is the debate on how much education is necessary to prepare a "professional nurse". The question has been hotly debated for years, in the nursing schools, to solve the problem.

(c) Syllabus

In order to maintain utmost care of sick people, it is the responsibility of schools to make a full-fledged syllabus which can provide the required knowledge about the sickness, its diagnosis and treatment. For example, a number of studies reveal that in the traditional medical schools, the medical students were merely apothecaries and nurses were specialized in making bed and washing linen and bandages. In due course of time, the two professions have changed. The schools have revised their syllabi. In nursing syllabus, which includes subjects such as elementary Anatomy and Physiology, elementary Hygiene and Psychology, Bandaging and First Aid ethics, history of nursing, nutrition and Dietetics, elementary Physics, Chemistry, microbiology and practice of surgical and

gynaecological nursing etc (Alam, 1975;124). In the syllabus of medical education, all sciences related to medicine are studied at the level of Graduation. Surgery has become a focal point in the medical education.

### Social Process in the Medical and Nursing Schools

A number of sociological studies have focussed on the process of socialisation of the medical students for a professional role. In a medical environment, both medicine and nursing students begin to acquire more knowledge and develop skills, and most importantly they begin to interact with the faculty members, while studying actual patients. For during the clinical years these students perceive the uncertainties more in terms of a gap in knowledge than as a personal failing. This attitude too receives group support. Sociologically speaking, they form student culture in the process of professional training.

Secondly, the realisation that they simply cannot become master of all the currently available medical knowledge, they enter into specialisations. This is the only way to become competent at least in one area. This further leads to a division of labour of professional authority which is based on professional socialisation.

The third important attitude which develops in the process

training considered necessary for the professional practice, is a "detached concern", a perspective of objectivity in dealing with disease, death and human body. For example, a physician or a nurse must avoid emotional entanglements with patients, yet nurses cannot be stay detached while dealing with patients. This is so because they are motivated by humanitarian attitudes. But in the case of physicians, in order to gain objectivity, they examine the patients, and prescribe the appropriate treatment, and avoid emotional entanglements with patients. Finally, the crucial phase in the process of socialisation is internship. This is the year in the doctor's life that very powerfully moulds and influences his entire professional life. This year is the proving ground where he/she takes upon himself/herself the burden of responsibility and his/her handling of it determines his/her success or failure. As Rodney rightly stated, "Just as the three years or four years tenure of medical school is crucial to the initiation of professional attitudes and values, so the period of internship is important to the internalisation of attributes of physician's role" (Gee, 1978:218)

Thus, professional socialisation is crucial in acquiring the status of a professional where he/she learns the cultural, values, norms, code of conduct of a specific profession. As the model of medical profession is indeed migrated from the west. Hence Indian health planners have planted the same system in

India and contained it as it was in the period of British rule. Banerji notes: "The colonial character of health services had also profoundly influenced almost all aspects of medical education in India in shaping the institutions, in developing the course content and perhaps, most important of all, in shaping the value system and social outlook of Indian physician (Banerjee, 1983, 59).

Jeffery writes, why Indian medical council has accepted the British model, "the medical council of India <sup>accepted</sup> The British norms of medical education in order to gain recognition for Indian medical degrees from the general medical council of Great Britain" (Jeffery, 1979, 301-326).

Hence, accepting the same philosophy, we are made to believe that all socialising processes would be same. However as written earlier social environment would be different. Coonen has studied the sources which influenced young boys and girls to pursue their career as doctors and nurses. He found four forces working behind the selection - personal network (relatives and friends), occupational network (teachers, doctors, nurses), mass media (movies, literature, press, reports etc.) and others. In his study of doctors and nurses he found "67 percent of doctors and 45 percent of nurses were influenced by personal network in choosing their occupational careers, a limited number in all the categories; 8 percent doctors, 11

Percent nurses were influenced by occupational network. The influence of mass media was negligible as only 8 percent nurses and 2 percent doctors were influenced by this source. Other sources which included a large variety were mostly in the nature of personal contacts, which influenced 18 percent nurses, 21 percent doctors...in choosing their career (Common, 1978; 59-60). Personal network as talked by Common can be explained in terms of Father, Mother, Brother etc. who choose the career. Shyama Singh notes, "To a large extent, education and choice of profession by the children depends on the educational background of the family (Shyama Singh, 1981; 21). This is perhaps also true in case of women doctors and nurses. This trend can be checked against Nagla's findings. She, in her study tried to highlight the type of schools attended by the doctors before joining medical schools. She observed 60 percent attended government school, 28.8 percent public school and 11.1 percent other schools. She also highlighted that 60 percent joined medical school before graduation and 40 percent joined after graduation (Nagla, 1980; 51). Thus, it can be assumed that selection of a particular school is also dependent on parent's education who chooses the career for their children. No information is now available at present on nurses but we may assume that nursing was not considered by the parents to be an occupation for their children and thus no choice to particular schools. This is also true in the case of choosing the subjects.

In medicine, aspirants choose science subjects. But in case of nursing education no particular subject is needed. Madan finds in his study of Ghazipur the decision of a school about a boy or a girl of about 14 years of age, the choice of subjects or courses may not always be related to any plans for future, and indeed may not be his decision at all but that of his parents and teachers. Even when a student decides to study the particular subjects for admission to a medical college, his plans may not be materialised because of the inability of his family to pay for his medical education (Madan, 1972) 38) Thus, it may be said that the choice of medical profession depends mainly on two characteristics:

- 1) Cost of medical education and family's professional background, and
- 2) Parents education.

These two characteristics make the surrounding for child whether they will go or not for medical education.

#### Professional Attitudes of Women Doctors and Nurses

Professional attitudes may be thought in three directions:

- 1) Women professional's attitude toward medicine profession and nursing profession.
- 2) Women professionals attitude towards patients.
- 3) Public attitude toward women doctors and nurses.

These are the ways through which one can understand the attitudes of women professionals and vice-versa. Due to lack of such studies we can not prove very conclusively but it is necessary to consider the problem.

First of all, we take the women professionals' attitude towards medicine and nursing profession. As it is known that women medical students choose medicine as a career and select "science" subject at a very early age, at the under-graduate level. Therefore this trend shows their "consciousness" towards this profession. Another perspective through which attitude of women in medicine can be analysed is the "motivation" behind medicine choosing as a career. This is so because, on the part of male professionals, it seems not necessary to make the decision of whether or not to make medicine as an career, perhaps due to the societal expectations of bread winner or full time worker. But societal expectation of women on the other hand, they have to consider whether they can be professionals or housewife or both. According to a 1976 study made by Urban and Rural Systems Associates (URSA) in San Francisco Calif, male students identify financial security, a comfortable lifestyle and the status of the profession as chief attractions. While female students identify the independence and power of the role of physician, the image of humanitarianism and potential for challenging involvement as their motivation (URSA, 1976, quoted in Jones, 1979:82). No information is available about the attitudes of women doctors in India.

However, in the nursing profession, it is believed that students were less conscious to choose nursing as a career.

As Patricia helps us to understand women in this context. In the old society, nurses came from poor economic families and devoted them to religious order due to faith in God, took care of sick people due to religious reasons. Thus, unlike ancient time, in modern days, a lack of consciousness is seen among women choosing nursing as a career.

The chief cause behind this career selection for nurses was financial. They usually come from poorer families, it therefore, helps improving their social and economic status. But Commen suggests: "Nurses are motivated by humanitarian orientation which reflects in responses such as desire to serve the sick and ailing, the profession offers an opportunity to help others" (Commen, 1978:75).

Thus women doctors and nurses both find their profession humane and get an opportunity to serve the sick, old and helpless people, beside financial gains and social prestige.

The second variable which is related to professionals is the attitude towards patients. This is however clear that this study confines to an organisational setting. This is so because in the private practice attitude of physician may vary from those who are working in an organisation. Only a few studies are available related to this aspect of medical professionals. Most of the doctor's attitude were found



informal or friendly with men patients. While women doctors may have informal or friendly relationship with women patients, Pamela Jane Gray describes the attitudes of men and women professionals in medicine "that males are more likely than females to work more than 40 hours a week but women physicians like women in general population continue to shoulder the major responsibility of child care and household duties (Gray, 1980).

Therefore, we can assume that women have failed to make positive relationship with their patients, due to extra labour or dual role performance. Whereas nurses maintain a close relationship with their patients. Most of them are not leading married life.

Finally, the attitude of public towards women doctors and nurses will be examined. As regard to measure public attitudes towards women physician and nurses <sup>Ross</sup> E. Susan and <sup>Sechat</sup> Nancy in a joint study conclude that men and women have long been habituated to exposing their bodies to and being examined by male physicians; but due to an increasing number of women physicians, how people feel about being examined and treated by women physicians? In the response to this question they noted: "Despite their relatively liberal society and efforts to depict physician as gender-less image, people prefer the

same sex physician. In the clinical cases men shifted more strongly towards the male physician and women shifted toward women physician' (Ross and Sechart, 1980):61)

Thus, it may be assumed that there is a strong sense of appropriateness of sex. People do not feel comfortable with women doctors. Besides, cultural values attached to sex seclusion are in practice in Indian society, which is reflected not only in social attitudes but in terms of professional attitude too. Another factor to analyse is how people think about the prescription of male doctor and a female doctor. This is necessary because attitude reflects in liking and disliking and of a person towards an object or person. A doctor may be evaluated by prescribing drugs and medicine. A very good study related to this aspect is done by Roy Hayes, who had analysed drug prescribing and effectiveness of practitioners in the context of professional's age and sex, and concluded that old practitioners are known to prescribe a larger percentage of proprietaries more than new professionals." In relation to sex, he explained "women doctor's effectiveness and drug prescription, that female professionals were satisfactory. There were only nine females out of 40 in the sample, who prescribed more than twice the average" (Hayes, 1977):74) In his study about the user of a particular medicine, he found that all females were found user of medicine and ranked conservative while all males ranked incontinent who prescribed once. Thus public attitude towards women doctors doesnot seem

positive in any respect.

In the case of nurses, people's attitude seem to be possessive that they expect too much of nurses for example, they wish to take almost care of themselves. As a matter of fact a nurse attends more patients than a physician in order to provide lodging and boarding facilities to the patients apart from therapeutic process which includes keeping record of their temperature, time-table for providing medicine etc.

Public attitude may be thought optimistic in terms of care system but socially nurses do not get positive image. However, attitude of women doctors towards women nurses is not discussed here due to lack of relevant studies.

## PART THREE

### Role Setting of Women Doctors and Nurses

Professionals within their limitations, entrusted upon by an institution (Hospital) have to perform certain skilled and specialised tasks to fulfil the goal of that particular organisation (Hospital), that is, to provide care and cure to needy persons and a community-oriented service for the welfare of the society. Thus, in a hospital setting, we find a three tier system -- doctor-Nurse-Patient. This three tier system is controlled by an organisation. However, the supreme authority of the organisation can not be an outsider. A Doctor, on the basis of experience and seniority commands and controls the whole system, as it is observed in other bureaucratic organisations. Needless to write, that these professionals come in the hierarchical order -- Physician at the top and orderlies and attendants at the bottom. However, nurses come at the middle rank. The professional hierarchy is determined by the tasks that are to be performed by the incumbents. On the basis of performance these professionals occupy certain statuses. This is what sociologists try to identify with role setting in an organisation. It may also be added that the patient is a key figure in this setting. Both the doctor and the nurse have to look after the patient's misery and trouble; and both have to make the patient comfortable, relaxed and restored.

