

A Profession on the Margins: Status Issues in Indian Nursing

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This joint paper¹ attempts an unusual collaborative approach that offers an understanding of the problems that registered nurses of India have faced. Through this paper, we seek to locate the problem of 'social status' in both historical and contemporary landscapes, representing a relatively rare attempt to bridge the gap between studies of the institutions of colonial society, and studies of the current fortunes of their post-colonial inheritors. The study of nursing provides an important opportunity to understand the complex interaction between colonial and post-colonial modernities, and some of the results of that interaction. This is an important exercise, especially because of the invisibility of nurses and nurse leaders anywhere in the discourse on/by the women's movement². Women teachers and doctors are highly visible, and nurses, who are seen as personification of women professionals, are almost completely absent. Even accounts of women's movements' history which are critical of elitism elsewhere and recognise, like Forbes, that 'our sources on women's work in the nineteenth and even much of the twentieth century are vague and unanalytical' (1996: 157), do not go beyond the scope of earlier writings and look only at women like Haimavati Sen, Anandibai Joshi and Muthulakshmi Reddy, , who were doctors, as representatives of women in modern professions, while pioneer nurses are lost to history.

This paper begins with an attempt to define and understand the concept of 'status'. Implications of status in the context of the nursing education and profession are discussed as part of this section. Status concerns in Indian nursing have to be located in the modern nursing of the West because of the strong colonial connections of the modern Indian health sector in general, and nursing in particular. An understanding of the causes and origins of status anxiety is provided in the paper. In the colonial context, constant anxiety over status stemmed from the refusal of all sections of society to recognise nurse leaders' claims that nursing was respectable, important, and could lay claims to being a profession. This anxiety was partly inbuilt into the institution of trained nursing, a gendered, culturally specific and relatively young institution of Anglo-American modernity.

Nursing in the West was also characterised by endemic status anxiety, resulting from the gap between what leaders wanted nursing to be - middle-class, professional, 'noble' - and what it was in reality - dominated by working and lower middle-class women, requiring labour very close to that of a domestic servant, and often viewed by the public as morally questionable. In colonial Indian society, working women's claims about the status and importance of nursing found even less acceptance. Indian society tended to view nursing as not only menial and morally dubious, but also as polluting work typical

¹ This paper is a direct outcome of the joint presentation by Sreelekha Nair and Madelaine Healey that took place on 6 February 2006 at the CWDS . It draws heavily on the study 'Gender, Status of Profession and Migration: A Study of Nurses from Kerala in Delhi' which is being conducted at the Centre for Women's Development Studies, New Delhi, for contemporary aspects of status issues, and on Madelaine Healey's doctoral research on the twentieth-century development of nursing in India. The first study is based on fieldwork and interview of 150 nurses from the state of Kerala, who are working as staff nurses in the hospitals of Delhi. Leaders of nurses' associations, unions and hospital administrators were also part of the discussions on status and other issues in the study. The second study has utilised materials on Indian Nursing during the colonial period and later, which are available at the India Office Library, London, and other libraries in the UK and the US, which otherwise would not have been available to researchers in India.

² We are thankful to Dr Mary E. John for this point.

of lower castes. Meanwhile, though the colonial state preached the importance of good nursing, it in practice treated nurses and the need for their services with contempt. Mission rhetoric was characterised by regret about the mainly low-caste and destitute Indian nursing candidates they attracted, and by a relentless focus on the possibility of attracting a 'better class' of students, which contributed further to the centrality of the status discourse. Concern over status also manifested itself in an intense division within nursing, with oppressive hierarchies of race and class coming to characterise the profession.

An attempt is made here to link the contemporary concerns of status among nursing professionals in India with the historical analysis of status issues. It has to be pointed out at the outset that clear differences of perceptions of status seem to exist among nurses in the study, who belong to a diverse age group ranging from 22–50 years, and reported on the contemporary status anxieties of nurses in India. Gender, class, ideology and the practical notions of hierarchy entrenched in Indian society have contributed towards the present status of nursing profession here. It can be pointed out beyond doubt that the colonial legacy and history of Indian nursing, as we will see in the following sections have at the same time contributed towards the professionalisation and status anxieties of Indian nursing.

I. What does 'status'³ mean?

The constant references to 'status' characterising the writings and conversations of India's nurses, past and present, have led us to examine this issue as central to an understanding of the profession. Yet the concept is slippery and difficult to define, encompassing as it does a range of social and professional experience. For sociologists, status has been a much-contested term, which is often seen as intimately related to, but not necessarily identical with, class (Grusky 1994: 15, 20). Status exists in a close relationship with the material, but is not always seen to be entirely determined by it. In the literature, status has often been seen to revolve around the ascription of honour and the sharing of 'special styles of life' (ibid.: 19–20). Status, as Weber described, is closely linked to occupation and educational attainment (1994: 125). Clearly, status is informed by wealth, occupational status and societal recognition. The literature on status is also closely linked to that on professions and occupational groups, which pursue material and public recognition of their claim to constitute a profession. The key to understanding nurses' experience of status is, we believe, in the element of 'honour' or public recognition, which is key to all understandings of the concept of status. Nurses have pursued professional status, but the necessary recognition by others of their claims has not been found. There has been a profound gap between nurses' understanding of themselves and the way society has understood them. Nurses are trained to see

3 Originally, the authors of this paper had contemplated exploring the issue of stigma in Indian nursing, but later changed the course of the discussion to status after reviewing the literature on stigma. Though 'the patterns of prejudice, which include devaluing, discounting, and discrediting' nurses exist and can essentially be called stigma, the degree of discrimination when compared to other groups commonly seen as stigmatised make it more a status issue. Moreover, responses of the nurses regarding their problems were defined within the framework of status rather than stigma. There has also been a concrete change in the attitude of people towards nursing and nurses as more and more people become involved in the profession. And favourable monetary changes like better salary, etc., has also led to better treatment of the nurses. Nevertheless, in a similar study of the immigrant Keralite nurses in the United States, Sheba Mariam George terms the class and gender status as stigma (George 144: 2005). She finds their labour stigmatised as well.

Stigma refers to all unfavourable attitudes, beliefs and policies directed towards people, often a group. Erving Goffman defines stigma as 'an attribute that is deeply discrediting. Stigma can arise of [one] possessing an attribute that makes [that person] different from others ... and of a less desirable kind [S/he] is thus reduced in our minds from a whole and usual person to a tainted, discounted one.' (Goffman, Erving 1963:2–3).

themselves as skilled professionals who have mastered the specialised body of knowledge necessary to achieve professional status. Yet, outside of the profession they have often been seen as unskilled, morally suspect women doing work similar to that of servants. The material recognition that they feel they deserve has not been extended to them. Once out of the educational system, opportunities for further development and advancement up a promotional ladder characteristic of other professions have not been theirs. This gap between self-image and public image has caused a painful anxiety about status, and made them aware of the injustice of it.

Despite the conceptual vagueness of 'status', nurses themselves are acutely conscious of the status of their profession. It is difficult to put that in absolute terms, though, as references to status is often in comparison to other professions and people, and depends on the imagination of the status enjoyed by others in their minds. Nurses in the empirical study mentioned earlier have definite points with which to reason out their understanding of their status, and there are practical manifestations of the low status of nursing. Sexual harassment at the workplace and questions raised regarding the morality of nurses because they work with strangers, including men, at all times are expressions of the unfavourable attitude that society harbours towards women.

