REGULATION OF NURSING PROFESSION IN INDIA- WITH SPECIAL REFERENCE TO THE STATE OF KERALA

Thesis Submitted to

The National University of Advanced Legal Studies, Kalamassery, Kochi

for the Award of the Degree Of

DOCTOR OF PHILOSOPHY

By

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Under the Supervision of

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DECLARATION

I do hereby declare that this thesis entitled **'Regulation of Nursing Profession in India-With Special Reference to the State of Kerala'** for the award of the degree of Doctor of Philosophy is the outcome of the original research work carried out by me under the guidance and supervision of Dr. Sheeba S. Dhar, Assistant Professor, National University of Advanced Legal Studies, Kochi. I further declare that this work has not been previously formed basis for the award of any degree, diploma, or any other title or recognition from any University/Institution.

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PREFACE

The Study is about "the angels who devote their selfless care and love to the service of others….one among those face which smiles at us when we initially steps out of mother's womb… the initial care takers of our lives……the magical touch which can console, care and bring us back to health…."

Nurses are the highest manifestation of service. The study travels through the life of nurses, their concerns and worries. As a socio-legal study, it portrait the regulatory aspects of nursing profession in India with the perception society have towards nursing. Though, nursing has reached its advanced stage with more specialized education, still need is felt for awarding a special status to nurses as 'healthcare professionals'. The need for a regulatory framework on the standard of practice of nurses is also examined.

This thesis work is not solely the product of the effort of one individual, but that of support of many. It is my solemn duty to acknowledge each one of them for their supports showed to me.

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PRIYA R.

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ABBREVIATIONS

AACN	American Association of Critical Care Nurses
AIR	All India Report
Am. J. Prev. Med.	American Journal of Preventive Medicine
Am.J.L.&Med.	American Journal of Law & Medicine
Cent Eur J Nurs Midw	Central European Journal of Nursing
CESCR	Committee on Social and Cultural Rights
CERD	Convention on the Elimination of Racial Discrimination
CJNR	Canadian Journal of Nursing Research
CLR	Columbia Law Review
Clev.St.L.Rev.	Cleveland State Law Review
Colum.Hum.Rts.L.Rev.	Columbia Human Rights Law Review
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of People with Disabilities
CULR	Cusat Law Review
Conn.L.Rev.	Connecticut Law Review
EPW	Economic and Political Weekly
ETS	European Treaty Series
FICCI	Federation of Indian Chambers of Commerce and Industry

GA.R	General Assembly Resolution
HHRJ	Health & Human Rights Journal
IACHR	Inter-American Commission on Human Rights
IBEF	Indian Brand Equity Foundation
ICN	International Council of Nurses
ICRC	International Committee of the Red Cross
ICRMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
INC	Indian Nursing Council
IJNER	International Journal of Nursing Education and Research
IJCS	International Journal of Caring Sciences
Im. J. Nurs. Stud.	International Journal of Nursing Studies
III.SC	Illinoss Supreme Court
ILO	International Labour Organisation
I.M.N.S	Indian Military Nursing Service
Int. J. Equity Health	International Journal for Equity in Health
JCL	Journal of Constitutional Law
J Med. Sci.	Journal of Medical Science
JILI	Journal of Indian Law Institute
K.B.	King's Bench

KHC	Kerala High Court Case
KLT	Kerala Law Times
LOJ Nur. Heal. Car.	Lupine Online Journal of Nursing & Health Care
L.Q.R	Law Quarterly Review
Med.Sci.	Law Medicine Science & Law
Milbank Q.	Milbank Quarterly
NCHRH	National Commission for Human Resources for Health
NJI	Nursing Journal of India
NSW	New South Wales
NSWSC	New South Wales Supreme Court
OHCHR	Office of the High Commissioner for Human Rights
SC	Supreme Court
SCC	Supreme Court Cases
S.E	South Eastern Reporter
SSLR	Symbiosis Student Law Review
TALR	The Academy Law Review
TRNAI	Trained Nurses Association of India
UDHR	Universal Declaration of Human Rights
U.L.Rev.	University Law Review

U.Pa.L.Rev.	University of Pennsylvania Law Review
UN	United Nations
USAID	United States Agency for International Development
QCA	Queensland Court of Appeal
W.Va.L.Rev.	West Virginia Law Review
WISH	World Innovation Summit for Health
WHO	World Health Organisation

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CHAPTER I

INTRODUCTION

Man as a social animal loves to be cared by others. He expresses his love and kindness to his fellow human beings in a societal set up. In need, he consoles his brothers in their sufferings or sickness. It is a value inherent in human life. Moral values such as empathy, devotion, love, and passion are its attributes. Providing unconditional care to others to reach one's best self is the underlying notion behind it[1].It is the very essence of a dignified life. Caring for others is reflected in Indian philosophy as a means to attain salvation. It is a devotion which one offers wholeheartedly. Such love and compassion are considered to be the backbone of healthcare services.

Caring for the patient is its essence as it follows the restoration of health. Among them, nursing professionals are considered as ideal care providers. They are called synonyms of care. When doctors cure illness, nurses care the patient for the successful administration of treatment. It is their magical touch of care that eases all pains and sufferings. No wonder they are often called 'angels of mercy.

In India, different types of nurses such as Auxiliary Nurse-Midwife; Lady Health Visitor; Public Health Nurse; Public Health Nurse Supervisor and District Public Health Nurse form part of the public healthcare level. Categories of nurses

[1] Pettersen Tove, *Conceptions of Care:Altruis, Feminism, and Mature Care*, JSTOR (12 Jan. 2018),http://www.jstor.org/stable/23254909.

such as Staff Nurse, Nursing Superintendent, and the Chief Nursing Officer forms part of the Hospital healthcare level.

The Indian Nursing Council (INC) records around 8, 85,383 Auxiliary Nurse Midwives (ANM), 21, 29,820 Registered Nurses and Registered Midwives (RN&RM), and 56,644 Lady Health Visitors (LHV) in the Country.[2]

However, studies reveal a shortage of trained and skilled nurses in India on the demand level. As per the Official Statistics available with the Ministry of Health and Family Welfare, Government of India, India stands at the 75th rank amongst 133 developing countries, in terms of number of nurses.[3]The Nurse patient ratio in India at present is 1.7 nurses per 1000 population.[4] The World Health Organization points out the need for an additional 2.4 million nurses in India to achieve the Government's aim of the nurse-patient ratio of one nurse per 200 populations.[5]The increasing migration of nurses from India is another important area of concern, which adds to the shortage. Better social status and job satisfaction are the primary reasons that attract nurses to move abroad.

An important aspect in India is the lack of a legal framework that recognizes nurses as 'health care professionals.' Neither the Central nor the

[2] MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA (19 Jun. 2017), http://164.100.24.220/ loksabhaquestions/annex/ 172/AU4358.pdf.
[3]DATA IS INFO (16 June 2021),https://datais.info/loksabha/ question/dd3cb57e87 a41198165c35 ab16308bf2/ doctors+nurses+patient+ratio/. *See also* PHARMATUTOR (4 Oct. 2021),https://www.pharmatutor.org/pharma-news/doctors-population-in-india.
[4] MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA (8 June 2017), http://164.100.24.220/ loksabhaquestions/ annex/173/AU4472.pdf.
[5]Kathryn Sen, *Wanted : 2.4 million nurses, and that's just in India*, BULL WORLD HEALTH ORGAN(13 Nov. 2017), http://www.environmentportal.in/files/Wanted%20nurses.pdf.

State legislative framework in India defines nursing as a professional sphere of action. Though they form the largest sector of the healthcare team, they remain 'ignored' and unrecognized. In India, the inclusion of 'hospitals' within the definition of 'industry' by the Bangalore Water Supply Case (1978) impliedly keeps nurses within the meaning of 'workmen.' As a labor class, they are entitled to all the benefits guaranteed by the labour laws in India. But the question of implementation of the rights, especially to those staff nurses working in the private sector, is a matter of concern. The strikes organized by nurses for protecting their rights and the petitions filed before the Supreme Court of India highlight the issues.

A further vital issue in India is the need for a uniform legislative framework for regulating the nursing sector in India. The nursing profession in India is regulated mainly by three sources: central legislation, state enactments, and common law principles that fix liability for medical negligence. The Nursing Council's Constitution at the Central and State level is the primary aim of both legislations. Compared to the central Act, the state laws provide detailed accounts on mandatory registration for practice, qualifications/conditions for registration, prohibition of unregistered persons from practice, grounds for taking disciplinary actions, the role of nursing councils, and penalties for non-conformity with the prescribed standards of practice. A critical analysis of the legislative framework highlights various issues and concerns that need an urgent cure.

The chief concern is the definition of 'Nurse.' The state legislations define the term in various ways. Several categories of persons are included without explaining the qualifications and duties they need to perform. Provisions explaining the standard of practice and scope of nursing practice were lacking in the legislation. Though registration of nurses is mandatory prescribed, a meager amount of fine is the only penalty imposed for its violation. The Constitution of the Nursing council with adequate representation from nursing is another matter which requires clarity. Proper representation from the nursing community is lacking in the council, which impairs the self-regulatory character of the profession itself.

Scrutiny of each provision of state legislations also reveals the need for uniformity regarding the standards for judging misconduct by nurses. Besides, the rights of nurses remain unnoticed by both the central and the state legislations. The need for a central law to regulate the standards of practice of nursing profession is an important issue highlighted in the Study. An empirical study is conducted with particular reference to the State of Kerala to understand the practical issues faced by staff nurses working on the clinical side.

The need for fixing the duties of nurses is discussed in order to identify the extent of their liability for medical negligence. The thesis also looked into the need to regulate nursing education in India, especially in the light of mushrooming private nursing educational institutions.

1.1 Significance of the Study

The study is significant in the light of the expanding needs and advancements in health care. According to the recent report submitted by IBEF, Health care has become one of India's largest sectors- both in terms of revenue and employment.[6] Factors such as the strengthening coverage and increasing expenditure provided by the public and the private sectors; rising frequency of lifestyle diseases; increasing demand for affordable healthcare delivery systems; technological advancements; the emergence of telemedicine; rapid health insurance penetration and government initiatives like e-health; tax benefits and incentives are pointed out as major driving forces of India's health care system.[7]It is reported that the increasing life expectancy, rise in lifestyle diseases, increased medical tourism, rising income levels, and the enormous geriatric population in India are expected to boost healthcare services demand in the future.[8]

Besides the new health initiative of the Government, the Ayushmann Bharat is anticipated to create a nationwide network of 1.5 health and wellness centres by 2022.[9]This positive vibration calls India to be well equipped with sufficient resources. A well-trained and efficient healthcare professional team has become one such prerequisite. As the backbone of the health care system, the services of nurses are inevitable in this regard.

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[6] INDIAN BRAND EQUITY FOUNDATION OF INDIA, INDIAN HEALTHCARE INDUSTRY REPORT (10 Feb.2018), https://www.ibef.org/ industry/healthcare-India.aspx.
[7] *Id.*
[8] *Id.*
[9]MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA (18 June 2019), https://pib.gov.in/ Press Release IframePage. aspx?prid=1559536.

The National Health Policy, 2017, framed by the Ministry of Health and Family Welfare, Government of India, necessitates basic health infrastructure requirements like doctor-patient ratio, patient-bed ratio, nurse-patient ratio, etc., to ensure the right to health.[10]The Policy suggests establishing cadres like Nurse Practitioners and Public Health Nurses to increase their availability in the most needed areas.[11]

A High-Level Group on Health, constituted by the Fifteenth Finance Commission, highlights the shortfall in human resources required for the Country.[12]It is pointed out that the current doctor-population ratio is 1:1511. In contrast, the WHO norm is 1:1000, and the nurse-population ratio is 1:670, whereas WHO mandates it to be 1:300 (population taken as 128 Crores).[13] Some of the significant recommendations of the group are to strengthen the nursing profession with new specializations as to the role of nurse practitioner, clinical nurse specialist, emergency care nurse, school health nurse, occupational nurse, physician assistant, nurse anesthetist, etc. for better utilization of nursing professionals.[14]

[10] MINISTRY OF HEALTH & FAMILY WELFARE, NATIONAL HEALTH POLICY, 2017 (7 Aug. 2018) https://www.nhp.gov.in/nhpfiles/national_health_policy_2017 pdf.
[11] *Id.*
[12]A REPORT OF THE HIGH-LEVEL GROUP ON HEALTH SECTOR, FIFTEEN FINANCE COMMISSION OF INDIA (18 Aug. 2020)https://fincomindia.nic.in/ writereaddata/html_en_files/ fincom15/Study Reports/High%20Level%20group%20of%20Health%20Sector.pdf.
[13] *Id.*
[14] *Id.*

Moreover, the study is relevant in the current scenario of national level discussions on the need for Nurse Practitioners.[15]The advancements in specializations in nursing such as Mental Health Nursing, Medical-Surgical Nursing, Child Health Nursing, Obstetric, and Gynecologic Nursing, Community Health Nursing, Pediatric Nursing, Neonatal Infant and Newborn Nursing, Critical Care Nursing calls for providing more professional status to nurses to be called as 'healthcare professionals.'

The current COVID-19 scenario also points out the need for protecting the rights and privileges of nurses. The petitions filed before the Supreme Court and the media reports highlight the issues faced by nurses while taking care of COVID-19 affected patients.

1.2 Objectives of the Study

- To examine the role of nurses in promoting quality healthcare.
- To know how far the legislative frameworks in India defines the term 'nurse' and includes various categories of persons within its purview.
- To understand the rights enjoyed by nurses and the duties imposed under the Indian regulatory framework.
- To examine the existing regulations on the Standard of education and practice of nursing in India.
- To examine the existing legislative framework that imposes liability on nurses for professional negligence.

[15] INTEREST IN ADVANCED PRACTICE NURSING IN INDIA (3 Aug. 2021), https://international. aanp.org/ Content/docs/ India.pdf.

- To examine how far the judiciary as a third organ of the Government has contributed to protect the rights of nurse's in India.
- To know how far the legislative framework of countries, apart from India, accommodates and incorporates good practices to regulate the nursing profession.
- To understand the socio-legal problems faced by nurses, both in private and Government sectors, especially in the State of Kerala.
- To check the scope of uniform central legislation for regulating the nursing profession in India.
- To provide suggestions that are needed to improve the existing legislative framework dealing with the nursing profession in India.

1.3 Hypothesis

The existing legislative framework in India lags behind in regulating the standard of practice of nursing professionals with respect to their rights, duties and liabilities for ensuring quality health care.

1.4 Research Questions

1. How far legislative frameworks in India recognize the role of nurses as health care professionals?
2. Whether the existing legislative framework is adequate to provide clarity to define the term 'nurse'?

3. How far the legislative framework dealing with the nursing profession in India protects the rights of nurses?

4. How far do the advancements in nursing education in India contribute to achieving a professional status for nurses?

5. Whether the existing legislative framework is adequate to ensure proper standards of nursing practice in India?

6. Whether there is proper regulation concerning the fixation of liability for negligence on nurses?

7. How does the judiciary deal with the issue of rights and professional misconduct on the part of nurses?

8. How far the legislative framework of countries, apart from India, incorporate good practices to regulate the nursing profession

9. What are the major socio-legal problems faced by nurses employed in the Government and private sector in Kerala?

1.5 Review of Literature

Literature on nursing professionals mainly focuses on the issues faced by nurses at their workplace. However, enormous books and articles are available on the history of nursing, features of nursing, the role of nurses in healthcare, nursing negligence and nursing education.

The Public Health Foundation of India (2012) report is one of the crucial documents that state that quality of health care depends upon the

competencies of healthcare professionals- their skills, knowledge, and competency to provide health care. This document discusses the relationship between the working atmosphere and educational training of healthcare professionals and how it ensures quality healthcare. World Health Organization (2003) provides elaborate details on the concept of health systems and their principles. The document explains the role of healthcare providers as one of the major building blocks in health systems. World Health Organization (2008) describes the concept of healthcare and the obligations of the State in achieving healthcare. The obligations of the State, such as the obligation to respect, the obligation to fulfill, and the obligation to protect, are explained in a detailed manner.

Paul Hunt (2016) narrates the concept of health from a human rights-based approach by examining the primary international documents dealing with the right to health. Paul Celkins (2011) discusses the right to healthcare, its interrelationship with other human rights, and the State's obligation towards achieving the right to health.

There are enormous articles and books that trace nursing profession's history in India through different stages. Detailed accounts on the development of hospitals and nursing education are available. Trained Nurses Association of India (2001) provides an elaborate version of the historical background of the nursing profession in India. Madelaine Healey (2014) discusses the evolution of the nursing profession from 1907-2007. The outlook of the society to nurses

is included in it. Sreelatha Nair (2012) discusses the opportunities which migration has offered to nurses.

Books that focus on the definition and characteristic features of nurses are other important sources of information. Florence Nightingale (1860) discusses the nature, meaning, and features of nursing. She defines nursing as the wholesome caring of the patient. The question of nursing as a profession is also addressed by some of the books. Discussions favoring and criticizing the same can be found. The modern advancements in nursing education and the role of nurses invariably keep nursing within the framework of a profession. Jogindra Vati (2012) points out the significant features that incorporate nursing within the framework of a profession. The International Labour Organization (2012) classifies occupations into different classifications based on skill levels wherein nursing is included within the category of health professionals.

Reports submitted by various committees and commissions appointed to study the problems of nurses in India are valuable sources of information. High Power Committee (1987) put forward the suggestion for improving the status of nurses in India. Balaraman Committee (2012) and the Veerakumar Committee (2013) were other major reports which provide recommendations for improving the conditions of nurses in the State of Kerala.

The Nursing Personnel Convention (1977) provides a framework for identifying nurses' rights, especially regarding their social and economic welfare. Loric Lorice Ede (1969) provides a detailed explanation on the kinds of legal relations which nurses have with others such as doctors, patients and

hospital authorities. It is based on Hohfeld's principles of right, duty, privilege, power, no-duty, and liability.

International Council of Nurses (1953) high lightens the significant philosophies and ethics of the nursing profession. It also includes the primary responsibilities which nurses must abide by in order to maintain and promote health of the people. Charles worth & Percy (1996) discuss the concept of negligence and its features. Jackson & Powell (1997) provide a detailed account of professional negligence and its essential components. Nathan Hershey (1965) discusses the idea of nursing negligence and case laws which deal with the issue of nurse's negligence and malpractice. Again, Edie Brous (2019), Eileen M. Crooke (2003), Barbara R. Benninger (1988), and Frank J. Cavico (1995) discuss the concept of nurse's malpractice and the issue of negligence committed by nurses by examining case laws. Nurses' duty to follow the orders of doctors and their duty to question improper orders are discussed by examining the principle of respondent superior.

Thus, on an overall analysis the research finds that majority of the books and articles deals with the issue of nurses at their workplace. Enormous studies can also be found on the issue of migration of nurses from India. Reports of WHO (2017) provide a detailed estimate on the production, stock, and migration of nurses from the State of Kerala.

WHO (2015) illustrates the guiding principles and the standards of nursing education. Navdeep Kaur (2014) and Jaspreet Kaur (2017) stated the

importance of a framework for the scope and purpose of nursing education. Sreelekha Nair & S Irudaya Rajan (2017) highlights the challenges of nursing education in India.

Prof. PM Bakshi (1994) provides an insight on the significant lacunae in the present regulatory framework dealing with nursing profession in India.

WHO (2002) analyzes the concept of regulation and how it applies to nursing professionals. Matters such as registration, definition, and functions of nurses, disciplinary proceedings, professional misconduct, penalties imposed, etc., are discussed.

Though enormous materials are available on issues faced by nurses, studies on legal framework of nursing is limited. Thus, the research is novel as it studies the major legal issues, especially the need to define the term 'nurse,' their duties, rights, and the need for uniform legislation incorporating those good practices followed by other countries outside India.

1.6 Research Methodology

The Study is doctrinal and empirical. The primary sources of data are the Constitution, Legislation, and Judicial decisions on nurses in India and abroad. The secondary source includes the Statements and Reports issued by the International Council of Nurses, World Health Organization; International Labour Organization; Indian Nursing Council, and State Nursing Council. Reports submitted by committees appointed by the Government to study about the conditions of nurses; debates and discussions made in Indian Parliament as well in Kerala Legislative Assembly; research studies conducted by private

organizations as well as individuals (thesis); newspaper reports; journal articles; conference articles; website materials; magazines and books. Materials were also collected through personal interviews with experts and experienced persons in nursing and by submitting applications under the Right to Information Act, 2005.

An empirical study is also conducted to know the real-life issues staff nurses face while working in government and private hospitals. A self-administered questionnaire and personal interview techniques were used to elucidate information from them. The sample size was selected by using Multi-stage Random Sampling. In the first stage, the 14 districts of Kerala were divided into geographic zones such as Northern Zone, Central Zone, and Southern Zone. Then, one district from each Zone is selected, such as Calicut from the Northern Zone, Ernakulam from the Central Zone, and Trivandrum from the Southern Zone. In the Second Stage, hospitals in these three districts were divided into private and Government hospitals. Using the Multistage Random Sampling method, one government medical college hospital and five private hospitals from each selected district were selected. Finally, 50 staff nurses from each government hospital and 50 staff nurses from private hospitals were chosen from the selected districts were included based on the convenience sampling method, thus comprising 300 staff nurses in total. That means, 150 nurses from the government sector, and 150 nurses from the private sector.

1.7 Limitation of the Study

The study mainly deals with the regulation of the nursing profession in India. Staff nurses working in government and private hospitals are included in the study to understand the practical issues faced by them at their workplace. The limitation of the Study is on obtaining data from private hospitals. Though nurses working especially in the private sector are interested in having a new legislative framework that recognizes their profession, still they are reluctant to share their service conditions. Fear of repercussion from the side of management obstructs most of them from exchanging the information freely.

1.8 Scheme of the Study

The Study is divided into eleven chapters.

Chapter I provides the initial framework of the Study. It discusses matters such as the significance of the study, objectives of the study, hypothesis, research questions, limitations of the study, review of literature, research methodology, and scheme of the Study.

Chapter II analyzes the concept of health care. The chapter begins with the concept of health and its dimensions. The aspect of public health and individual health is examined to know the role of nurses in both. The aspect of health as a right is discussed in a detailed manner by analyzing its significant components such as the 'underlying determinants of health' and 'right to health care. The chapter analyses the role of the State in ensuring the right to health. International conventions and treaties that deal with the right to health and the

obligation of the State are examined. The chapter also explores the concept of the right to health under the Indian Constitution. A detailed interpretation of the judiciary on various dimensions of health care is included. The role of healthcare providers is also analyzed.

Chapter III portraits the role of nurses in health care. The chapter starts with a general discussion on the concept of care. How nurses differ from other healthcare providers is answered by examining the unique features of nursing. Further, it discussed the definition, meaning, and features of nursing. The role of nurses at three levels of health care, such as the public health level, the individual health care level, and the global health care level, is included with a detailed description on the significant activities undertaken at each level. Finally, the chapter tries to probe into the question of the professional status of nurses, 'How the legislative frameworks of selected jurisdictions of the world do define nursing?' is analyzed. A brief comparison with roles performed by nurses in countries such as the USA, UK, Canada, Australia, South Africa, Philippines, and Middle East Countries are included to know how these countries treats "nurses" within their legislative framework.

Chapter IV traces the evolution of the nursing profession in India. The historical background of the development of nursing in the United Kingdom by listing out the period of professional development such as the Pre-historical period, Middle Ages, Renaissance Period and finally the foundation of training schools of nursing by Ms.Florence Nightingale is discussed. The development of nursing in India is included with references to Samhitas, Buddhist,

Brahmanical period, Western Influence, and the influence of Florence Nightingale. A historical glance at the development of nursing associations in India especially, the Trained Nurses Association and its alliance with the International Council of Nurses, are specifically looked into. An analysis of recommendations made by various committees appointed to study the problems faced by nurses in India is also made. A brief account of the evolution of nursing in the State of Kerala can also be found in this chapter.

Chapter V examines the rights of the nurse in the light of International Conventions and Instruments. Conventions such as the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces 1949; the Nursing Personnel Convention, 1977; the Position Statements released by the International Council of Nurses on Socio-Economic Welfare of Nurses and the Nurses Bill of Rights are inspected to know the various rights that are guaranteed to nurses. The rights of nurses are also examined in the light of various provisions of the Constitution of India. Rights such as the right to practice the profession, right to form associations or unions, right to health, right against exploitation, and right to just and humane conditions of work, are interpreted in the light of judicial pronouncements.

Chapter VI scrutinizes the duties and responsibilities of nurses. The International Code of Ethics for Nurses, 1953, is examined to understand the fundamental responsibilities of nurses towards patients, practice, profession, and co-workers. The duties of nurses in India are analyzed within the framework of State legislations, the Charter of Patients Rights, and the Code of

Ethics for Nurses (2006). Discussions about the concept of negligence, professional negligence, and nurse's negligence are included with judicial interpretations. Common law principles which are used for defining negligence and the concept of vicarious liability are also discussed.

Chapter VII deals with the legislative framework of the standard of the practice of nursing professionals in India. A critical examination of the Central Act, titled the Indian Nursing Council Act, 1947, and the State Nursing Council legislations are included. Aspects such as the need for a uniform definition of nurse, adequate representation of nurses in the State Nursing Councils, need for renewal of registration of nurses, need for uniformity in disciplinary proceedings is included. A special note on the Kerala State Nursing Council Act, 1953, is prepared. The Nursing and Midwifery Commission Bill, 2020 is also examined critically.