In the process of making patient healthy, all interact and react with each other. Thus a social situation arises which is

reflected in the behaviour of professionals and patients;

1. This process reflects in the relationship between doctor-patient and between nurse-patient relations;
2. This process creates such situation when doctor and nurse perceive their role worth or poor and develop some sort of expectation from the patient and vice-versa;
3. It may also be true that this process creates tensions and conflicts among the roles of doctors and nurses; since they are a part of society and lead normal family and social life;
4. Finally, this process brings a gap between what doctors and nurses are expected by an organisation to do and what they actually do to meet their professional commitment, or to save their hypocratic oath which they swear at the time of becoming professional.

These processes are termed by sociologists as role relationship, role perception, role performance, and role conflict. Thus, it will appropriate to throw some light on professional role of women doctors and nurses under these subtitles.

#### Role Relationship

In a hospital setting three types of role relations develop within these different functionaries. These are: professional-client relations (doctor-patient, nurse patient), collegial relations (doctor-doctor, nurse-nurse), inter-

occupation relations (doctor-nurse, doctor-administrative body relations, nurse-administrative body relations).

Commen has emphasized the occupational role relations of doctors and nurses. In his study, he found that professional client relations are informal (friendly, brotherly, sisterly). However nurses-patients relations may vary due to three factors - hospital size, rural-urban background and occupational rank. Explaining these factors, he writes: "More doctors in big and small hospitals described their relations with patient as informal equilateral as compared with doctors from medium size hospitals. But a lesser number of nurses from small hospitals characterized their relations with patients as authoritarian bureaucratic, as compared with big and medium hospitals. ... thus, in overall terms it would seem that authoritarian bureaucratic orientation in role relations are definitely associated with organizational size; the larger the organization, the greater the possibility of professionals acting in an authoritarian bureaucratic manner" (Commen, 1978; 169-70). Madan goes on to show a negative picture of professional-client relations, that is formal. He argued that doctors only see patients illness and patients treatment; they do not work for patient's welfare like suggestions on preventive medicine or family planning, a few of the leading agents of modernisation. However, he himself explained the reasons: "For hospital doctors, it is a question of examining every patient who turns up within the fixed time, and a large number of approximately 300 patients attend an outsider outdoor

ward of each hospital on every working day. Consequently, the doctor is able to spare only a very little time, seldom exceeding 5 minutes for each patient... There simply is no time for it." The second reason for the very limited role definition, according to his information is, that "the large majority of patients are illiterates or poorly educated and, therefore, do not appreciate it if the doctor tries to take a broader interest in them" (Madan, 1972:97).

Thus we find that a fear is prevalent among the patients which is discussed by various sociologists like Coomans, Venkataratnam, Ananta and others.

Hasan talks of rural patients and discusses how a gap emerges between a doctor and a patient, "the formal education of the physician and his way of living gives him a status of belonging to a wealthier class. This results in the creation of gap and distance between doctor and the village folk" (Hasan, 1979:181). Thus, in the same way Minocha shows that there exists a fear between the doctor and the patient in a hospital ward. She argues that mostly patients are ignorant, poor, illiterate, and having less or no knowledge about modern medicine, its instruments, techniques, norms and procedures;

2. The patients were not aware that doctors in the hospital constituted the differentiated categories;

3. All doctors are rich, high caste, educated, smart and fashionable (Minocha, 156). Further she adds, "Doctors normally

talked to each other in English which the patients barring three or four, could not understand" (Ibid, 168). Thus, it appears that patients feel a sort of discomfort; and doctor-patient relations can not be informal any more. Although Minocha has justified the role of doctors but she is agreed to that "Patients do not understand this part, they feel reluctant to say, or feel hesitant in saying their complaints to doctor when they visit them" (Ibid, 182). The second notion was collegial relations in the series of role relations in a hospital. In this regard, it is regretted that not much literature is available. However, we can use the findings of Coenen in order to understand collegial relations. He found that collegial relations are likely to be more hostile among doctors, and least hostile among nurses. The factors, according to him, for moulding collegial relations within a profession seems to be its internal inherent structure. Thus the higher the degree of professionalization an occupation attains, the greater its internal autonomy and the more its reliance on colleagues for evaluation and judgement relating to professional competence" (Coenen, 1970; 124).

The above cited statement can be understood in a better way by means of an example. If a student presents a thesis and external examiner evaluates his/her thesis, this evaluation may be called impersonal and therefore, felt to be impartial. But if any colleague evaluates and makes some comments, this may be termed as jealousy-oriented comments, or useless comments.



That is why doctor-doctor relations are likely to be hostile. But in case of semi-professionals such as nurses, they are not entitled to or capable of making evaluations of peers. This is because, the evaluations are made not only by professional colleagues but also by their superiors (doctors). Nurses are made to believe that superiors are prone to blame inferiors. This is the reason, "in case of those who occupy lower positions in the hospital hierarchy, hostile relations are likely to be rooted in superior-inferior relations, in contrast to those who occupy superior positions in whose case hostile relations are anchored in the peer group. Inevitably, those who occupy higher positions face hostility from two sources; equals and inferiors. Conversely, those who occupy inferior positions face hostility mainly from superiors (Coomen, 1978, 175-76).

Madan also finds "a notable fact is that doctors almost never discuss complicated or interesting cases with each other. Fear of loss of patients is real, and competitiveness is almost as prominent as in a trade (Madan, 1972, 94). This business mentality has entered the profession due to westernization, commercialisation of jobs and due to unemployment situation in India. Finally interoccupational relations, as indicated by Coomen, are informal. But doctors-nurses too perceive their relations different in different situation such as a formal situation within the hospital, and an informal situation outside the hospital. Coomen finds, "A substantial proportion of the n

expects or confirm to authoritarian behaviour in hospital situations, both formal and informal, an overwhelming majority of them show equalitarian tendency in their behaviour in situations outside hospital" (Coonen, 1978:181).

A further distinction is made by Coonen, in the relations of doctors-nurses on the basis of hospital, marital status and type of role activity. He found that in the large size of hospitals, doctors tend to behave in lesser authoritarian manner (impersonal, formal) as compared to medium or small size of hospitals and informal hospitals situation. However, when it comes to informal situation (outside the hospital) the responses of doctors working <sup>in</sup> big and small hospitals are almost identical in contrast to those working in medium hospitals.

In case of nurses "the majority of nurses accept authoritarian behaviour as natural both in the formal and informal contexts in hospitals, while an overwhelming majority of them perceive their relations with doctors as equalitarian, in informal situations outside the hospitals... Again the similarity in the response pattern of nurses from big and small hospitals persists while the nurses working in medium hospital show a different tendency" (Coonen, 1978:185-88).

On the basis of marital status, unmarried doctors are more authoritarian in their attitude to nurses as compared to

married doctors, whereas more married nurses perceive their relations with doctors as authoritarian as compared to unmarried nurses, both in formal and informal situations. On the basis of role activity, it is found that administrators show a higher authoritarian tendency and teachers show a higher equalitarian tendency in role relations and clinicians come in between. On the basis of rank that nurses occupy in their occupational stratification system, seems to affect their behaviour only in informal situations outside hospitals. Those who occupy supervisory positions are less authoritarian and more equalitarian in their relations with doctors. This may be because, as compared to nurses who occupy subordinate positions, the status gap between doctors and nurses who are occupying supervisory positions is less. This means that the lesser the status gap between two occupational categories, the greater is the possibility of developing equalitarian relations between them, particularly, in informal interactional context.

In the context of relationship between doctors and administrative body it may be stated that doctors are not supervised by seniors but evaluated by peers. Hence their relations do not seem bureaucratic oriented. Whereas, nurses are supervised by their seniors and administrators. They are more subjected to bureaucratic rules and regulations. Nurses perceive their relations as authoritarian bureaucratic.

### Role Expectation of Women Doctors and Nurses

The ideal role images of doctors and nurses in Government hospitals are perceived as "public servants" discharging their duties to the clients from whom they are legitimately not expected to receive any rewards, except in symbolic terms such as praise, respect, deference etc. These factors may structure the role perception of professionals. Commen has categorized the ideal role images into four conceptual categories:

- 1) Patient orientation
- 2) Bureaucratic orientation
- 3) Professional orientation
- 4) Personality orientation.

Explaining these attributes he has stated: (1) all three categories — doctor, house surgeon and nurses — are patient orientation. (2) The higher bureaucratic orientation of nurses as compared to doctors, including house surgeons. (3) The higher professional orientation of doctors and house surgeons as compared to nurses, although the difference becomes sharp only with the second preference (reading books and articles to keep abreast with recent developments) and the third preferences (ability to do research) but not this in the first preference (willingness and ability to apply knowledge in practical situations). (4) The total absence of personality orientation in the ideal role image contained by nurses and its near insignificance in the case of doctors! <sup>(Commen: 1978: 100)</sup> Patient orientation role image as talked about by Commen is confirmed with Jeffrey's

descriptions "One major concern of the doctor thus, has been to defend their image as community oriented. They have also been concerned with their image as scientists or as modernizing forces". Further he adds, "The favourite phrase of doctors when describing their role is to say that they are friends, philosophers and guides to their patients" (Jeffrey, 1978;195).

However, in the context of professional orientation Madan (1972;93-94) does not find higher orientation among doctors. As he notes, "Not one of the doctors defended his role in terms of medical research, not even the 2 specialists who engaged in such work while preparing for their Doctor of Medicine (M.D.) examination. Only 2 doctors have published papers but this was done while they were at college. Only 2 doctors attended a medical conference (at the expense of the employer) in the two previous years, only 15 doctors subscribe to any medical journal other than the Journal of the Indian Medical Association which the members receive free. Attendance at the monthly meetings of the local branch of the Association seldom exceeds 15 and few questions are asked of the speaker. Only half a dozen doctors were really interested in the meetings at which specialists from Delhi are invited to speak (Madan, 1972;93-94).

Venkataraman (1979;105) notes in the context of professional role expectation of doctors such as taking medical history, physical examination using laboratory help and prescribing a treatment after arriving at a sound diagnosis. The acceptance

of the professional dimension indicates that these sequence of activities expected of a physician, are taken as "necessaries" to carry out their professional role. Whereas, the professional role of nurse can be divided into different tasks; liason, physical care, supportive emotional care and patient education. However, Venkataratnam has added the academic role expectation of doctors and nurses along with other role expectations. Academic role involves teaching and research. "Teachers in higher educational institutions are supposed to guide the students and motivate them, but only to the importance of learning in a field, but also to help develop specific skills relevant to the occupation the student might take after graduation".

Academic role of nurses was also found to be the same as was described about doctors (Venkataratnam, 1979:127). Bureaucratic role may be described in the context of the organization, its rules, and ethics for doctors. Organization being maintained by the state to serve the people who seek its services should be given admission. After having admitted, if the patient is accepted as "indigent" he should be provided with all services free of charge. These two organisational requirements have been acknowledged as the expected role of doctors, bordering on affective neutrality. The other bureaucratic expected roles of doctor are; ordinary prescriptions will be written up and signed by the Assistant Medical Officer. Costly drugs requiring the sanction of the Superintendent (Medical Superintendent) will be written only by the Medical Officer

(Chief)" (Venkataratnam, 1979:138-39). Bureaucratic role expectations from the nurses is different from doctors. Punctuality should be observed by nurses. The organization permits nurses to give intra-muscular injections, but it specifically prohibits them from giving intravenous injections. This organisational requirement is upheld by majority of nurses. Welfare role expectation from both doctors and nurses are perceived in that both should take interest in the patient, apart from patient care and cure. As to provide suggestions on preventive medicine, family planning and care to be taken in between the treatment are the functions of doctors and nurses. Practice should be more community oriented. Patients should be viewed as total person and not mere individuals with a disease. The welfare role of doctors and nurses can be said to educate patients about the socio-medical problems and they should be ready to serve patient any time other than their regular duties in a hospital ward.