Low status is manifested in certain practical, everyday experiences of nurses. There were variations in the expressions of their own experiences. Older nurses talked of their experiences and younger ones spoke more about what they had heard were the problems of status. There were shared feelings regarding the difficulty in getting marriages arranged for them because they were nurses. There was also talk of changes in perception- because nurses are seen as having a better chance of immigration to Europe and the US. This new development is seen by nurses as a strong indicator of the improvement in their status. Yet in the recent study of immigrant Keralite nurses in the US (George 2005), there was an observed difference between nurses' families and others', and marriage proposals were rejected by high-status families because the mothers of the prospective brides/grooms were nurses.

Sexual harassment is an unavoidable experience for many of them and it happens at the hands of not only superiors and doctors, but also the ward boys, relatives of patients and other workers in the hospitals. Nurses on night shifts are more vulnerable. This is an indicator of the low status of women in society, as well as often a reminder to women about the deviance of being seen in a public space at night. This deviance is not only because of their physical presence, but also due to their unusual role as breadwinners.

The moral status of nurses as a group is questioned (George 2000: 150; Nair ongoing; Percot 2006). Questioning women's morality when they step outside the domestic sphere seems usual in rural patrifocal communities. Eugenia Georges' (1992) study on women and work in the Dominican Republic has a comparable situation. The late marriages of nurses, especially among the earlier generations, seemed to have made them more vulnerable to questions about their moral and sexual purity, which are of utmost importance in the patrifocal society that they live in (Nair ongoing).

The self-perception of the nurses on their status seems to be precarious, as is very evident from the fact that not even a single nurse in the ongoing study mentioned earlier wants their children to become nurses. At best, their response is that they leave it to their children to decide their careers. However, responses stating that they want their children to be doctors, engineers, and in some cases military officers are quite definite and firm. There were statements and explanations that suggested they were apologetic about being nurses. A few reasons were offered as explanations for their decisions to be nurses, despite that not being what they wanted. Poor financial status of their parents, their inability to pass the medical entrance examinations required to become doctors, not having enough information about other courses, ignorance regarding the everyday working lives of nurses, and so on are important

pointers towards their perception of the gap between their actual status, and their ideas of the status they deserve. Unqualified or semi-trained women who work as nurses add to the status anxieties of their well-trained colleagues, intensifying the deeply entrenched hierarchies within nursing.⁴

II. Locating status anxiety

The deep concern of India's nurses with professional status must first be located within the institution of nursing as it developed in the West. The models of nursing that were developed in India by western nurses had already been shaped by status problems encountered at home. While, as Madsen suggests, carers and caregivers have been a feature of all societies, 'professional nursing is essentially a modern invention', developing from the mid-nineteenth century (2003: 40). The evolution of nursing during this time involved a deliberate and concerted effort to distance it from its working-class roots. Beginning with Florence Nightingale's influential and well-publicised reforms, nursing was remade as a respectable occupation, suitable for 'ladies'. Nursing became a dimension of the mid-nineteenth century trend that middle-class and elite women followed to participate in public life through philanthropic, charitable and religious projects (Helmstadter 2001:127–40).. The idea that nurses should be motivated by vocations and a desire to serve rather than material gain came into vogue. Florence Nightingale and other nurse reformers in both Britain and the USA promoted the notion that, as Rosenberg says, 'the trained sensibility of a middle class woman could alone bring order and morality to the hospital's grim wards' (Rosenberg 1987: 212).

Nursing in the West thus represented one of the first routes into work and the public sphere for middle-class women, and it was unsurprisingly defined by a set of extreme anxieties that accompanied this rather radical change in the position of women. Nurse leaders were anxious to distance the new brand of 'lady-nurse' from the working-class, untrained nurses who preceded her in Victorian hospitals. These women were often stereotyped as dissolute, gin-sodden and dirty, along the lines of Dickens' Sairey Gamp. Working-class, semi-trained caregivers continued to work alongside trained nurses, and continued to cause considerable anxiety about the status of the profession in the public eye. Melosh quotes the 1928 Burgess report on American nursing, which claimed that 'the willingness of some hospitals to admit young women of doubtful character and low intellectual capacity is so well known that in some places the public assumes that all nurses must be of that type' (Melosh 1982: 42–43).

The response to all of this was the development of an intensive discipline and a restrictive professional discourse of service, obedience and self-sacrifice. The moral purity of nurses, symbolised in their starched white dresses and winged caps, was diligently guarded through the imposition of a lifestyle akin to that of a nun. Status anxiety was also linked to the desire of nurse leaders from Florence Nightingale onwards that nursing duties be not seen as 'mere extensions of the duties and obligations of wives and mothers', or worse, as close to the work of the humble domestic servant (Schlotfeldt 2006: 288). As nurses such as Ethel Bedford Fenwick in early twentieth-century Britain fought for the state registration for nurses, this became a strong concern. Goldthorpe comments that the prestige status of occupations depends on the 'symbolic significance' of the work they involve, and nursing leaders struggling for recognition as a profession were strongly focused on what they saw as the increasingly advanced and scientised function of the modern nurse (Goldthorpe and Hope 1994: 213). They assiduously attempted to portray the skill of the properly trained nurse as essential to the effective provision of the increasingly high-tech healthcare available in hospitals.

⁴ This is one of the findings of the ongoing study mentioned earlier, which examines status aspects of nursing profession in detail.

Emissaries of modern trained nursing in India, therefore, brought with them a professional model replete with anxieties about status and complete with a set of strategies - heavy discipline, a discourse of purity and 'nobility', the perception of nursing as a vocation or calling rather than a job, a notion that nurses were above materialistic motivation - designed to safeguard the moral status of nurses in public view, and distance them from their working-class predecessors. As nurse leaders pushed for state registration and educational improvement, a strong concern about nursing's claim to professional status also developed. A preoccupation with nursing's status in the public sphere was built into the institution brought by western nurse leaders to India.

III. Colonial nursing and the status question

Nurses came to India from the eighteenth century onwards, and attempts to train Indian nurses are generally thought to have begun around 1867, when missionaries working at St Stephen's Hospital in Delhi began the systematic instruction of Indian women as nurses (Wilkinson 1958: 38). Serious professional development along the lines of the modern trained nursing that had emerged in Britain during the mid-nineteenth century began in India from the start of the twentieth century. The section below concentrates on the period between 1908-1947, and seeks to provide an understanding of the status issue as it emerged during this period.

(a) Race, class and the status question

Extreme status anxiety could also be seen in nurses' interactions with and treatment of one another. The tendency of nurses to practise the 'horizontal violence' typical of oppressed groups has been widely documented in the sociological literature on nursing (see Roberts 2006 for an account of this research). In short, the exploitation and denigration experienced by nurses from both the wider society and their medical colleagues manifested themselves in a brutal internal hierarchy. At the top of the nursing hierarchy were the nurses who had been trained in England and had passed through a stringent interviewing process that heavily emphasised their class backgrounds and status as 'ladies'. These women were found in Lady Minto's Nursing Association, which provided private nurses to white families in India, and in Queen Alexandra's Imperial Military Nursing Service (QAIMNS). Accounts of nursing during World War II show that the QAs saw themselves as socially and professionally superior to all other branches of Indian nursing. Catherine Arnold Hutchinson, a QA posted to Ernakulam, was shocked at the depth of race and class prejudices amongst her colleagues. A sister with a 'slight cockney twang' was socially excluded. There was a general desire among the QAs to avoid being posted on Indian wards, and they wrote that 'they considered that they had come to nurse British patients'. 'Indian patients should have Indian nurses' was their view. One matron considered that the vast majority of her QAIMNS staff 'very properly objected' to service on the Indian wards (Hutchinson 2001). The QAIMNS was characterised by disdain for lower middle-class domiciled European women trained in India, pervasive snobbery, and a sense of racial superiority.