Chapter VIII describes the legal regulation of Nursing Education in India. The powers of the State Nursing Council in recognizing and withdrawing the qualifications of nursing education and the present structure of nursing education in India are discussed. The significant challenges faced by nursing education such as disparity in fee structure between the private and the government nursing institutions, concerns surrounding the new admission process which allows art stream students to B.Sc. nursing, geographic imbalances in nursing education, need for regulation of private nursing institutions imparting nursing education, lack of proper infrastructure facilities to impart clinical training to nursing students are discussed critically.

Chapter IX deals with the legislative framework of nursing professionals at the international level. Comparative analysis of the legislative framework of States such as the USA, UK, Canada, Australia, South Africa, United Arab Emirates, and the Philippines is made to know the good practices followed by these countries. Aspects such as the purpose of the legislation, definition of nurses, nursing services, their functions and role, the structure of the councils, powers enjoyed by nurses, matters of registration, disciplinary proceedings etc., are analyzed.

Chapter X deals with Empirical Study on the work conditions of staff nurses in private hospitals and government hospitals in the State of Kerala. For the Study, the State of Kerala is divided into three zones: the Northern, the Central, and the Southern. One district from each Zone is randomly selected by using the multi-stage sampling method. Districts such as Kozhikode from the Northern side, Ernakulam from the Central part, and Trivandrum from the Southern side are selected. Around 100 staff nurses from each Zone, 50 representing the government sector and 50 representing the private sector, comprising 300 nurses from three districts, were selected based on the convenient sampling method.

Chapter XI deals with the conclusion and suggestions. The study's significant findings are discussed with suggestion as to the need for a new legislative framework for nursing professionals in India.

CHAPTER II

RIGHT TO HEALTH CARE: CONCEPTUAL ANALYSIS

Introduction

Health is a fundamental right of every human being. As a right, it casts obligations on the State to ensure conditions required to enjoy the right to health. These conditions are known as the 'underlying determinants of health,' without which the right to health is unattainable. It includes all those interrelated rights such as right to food, right to healthy working conditions, right to water, right to education, and all the other rights needed to realize the right to health.

Besides ensuring these conditions, State is obliged to take necessary measures that are essential for the realization of the right to health. It includes measures such as the prevention and treatment of illness and the Constitution of structures and services supporting health care promotion. Establishing a people-centered health system with health care facilities functioning in coordination between public and private entities is such a requirement. Similarly, the availability of a sufficient quantity of well-trained healthcare professionals within the State is an essential prerequisite for ensuring the right to health. They form one of the primary building blocks of the healthcare system. The chapter analyzes the concept of health, healthcare, and the obligation of the State in ensuring the right to health. The role of the judiciary

is examined to know various interpretations given to the concept of healthcare. The role of healthcare providers in health care is also analyzed.

2.1 Health: Concept and Dimensions

The word 'Health' is derived from the Old High German and Anglo-Saxon Words meaning 'whole, hale and holy.[1]The etymology of health has been traced to a Proto-Indo-European root,' kailo,' meaning whole, uninjured, of good omen.[2]Thus health is linked to the concept of wholeness, holiness, hygiene, cleanliness, saintliness, goodness, and godliness.[3]The idea of health has different interpretations extending from an ideal state to the absence of medically defined and certified diseases. The Merriam Webster's Collegiate Dictionary defines health in terms of liberation from physical pain. The soundness of body, mind, or spirit is included within it.[4]A similar definition is provided in the Black's Law Dictionary (1979). It defines health as 'the conditions of being sound or whole in body, mind, soul or freedom from pain or sickness".[5]The most acceptable definition of health as the complete wellbeing of mental and physical conditions is given by the Constitution of the World Health Organization (1946). It defines health as "the state of complete

[11] DAVID F MARKS "et al." HEALTH PSYCHOLOGY: THEORY, RESEARCH AND PRACTICE, 4 (Sag, 2011); *See also* CHRIS BROOKER & ANNE WAUGH, FOUNDATIONS OF NURSING PRACTICE: FUNDAMENTAL OF HOLISTIC NURSING 4 (Elsevier 2007).
[2] *Id.* at 4.
[3] *Id.* at 4.
[4] *Health*, MERRIAM WEBSTER COLLEGIATE DICTIONARY(10th ed. 2001).(Health is defined as "the condition of being sound in body, mind or spirit, especially freedom from physical disease or pain").
[5] *Health* , BLACK'S LAW DICTIONARY (Thomas Reuters, 2009).

physical, social and mental well being and not merely the absence of disease or infirmity.[6]Thus, ultimately health is the welfare of both the body and mind.

When we analyze the works of literature, three views can be seen to explain health such as the Biomedical or the Traditional Health concept, which view health as a disease-free state; the World Health Organization concept, which includes a holistic view of health as physical and mental wellbeing and the Ecological idea of health, which views health as a dynamic equilibrium between man and his environment, and disease as maladjustment of the human organism to the environment.[7]Thus, as a whole, health can be related to various dimensions such as physical, mental, social, spiritual, emotional, and vocational.[8]

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[6] WHO CONST. 1946.

[7]Evely Boruchovitch & Birgitte R. Mednick *The meaning of health and illness: some considerations for health psychology*, RESEARCH GATE (26 Oct.2016),https:// www.scielo. br/j/pusf/a/dVT9YdbssXYcg8fZyHKMdpz/?lang=en&format=pdf.
(The traditional concept of health was based on the assumption that health and disease were objective and observable phenomena. The World Health Organization Concept of Health view health as presence of absolute and positive qualities. It includes social, psychological, physical, economic and political aspects into the scope of health. The third view, the Ecological Concept of Health included two aspects such as conceiving health as a more relative sort of concept and, as an interrelationship between the environment and the individual's quality of life. It defines health either in terms of functional capacity which allows the individuals to carry out their duties and responsibilities or in terms of certain quality of life which enables individuals to live happily, successfully, fruitfully and creatively. It geared more towards associating health with adaptation; health has been conceptualized as individual's capacity to adjust adequately to their environment). *See also* Vijay Kumar Yadavendu, *Changing Perspectives in Public Health From Population to an Individual*, JSTOR(6 Jan.2020), https://www.jstor.org/stable/4414375?refreqid=excelsior%3 Aa1c0388 781fadc 115bc37bdc34b63568.

[8]KALYANI BHAGAWATHI, HEALTH CARE MANAGEMENT: A STUDY OF THREE SUPER SPECIALTY HOSPITALS IN VISHAKHAPATNAM, SHODHGANGA (26 Jun. 2019), https://shodhganga.in flibnet.ac.in/bitstream/ 10603/38985/9/09_chapter-i.pdf.(Physical dimension of health refers to the normal functioning of all the tissues, organs and systems of the body resulting in harmonious functioning of the body. Mental dimension is related to the mind and refers to normal functioning of mind not merely absence of mental diseases. It is a state of balance between the individual and his self on one side and between the individual

2.1.1 Individual Health and Public Health

The scope of health can be studied under two disciplines –individual and public health—the former deals with the individual's health, whereas the latter deals with the health of populations.[9] Individual health care refers chiefly to those personal services provided directly by physicians or rendered as the result of physicians' instructions.[10]It ranges from domiciliary care to resident hospital care.[11]It aims mainly at the diagnosis and treatment of the whole patient.[12]

Even though both aim to prevent disability and diseases, thereby promoting health care services, the ambit of public health is wider.[13]The promotion of the health of the whole community is the central goal of the public healthcare system. It includes everything that pertains to the health and well-being of the people-physical, mental, emotional, social and the mandate of the people, the organized community effort.[14]An expanded definition of Public Health as inclusive of prevention and promotion of activities related to health through community efforts is provided by C.E.A. Winslow, an American

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and his external environment on the other side; Social dimension includes social well-being of a person. It includes harmony and integration within the individual, between each individual and other member of the society and between the individual and the world in which they live. ; Spiritual dimension takes into account the individual as a whole, comprising of his mind, body and soul. Emotional Dimension denoted a controlled mind which can control all emotions at the right time; vocational dimension is concerned with occupational and earning livelihood).

[9]Jonathan M. Mann "et al.", *Health and Human Rights*, HHRJ (12 Aug.2019), https:// www. hhrjournal.org/archives/volume-1-issue-1/.

[10]DR.BISMI GOPALAKRISHNAN, ROLE OF STATE IN THE REALIZATION OF RIGHT TO HEALTH (Thesis) University of Kerala, 2007.

[11] 24 K. PARK, PARK'S TEXTBOOK OF PREVENTIVE AND SOCIAL MEDICINE 926 (M/s Banarsidas Bhanot Publishers 2017).

[12] *Id.*

[13] PAULI MATHEW MURICKEN , PUBLIC HEALTH PROTECTION THROUGH AIR QUALITY CONTROLS, (Thesis) Cochin University of Science and Technology, 2009.

[14] Mc Gavran & Edward G, *What is Public Health ?,* JSTOR (5 Apr.2020), https://www. jstor.org/stable/41980493.

public health expert.[15] Matters such as sanitation of the environment, community infection control, individual education in personal health, organization of health care services, etc., are included.

Another notable definition of public health from the viewpoint of the State is provided by Lawrence O. Gostin,[16]an American law professor who specializes in public health. He defines public health in terms of an effort of the State and its partners for the wellbeing of the people. All government, local authorities, health authorities, and other critical agencies for improving public health come under it.[17] The introduction of Vaccinations to eradicate smallpox, measles, rubella, tetanus, and other infectious diseases; motor vehicle safety;

[15]SS HIREMATH, TEXTBOOK OF PREVENTIVE AND COMMUNITY DENTISTRY 526 **(**Elsevier 2007**) (**Public Health is defined as "the science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in personal health, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance or improvement of health……..").

[16] LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW : POWER, DUTY, RESTRAINT 4 (University of California 2008). (Public Health is defined as "the study of the legal powers and duties of the state, in collaboration with its partners (e.g., health care, business, the community, the media, and academic), to assure the conditions for people to be healthy (to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the common good. The prime objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice").

[17]PUSHPALTHA PATTNAIK , PUBLIC HEALTH LA, ETHICS AND HUMAN RIGHTS 1 (Black Prints.,2013). ("Public health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals". It is concerned with threats to health based on population health analysis. Improving the quality of life through the prevention of disease and the promotion of healthy behaviors are its major aim. Promotion of hand washing and breast feeding, delivery of vaccinations, and distribution of condoms to control the spread of sexually transmitted diseases are examples of common public health measures. Modern public health practice requires multidisciplinary teams of professionals including physicians specializing in public health/ community medicine/ infectious disease, epidemiologists, biostaticians, Public health nurse etc.).

access to family planning and contraceptives; recognition of tobacco usage as a health hazard; Control of contagious diseases; Safer and healthier foods and availability of clean water are some methods that are adopted for the furtherance of public health.[18] Thus, it is based on the notion that realization of the right to health affects not only the health of an individual but also society's public interest.[19]This societal dimension of health can be seen in the Declaration of Alma-Alta (1978), which described health as a social objective that requires action from all the sectors of society.[20]Thus the modern concept of health includes the broader societal dimensions and context of individual and population well-being.[21]

2.2 Health as a right: Key Aspects

Health is regarded as a right that is so essential for the fullest development of one's personality[22]. As a right, it casts positive and negative obligations on the state.[23] As an affirmative aspect, the right to health imposes a duty on the state to intervene or act, to the extent of its available resources, to prevent, reduce, or address severe threats to the health of individuals or

[18] *Id.* (Health is defined as a "...social goal whose realization requires the action of many other social and economic sectors in addition to the health sector…").
[19]*Id.* (For example, if an individual catches a contagious disease, the health of not only himself but also all the people around him will be affected and threatened. Problems such as environmental pollution and infectious diseases harm public health and the interests of huge numbers of families).
[20] DECLARATION OF ALMA ALTA (8 June 2020), https://www.who.int/ publications/ almaata_ declaration_en.pdf.
[21]Jonathan M . Mann,"et al.", *Health and Human Rights*, HHRJ (6 Jun.2020),https://cdn2. sph.harvard.edu/wp-content/uploads/sites/13/2014/03/1-Front-Matter4.pdf.
[22]Pauly Mathew Muricken, *Right to Health and Public Health: Conceptual and Jurisprudential Overview*, 37 C.U.L.R 1 (2013).
[23]Steven D. Jamar, *The International Human Right to Health*, SSRN (18 Apr.2020) https:// papers.ssrn.com/sol3/papers.cfm?abstract_id=1093085.

populations.[24]Viewed negatively, rights are those opportunities, the absence of which deprives man of something essential[25]. Examples of negative aspects include the duty of the States to refrain from barring access to health-related information and the responsibility of the States not to take health-harming actions.[26]

Freedoms and entitlements are the significant attributes of the right to health.[27] The State is obliged to guarantee both these for ensuring the right to health. Freedoms include the right to control one's health and body, including sexual and reproductive freedom, freedom from interferences such as torture, non-consensual medical treatment, such as medical experiments and research or forced sterilization.[28]Entitlements include access to health care services that are needed to enjoy the highest attainable level of health, access to safe and healthy working conditions, and other socio-economic determinants of health, such as food, water, and sanitation.[29]

The right to Non-discriminatory treatment is yet another vital principle attached to the right to health.[30]It means that the State must provide all health services, goods, and facilities without any discrimination.[31] It is also within its

[24] *Id.*
[25] MURICKEN , *supra* note 22.
[26]JAMAR, *supra* note 23.
[27]UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURE RIGHTS, GENERAL COMMENT NO.14 (2000) ESCR (6 Oct. 2017),https://www. refworld.org/pdfid/4538838d0.pdf.
[28] *Id.*
[29]*Id.*
[30] *Id.*
[31] *Id.*

purview to provide special protection and considerations, particularly to vulnerable groups such as women, children, and persons with disabilities.[32]

'Availability, Accessibility, Acceptability, and Quality' are the four essential attributes of health rights.[33]Availability signifies that the availability of public healthcare facilities and services within the State.[34]Availability of safe drinking water, sanitation facilities, hospitals, clinics, trained medical and professional personnel and essential drugs are examples.[35]

Accessibility means the accessibility of health facilities, goods, and services have to be accessible to everyone without discrimination, within the State, especially to the vulnerable or marginalized groups, such as women, children, adolescents, persons with disabilities, and persons with HIV/AIDS[36]. It also implies that "medical services ….are within safe physical reach…including rural areas".[37] Accessibility of health facilities, goods, and services to all, affordability of healthcare services, whether privately or publicly provided, must be affordable for all is the concept.[38]

Acceptability implies that all health facilities, goods, and services must be respectful of medical ethics and culturally appropriate such as respectful of

[32]UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURE RIGHTS, GENERAL COMMENT NO.14 (2000), ESCR (6 Oct. 2017), https://www. refworld.org/pdfid/4538838d0.pdf.
[33] *Id.*
[34]WORLD HEALTH ORGANIZATION HUMAN RIGHT AND HEATH (9 Oct. 2019), https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health.
[35]CESCR, supra note 27.
[36] *Id.*
[37] *Id.*
[38] *Id.*

the culture of individuals, minorities, peoples, and communities.[39]Here, it means approving rights to healthcare facilities without discrimination as to gender, culture, etc. The best example is the rights of tribes and women.[40]They must also be guaranteed the right to health through social security measures and programs.

Quality specifies that health facilities, goods, and services must be scientifically and medically appropriate and of good quality.[41]It requires skilled medical personnel, scientifically approved and unexpired drugs, hospital equipment, safe water, and adequate sanitation.[42]Thus, the right to health is related to many essential aspects for the fullest development of human beings.

2.2.1. Right to Health: International Instruments

The manifestation of health as a human right can be found in various international instruments and conventions. The first document which manifests health as a right is the Constitution of the World Health Organization (1946). It states that "the enjoyment of the highest attainable standard of health is one of

[39] *Id.*(Acceptability refers to sensitizing a social protection programme toward the multiple forms of discrimination that might arise at the intersection of race, gender, class, ethnicity, disability or other identities and backgrounds. For example, indigenous peoples may find it difficult to use health centres where their mother tongue is not spoken or where no efforts are made to reconcile modern health care with their traditional practices. similarly, patriarchal attitudes towards women can often lead to situations where women are not treated with respect when they come to seek entitlements or lodge complaints. To comply with this principle, social protection programmes should assess the asymmetries of power that exist in communities by holding broad consultations with the respective rights-holder groups. Special attention must be paid to groups that suffer from structural discrimination as a matter of priority in the design, implementation and monitoring of programmes in order to meet obligations assumed in human rights instruments).

[40] *Id.*

[41]WORLD HEALTH ORGANIZATION, THE RIGHT TO HEALTH (2nd Oct. 2017), https://www.ohchr.org/ Documents/Publications/Factsheet31.pdf.

[42] *Id.*

the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition." [43]

The idea of health as a right was again embraced in the American Declaration on the Rights and Duties of Man, 1948. It is mentioned that "every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing, and medical care, to the extent permitted by public and community resources."[44] Again Right to health is included in the Universal Declaration of Human Rights, 1948, and a series of economic and social rights.[45]

The right to the highest attainable health achieved its independent status on the international stage with the adoption of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) in 1966, which recognizes the right of everyone to the enjoyment of the highest standard of physical and mental health.[46]

Time and again, the right to health is mentioned in other International human rights treaties such as the International Convention on the Elimination of All Forms of Racial Discrimination,[47] the Convention on the Elimination of

[43] WHO CONST.

[44] AMERICAN DECLARATION ON THE RIGHTS AND DUTIES OF MAN, art. xi, 1948.

[45] UNIVERSAL DECLARATION OF HUMAN RIGHTS, art. 25 (1), Dec. 10, 1948, GA.R.217/A. (It states "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services…..").

[46] INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, art. 12, 16 Dec. 2016, 1966, GA.R.2200A(XXI).

[47] INTERNATIONAL CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION, art. 5, 21 Dec. 1965, GA.R2106(XX).

All Forms of Discrimination Against Women,[48]the Convention on the Rights of the Child,[49]the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families,[50] and the Convention on the Right of People with Disabilities.[51]

Right to health is also found reflected in regional charters such as the European Social Charter,[52] the Ottawa Charter for Health Promotion 1986,[53]the African Charter on Human and People's Rights 1986,[54] the African Charter on the Rights and Welfare of the Child,[55]and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights referred as 'Protocol of San Salvador,' 1988.[56] Similarly, the right to health has been proclaimed by the Commission on Human Rights as well as the Alma Ata Declaration, [57]and the Vienna Declaration of Programme of Action of 1993.[58]

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[48] CONVENTION ON ALL FORMS OF DISCRIMINATION AGAINST WOMEN, art.11, 18 Dec. 1979, GA.R.34/180.
[49]THE CONVENTION ON THE RIGHTS OF THE CHILD, art.24 Nov. 20, 1989, GA.R.44/25.
[50]INTERNATIONAL CONVENTION ON THE PROTECTION OF THE RIGHTS OF ALL MIGRANT WORKERS AND MEMBERS OF THEIR FAMILIES, art.25, Dec. 18, 1980, GA.R.45/158.
[51] CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES, art.25, 13 Dec.2006. GA.R.61/106.
[52] EUROPEAN SOCIAL CHARTER, art.11, Oct. 18, 1961, ETS 163.
[53]THE OTTAWA CHARTER FOR HEALTH PROMOTION, 21 Nov. 1986. (The charter defines "health promotion as the process of enabling people to increase control over, and to improve, their health…. to reach a state of complete physical mental and social wellbeing……...").
[54] AFRICAN CHARTER ON HUMAN AND PEOPLE'S RIGHTS, 27 Jun. 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58,1982.
[55] AFRICAN CHATER ON THE RIGHTS AND WELFARE OF THE CHILD, art.14, 11 Jul.2011, 1999, OAU Doc. CAB/LEG/24.9/49 (1990).
[56] ADDITIONAL PROTOCOL TO THE AMERICAN CONVENTION ON HUMAN RIGHTS in the area of Economic, Social and Cultural Rights,art.10, 17 Nov. 1989.
[57]ALMA ALTA DECLARATION, art. VIII, 12 Sept. 1978.
[58] VIENNA DECLARATION AND PROGRAMME OF ACTION, art.24, 25 Jun. 1993.

2.2.2 Underlying Determinants

Health as a right is again related to two other significant components such as ' underlying determinants of health' and 'timely healthcare.' When the former deals with the factors (rights) that are essential for the enjoyment of the right to health, the latter deals with the steps to be taken by the States to reach the goal of the right to health.[59]

The concept of the right to health is illustrated in the table below:

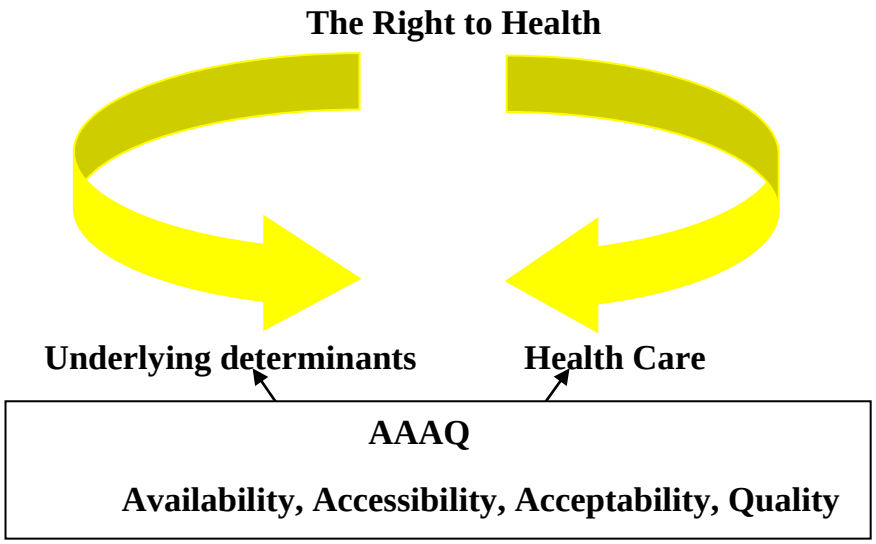

Figure 2.1, Source: World Health Organization[60]

As noted before, the right to health is an inevitable element for enjoying other rights.[61]As an inclusive right, the right to health includes many factors that can help us lead a healthy life.[62]It is one of the human rights without

[59] WORLD HEALTH ORGANIZATION, THE RIGHT TO HEALTH FACT SHEET NO.31 (2 Oct. 2017), https://www.ohchr.org/Documents/Publications/Factsheet31.pdf.
[60] *Id.*
[61] UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURE RIGHTS , GENERAL COMMENT NO.14 (2000) ESCR (6 Oct. 2017), https://www.refworld.org/pdfid/4538838d0.pdf.
[62] WORLD HEALTH ORGANIZATION, THE RIGHT TO HEALTH,(2 Oct. 2017), https://www.ohchr.org/Documents/Publications/Factsheet31.pdf.(Good health is influenced by several factors that are outside the direct control of the states, such as an individual's biological make-up and socio-economic conditions).

which it becomes difficult to exercise other rights.[63] Without the right to health, men may not secure their own economic, political, and social rights, such as the right to a healthy environment, social security, human equality and autonomy.[64]

The importance given to the 'underlying determinants of health' to achieve the right to health shows that the right to health is closely related to and dependent upon the realization of other human rights.[65]These include the right to food, right to safe water, right to housing, right to work, right to education, right to human dignity, right to life, right to non-discrimination, right to equality, right to the prohibition against torture, right to privacy, right to access to information, and the right to freedoms of association, assembly and movement.[66]These and other rights and freedoms address integral components of the right to health.[67]

2.2.3 Health Care

'Timely and appropriate health care is another important constituent of the right to health.[68] It deals with the steps (means) to be taken by the States to reach the goal of the right to health.[69]The obligation of the State to ensure conditions that are essential for the enjoyment of the highest attainable standard

[63] Paulius Celkins *Relationship between the Right to Dignity and the Right to Healthcare,* 3 IJAC 167-176, 168 (20 Oct. 2017), https://www.ijac.org.uk/images/ frontImages/gallery/Vol._3_No._5/14.pdf.
[64] *Id.*
[65] WORLD HEALTH ORGANIZATION, THE RIGHT TO HEALTH (3 Oct.2017), https://www.ohchr.org/Documents/Publications/Factsheet31.pdf.
[66] UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURE RIGHTS , GENERAL COMMENT NO.14 (2000) ESCR (Oct. 6, 2017), https://www.refworld.org/pdfid/4538838d0.pdf.
[67] *Id.*
[68] *Id.*
[69] *Id.*

of health is the core of the concept of health care.[70]The concept is based on the notion that the "state cannot guarantee or provide health directly; it can only provide conditions conducive to the attainment of health."[71] It is based on the assumption that "an individual cannot properly claim, 'I have a right to health so make me healthy,' but the person can assert ……. 'I have a right to health, so do the things necessary to enable me to have health'.[72] Viewed as such, the right to health can be understood as "implemented only as of the right to health care, rather than the absolute right to good health".[73] Thus the right to health care can be identified as the right to resources, goods, services, and necessary conditions that are needed to attain it.