#### Role Performance of Women Doctors and Nurses

Role performance is an articulation of expected role or behaviour of a person which determines person's status in the society. Here this term "Role Performance" is used to describe the behaviour of women doctors and nurses in the hospital setting, where they wear the cloth of impression and action of their expected role as determined by the administrative body, professional staff and the patients. First of all, let us see

how role of doctors and nurses has changed over time. Due to change in role of doctors and nurses, their performance may differ from what actually they are expected to do. It may also create conflict in due work of doctors and nurses rather than helping them to perform their required roles. <sup>Minocha</sup> ~~Anasta~~ has rightly commented "the growth of specialisation has resulted in changing the doctor's role from a "know-all" and "cure all", generalist to a specialist to in a narrow field." <sup>Minocha: 1974:161</sup> The Editor of the Journal of the Indian Medical Association commented on it in this way: "Unfortunately, general practice and the general practitioners in India, neither get the importance nor respect from the medical profession. The present specialist-oriented medical education feels shy to pay the general practitioners' their legitimate due" (JIMA, 1980; Editorial). However, in terms of women doctors, no specific change has observed as Margaret Balfour and Ruth Young has described from the very beginning lady doctors are more or less a specialist in Obstetrics and Gynaecology" <sup>Balfour</sup> (Margaret, et.al., 1924;91). In modern medical system, a few of the women also specialise in Paediatrics and Anesthesia. Madhu Nagla found in her study, "Women Doctors prefer mainly Gynaecology, Paediatrics, Obstetrics, Anesthesia and Pathology" (Nagla, 1980:5). Madhu also noted similar trend "in actual practice all the lady doctors function as specialist concentrating on the treatment of women and children" (Madan, 1972:87).



This is evident from the above discussion that women have continued to specialise in the treatment of women and children and they are not attracted, in large number, towards such new fields of specialisation as Veterinary, Surgery and Dentistry. However, it may be noted that a few of them also see ordinary ailments of respiratory or digestive system, or ENT cases in the out-patient departments of the hospitals. In this manner we can assume that role of lady doctors are changing from specialist to a generalist, very gradually.

On the contrary the role of nurses have positively undergone change over time. In the beginning, nurses were merely help-mates of doctors (male), when nursing acquired a place with missionaries, her role was slightly changed as they were defined as mediators. This necessity arose due to the fact that Indian patients did not understand English language. They were helpless to understand what doctor said or prescribed. Since then they also began patient care and they engaged themselves in making bed, washing linen and bandages, taking care of diets and serving the patients and so on. With the passage of time they left the unclean tasks and started keeping a chart of temperature, giving medicines in time and other requirements needed by patients. In this process, they became agents of socialisation of patients.

Now the role of a nurse has entirely changed. She is no more a mediator or helper but she is a part of therapeutic process. Safdarjung Hospital Nursing Manual clearly describes the role of nurse: "Nursing means to nourish, to cherish, to protect and to support. It also means to sustain, to conserve

energy, to keep in good health and avoid injury. Nursing also means to train to cultivate, to educate and to supply with whatever promotes growth, development or process" (Saidarjung Hospital, 1967, 1967). This definition covers all roles which we have already discussed in the context of role expectations. Hence over time, the change has brought much autonomy and prestige to nursing profession as compared to past.

Therefore we can, in general, safely assert that the role of doctors and nurses has changed. Now we will throw some light on role performance of women doctors and nurses. In doing so we will first describe Coonan's findings. He has measured role performance in four categories as mentioned earlier while discussing the expectation of doctors and nurses. He found that there is a major gap what doctors expect and what they actually do in practice. "It was observed that except for a few, most of them were looked at patients not as persons but as a bundle of clinical symptoms. Therefore, doctors depended more on their own skills and diagnostic tests to know what the disease was than on what the patients said about themselves and their symptoms. Thus, there was hardly any communication between doctors and patients, and most doctors did not consider this as unethical or a lapse in their duty. (Coonan, 1978; 193-200).

The lack of communication is talked about in almost all the studies that due to fear, anxiety and lack of rapport between doctor and patient, patients hesitate to talk to doctors and

Doctors also feel that talking to a patient is a 'waste of time'. Continuing the theme, Coomra writes: "Notwithstanding the fact that doctor's role behaviour did not conform either to the expectations and clients entertained, or to the ideal role perceptions they had of themselves, or the value orientations they uphold. . . , majority of doctors in public hospitals do not consider the welfare of patients as their most important role obligation. Part of the problem emanates from the fact that overwhelming majority of patients coming to public hospitals need only routine medical treatment and doctors do not find much professional fulfilment in this" (Coomra, 1978;200-201).

Venkataratnam also corroborates the crude reality of professional performance of doctor's role, that the absence of affective neutrality was found at the group level, which is the nucleus of the profession. He found preferential treatment to patients on the basis of: (i) their own religion and caste, (ii) high economic status, (iii) high political status (Venkataratnam, 1979;179). In addition they also violate their other role expectations of bureaucratic and academic nature. The same observations are made by Madan and others. But at the same time, all sociologists have mentioned some excuse for this lapse in the role performance of doctors. These can be put in this way: more work load, the excessive hours of work, the bureaucratic nature of large hospitals, emergency calls when doctors had to be awake the whole night attending the patients and yet had to report for duty next morning. The mental strain becomes enormous

since they have to be alert all the time, ready to apply their knowledge and skill and to work amidst suffering, misery and death.

Let us study the actual role performance of women doctors. First of all, as we have already described, they mostly work as specialists as Madan also says that all the lady doctors expressed a preference for confining their professional role to the treatment of women and children because of specific needs of women patients, assistance of contracts with all kinds of male patients, or the feeling that the male patients were likely to make a misuse of themselves (Madan, 1972:292). Thus, in general, women also violate the basic attribute of neutrality of work of a profession. Kinoshita, however, also talks about the work load of lady doctors and time constraints, as she noted: "Normally the patients saw doctors in the ward two to three times a day. The doctors took their round in small groups, each consisting of doctors from different levels of the medical hierarchy. They moved slowly walking near a patient and standing on either side of her bed for ten minutes or longer or for hardly

a minute (this being a case of about one third of the patients in the ward (Minocha, 1974, 181).

Although Minocha also gives an excuse for these actions but one thing is clear that doctor's role behaviour differs from what they expect even from themselves. To prove this further a case study related to a lady Gynaecologist's role in the labour room, may be cited as provided by Hurst and others. They jointly focussed the role behaviour of lady doctors and nurses in the labour room. Many women described instances where they were cursed out by the doctor for screaming while in labour or where they were simply ignored;" (Hurst, et.al., 1980, 5121). Sexist remarks by physicians and snide comments by nurses that made the patient uncomfortable were considered almost routine.

At the same time nurses also violate the ideal role image. This is evident from all related sociological studies. We can, therefore, conclude as this <sup>research</sup> ~~was~~ the nurses seemed less committed to the profession than that the doctors were. They were satisfied by doing their jobs in a routine manner, for most of them it was just a job like any other job; the humanitarian element was entirely absent from their outlook. Their role behaviour differed substantially from the expectations that their profession and the public have demanded of them; and even from their own ideal. The nurses took the human factors much less into consideration than the doctors did, not withstanding the dominant service ethics and dedication characteristic of nursing as an

occupation. Thus although the nurses were patient oriented in their role perception, and their value orientation was humanitarian, their role behaviour was predominantly bureaucratic in orientation (Commey: 1978: 203)

### Role Conflict of Women Doctors and Nurses.

Role conflict is the result of tension and strain arising out of the multiple dimensions of a role set in an individual. In respect of doctors and nurses, a conflict is perceived between their ideal role expectation, and articulation of their role. Thus we can analyse these conflicts in three ways:

- 1) Organisational conflict
- 2) Professional conflict
- 3) Familial conflict

We have discussed that in a hospital doctors and nurses are directed to behave according to bureaucratic norms. Where 'should or should not' is clearly laid down for them by the Administrative staff. But at the same time, only a doctor must be the head of the organisation. Hence he has to perform two roles and at one point of time there may create tension which may reflect in his behaviour. As Venkataratnam notes: "A professional (doctor) occupies the administrative position he exercises his authority over this professional subordinates, most of the time on administrative matters and not on professional activities (Venkataratnam, 1979:95). The

extension of role of doctors leads to conflict between professional tasks like patient treatment, drug prescription, etc. and their personal demands to be professionals. Jeffrey commented upon "Doctors in the service system are treated purely and simply as employees (as indeed they are in other public sector settings on tea states and in the coal mines) so that they are liable to transfer and promotion on the same terms as other employees, with very little recognition of skill or ability; length of service is the main criterion for promotion, specialist qualifications are often ignored. When appointments are made, even when in services generally the medical personnel are subjected to control by administrators (Jeffrey, 1978, 108). This factor prevents doctors from becoming humanitarian towards patients and creates a conflict in their role performance. However, due to bureaucratic nature of hospitals, the state intervenes by specifying which doctor may prescribe certain drugs. There are two categories of doctors... 'specialists and others' and the various branches of the public sector decide through bureaucratic processes, in which doctors are represented but not dominant, that some drugs may only be prescribed by specialists. This has been the subject of constant conflict within doctor's role of patient treatment.

Professional conflict can be understood by knowing the nature of profession itself which is responsible for this situation. The practice of medicine for the welfare of society, and a total

denial of personal demands generates certain conflicts. Profession defines the ideal role image of doctor as "selfless image" which is equivalent to 'altruism' defined earlier. We would assume that due to selfless image of doctors and in part as human beings they perceive role conflict. As Jeffrey writes: "Professions' in underdeveloped countries are not in fact the same breed as their counterparts in the developed capitalist countries, partly because of different role by the state in these countries. True, professions have migrated from the West and especially in India, British colonial character has affected the profession which was totally different in the pre-colonial Indian society. The two notions of values, the Western professional and Indian cultural, come in conflict with each other and reflected the role behaviour of doctors.

Finally, the familial conflict is the most crucial in the lives of doctors. Commendes not find intense conflict in case of doctors. A predominantly male category of professionals (doctors) are less likely to experience intense conflicts between familial and occupational roles, as compared to an exclusive female category of professionals (nurses). However, no information is available about women doctor's familial role *Conflict* but in general women experience much tension as it is confirmed from various studies on "Problems of working women in India".



Not only in India but in the west also, women perceive familial role conflict. Simpson and Simpson (1959, 206) notes "Married women workers are apt to find that the family role competes with the work role. In this competition, work tends to come out second. The culture defines woman's responsibility to home and family as her primary one. When home and work obligations conflict, the home has to take their precedence. Woman's self-image are built chiefly around their family role, whereas man's are conditioned more by occupational roles. Moreover, women have more household tasks than men have. Such household duties as men have, can usually be routinized, scheduled, and, if necessary, postponed when work obligations intrude, but a woman cannot so easily postpone cooking dinner nor can she schedule the times when her children will need her attention."