Nursing society in general looked down on those from a 'domiciled European' background, who were often the daughters of merchants or businessmen. These women were considered wanting not only in their class backgrounds, but also professionally, as the training they had received in India was considered inferior to that on offer in the West. Eleanor Palmer, an army nurse during World War II, left a long, embittered memoir in the archives of the Imperial War Museum in London, detailing the isolation and exclusion that she encountered as a domiciled European working with British trained nurses. She was

lonely and ostracised by the QAs, who preferred not to socialise with her because she had trained in Rangoon (Abel-Smith 1960: 242).

Another important factor was the identification of nursing with low class and servants. As Abel-Smith wrote, there was an ongoing preoccupation with distancing the public image of the nurse from that of the servant (ibid.: 242). These anxieties about the proximity of nursing to servants' work had strongly informed the growth of professional nursing in the West. Nevertheless, the narratives that had evolved in the West from a peculiarly English, Christian, Victorian religious revival about service and the nobility of the basic care of the body had succeeded in instilling values that respected labour.

Nursing was generally intensely divided along racial lines. A large section of the ranks of India's nurses was Anglo-Indian, or Eurasian. Anglo-Indians had considerable advantages over their Indian colleagues in some respects. In 1945, Janet Corwin, Nursing Advisor at the Rockefeller Foundation, made a five-month tour of Indian hospitals. She found plentiful evidence of discrimination in favour of Anglo-Indians and white women, and write that government authorities still 'in certain places ... tended to discourage those other than Anglo-Indians and domiciled Europeans from becoming nurses' (Corwin 1945). At the same time, however, Anglo-Indian nurses were members of a liminal community with quite different gender practices from other sections of Indian society, and were subjected by both westerners and Indians to the stereotype of the 'Anglo-Indian whore' (Chew 2002: 3).⁵ Catherine Hutchinson wrote that British officers were instructed to avoid Anglo-Indians for fear of producing 'dark' children (2001: 128). In analyses of the fortunes of the profession in India, it was often obliquely stated that Anglo-Indians' long-standing association with nursing was rather unfortunate, and tended to deter Indian girls from good families from coming forward for nurse training. Hilda Lazarus felt that it was most important to encourage educated Indian women to take up nursing, rather than continuing to rely on Anglo-Indians, 'the majority of whom take up nursing not as a vocation but as an easy means of livelihood' (Lazarus 1945: 11).

Indian nurses received the most discriminatory treatment. As was sometimes the case with early Indian women doctors, Indian nurses were frequently subjected to exclusion on the grounds of professional standards (Forbes 1996: 166). Indian women usually had access to only B-grade or junior grades of training, which were given in the vernacular or which did not require them to nurse men.⁶ This tendency for Indian women to occupy lower professional grades excluded them from positions of authority.⁷ A small but significant number of Indian women had trained as nurses; by 1923, 1,262 Indian

5 Anglo-Indians often self-consciously pursued a lifestyle close to that of the British, and according to W.T. Roy represented a sub-culture with 'a tradition of fairly free mixing of the sexes' (1974: 60). It was common for Anglo-Indian women to pursue paid employment, and they also dominated the ranks of air hostesses and clerical assistants.

6 Missions, a large percentage of which maintained hospitals for women and children only, were frequently only able to teach the 'B' grade of nursing qualification, even if their Indian students had been willing to nurse men. Out of the 40 hospitals affiliated to the North India United Board of Examiners for Mission and Other Hospitals, 35 were exclusively for women (Watts 1931: 77). In the first decades of the well-regarded School of Nursing at St Stephen's in Delhi, for example, only 'B' nurses could be trained, until affiliation with the Christian Medical College Hospital at Ludhiana was gained, which meant that nurses could be posted there to gain the necessary experience in nursing men (Anonymous 1972).

7 The exclusion of Indian nurses from the structure of leadership could not be entirely justified on the grounds that there were no well-qualified or senior Indian nurses available. Although the voices of Indian nurses were seldom heard in the NJI, there is evidence of capable individuals pursuing nursing careers outside the TNAI world. In the city of Bombay, for example, nurses seemed to suffer less from the stigmatisation of the profession, and the training and employment of Indian nurses were more acceptable and pursued more enthusiastically. A 1925 article published in the journal of the ICN suggested that in Bombay, Parsi, Christian and Hindu women worked as private nurses within their communities, and were well-respected for the work (Stuart, Meryn and Geertje Boschma 1999 : 109–10.) Miss

and 1,250 Anglo-Indian nurses had been trained, encompassing all educational sectors (an estimate considered conservative by Margaret Balfour). Almost no Indian woman, however, occupied leadership posts. Balfour felt that this was partly due to the fact that many senior posts were in state hospitals which nursed both sexes, and that therefore Indian women were reluctant or unqualified to work in them. This, she suggested, was one of the reasons why nursing found it so difficult to attract good Indian candidates. In comparison, the teaching and medical professions both boasted of successful Indian women in their ranks. It was no surprise, she felt, that Indian women did not come forward to train in a profession in which it was clear they could not advance (Balfour 1923: 31, 34).

Professional organisations also maintained a consistent policy of racial exclusion until the mid-1930s. At the 1920 TNAI conference, there were no Indian or Anglo-Indian attendees at all (Noordyk 1958: 339). Indians and Anglo-Indians began to attend in small numbers from the 1930s, but it was not until the 1939 conference at Mysore that Indian and European attendees ate at the same table (ibid. : 340). During the 1930s, pressure mounted for nurse leaders to address the low level of Indian participation at the leadership level. Ethel Watts wrote in an article she prepared for the ICN's journal in 1930 of being 'challenged constantly for going slowly' in the promotion of nursing for Indians. Watts wrote that western nurses in India had recognised the vital need to be 'yokefellows to the utmost with those who have come boldly forward, disregarding their national difficulties' (1931: 55).⁸ Some positive steps were taken towards encouraging Indian women, including the formation of the Student Nurses' Association, which focused heavily on this goal. In 1933, Miss B.J. Singh became the first Indian woman to be sent as a representative of the TNAI to the ICN Congress in Rome (Anonymous 1958: 343). Nevertheless, there was an ongoing dominance by western nurses, and the TNAI did not appoint an Indian president, general secretary or NJI editor until 1948 (ibid. : 344). Compared to the teaching and medical professions, at the time of independence the TNAI was remarkably devoid of high-level participation by Indians (Committee from the Christian Medical Association 1947: 14).