2.2.3.1 Obligation of the State

The obligation of the State in the realization of the right to health through health care includes three aspects: the Obligation to respect, the responsibility to protect, and the Obligation to fulfill.[74]The responsibility to respect requires States to abstain from interfering directly or indirectly with the right to health.[75]The responsibility to protect requires States to prevent third

[70] Steven D. Jamar, *The International Human Right to Health*, SSRN (2 Apr.2020), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1093085.
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] WORLD HEALTH ORGANIZATION, THE RIGHT TO HEALTH (3 Oct. 2017), https://www.ohchr.org/Documents/Publications/Factsheet31.pdf.
[75] UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURE RIGHTS , GENERAL COMMENT NO.14 (2000) ESCR (6 Oct. 2017), http://www.refworld.org/pdfid/4538838d0.pdf.(States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs).

parties from interfering with the right to health.[76]Finally, the obligation to fulfill requires States to adopt suitable measures to fully realize the right to health.[77]

As the right to health is included in the purview of economic, social, and cultural rights, it is subject to progressive realization and resource availability principles. The focus of progressive realization requires the state to move as expeditiously and effectively as possible towards the full realization of the right to health.[78]

2.2.3.2 Constitutional Framework in India

The Constitution of India obliges the State to ensure the right to health. Under the Constitution of India, Health is regarded as a State subject.[79]It casts an obligation on the States to provide conditions of good health such as improving the health and strength of workers,[80] children,[81] humane conditions of work,[82] and raising the level of nutrition.[83]These directives are fundamental

[76] *Id.*(Obligations to protect include, inter alia, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct).

[77] *Id.* (Measures such as legislative, administrative, budgetary, judicial, promotional etc. The obligation to fulfill requires States parties, inter alia, to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health).

[78]ESCR, *supra* note_____

[79] INDIA CONST.Sch.XII, List II, State List, Item 6 (Public health).

[80] INDIA CONSTI.arti.39 (e).

[81]INDIA CONSTI.art.39 (f).

[82] INDIA CONSTI.art.42.

[83]INDIA CONSTI.art.47.

in the governance of the Country. In addition to the constitutional provisions, various international conventions and multilateral obligations such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) are ratified by India.[84]

2.2.3.3 Judicial Interpretations

Though the right to health is not explicitly provided in the Constitution, the judiciary has read into the right to health under Article 21.[85]The various decisions of the Supreme Court show that the concept of the right to health has been discussed under Article 21 along with the Directive Principles of State Policy. Further, the Court has also widened its scope by examining the liability of the State to provide health care. In most of the cases, the court recognized the right of workers to health care, the role of the Government in ensuring healthcare, the right to emergency medical care, the right to a safe and healthy environment, etc.

[84]Ratified on 10 Jul. 1979 (In Vishaka v. State of Rajasthan AIR 1997 SC 3011, It is held that the state had a constitutional obligation to promote international law, and vacuum left unattended by domestic law. In case of health law, this observations hold relevance so as to fill the gaps in the domestic health law).

[85] Consumer Education and Research Centre v. Union of India (1995) 3 SCC 42; State of Punjab v. Mohinder Singh Chawla (AIR 1997 SC 1225); Hinch Lal Tiwari v. Kamala Devi (20001) 6 SCC 496; State of H.P. v. Umed Ram (AIR 1986 SC 847); Kirloskar Brothers Ltd. v. Employees' State Insurance Corp (1996)2 SCC 682; Bandhua Mukti Morcha v. Union of India AIR 1984 SC 802, Para 10;Occupational Health and Safety Association v. Union of India AIR2014 SC 1469; L/C of India v. Consumer Education & Research Centre (1995)5 SCC 482).

Vincent Panikulangara v. *Union of India*,[86] is one of the classic cases which reminded the State of its obligation to protect the citizen's right to health. As the custodian of citizens, the State is obliged to create conditions that support the public's health. It is observed that:-

> *"…. In a welfare State, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health….maintenance and improvement of public health has to rank high as these are indispensable to the very physical existence of the community….*".

Parmanand Katara v. *Union of India*,[87] is one of the significant cases where the Supreme Court provides important directions about the obligation of the State and medical professionals to uphold the right to health. *C.E.S.C. Limited* v. *Subhas Chandra Bose*,[88] is another case where the Court has given an expanded definition of health to include the aspect of stable workforce for economic development. The importance of healthcare of workers has been projected in this case.

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[86]Vincent Panikurlangara v. Union of India, 1987 SCC (2) 165, Para 16.(The case relates to a PIL filed by Petitioner, Vincent Panikurlangara for implementation of an adequate, central policy and establishment of a central drug standards authority, with suitable enforcement powers to ban "harmful and injurious drugs" under Sections 10-A and 26-Aof the Drugs and Cosmetics Act, 1940 .This petition was based on Article 21 of the Constitution which guarantees the right to life, "which includes medical attention and a life free from diseases.").

[87]Parmanand Katara v. Union of India, AIR 1989 SC 2039, Para7 & 8. (In this case, a PIL was filed praying for directions to be issued by the Union of India regarding the immediate medical aid to persons who have sustained injurious).

[88]C.E.S.C. Limited v. Subhas Chandra Bose (1992) 1 SCC 441 at 463, Para 31.(Case relates to the interpretation of the term "Supervision" under the Employee State Insurance Act, 1948 so as to determine the claim of the employees of the Appellant to insurance coverage).

In *Consumer Education & Research Centre* v. *Union of India,* [89]Court upheld the right of health and medical care of workers employed in various industries as a fundamental right under the right to life which shall be read with articles 39 (e), 41,43 and 48 A of the Constitution. The importance of health insurance to workers, during service, and after retirement was also held to be a fundamental right and an obligation of the private entities.

Paschim Banga Khet Mazdoor Samity v. *State of West Bengal,*[90] is another relevant case which deals with the obligation of the government hospitals and doctors to provide immediate medical relief to injured persons.

In *Bandhua Mukti Morcha* v. *Union of India,* [91] Court again discussed the obligation of the State to protect the health of workers. Court interpreted the right to health and medical care of the workmen as a part of the right to live with human dignity.

The right to health as an obligation of the private entities is discussed in *Kirloskar Brothers Ltd.* v. *Employees State Insurance Corporation.*[92]It is held

[89] Consumer Education & Research Centre and Others v. Union of India (1995) 3 SCC 70. (Occupational health hazards and diseases to the workmen employed in asbestos industries are of our concern in this writ petition filed under Article 32 of the Constitution by way of public interest litigation at the behest of the petitioner, an accredited Organization).

[90]Paschim Banga Khet Mazdoor Samity v. State of West Bengal AIR 1996 SC 2426 Para.9. (Case relates to denial of immediate medical relief by various government hospitals in Calcutta to Mr.Akim Seikh (Petitioner) who suffered brain hemorrhage after a fall from train).

[91]Bandhua Mukti Morcha v. Union of India AIR 1984 SC 802, Para 10.(A PIL was filed for the implementation of social welfare laws in favour of bonded labourers working in various parts of India. It is held that right to health envisaged in Article 21 shall be read along with clauses (e) and (f) of Article 39 and Article 41 and Article 42 of Directive Principles of State Policy).

[92]Kirloskar Brothers Ltd. vs. Employees State Insurance corporation (1996) 2 SCC 682. (The case is regarding the payment of health insurance benefits to the employees working in factories of the appellant under the Employees State Insurance Act, 1948).

that promoting opportunities of health to workers cannot be limited to the function of the State alone; the private entities are also duty-bound to ensure the safety and health of workers employed by them.

State of Punjab v. *Mohinder Singh Chawla,*[93]the Supreme Court again upholds the constitutional obligation to provide health care and medical facilities to its citizens. *L/C of India* v. *Consumer Education & Research Centre,* [94] is another case in which the Court interpreted the right to healthcare within the universal declaration of human rights framework. It is held that the right to health covers other interrelated rights such as the right to food, clothing, housing, and medical care.

The amount of payment towards reimbursements of medical facilities availed by government employees in private hospitals is examined by the Court in the *State of Punjab* v. *Ram Lubhaya Bagga.*[95] The Court upheld the jurisprudential concept of the right-duty relationship by interpreting the citizen's right to health as imposing a correlative duty on the employer or the State. Balancing the rights of the employees with the state's obligation, the Court accepted a regulatory approach by observing that the right of the citizen or the employees to health or medical facilities shall be to the extent of financial capacity of the State.

[93]State of Punjab v. Mohinder Singh Chawla, AIR 1997 SC 1225 at 1227.
[94] L/C of India v. Consumer Education & Research Centre (1995) 5 SCC 482.
[95]State of Punjab v. Ram Lubhaya Bagga , AIR 1998 SC 1703 at 1706.

In addition to these constitutional obligations, India is obliged to implement the international instruments dealing with the right to health, especially the International Covenant on Economic, Social, and Cultural Rights (ICESCR).[96]

Centre for Public Interest Litigation v. *Union of India,*[97]is yet another case that discussed the obligation of the State to protect the health of the people in the light of access to quality food. It is held that any food articles harmful to public health are a potential danger to the fundamental right to life.

Thus, all these judicial decisions highlight health as a right and the obligation of the State in ensuring the same.

2.2.3.4 Healthcare System

All the steps taken by the state to implement the right to health care are within the purview of the right to healthcare.[98]It requires the State to take necessary measures such as prevention and treatment of illness and the creation of necessary structures and services that would ensure the right to health care.[99] Thus, on the one hand, it demands the state to guarantee protection against external threats such as unsafe drinking water or diet, measures ensuring the safe working environment and healthy living conditions, development of

[96]Ratified on 10 July1979.
[97]Centre for Public Interest Litigation v. Union of India, (2013) 16 SCC 279.
[98] UNITED NATIONS, INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, art.12, 16 Dec.1966, GA.R.2200A(XXI) (25 Jan. 2017),http://www.un-documents.net/icescr.htm.
[99] Paulius Celkins *Relationship between the Right to Dignity and the Right to Healthcare,* IJAC (23 Sept.2019), https://www.ijac.org.uk/images/ frontImages/gallery/Vol._ 3_No._5/14. pdf.

health, on the other hand-the state must ensure the availability of health care services of respective quality of people by creating conditions for meeting the needs of the most vulnerable groups.[100]

The first and foremost obligation of the state in this regard is the creation of a system known as 'Health systems,' consisting of all the organizations, institutions, and resources devoted to producing health actions.[101]It includes a combination of all the interrelated elements that contribute to health in homes, educational institutions, workplaces, public places, communities, and the physical and psychological environment and health and the related sectors.[102]

The Health system is regarded as the critical factor for attaining the highest attainable standard of health. It is observed that "an effective and integrated health system, encompassing medical care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all is at the heart of the right to a highest attainable standard of health".[103]They play a vital role in promoting the well-being of the individuals, communities, and population';[104] transparency;[105]equity, equality, and non-

[100] *Id.*

[101] THE WORLD HEALTH REPORT, 2000 HEALTH SYSTEMS: IMPROVING PERFORMANCE (20 Aug.2019), https://apps. who.int/iris/ bitstream/handle/ 10665/42281/ WHR_2000-eng.pdf?sequence=1&isAllowed=y. (Health action is defined as any effort, whether in personal health care, public health services or through intersect oral initiatives, whose primary purpose is to improve health).

[102]Paul Hunt and Gunilla Backman, *Health Systems and the Right to the Highest Attainable Standard of Health* (28 Mar. 2019), https://healthcareisahumanright.org/wp-content/uploads/2015/04/Health_Systems_and_the_Rights_Backman_Hunt.pdf.

[103] *Id.*

[104] *Id.*(Health care and health systems must embrace a more holistic, people-centered approach. The right to the highest attainable standard of health places the well being of

discrimination;[106]respect for cultural difference;[107]medical care and underlying determinants of health; progressive realization and resource availability; duties of immediate effect; quality; a continuum of prevention and care with effective referrals;[108]careful determination of intervention (vertical or integrated); [109] and co-ordination across a wide range of private and public actors.[110] It includes an appropriate mix of primary (community-based), secondary (district-based), and tertiary (specialized) facilities and services, providing a continuum of prevention and care.[111]

Effective coordination between private and public actors and various sectors and departments, such as health, environment, water, sanitation,

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individuals, communities and populations at the centre of a health system, the right to health can help to ensure that a health system is neither technocratic nor removed from those it is meant to serve).

[105] *Id.* (Access to health information. Health information enables individuals and communities to promote their own health, participate effectively, claim quality services, monitor progressive realization, expose corruption, hold those responsible to account, and so on. The requirement of transparency applies to those working in health-related sectors, including states, international organizations, public private partnerships, business enterprises and civil society organizations).

[106]*Id.* (A state has a legal obligation to ensure that a health system is accessible to all without discrimination, including those living in poverty, minorities, indigenous peoples, women, children, slum and rural dwellers, people with disabilities and other disadvantages individuals and communities. It means "equal access to health-care according to need". The twin principles of equality and non-discrimination mean that the outreach programmes must be in place to ensure that disadvantaged individuals and communities enjoy, in practice , the same access as those who are more advantaged).

[107]*Id.* (A health system must be respectful of cultural difference. It is required to take into account traditional preventive care , healing practices and medicines. Strategies should be in place to encourage and facilitate indigenous people to study medicine and public health. Training in some traditional medical practices should also be encouraged).

[108] *Id.* at 47, (The system also needs an effective process when a health worker assesses that their client may benefit from additional services , and the client is referred from one facility or department Referrals are also needed , in both directions, between an alternative health system (e.g., traditional practitioners) and mainstream health system).

[109] *Id.* at 48.

[110] Paul Hunt & Gunilla Backman, *Health Systems and the Right to the Highest Attainable Standard of Health*, 40-58, 48 (28 Mar. 2019), https://healthcareisahumanright.org/wp-content/uploads/2015/04/Health_Systems_and_the_Rights_Backman_Hunt.pdf.

[111] *Id.*

education, food, shelter, finance, transport, and within the departments, such as the Ministry of Health, are other features of the health system.[112]

Five significant sectors represent the health care system in India as Public Health Sector; Private Sector; Indigenous Systems of Medicine; Voluntary Health Agencies and National Health Programmes.[113]The Public Health Sector comprises of four major divisions such as the Primary Health Care, which consist of Primary health Centres and Sub-centre's, Hospitals/Health Centres consisting of community health centre's, rural hospitals, district hospitals/health centre, specialist hospitals, and teaching hospitals; Health Insurance Schemes consisting of Employees State insurance and Central Government Health Scheme and Other agencies consisting of defense services and railways.

Primary health care is known as the first level of contact between the individual and the health system where essential health care is provided. This level of care is closest to the people. Secondary health care comprises of essentially curative services and is the first referral in the health system. Tertiary health care offers super-specialist care and supports and complements the actions carried out at the primary level. The Private Sector includes mainly two divisions: private hospitals, polyclinics, nursing homes and dispensaries, and General practitioners and clinics.

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[112] *Id.*

[113] 24 K.PARK , PARK'S TEXTBOOK OF PREVENTIVE AND SOCIAL MEDICINE, 34 & 927-929 (M/s Banarsidas Bhanot Publishers 2017).

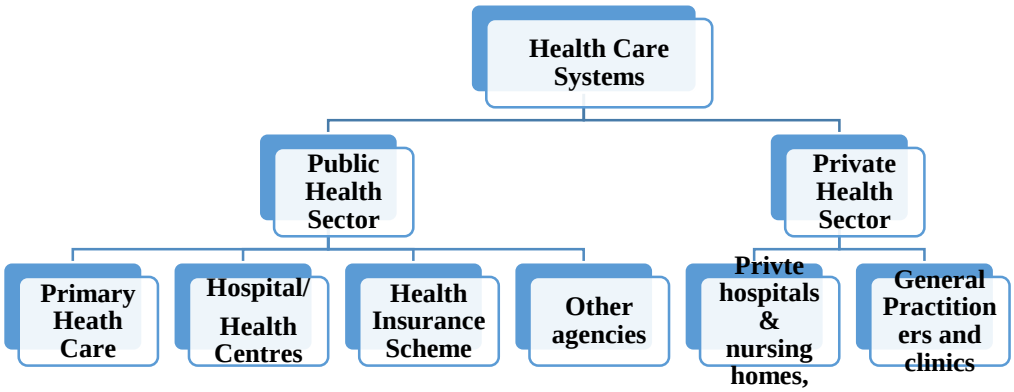

Figure 2.2

2.2.3.5 Role of Healthcare Providers

Being a significant part of the health care system, it is vital to understand the role of healthcare providers. The term 'Health care providers' describes "an institution or member of the healthcare team providing health care".[114] They include a "group comprising a variety of professionals such as medical practitioners, nurses, physical and occupational therapists, social workers, pharmacists, spiritual counselors, as well as family members, who are involved in providing coordinated and comprehensive care".[115]

Usually, delivering quality health services to the maximum number of people in a cost-effective way is pointed out to be one of the finest traits of their service.[116]Also known as Healthcare Professionals, they perform a wide range of healthcare services. Protection of health and prevention of diseases is

[114]DEFINITE HEALTH CARE (6 Oct. 2021),www.monocl.com/glossary/healthcare-provider-hcp/.
[115] *Id.*
[116]*Id.*

their primary area of function.[117]As per the definition of the International Labour Organization, healthcare professionals are qualified and educated persons with sufficient training in health care.[118]Usually, they require a license to practice their profession. Generalist medical practitioners, specialist medical practitioners, Nursing professionals, midwifery professionals, Traditional and Complementary professionals (such as Ayurvedic practitioners, homeopaths, Unani practitioners), Paramedical practitioners, Dentists, Pharmacists, Occupational health and hygiene professionals, Physiotherapists, and Dieticians are examples of health care professionals.

A broader explanation of the functions and qualifications of healthcare professionals are provided by the International Labour Organization as

> *"Health professionals study, advise on or provide preventive, curative, rehabilitative and promotional health services based on an extensive body of theoretical and factual knowledge in diagnosis and treatment of disease and other health problems. They may conduct research on human disorders and illnesses and ways of treating them and supervise other workers. The knowledge and skills required are usually obtained as the result of Study at a higher educational institution in a health-related field for a period of 3–6 years leading to the award of a first degree or higher qualification ".*[119]

Thus, healthcare providers perform a wide range of functions. It is also important to understand the difference between medical care and healthcare. It

[117]*Id.*
[118]*Id.*
[119]WHO, *Classifying Health Workers : Mapping Occupations to the international standard classification*, WORLD HEA(28 Sept.2020),https://www.who.int/hrh/statistics/Health_ workers _classification.pdf.

is to be noted that Medical care is a 'subset of the health care system.' It refers chiefly to those personal services provided directly by physicians or rendered as the result of physicians' instructions.[120]It ranges from domiciliary care to resident hospital care.[121]Whereas health care is a broader area, it includes medical care and all aspects of pro preventive care.[122]All the steps taken by the State and its entities for achieving the right to health come under it.

As stated, it is the sharing of responsibility for health between private individuals (for their health and that of others), the state and those who take on responsibility through their status as employers or health professionals, administration of health services and the law's role in maintaining public health. Thus, all the efforts from the side of the State and its entities, including the private individuals, are included under the concept of health care. Being one of the building blocks of the health system, healthcare professionals deliver health care services to the people. Thus, in this sense of service of healthcare providers, health care can be defined as "the prevention, treatment, and management of illness and preservation of health through services offered by medical, nursing and allied health professions".[123]

[120]*Id.*
[121]*Id.*
[122]R. Srinivasan,*Health Care in India – Vision 2020 Issues and Prospects,* PLANNING COMMISSION(20 Aug. 2019),planningcommission.gov.in/ reports/genrep/bkpap2020/26_bg 2020.pdf.
[123]WORLD HEALTH ORGANIZATION(8 Jan. 2021),https://www.who.int/workforcealliance/ media/qa/04/en/.

It is also notable that the 'availability, accessibility, acceptability and quality of healthcare providers are regarded as rights of the people.[124]Here, 'Availability' means the sufficient supply and stock of health workers, with the relevant competencies and skill mix that correspond to the health needs of the population.[125]'Accessibility' includes equitable access to health workers, including travel time and transport, opening hours, and corresponding workforce attendance, whether infrastructure is disability-friendly, referral mechanisms, direct and indirect cost of services, both formal and informal.[126]

'Acceptability' is the characteristics and ability of the workforce to treat everyone with dignity, creates trust, and promotes demands for service.[127] 'Quality' includes the competencies, skills, knowledge, and behavior of the health worker as assessed according to professional norms as perceived by users.[128]Thus, the State is required to make available a sufficient quantity of skilled and educated healthcare providers to protect and promote quality healthcare.

Among them, nurses are the direct providers of health. They are regarded as '… the first point of referral to a health professional, representing one-half of the total number of health workers worldwide'.[129]Known as the'

[124]*Id.*
[125]*Id.*
[126]*Id.*
[127]*Id.*
[128]*Id.*
[129] Nigel Cirsp, & "et al." *Nursing and Midwifery: The key to the Rapid and Cost-effective Expansion of High-Quality Universal Health Coverage*, A REPORT OF THE WISH NURSING AND UHC FORUM (2 July 2018),https://www.jjcct.org/wp-content/uploads/2018/12/IMPJ6078-WISH-2018-Nursing-181026.pdf.

lynchpin of health teams,' they play a vital role in health services - promotion, disease prevention, treatment, care, and rehabilitation.[130]They can be called as 'care-takers of the whole community.[131] They involve in medical and a wide range of non-clinical functions necessary for the delivery of healthcare.[132]They develop a plan of care in collaboration with physicians, therapists, the patient, the patient's family, and other team members.[133]In the contemporary world, nurses play extended roles with titles as advanced practice nurses, nurse practitioners, clinical nurse specialists, and nurse anesthetists. Thus, being a significant part of the health system, nurses play an essential role in upholding the rights of the people to quality healthcare.

2.3 Conclusion

Thus, health can be regarded as one of the most precious assets of a person, without which he cannot enjoy his best self. As an inseparable right, health is so interconnected with other rights and vice-versa. All the other rights, such as the right to safe water, pollution-free environment, hygiene food, adequate sanitation, can be enjoyed only when the right to health is protected. Similarly, the right to health can be enjoyed only when these rights are ensured and guaranteed by the State. All those deliberate measures undertaken by the State for realizing the right to health can be called health care. It includes

[130] WORLD HEALTH ORGANIZATION (5 Sept. 2018), http://www.who.int/hrh/news/2018/int-nurses-day-2018-voice-to-lead/en/; *See also* ARATHI PRASAD, WHO CARES? SOCIO-ECONOMIC CONDITIONS OF NURSES IN MUMBAI 5(Himalaya Publications 2014).
[131] *Id.*
[132] Rosamma Jose, *Leadership for nurses in India:A futuristic perspective,* EXPRESS HEALTHCARE(8 Mar.2018),http://www.expressbpd.com/healthcare/life-healthcare/ leadership-for-nurses-in-india-a-futuristic-perspective/389253.
[133] *Id.*

matters such as safe working conditions, promotion of health education, protection of women's health, the health of the children, Old age, and the vulnerable sections, including the disabled persons. The Constitution of India has incorporated the obligation of the State in implementing health care as one of the essential features of the State's policies and programs.

Establishing a patient-centered health system with a sufficient quantity of well-trained and well-qualified healthcare service providers is another essential obligation entrusted to the State. Healthcare providers play a significant role in delivering health care to the people. Healthcare providers include mainly three categories of service providers: physicians, Nurses, and Allied Health care providers. Among them, nurses are the direct providers of healthcare to the people. They function near the people and are often described as the real heroes of healthcare. They deliver health care at three levels such s the individual, the community, and the global health care level, thereby contributing towards the universal goals of the highest attainable standard of healthcare. The recent episode of extending admirations and worldwide applauses to nurses for their selfless efforts and services as real warriors against the Covid-19 pandemic reveals the unconditional devotion and love which they owe to their profession.

CHAPTER III

ROLE OF NURSES IN HEALTH CARE

I see God in every human being. When I wash a leper's wound, I feel I am nursing the Lord himself. Is it not a beautiful experience?

Mother Teresa (1974).[1]

Introduction

Service to humanity is the mission of human life. As preached by all religions, it is a service to God. It is a union of oneself with God; a means to attain self-realization. Values such as sympathy, love, compassion, trust, respect, devotion, loyalty are its attributes. It is a feeling of being with the other, selfless dedication, and the best means to define the purpose of life. As the noblest profession, nursing reflects the highest manifestation of service. As providers of care, nurses foster the concept of 'sanctity of life',[2]and bind human relationships and one's interests with the other[3].The altruistic notions of 'Caring' and 'Self-sacrifice' are attached to the concept of nursing. It can be related to a sense of ethical obligation which they owe to the other person.

Generally, it is the magical tough of 'care' which tightens the nurse-patient relationship. Caring for the patient as a whole can be regarded as the

[1]B.K CHATHURVEDI, MOTHER TERESA: MESSIAH OF THE POOR 1(Diamond Pocket Books (P) Ltd 2018).
[2]JUDITH PHILIPS, CARE 16(Polity Press 2007).(He explains caring as "to have concern for another person is above all else, to experience a felling, movement of the soul, in which that person's being is honored and respected as if it were one's own").
[3]VIRGINA HELD, THE ETHICS OF CARE: PERSONAL, POLITICAL AND GLOBAL 10(Oxford University Press 2006).

'heart of nursing',[4]and the best means by which nurses protect the best interest of the patients. Apart from delivering patient care, nurses are best known for their service to the community and public health care. The chapter analyses the significance of nurses in health care. The meaning and features of nursing as a profession and the role of nurses in India and abroad are examined.

3.1 Meaning, Definition, and Features of Nursing

The term 'nurse' is derived from the Latin term *nutricius*, which means nourishing.[5]The Merriam-Webster Dictionary explains the meaning of the word nurse as a verb are "to promote the development or progress of," "to manage with care for and wait on," and "to attempt to cure by care and treatment.[6] Again the word nurse is explained as "a licensed healthcare professional who practices independently or is supervised by a physician, surgeon, or dentist and who is skilled in promoting and maintaining health".[7]Thus, nursing can be considered as a process of helping the patient to meet his basic health needs until he can meet them for himself without assistance.

Virginia Henderson,[8]the first lady of nursing, regarded nursing as a method of entering into the situation to understand the other person's desires.