With regard to professional work and familial work, it is the woman who has to take a middle path. In the absence of such adjustment women suffer with severe conflict. As described by Coenen, "This is because societal role definitions and expectations from these categories are radically different. In so far as the predominant societal role image of females is that of home-bound housewives and so long as they themselves would accept it, extra familial occupational roles are likely to create intense role conflicts for them, as acceptance of such roles would entail actual or imaginary inadequate performance of

traditionally defined familial roles. Conversely, the male being accepted as the chief bread-winner the societal expectations compel him to concentrate on occupational roles even at the cost of familial roles (Coomen: 1978:161)

In brief, women professionals experience much conflict as compared to male professionals. Madan also found the same situation. All lady doctors complained of the strain of combining family life with successful professional career. Given the Indian situation, the children and older people both are supposed to be pampered. It is usually the professional duties that suffer from the lack of adequate attention (Madan: 1972: 87)

However, nurses perceive much conflict as compared to women doctors. Nurses as semi-professionals, are much subjected to bureaucratic norms. We indicated earlier that rules and regulations are made by bureaucrats according to their interests. These rules misfit the expectations of the professionals, and is a source of strain and a visible conflict is reflected in the role performance of the nurses.

Venkataraman notes: "Wherever organisational demands cut across the personal, professional or group interests of these groups, they (organisational demands) are discarded and disobeyed provided, their role behaviour does not go against the essential functions of the hospitals" (Venkataraman, 1979:252). Alongwith bureaucratic rules, the occupational role of nurses

itself creates tension among nurses. The occupational role such as long working hours, night calls, emergency duty and less autonomy of giving certain injections, may be attributed to the conflict in the nurses. Also, as they receive less prestige and less professional rewards i.e. respect, honour, praise etc. it makes the nurses miserable and less oriented towards professionalism. More so by virtue of their womanhood, they swing in the conflicts of familial roles. They are more attached to the family obligations and loyalty towards joint family. It may be because of economic constraints. Hence they are more likely to face more intense conflict. However, nurses resolve this problem either by marrying male nurses or by remaining unmarried. This trend is supported by a number of sociologists. In this study, it is also mentioned that many nurses remain unmarried. However, conflict may reduce <sup>with</sup> the professional success. In other words, when the excellency and mastery of a professional is recognised in certain professional field in a distinguished manner, the professional will be adjusted to the given situation, and will be more committed to his/her profession.

## PART FOUR

### The Position of Women Doctors and Nurses in the Professional Community

Professional community means, when professionals with a particular profession acquire a "we-feeling" concept and accept it, and when a profession, like any community, makes certain rules and regulations regarding professional behaviour, code of conduct, mode of behaviour, norms and values, checks the professional's entry, defines the status, describes the role of a professional. In a professional community, position of professional is very crucial through which a person gets prestige and respect. The term position is a set of combination of status and role. Status is considered to be a social position, whereas role is considered to be a task performance. Jensen describes, it thus, "Social position has two parts; status and role, role referring to obligations, status referring to rights" (Johnson, 1980:16).

In addition, a person being a member of a society, is allowed to have certain privileges and autonomy. At the same time he/she is expected to do certain functions which are associated with that status. In this manner status is related with some kind of expectation from society while role is the expectation of performance by the person himself/herself. Hence, in a professional community, professionals are ranked in a hierarchical order. Status and role are associated with each

rank. This is also visible that professionals are mostly engaged in bureaucratic organisation where this rank system is exercised on top and nurses at the bottom. Today, this has slightly changed, the doctors remained on the top but nurses upgraded and got the fifth place from bottom. Question arises as to what status doctors occupy in a hospital and what status women get among male doctors, and to what extent women perceive discrimination or relatively lower position in the professional community.

We have already discussed that, in medical setting, in the past, doctors were found on top and nurses on the bottom. In fact there was a time when no nurse found any place for them in the medical hierarchy. Doctors, compounders and attendants all were males who were the core functionaries in medical ward. Today this attitude has changed and nurses are upgraded and found on fifth place from the bottom. Now order lies and attendants are touching the toes of a medical pyramid. Hence question arises: what status doctors occupy in a hospital and what status women get among male doctors? Upto what extent women perceive discrimination or relatively lower position in the professional community.

It is already known that women appeared in the health care system quite late, almost in the beginning of the 20th century as compared to men. Moreover, they often tend to

specialise in Gynaecology and Obstetrics rather than surgery and veterinary, mostly the muscular fields. It may be true because of the need of proper care for women patients who were and are suffering due to inadequate pre- and post natal care. However women doctors are found more conservative and routinized in the specialities as compared to men. This attitude has slightly changed overtime. Today they are offering new branches too. As we have discussed earlier that women are finding place in Paediatrics, Anaesthesia, Pathology, Para-clinical and other fields of medicine. Hence we would assume that they are becoming generalists from being specialists. If they tend to opt other fields rather than Gynaecology and Obstetrics, they will lead towards generalist rank who find 'inferior' position as compared to specialists. As we have also pointed out that costly and important drugs are prescribed only by specialists which create conflicts in generalists particularly and doctors in general. To conclude, women doctors perceive their position less prestigious because they are considered traditional or conventional and if they opt for new fields they will be described generalist, who have less prestige in the medical hierarchy. Thus, there is a need to specialize in other fields especially in 'masculine' fields, if they want to rise their position in the medical hierarchy. However, the women doctors do not show any difference in their personal attributes, i.e. education, socio-economic background, parent's education, age, salary, marital status. But they may show a negative picture in the

professional success. Personal attributes, professional autonomy or salary are not enough to raise the status of women doctors unless they get greater say in the decision making process to get an opportunity in managerial posts, or in administration. If we look carefully it is believed that situation is changing. Tara Ali Beg reports: "In medicine, not only is Indira Amla, Principal of Men's Medical College in Mysore, but in Delhi alone, four Heads of Orthopaedic Department in the leading six hospitals are women. Dr Padnavati is Director of the Maulana Azad Medical College. In 1958, Mary Poonen Luxose of Kerala was the first woman surgeon-general. It is estimated that 20 to 25 per cent of the total medical students and staff of medical institutes in India are women. Dr S. Padnavati also has the distinction of being president of Indian Academy of Medical Sciences. In international women's year, five out of the twelve scientists honoured with awards in the field of bio-medicine were women. (Beg,<sup>1976</sup> ↑199). This statement confirms that the considerable proportion of women are engaged in medical administration. We can easily say they are moving towards achieving equal positions to men. However, managerial posts are still far from the limits of women. This is partly true that few health care delivers are trained in the use of managerial skills or tools due to its separate management theory. Laxman Santharan suggests, if women want to raise their position, they should belong to the achieving class of persons -- those cadre

of men and women who put in that much additional effort and performance than the others to achieve recognition in one form or the other. This is so because "Talent does not have a gender - nor does it have intelligence". McCord Bird has identified following features of an achieving woman:

- 1) A high level of motivation and achievement need,
- 2) An identification with a field of profession
- 3) A high degree of individuality, and
- 4) Strong self esteem. (Sankaran, 1979:6).

At present women are not enjoying very sound position in the medical hierarchy. This is evident from all studies and census figures that women are holding fewer and lesser positions as compared to men. But as belonging to a fullfledged professional class they are much better placed than nurses.

Nurse's position is subjected more and less in the medical hierarchy while the role of nurse has changed a lot than what was expected in the past. We have clearly stated in the column of role performance, how nurse role changed and status also changed accordingly. Today nurse is no more a helpmate or a caretaker but a professional nurse has moved into diagnosis, treatment, and prescribing territories that were for all limits of nurse of the past. At least they are upgraded from lower cadre to middle cadre. They exercise the power over subordinates in a bureaucratic manner, especially those who are



in senior posts or in administration (nursing administration) are perceived in a relatively high position. Alongwith ICN, ANA, FNIA, Indian Nursing Association also is trying to enhance the status of nurses, to make nursing professional scientific and to get more professional attributes.

To conclude, we find a trend that women doctors experience less prestigious position as compared to man doctor. Although this is not far away when they will be equal to man doctor. But as compared to nurses they occupy high position, may be because of that fullfledged professional's attributes.

## CHAPTER IV

### WOMEN DOCTORS AND NURSES IN INDIA: A STATISTICAL PROFILE

In the earlier chapter attempts have been made to present a review of the available literature on women's participation in medical and nursing profession, their role structures and the position of women in the professional community at large. The <sup>statistical</sup> data of these studies were of remote past that is upto 1964, because of which the recent changes in the women's participation in professional employment particularly challenging professions like doctors, could not be ascertained. Hence, an attempt has been made in this present chapter to study the recent trends and pattern of female employment in medical profession at different levels. More specifically the chapter addresses to issues like Women participation at University level, zonal differences, state differences, rural-urban differences, In the female participation in Medical and Nursing professions, and opportunities provided by public, private sectors and local government concerns to the women doctors and nurses. Attempts are also made to study, the systems of medicine, women would generally prefer to choose for employment. The chapter also tries to show the present employment status of both males and females by their educational background, and their involvement in different specialized disciplines of medicine.

Table 4.1

**Trends and Pattern of Women-employment in Indian Universities during 1950-71**

| <b>Faculties</b>          | <b>50-51</b>       | <b>60-61</b>        | <b>70-71</b>        | <b>Change in</b> | <b>Change in</b> |
|---------------------------|--------------------|---------------------|---------------------|------------------|------------------|
|                           | <b>% of women</b>  | <b>% of women</b>   | <b>% of women</b>   | <b>50-60</b>     | <b>61-71</b>     |
|                           | <b>employed</b>    | <b>employed</b>     | <b>employed</b>     | <b>Compare</b>   | <b>Compare</b>   |
| <b>Arts</b>               | 16.1<br>(1,82,005) | 24.6<br>(4,86,228)  | 31.7<br>(13,29,626) | +8.5             | +7.1             |
| <b>Science</b>            | 7.1<br>(1,27,168)  | 10.5<br>(3,02,700)  | 17.8<br>(9,48,009)  | +3.4             | +7.3             |
| <b>Commerce</b>           | 0.6<br>(34,067)    | 0.9<br>(90,214)     | 3.7<br>(3,44,108)   | +0.3             | +2.8             |
| <b>Education</b>          | 32.4<br>(4,135)    | 32.8<br>(19,005)    | 36.5<br>(56,922)    | +0.4             | +3.7             |
| <b>Engg./Technology</b>   | 0.16<br>(12,094)   | 0.18<br>(45,389)    | 1.0<br>(90,034)     | +0.73            | +0.11            |
| <b>Medicine</b>           | 16.3<br>(15,260)   | 21.9<br>(32,215)    | 22.8<br>(97,601)    | +5.6             | +0.9             |
| <b>Agriculture</b>        | 0.17<br>(4,744)    | 0.45<br>(27,584)    | 0.4<br>(43,352)     | +0.28            | -0.05            |
| <b>Veterinary Science</b> | 0.45<br>(1,101)    | 0.71<br>(5,385)     | 0.7<br>(6,222)      | +0.26            | -0.01            |
| <b>Law</b>                | 2.1<br>(13,649)    | 3.0<br>(27,251)     | 3.7<br>(70,618)     | +0.9             | +0.7             |
| <b>Others</b>             | 18.8<br>(2,522)    | 26.8<br>(10,893)    | 40.0<br>(14,800)    | +8.0             | +13.2            |
| <b>All faculties</b>      | 10.9<br>(3,96,745) | 16.2<br>(10,49,864) | 21.9<br>(30,01,292) | +5.3             | +5.7             |

Figures in parentheses indicate the total number of persons employed.