(b) Professional organisation and the status question

Notions of nursing as a profession requiring standardisation, registration and a theoretical education were introduced in India from the beginning of the twentieth century. In the nineteenth century, as Rosemary Fitzgerald has written, western nurses working in India had dubious qualifications, if any, and were often soldiers' widows or deserted wives who took up nursing in the absence of any alternative. From the beginning of the twentieth century, however, nurses came to work in India in larger numbers and with improved qualifications. They took up appointments in government hospitals, as private nurses with Lady Minto's Nursing Association, as military nurses, in hospitals sponsored by the philanthropic Dufferin Fund, and in missionary institutions. In the missions, nursing and the training of local nurses emerged as the major focus of medical work in India (Fitzgerald 1997: 76-77). This, though, was not true of the work done by 'philanthropic' organisations in India. For example, there was not much attention given to nursing by the Rockefeller Foundation in Thiruvithamkoor in the early twentieth century, where the focus was on medical research on tropical diseases, and training doctors specialising in the cure of these

Jankibai Sabnis, a Bombay nurse, gave up marriage and family to pursue a career at the renowned Cama Hospital, where she worked from 1907–46. The author of her obituary wrote that 'As Lady Superintendent she did much to improve nursing conditions and her skill as a nurse was widely testified'. (Anonymous 1950: 203). In Calcutta in 1935, Diana Hartley met Mrs Belwant Kaur, a nurse and Health Visitor who was in sole charge of a local infant welfare clinic (Hartley 1935: 12-13). In Delhi in 1930, the new Women's Medical College Hospital was said to be 'staffed almost entirely by well-educated Indian girls' (Watts 1931: 59).

8 Also published in *The International Nursing Review*, May 1930.

diseases (Kabir 2003).⁹ Although many nurses in India were uninterested in the development of the profession, others among the better-educated nurses began to view themselves as emissaries of the reformed models of nursing that had developed at home, with their emphasis on standardised education and the state registration of nurses (Fitzgerald 1997: 75). Fitzgerald characterises these women as a new variety of elite, professional nurses, who felt an explicit desire 'to lay the basis of an Indian nursing profession modelled on the styles and standards of nursing in the West' (ibid.).

From the early 1900s, these women superintended the development of structures of professional leadership. In 1905 in Lucknow, a group of trained nurses from government and mission hospitals created the Association of Nursing Superintendents in India (ANSI), and then at the Annual Conference at Bombay in 1908, the Trained Nurses' Association (TNAI) was formed (in 1922 the two were merged as the TNAI) (Anonymous 1998: 9). The ANSI took as its model the Matrons' Council of Great Britain and Ireland, and hoped to engage the 'united efforts of every trained nurse in the country' in their pursuit of educational improvement and professional standardisation (Association of Nursing Superintendents in India 1908: 9–10). The TNAI proposed a professional journal in 1908 and launched *The Nursing Journal of India (NJI)* at the Annual Conference in Agra in 1909, publishing the first issue in 1910.

Although the TNAI functioned partly as a sort of colonial ladies' club, organising hill-station picnics, providing advice on the rigours of train travel, and dealing with servants, from the beginning it also displayed a strong concern for professional development. It monitored the fight for nurse registration in Britain, published articles on progressive nurse education in the USA, and discussed the application of these trends to India. The only other representative body controlled by nurses was the Nurses' Auxiliary of the Christian Medical Association of India (CMAI), formed in 1930. The Nurses' Auxiliary was similarly supportive of professional development, which it saw as an important dimension of Christian work in India, in line with a general reorientation of missionary medical work as 'a service to be performed for its own sake' rather than predominantly a means of attracting converts (Balfour and Young 1929: 88).

Throughout this period, there was little emphasis by hospital employers on nursing qualifications and trained nursing remained underdeveloped, to the extent that in 1947, there were still only 7,000 trained nurses throughout the whole of India (Wilkinson 1958: 96).¹⁰ Nevertheless, the professional environment did undergo some important changes, particularly in the urban centres of Bombay and Madras. In 1926, the first Registration Act was passed in Madras. The Punjab followed in 1932, as did Bengal and UP in 1933, Bihar, Orissa and Bombay in 1935, and Madhya Pradesh in 1936. State Nursing Services, with standardised pay and terms of service, was instituted in Madras in 1941, in UP in 1944, and in Bengal in 1946. By 1944, there were eight registration acts in force in India, and proposals for an All India Nursing Council to regulate the profession were afoot (Hartley 1944: 12).

At all times, western and Indian nurses working during this period displayed an acute concern for the social status of the profession and the objectives of nursing organisations were centred around this anxiety. The ANSI, for example, hoped that it would be able to:

elevate nursing education by obtaining a better class of candidates, by raising the standard of training, and striving to bring about a more uniform system of education, examination and certification for trained nurses, both Indian and European (Barr 1917: 164)

⁹ Though, later there are references that suggest engagements by the Foundation with Indian nursing, as mentioned earlier in this paper.

¹⁰ It was suggested, however, by the eminent doctor and politician Sir Jivraj Mehta, that although 7,000 nurses were on the register, double registration and marriages meant that the figure actually working may have been closer to 3,000 (Mehta 1965: 1001).

The TNAI aimed to 'uphold in every way the dignity and honour of the nursing profession, to promote a sense of *esprit de corps* among all nurses, to enable members to take counsel together on matters affecting their profession' (ibid.). A 1922 textbook for Indian nurses suggested that if a student followed the rules laid down in the section on Nursing Ethics, she would 'do much to raise her profession in the eyes of the public' (South India Medical Missionary Association Nursing Committee 1922: 2). That same year, Miss Darbyshire, President of the TNAI, lamented the fact that most other countries were 'now far ahead of India in the recognition of Nursing as an honourable profession' (Darbyshire 1922: 6). Diana Hartley, who worked for the TNAI in India from 1935 until 1944, wrote of the essential need to 'raise the prestige of the Nursing Profession' (Hartley 1938: 1). Reviewing her time in India, she felt that the status issue had been at the heart of western nurses' work in India, and wrote that 'the status of the nurse has always been a vexed question ... nurses in other countries had to fight to gain and maintain their position; things were even more difficult in India' (Hartley 1958: 337). In 1947, nurse leaders from the Nurses' Auxiliary of the CMAI wrote of 'the fact that nursing is not publicly accepted as a profession but looked upon as a lower menial service', the urgent need to obtain students from 'higher cultural and social backgrounds', and the lamentable and retarding failure of the public to understand the 'fine history of service which has been attached to this profession since the days of Florence Nightingale' (Committee from the Christian Medical Association 1947: 6, 9)

It is clear, then, that a considerable anxiety about the question of status was a dominant preoccupation for early nurse leadership in India. This anxiety revolved around prestige, the problem of public miscomprehension of nursing, and a general failure by those outside the profession to recognise its 'honour'. Nevertheless, the gap between self-understanding and public image is clearly evident. The following sections examine the reasons behind the emergence of this gap.

(c) Missions and the status question

Christian missions in India were largely responsible for training Indian women as nurses, and also played a dominant role in the evolution of professional organisation and infrastructure. At the same time, the emergence of a recruitment base of low-status Christian converts, nurses' own anxieties about these recruits, and their treatment within mission hospitals all contributed to an increasing concern about status. Most nursing students in mission schools (apart from a few exceptions such as CMC Vellore and the Christina Rainy Hospital in Madras) throughout this period were drawn from very low-status, formerly low-caste communities of Christian converts, and a large percentage were widows and orphans. John Carman wrote of defending his nurses' honesty to a sceptical Brahmin patient, whom he informed, 'these girls are Christians, though they may appear to you as outcaste sweepers who have just cleaned up and put on uniforms' (Carman 1936: 97). Hilda Lazarus, an eminent doctor who was the first Indian Chief Officer of the Women's Indian Medical Service, wrote that the ranks of nurses were filled by unfortunate orphans. According to Lazarus, those in charge of orphans were anxious about their future and decided thus: if a girl were pretty she was sure to get married, if good at passing examinations she was made a teacher; and if she possessed neither of the former she was sent to be trained as a nurse or midwife (1945: 10)

Effectively, mission schools of nursing monopolised nurse education, and in the public eye nursing inevitably became strongly associated with the destitute women they relied on for recruitment, making it unlikely that either non-Christian or 'respectable' Christian families would allow their daughters to train as nurses. According to Lazarus, a central problem facing nursing when India achieved independence was dissociating nursing from these low-class, low-caste origins, and

attempting to attract 'the beautiful and the cultured, the educated and the intelligent, the sympathetic and the understanding' into the ranks of nurses (ibid. : 25).