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[4]MARLAINE"et al", CARING IN NURSING CLASSICS 37 (Springer Publishing 2013).*See also* Renee C. Fox "et al", *The Culture of Caring : AIDS and the Nursing Profession*, JSTOR (2 Jan.2020), https://www.jstor.org/stable/3350052.

[5]5 SR.NANCY, STEPHANIES PRINCIPLES AND PRACTICE OF NURSING 22 (N.R Publishers 2002).

[6] MERRIAM WEBSTER COLLEGIATE DICTIONARY 534 (10th ed. 2001).

[7] MERRIAM WEBSTER COLLEGIATE DICTIONARY 534 (10th ed. 2001).

[8] NURSE SLABS, (8 Jun.2016), https://nurseslabs.com/virginia-henderson/.(Virginia Henderson (1897-1966) was a nurse, theorist and author. She is known as "The 20th century Florence

As she quotes, a nurse is "to get inside the skin of each of her patients to know what he needs".[9]Her definition explains nurses as assistants to individuals, especially the sick, in performing activities that they can do at normal times to make them independent. She quotes-

> *"The unique function of the nurse is to assist the individual, sick or well in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge and to do this in such a way as to help him gain independence as rapidly as possible (1966) ".* [10]

An exclusive vision of nursing as a wholesome caring of the patient is provided by Florence Nightingale, the founder of modern nursing. She explains the primary duty of a nurse as 'to aid patients to become agents for their health care management. She used the word 'nurse' for 'want of a better'.[11]She defines

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Nightingale". She was the author of three editions of "Principles and Practices of Nursing," a widely used text, and "Basic Principles of Nursing," (1966) and revised in 1972, has been published in 27 languages by the International Council of Nurses).

[9] *Id.*

[10]2 KATHLEEN MASTERS, ROLE DEVELOPMENT IN PROFESSIONAL NURSING PRACTICE 49 (Jones & Barlett Publishers 2009);*See also* Henderson V *We've Come a long way, but what of the direction?*PUB.MED(26 Jan. 2019),https:// pubmed. ncbi.nlm.nih.gov/585836/.(Henderson identified 14 basic needs upon which nursing care is based such as Breathe normally, Eat and drink adequately, Eliminate bodily waste; Move and maintain desirable postures; Sleep and rest; Select suitable clothes; dress and undress; Maintain bodily temperature without normal range by adjusting clothing and modifying the environment, Keep the body clean and well groomed and protect the integument, avoid dangers in the environment, and avoid injuring others, communicate with others in expressing emotions , needs, fears, or opinions, Worship according to one's faith, Work in such a way that there is a sense of accomplishment, Play or participate in various forms of recreation. Henderson indentified 14 basic needs upon which nursing care is based such as Breathe normally, Eat and drink adequately, Eliminate bodily waste; Move and maintain desirable postures; Sleep and rest; Select suitable clothes; dress and undress; Maintain bodily temperature without normal range by adjusting clothing and modifying the environment, Keep the body clean and well groomed and protect the integument, Avoid dangers in the environment, and avoid injuring others, communicate with others in expressing emotions , needs, fears, or opinions, Worship according to one's faith, Work in such a way that there is a sense of accomplishment, Play or participate in various forms of recreation).

[11] *Id.*at 2.

the role of the nurse as"....what nursing has to do is to put the patient in the best condition for nature to act upon him".[12]To her, nursing comprises the complete caring of the patient, even the surroundings in which he or she lives is vital. Fresh air, light, warmth, cleanliness, quiet, and a balanced diet are factors that nurses have to consider while providing nursing care.[13] She observes:

> *"Nursing has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet-all at the least expense of vital power to the patient."* [14]

An elaborate discussion on the role of the nurses is provided in the definition provided by the International Council of Nurses. A Nurse is defined as "a person who has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice

[12]8 FLORENCE NIGHTINGALE, NOTES ON NURSING: WHAT IT IS, AND WHAT IT IS NOT,196 (D. Appleton 1860).(She explains What is a Nurse as "The very alphabet of a nurse is to be able to interpret every change which comes over a patient's countenance, without causing him the exertion of saying what he feels…. a Nurse as "ought to understand in the same way every change of her patient's face, every change of his attitude, every change of his voice. And she ought to study them till she feels sure that no one else understands them so well").

[13]*Id.*at 3.(Nightingale explains 13 canons of nursing care such as Ventilation and Warmth which includes the keeping the patient and the patient's room warm and keeping the patient's room well ventilated and free of odors, Health of houses which includes five essentials such as pure air, pure water, effluent drainage, cleanliness and light; Petty management which includes continuity of care for the patient when nurse is absent; Noise which provides instructions as to the avoidance of sudden noises that startle or awaken patients and keeping noise in general to a minimum; Variety which refers to an attempt at variety in the patient's room to avoid boredom and depression; Food intake which mentions the documentation of the amount of food and liquids that the patient ingested; Food which provides instructions as to patient's food preferences, Bed and Bedding which includes comfort measures related to keeping the bed dry and wrinkle free, Light which is related to adequate light in the patient's room; Cleanliness in room and walls which focuses on keeping the environment clean; Personal Cleanliness which provides measures such as keeping the patient clean and dry; Chattering hopes and advise which include the avoidance of talking without reason or giving advice that is without fact and Observation of the Sick which is related to making observations and documenting observations).

[14]*Id.*

nursing in his/her country."[15]The definition further explains nursing as "an autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well and in all settings."[16] Activities such as promotion of health, prevention of illness, advocacy, endorsement of a safe environment, research, participation in shaping health policy, inpatient and health systems management and education are included as part of nurse's function.[17]

A broader definition of nursing can be found in the definition of Erline W. Perkins. She defines nursing as inclusive of the teaching of health education and related activities. She defines nursing as

> *"an art and a science which involves the whole patient-body, mind and spirit-promotes his spiritual, mental and physical health by teaching and by example, stresses health education and health preservation as well ministration to the stick; it involves care of the patient's environment-social and spiritual as well as physical; and gives health services to the family and the community as well as the individual."* [18]

Nursing has always been used as a synonym for the word 'Service.' Other altruistic qualities such as patience, care, love, compassion, mutual trust,

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[15]INTERNATIONAL COUNCIL OF NURSES, (10 Jun. 2016), http://www.icn.ch/who-we-are/icn-definition -of -nursing/.

[16]*Id.*

[17]*Id.*(Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research participation in shaping health policy and in patient and health systems management, and education are also key nursing roles).

[18]Erline W. Perkins, *The Registered Nurse:A Professional Person,* JSTOR (10 Jun. 2016), https://www.jstor.org/stable/3452603.

acceptance, assistance, mutual respect, etc., can be attached to the nursing profession. Factors such as uniqueness, patient-centered care, shared decision making, collaboration (with patient, co-workers), open discussions (with the patient and his family), respect for human dignity, and strict adherence to professional values make the nursing profession distinct from other health care profession.[19]Thus in a broader view, nursing cannot be limited to the removal of illness or disease but enrichment of 'quality of life, 'inclusive of everything interwoven with men. The function of nurses in health care is explained in the figure below:-

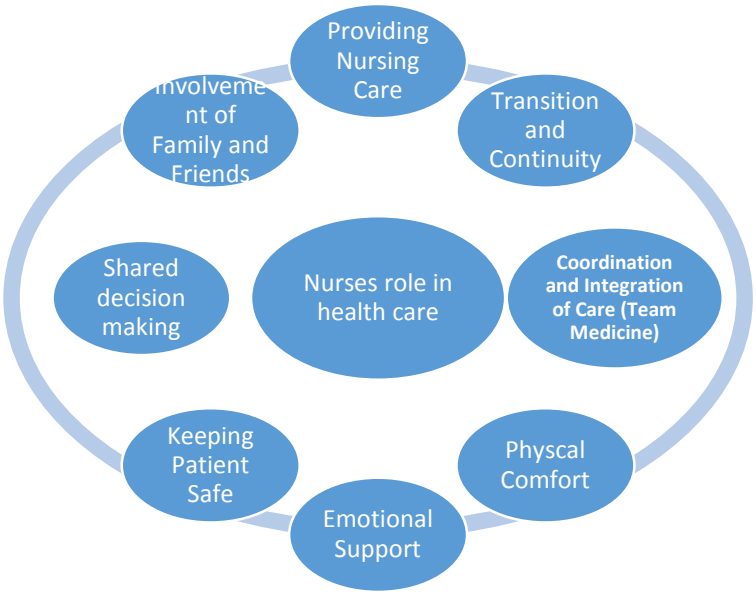

Figure 3.1: Source: FICCI.[20]

[19]AMERICAN NURSES ASSOCIATION NURSING : SCOPE AND STANDARD OF PRACTICE (26 Mar. 2018), https://www.iupuc.edu/health-sciences/files/Nursing-ScopeStandards-3E.pdf.
[20] FEDERATION OF INDIAN CHAMBERS OF COMMERCE & INDUSTRY, NURSING REFORMS PARADIGM SHIFT FOR A BRIGHT FUTURE (19 July 2018), http://ficci.in/spdocument/20756/FICCI_heal-Report_Final-27-08-2016.pdf.

3.2 Role of Nurses in Health Care

The close intimacy which nurses maintain with the patients and the community is a unique feature that differentiates nurses from other healthcare providers.[21]Their ability to handle non-communicable diseases, age-related comorbidities, emergencies including disasters; detection of early signs of illness; initiation of public health programs including health literacy or awareness are pointed out in most studies.[22]The role of nurses in health care can be reflected at three levels such as personal, community and public health.[23]The personal care level can also be called the patient-centered level, where nurses are concerned about protecting the rights of the patient, especially about health information,[24]and informed choice.[25]Ensuring patient safety by informing the patient about the potential risk and adverse events of treatment can be regarded as unique features of nursing service at this level.[26]

At the public health level, nurses are concerned with the health of the people as a whole. Community-level services can be included in this category. At this level, nurses were considered as promoters of public health and disease prevention.[27]They are expected to conduct and spread awareness programs on

[21] *Id.*at 14.
[22] *Id.*
[23] *Id.* at. 9 & 34.
[24]INTERNATIONAL COUNCIL OF NURSES (20 Apr. 2018),https://www.icn.ch/nursing-policy/position-statements.
[25]*Id.*
[26]*Id.*
[27]TRIPLE IMPACT : HOW DEVELOPING NURSING WILL IMPROVE HEALTH, PROMOTE GENDER EQUALITY AND SUPPORT ECONOMIC GROWTH, A REPORT BY THE ALL-PARTY PARLIAMENTARY GROUP ON GLOBAL HEALTH (20 Jan. 2018), http://www.app.globalhealth.org.uk/.

health education among the local populations, empower patients and families, and help to build health resilience in their communities.[28]Actions in support of Antimicrobial resistance,[29] Breastfeeding,[30]Care for dying patients and their families,[31] Care of detainees and prisoners,[32]campaign against Tobacco use and health,[33]Promotion of Women's health,[34] and health of migrants, refugees, and displaced persons,[35] can be included in it.

Eradication of non-communicable diseases, enhancement of primary healthcare, improvement of maternal and newborn care quality in low-income countries, advancement of Preterm birth outcomes, TB prevention, Immunization and promotion of leadership, and appropriate care for persons with mental disorders are other imperative areas of nursing services.[36] Furthermore, the role of nurses in social issues such as the prevention of armed conflicts,[37]promotion of human rights,[38]elimination of weapons of war and conflict,[39]climate change and health,[40]disaster risk reduction,[41]and in the eradication of substandard and falsified medical products,[42] is spotlighted by

[28] *Id.* at 34.
[29] POSITION STATEMENT ON ANTIMICROBIAL RESISTANCE, INTERNATIONAL COUNCIL OF NURSES (20 Apr. 2018), https://www.icn.ch/nursing-policy/position-statements.
[30]*Id.*
[31]*Id.*
[32]*Id.*
[33]*Id.*
[34]*Id.*
[35]*Id.*
[36]*Id.*
[37]INTERNATIONAL COUNCIL OF NURSES (20 Apr. 2018), https://www.icn.ch/nursing- policy/ position-statements.
[38]*Id.*
[39]*Id.*
[40]*Id.*
[41]*Id.*
[42]*Id.*

the International Council of Nurses as other functions which can be related to this level.

Attainment of Universal Health Coverage is the primary goal of nurses at the global level.[43]Researchers have also discussed the role of nurses in 'international health diplomacy efforts, ' especially as supporters of human rights.[44]The extended roles that nurses perform, such as advanced nurse practitioners, nurse consultants, and nurse specialists. They often run clinics, undertake procedures, and prescribe medications. These roles are examples of their role at the global level.[45]

3.2.1 Nurses as Healthcare Professionals

In the olden days, nursing was not considered a profession. To call nursing, a profession was considered to be an absurd concept. Mary A Messer and Manchester N.H points out that [46]

[43]NIGEL CIRSP & "et.al" ,NURSING AND MIDWIFERY : THE KEY TO THE RAPID AND COST-EFFECTIVE EXPANSION OF HIGH-QUALITY UNIVERSAL HEALTH COVERAGE, A REPORT OF THE WISH NURSING AND UHC FORUM (2 July 2018), https://www.jjcct.org/wp-content/uploads/2018/12/IMPJ6078-WISH-2018-Nursing-181026.pdf. *See also* Pamela H. Mitchell, *Nursing and Health Policy Perspectives*, WILEY ONLINE LIBRARY (20 June 2018), https://onlinelibrary.wiley.com/doi/full/10.1111/inr.12212.*See also* INTERNATIONAL COUNCIL OF NURSES (20 June 2020),https://www.icnvoicetolead.com/.

[44] Karen Lucas Breds, *What is Nursing's role in International and Global Health?*(18 June 2019), https://www.scielo.br/j/tce/a/V3LYNJF7p6tjzsRkqp3hwHR/?lang=en&format=pdf. (Global health diplomacy is a new concept. It is a transdisciplinary endeavor blending and synthesizing knowledge from international relations, culture, and politics with medicine and other health sciences to step beyond the disciplinary boundaries of each of these fields". It has two goals such as to improve global health and to enhance international relations particularly , but not exclusively , in struggling areas of the world).

[45] Pamela H. Mitchell, *Nursing and Health Policy Perspectives*, WILEY ONLINE LIBRARY, (18 June 2019), https://onlinelibrary.wiley.com/doi/abs/10.1111/inr.12577.

[46] Mary A Messer, *Is Nursing a Profession?*, JSTOR (13 Apr. 2018), https:// www.jstor.org/ stable/ pdf/3404530.pdf.

> *"Nursing is considered as an honorable calling implying proficiency in more or less mechanical duties. It is believed that nursing did not contribute to human knowledge or the advancement of science. The only duty entrusted to a nurse is to make a patient comfortable in bed. It was believed that every intelligent woman, not educated, can acquire the skill of nursing by carrying out the directions of the physician….now, this concept has undergone significant changes. It is come to understand that nursing requires skill and intelligence and education and special knowledge……. nurses are well-trained and organized to call them 'professionals.'*[47]

It is argued that factors such as a well-defined body of knowledge; strong practical service orientation; theoretical base; code of professional ethics; autonomy; belongingness to a professional group; emphasis on research and development; accreditation and inspections of schools and colleges of nursing; license and registration to practice; legal accountability towards the public; set of organizational standards for its practice the existence of Professional nursing organizations;[48]employed regularly;[49] and the presence of nursing code of ethics adds nursing into the criterion of the profession.[50] It is identified that the expanded role of nurses such as that of clinical specialists, nurse practitioners, nurse-midwife, nurse anesthetists, nurse educators, nurse entrepreneurs, and nurse administrators are a significant factor that incorporates

[47] *Id.*

[48] *Id.*(Professional nursing organizations have existed since the beginning of the 20th century in India).

[49] *Id.*(Registered nurses and employed nurses are appointed on regular basis like other government employees).

[50] Prof. Sumitra Chakraborty, *Future Implications for Nursing Practice*, 12 NJI 12, 12-24 (2008). *See also* MARY SURALASKSHMI IMMANUEL, NURSING FOUNDATIONS: PRINCIPLES AND PRACTICES (University Press 2014); See Genevieve Knight Bixler & Roy White Bixer, *The Professional Status of Nursing*, JSTOR (10 June 2018),https://www.jstor.org/stable/3416626.

nursing within the sphere of professional activity.[51]The problem of full autonomy is pointed out to be the major factor against conferring nurses' professional status.[52]

It is necessary to note the characteristics which make an occupation a profession.[53] Factors such as skilled and specialized nature of work involving a substantial part mental works than manual; dedication to moral principles; a broader duty to the community which may transcend the task to a particular client or patient; a professional association which regulates admission and tries to uphold the standards of the profession through professional code of conduct and ethics; and high status in the community are the major features of a profession. So finally, when we analyze these four features, we can conclude that nursing can be very included within the definition of a profession. However, it fails in the test of autonomy, leadership, and status.

3.2.2 International Legislative Framework

The World Health Organization identifies that nurses are part of a healthcare team that comprises other professionals such as medical practitioners, physical and occupational therapists, social workers, pharmacists, spiritual counselors, and family members who provide coordinated and

[51]Vijayaraddi Vandali, *Nursing Profession : A Review*, 5 IJNER 446, 444-447(2017).
[52]JOGINRA VATI, PRINCIPLES & PRACTICE OF NURSING MANAGEMENT & ADMINISTRATION FOR BSC & MSC NURSING 5 (Jaypee Brothers Medical Publishers (P) Ltd 2013).
[53]RUPERT M. JACKSON & JOHN L. POWELL, PROFESSIONAL NEGLIGENCE 1 (Sweet & Maxwell, 2000).(To identify occupations as professions have accorded professional status to seven specific occupations, namely, architects, engineers and quantity surveyors, surveyors, accountants, solicitors, barristers, medical practitioners and insurance brokers).

comprehensive care.[54]WHO again classified health workers in the health industry into two categories: health service providers who deliver health services directly and health management and support workers who are indirect providers of health services. Nurses are included in the first category as health service providers (along with doctors).[55]

The International Standard Classification of Occupations (ISCO-08) issued by the International Labour Organization,[56]has classified 'Nursing Professionals as Health Professionals.'[57] Different categories of nurses like the clinical nurse consultant, District nurse, Nurse anesthetist, Nurse educator, Nurse practitioner, Operating theatre nurse, Professional nurse, Public health nurse, and Specialist nurse are included in this category.[58]The nature of work

[54] WORLD HEALTH ORGANIZATION, HEALTH WORKERS (21 June 2021), https://www. who.int/ whr/2006/06, chap1 en.pdf.

[55]*Id.*

[56]INTERNATIONAL LABOUR ORGANIZATION, INTERNATIONAL STANDARD CLASSIFICATION OF OCCUPATIONS (18 Sept.2019),https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/ public cation/wcms_172572.pdf.(ISCO-08 is a four-level hierarchically structured classification that allows all jobs in the world to be classified into 436 unit groups. These groups form the most detailed level of the classification structure and aggregated into 130 minor groups,43 sub-groups and 10 major-groups, based on their similarity in terms of the skill level and skill specialization required for the jobs. According to them, the tasks performed by professionals include conducting analysis and research, and developing concepts, theories and operational methods; advising or applying existing knowledge related to physical sciences, mathematics, engineering and technology; life sciences, medical and health services, social sciences, and humanities; teaching the theory and practice of one or more disciplines at different educational levels; teaching and educating persons with learning difficulties or special needs ; providing various business, legal and social services; creating and performing works of arts; providing spiritual guidance; preparing scientific papers and reports).

[57] *Id.*

[58]*Id*. (Health Professionals conduct research; improve or develop concepts, theories and operational methods; and apply scientific knowledge relating to medicine, nursing, dentistry , veterinary medicine, pharmacy, and promotion of health According to them, tasks performed by workers in this sub-major group usually include :conducting research and obtaining scientific knowledge through the study of human and animal disorders and illness and ways of treating them; advising on or applying preventive and curative measures, or promoting health; preparing scientific papers and reports. Competent performance in this group requires skills).

performed by the nurses with the tasks mentioned in the definition keeps nursing within the category of professionals.[59]It explains the role of nurses as

> *"to provide treatment, support, and care services to the people who are in need of ….They assume responsibility for the planning and management of the care of patients, including supervision of health care workers, working autonomously or in teams with medical doctors and others in the practical application of preventive and curative measures".* [60]

Compared to India, the titles of nurses are different in other parts of the world. In the USA, nurses were classified as Certified Nursing Assistants who perform functions such as bathing the patient, taking vital signs, dispensing prescribed medications, applying bandages;[61]Licensed Practical Nurse who administers injections, perform therapeutic massage, prepare patients for surgical procedures and maintain medical records;[62]Registered Nurse who assists administer medications and treatments, assist in diagnostic testing and

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[59]*Id.* (Tasks includes planning, providing and evaluating nursing care for patients according to the practice and standards of modern nursing; coordinating the care of patients in consultation with other health professionals and member so of heath teams; developing and implementing care plans for the biological, social and psychological treatment of patients in collaboration with other health professionals; planning and providing personal care, treatments and therapies including administering medications, and monitoring responses to treatment or care plan; cleaning wounds and applying surgical dressings and bandages; monitoring pain and discomfort experienced by patients and alleviating pain using a variety of therapies, including the use of painkilling drugs; planning and participating in health education programmes, health promotion and nurse education activities in clinical and community settings ; answering questions from patients and families and providing information about prevention of ill-health, treatment and care; supervising and coordinating the works of other nursing, health and personal care workers; conducting research on nursing practices and procedures and disseminating findings such as through scientific papers and reports).

[60] *Id.*

[61]HUFFSPOT (25 Mar.2020), https://www.huffpost.com/entry/how-to-become-a-certified_b_3720475.

[62]SOUTHERN NEW HAMPSHIRE UNIVERSITY (12 Mar.2020), https://www.snhu.edu/about-us/newsroom/2018/05/types-of-nurses-infographic.

provide health education to patients and families;[63]Advanced Registered Nurse Practitioners who diagnosis patients, manage treatments, order tests and prescribe medications;[64]and Nurse Practitioners who can examine patients, analyze test results, diagnose health problems, administer medications and treatments.[65]

A similar role of nurses in the USA can be found in the United Kingdom, where nurses were classified as registered nurses, Licensed Practices nurses, Certified Nursing Assistant, and Advanced Registered Nurse Practitioner. Among them, Registered Nurses can diagnosis patients, manage treatments, and order tests.[66]Persons such as Community practitioner nurse prescribers, Nurse independent prescribers, and Nurse Independent/Supplementary prescribers can prescribe medicines.[67]Mainly two titles are granted to nurses working in Canada, such as the Registered Nurses and the Registered Practical Nurses.[68]Among them, the registered nurse enjoys rights to prescribe, dispense, sell and compound drugs.[69]

Regarding the legislative framework, which defines nursing as a Professional sphere of activity, legislations in Canada and South Africa are notable. The Regulated Health Professionals Act, 1991 in Canada incorporate

[63]*Id.*
[64]*Id.*
[65]*Id.*
[66]United Kingdom, the Medicinal Products: Prescription by Nurses etc, C.28, Acts of Parliament, House of Lords (1992).
[67] *Id.*

[68] The Nursing Act, § 8, ch.32, Legislative Assembly of Ontario (1991).
[69] *Id.* (Nursing Regulation 275, Part II, Rule 17).

nursing into the category of Self Governing Health Professions.[70] The Nursing Act, 2005 defines nursing as "a person who is qualified and competent to practice …to the level prescribed independently and who is capable of assuming responsibility and accountability for such practice".[71] Thus, the practitioner status conferred by the legislative framework can be regarded as the primary factor which differentiates registered nurses working in India from other countries of the world.

3.3 Role of Nurses in India

The role of nurses in India can be divided into two levels: the public health care level, which is provided exclusively by the State, and the hospitals level, in which both the State and private entities are part. At the public health care level, the role of the nurses can be classified as Auxiliary Nurse-Midwife/Female Health Worker;[72]Male Health Workers;[73]Lady Health

[70] Regulated Health Professionals Act, Sch.1, Legislative Assembly of Ontario (1991).
[71] *Id.* Sec 30 (1).
[72] TRNAI, NURSING IN INDIA 2005-2006, 5 TNAI BULLETEIN,141(2006).(Under the Multipurpose Worker's Scheme, a Health Worker (Female) is expected to cover a population of 5,000 Functionally, she assists in conducting MCH and Family Planning Clinics; Surveying the area and maintaining contact with the local Dais; Supervising the work of local Dais, especially in conducting delivery cases, and assisting in the training of these Dais; regular home visits for treatment of minor Ailments; Antenatal care, intra-natal care, post natal care ; Family planning follow-up, Nutrition education; maintaining records of daily work; assisting in the registration of deaths and births and other vital events occurring in her areas, assisting in the immunization programmes; associated with the school health programme; providing Primary Medical care in treatment of minor ailments first-aid in emergencies and referring of cases; any other duties assigned to her by LHV/PHN/Medical Officers).
[73] *Id.* (Under the Multipurpose Worker's Scheme, a Health Worker (Male) is expected to cover a population of 5,000 wherein he is to carry out the responsibilities assigned to him. He will have different sets of responsibilities for MCH, family planning, immunization and nutrition in the intensive and twilight areas of the Health Worker(Female) functions includes-making visit to each family once a month, to identify and notify communicable diseases like malaria, T.B, etc., educate public about identification, prevention and control of diseases, etc.).