Source: Towards equality, "Report of the Committee on the Status of Women in India, Govt. of India, Ministry of Education & Social Welfare, Department of Social Welfare, New Delhi, 1974, p. 241.

### Employment of Women At University Level

This section briefly reviews the trends and patterns of female employment in Indian Universities over a period of Thirty years beginning from 1950 through 1971. The analysis of the data is presented in Table 4.1.

Table 4.1 shows that over time the recruitment of females in various Indian Universities was on the increase while the overall female employment increased by 5 per cent points for 11 per cent in 1950.51 to 16.2 in 1960-61, during the succeeding decade (1960-70) the percentage of women employed increased to 22 per cent registering again an increase of 5.7 percent points.

Facultywise, analysis of the data indicates that women's participation was some what better in the faculties of 'Arts' and 'Science', education and medicine. While their participation was still marginal in the areas of Commerce, Engineering, Law and Agriculture and related sciences. However, of late, there has been steady progress in their participation in the faculty of Commerce (3.7 per cent points increase in 1961-71). A close look at the table further indicates that there has been virtual stagnation in the faculties of medicine (21.9 per cent in 1960-61 to 22.8 per cent in 1970-71), while in the faculties of Agriculture and

related sciences a negative trend has been set in. However, the Faculties of Arts and Science continues to attract the women considerably, in each of which about 7.1 per cent points increase was registered with regard to female participation.

**Table 4v2****Zonal Enrolment of Women in Medicines by Level of Education in Universities/Colleges**

| Zonal   | Graduate                       | Certificate                  | Diploma                       | Post-Graduate                 | Research                     | Total                           |
|---|--------------------------------|------------------------------|-------------------------------|-------------------------------|------------------------------|---------------------------------|
| Central   | 14.38<br>(16936)               | 0.0<br>(5)                   | 35.76<br>(439)                | 21.15<br>(1007)               | 16.13<br>(62)                | 14.97<br>(18449)                |
| Northern  | 24.91<br>(10508)               | 30.43<br>(23)                | 34.11<br>(1035)               | 26.95<br>(1028)               | 21.57<br>(51)                | 25.83<br>(12645)                |
| Eastern   | 14.63<br>(14062)               | 64.49<br>(245)               | 20.62<br>(839)                | 18.62<br>(896)                | 9.52<br>(21)                 | 15.87<br>(15763)                |
| Western   | 22.46<br>(17312)               | 23.29<br>(73)                | 21.98<br>(1215)               | 29.61<br>(2425)               | 17.65<br>(34)                | 23.26<br>(21069)                |
| Southern  | 23.48<br>(28968)               | 36.22<br>(624)               | 27.76<br>(1524)               | 19.30<br>(1927)               | 30.77<br>(18)                | 23.68<br>(33056)                |
| Birla Institute of<br>Technology and<br>Science                     | 1.56<br>(128)                  | 0.0<br>(00)                  | 0.0<br>(00)                   | 5.26<br>(19)                  | 0.0<br>(01)                  | 2.03<br>(148)                   |
| Post-Graduate Insti-<br>tute of education,<br>Research (Chandigarh) | 10.61<br>(66)                  | 0.0<br>(00)                  | 0.0<br>(00)                   | 20.16<br>(253)                | 9.52<br>(42)                 | 17.17<br>(361)                  |
| AIIMS<br>(New Delhi)  | 23.19<br>(263)                 | 0.0<br>(0)                   | 23.81<br>(21)                 | 26.15<br>(325)                | 0.0<br>(0)                   | 24.79<br>(609)                  |
| <b>Total</b>  | <b>20.25</b><br><b>(88243)</b> | <b>42.06</b><br><b>(970)</b> | <b>27.16</b><br><b>(5073)</b> | <b>24.12</b><br><b>(7590)</b> | <b>16.52</b><br><b>(224)</b> | <b>21.08</b><br><b>(102100)</b> |

Figures in parentheses indicate the total number of enrolment.

Source: Government of India: Third All-India Educational Survey; higher education during 1973-74; published by U.G.C., Ministry of Education, 1978, pp.88-89.

### Zonal Participation

In the earlier section we have seen that about 23% of the Medical Staff were females during 1970-71. Now it will be of our interest perhaps to see what would be the enrolment of women in medicines as such. Hence, in this Section, an attempt is made to study zone-wise enrolment of female student in the field of medicine. Interestingly table 4.2 shows that at all India level, 21% of the students enrolled are females. Zonewise and institutionwise data shows universities belonging to Western and Southern and Northern zones enrolled for relatively larger per cent of female students (23 to 25 per cent) as compared to the remaining zones namely Central, Eastern (about 15 per cent). The prestigious research institutions, namely AIIMS and PGI Chandigarh enrolled 25 per cent and 17 per cent female students respectively.

A close look at the table somewhat suggests that female students are also pursuing for further courses like Diploma and certificate courses after completing their basic degrees in Medicine.

Table 4.3

**Statewise Rural-Urban Differentials in Women Doctors  
Participation in India  
1971 (in %)**

| <b>State/Union Territory</b> | <b>Urban</b>     | <b>Rural</b>     | <b>Total</b>     |
|------------------------------|------------------|------------------|------------------|
| Andhra Pradesh               | 21.47<br>(5356)  | 15.04<br>(12437) | 16.98<br>(17783) |
| Assam                        | 6.03<br>(979)    | 2.97<br>(2020)   | 3.97<br>(2999)   |
| Bihar                        | 12.03<br>(3950)  | 2.82<br>(2876)   | 8.15<br>(6826)   |
| Gujrat                       | 15.18<br>(4072)  | 5.11<br>(978)    | 13.23<br>(5050)  |
| Haryana                      | 15.38<br>(845)   | 3.12<br>(1280)   | 8.00<br>(2125)   |
| Himachal Pradesh             | 20.48<br>(210)   | 4.17<br>(168)    | 13.23<br>(378)   |
| Jammu & Kashmir              | 24.61<br>(768)   | 6.52<br>(211)    | 21.14<br>(979)   |
| Kerala                       | 29.19<br>(2295)  | 13.16<br>(1900)  | 21.93<br>(4195)  |
| Madhya Pradesh               | 15.57<br>(4623)  | 5.70<br>(1930)   | 12.67<br>(6553)  |
| Maharashtra                  | 22.41<br>(11674) | 5.25<br>(4571)   | 17.64<br>(16445) |
| Manipur                      | 22.89<br>(83)    | 6.49<br>(231)    | 10.83<br>(314)   |
| Meghalaya                    | 15.79<br>(152)   | 2.22<br>(45)     | 12.69<br>(197)   |
| Mysore                       | 15.59<br>(465)   | 5.04<br>(2181)   | 12.22<br>(6832)  |
| Nagaland                     | 8.33<br>(36)     | 10.71<br>(28)    | 9.37<br>(64)     |
| Orissa                       | 21.30<br>(1779)  | 13.13<br>(990)   | 18.38<br>(2769)  |
| Punjab                       | 14.70<br>(2585)  | 5.13<br>(780)    | 12.48<br>(3365)  |
| Rajasthan                    | 15.79<br>(2559)  | 1.43<br>(1325)   | 10.89<br>(3884)  |

(contd....)



**Table 4.3 contd....**

|                      |                 |                 |                 |
|----------------------|-----------------|-----------------|-----------------|
| Sikkim               | 0.0<br>(10)     | 0.0<br>(13)     | 0.0<br>(23)     |
| Tamil Nadu           | 25.54<br>(6614) | 11.97<br>(1587) | 22.91<br>(8201) |
| Tripura              | 9.32<br>(118)   | 0.35<br>(284)   | 2.99<br>(402)   |
| Uttar Pradesh        | 8.46<br>(6214)  | 4.77<br>(6456)  | 6.58<br>(12670) |
| West Bengal          | 8.57<br>(11380) | 3.64<br>(7140)  | 6.67<br>(18520) |
| Andman Nicobar       | 30.00<br>(10)   | 8.33<br>(12)    | 18.18<br>(22)   |
| Arunachal Pradesh    | 8.33<br>(24)    | 4.26<br>(47)    | 5.63<br>(71)    |
| Chandigarh           | 20.04<br>(509)  | 50.00<br>(2)    | 20.16<br>(511)  |
| Dadra & Nagar-Haveli | -               | 0.0<br>(8)      | 0.0<br>(8)      |
| Delhi                | 28.26<br>(4179) | 11.54<br>(78)   | 27.95<br>(4257) |
| Goa & Daman-Diu      | 20.06<br>(354)  | 6.17<br>(227)   | 14.63<br>(581)  |
| Lakshdweep           | -               | 0.0<br>(8)      | 0.0<br>(8)      |
| Pondichery           | 18.71<br>(278)  | 15.15<br>(33)   | 18.33<br>(311)  |

Figures in parentheses give the total number of doctors.

Source: Census of India, 1971, General Economic Tables.  
Part II-B (IV) (Table B-V), vol. I + II  
Government of India, New Delhi.

**Statewise Rural-Urban Differentials in Women Participation  
in Medicine**

Table 4.3 shows that participation of women doctors in employment in different states is in consistent with an earlier observation on their enrolment in the field of medicine. For example, the Southern States like Kerala, Tamil Nadu, the participation rates were as high as around 22 per cent of the total number of doctors employment. The states belonging to Western Zone, like Maharashtra, Gujrat, the participation ranged between 13-18 per cent. Interestingly the participation rates in Jammu-Kashmir was as high as 22 per cent and at par with some of the good states like Tamil Nadu and Kerala. The states where participation rates were not even 10 per cent were Assam (4 per cent), Uttar Pradesh (7 per cent), West Bengal (7 per cent), Bihar (8 per cent).

As far as among the Union Territories, Delhi (27 per cent), Chandigarh (20 per cent), Pondichery (18 per cent) were the best in terms of providing opportunities to the women doctors.

As regards to urban-rural differentials, Table 4.3 shows the observation remains same in the sense that again in urban areas of Kerala the participation was as high as 29 per cent followed by Tamil Nadu (25.5%), Jammu-Kashmir

(24.6%), Maharashtra (22.4%) and Himachal Pradesh (20.5). Interestingly, the states where the participation was below 10 per cent even the performance in urban areas too the participation rate is below ten per cent.

Among the Union Territories, data show that same pattern in urban areas too. In the case of rural areas, participation of women seeming to be not satisfactory. The maximum participation was the order of 15 per cent in Andhra Pradesh followed by Kerala (13 per cent) and Orissa (13 per cent), Tamil Nadu (12 per cent). In the remaining major states, such as Uttar Pradesh, West Bengal, the participation rates were around only 5 per cent.