Although mission nurse leaders were deeply concerned about the low social status of the profession and made this the central focus of their work in nursing associations, they were able to take little practical action to soothe public anxieties about the respectability of the work.¹¹ The perception that missionary hospitals were less than ideal environments for Indian 'ladies' to work in was generally entirely true. In most cases the work was hard, living conditions were poor, and the pay was low. Indian probationers in mission hospitals were often treated as cheap labour rather than students, and received the most minimal education. In 1914, Florence Gifford of the London Missionary Society (LMS) hospital in Murshidabad District, Bengal, wrote to the *NJI* to protest the fact that Indian probationers were being cynically recruited as a means of cheaply staffing the wards. The average hospital, in her experience, had 60 beds, 10 probationers and one trained nurse, with the obvious result that there was no time at all for teaching. This led to a severe wastage problem; although the LMS had been training Indian women for years, none of the three hospitals with which she was familiar had a single trained Indian nurse on staff. Students, receiving an exhausting and unstimulating 'training', tended not to stay in the profession. This situation did not change much throughout the period; in a 1947 survey of nursing by the CMAI's Nurses' Auxiliary, it was commented that 'practically the whole nursing care' in mission hospitals was supplied by probationers. Though nurse leaders lamented the negative public image of their profession, in actuality this image had a strong base in the reality of their hospital wards.

Reliance on low status, badly educated and often destitute women engendered considerable anxiety amongst western trained nurses, who were concerned about the image of their profession in India. Nurses at the American Baptist Mission Hospital in Nellore during the 1930s reported being 'compelled to take girls of a lower grade' because in wider society, 'nursing was not considered a profession'. This, they said, was discouraging both for teachers and for the students themselves, who 'had to endure many taunting remarks about 'taking nurses' training' (Magilton et al. 1930: 9). A committee of mission nurses constituted in 1947 to plan for the post-independence future of the profession commented that 'for many, many years Mission nursing sisters have struggled toward the goal of procuring more desirable and better nursing candidates' from 'the higher cultural and social backgrounds' (Committee from the Christian Medical Association 1947: 6). As had happened in the West, nurses' own understanding of nursing- as a profession requiring theoretical education – clashed rather badly with the reality, which was that the wider society and hospital administrators viewed nursing as menial work. This clash produced a strong focus on status, class and social location amongst mission nurse leaders.

(d) State neglect of nursing

If nurses were not accorded 'honour' in the public eye, neither were they accorded material recognition of their claims to professional status, either in terms of pay or the provision of a clean, safe working environment. While the low status of nursing in India was often seen as the result of local preoccupation with notions of pollution and class and caste hierarchy, it was also related to the dreadful conditions under which nurses were asked to work. Governments at all levels often excused their failure to encourage the development of nursing on the grounds of local prejudices, which they felt precluded any large-scale recruitment of Indian women. By the late 1930s, however, experts were beginning to

11 This is the main criticism against them. The Delhi chapter of the All India Nurses' Federation which is open to all government nurses and is called Delhi Nurses' Union, was organised and mobilised mainly on the grounds that the existing organisations and nurse leadership had not taken any practical step to improve the working conditions or status of nurses (Personal communication, General Secretary, DNU, March 2005).

question the sustainability of that position. Diana Hartley felt that 'while old customs certainly held up progress in the first place', from the late 1930s onwards it could fairly be stated that 'lack of insight and parsimoniousness of the government and other authorities has been the real cause of the present shortage of nurses' (Hartley n.d.). Alice Wilkinson wrote that in budgetary considerations at every level, nursing was the last priority. She felt that the failure of Indian women to join nursing could be explained by the fact that state-run hospitals had 'failed to supply a sufficient number of qualified nurses to teach and train', 'failed to provide sufficient accommodation', and that 'in many hospitals the accommodation provided is disgraceful' (1944: 9–10). At the same conference, Major-General Hance, the Director General of the Indian Medical Services, expressed a similar feeling with even greater vehemence:

I will merely express my conviction based on a not inconsiderable experience that the alleged failure of the nursing profession to appeal to the right type of women in India is due far more to the attitude of the authorities responsible for the maintenance of hospitals, and to the conditions in which, too often, probationers are trained and nurses are expected to work, than to the alleged reluctance of educated Indian women to undertake the care of the sick. As long as trained nurses are regarded, paid and housed as menials it is not reasonable to expect that large numbers of Indian ladies will come forward to dedicate themselves to this work (1944: 6–7)

Independent India inherited a nursing system that was already in place, though there were many areas where state initiatives were indeed crucial. Post-independent governments in India focused on developments in the fields of medicine and medical technology, and made efforts to fight the prevalence of diseases like malaria, tuberculosis, plague, leprosy, smallpox, typhoid, cholera and so on. Among the meagre resources allotted to the nursing sector within the health services, nursing education and public health nursing received the maximum attention. Public health nurses and health visitors have been used in major ways to reach out to people in an effort to create awareness on health issues.

The neglect of nursing by the state in India did much to reinforce the low status of the profession. The failure to adequately fund schools and nursing accommodation, and a willingness to allow the recruitment of untrained or semi-trained nurses reinforced the widespread feeling that nursing was dirty and dangerous work. Nurse leaders' claims to professional status were not recognised in terms of public esteem, and neither were they given recognition through the provision of a fair salary or decent working conditions.

The nursing profession, therefore, was characterised by a fixation on internal as well as external concerns about status. It maintained a harsh hierarchy with overt discrimination, as well as an internal structure in which class and race determined opportunities and advancement. Nursing, unsurprisingly, replicated the same fault lines of race and class that divided colonial society.

IV. Status issues and their origins in the Indian context

Apart from their colonial origins, status problems in nursing were also determined by aspects of Indian society. The caste system and the notions of hierarchy entrenched in Indian society definitely contributed to the status question of nursing. Gender and class-based status issues have been important, and they all function at the level of local social practices.

(a) The Role of Religion, caste and class in understanding the status question

Nursing and care of the sick and the old involved cleaning and bathing sick and diseased bodies, and was seen as dirty work. This had a close similarity with the menial jobs of the 'lower' castes in the Indian

context. Nursing, thus, was ascribed a low status, mediated through the structural hierarchies made visible by religion, caste and class. It suffered greatly from the perception that it was too close to the polluting work of sweepers (who were, of course, employed alongside nurses). John Carman, a missionary doctor in India from 1928 until the 1950s, wrote of the nurses in his hospital at Ongole:

They are eager to pass on the menial but essential tasks to the new probationers ... to the patient's relatives, or to some scrub-woman. They don't want to be ridiculed, called by the various names which people apply to sweepers, no, not even if their grandparents did have to do that work before they became Christians. In that case, as a matter of fact, they are even more sensitive (1936: 145)

Most detailed accounts of the education of Indian nursing students during this period discuss the difficulty of persuading Indian students to attend to the personal care of patients. Disputes were frequent between western nurses, who strongly felt that the nobility of nursing lay in a willingness to tend to every need of the human body, and their Indian students, who often felt that their experience of life within the hospital and society would be much easier if bedpans and baths could be delegated to sweepers and ward-boys. In the early 1950s, the western director of the School of Nursing at Vrindaban wrote to the *NJI* demanding to know, after decades of professional development in India, 'why cannot we dignify all tasks that are necessary in caring for the human body in illness?' (Barry 1953: 203). Despite all the educational emphasis on the desirability of nurses personally caring for patients, on most hospital wards she had observed that it was common practice for the bathing and personal care of the patients, and even the giving of enemas, to be delegated to the sweepers. In military hospitals, it was reportedly common for not just the nurses, but also the nursing *sepoys* (who were usually untrained or, at best, had taken six-month courses) to refuse to administer bedpans (Carswell 1990: 279).