Visitor;[74]Public Health Nurse (Junior);[75]Public Health Nurse (Senior);[76]Public Health Nurse Supervisor;[77] and Chief/District Public Health Nurse.[78] The Auxiliary Nurse Midwives (ANM) is called the first level community nurse, and its first supervisor is Lady Health Visitor (LHV).[79]They are the primary health care providers and are accountable for implementing health programmers and extending the clinical outreach services at the community level. They bring together other community-level health volunteers known as the Accredited Social Health Activist (ASHA), and Women and Child Health volunteers called the Anganwadi workers (AWW). Identifying the problem of the patient is their primary role. Role of nurses at the hospital level are classified as,[80]Staff Nurse,[81] Nursing Sister/Ward Sister/Supervisor,[82]Assistant

[74] *Id.* (Lady Health Visitors are directly responsible for the preventive, promotive, curative and rehabilitative health care carried out in the health centres maternity homes, hospitals and in the community. Each health visitor is responsible for the care of 40,000 populations in the community. She is the next responsible to the Medical Officer in charge of the centre. She independently runs the family planning and maternity centres, maternity homes, maternity section of the P.H.C and Anganwadis in I.C.D.S projects. She performs her works in clinics, fields, maternity homes and hospitals, family planning camps, emergency duties in flood and epidemic areas).

[75] *Id.* (Public Health Nurse (Junior) assists senior PHN in carrying out her responsibilities).

[76]*Id.*(The major duty of Public Health Nurse (Senior) is to provide health care (preventive, promotive, and curative/rehabilitative) to all individuals, families and community in any field that she is appointed).

[77]*Id.*(Public Health Nurse Supervisor is responsible to Chief Public Health Nurse/Medical Officer for the supervision and improvement of community health care within the assigned area allotted) .

[78] *Id.* (Chief/District Public Health Nurse provides health services to the community according to the policies of the department in the area of preventive, promotive, curative and rehabilitative care).

[79] Divya Aggarwal, Sumant Swain and Sanjv Kumar, *Primary Healthcare Nursing Cadre in India : Needs Paradigm Shift*, 2 NUR HEAL CAR 171-172.

[80] TNAI BULLETIN, *Supra* note 72.

[81] *Id.* (The Staff Nurse is a first-level professional nurse who provided direct care to patient or a group of patients assigned to her during duty shift. The main duty is to assist in ward management and supervision. Three functions entrusted in him/her includes Direct patient care which includes admits and discharge the patient,(b) maintains personal hygiene and comforts of the patient ,(c) attends to the nutritional needs of the patient, (d) maintains clean and safe environment for the patients, (e) implements and maintains ward policies and routines, (f) Co-ordinates patient care with various health team members, (g) performs

Nursing superintendent,[83]Deputy Nursing superintendent,[84]Nursing superintendent,[85]and Chief Nursing Officer.[86]

technical tasks such as administration of medication, assisting doctors in various medical procedures, recording vital signs, tube feeding, giving enema, bowel wash dressing, stomach wash, eye and ear care, collection and sending of specimens, pre-and post-operative care, baby care etc, (h) helps doctors in diagnosis and treatment, (i) maintains intake and output chart, (j) observes changes in patients conditions and records, (i) imparts health education to the patient and his/her family, () accompanies very ill persons sent to other departments or transferred to other institutions. (2) Ward Management which includes hands and takes over the patient and ward equipment and supply, keeps the wards need and tidy, maintains safety of the ward equipment, prepares and checks ward supplies, assists ward supervisor/sister in ward management and officiates in her/his absence, supervise students and other junior nursing personnel working with her/him, maintains ward records and reports assigned to her/him by the sister in charge.(3) Educational functions –participation in clinical teaching, both planned and incidental; teaches and guides domestic staff, helps in the orientation of new staff, participates in staff education programme and guides student nurses).

[82] *Id.* (Nursing Supervisor is accountable for the Nursing care management of a ward or a unit assigned to her/him. She is responsible to the Nursing superintendent/Assistant Nursing superintendent for her ward management. She takes full charge of the ward and assigns work for various categories of nursing and non-Nursing personnel working with her. She is responsible for safety and comfort of the patient in her ward. In a teaching hospital she is expected to ensure good learning fields. Direct patient care, supervision and administration of the ward and promotion of educational programmes to the new staff are their major functions).

[83] *Id.* (Assistant Nursing Superintendent is responsible for supervising Nursing services of a department or a floor consisting of two or more wards managed by the ward supervisors. These units may be In-patient wards, Out-patient Departments/Clinics, Operation Theatres, Obstetric units, central supply departments, etc. she/he is responsible for the Nursing superintendent and Deputy Nursing superintendent. Patient Care/Ward Management is their major function).

[84] *Id.* (Deputy Nursing superintendent is responsible to the Nursing superintendent and assists her/him in Nursing Service administration of the Hospital. She/he is independently in charge of Nursing Service Department of a less than 400 bedded hospital. Participation in the formulation of nursing services, philosophies and objectives is the major role. He/she also maintains confidential reports and records of the nursing staff and interprets policies and procedures of the hospital care to subordinate staff and others).

[85] *Id.* (Nursing superintendent is responsible to the Medical superintendent, in a hospital having 400 or above bed strengths. She is accountable for the efficient running of Nursing departments in the hospital).

[86] *Id.* (The Chief Nursing Officer will have the role of coordination and overall supervision and guidance. She is responsible to the Director of the Institution. She is accountable for efficient running of Nursing services in the main hospital and the centres of the Institution).

The picture below shows the cadre structure and functions of nurses in the Indian health system.

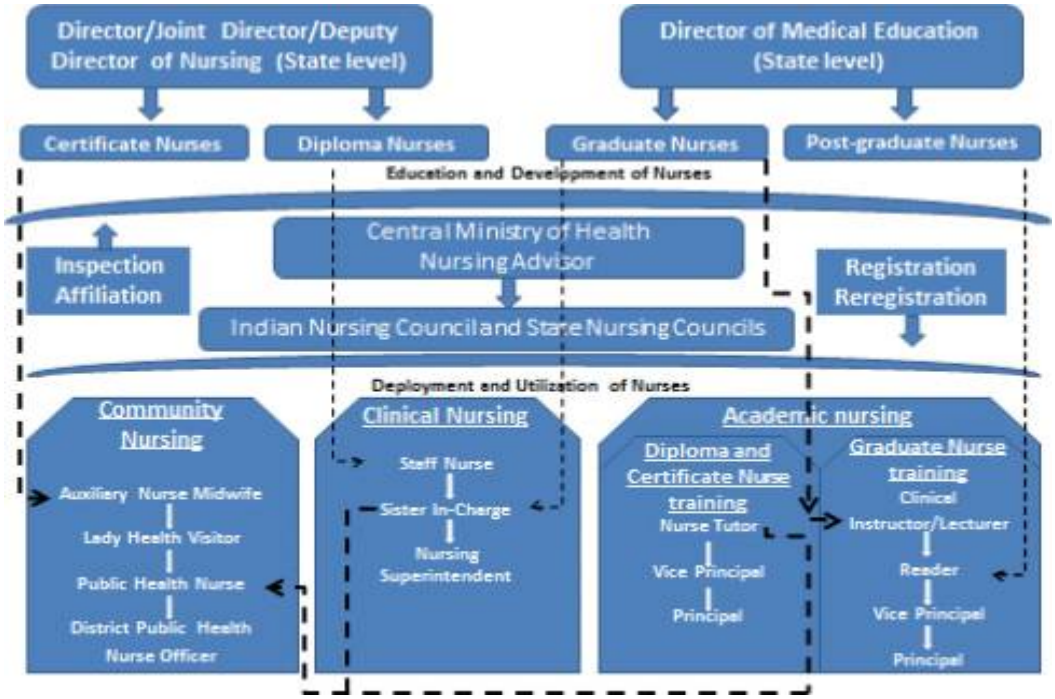

Figure 3.2 [87]

3.4 Conclusion

Aiding doctor's in the successful completion of treatment by carrying out their instructions and caring for the patient were the primary task performed by nurses during ancient times. With advancements in medicines and nursing education, nurses perform various activities, from assisting patients to prescribing medications. At the public healthcare level also this change is reflected. The proclamation of nurses as the voice of health by the International Council of Nurses itself shows that nurses have become an indispensable and

[87] Varghese, J., Blankenhorn, A., Saligram, P. *et al. Setting the agenda for nurse leadership in India: what is missing*,17 INT J EQUITY HEALTH 98 (2018).

unavoidable factor in healthcare. They have become champions and leaders of healthcare expanding their sphere of actions to the 'mainstream of society. They have become the voice of universal health care and sustainable development goals. The preparation of nurses for handling emergencies, especially disasters, has gained relevance. The latest Covid-19 issue is a good example in which nurses have played a significant role.

In India, advancements can be found in nursing education. Developing nursing at par with the western style of education has always been the motive since colonial times. The Christian missionaries in India have a profound impact in this regard. Institution of the Indian Nursing Services, Promotion of overseas education and training programs for Indian nurses by the international organizations, the initiation of nursing education institutions in India, and the constitution of nursing associations were relevant landmarks in the history of the nursing profession in India. These historical advancements can be called the boosters, which add wings to nurses to expand their horizons from the so-called 'assistant' level to an 'advanced professional practitioner level.'

CHAPTER IV

EVOLUTION OF NURSING PROFESSION IN INDIA

"Men do not make records of ordinary events but usually of unusual ones. People nurse their sick as a matter of course.....the early history of nursing is lost in obscurity, and the only records we have are those of hospital nursing after it became a fact".

- Mr. Minnie Goodnow.[1]

Introduction

Nursing, as it exists today, has a long history to deal with. It was a usual course of conduct, an ordinary practice followed by humans in caring for the sick. Various changes in society, including the changing status of women shaped nursing into its current form. The spread of Christian beliefs and values such as self-sacrifice and subservience has a profound influence on nursing. Three Images of nurses can be identified from the historical accounts such as Folk Image, played by Mothers as nurses in the pre-historical time, the Religious Image, played by Deaconesses guided by Christian beliefs and the Servant Image where the ignorant and illiterate women played the role of nurses during Renaissance and Reformation. The period of Deaconess and Florence Nightingale have profound impacts on the development of nursing as a profession. The opening of training schools for nurses adds a modern version to nursing as an art/ profession which requires skill and education. The introduction of the western style of education in India accelerated the growth of

[1]MINNIE GOODNOW R.N, OUTLINES OF NURSING HISTORY 15 (W B Saunders Co.1918).

the nursing sector in India, even in the midst of rigid religious sentiments and beliefs. The chapter traces the origin of nursing as a profession. The recommendations made by various committees appointed to study nurses' issues in India are also looked into.

4.1 Nursing in the Pre-historic Period

In the Pre-historic period, caring was a usual event. It is based on the religious notion that those who care for the sick will get blessings from God. The belief, "disease as the anger of God" is rooted in the medical history of mankind[2]. Animals and Mother Goddess, Plants, and Nature were worshipped by humans to get rid of all their troubles. Magic and prayers were used to heal diseases or to scare away the evil spirits[3]. The influence of religion on medicine was so intrinsic that even temples cared for the sick by offering prayers to God.[4]Usually, women were looked upon as caretakers due to their natural ability to nurture infants.[5]Oral traditions and practices followed by generations to generations formed the art of caring.[6]Thus in the pre-historic time, caring or nursing was a usual event, a matter within the family performed merely on common sense.

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[2]CAROL A LINDEMAN & MARYOU MC ATHIE, FUNDAMENTALS OF CONTEMPORARY NURSING PRACTICE 4 (W.B Saunders Co. 1999).

[3]*Id.*

[4]GOODNOW, *supra* note 1, at 15.(In ancient Egypt the sick went to the temples of the Gods of Osiris and Serapis; In Greece temples were built to honoe Asclepius, the God of medicine, to care for the sick. In India, there were hospitals in the Hindu villages to provide care to the sick).

[5]Sharp, Ella E, *Nursing during the Pre-Christian Era*, JSTOR (5 Apr.2018), https://www.jstor.org/stable/3405734.

[6]JONES AND BARLETT(23 Nov.2018),https://samples. jblearning.com/ 0763752258/ 52258_ch01_roux.pdf.

4.2 Nursing in Middle Ages

The Middle Ages (476 BC- 1450 AD) witnessed the emergence of the Order of deaconesses and military nursing. Both the developments had brought far-reaching impacts on nursing.[7]The modern concept of visiting nurses or home nurses can be traced back to the order of deaconesses.[8]It consists of groups of Christian women known as the Deaconesses.[9]They include mature women, unmarried or widows who devoted themselves to the service of other women. They may be regarded as the first 'visiting' nurses as they visit the sick and provide nursing care at their homes.[10]During this time, the nursing was done by women who were either virgins or widows (to maintain the purity of the body). This Oder of Deaconesses was later begun to know as nuns.[11] Historical accounts also show that the concept of a nurse grew from these Christian Orders of nuns who were solely dedicated to serving the ill with the purity of the body.[12] This is regarded as one of the reasons for calling nurses 'sisters'. A large number of Nursing Brotherhoods were also founded during this time.[13]The sisters nursed women, and brothers nursed men. Historical accounts also mention that women joined as nuns for protection from starvation

[7]*Id.*

[8]8 JOANN ZERWEKH & ASHLEY ZERWEKH GARNEAU, NURSING TODAY TRANSITION AND TRENDS 127 (Elsevier Saunders 2014).

[9]NAVDEEP KAUR BRAR & H C RAWAT, TEXTBOOK OF ADVANCED NURSING PRACTICE 4 (Jaypee Bothers Medical Publishers 2015).(The term "Deaconesses"originated from the Greek word 'diakonia' which means 'to minister' or to serve' in both the material and spiritual sense).

[10]Dimitrios Theofanidis RN & Despina Sapountzi-Krepia, *Nursing and Caring : An Historical Overview from Ancient Greek Tradition to Modern Times*, 8 INT.J.CAR.SCI.791-800 (2015).

[11]ZERWEKH, *supra* note 8.

[12]*Id* .

[13]9 AUDREY BERMAN & SHIRLEE SNYDER, FUNDAMENTALS OF NURSING CONCEPTS, PROCESS AND PRACTICE 2(Pearson 2013).

and poverty.[14]

4.3 Nursing in the Renaissance Period

The period 1500-1700 is marked by the beginning of the Renaissance and Protestant Reformation in England. Achievements in the field of pharmacology, chemistry, and medical knowledge were major milestones of this period.[15]On the other hand, the period was marked by revolt against abuses within the church.[16]This impacted nursing too. Convents and Monasteries were closed, and hospitals functioned without any regulations and orders.[17]The activities of women were limited to household chores. Care of the sick was provided by a group comprising of prisoners, prostitutes, and drunks. They were illiterate and harsh. They were paid less and were subjected to long hours of work.[18]There were no proper standards to govern nursing. It is reported that nurses were sanctioned for fighting, using foul language, and extortion of money from patients.[19]Thus this period (1550-1850) was referred to as the 'Dark Ages of Nursing.'

4.4 Revival of Deaconesses

The 17th century was marked by social reforms that reconstructed nursing most finely. The best example is the formation of the Sisters of Charity

[14] ZERWEKH *Supra* note 8.
[15]BARBARA CHERRY & SUSSAN R. JACOB, CONTERMPORARY NURSING : ISSUES, TRENDS & MANAGEMENT 9 (Elsevier 2016).
[16]GRACE PAUL N. RAO, HISTORY OF NURSING 51(N.R.Brothers 2007).
[17]LINDEMAN *Supra* note 2.
[18]CAROL R. TAYLOR, & "et.al", FUNDAMENTALS OF NURSING 7(Lippincott Williams & Wilkins 2014).
[19]*Id* .

by St.Vincent De Paul, a Catholic Priest in 1633 in Paris.[20]The primary objective is to extend care in hospitals, asylums, homes for insane, abandoned children, home visits, and develop an educational program for the intelligent young women recruited. Other Social reformers such as Mlle-le-Gras,[21] John Howard,[22]Elizabeth Gurney Fry,[23]Amelia Sieveking,[24] Charles Dickens,[25]and Dorothea Lynde Dix,[26]also brought profound societal changes.[27]Changes were reflected in the life of women also. Women became more active and learned.

Another important event is the revival of modern Deaconesses by Pastor Fliedner and Mrs.Frederika Fliedner.[28]A training school for Deaconesses was started at Kaiserwerth (Germany) in 1836 by these couples. They provided training to nurses with regular classes. The nurses visited homes and cared for patients as members of the family. The deaconess nurses were too religious and followed the doctor's orders. They did not take vows or salaries for their service. The deaconesses' movement has influenced many modern training

[20] L.R UYS, FUNDAMENTAL NURSING 18(Maskew Millew Longman 1990).
[21] *Id.*(Mlle-le-Gras was a pious widow from a noble family of Paris. She assisted St.Vincent de Paul to organize the sisters of charity in 1633).
[22]*Id.*(Amelia Sieveking was an Englishman. He brought changes in the conditions of prisons by reporting and publishing it).
[23]*Id.*(Elizabeth Gurney Fry founded the Protestant Nursing Sisters in 1840).
[24]*Id.*(Amelia Sieveking was a well known author and prominent in women's movement. She organized a home visiting association known as the "Friends of the Poor" at Germany to take care of the cholera patients).
[25]*Id.*(Charles Dickens wrote humorous stories and described the poor manners of nurses. These writings help the public to be aware of the need for reforms).
[26]*Id.*(Dorothea Lynde Dix worked for caring the mentally ill. She won the title of 'John Howard of America').
[27]PAUL RAO, *Supra* note 16.
[28]Susanne Kreutzer & Karen Nolte, *Deaconesses in nursing care: A transnational history*, RESEARCH GATE (20 Jan. 2016), http://www.steiner-verlag.de/uploads/tx_crondavtitel/ datei-datei/9783515113557_p.pdf.(It is also noteworthy that Ms.Florence Nightingale has also took four months training at Kaiser worth).

schools and spread to many countries of the world.[29]It can be said to have revolutionized hospital training.[30]

4.5 The Nightingale Effect

The art of nursing, "what it is and what it is not," is greatly indebted to the outstanding contributions of Ms. Florence Nightingale, the founder of modern nursing.[31]She added various dimensions to nursing, which was limited to the administration of medicines. She viewed nursing as 'want of a better, which includes all the least expense of vital power to the patient-proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet.[32]

The outbreak of the Crimean War (1854-1856) provided a turning point in her carrier. The method of nursing followed by her to nurse the injured

[29]*Id.*(It is observed that ten years after the founding of the school at Kaiser worth, there were over one hundred deaconesses in it, and the work had begun at several other stations. By 1864,there were thirty-two deaconesses' houses and sixteen hundred deaconesses were at work in four hundred fields. In 1846 Flidner went to London with four deaconesses and started them at work in the German Hospital).

[30]*Id.*

[31]Asha Shetty, *Florence Nightingale: The queen of nurses*, ARCHIVES OF MEDICINE AND HEALTHSCIENCES (3 Aug. 2021),https://go.gale.com/ ps/i.do?id=GALE% 7CA454919085 &sid=googleScholar&v=2.1&it=r&linkaccess=abs& issn=23214848&p= AONE & sw= w & userGroupName=anon%7E302dc6ef.(Ms. Florence Nightingale (1820-1910). She was an educator, nurse, administrator, communicator, statistician and environmental activist. She was the innovator of the British Army Medical reform that included reorganising the British Army Medical Department , creating an Army Statistical Department and Collaborating on the first British Army Medical School, including developing the curriculum and choosing the professors. She was the first woman who received the Orders of Merit in 1902 and also the first woman to be admitted to the Royal Statistical Society. She was also the adviser-in-general to the whole United Kingdom upon everything pertaining to hospitals and nursing. She was called upon to criticize plans for new hospitals, to advise in detail of construction, equipment, management and question of policy. Her book on hospitals, "Notes on Hospitals", published in 1858 is the most valuable work ever been produced and revolutionized the hospital construction).

[32] FLORENCE NIGHTINGALE, NOTES ON NURSING : WHAT IT IS, AND WHAT IT IS NOT 8(D. Appleton, 1860).

soldiers brought a new insight to nursing.[33]Her dedication to nurse those wounded soldiers in the midst of the non-availability of hospital facilities (including beds, food, medicine, or candle lights) has been described in almost all the historical accounts on nursing.[34]Even in this worst situation of the hospital, she succeeded in providing proper care to the soldiers.[35]Her night rounds in the wards with an oil lamp gave her the name 'Lady with the Lamp.' She started the first training school for nurses in 1860 at St. Thomas Hospital, London.[36]Thus through her valuable efforts, she succeeded in providing a new dimension to nursing, thereby expanding training schools for nurses in England, and all over the world. [37]

[33]9JANICE RIDDER ELLIS& CELIA LOVE HARTLEY, NURSING IN TODAY'S WORLD 133 (Lippincott Williams & Wilkins 2004); *See also* 6 BARBARA MONTGOMERY DOSSEY & LYNN KEEGAN,HOLISTIC NURSING 8 (Jones & Bartlett Learning 2015).

[34]CHERRY, *Supra* note 15. (Nightingale and her team were assigned to the Barracks Hospital at Scutari. The Barrack hospital was dilapidated. Thousands of Cholera Victims and battle causalities were taken to Scutari. To get the hospital form the front lines, the wounded and ill soldiers were placed in hospital ships and then had to cross the long and often tortuous Black Sea. The sick and wounded were packed into the hospital that was designed to accommodate 1700 patients. Between 3000 and 4000 sick and wounded were packed into the hospital that was originally designed to accommodate 1700 patients. There were no beds, blankets, food or medicine. Many of the wounded soldiers were placed on the floor where lice, maggots, vermin, todents and blood covered their bodies. There were no candles or lanterns. All medical care had to be rendered during the light of the day").

[35] GOODNOW, *Supra* note 1.

[36]JANICE RIDDER ELLIS& CELIA LOVE HARTLEY, NURSING IN TODAY'S WORLD 133(Lippincott Williams & Wilkins 2004).(Her conception about nursing school includes the principles such as:- (a)Nurses would be trained in teaching hospitals associated with medical schools and organized for that purpose; (b) Nurses would be selected carefully and would reside in nurse houses designed to encourage discipline and form character; (c) The school matron would have final authority over the curriculum, living arrangements; and all other aspects of the school; (d) The curriculum would include both theoretical material and practical experience; (e) Teachers would be paid for their instruction and (f) Records would be kept on the students, who would be required to attend lectures, take quizzes, write papers and keep diaries).

[37]GOODNOW, *Supra* note.(From 1840 to 1852, a number of training schools were started in England. Some of them are the All Saints Sisterhood (1851) in London, Sisterhood of St.Margaret's order (1854),Training School for Mid-wives at King's College Hospital (1862), The Institution for Training Nurses in Ireland (1866) etc. Other important achievements

4.6 Nursing in India

From initial days onwards, nurses were ridiculed as morally suspicious women or prostitutes.[38]The interactive nature of their job, which required intimate caring of strangers, night shift works, and living outside the home, was pointed out as the reasons for this attitude towards nurses.[39] They were considered as mere 'servants' or 'untouchables' due to their profession's 'touch and care' nature.[40]It was regarded as a profession unsuitable for women from respectable families.[41]Notably, nursing was once an exclusive choice of women from the Anglo-Indian Community in India.

Until the 1930s, most nursing candidates were widows, orphans, or destitute converts who had no other option.[42]The prevalence of the rigid caste system and the notion of 'pollution' (due to their involvement with bodies, polluting bodily matter, and the birth process) emerged as a crucial aspect for nurses' subordinate or inferior status.[43]The belief prevailed even at the solid efforts of the Western colonial powers to improve nursing in India. The

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includes establishment of The Queen's Jubilee Institute for district nursing (1887), The National Pension Fund for Nurses (1887), The Scottish Branch of the Queen's Jubilee Nurses (1880), School Nursing (1892) etc.).

[38] MADELAINE HEALEY, INDIAN SISTERS : A HISTORY OF NURSING AND THE STATE, 1907-2007,48 (Rutledge Taylor & Francis 2013)

[39] *Id.*

[40] *Id.* at 49. (Nurses touch was considered as against pollution pure theory where the forward caste will not support the lower caste. Again women touching men including strangers were also against the moral concepts prevalent in Indian society).

[41]SREELEKHA NAIR, MOVING WITH THE TIMES : GENDER, STATUS & MIGRATION OF NURSES IN INDIA 30(Routledge 2012) Factors such as low status, lack of educational facilities and poor living and working conditions prevented suitable girls from choosing the profession.

[42] HEALEY *supra* note 38. (He cited the words of Lazarus as "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").

[43] *Id.*at 44 & 52.

withdrawal of the colonial State as a provider of health care by the 18th and 19th centuries is pointed out to be one of the significant reasons which obstructed the development of nursing in India.

The acceptance and recognition of nursing as an advanced profession is still an issue in India. The recent strikes organized by the nursing association's portraits images of unsatisfied nurses. Implementing social security measures to nurses, especially working in private hospitals, is still in its early stage. Even though many committees were appointed to study and make recommendations on the issues of nursing, still the rigorous attitude of Indian society and the reluctance of the State in improving their working conditions prevail. The proceeding paragraphs explain the various stages of the development of nursing in India.