Table 4.4

**Statewise Urban Rural Differentials in Women Participation  
In Nursing in India**

| State/Union Territory  | Urban            | Rural           | Total            |
|------------------------|------------------|-----------------|------------------|
| 1. Andhra Pradesh      | 92.12<br>(5645)  | 76.47<br>(1020) | 89.72<br>(6665)  |
| 2. Assam               | 92.6<br>(1015)   | 81.35<br>(1019) | 86.97<br>(2034)  |
| 3. Bihar               | 95.34<br>(2469)  | 91.84<br>(1911) | 93.81<br>(4380)  |
| 4. Gujrat              | 97.97<br>(3618)  | 63.96<br>(1881) | 86.31<br>(5499)  |
| 5. Haryana             | 98.08<br>(780)   | 88.94<br>(633)  | 93.98<br>(1413)  |
| 6. Kerala              | 95.04<br>(3160)  | 94.42<br>(5020) | 93.89<br>(8180)  |
| 7. Tamil Nadu          | 92.85<br>(7061)  | 81.17<br>(3089) | 90.51<br>(10150) |
| 8. Maharashtra         | 98.61<br>(12977) | 80.19<br>(2780) | 95.49<br>(15757) |
| 9. Nagaland            | 98.26<br>(115)   | 90.96<br>(166)  | 93.95<br>(281)   |
| 10. Orissa             | 91.92<br>(1608)  | 80.82<br>(1512) | 86.54<br>(3120)  |
| 11. Punjab             | 97.12<br>(1215)  | 90.60<br>(9577) | 94.24<br>(2172)  |
| 12. Uttar Pradesh      | 94.39<br>(3923)  | 80.69<br>(1502) | 90.60<br>(5485)  |
| 13. West Bengal        | 92.21<br>(9814)  | 86.52<br>(3710) | 90.58<br>(12894) |
| 14. Rajasthan          | 97.10<br>(2935)  | 88.38<br>(1385) | 94.31<br>(4320)  |
| 15. Madhya Pradesh     | 97.63<br>(4858)  | 75.25<br>(1899) | 91.34<br>(6757)  |
| 16. Mysore (Karnataka) | 90.11<br>(5513)  | 73.61<br>(1815) | 86.03<br>(7328)  |
| 17. Delhi              | 95.60<br>(3045)  | 80.00<br>(50)   | 95.35<br>(3095)  |

Table 4.4 (contd...)

|                        |                |                |                |
|------------------------|----------------|----------------|----------------|
| 18. Himachal Pradesh   | 96.43<br>(476) | 94.71<br>(227) | 95.87<br>(703) |
| 19. Tripura            | 99.05<br>(211) | 84.83<br>(178) | 92.54<br>(389) |
| 20. Manipur            | 95.09<br>(163) | 52.27<br>(314) | 66.25<br>(477) |
| 21. Meghalaya          | 97.65<br>(341) | 97.70<br>(87)  | 97.66<br>(428) |
| 22. Jammu-Kashmir      | 97.73<br>(396) | 64.23<br>(137) | 89.12<br>(533) |
| 23. Sikkim             | 88.34<br>(34)  | 100.0<br>(32)  | 93.94<br>(66)  |
| 24. Arunachal Pradesh  | 100.0<br>(6)   | 78.05<br>(41)  | 80.85<br>(47)  |
| 25. Chandigarh         | 100.0<br>(298) | 15.79<br>(19)  | 94.95<br>(317) |
| 26. Dadra Nagar-Haveli | -              | 100.0<br>(8)   | 100.0<br>(8)   |
| 27. Pondichery         | 88.59<br>(366) | 92.31<br>(52)  | 89.00<br>(418) |
| 28. Goa, Daman & Diu   | 85.16<br>(438) | 90.13<br>(223) | 86.84<br>(661) |
| 29. Lakshdweep         | -              | 90.00<br>(10)  | 90.00<br>(10)  |

Figures in parantheses give the total number of Nurses

Source: Census of India, 1971, General Economic Tables, Part II-B (IV) (Table B-V) Vol. I + II, Government of India, New Delhi.

This table 4.4 brings into focus the participation of women in Nursing Profession in different states and Union Territories of India. It is interesting to see that in almost all the states, the nursing profession is taken over by females only, for example, Maharashtra as high as 95 per cent of the nurses are females. Similarly large percentage of women can be seen from the Table. However, in Manipur state, 33 per cent were constituted by males. Other states where males are also participating nursing like Mysore, Orissa, Gujrat and Assam, where about 15 per cent of the nurses were males.

An urban-rural break-up data suggests that while in urban areas of many states, nursing profession was dominated by women. In rural areas, at least in certain states males also participated considerably, for example, in states like Andhra Pradesh, Madhya Pradesh, Karnataka around 25 per cent of the nurses were males. In Gujrat state, the corresponding percentage were as high as 36.

These minor rural-urban differentials in women participation in nursing might be due to lack of favourable conditions particularly for women in rural areas.

**TABLE: 4.5: Levels and changes in the Recruitment of Women doctors in different specialities by Private & Public Sectors during 1975-78 specialisations**

| Specialisation                     | Private Sector                |                                |              | Public Sector                  |                                |            |
|------------------------------------|-------------------------------|--------------------------------|--------------|--------------------------------|--------------------------------|------------|
|                                    | 1973                          | 1977                           | % change     | 1974                           | 1978                           | % change   |
| Physician General                  | 19.60<br>(3347)               | 23.95<br>(4217)                | + 4.35       | 15.57<br>(13540)               | 17.03<br>(18558)               | 1.46       |
| Surgeon General                    | 21.80<br>(344)                | 18.80<br>(399)                 | - 3.00       | 19.61<br>(6473)                | 17.04<br>(7980)                | 2.57       |
| Psychiatrist<br>Physician          | 15.15<br>(33)                 | 23.00<br>(39)                  | + 7.93       | 4.10<br>(195)                  | 22.62<br>(84)                  | 18.52      |
| Neurologist                        | 80.00<br>(5)                  | 0.0<br>(2)                     | -            | 8.00<br>(25)                   | 14.29<br>(14)                  | 6.29       |
| Dermatologist                      | 33.33<br>(42)                 | 0.0<br>(11)                    | -            | 8.43<br>(83)                   | 0.0<br>(11)                    | 8.43       |
| Ear, Nose, Throat<br>Specialist    | 0.0<br>(3)                    | 0.0<br>(13)                    | -            | 9.00<br>(100)                  | 4.00<br>(25)                   | 5.00       |
| Cardiologist                       | 4.55<br>(22)                  | 18.18<br>(11)                  | +13.63       | 15.71<br>(70)                  | 57.14<br>(84)                  | 41.43      |
| Tuberculosis<br>Specialist         | 0.0<br>(11)                   | 31.25<br>(16)                  | +31.25       | 4.71<br>(85)                   | 1.90<br>(105)                  | 2.81       |
| Ophthalmologist                    | 5.13<br>(78)                  | 9.01<br>(66)                   | + 3.96       | 6.25<br>(32)                   | 10.67<br>(75)                  | 4.42       |
| Venereologist                      | 0.0<br>(1)                    | 33.33<br>(9)                   | 33.33        | 6.02<br>(83)                   | 8.33<br>(12)                   | 2.31       |
| Obstetrician                       | 40.00<br>(5)                  | 18.18<br>(11)                  | 21.82        | 87.50<br>(8)                   | 25.49<br>(51)                  | 62.01      |
| Gynaecologist                      | 90.18<br>(34)                 | 84.48<br>(58)                  | 6.70         | 48.98<br>(49)                  | 71.05<br>(76)                  | 22.07      |
| Paediatrician                      | 45.45<br>(11)                 | 44.00<br>(25)                  | 1.45         | 22.22<br>(72)                  | 23.40<br>(47)                  | 1.00       |
| Orthopaedist                       | 13.79<br>(29)                 | 30.77<br>(26)                  | 16.98        | 11.54<br>(52)                  | 21.95<br>(41)                  | 10.41      |
| Medical and Surgical<br>Specialist | 2.48<br>(4356)                | 24.56<br>(5636)                | 22.08        | 19.55<br>(37)                  | 17.03<br>(30)                  | 2.52       |
| Anatomist Medical                  | N.A.                          | 32.76<br>(58)                  | -            | 13.24<br>(476)                 | 18.05<br>(338)                 | 4.81       |
| Anaesthetist                       | N.A.                          | 38.55<br>(83)                  | -            | 37.58<br>(149)                 | 10.31<br>(97)                  | 27.27      |
| Radiologist                        | N.A.                          | 9.38<br>(32)                   | -            | 7.63<br>(131)                  | 1.92<br>(104)                  | 5.71       |
| <b>Total =</b>                     | <b>10.92</b><br><b>(8321)</b> | <b>24.44</b><br><b>(10712)</b> | <b>13.52</b> | <b>70.11</b><br><b>(25377)</b> | <b>70.11</b><br><b>(57834)</b> | <b>0.0</b> |

An analysis of the data on recruitment of women to the different specialization of medicine in both private and public sectors is presented in Table 4.5. The data refers to the situation prevailing at two points of time in 1973 and 77 for private sector and 1974 and 1978 for public sectors. An attempt is made to gauge the improvements in women's participation in medical profession across the public and private sectors on the one hand and over the two points of time. The data indicates that in the areas of obstetrician a 62 per cent increase in women participation in public sector was registered, followed by the category of cardiologists (41.43 per cent), anaesthetists (27.3 per cent), Gynaecologists (22.1 per cent), psychiatrists (18.5 per cent) compared to the increase of women participation in public sector, in the private sector woman participation was however registered mostly in the category of medical and surgical specialities (22.1 per cent), followed by obstetrician (21.8 per cent), cardiologists (13.6 per cent). However, other fields had registered a marginal increase both in private and public sector (see Table 4.5).

A comparison of the increase of women participation in medical profession in private vis-a-vis public sector indicates that while in public sector the women participation



has increased many fold, it has not shown such a trend in private sector.

This trend shows women preference for working in government organizations rather than private organizations, Also as we have already discussed in Chapter III that the main field of specialization for women in the earlier years had primarily been Gyneacology and obstetrics. In the recent years, more and more women are entering areas of medical specialization other than the ones in which they have been traditionally specializing. This is indicative of the women doctors becoming more generalists rather than specialists in a certain field. The data confirms the observations.

TABLE 6: Women Participation in Ayurvedic, Homeopathic and Unani System of Medicine

| Classification<br>of occupation | Private Sector |                |          | Public Sector  |                |          |
|---------------------------------|----------------|----------------|----------|----------------|----------------|----------|
|                                 | 1973           | 1977           | % change | 1974           | 1978           | % change |
| <b>Physician Ayurvedic:</b>     |                |                |          |                |                |          |
| Physician<br>Ayurvedic          | 8.85<br>(373)  | 9.76<br>(379)  | 0.91     | 4.76<br>(7880) | 4.17<br>(9132) | 0.59     |
| <b>Physician Homeo:</b>         |                |                |          |                |                |          |
| Physician<br>Homeopathic        | 12.50<br>(56)  | 16.28<br>(86)  | 3.78     | 4.92<br>(366)  | 6.30<br>(651)  | 1.38     |
| Physician<br>Bio-Chemic         | 7.25<br>(69)   | 18.45<br>(103) | -        | 13.30<br>(45)  | 9.09<br>(22)   | 4.21     |
| <b>Physician Other:</b>         |                |                |          |                |                |          |
| Physician Unani                 | 1.14<br>(88)   | 3.85<br>(26)   | 2.71     | 7.61<br>(578)  | 4.67<br>(321)  | 2.94     |
| Physician<br>Naturopathy        | 0.0<br>(97)    | -              | N.A.     | -              | -              | -        |

Source: D.G.B & T, "Occupational Pattern in Private and Public Sectors during 1973-78 (Tabulation Register)", Ministry of Labour, Government of India, New Delhi.