Issues of caste and pollution thus clearly formed part of the daily experience of the average Indian nursing student, who strove to distance herself from the 'polluting' aspects of the work, which had negative caste and class associations. The substantive content of nursing duties thus strongly informed the perception in India that nursing was low-status work. In a society strongly defined by notions of pollution and purity, the nature of nursing duties prevented the acceptance of nurses' claims to professional status. Again, a gap emerged between self-perception and public image.

Commentaries on nursing produced by observers and by nurses themselves are so strongly infused with an awareness of caste and pollution that it must be acknowledged as a valid impediment to professional progress. Thus, caste ideals and ritual purity that existed in Indian society were predominant in everyday lives, and seemed to have affected the status of nursing quite negatively. The idea that 'respectable' Indian women would never be persuaded to enter nursing due to the ritually polluting nature of nursing work was often expressed in the earlier years of nursing. The requirement for nurses to come into regular contact with stigmatising bodily fluids was regarded as a major factor in the low level of social status accorded to Indian nurses. Prior to the establishment of western hospitals, the only local female caregiver working for payment was the *dai* or indigenous midwife, who in most parts of India was considered untouchable. There was a very strong expectation in most parts of India that care of the sick should be provided at home by women of the family.

Nurses were identified as low-class workers from poor families and that contributed to the already defined low status of nursing. Stipends were offered to students, initially to attract more of them to nursing. This, along with the fact that they did not have to pay for the studies or job and that an income was assured at the end of the training are described as the incentives for girls from poor families to enter nursing. The need for a job seemed to have outweighed their concern for the potential damage to their reputation. Girls from landless poor families with minimum education looked upon nursing as a strategy

to get out of poverty. Even recent studies on nurses reveal the class characteristics of nurse aspirants. For example, in George's study 'their families were not able to afford the expense (to go to medical school and so) nursing became a substitute' (2000: 150).

Nursing was associated with Christianity, so much so that everyone in the profession was considered to be Christian due to its colonial and missionary connection. Christian missions in India took an interest in developing a modern nursing profession, in the image of the model in western countries. Christian converts were initially recruited for nursing, and these associations continued to be made between Christianity and nursing. In Kerala, which had a substantial Christian population, there was explicit understanding of nursing as a Christian profession and nurses as Christians. Many non-Christian nurses felt that nursing as a profession had carried with it many characteristics from the Christian religion.

To the population outside Kerala, women who migrated to work as nurses in the hospitals of their cities were from Kerala and were Christians. Kerala, Christianity and nursing were seen as one and the same! However, much like their Hindu sisters, girls from affluent and powerful Christian families entered the medical profession as doctors (Jeffrey 1992). That is to say, not all Christians joined nursing, and it is this interplay between religion, caste ideals (that appeared in many meandering ways), and class, which acted as determinants of Christian girls' decision to join nursing. Among Hindus and Muslims as well, class remained the most important factor in the choice of their profession.

(b) Gender, work and status issues

In the colonial context, local gender norms strongly limited nurse recruitment and training. Diana Hartley wrote of 'caste and purdah systems' as the major problems when it came to attracting educated Indian women into nursing schools during the first decades of the twentieth century, commenting that 'it is wrong to say they would not, they simply and obviously could not become nurses' (Hartley n.d.). Borthwick writes that 'in Hindu society the position of women had always been a symbol of male honour, to be maintained by careful control over female sexuality' (1984: 6)¹² Women's work outside the home destabilised this control, and thus during the period under discussion there was limited space for Indian women to work outside the home at all, and relatively few had the level of education required to do so. Women were largely expected to remain within the confines of a feminised private sphere- indeed, as Sarkar has argued, an idealised Hindu domestic sphere with virtuous Indian women at its centre was at the heart of the nationalist critique of colonialism, and even represented an 'alternative order' to that of colonial society (quoted in Powell and Lambert-Hurley 2006: 5). Although middle-class or elite women who took up professional employment as teachers, doctors or lawyers often 'gained respect, independence and personal satisfaction', most also faced disapproval, discrimination and harassment (Forbes 1998: 186).¹³

A lot of stigma arose around the expectation that nurses should care for men, and in many parts of India a 'B' grade of nurse arose, who was trained only to nurse other women and children (Adranvala 1955: 394). It was no surprise to anyone that, as Sarah Tooley wrote in her history of nursing in the Empire, the 'modern' Indian woman was 'more ambitious to use her new-found wings of learning to soar into the medical or some other profession rather than that of nursing' (Tooley 1906: 346). A virulently persistent discourse associating nurses and prostitutes also sprang up. Even among the missionaries themselves, it was perceived that nursing students and nurses were susceptible to agents of the brothels.

12A clear manifestation of this anxiety about female sexuality in the public domain of the hospital was the restriction of Indian nurses in many parts of India to nursing women and children. In 1952, there were 53 schools of nursing which did not teach the nursing of men (Adranvala 1955: 394).

13 See also Geraldine Forbes' account of pioneer women doctors in *Women in Colonial India: Essays on Politics, Medicine and Historiography*, 2005.

Undoubtedly some nurses, entrapped or motivated by financial desperation, or desiring to escape the hard labour and heavily circumscribed institutional existence of the nurse, did take up work as prostitutes. Hilda Lazarus, an eminent Indian doctor at the CMC, commented in a pamphlet for the All India Women's Conference that:

Their task was arduous and irksome The strain was great, and when temptation came in the guise of a kind invitation from a generous-hearted man, it was accepted ... Repeated invitations came, she could not resist the temptation and she fell - a ruined woman, a greater outcaste in Society, the finger pointed at her. Was the profession such! How could any self-respecting parents countenance their daughters going in for nursing or midwifery! (1945: 10)

There was thus a strong association in the public eye and even within the medical workplace between nurses and prostitutes. In the nursing schools of India, teachers instructed their students in the nobility of the profession and its heritage of dignified Christian service. Outside, the public image of nurses included the perception that they were morally unsound and liable to be prostitutes. Again, the gap between the self-image of the profession and societal perceptions of it was significant, and the cause of some anxiety. In 1939, E.M. Tomkinson wrote in the *NJI*:

When we have heard of nurse-probationers and nurses who have fallen into sin we have felt their disgrace to be our shame, and the dishonoring of our Nursing ProfessionWhy has the Nursing profession in India been dragged so often into the mire of immorality? (1939: 57)

Nursing work, as we saw earlier, involved constant and close contact with unfamiliar male patients and other workers of the hospital. Traditionally women (from 'good' families) were not allowed to even speak in front of male relatives¹⁴ and strangers. Indian society in general practised the seclusion of women. In many communities like that of the Nairs, which was a matrilineal community, women who had attained puberty could not visit the front of the house where men-including kins and relatives- were present. In such a setting of strict gender seclusion and avoidance, it was only natural that women, who were seen at night and other odd hours with male patients, lost their status.