4.6.1 Ancient Indian Texts

The historical accounts of Nursing in India can be found in the Samhitas or treatises of Susruta and Charaka, the authorities in Ayurveda. According to Samhitas, the Physician, the Drugs, the Nursing attendant, and the Patient were the four factors of Medical Practice.[44]Charaka Samhita (600 BCE and 100 CE) explains the qualities of the medical assistant or upasthatra as "Knowledge of the manner in which drugs should be prepared or compounded for

[44] SREELEKHA NAIR, *Supra* note 41 at 25.

administration, cleverness, devotedness to the patient waited upon, and purity of body and mind."[45]

According to Sushruta Samhita (between 600-350 BCE), assistants are friendly, non-critical, and care for the sick. They are physically strong, obedient, and tireless.[46]Male assistants assisted men, and female assistants assisted women.[47]The Sushruta Samhita also mentioned midwives as "…. to be mature, not easily upset, experienced at assisting during childbirth".[48]

4.6.2 The Buddhist and Brahmanical Influence

The Buddhist period (500 B.C to A.D 300) is called the 'golden age of medical advancement' in India.[49]King Asoka established a large number of hospitals. Hostels were built to house the sick, blind, and deformed. According to King Asoka, Doctors and Nurse should be trustworthy, skillful, and hygienic.[50]

However, by 1000 AD, the Brahmanical influences prevailed, resulting in the 'death end of medical innovations' in India.[51] Buddhist hospitals disappeared, and the rigid Hindu Caste System flourished. Medicine remained in the hands of Priest Physicians who were Brahmins. Operations were

[45] *Id.*
[46] HEALEY *Supra* note 41.
[47] *Id.*
[48]*Id.*
[49] TRAINED NURSES ASSOCIATION OF INDIA, HISTORY AND TRENDS IN NURSING IN INDIA 5 (TNAI Publications, 2001).
[50] GRACE PAUL N. RAO, HISTORY OF NURSING 11(N.R.Brothers 2007).
[51]4 CHRISTIAN MEDICAL ASSOCIATION OF INDIA, THE FOUNDATION OF NURSING 15 (B.I Publications 2002).(The Brahmins refused all kind of physical contact with non-caste people. They believed that such contact will make them contaminated touching pathological tissues, fluids and body part was considered as 'pollution').

preceded by religious ceremony and prayer. More up-to-date practices replaced superstition and magic.[52]

The Brahmanical influence developed the rule of 'purity and pollution, whereby they refused any kind of physical contact with non-caste people or 'mleccha' as it will contaminate them.[53]Touching pathological tissues, fluids, and the body were considered pollution.[54]Medicine as a profession and nursing declined due to religious restrictions. The Mohammedan period (A.D 1200) again led to the decline of medical advancement. Nurses were unheard of due to the low status of women.[55]

4.6.3 The Western Influence

Nursing is further developed by the influence of westerners in India. The Portuguese, the French, and the British who came to India developed nursing in a planned manner with a professional approach to nursing. Their long-term goals or interests promoted the establishment of various hospitals and nursing care in a well-defined way. The notion of nurses as "well educated, well trained and well dressed" can be attributed to western influences.[56]As observed by Ms.Sreelekha Nair,"British colonial efforts in organizing care professions for

[52]TNAI, *Supra* note 49.
[53] *Id.*
[54] *Id.*
[55]*Id.*at 15.
[56] NAIR, *Supra* note 41.

the Indian forces, vital to fight imperial wars across the globe, consolidated the system of modern nursing in India."[57]

The first attempt of the East India Company towards health care in India was the establishment of a civil hospital for soldiers in Madras in 1664.[58]Later it became the Government General Hospital. Nursing in military hospitals was carried on by soldiers, male orderlies, and the menial staff. During the period 1679 to 1688, a hospital was built for civilians in Madras. The same team of the military hospital took care of both hospitals. In 1797, another hospital was created for the poor people of Madras named as the 'Lying in hospital'.[59]The Lying-in Hospital, Madras started the first Training School of Midwives in 1854.[60]By 1859 a scheme for the training of Nurses was started. Hospitals such as the Allahabad General Hospital (1858), the Calcutta Hospital Nurses Institutions (1859), and the General Hospital in Madras (1871) trained women nurses.[61]

The first plan for providing training to women was initiated by the National Association by Supplying Female Medical Aid to the Women of India, known as the Dufferin Fund in 1885.[62]This plan made grants to selected hospitals to build nurses hostels, supply teaching equipment to training schools, employ trained nurses in hospitals, and send trained nurse for administrative

[57] *Id.*
[58] *Id.*
[59] PAUL, *Supra* note 50.
[60] ADITI IYER & "et.al", WOMEN IN HEALTH CARE: AUXILIARY NURSE MIDWIVES 11 (The Foundation for Research in Community Health 1995).
[61] HEALEY *Supra* note 38.
[62] NAIR, *Supra* note 41. (It was launched by the Vicereine Lady Dufferin at the direct request of Queen Victoria).

training abroad. But one of the major demerits of the plan was the discrimination of Indians in the admission processes and poor training and living conditions for nurses and students.[63]In 1947, all hospitals coming under the Dufferin Fund were handed over to Government, and a Uniform standard of teaching was established. Several Indian hospitals funded by Indian philanthropists also trained nurses. The Jamsetjee Jeejeebhoy Group of hospitals in Bombay (1891); the Matru Seva Sangh at Nagpur (1921) which was established to train widows and offer general nurse's training; the Ramabai Ranade's Seva Sadan to train Brahmin widows, etc. were examples.[64]By 1946, nursing education became the major focus, and around 80 percent of Indian nurses were trained under missionary programs.[65]It is cited that by 1947, the Anglo-American Protestant missions have monopolized the training of Indian women as nurses.[66]

4.6.4 Nightingale's Influence in India

Another important event in the history of nursing in India is the reorganization of the Indian Army services by Ms. Florence Nightingale.[67] In 1859, the Royal Sanitary Commission on the Health of the Army in India was appointed under Ms. Florence Nightingale. She submitted her report in 1863,

[63] HEALEY *supra* note 38.
[64] *Id.* at 72.
[65] *Id.* at 73.
[66] *Id.*(The training of Indian women as nurses was monopolized by Anglo-American Protestant missions, which by 1947 were running 75 schools of nursing in India. Nurse education became an increasingly strong focus, so that in 1946, 80 per cent of Indian nurses had been trained under missionary programmes).
[67] HEALEY *Supra* note 38.

identifying the need for providing nursing care to the soldiers in India.[68] As a result, the Indian Nursing Service (INS) was established to care for British soldiers. On 28th March 1888, INS was officially launched with ten fully qualified Certified Nurses in Bombay.[69]Miss Elizabeth Locke was the first Lady Superintendent. She played a significant role in raising the standard of Nursing in all Military Hospitals. Initially, there were objections against women as nurses in the Army,[70]but later services of the Sisters were appreciated. In 1893 a regular system of training men for hospital work was inaugurated.[71]Lectures were given on First Aid and Elementary Nursing to those men who applied for the course. This laid the foundation for the training of Nursing Orderlies in India.[72]The present system of training and the higher education of all Nursing Orderlies were built upon it.[73]In 1903, this Indian Nursing Service was renamed the Queen Alexandra Military Nursing Service for India. Later, it was replaced by nurses posted through the empire-wide service, Queen Alexandra's Imperial Military Nursing Service.[74]

[68]TNAI, *Supra* note 52. (Although, she never visited India, she succeeded in gathering immense information about military services from military stations in India Miss Florence nightingale obtained information from answers to detailed questionnaire , which she drafted for a 'Circular of Enquiry 'which was sent to all military stations in India. She also wrote to two hundred of the larger stations asking for copies of all regulations, including those relating to the health and sanitary administration of the Army. The Circular of Enquiry was drafted for obtaining a vast range of facts, which would provide a history of the health of the troops in every Indian station for the past ten years. She set out minutely detailed questions from to secure figures of sickness, mortality, age and length of service of each person at the time of death and regarding the situation and amenities of each station).
[69]*Id.* at 11.
[70]*Id.*
[71]*Id.*
[72]*Id.*
[73]*Id.* at 12.
[74]HEALEY *Supra* note 38.

4.6.5 The World Wars

The world wars have tremendously influenced nursing. The problem of enough availability of people to care of the First World War veterans led to the establishment of the Red Cross Society in 1920. The growth of the Indian Military Nursing Service is also attributed to the First World War.[75]Second World War also had a profound impact on nursing in India.[76] The development of the Auxiliary Nursing Service in 1942,[77]and the opening of the School of Nursing Administration in Delhi in 1943 were the most significant outcomes of the war crises.[78]The war initiated the first step in establishing a standardized voice for the profession in government by appointing Mr. E.E Hutchings, former matron of the Dufferin hospital in Calcutta as the first nursing advisor to the Government of India in 1942.

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[75]*Id.*at 13. (By 1927, they received the description of the Indian Military Nursing Service (I.M.N.S.). It was composed of twelve Matrons, eighteen sisters, and twenty five Staff Nurses, a total of fifty five. During the Second World War, they served both India and overseas under the direction of the Chief Principal Matrons of the Q.A.I.M.N.S. After the war, there was further development in the training of personnel for the Indian Military Nursing Service. Preliminary Training Schools were established for training the members of I.M.N.S under the charge of fully trained Sister Tutors. After successfully completing the course in these schools, the Student Nurses were provided training in the Military Hospitals. Those who have passed the final State examination became a Registered Nurse and were commissioned as a member of the Indian Military Nursing Service).

[76]*Id, at* 108. (There was severe scarcity of trained nurses during the World War II. In 1943, an army report recorded that the forces in India would have only 55 percent of the British nurses allocated as essential. Only 41 percent of the available Indian nurses were fully qualified trained nurses, with the remainder composed of 'auxiliary nurses with very little nursing experience').

[77]IYER, *Supra* note 60. (A basic training was given for six months in civil hospitals and those who passed it were sent to Military hospitals. Preliminary Training Schools were established to provide training to those members of the Auxiliary Nursing Service. Lectures and training were provided by fully qualified Sister Tutors who were serving in the Q.A.I.M.N.S. The Student Nurses who passed the State Final Examination were eligible to join the permanent Military and Naval Nursing Services. It is observed that Auxiliary Nurse sought to "provide an adequate supply of nursing profession for the Indian Army while safeguarding the rightful status of the nursing profession).

[78]HEALEY *Supra* note 38. (The School provided post-diploma nursing in general and ran a short sister tutor course for civilian nurses).

4.6.6 Darkest Period in Nursing

One of the important factors that discouraged providing training to nurses in India was the prevalence of prejudice against allowing girls to do any work involving contact with people. Most of the trainees were Europeans and Anglo-Indians. This is due to their higher educational levels compared to the very low academic levels of the general population. It is cited that low status, lack of educational facilities, and poor living and working conditions were the reasons for the lack of interest in suitable girls.[79]

The period between the eighteenth and nineteenth centuries can be regarded as the darkest period of nursing in India. It was the period of withdrawal of the state as the provider of health care.[80]There was complete deterioration in the health care of the people. Various diseases such as Malaria, Plague, Leprosy, Smallpox, Cholera, Typhoid, etc. prevailed. Mortality rates, including Infant mortality, maternal mortality, and death rate among women and children, were also high. Nursing facilities were neglected. It is shown that there were only 7000 Nurses in the entire country with a population of about 40 crores.[81]

The first two decades of the 20th century (the 1930s) also witnessed unsafe and unclean working conditions of nurses.[82] Nurses lived and worked in dangerous and arduous conditions. There were objections to nursing because it

[79] NAIR *Supra* note 41.

[80] HEALEY *Supra* note 38.
[81] *Id.*at 60.
[82] *Id.* at 75.

was considered dirty, morally dangerous, and low-status work.[83]It is observed that the low salaries paid to nurses, especially those trained in mission hospitals, left them vulnerable to brothel-keepers.[84]Conditions in the wards in many hospitals were dangerous and unsanitary. It is reported that there were smallpox wards with between four and six nurses to care for 300-400 patients.[85] There were continuing ill health, exhaustion, and disillusionment of nurses.[86]

4.6.7 Nurses Associations and International Alliances

The period 1905-1947 witnessed the unification of nurses through associations. Nursing associations such as the Trained Nurses Association of India (TNAI, 1908) and the Nursing Auxiliary (1930) were formed during this period.[87] The first nursing journal, the Indian Journal of Nursing (1910) was published as a forum for nurses to exchange their views and experiences.[88]The emergence of health as a key concern for Indian nationalists influenced nurses to form associations. Nursing organizations were influenced by the increased participation of women in the public sphere, especially in women's health, and maternal and child welfare.[89]The promotion of the International alliance is

[83]*Id.*
[84] *Id.*
[85]*Id.* at 76.
[86] *Id.* at 77.
[87] HEALEY *Supra* note 38. (The Trained Nurses Association of India was founded at the annual conference in Bombay in 1908. The main aim of the association is lifting the standards of nursing profession, nursing education, nursing training and to bring about a more uniform system of education, examination and certification for trained nurses, both in Indian and in European. Another association named the Nurses Auxiliary was also formed in 1930. It conducted examinations and awarded diplomas for missionary hospital trained nurses).
[88]*Id.*
[89] *Id.* at 84.

another significant move by TNAI. One of the notable incidents in this regard was the support given by TNAI towards the International Council of Nurses (ICN) to represent India at its conference from 1912.[90]

Another step was the promotion of nurses for abroad education.[91] It is cited that from 1912 onwards, Indian women were periodically sent to London to take the course in public health nursing at Bedford College, run by the League of Red Cross Societies and the Royal College of Nursing, and the Florence Nightingale International Foundation.[92]The financial support provided by the Vicereine Lady Reading to train Indian nurses in London as matrons and administrators were the finest examples in this regard.[93]Thus shaping nursing into an international sisterhood was an integral part of western leaders' work in India.[94]Initiatives such as registration of nurses, representation of nurses in affairs of government, expansion of community health nursing,[95]and improvement of education of nurses were other significant efforts on the part of the leaders of TNAI.[96]

[90]*Id.*at 85, (In the Indian Context, where nurses were few and had minimal local power and influence, alignment with nursing internationalism was seen as crucial to successful advocacy for nurses.ICN provided a valuable source of ideas and leverage for nurse leaders in India. At the 1909 Conference in Agra, C.R Mill, a prominent ANSI and TNAI leader, even declared that the TNAI would be small –scale version of the ICN. In 1914, Annie Goodrich, president of the ICN , was made an honorary member of the TNAI).
[91]*Id.* at 86.
[92] *Id.* at 86-87.
[93] *Id.*
[94] *Id.*
[95] *Id.* at 89 &91.
[96]*Id.*(The effort of TNAI to register and represent nurses in Government is also an important initiative to raise the standard of nursing profession Following it, 1926, the first registration Act was passed in Madras, followed by Punjab in 1932, Bengal and Uttar Pradesh in 1933, Bihar, Orissa and Bombay in 1935 and Madhya Pradesh in 1936. State Nursing Services with standardizes pay and terms of service were initiated in Madras in 1941, Uttar Pradesh in 1944

4.6.8 The Silent State and Leadership

Apart from these efforts to improve nursing education, the working conditions of nurses remain worst. The lack of interest on the part of the State is regarded as the major problem that hindered the development of nursing in India.[97] Both the Central and the provincial governments remained silent towards the complaints of nursing leaders. As observed by Madelaine Healey

> *"The state at the central and provincial level accepted a situation in which the majority of hospitals functioned with either a minimal or no nursing staff at all……. The care of patients in Indian hospitals was in practice provided by relatives and by a range of semi-trained or untrained personnel, holding a series of titles, including ward boy, orderly, sweeper, compounder, and ayah".* [98]

It is also stated that the care of patients in Indian hospitals was in practice provided by relatives and by a range of semi-trained or untrained personnel, holding a series of titles, including ward boy, orderly, sweeper, compounder, and ayah.[99]Notably, most of the trainees in government hospitals were mainly Anglo-Indians and domiciled European nurses.[100]

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and in Bengal in 1946. In 1931, the TNAI passed a resolution that all registrars should be trained nurses. The promotion of registration and representation in government was not only motivated by self-interest ,but also by the desire of leaders to put in place the structures of a Western-style profession. With the backing of registration, legislation and institutionalized representation in government, modern training nursing would theoretically be defended from the initiatives sporadically produced by local politicians that proposed the lowering of training standards).

[97] *Id.* at *103.*
[98] *Id.* at 105.
[99] *Id.*
[100]*Id.* at 106.

The dominance/occupation of a racial and professional elite group (primarily westerners) in the nursing leadership is another primary reason for the non-representation of the real cause of Indian nurses.[101] The leaders failed to represent the issues of the non-elite low-middle class nurses. The exclusion of Indians from higher grader of training and pay, application of English language as the medium for 'Nurse Examination', the dominance of medical profession of the organization and administration of nursing, etc were pointed out to be other reasons.[102]Indian nurses were excluded from the higher grades of training, pay, and responsibility.[103]

4.6.9 International Nurses in India

Post-colonial India (1947) is known for the internationalism of nursing with an emphasis on professionalism and standardization.[104]During this period, most international organizations such as WHO, the Rockefeller, etc., have established nursing assistance programs in India.[105]International nurses adopted three central policies to promote professionalism: sponsorship of degree

[101]*Id.at* 96 (Nurses were non-elite, lower middle-class women with a somewhat tenuous position within colonial society and the Indian women they worked with were from among the most economically and socially disadvantaged groups in local society).

[102] MADELEINE HEALEY, INDIAN SISTERS : A HISTORY OF NURSING AND THE STATE, 1907-2007, 90 (Rutledge Taylor & Francis 2013). (Doctors almost ubiquitously allowed minimal authority to nursing superintendents and school principals, and monopolized positions on nursing boards and councils).

[103]*Id.* at 97.

[104]*Id.* at 123.

[105] *Id.*(The WHO ran 22 nursing projects between 1948 and 1958, 15 percent of all its project in India. The Colombo Plan provided considerable assistance throughout this period in raising the standard of nursing education, with the participation of the United States, Australia and New Zealand. The USAID focused financial aid and personnel to support three new degree colleges of nursing. The Rockefeller foundation focused on providing expert assistance to the Colleges of Nursing in New Delhi and Vellore and the School of Nursing in Trivandrum, as well as sponsoring Indian nurses for advanced education in North America, especially in teaching, administration and public health).

education for nurses, overseas education programs for Indian nurses, and promotion of public health nursing.[106]

The promotion of University education and abroad education for Indian nurses were primary goals of 'international nurses'. But the issues such as hostility from the medical profession, lack of practical state support, opposition from nursing staff in the hospitals, incomplete understanding of the local socio-cultural context, etc., restricted them from realizing it.[107]Again the problem left is concerning the improvement of conditions of nurses rather than nurses themselves. The primary concern had been the poor working conditions of nurses. Deplorable living conditions of nurses' hostels, poor quality, insufficient food, gross lack of equipment in hospitals, overcrowding, unsanitary conditions, long working hours, and meager salaries were pointed out as the major issues faced by nurses.[108]Violence in the form of verbal and physical abuses against nurses were reported. Patients and relatives have frequently harassed nurses. Harassment from the side of hospital employees were other major threat.[109]

4.6.10 Committees and Commissions

The period from the 1930s viewed the appointment of various committees and commissions to study health conditions in India. This attempt

[106]*Id.* at 129.
[107]*Id.* at 150.
[108]*Id.* at 156.
[109]*Id.*

was mainly due to the India Act of 1919, whereby health was sifted to governments elected at the provincial level.

4.6.10.1 Bhore Committee

The first committee appointed to provide a detailed survey of health conditions and make recommendations was the Bhore Committee or '*The Health Survey and Development Committee'*. [110]The Committee was appointed by the Government of India in October 1943, under Sir Joseph Bhore. The Committee submitted its report in December 1946. The committee studied all aspects of health and suggested measures for reconstructing health services in India. Some of the significant suggestions of the committee include providing training to midwives and nurses,[111]creating an All India Nursing Council,[112]training of male nurses,[113]training of Public Health Nursing,[114]

[110]GOVERNMENT OF INDIA, RECOMMENDATIONS, HEALTH SURVEY AND DEVELOPMENT COMMITTEE (18 July 2016), https://www.nhp.gov.in/bhore-committee-1946_pg.

[111] *Id.* at 388-389 (The committee suggested the establishment o preliminary Training Schools to provide elementary instructions to students who wished to become Nurses and Midwives. The Committee also suggested two grades in the Nursing Profession corresponding to the type of training-a junior grade and a senior grade. The committee also proposed the establishment of a University Degree Course and post graduate courses for nurses).

[112]*Id.* at 462-463 (The committee pointed out the need for proper regulation of nursing profession. It suggested that the current mechanism of regulation, the Provincial Council should primarily consist of members of the profession it design to regulate. It also suggested the need for an All India Nursing Council to co-ordinate the activities of the Provincial Councils, to lay down minimum educational standards and to safeguard their maintenance).

[113]*Id.* at 394 (The committee discussed the need for providing training and employment to male nurses in the male wards and male outpatient departments of government hospitals).

[114]*Id.* at 395 (The committee discussed the importance of Public Health Nurse and recommended appropriate training for them . The committee also pointed out the problem of non availability of properly trained and qualified teachers or supervisory staff capable of conducting public health nurses training school in India. The committee suggested that the Public Health Nurses should be trained in centres, where medical colleges and nursing educational institutions for the higher grade of nurses are provided).

Increasing the number of trained nurses,[115]and providing stipends to nursing students.[116]

The Indian Nursing Council (1947) to regulate the standards of Nursing Education, the Institution of two-degree colleges for Indian nurses in Delhi and at Christian Medical College, Vellore, were the major outcomes of the committee report.

4.6.10.2 Shetty Committee

In the year 1954, the Shetty Committee (the High Power Committee on Nursing and Nursing Profession) was appointed by the Government of India to review the working conditions of the Nursing Profession with Mr. A. B Shetty as its chairman.[117]The significant recommendations were about raising the standard of nursing education; having teaching wards in the hospitals; providing adequate residential facilities to student nurses; having refresher courses in Public Administration and Public Health Nursing; and having a good teaching staff for the training of Nurses and Midwives in the hospitals.[118]

Appointment of a Superintendant of Nursing Services in each state, consolidation of nursing services for different levels of education, the

[115]*Id.* at 348 (The committee recognized the need for increasing the number of nurses. It is pointed out that the number of trained nurses shall be raised from the current availability of 7000 nurses to 80,400 nurses. The need for raising the number of public health nurses are also stressed in the report).
[116]*Id.* at 349 (The committee also felt the need for providing a monthly stipend of Rs.60 to cover the cost of maintenance and training for all suitable candidates).
[117]HIGH POWER COMMITTEE ON NURSING AND NURSING PROFESSION, GOVERNMENT OF INDIA (1954).
[118] *Id.*

permission of married women to work part-time, promotion of Male Nursing programs, representation of nurses in Nurses Registration Councils and to increase allowances for all Nurses are other significant recommendations of the Committee.[119]

4.6.10.3 Mudaliar Committee

On 12th June 1959, the Ministry of Health, Government of India set up a Committee known as 'Health Survey and Planning Committee,' popularly called the 'Mudaliar Committee (August1959-October 1961)'.[120]The committee pointed out the need for training and practical experiences for student nurses.[121]It recommended three grades of nurses such as the general nurses with four years of training, the auxiliary nurse midwife with two years of training, and the nurse with a degree qualification.[122]It is suggested to provide age relaxation for admission in regions where girls were not joining nursing.[123]It also urged for the utilization of hospitals for training nurses,[124]and providing more facilities for nurse trainees.[125]

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[119] *Id.*

[120]GOVERNMENT OF INDIA, MUDALIAR COMMITTEE RECOMMENDATIONS (3 Jun. 2017), https://www.nhp.gov.in/sites/default/files/pdf/Mudalier_Vol.pdf.

[121] *Id.* at 369.

[122] *Id.*at 368.

[123] *Id.* at 369.

[124]*Id.* at 370 (The committee suggested that all district headquarters hospitals and hospitals with bed strength of 75 to 100 should be utilized for nurses training).

[125]*Id.* at 370 (The committee suggested that nurse trainees should not be subjected to too much of night duties in the hospital concerned. The committee accepted the proposal of the trained nurses association regarding the 48 hours work on six-day basis. It also suggested the need for providing full furnished accommodation for probationers in hostels attached to hospitals. Free boards, free supply of uniforms and laundry arrangements including free medical services were also provided to them. It also recommended Stipends with a minimum of Rs.35/-increasing by Rs.10/- every year).

Other suggestions of the committee include the creation of Nursing School Advisory Committee;[126]separate budget for nursing schools;[127]training of auxiliary-nurse midwives;[128]Public Health Nurses;[129]and Dias. The committee felt the need to appoint nurses to higher posts and train male nurses.