**Table 4.6**

The women participation in other systems of medicine such as Ayurvedic, Homeopathic, Unani, Naturopathy, Dentist, and Veterinary sciences has been gauged through a similar set of data on private and public sector for over two points of time. The data are presented in Table 4.6. The data suggest that in Homeopathic system of medicine, the women participation had increased by 4.2 per cent. in Public sector specially in the field of Bio-chemic Physicians, while in the case of Unani the women participation had witnessed an increase of 2.94 per cent. In other systems of medicine the women participation has increased merely by less than a per cent (ranging between 0.22 per cent to 0.90 per cent) in public sector. A similar pattern was discernable in the private sector.

**TABLE 4.7: Levels and Changes in the Recruitment of Nurses, Other Medical Health Workers by Private and Public Sectors During 1973-78**

| Distribution of occupation | Private Sector   |                  |         | Public Sector     |                   |         |
|----------------------------|------------------|------------------|---------|-------------------|-------------------|---------|
|                            | 1973             | 1977             | % diff. | 1974              | 1978              | % diff. |
| Nurse General              | 88.60<br>(8446)  | 88.04<br>(10118) | 0.56    | 79.70<br>(34976)  | 86.94<br>(40799)  | 7.24    |
| Nurse specialised          | NA               | 86.30<br>(294)   | †       | 74.21<br>(981)    | 95.15<br>(557)    | 20.94   |
| Nurse Industrial           | 86.05<br>(988)   | 88.27<br>(375)   | 2.24    | 86.38<br>(1285)   | 86.82<br>(402)    | 0.44    |
| Professional Nurse         | NA               | 88.03<br>(11271) | -       | 69.94<br>(2213)   | 87.09<br>(42073)  | 17.15   |
| Mid-wife                   | 17.89<br>(1808)  | 90.94<br>(2517)  | 73.05   | 94.13<br>(27096)  | 91.77<br>(33922)  | 2.36    |
| Lady Health Visitor        | 64.71<br>(68)    | 94.37<br>(71)    | 29.66   | 86.72<br>(35586)  | 72.57<br>(6816)   | 14.05   |
| Total =                    | 88.12<br>(11310) | 88.32<br>(24644) | 0.21    | 85.64<br>(103137) | 87.56<br>(124569) | 1.92    |

Source: D.O.B & T, "occupational pattern in private and public sectors during 1973-78 (Tabulation Register), Ministry of labour, Government of India, New Delhi.

**Table 4.7**

Table 4.7 presents the extent of women participation in Nursing, mid-wifery and lady health visitors professions. The data reflects that while in the public sector there was a phenomenal increase of 20.94 per cent in women participation in specialized nursing, it was 17.15 per cent in professional nurse. The women participation in the lady health visitors profession had, however, registered an increase of 14.15 per cent in public sector while it was 29.66 per cent in Private sector. In the midwifery category, there seems to have been a sudden spurt of women participation in private sector as is evinced by an increase of 73.05 per cent over the period of 1973-77. This is perhaps due to the opening of large number of private medical clinics, and nursing homes in cities. Necessitating a bulk recruitment of women as midwives in the public sector, however, there was a very marginal increase of 2.4 per cent. In other allied categories of health workers both in private and public sector there was a limited increase.

TABLE 4.8: Percentage of Women,—Doctors and Nurses in Different Levels of Government Concerns

| System/Category                      | Central         |                 | State            |                  | Quasi           |                 | Local Bodies     |                 | Total            |                  |
|--------------------------------------|-----------------|-----------------|------------------|------------------|-----------------|-----------------|------------------|-----------------|------------------|------------------|
|                                      | 1974            | 1978            | 1974             | 1978             | 1974            | 1978            | 1974             | 1978            | 1974             | 1978             |
| <b>Physician Ayurvedic</b>           |                 |                 |                  |                  |                 |                 |                  |                 |                  |                  |
| Physician & Surgeon Ayurvedic        | 0.0<br>(19)     | 22.0<br>(50)    | 6.10<br>(5231)   | 4.48<br>(6321)   | 3.21<br>(156)   | 25.32<br>(158)  | 2.06<br>(2474)   | 1.81<br>(2603)  | 4.76<br>(7890)   | 4.17<br>(2132)   |
| <b>Homeopathic</b>                   |                 |                 |                  |                  |                 |                 |                  |                 |                  |                  |
| Physician Homeopathic                | 0.0<br>(3)      | 25.0<br>(8)     | 6.37<br>(267)    | 6.64<br>(497)    | 0.0<br>(16)     | 33.33<br>(6)    | 1.25<br>(80)     | 2.86<br>(140)   | 4.92<br>(366)    | 6.30<br>(651)    |
| Physician Bio-chemic                 | 0.0<br>(1)      | 29.0<br>(7)     | 13.95<br>(43)    | 18.18<br>(11)    | 0.0<br>(0)      | 0.0<br>(4)      | 0.0<br>(1)       | 0.0<br>-        | 18.83<br>(4524)  | 9.09<br>(22)     |
| <b>Physician &amp; Surgeon Unani</b> |                 |                 |                  |                  |                 |                 |                  |                 |                  |                  |
| Physician Unani                      | 0.0<br>(6)      | 0.0<br>(1)      | 10.61<br>(396)   | 3.98<br>(251)    | 0.0<br>(18)     | 36.36<br>(11)   | 1.27<br>(128)    | 1.72<br>(58)    | 7.61<br>(578)    | 4.67<br>(321)    |
| <b>NURSES AND OTHER H.W.</b>         |                 |                 |                  |                  |                 |                 |                  |                 |                  |                  |
| Nurse General                        | 92.73<br>(2009) | 86.66<br>(1821) | 80.77<br>(28547) | 86.13<br>(33604) | 64.89<br>(2170) | 82.68<br>(2004) | 68.76<br>(2250)  | 97.72<br>(3370) | 79.70<br>(34976) | 86.94<br>(40799) |
| Nurses specialised                   | 100.0<br>(56)   | 78.26<br>(23)   | 72.56<br>(911)   | 96.67<br>(510)   | 83.33<br>(12)   | 100.0<br>(11)   | 50.00<br>(2)     | 61.54<br>(13)   | 74.21<br>(981)   | 95.15<br>(557)   |
| Professional Nurse                   | 95.00<br>(100)  | 86.91<br>(1994) | 65.06<br>(2579)  | 86.35<br>(34477) | 77.60<br>(125)  | 83.07<br>(2197) | 92.18<br>(409)   | 97.27<br>(3405) | 69.94<br>(3213)  | 87.09<br>(40273) |
| Nurse Industrial                     | 88.37<br>(43)   | 66.67<br>(27)   | 81.12<br>(784)   | 91.24<br>(194)   | 85.42<br>(96)   | 88.96<br>(163)  | 97.79<br>(362)   | 271<br>(18)     | 86.38<br>(1285)  | 86.82<br>(402)   |
| Midwife                              | 93.17<br>(410)  | 91.57<br>(439)  | 92.96<br>(16582) | 90.91<br>(23263) | 77.35<br>(362)  | 61.31<br>(747)  | 96.78<br>(9742)  | 96.29<br>(9473) | 94.13<br>(27096) | 91.77<br>(33922) |
| Lady Health Visitor                  | 91.65<br>(539)  | 88.78<br>(98)   | 85.07<br>(23120) | 69.60<br>(5631)  | 76.51<br>(430)  | 56.44<br>(101)  | 94.48<br>(10973) | 89.55<br>(986)  | 86.72<br>(35586) | 72.56<br>(6816)  |

Source: D.O.E. & T, "Occupational pattern in Public sector (1974-78), Tabulation Registers, Ministry of Labour, Government of India, New Delhi.

**Table 4.8**

A review of the women participation in medical profession by the respective cadre they serve in such as Central, State, Quasi-Govt., local bodies etc. has been analysed in Table 4.8. The data indicates that in the category of Ayurvedic Physicians there was a marginal decline (0.59 %) in women participation in the overall situation. Whereas in the central sector in the same professional category there was an increase of 22% in female participation. The state sector witnessed a decline, while in the Quasi government sector there was an increase of 22.11 % in women participation.

In the Homeopathic system of medicines there were three categories - Homeopathic Physicians, Bio-chemic physicians and physician and Surgeon in the State sector, the women participation had increased in the first two professional categories from 1974 to 1978, however, the increase had been of a rather marginal proportion. Also in the local bodies, the participation and employment of women had registered an increase, particularly in the category of Homeopathic physicians. It is interesting to note that while there had been a general increase in the women employment in the category of Homeopathic physicians. There was a slump in the women participation in the category

of Bio-chemic physicians. In the Unani system, the women participation has seen a decline of 2.94 per cent in the overall situation but there was a marginal increase - 0.45 in women employment in the local bodies. In the state sector, too, there was a decline (6.63 %) in women employment over the years.

A similar analysis of participation of nurses reveal that in the state sector there was an increase in women participation in general nursing, specialized nursing, nurse industrial, professional nurse categories in the state and quasi government sector employment, while in the central sector, there was no increase in central sector. In the overall situation there had been an increase in women participation in all categories. In mid-wifery and lady health visitor is category the women participation in the all sector had declined.



TABLE 4.9: Distribution of Degree-Holders and Technical Personnel in the Field of Medicine According to their Present Employment Status

| Subject-Field               | Total  | Employees | Self-Employed | Student | Trainees | Apprentices | Retired | Un-employed |
|-----------------------------|--------|-----------|---------------|---------|----------|-------------|---------|-------------|
| <b>MEDICINE (ALLOPATHY)</b> |        |           |               |         |          |             |         |             |
| <b><u>Females</u></b>       |        |           |               |         |          |             |         |             |
| Doctorate                   | 146    | 111       | 15            | 2       | 2        | -           | 2       | 11          |
| H% (1.0)                    | (76.0) | (10.3)    | (1.4)         | (1.4)   | -        | (1.4)       | (7.5)   |             |
| Master's Degree             | 1479   | 1126      | 225           | 15      | 8        | 1           | 24      | 80          |
| H% (10.6)                   | (76.1) | (152)     | (1.0)         | (0.5)   | (0.1)    | (8.3)       | (1.6)   |             |
| Other PG Degree             |        |           |               |         |          |             |         |             |
| Diploma                     | 1224   | 760       | 306           | 48      | 5        | 1           | 21      | 74          |
| H% (8.8)                    | (62.8) | (25.0)    | (3.9)         | (0.4)   | (0.1)    | (1.7)       | (6.1)   |             |
| Bachelor's Degree           | 9409   | 5074      | 1391          | 616     | 988      | 156         | 119     | 1065        |
| H% (67.3)                   | (53.9) | (14.7)    | (6.5)         | (10.5)  | (1.7)    | (1.3)       | (11.3)  |             |
| Bachelor's Equiv.           | 100    |           |               |         |          |             |         |             |
| H% (0.7)                    | (46.0) | (29.0)    | -             | (7.0)   | -        | (3.0)       | (15.0)  |             |
| Diploma                     | 608    | 262       | 170           | 5       | 2        | -           | 86      | 82          |
| H% (4.4)                    | (43.1) | (28.0)    | (0.8)         | (0.3)   | (0.2)    | (1.41)      | (13.5)  |             |
| Certificate                 | 296    | 109       | 102           | 1       | -        | -           | 35      | 48          |
| H% (2.2)                    | (36.8) | (34.5)    | (0.3)         | -       | (0.3)    | (11.8)      | (16.2)  |             |
| Total =                     | 13962  | 7497      | 2238          | 687     | 1012     | 160         | 290     | 1378        |
|                             |        | (56.5)    | (16.9)        | (5.2)   | (7.6)    | (1.2)       | (2.2)   | (10.4)      |