V. Status anxiety: Contemporary terrain

Status anxiety has thus defined the Indian nursing profession from its earliest days. To some extent concern with status was part of the institutional legacy of modern nursing, which had its origins in the desire of 'lady-nurses' to distance themselves from working-class nurses. It has been argued that in the context of colonial society, status anxiety also stemmed from the gap between nurses' own self-perception – as professionals, as requiring advanced education, as motivated by a noble desire to serve – and the manner in which the Indian and colonial public perceived nurses – as menial workers, as morally suspect women, and as undeserving of the pay and conditions that would have allowed nurses to live 'respectably'. This status anxiety also manifested itself in a harsh internal hierarchy, in which individual nurses suffered from the overwhelming preoccupation with social standing and respectability within colonial society, itself driven by race and class prejudice.

14 For example, in Kerala from where the majority of Indian nurses came, it was a complex mix of gender and age hierarchy, and the latter was applicable to young men as well. The first published novel in Malayalam, 'Indulekha', illustrated this conflict between generations, and is often quoted as an example of the discussion on the theme of modern and young versus old and traditional schools of thought. Norms of gender boundaries and seclusion of women render 'purdah' a pan-Indian character, but local manifestations and community specificities are seen to depend on its interaction with other local practices.

The contemporary scenario in Indian nursing is that of a profession troubled by status anxieties. The discourse on status marks the most vibrant theme at present among the nurses and their professional circles. Most of the struggles that the nurses have undertaken in the past two decades from the 1980s have to do with issues of status. The idea of nursing as dirty work seems to have become culturally embedded in the Indian context. It goes beyond the physical setting of India, and George captures this perception in the context of Keralite immigrant nurses and the wider community in the United States, where a transplantation of cultural ideals differentiate 'dirty' nurses from the rest (2000: 144–74).

As mentioned at the beginning of this paper, nurses think of their pitiable service conditions in Indian hospitals as a reflection of their low status. Pay is low, and night shifts are very exacting. According to many of them, family life, especially when children are young, is adversely affected by night shifts. The nurse-patient ratio is very poor, and nurses need to attend to many more patients than they are expected to. Thus in many hospitals the average nurse-patient ratio is 15:1 and even 30:1 in some cases, whereas the permitted ratio is 1:6 on hospital floors.¹⁵

Gender-based status issues are relevant to nursing even today, as nurses would testify from their personal experiences. Women are not expected to be working for a livelihood, and when women are seen to be working, it is assumed that they are doing it out of extreme necessity. Nurses in Delhi hospitals in the context of the current situation disapprove of the fact that the local population and patients sympathise with them for having had to migrate to a strange city to work and earn their livelihood. They protest that their service is not appreciated, and that they are not seen as workers and are visible to others as only strange women doing the job of 'caring'.

Women's identification with the private space and sanction against their presence has been ordained by religion. Thus Hindu, Muslim and Christian places of worship have their rules regarding the admission of women, though women are the real perpetuators of the patrifocal institution of religion through their roles as socialisation agent, and observers of rituals and fasts. Gender-specific purity-pollution due to menstruation is also prevalent in the social sphere. Women are not expected to visit places of worship while menstruating though among Christians this has not been ritually forbidden. However, even in Christianity there have traditionally been practices that smack of a sexist ideology. Christians in Kerala, for example, practise ritual purity and pollution, and many churches do not approve of women attending communion while menstruating. It is as recently as 1987 that the Indian Orthodox Church revised the constitution to allow girls below the age of five to kiss the altar/shrine, which previously had been considered a natural right for boys.

Current social practices also point to lesser social independence and mobility in the case of young women in India. Interviews with young nurses certainly support the view that their economic independence brings with it a lot of autonomy, social independence and mobility. Apart from family control and peer pressures, constant chaperoning by neighbours and relatives is described by nurses as causes of anxiety, leading to constrained mobility. Many of them also point out that increased mobility costs them their respectability, because they are seen as deviants from an ideal womanhood-how women are 'supposed to be'. The traditional view of women as being incapable of an independent life with character and integrity without male supervision and guidance still prevail, and education in that sense is not seen to empower women in the way that would empower men. For instance, it is interesting to see how Keralite nurses working in the countries of the Persian Gulf are seen as 'loose women' by men who have never travelled anywhere outside Kerala even once. 'Who knows how they make so much money in

¹⁵ The ongoing study 'Gender, Status of Profession and Migration: A Study of Nurses from Kerala in Delhi' finds the ratio to be even worse in some private hospitals during nights.

the Gulf? ... These Arabs have a lot of money ...'.¹⁶ 'She is a nurse from the Gulf'-that is how they say it-contemptuously' (George 2000: 153).

George states that nursing just helps women in Kerala to transform themselves from 'burdens to assets'. She calls it a 'transformation of women's worth in Kerala' (ibid.: 149). Yet, one can see that despite her taking up the onus to show her worth to her family and others, she is still considered a liability. This contradiction is layered in the case of nurses who are to live with the burden of having to prove their purity and morality in the absence of a chaperone on the one hand, and have to live through the consequences of being in a low-status profession on the other.

The contemporary discourse on morality - with its parallels in the West - has also been unsympathetic to nurses. The white dress, which is the traditional uniform and again a colonial legacy, is reported as the most problematic factor for the image of nurses as being compromising in their character. Nurse leaders point that out as the reason for the depiction of nurses as 'loose women' in mainstream movies and serials. The movie '*Dil ka Doctor*' (Doctor of Hearts), screened by a leading television channel, in which nurses were shown in compromising positions with male doctors provoked nurses who were part of the All India Nurses' Federation to go on strike en masse in 1995. Since they considered the state to be doing nothing to redress their grievances in this regard, nurses decided to 'Indianise' their uniform and changed them to *saris* on their own, though various governments have till date refused to legalise this change.

The contemporary state has also neglected nurses and nursing. The role of the state in India has remained confined to the modification of curriculum, and the establishment of degree courses, and measures to meet the shortage of nurses. The number of nursing schools and colleges increased manifold in independent India, but failed to meet the rising demand for nurses. State measures have remained inadequate with there being no standardisation of nursing or proper regulation of registration in many parts of India. This has left the hierarchies in nursing to be dealt with within the profession itself. The state has also not effectively addressed the issues of the pitiable service conditions and status concerns of nurses.¹⁷

Measures undertaken by the state in India include the appointment of a number of high power committees to survey the healthcare services in India, and suggest remedies for the maladies of the health sector. The first of these committees was appointed before independence, and had a number of significant recommendations for the regulation and standardisation of the nursing profession. The Indian Nursing Council was established in 1947 as a response to these proposals, which was instrumental in the existing standardisation of nursing education.

The health sector is extremely hierarchical, and state funding and other policy measures reinforce the status quo where nursing seems to be getting a bad deal. Nursing appears to be understood as the lesser of the professions in comparison to medicine and this hierarchy is practically upheld in the hospitals. Nurses in the administrative arrangement of hospitals are placed under the supervision of Nursing Superintendents, but for all practical purposes nurses are seen as subordinate to doctors, whereas they are actually to be treated as colleagues with different yet complementary services in the patients' care. The absence of a wholesome care for patients-mental, emotional and physical - also adds to the rather ignorant treatment of nursing as unskilled work, which can be equated with menial jobs. It is important to highlight the skilled aspect of their work.