The period 1950-1970 could be considered as a period of renaissance in Nursing Services and Education. International efforts and cooperation to tackle health problems were taken by International Agencies like WHO, UNICEF, and USAID. Many Nursing Schools were built. Nurses were given grants for taking up advanced education abroad.[130]Nursing Education became more organized, and nurses became more conscious about their rights and privileges.[131]

4.6.10.4 Kartar Singh Committee

Again in 1973, the Kartar Singh Committee or 'Committee on Multipurpose Workers under the Health and Family Planning Programme' was

[126]*Id.* at 371 (The committee recommended the creation of Nursing Advisory Committee for the purpose of advising on the care to be taken of nurse probationers and on their health and welfare. Such committee may consist of the administrative head of the hospital, the nursing superintendant , one senior sister tutor and two lady members , one of whom should be a non-medical educationist).
[127]*Id.*(The committee suggested that the separate budget for nursing school should include the expenditure to be incurred on the nursing probationers, provision for audio-visual aids and library facilities on nursing subjects as well as general reading materials).
[128]*Id.* at 372 (The committee suggested two year training for auxiliary nurse midwives in selected hospitals and an 18 months training in midwifery and a certain amount of training in general sick nursing).
[129]*Id.* (The committee suggested basic nursing qualification and one year further training for public health nurses. The committee also suggested the need for replacing health visitors with the public health nurses).
[130]*Id.* at 96.
[131] *Id.*

appointed.[132]It dealt with the need to recruit nurse-midwives with community health training or public health nurses to make up for the shortage of female health supervisors.[133] The year 1973 witnessed the creation of posts of Nurses at the Directorate of Health Services level by various States in India.[134]

4.6.10.5 Shrivastava Committee

By the year 1975, the Shrivastava committee was appointed under the chairmanship of Dr.J.B Shrivastava.[135] This committee is also called as the 'Group on Medical Education and Support Manpower'. The Committee advocated the development of semi-professional community-based health workers to provide simple promotive, preventive, and curative health services the community needs.[136]The Community Health Workers Scheme of 1977 and the Rural Health Scheme by the Government in 1977 were the outcome of this report.[137]

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[132]KARTAR SINGH COMMITTEE REPORT, GOVERNMENT OF INDIA (23 Jan.2019), https://www.nhp.gov.in/ sites/default/files/pdf/ Kartar_Singh_Committee_Report.pdf.
[133]*Id.* at 45.
[134] TRAINED NURSES ASSOCIATION OF INDIA, HISTORY AND TRENDS IN NURSING IN INDIA105 (TNAI Publications, 2001). (In West Bengal, the post of Assistant Director Nursing was created. In Calcutta, 15 Nurses were appointed at the Directorate level. Designation of nurses working in hospitals also varied, they were earlier called as Matrons, Ward Sisters, and Staff Nurses according to British system. Later these were called as Nursing Superintendent, Assistant Nursing Superintendent, Head Nurse and Staff Nurse).
[135]SHRIVASTAVA COMMITTEE REPORT, GOVERNMENT OF INDIA (20 Jan. 2019) https://www.nhp.gov.in/shrivastav-committee-1975_pg.
[136]*Id.* at 40.(Recommendation 8.03 include dais, family planning workers, persons who could provide a simple curative service, and persons trained in promotional and preventive health activities , including the control of communicable diseases).
[137]TNAI, *Supra* note 134 at 113.(The programme of training of village level Health Workers was initiated during 1977-78.Steps were taken for the involvement of Medical Colleges in the total health care to re-orient medical education to the needs of the rural people and reorientation training of multipurpose workers engaged in the control of communicable diseases programmes into unipurpose workers).

4.6.10.6 Mehta Committee

In 1983, the Medical Education Review Committee or Mehta Committee was appointed.[138] The committee suggested the creation of Universities of Health Services by the Central Government to coordinate between medical and health care training institutions.[139]In 1986, the Bajaj Committee was appointed with Dr.J.S Baja, Professor, All-India Instituted of Medical Sciences, New Delhi, as the Chairperson of the committee.[140]One of the committee's significant recommendations is the enunciation of a National Policy on Education in Health Sciences.[141]

The Committee suggested the formation of policy guidelines for health human resources development,[142] and the creation of an Education Commission for Health Sciences.[143]The Committee's suggestions influenced the reaction of

[138]MEHTA COMMITTEE REPORT, GOVERNMENT OF INDIA (21 Aug. 2018), http://www.community health.in/~ commun26/ wiki/images/ d/da/Mehta_Committee_report_1983.PDF.pdf.

[139]*Id.* at 36 & 43.(Both reads as the Central and State Governments should establish universities of Health Sciences in order to bring about coordination between the various educational and training institutions of the modern and various Indian Systems of Medicine, nurses, pharmacists ,etc … the beginning the Central Government may establish one such University on a trial basis, to cover all the medical and health institutions in a given State for a region).

[140]BAJAJ COMMITTEE REPORT, GOVERNMENT OF INDIA (2 Oct. 2018), https://www.nhp.gov.in/ sites/default/files/pdf/ Bajaj _Committee _report.pdf.

[141]*Id.* at 10.(It explains the purpose of the National Medical and Health Education Policy as (i) to set out the changes required to be brought about in the curricular contents and training programmes of medical and health personnel, at various levels of functioning, (ii) takes into account the need for establishing the extremely essential interrelations between various functionaries of various grades, (iii) provides guidelines for the production of health personnel on the basis of realistically assessed manpower requirements , (iv) seek to resolve the existing sharp regional imbalances in their availability, and (v) attempts to ensure that personnel of all levels are socially motivated towards the rendering of community health services).

[142] *Id.* at 10 (Recommendation 2.4.2).

[143] *Id.* at 36 (Recommendation 6.2.1 & 6.2.1.1 reads as the major role of the commission should be to prescribe standards of education in all branches of health sciences, including

health universities in different parts of India, including state-level universities that standardized courses, including nursing education in various colleges.[144]

4.6.10.7 High Power Committee

In 1987, a High Power Committee was set up by the Government of India to consider the matters relating to the conditions and status of nurses.[145] Some of its suggestions included the reiteration of previous commissions and committees and National Convention for Nurses, development of Nursing Profession and Nursing Services, to accord due status to the Nursing profession. Other suggestions include improving the Working Condition of Nursing personnel,[146] the Development of Nursing Education including Post-Certificate degree and post-graduate programs,[147]Continuing Education and Staff Development,[148]the Establishment of a National Institute of Nursing Education, Research and Training and the establishment of National Services/Hospitals and Institutions in urban areas.[149]The need to raise the status of nurses by giving them gazette ranks is suggested by the committee.[150] It is also recommended to amend Indian Nursing Council and State Nursing Councils Acts to control the Indian Nursing Council on State Nursing

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medical sciences at all levels, as also of nursing , pharmaceutical and dental sciences and for other categories of paraprofessionals).

[144] *Id.*

[145]REPORT OF THE HIGH POWER COMMITTEE ON NURSING AND NURSING PROFESSION, GOVERNMENT OF INDIA (18 July 2018), https://ruralindiaonline.org/ta/library/resource/report-of-the-high-power-committee-on-nursing-and-nursing-profession/.

[146]*Id.*at 38(Recommendation 5.1).

[147] *Id.* at 39 (Recommendation 5.2).

[148] *Id.* (Recommendation 5.3).

[149] *Id.* (Recommendation 5.4).

[150]*Id.* at 40.(Recommendation 5.5).

Councils.[151] A National Nursing Policy and a Nursing Advisory Committee for advising the Government were also recommended.[152]

4.6.10.8 Varadappan Committee

In 1990, the Sarojini Varadappan Committee, appointed to study nursing education issues, submitted its report.[153]The committee recommended two nursing personnel levels such as a post-basic B.Sc nursing degree, a Master's in nursing program, a doctorate in nursing program in selected universities; and a continuing education and staff development courses for nurses.

In 1991, the working group on nursing education and manpower made suggestions as to the phasing out of GNM programs by 2020, modification of B.Sc nursing, improvement in the functioning of INC, and plans for the preparation of teachers in MS.c./M.Phil and Ph.D. degrees.[154]

But the miserable fact in India is that despite all these recommendations by the Commissions and Committees, the status of the nursing profession remains low. As pointed out by Miss Sreelekha Nair, “there are wide disparities between the desired goals and the implementation of the objects.”[155]

Thus, nursing is still given low status, and the woes of nurses continue without sufficient safeguards and social security measures.

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[151]*Id.* at 41.(Recommendation 5.8).
[152] *Id.*at 43. (Recommendation 5.10).
[153]NATIONAL HEALTH PORTAL (8 Jan. 2018), https:// www.nhp.gov.in/ miscellaneous/ committees-and-commissions.
[154] *Id.*
[155] NAIR, *supra* note 41.

4.6.10.9 Jagdish Prasad Committee

The most recent committee was appointed in 2016 under Prof. Jagdish Prasad. It was constituted as per the judgment of the Supreme Court in *Trained Nurses Association of India* v. *Union of India.*[156] The committee recommended for the payment of minimum wages to nurses as per the hospital-bed ratio and the application of the same working conditions to nurses working in the government and private sector. The need for framing legislation or guidelines by States for implementation of minimum wages by the private hospitals is another important suggestion put forth by the committee.

4.7 Nursing in Kerala: Historical Glimpses

As the empirical study of the thesis is conducted in the State of Kerala, it is important to understand the historical evolution of nursing in Kerala.

It is interesting to note from the historical accounts that the State of Kerala is the first state to provide a large group of educated but poor women to a nursing career in India.[157]As per the study conducted by the Bureau of Economics and Statistics, Trivandrum, the 'New Civil Dispensary' in Kerala came into existence in 1864, when his Highness Ayilyam Thirunal Maharaja

[156] 2016 SCC Online SC 95.

[157] MADELEINE HEALEY, INDIAN SISTERS : A HISTORY OF NURSING AND THE STATE, 1907-2007, 65(Rutledge Taylor & Francis 2013) The State of Kerala provided a large group of educated but poor women who were comparatively mobile and independent, which needed the security and later, the potential social mobility that nursing careers could provide. These predominantly Christian Women could more easily enroll in the nursing schools that, even when government runs, were heavily associated with Christianity. Thus , in spite of the anti-nursing stigma (probably less in Kerala than elsewhere but nonetheless virulent) they became a sustainable recruitment base for the Indian population.

ruled Travancore.[158]This hospital later became 'the General Hospital', Trivandrum.[159]

The initial history of nursing started with the year 1906. A two-year nursing and midwifery program was started in the General Hospital, Trivandrum, under Dr.Punnen Lukose.[160] The London Mission Hospital, Neyyoor, Tamil Nadu (1806), and the Medical College Hospital, Vellore (1924) were the major nursing training schools in South India during those days.[161]Beginnings of formal training of nurses were reported in various parts of the State. The revised certificate course in General nursing and one-year Midwifery in the School of Nursing attached to the General Hospital, Trivandrum, is an example.[162]

Notably, nurses were not allowed to marry during the first five years of training after their final examination.[163]Incidents of termination of married

[158] LILLYKUTTY K. VARGHESE, THE NURSING PROFESSION IN KERALA : A MANPOWER STUDY, 2 BUREAU OF ECONOMICS AND STATISTICS (1977).
[159]*Id.* at 2
[160]*Id.*
[161]*Id* .
[162]*Id.* at 3.
[163] ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY (Travancore Legislative Council Discussions, Que. No. 29, & No. 61(5 Aug. 1926), Government have not laid down rules declaring that women in the public service shall not marry; but in the notice inviting candidates for the nursing class by the Medical Department , one of the conditions laid down was that matrimony during the training period and during the five years they are bound to serve after final examination will terminate their service. The training was done by the Medical Department. It is also shown that it was the recommendation of the Administrative Board, Medical Services and the Government has accepted it. The major reason cited is the job nature of the nurses. Also see Ans. No. 6 (18 Apr. 1931), Nurses have to attend their work throughout day and night and it may interfere with their work if they are married). Also see Ans. No. 367 (4 Apr. 1941), (In the Madras Presidency pupil nurses are not permitted to marry during the period of their training and one who does so will be deemed to have left the training school without notice and she will be required to refund the stipend received by her during the last three months prior to the date of such marriage. Staff nurses are permitted to marry and continue in the service of the Government with the approval of the Surgeon-

nurses from service can be found in the historical accounts. "Marriage reduces the efficiency of the nurses" was the central argument that favored this prohibition.[164] Debates as to observations showing comments saying "married women's interest will be to nurse their husbands and children and they won't be interested in nursing the patients" can also be found in the legislative assembly discussions.[165]

It is also interesting to note the Caste-War Statement of Midwives and Nurses in Government Service during 1934.The Nair's formed the highest number among Hindu nurses; Roman Catholics (Latin-rite) and Syrians (Marthoma) form the highest number among the Christians. No representation from the Musalmans community is reported.[166]Records also show that only those who have passed or completed School final (not necessarily given) were appointed as nurses.[167]Though it was considered the requisite qualification, nursing by unqualified persons such as relatives of patients were also reported in cases where qualified nurses were unavailable.[168]The increased demand for

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General subject to the condition that the nurse concerned produces a declaration from her husband that he has no objection to her remaining in Government Service and that he will not frequently visit the Nurse's Quarters if and when she has to live in the common quarters provided for the nursing staff. The primary duty of the married woman will be towards her husband and children. But in the case of a nurse she should devote all her time and attention to patients entrusted to her care.(not prevalent in Europe but in India) married women could not carry out even the ordinary duties of a nurse efficiently *See also* Ans. No. 25 (25 Aug. 1944).

[164] *Id.*

[165]*Id.* ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY Q& A.71 (4 Aug. 1945).

[166]*Id.* ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY Ans.No. 147 (2 Aug.1934).

[167] *Id.* ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY Ans.200 (13 Aug. 1937).

[168]*Id.* ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY Ans. No. 61(6 Aug. 1930) (It is stated that even though they are not qualified for work, they have practical, elementary knowledge for the method of attending to patients).

dowry among Christians during marriage was one of the significant reasons that forced women to choose nursing as their career.[169]

The appointment of male nurses in nursing services was mentioned to have started in September 1939.[170]It is notable that Delhi was one of the major training centres for nurses from Kerala. The nurses were supposed to pay an amount of Rs.2000/- or landed property as security for getting trained. The said amount is refundable after five years of training.[171]

Historical accounts also narrate the incident of welcoming the Catholic Orders of Sisters of the Holy Cross from Switzerland by the Maharaja of Thiruvithamkoor.[172]They played a significant role in imparting technical and practical training to nurses in the School of nursing (Thiruvananthapuram, 1943).[173]

During the year 1947, three classes of nurses were found in the Govt. Service such as the staff nurses who take care of the patients'; the nursing sisters who are in charge of wards and to supervise the work of nurses; and the

[169] MADELEINE HEALEY, INDIAN SISTERS : A HISTORY OF NURSING AND THE STATE, 1907-2007, 62(Rutledge Taylor & Francis 2013).The economic attractions of nursing as the source of livelihood and a means of saving for the punitively high Syrian Christian dowry meant that thousands of Kerala women joined nursing despite this stigma. Nursing was chiefly attracted lower middle class and working class Malayali women.

[170]*Id.*ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY Ans. No. 94 (23 Jan. 1941).

[171]*Id.*ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY Q.Ans. No. 19 (25 Jul. 1944), (After training, they were named as Sister Tutors).

[172] SREELEKHA NAIR, MOVING WITH THE TIMES: GENDER, STATUS & MIGRATION OF NURSES IN INDIA 42 (Rout ledge 2012) (It is pointed out that formal nursing courses were established in hospitals at Thiruvananthapuram and Ernakulam in the 1920s. By 1938 Thiruvithamkoor had 108 nurses of whom more than 50 were Europeans . Moreover, dowry has become an integral part of Christian marriages because of which women from the middle class had to earn for their own marriage).

[173]*Id.* at 42.

Mother Superior of the matron who is the administrative superior and allotted work to nurses and posts them to different wards.[174]The hierarchy of nurse's promotion is from staff nurse to nursing sisters or mother superiors or matrons. It is also notable that among sisters, some were nuns. The requisite qualifications for appointment as staff nurses (both male and female) were fixed as S.S.L.C and four years training in the Nursing Class, conducted by the Medical Department.

Discussions about the appointment of nurses for 12 hours a day (without allowances as to overtime work) can be found in the historical records[175]. Another notable aspect is the first committee's appointment to inquire into Nurses' grievances in Kerala (1947).[176] It consists of Chief Medical Officer, Government Secretary, Department of Development; Comptroller and Finance and Accountants; Three Doctor's; and Mother Superior, General Hospital, Ernakulam. One of the significant demands of the nurses was to enhance their salary in proportional to their experience in Government service.

Notably, the first legislation of nurses in Kerala, known as the Travancore Midwives, Nurses, and Dhais Bill, was passed on 6th February 1946.[177]On 4th November 1952, the Travancore-Cochin Nurses and Midwives

[174]DIGITAL ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY, *supra* note 412, Que.& Ans. No. 215 (6 Aug. 1947).
[175] *Id.* ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY Q.No. 345(16 Apr.1947).
[176]*Id.* ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY Q.No. 287(10 Feb. 1947).
[177]ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY, PROCEEDINGS OF THE SHRI MULAM ASSEMBLY, (4 Feb. 1946).

Bill were introduced to extend its application to the areas of Cochin.[178]Notably, the new bill has deleted the term 'dhai' from its title due to their non-availability in the regions of Cochin and Travancore. There were debates as to the need for separate legislation for nurses. Arguments were raised as to their inclusion within the Medical Practitioners Bill that includes the medical system.[179]

Meanwhile, the State of Kerala was formed in 1956 due to the unification of three regions: Thiruvithamkoor, Kochi, and Malabar. Finally, the difference in duties performed by the nurses and medical practitioners was accepted. After lengthy discussions, the Bill was passed on 31st March 1953, and the Kerala Nursing Council was constituted.

It is to be noted that since the inception of the Council, nurses and midwives who have passed from the recognized institutions of the council were allowed to practice in the Government Service. Nursing School at Ernakulam,

[178]*Id.* ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY, TRAVANCORE-COCHIN LEGISLATIVE ASSEMBLY DEBATES (4 Nov.1952).

[179]*Id.* ARCHIVES OF KERALA LEGISLATIVE ASSEMBLY.(Shri K Balakrishna Menon -I don't agree with the Government regarding the necessity of having a separate Bill for midwives and nurses. In my view, the purpose of the Bill could very well be served by the Medical Practitioners Bill the scope of which could be widened, and representation to the nurses and midwives may be given. The object of the Bill, if I have understood is practically the same as that of the Medical Practitioners Bill. That is, both these Bills seek to establish an efficient medical system in the State. Now, doctors are as much as necessary part of the medical service. In fact, one is the complement of the other. If that is so, I do not see why these should be a separate organization for the midwives and nurses. You can as well have one of their representatives in the Council constituted under the Medical Practitioners Bill. What I fine from the Medical Practitioners Bill is that the Council provided by the Bill controls the work, training, etc., of medical practitioners. The same functions are contemplated under this Bill also. That being so why should we disintegrate the component parts of the medical system and try to organize them as though on trade union lines ? Is it not much better to have a sort of integration and coordination among them? Would it not be very conducive for promoting a more efficient medical systems in the State?).

L.M.S Hospital, Neyoor; C.B Hospital, Nagarkovil, and Medical Mission Hospital, Thiruvalla were considered to be the recognized (by the council) training centres of nurses in Kerala during those days.[180]

The presence of traditional private nurses and midwives called *pettachi or vayattatti* who helped women with the delivery of children were recorded in the history of Kerala.[181]

In 1956, the Indian Province of the Holy Cross Sisters had 79 sisters, of whom 57 were Europeans and 22 Indians. In 1958, the Holy Cross Sisters were permitted to start a training school for auxiliary nursing midwives.[182]The first nursing school in Malabar was opened at Kozhikode in 1958.[183]

It is also notable that women belonging to the Anglo-Indian community who maintained a western style of life form a significant part of the nursing field.[184]Historical records show the presence of 886 female nurses and 64 male nurses in the State Kerala during the year 1959. On 21st July 1960, there were a total of 67 government hospitals and 190 dispensaries in the State of Kerala, for which the number of nurses was reported to be 1077. New nursing schools attached to hospitals were started during this period. In 1960, a Diploma Course in Nursing was started and recognized by the University of Kerala.[185]It is shown that the year 1961 witnessed a total number of 933 nurses, and it went

[180]*Id.* (20 Apr.1955).
[181] NAIR, *supra* note, at 41.
[182] *Id.*
[183]*Id.* at 42. (In 1958, the Holy Cross Sisters was given permission to start a training school for auxiliary nursing midwives. 75 listed mission schools were also founded in South India).
[184] *Id.* at 65.
[185] NAIR, *Supra* note 41.

up to 4,894. By 1983, B.Sc. Degree Course in Nursing has also started functioning in the College of Nursing, Trivandrum.[186]Thus, by the year 1960, nursing was witnessed as a job well suited for women.

As pointed by Sreelekha Nair :

"The expansion in nursing job opportunities led to a greater supply of young women of nursing. It was a guaranteed form of employment where they could invest even if the pay were low……Nursing had more to do with getting a job than a religious calling, although the association between religion and nursing is still very strong." [187]

By 1972, four years Basic B.Sc Degree Programme was started functioning in the College of Nursing, Trivandrum.[188]It is also noted in the historical accounts that 'Kerala is the first state in India to have supervisory public Health Nurses posted at the district level'.[189]By 1977, due to increasing demand, more nursing schools (fee-paying courses) were started, nine government and 17 private nursing schools, producing about 450 nurses a year.[190]It is also shown that in the year 1978, most of the women from the

[186] HEALEY *Supra* note 38. (He mentioned the presence of Rockefeller assistance to the School of nursing in Trivandrum. In 1952, Rockefeller assigned Lillian Johnson to assist with upgrading the Trivandrum School of Nursing , which had until then been run by Swiss nuns who had taught only a basic nursing course. She set about improving basic conditions in the Trivandrum General Hospital. She focused very strongly on the need to address hospital administration. In 1976, Lucy Peters, the Kerala nurse became the principal of the School of nursing at the end of Johnson's time).
[187]*Id.* at 44. (Customs of dowry and disproportionate inheritance of parent's property due to patrilineal practices, particularly among Syrian Christians, made it difficult for many to manage without women working to earn their dowry. This was true of Christian's among whom these traditions were very strong).
[188]BUREAU, *supra* note 158.
[189]*Id.* at 4 . (Public health interventions were made by the Rockefeller foundation . Its main focus was on research in tropical diseases and US trade interests).
[190] MADELEINE, *supra* note 434, at 46.

poorer families were attracted to nursing, and they took nurse training.[191] A high level of mobility is one of the distinctive features which attract Malayali nurses to the nursing profession.[192]The issue of the low social status of nursing is also high lightened by historians.

Madelaine Healey observes

> *"…the unusual mobility of Kerala nurses has contributed to the stereotype of the nurse-prostitute, with intense suspicion attached to women living independent lives away from home and family ……high mobility may have also contributed to the general disempowerment of nurses."*[193]

Thus, though migration and the popularity of Malayali nurses abroad have increased their ability to secure high wages, it still did nothing to enhance their status in Kerala.[194]Their position in India continues to be low, and they continue to be unrecognized and unprotected.

The Balaraman Committee (2012) and the Veerakumar Committee (2013) were constituted in Kerala to study nurses' conditions in the private sector.[195]Both the committees have made significant recommendations, including registration, terms and conditions of services, reservation rules, leave benefits, and other social security measures that nurses shall implement.

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[191] T.K OOMMEN , DOCTORS AND NURSES : A STUDY IN OCCUPATIONAL ROLE STRUCTURES 59 (Macmillan,1937).

[192] MADELEINE, *Supra* note 434, at 63 ,258 & 259. (Nurse migration to the Gulf was dominated by nurses from Kerala, who had a long-established tradition of high domestic mobility. Difficult conditions in their home state and more lucrative work elsewhere had motivated them to train and work in other Indian states since the 1930s).

[193]MADELEINE, *Supra* note 434, at 63 &65.

[194] *Id.* at 261.

[195]APPENDIX 1,RECOMMENDATIONS OF BALARAMAN COMMITTEE (2012) AND THE VEERAKUMAR COMMITTEE (2013).

4.8 Conclusion

Time and again, the historical accounts disclose the concerns and the need for recognition and protection that shall be stretched to nurses in India and Kerala. Even though there has been progression towards professionalism through education and training, their rights remain untouched and unnoticed by the State. The caste-based notions attached to the profession with moral suspicion of treatment as 'prostitutes' have worsened the situation. Though the various committees and commissions have made valuable recommendations, they lag behind its proper implementation. The ongoing concern of nurses as to the availability of Personal Protective Equipments for ensuring safety while caring for the Covid-19 victims itself spotlights one of the significant issues on their health and wellness. The call for reasonable remuneration with favorable conditions of work has always been projected by nurses every time. The concern of the judiciary is notable in this regard. Often, the Supreme Court of India has brought out the need for proper implementation of labour legislation by the States. The reluctant attitude of the State in implementing committee reports is also reflected. Time has arrived to protect the rights of nurses to ensure quality health care.

CHAPTER V

RIGHTS OF NURSES: HUMAN RIGHTS AND CONSTITUTIONAL PERSPECTIVES

"Nursing has its own identity as a health profession. Hence the recognition needs to be given to the role and contribution of nursing personnel to health care services in the hospital and the community." [1]

Introduction

Nurses have been fighting for their rights since the initial days of the advancement of their profession. Human rights violations relating to their professions such as low salary, lack of professional status, insecurity of job, lack of promotional avenues, sexual harassment or violence at the workplace, lack of safety against occupational hazards, and long hours of work has been reported by the media's and research studies. Non-payment of minimum wages is one of the major concerns raised by nurses. The lack of recognition and protection as a 'health care professional' is another unidentified right to which nurses are entitled. The chapter examines the rights of nurses within the framework of human rights and constitutional perspectives. The Hohfeld theory of the right-duty relationship is used to identify the rights of nurses in their professional capacity. Moreover, an attempt is made to understand the key areas wherein nurses face challenges in recognition their rights.

[1] TRAINED NURSES ASSOCIATION OF INDIA, INDIAN NURSING YEAR BOOK 1 (Trained Nurses Association of India, 1990-1992).

5.1 Rights of Nurses: Jurisprudential Analysis

Nursing is attached to the term ‘care’’. The duty to take care of the patient is the utmost responsibility of a nurse. When we analyze the relationship created by a nurse, we can see various dimensions such as nurse with the patient, nurse with the physician, and nurse with the hospital authority. Among all this, the relationship with the patient is of vital importance. It is the relationship that is purely based on trust.

In nurse-patient relations, the relationship intends to achieve specific goals such as the pre-diagnostic phase, diagnostic phase, or post-diagnostic phase. It will end upon termination of the relationship by the patient or the nurse. In law, this kind of relationship is considered to have characteristically unequal power. That means the patient's interest is supreme. Here, the bargaining power of the nurse is less. A nurse is expected to recommend the healthcare patterns according to the needs of patients or else according to the physician’s instructions based on his medical records. This creates unwelcomed barriers in executing care independently upon the nurse, for example, the requirement of consent. Apart from conferring power or rights or privileges upon nurses, the fiduciary relationship creates a position of vulnerability in nurses.