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**Distribution of Degree-Holders and Technical Personnel in Subject-Field  
by Status and Level of Education**

|                          | 1                 | 2              | 3           | 4           | 5           | 6          | 7           | 8             | 9            |
|--------------------------|-------------------|----------------|-------------|-------------|-------------|------------|-------------|---------------|--------------|
| <b><u>NURSING</u></b>    |                   |                |             |             |             |            |             |               |              |
| <b><u>Females</u></b>    |                   |                |             |             |             |            |             |               |              |
| Doctorate                | 3<br>H% (0.1)     | 2<br>(66.7)    | -           | -           | -           | -          | -           | -             | 1<br>(33.3)  |
| Master's<br>Degree       | 62<br>H% (1.8)    | 52<br>(83.9)   | 3<br>(4.8)  | -           | -           | -          | -           | 2<br>(3.2)    | 5<br>(8.1)   |
| Other PG<br>Degree DIP.  | 11<br>H% (0.3)    | 7<br>(63.6)    | -           | -           | -           | -          | -           | -             | 4<br>(36.4)  |
| Bachelor's<br>Degree     | 392<br>H% (11.6)  | 279<br>(71.2)  | 17<br>(4.3) | 2<br>(6.5)  | 2<br>(0.5)  | 2<br>(0.5) | 2<br>(0.5)  | 5<br>(1.3)    | 85<br>(21.7) |
| Bachelor's<br>Equivalent | 12<br>H% (0.4)    | 7<br>(58.3)    | 1<br>(8.3)  | -           | -           | -          | -           | 2<br>(16.6)   | 2<br>(16.6)  |
| Diploma                  | 2467<br>H% (73.1) | 2093<br>(84.8) | 51<br>(2.1) | 24<br>(0.9) | 61<br>(2.5) | 6<br>(0.2) | 23<br>(0.9) | 209<br>(8.5)  |              |
| Certificate              | 430<br>H% (12.7)  | 371<br>(86.3)  | 9<br>(2.1)  | 9<br>(2.1)  | 2<br>(0.5)  | -<br>(0.2) | 16<br>(0.2) | 38<br>(8.8)   |              |
| Total =                  | 3377              | 2811<br>(83)   | 81<br>(2.4) | 35<br>(1.0) | 65<br>(1.9) | 8<br>(0.2) | 33<br>(1.0) | 344<br>(10.2) |              |

Source: Census of India, 1971, series 1 - India, Part VII (1), Degree Holders and Technical Personnel, special Table G-II, pp. 28-31, Govt. of India, N. Delhi

**Table 4.9**

Table 4.9 shows the women's education level in the faculty of medicine and their employment status. It can be seen from the table that majority of women (67.3%) who sought medical education had completed only their graduation. While the remaining 33 per cent further pursued either P.G. Diploma (8.8%), Masters degree (10.6%) or certificate course (2.2%), or carried out research and obtained doctorate degree (1.0%).

Further, out of 13,962 women with medical qualification, 56.5 per cent were employed in one place or other 17 per cent started their independent practice. About 10% of the qualified doctors remained unemployed. A close look at the table shows irrespective of the level of education, the trained women doctors mostly preferred to seek employment rather than starting their own practice are remaining unemployed. However, women with higher level of education seeming to be preference for self-employment.

As regards to Nursing profession, most of the women nurses (73%) had got only diploma in nursing. Of 337, only 83 were employed and another 10% were employed, while the remaining 7 per cent were either pursuing further studies (1.0%) or undergoing further training or apprenticeship (2.1%) or set up their own profession. This table further suggests irrespective of level of education, the female nurses prefer to choose employment rather than remaining at home.

Table No. 410

The percentage of women employed in teaching profession  
in the field of medicine in various Universities/  
Institutions/Colleges.

|  | Total            | Women | Percentage |
|--|------------------|-------|------------|
| <b>1. Name of Universities</b>   |                  |       |            |
| Andhra   | 19               | 1     | 5.26       |
| Calcutta   | 243              | 6     | 2.47       |
| Banaras  | 215 <sup>4</sup> | 22    | 10.23      |
| Gujarat Ayurveda   | 16               | 0     | 0.0        |
| Jalapur  | 21               | 3     | 14.29      |
| Lucknow  | 237              | 36    | 15.19      |
| Nagpur   | 19               | 1     | 5.26       |
| Punjab   | 19               | 1     | 5.26       |
| Sargar   | 11               | 0     | 0.0        |
| S.N.D.T. Women's University  | 30               | 30    | 100.00     |
| <b>2. Instt. deemed to be Universities</b>                             |                  |       |            |
| Birla Instt. of Tech.<br>& Science                                     | 7                | 0     | 0.0        |
| <b>3. Instt. of National Importance</b>                                |                  |       |            |
| AIIMS, New Delhi   | 286              | 75    | 26.24      |
| Post-graduate Instt. of<br>Medical Education &<br>Research, Chandigarh | 249              | 62    | 24.90      |
| <b>4. Colleges</b>   |                  |       |            |
| All colleges   | 14,490           | 3,197 | 21.79      |

Source: Govt. of India, Third All-India Education  
Survey, Higher Education, 1973-74, published  
by UGC, Ministry of Education, New Delhi,  
1978, pp.128.

### Participation in Teaching in the Faculty of Medicine

An analysis of the women's employment in teaching profession in the faculties of medicine in various universities institutions and colleges is presented in Table 4.10. The data shows that the overall the women got a share of about one out of every five persons engaged in teaching profession in medical institution. It is interesting to note that in the SNT women's university, the percentage of women employed was as high as 60 per cent followed by 25.34% at AIIMS, New Delhi and 24.9% at Post-Graduate Institute of Medical Education and Research, Chandigarh. The medical institutions at Lucknow, Jadavpur and Varanasi have the percentages of women range between 10 to 15 per cent. While in various other universities the percentage of women employed in teaching is as low as 5.26 per cent. This situation holds in Andhra, Nagpur and Punjab medical schools. While Sagar University did not recruit at all any female in the teaching side in the faculty of medicine, Calcutta University also had very marginal percentage of female teachers in the same faculty.

## CHAPTER V

### CONCLUSION

Medical profession is one among such professions as have recruited a large number of women not only in India but in other countries as well. Also, nursing, even though a semi-profession, is equally well-spread throughout the world is well developed except in the case of a few countries like Bangladesh. It is probably true that in yesteryears nursing was almost negligible in the whole of the Islamic world where such a profession is not permissible to women by religion. The attraction of status is a great inducement to women to go into both these professions but other factors such as education, urbanism, technology and economic liabilities have played no less role in expanding women involvement in them. Another prominent feature of both these professions is their orientation to the care and welfare of community. This leads additional responsibility to them and promotes the motivation of women to join them. Being a supplementary relevance to the medical profession, nursing gets a relatively lesser esteem and thus a lower social ranking. But despite this, as our data indicates, there is much larger proportions of women in the nursing than in the medical profession in the Indian society. This is practically due to the fact that the education and training needed for nursing is far less costly than that required for the medical profession as mentioned in Chapter-III.

Also, in a relatively lesser time, a nurse can start earning and even supporting her family than a woman doctor. This also fits in with the generally available unemployment and widely pervasive poverty in the Indian society. Moreover nursing education does not need any particular subject or group as compared to medical profession which employs only those having science background. Hence nurses are large in numbers than women doctors.

Earlier in the Indian society, women doctors were confined more to gynaecology and obstetrics since their services were heavily in demand in these areas. This is perhaps the reason women participation has mounted many fold in medical profession since independence. However, today, a change is seen in their area of specialisation and in their level of education. For instance they are ventured into other areas such as Anaesthesia and Cardiology. However, obstetrics remains high in their order of preference. This trend shows that moving from specialised to generalised practice. At the same time they are offering new courses such as Post-Graduate diploma and certificates, as mentioned in Chapter IV. Moreover their number is much higher in urban areas than in rural areas.

As compared to Allopathic medicine, there are a number of other systems of medicine also such as Homoeopathy and Unani, which recruit women doctors. However in the field of Ayurvedic

medicine, a decline is visible in government hospitals. Women participation has not improved in veterinary. In Dentistry, however, a marginal increase has been noticed. A very detailed and differentiated data on these aspects is however not available.

A very important feature of the female doctors role discharge which was brought out in our study is that a much smaller proportion of them as compared to the male doctors are found in independent practice. This may at once reflect the societal bias towards women as well as their own inability to take risk of independent practice, rather than managing through salaried jobs. This may also reflect that even now, they are at best considered as supplementary breadwinners in the family. Another reason for this may be a socially and culturally conditioned and inhibitions among them not to get involved in problems of "organising" and "management" which are invariable ingredients of independent practice.

In the context of an organisational setting that is hospitals mostly run by state, the role of women professionals is viewed much more casually and lightly especially when they are discharging their role outside the area of obstetrics and gynaecology, their role is mostly viewed as confined to that of drug prescription etc. Even the bureaucratic rules which prohibit the prescription of costly drugs by the women doctors



simply because they have a narrow specialism and also because they are not considered competent as generalists. Further add to this narrowing of the professional role of women doctors. Also women doctors are prevented from developing informal relations with their patients on account of certain cultural inhibitions.

There is, thus, an apparent discrepancy which occurs between their role expectation and their actual role performance. The sources of these conflicts are located in various cultural settings for example, the cultural expectation from a woman doctor to efficiently perform the role of a mother comes in the way of their roles as full professionals. Further the bureaucratic rules and regulations which place women in inferior positions also blow up this role conflict between that they should be and what they are. All these leads to a slow career growth on their part as compared to men doctors. This comes out distinctly from what the women doctors perceive their career. Thus despite several indications of increasing entry of women into professions they continue to be hampered by several cultural and value biases from developing into full professionals. A change in the situation is possible only if women are accepted as equals in the larger social cultural milieu.

Nursing profession also now come to attract a much larger proportion of women in India than before. This, as mentioned before, is explainable in terms of their desire to seek security

and economic autonomy with lesser investment of both time and money than what is required in medical profession. In the area of nursing specialisation ward sisters have increased in proportion as compared to psychiatric nursing, paediatric nursing and sister-tutor. On the whole women participation has increased both in specialised nursing and in general nursing. However it is quite interesting to note that midwifery has increased manifold both in private medical clinics and nursing homes as well as in state run hospitals. Simultaneous to women doctors, nurses are also confined to urban areas and confirm the traditional pattern of participation.

The professional role of nurse has changed a lot from what was expected of her in the past. Today nurse is no more a mere helpmate or mere caretaker but a professional nurse who has moved into diagnosis and treatment that were for all limits shut off to them in the past. However they are now subjected to bureaucratic norms which prohibit from playing a more active professional role vis-a-vis the patients. This definitely brings in a separate set of professional irritants in their functioning.

Within the framework of para-medical staff, the position of nurses have been upgraded, but within the general context of medical profession, there is only, if at all, a marginal change. One may conjecture that with the growing concern of

the state with the health of the citizens and with the consequent importance of nurses, the status of nursing as a "profession" would improve further and more substantively.

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