16 Personal communication with Marie Percot during the discussion on the paper '*Comment s'ouvrir les frontieres du monde: La migration des infirmieres indiennes*', October 2005, lab Anthropologie Urbain, Ivry sur Seine, Paris.

17 Interviews with participants in the study '*Gender, Status of Profession and Migration: A Study of Nurses from Kerala in Delhi*', which will be available shortly.

Hierarchy within the hospitals and the class differentials between both doctors and patients are also part of the status anxiety of nurses. Nurses are supposed to be submissive workers who take orders well and do not question the doctors. They do not seem to have any room for innovation in their work. Many of them complain of being 'shouted at and being treated like inferiors' in hospitals by doctors. Hospital authorities also reportedly have a casual attitude towards their problems. The occupational role hierarchy within hospitals is known to affect the self-perceptions of all the players, especially that of doctors and nurses, and thereby affect the behaviour and interaction between these two professional groups (Oommen 1978).

Internal hierarchies within nursing constitute an important feature that works against the collective bargaining power of the nurses. Graduate nurses are seen as elites within nursing, who get absorbed in military nursing and teaching and consider themselves as belonging to a different group that is the true inheritor of the colonial legacy. Ordinarily one finds nurses with diplomas in General Nursing and Midwifery as qualified staff nurses in hospitals. There are women who are not trained in any of these courses, but have registered for certificate courses of one year or even less. They are meant to be nursing assistants, but are employed as nurses widely across hospitals in India. The latter type of 'nurses' are sources of very cheap caring labour, and are the main accomplices for the reduction of the cost of running the hospitals. These women cause resentment and status anxiety among their well-qualified sisters. Moreover, a lack of regulation and standardisation has led to diverse service conditions for nurses across hospitals. Central and state government hospitals in urban, metropolitan areas of India are better in service conditions compared to their rural counterparts. Similarly, there is a huge diversity in service conditions among private hospitals.

Nurses themselves attributed the low status of nursing to the low socio-economic status of women in India, 'as Nursing is primarily a women's profession' (TNAI 2001: 60). Nurses and leaders of nursing take the stand that the traditional subordination of Indian women in society has determined their own subordination in the workplace. TNAI's publication on the history and trends in Indian nursing found the basis for the 'subordination of Nursing profession to the male-dominated Medical profession' in the overall subordination of women in Indian society (ibid.).

Thus, notions of ideal gender behaviour, which are mediated through various hierarchies and institutions prevailing in society and organisations, create an ambiguous arena of status anxiety for nurses. In fact, nursing symbolises the tensions between the modern notions of economic independence of individuals resulting from education and employment on the one hand, and the patrifocal notions of women's dependence on male members of the family and community on the other, which are characteristic of a rural, agrarian society. Nurses and the way their status questions are dealt with are classic examples of negotiations with and within a patrifocal society.

Last but not the least, nursing is seen predominantly as a feminine profession, and this seems to be one of the reasons for the low status of the profession. Nurses voice the opinion that their demands for better service conditions were often not met in the past by authorities (private and government managements) because women had asked for them. Collective bargaining is not perceived to be effective in the case of women-majority professions.

Nevertheless, it has to be pointed out that there has definitely been a shift in the status of nursing and nurses in India over the last few decades. A change in the discourse from the concern over stigma to the status of nurses is an important point to be noted in this process. There have been attempts to perceive status in clearly defined material and tangible terms. This has helped nurse leaders in the past to identify ways and means of achieving improved status. Improvements in economic and service conditions of nurses help in the betterment of their status. Indian nurses are seen to be utilising the

opportunities available in rich nations of Europe, North America and the Persian Gulf which have arisen because of the shortage of nurses in these countries and infrastructure development. These migration opportunities have enhanced the economic and social status of nurses. Matrimonial advertisements in Indian newspapers come out with explicit demand for nurses who pass CGFNS¹⁸ qualifying examinations, which equip them to be employed in the United States. A 24-year-old nurse migrant from Kerala in the ongoing study on nurses mentioned earlier says that young nurses are looking for all the opportunities to go abroad, which enhances both their status and worth as a nurse.

We are preparing for CGFNS ... almost everyone Service condition, salary and status being so bad in India, going to the western countries is the best option America is the first preference and then Europe. If one cannot get through to any of the countries there, one looks to Kuwait, Saudi Arabia or Oman

Employment of *ayahs* and ward boys for basic toil like cleaning the patients, changing the bedpans, etc., remove a lot of the resentment of the nurses, who want to separate their skilled tasks with the unskilled everyday jobs mentioned. This changes the perception of those who are not in the profession as well. Dealing with technical equipments like ultrasound machines and highly equipped operation theatres raise the confidence of nurses, and they are seen as specialised by patients and others. Attempts to professionalise nursing in India through stricter admission norms and accreditation, and even high amounts of capitation fees for admissions have contributed to raising the status of nursing.¹⁹

The transition of nursing from a vocation to a job for sustenance has brought with it a break with several assumptions and conditions for nurses, as well as for others who want to define them in relation to a set of ideals. The earlier period saw a religious commitment to serve the poor and needy, and the ensuing status in the spiritual or non-material sphere as the reward for the hard labour nurses put in. As the modern system of medicine spread far and wide, demand for various service personnel started growing beyond the religious orders, the military and the privileged.

The role of professional organisation has been important for the improved social and economic status of nursing. TNAI, as discussed earlier in the paper, though largely criticised as 'existing in a world far removed from the real lives of staff nurses in Indian hospitals', has contributed towards the betterment of the status of nursing. They have resorted to lobbying in political circles, seemingly following the policies of the Indian nationalist movement before it took to mass mobilisation. There has been insistence on the part of TNAI to stick to the traditional sets of uniforms from the colonial times, which seem to be seen as defining the identity of nurses. On the other hand, more mass-based organisations, which believe in collective bargaining to achieve better status, like the Delhi Nurses' Union, for example, believes in 'transforming Indian nursing to suit its local surroundings', and measures discussed earlier like changing the uniforms to *saris* and *salwar kameezes* have been intended to bring about this effect.

While condemning the state for not doing enough for the deserving status of Indian nurses, nurses do talk about legislations and state initiatives that have helped their service conditions and status. Though highly inadequate in number, working women's hostels have been set up by various governments in an effort to accommodate the mainly single, migrant women workers in cities. At repeated requests and protests, housing colonies also have come up for nurses, just like the one in Srinivaspuri, Delhi. Legislations on night shifts and other legal provisions on service conditions have also benefited nurses.

¹⁸ Commission on Graduates of Foreign Nursing Schools (CGFNS) is an internationally recognised authority on credentials evaluation and verification related to the education, registration and licensure of nurses and healthcare professionals worldwide.

¹⁹ Interviews with Delhi Nurses' Union leaders, February 2006, and participants in the study 'Gender, Status of Profession and Migration: A Study of Nurses from Kerala in Delhi', which will be available shortly.

This overall betterment in the status of nurses in India has attracted women from higher classes and castes to nursing. Admittedly, nursing is 'no more that dirty'. Though this paper finds the need for nurses to constantly distance themselves and their skill from the 'dirty work' as an interesting research question to be critically looked at, the status anxieties of the practitioners of the nursing profession are perfectly reasonable in the contemporary period.

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