In another sense, here, the nurse carries the burden of duty and liability of care. They are quite devoid of any power or privileges like in ancient times. When we see at the history of nursing, they were not given any option to choose the standard or pattern of care they can offer to the patients. Their care

carried the weight of the instructions given by physicians. Their nature of duty in healthcare may be as an independent contractor, an employee, an agent of the doctor, or the immediate healthcare establishment. But whether they have been given equal rights as an independent contractor, agent, or employee is an exciting question to ponder.

Rights are the interests of man protected by the state. In a legal sense, it can be defined as an advantage or benefit conferred upon a person by the rule of law.[2]Whether inherent, vested or granted, it necessarily forms a pre-requisite condition for developing one's personality. Thus, right is an interest recognized and protected by the rule of law, a claim the violation of which would be a legal wrong done to him whose interest it is and respect for which is a legal duty.[3]By enjoying rights, a person impliedly imposes obligations on others, an obligation to respect it by doing an act or to forbear from doing it.

Apart from a nurse-patient relationship, the nursing care inclines to several other jural relations. As said earlier, the nature of care in nurses can take different forms, such as an independent contractor, an employee, or an agent of the doctor or the immediate healthcare establishment. The legal relationship between the nurse and other parties works so that power is created in him. A right accrues to him, a duty is owed to him, a privilege is available to him, and he incurs liability.[4]

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[2] *Id.*
[3] Hart, *Definition and Theory in Jurisprudence*, 70 L.Q.R.37 (1954).
[4] Lorice Ede, *Legal Relations in Nursing*, 22 OCC. HEALTH NURS.12, 1969, (9 Jan.2020), https://journals.sagepub.com/doi/pdf/10.1177/216507996901701201.

It may be interesting to apply Hohfeld's jural relationship theory to ascertain the gravity and nature of the legal relationship between nurses and other parties on the other side.[5] In 1913, the American jurist Hohfeld modified the right concept and worked out a table of jural relations. He used the principle of jural correlatives to explain the idea of right. He used eight terms such as "right-duty, privilege-no right, power-liability, and immunity-disability" to explain legal relations; combined with their correlatives, they form the fundamental legal relations.[6] He uses right to mean privilege, power, and immunity.[7] When we apply the relationship to nurses, the other parties here include the patient, employer, and physician with whom the nurse works.

5.1.1 Patient-Nurse Relationship

In Professor Hohfeld's conceptual analysis, every right presupposes a corresponding duty upon another person. It is a "legal claim (right) of one person that another person acts or omits to act in a certain way."[8]Similarly, whenever there is a duty there must be a correlative right and vice versa. Here, one with a duty is commanded by society to act or to forbear for the benefit of the other.[9] This theory, when applied to nurse-patient relations, the right of the patient to the service of nurses imposes a duty on the nurses to perform it. Thus, the right of the patient invokes a duty on the nurses. Similarly, nurses

[5] Hohfeld, Some *Fundamental Legal Conceptions as Applied in Legal Reasoning*, 23 YALE L.J. 16 (1913).
[6] Alan D. Cullison A Review of Hohfeld's Legal Concepts", 16 CLEV.-MARSHALL L. REV. 559,564 (1967) .
[7]DIAS, RWB, 25 JURISPRUDENCE (Butterworths 1985).(Rights are of four kinds such as privileges, powers and immunities with their correlatives as duties, no-rights, liabilities and disabilities).
[8] HOHFELD, *supra* note 5.
[9] EDE, *supra* note 4.

have a corresponding right to get paid for the services rendered to the patient, and the patient should pay the sum which is agreed-upon for the performance of the duty.

The Hohfeld-analysis of correlatives such as privileges-no right, power-liability, and immunity –disability can be applied here to understand how it functions for the relationship between the nurse and patient. Concerning power-liability, one with power can create a new relationship with another by its exercise without further actions by the other party. Here, the nurse exercises a privilege in offering care for a patient, thereby giving a patient legal power to create a new relationship if he accepts the offer. The acceptance of the offer is the existence of a legal power as it makes a new relation of duty on the part of the nurse.[10] It is to be noted that according to Hohfeld's analysis, the exercise of legal power by one creates or imposes liability on the other. [11]Likewise, a patient who accepts care from a nurse must disclose every medical history or information to the nurse. The nurse who offers to care for a patient is liable to take reasonable care of the patient.

The concept of Privileges in Hohfeld's analysis rests on the notion that "one with a privilege is free to conduct himself as he pleases towards another within the bounds of a certain matter."[12] Generally, the nurse and the patient have the privilege to offer and reject the nurse-patient relationship. Here, both of them have no right to demand an entrance into a legal relationship.

[10] *Id.*
[11]*Id.*

[12] Ede, *supra* note 4.

5.1.2 Nurse-Doctor Relationship

A nurse plays an essential role in executing the instructions of the physicians. A nurse acts as an agent of the physician, where she executes all the instructions given by the physician.[13] In cases of performing those medical functions assigned to her by the doctor, both the physician and nurse are liable for the acts delegated to her (physician for his delegation and nurse for her performance).[14]Usually, a nurse is obliged to perform the physicians' instructions, and if any injury happens to the patient, the physician is liable based on the vicarious liability principle. So again, a kind of fiduciary relationship can be seen between the nurse and the physician, the physician as the master and the nurse as the physician's agent of carrying out the physician's orders.

5.1.3 Nurse- Hospital Relationship

As said in the above two relations, similar nature of right-duty exists between the nurse and employer of the hospital. As an employee, nurses are entitled to rights such as the right to a safe working atmosphere, right to express their opinions, right to take part in discussions at the workplace, right to wages, right to leisure and rest, right to freedom against exploitation, right to protection against occupational hazardous and so on. Here, the employers (hospital management) are obliged to protect the rights of nurses.

[13] *Id.*
[14] *Id.*

In essence, the result of the nurse's interaction with the patient, doctor, and employer is not solely contractual. The role, purpose, and responsibilities of nurses carry legal consequences in her duty-oriented workspace. As we see power, privileges, and rights of nurses are devoid of bargaining. They necessarily have to adjust to the scope and expectations of the other parties to maintain their characteristic role as a nurse. The power to choose is worthy for every relationship, especially in the healthcare sector. The nurse as an agent or an employee has no option to choose, the standard and nature of the care they have to deliver to meets the healthcare needs of the patients. So the central issue is the need for more powers to nurses to carry out their functions effectively and as per the knowledge, training, skill, and judgment.

It is better to know about the concept of power and privileges of nurses before we examine their rights. In an ordinary sense, power means having control, influence, or domination over something or someone.[15] It can also be defined as the capability to get things done, activate resources, and get and use whatever a person needs for the goals they are endeavoring to meet.[16]As per this, the power of nurses includes their capacity to influence the patients, physicians, and other healthcare providers. It consists of the ability to influence others through the possession of knowledge or skill that is useful to others.[17]

[15] Milisa Manojlovich, *Power and Empowerment in Nursing: Looking Backward to Inform the Future,* RESEARCH GATE (2 June 2021),https://www.researchgate.net/ publication/ 6475658_Power_and_empowerment_in_nursing_Looking_backward_to_inform_the_future.

[16]*Id.*
[17]*Id.*

Healing and transformative powers of nurses are included within this.[18] Whenever a nurse uses her competency, knowledge, or skill, it can have used power. Power can be regarded as a means to achieve autonomy, a feature which every profession has to control the practice of their discipline.[19]

Three types of power are needed for nurses: control over the content of practice, control over the context of practice, and control over competence.[20] The first refers to the autonomy of the nurses. It means the freedom to act on what one knows.[21] The freedom to act according to one own knowledge and judgment comes under it. Bedside nursing is a good example, where the staff nurse knows the best need of the patient.

Along with power, nurses need control over the context of practice which means an empowering work environment.[22] It demands the inclusion of staff nurses in the hospital's decision-making process and physicians and other health care professionals.[23] A collaborative approach between nurses and other healthcare professionals is advocated in this approach. It is held that this will increase more patient outcomes. The last one is the competence of nurses, which can be gained through education and expertise.[24] Only a professionally educated and expert nurse can bring more patient outcomes, hence enjoying

[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*(The multiple entry levels into nursing practice, as well as the low educational level of nurses (relative to other health care professionals) may contribute to nurses' powerlessness. The statement, "Being less well-educated than other groups within the hospital puts nursing at a serious disadvantage in organizational politics").

more power. Thus, the nurse's power lies in each nurse's knowledge and expertise, contributing to patient care and society.

Privileges in nursing can be defined as the scope of clinical procedures and activities that practitioners within a specialty are authorized to perform at a healthcare organization based on their education, training, experience, and competence.[25] It includes the process of granting permission to provide a specific scope of patient care services based on the credentials and performance of the healthcare professional.[26] Thus educational qualifications and experience are the major factors that grant special privileges to nurses. Through privileging, nurses are given consent to use their unique knowledge and expertise for quality patient care. These privileges are open to review, and they must be practices as per the organizational policies. Nurses' clinical privileges include permission to provide medical and other patient care services in the granting institution, within defined limits, based on the individual's education, professional license, experience, competence, ability, and judgment.[27] Proper evaluation of the qualifications and expertise of the nurses is essential before granting privileges. Thus, both power and privileges are necessary to fully utilize the nursing profession's knowledge, skill, and expertise.

[25] AMERICAN ASSOCIATION OF NURSE ANESTHETISTS (25 Sept. 2020), https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/professional-practice-manual/clinical-privileges-and-other-responsibilities-of-crnas.pdf?sfvrsn=82011b35_2.

[26] *Id.*

[27] HEALTH MIL (23 Oct.2020),https://health.mil/Reference-Center/Glossary-Terms/2013/10/29/Clinical-Privileges.

5.2 Rights of Nurses: Human Rights Perspective

Human rights include minimal rights that every individual must have against the State or other public authority by being a member of the human family. The beginning of human rights can be traced back to Magna Carta (1215); the Bill of Rights in 1689; the Virginia Bill of Rights in 1776; the American Declaration of Independence in 1776; American Bill of Rights in 1789 and the French Declaration of Rights of Man in 1789. After Second World War, human rights gained momentum in the Universal Declaration of Human Civil Rights, 1947.

Later, the International Covenant on Civil and Political Rights, 1966, and the International Covenant on Economic, Social and Cultural Rights, 1966, were enacted to ensure all civil and political rights and economic, social, and cultural rights. Rights such as the right to life and liberty,[28] right to work,[29] right to rest and leisure,[30] right to remuneration,[31] right to health,[32] right to

[28] UNIVERSAL DECLARATION OF HUMAN RIGHTS, 1948. (Art.3 reads as "Everyone has the right to life, liberty and security of persons". *See also* THE COVENANT OF CIVIL AND POLITICAL RIGHTS, 1966, Art.6.1 reads as "Everyone has the right to liberty and security of person. …… No one shall be deprived of his liberty ……").

[29]UNIVERSAL DECLARATION OF HUMAN RIGHTS, 1948. (Art.23(1) reads as "Everyone has the right to work, to free choice of employment"; *See also* THE INTERNATIONAL CONVENTIONS ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, 1966,Art. 6 reads as "The States Parties to the present Covenant recognize the right to work…….").

[30]UNIVERSAL DECLARATION OF HUMAN RIGHTS, 1948. (Arti.6 reads as "Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay").

[31]UNIVERSAL DECLARATION OF HUMAN RIGHTS, 1948. (Art. 23 (3) reads as "Everyone who works has the right to just and favourable remuneration……";*See also* INTERNATIONAL CONVENTIONS ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, 1966, Art. 7 reads as " The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work ….. Remuneration …….").

freedom of peaceful assembly and association,[33] right to freedom of opinion and expression,[34] right to freedom against exploitation,[35] right to social security, are some of them. All these rights are vital for nurses to perform the obligations attached to their profession effectively.

5.2.1 The Geneva Convention

The rights of nurses as part of a medical team can be traced back to the "Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 12 August 1949,"[36] Affording protection to all the members of the armed forces is the primary aim of the convention. The Convention has special provisions for protecting nurses who are nursing the wounded or sick in the war field.[37]

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[32]UNIVERSAL DECLARATION OF HUMAN RIGHTS, 1948.(Art. 25 (1) reads as "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family……").

[33] UNIVERSAL DECLARATION OF HUMAN RIGHTS, 1948.(Art. 20 reads as "everyone has the right to freedom of peaceful assembly and association"; Art. 23(4) reads as "Everyone has the right to form and to join trade unions ……. *See also* INTERNATIONAL CONVENTIONS ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, 1966, Art. 8 reads as "The States Parties …… undertake to ensure the right of everyone to form trade unions and join the trade union ……").

[34] UNIVERSAL DECLARATION OF HUMAN RIGHTS, 1948.(Art.19 reads as "Everyone has the right to freedom of opinion and expression……").

[35] UNIVERSAL DECLARATION OF HUMAN RIGHTS, 1948. (Art.4 reads as "No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms". *See also* COVENANT ON CIVIL AND POLITICAL RIGHTS, 1966, Art.8.1 reads as "No one shall be held in slavery; slavery and the slave-trade in all their forms shall be prohibited").

[36] INTERNATIONAL COMMITTEE OF THE RED CROSS (ICRC), GENEVA CONVENTION FOR THE AMELIORATION OF THE CONDITION OF THE WOUNDED AND SICK IN ARMED FORCES IN THE FIELD), 1949 (19 Aug.2020), https://www.refworld.org/docid/3ae6b3694.html.

[37] *Id.* THE GENEVA CONVENTIONS OF 12 AUGUST 1949. (Art. 18 read as "No one may ever be molested or convicted for having nursed the wounded or sick". Art. 25 reads as "……. nurses …….in treatment of the wounded and sick shall likewise be respected and protected if they are carrying out these duties ……..").

5.2.2 The Nursing Personnel Convention

The International Labor Organization adopted the Nursing Personnel Convention, 1977 (No.149) on 21st June 1977.[38] It provides general standards concerning the employment and conditions of work of nursing personnel. The Convention defines "Nursing Personnel" as "all categories of persons providing nursing care and nursing services". [39] The convention calls out all the member states to protect nurses' rights, such as education, working conditions, remuneration, participation in the planning of nursing services, and negotiation with the employers.[40]Other rights of nurses such as the right to work, compensation for overtime work, inconvenient hours and shift work, weekly rest; paid annual holidays, educational leave; maternity leave, sick leave, social security, and occupational health and safety are mentioned in the convention.[41]

5.2.3 ICN Position Statements

Another important document in which the rights of nurses find mentioned in the Position Statements released by the International Council of Nurses.[42] On the rights of nurses, it is observed that:-

> *"Nurses have the right to practice in accordance with the nursing legislation of the country in which they work…….right to practice in a positive practice environment that provides personal safety, freedom*

[38]INTERNATIONAL LABOUR ORGANIZATION C149 - NURSING PERSONNEL CONVENTION, 1977(No. 149) (28 June 2020), http://www.ilo.org/dyn/normlex/ en/f?p= NORMLEXPUB: 12100:0::NO:12100:P12100_ILO_CODE:C149.
[39] *Id.* C149 –art.1.
[40] *Id.* C149 –art.2 & art.5.
[41] *Id.* C149 –art.6,7 &8.
[42] NURSES AND HUMAN RIGHTS, INTERNATIONAL COUNCIL OF NURSES (15 Sept. 2020). https://www.icn.ch/sites/default/files/inline-files/E10_Nurses_Human_Rights%281%29.pdf .

from abuse and violence, threats or intimidation and in which there is no fear of reprisal." [43]

The aspects of Socio-Economic Welfare of Nurses are found mentioned in the Position Statement as inclusive of rights such as the right to decent working conditions;[44] right to sufficient nurse staffing;[45] right to the safe and healthy work environment;[46]right against workplace violence;[47] right to migrate to other countries for professional advancements;[48] rights to freedom from discrimination including the right to accurate information as to the working environment;[49] right to equal pay for equal work;[50] right to access to grievance procedures;[51]and the right to join professionals associations.[52]

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[43] *Id.*

[44] *Id*. (It mentions about the right of nurses to have decent working conditions such as equitable remuneration, safe working environment, right to organize , to bargain collectively and to take industrial action).

[45] *Id*. (It mentions about the need for safe nurse staffing so as to protect the right of nurses to maintain quality and safe patient care).

[46]*Id.* ("….Occupational health and hazards …… impair the health and wellbeing of workers… psychological distress and job dissatisfaction often leading to increased turnover which further aggravates the nursing shortage and exacerbates nursing workforce issues.……'').

[47]*Id.* (It includes right to freedom from actual and attempted incidents of physical and verbal violence).

[48]*Id.* (It talk about nurse's right to migration (so as to enhance their professional development, fulfill their personal career goals and maximize their skills and qualifications) and freedom from recruitment abuses by recruitment agencies").

[49]*Id.* (Nurses have the right to expect fair and equal treatment on employment related issues, such as working conditions, promotion, and access to career development opportunities and continuing education. Nurses and employers must be protected from false information, the withholding of relevant information, misleading claims and exploitation).

[50]*Id.* (There should be no discrimination between occupations/professions with the same level of responsibility, educational qualification, work experience, skill requirement, and hardship (e.g. pay, grading).

[51]*Id.* (When nurses' or employers' contracted or acquired rights or benefits are threatened or violated, appropriate processes must be in place to hear grievances in a timely manner and at reasonable cost).

5.2.4 Nurse's Bill of Rights

The right recognized by the Board of directors of the American Nurses Association, titled the 'Nurses Bill of Rights, 2001' is another important document.[53] Rights such as the right to practice in a manner that fulfills their obligations to society; right to practice as per professional standard; right to practice following the Code of Ethics for Nurses; right to freely and openly advocate for themselves and their patients; right to fair compensation for their work, consistent with their knowledge, experience, and professional responsibilities; right to work in a safe environment and right to negotiate the conditions of their employment, either as individuals or collectively, are mentioned in it.

A similar set of rights are published by the Nursing Council of South Africa.[54] Rights such as the right to practice, right to a safe working environment, right to negotiate with employers, right to participation in policy matters and the treatment of patients, right to advocate patients, right to refuse tasks that are outside the scope of nursing practice, right to know the diagnostic test results of the patient and finally the right to handle emergencies have been listed out under the title headed as 'Nurses rights.' [55]

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[52] *Id.* (Nurses have the right to affiliate to and be represented by a professional association and/or union in order to safeguard their rights as health professionals and workers).
[53] AMERICAN NURSES ASSOCIATION , BILL OF RIGHTS (12 Sept. 2020), https://www.nursingworld.org/practice-policy/work-environment/health-safety/bill-of-rights-faqs/.
[54] SOUTH AFRICAN NURSING COUNCIL NURSES RIGHTS (2 Aug. 2020), https://www.sanc.co.za/policyrights.htm.
[55] *Id.*

5.3 Rights of Nurses in Indian Constitutional Framework

The first and the foremost right which every nurse must enjoy is the right to practice their profession. The constitution guarantees the right to practice any profession or occupation to every citizen.[56] It can be considered as one of the predominant rights of the nurse. All the other rights emanate from it. It means that the right to practice itself includes the right to be in an environment that allows the fullest realization of the objectives attached to their occupation. It includes rights such as the right to have a pleasant environment that ensures a dignified life; right to freedom from exploitation and other harassments; right to participate in decision making affecting nurses; right to protection against occupational hazardous; right to fair remuneration, and other social security measures such as maternity leave, leave with wages, and so on. Only if the right to practice their profession is protected can nurses effectively discharge their obligations.

The Supreme Court of India has pointed out nursing as an occupation in *Private Nursing Schools and Colleges Management v. The Indian Nursing Council.* [57] It is observed that:

> *"...consistent with their fundamental right under Article 19(1) (g) of the Constitution of India, to practice their occupation throughout the territory of India, legislation in the form of the Nursing Council Act of 1947 has not restricted nor does it purport to restrict their practice of*

[56] INDIA CONSTI. art.19 (1) (g).
[57] Civil Appeal No. 958 of 2019 (Arising out of SLP (C) No. 32603 of 2017),Decided On: 22.01.2019; MANU/SC/0402/2019.

nursing once a Degree or Diploma is granted by the State Authority to that State only." [58]

However, this right is not absolute. The State can impose reasonable restrictions in this right for the "interest of the general public and can determine the technical qualifications required for practicing it."[59]

Another fundamental right of nurses which is guaranteed by the constitution is the freedom to form associations and trade unions for the protection of their interests.[60]This right is of utmost importance as it helps nurses to negotiate their conditions of employment, either individually or as collectively, with their employer. The Trained Nurses Association of India, the Indian Nurses Association, and the United Nurses Association are examples of the Professional associations of registered nurses. They work for the general welfare of nurses and promote professional upliftment. These Associations have often approached the Supreme Court of India for redressing the grievances of nurses.[61] Like all other freedoms, the right to form associations and unions are also subject to reasonable restrictions imposed by the State in the "interests of the sovereignty and integrity of India or public order or morality."[62]

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[58] *Id.*
[59] INDIA CONST. art.19(6).
[60]INDIA CONST. art.19(1)(c).
[61] Trained Nurses Association of India v. Union of India 2016 SCC online SC 95;demanding payment of wages to nurses working at private hospitals; United Nurses Association of India v. Union of India,(15 Apr. 2020), https://indiankanoon.org/doc/56700454/) for protection of health workers who are on duty of Covid-19 patients and the availability of PPE Kits.
[62] INDIA CONST. Art.19(4).

The right of nurses to live with human dignity can be included within the scope of the right to life guaranteed by the Constitution.[63] This right can be the most fundamental and valuable one of all human rights. The judiciary gives the expression 'life' an expansive interpretation. In *Munn* v. *Illinois,*[64] it is held that the term 'life' means more than mere animal existence. The inhibition against its deprivation extends to all those limbs and faculties by which life is enjoyed. *Maneka Gandhi* v. Union of India,[65] is another crucial case wherein the court discussed the concept of the right to live in a detailed way and included the freedom of movement within its purview. The observation made by Justice V.R Krishna Iyer is notable in this regard. He observes that:

> *"….To sum up, personal liberty makes for the worth of the human person. Travel makes liberty worthwhile. Life is a terrestrial opportunity for unfolding personality, rising to higher states, moving to fresh woods, and reaching out to reality which makes our earthly journey a true fulfillment- not a tale told by an idiot full of 'sound and fury signifying nothing, but a fine frenzy rolling between heaven and earth. The spirit of Man is at the root of Art. 21. Absent liberty, other freedoms are frozen".* [66]

Francis Corlie v. *Administrator, Union Territory of Delhi*[67] is another case where the Supreme Court has expanded the scope of the right to life and included living with 'human dignity in it.[68] It is held that

[63]INDIA CONST. Art.21reads as "No person shall be deprived of his life or personal liberty except according to procedure established by law".
[64] 94 US 113.
[65] AIR 1978 SC 597.
[66] *Id.*
[67] AIR 981 SC 746.
[68] AIR 1981 SC 746 at 753.

> *"right to life includes right to live with human dignity and all those go along with it, via, the bare necessities of life such as adequate nutrition, clothing, and shelter over the head and facilities for reading, writing and expressing oneself in diverse forms, freely moving about and mixing and mingling with fellow human beings…."*[69]

In *Olga Tellis* v. *Bombay Municipal Corporation,*[70] it is held that the word 'life' in Article 21 includes the 'right to livelihood". In *D.K.Yadav* v. *J.M.A Industries,*[71] the court again retreated that the right to life consists of the right to livelihood. Therefore, termination of a worker's service without giving him a reasonable opportunity of hearing is unjust, arbitrary, and illegal.

The right of nurses to minimum wages is another facet of the right to life. In *Peoples Union for Democratic Rights* v. *Union of India,*[72] it is held that non-payment of minimum wages to workers is a denial of the right to live with human dignity. It is essential to note the notification issued by the Kerala Government to revise the minimum rates of wages of nurses employed in a private hospital.[73] The notification entitles every registered staff nurse working in private hospitals to a minimum salary of twenty thousand rupees. Supreme Court of India has highlighted the issue in *Trained Nurses Association of India* v. *Union of India,* [74] and a committee was appointed to study the matter. The committee headed by Prof. Jagdish Prasad submitted the report and made recommendations on the payment of minimum wages to nurses and the

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[69] *Id.*
[70] AIR 1986 SC 180.
[71] (1993)3 SCC 258.
[72] AIR 1982 SC 1473.
[73] APPENDIX II , GOVERNMENT OF KERALA NOTIFICATION, G.O. (P)NO.33/1018/LBR. (23 Apr. 2018.
[74]2016 SCC Online SC 95.

application of uniform working conditions to nurses working in the government and private sector.[75]

The right to health is a manifestation of the right to life.[76] The Constitution mandates the State to protect the health of workers, including men and women.[77] The right of the nurses to 'occupational health',[78] can be included within it. As nurses are easily prone to various diseases and injuries as part of their profession, ensuring their workplace safety is crucial.

The International Council of Nurses discussed the consequences of occupational health and safety to nurses as

> *"……nurses are often exposed to health hazards. Occupational injuries and illnesses increase psychological distress and job dissatisfaction often leading to increased turnover which further aggravates the*

[75] APPENDIX III, PROF.JAGDISH PRASAD COMMITTEE REPORT, (29 Jan. 2016).

[76] Consumer Education and Research Centre v. Union of India (1995) 3 SCC 42; In State of Punjab and Ors. v. Mohinder Singh Chawla (AIR 1997 SC 1225); In Hinch Lal Tiwari v. Kamala Devi and Ors. (20001) 6 SCC 496); State of H.P. v. Umed Ram (AIR 1986 SC 847); Kirloskar Brothers Ltd. v. Employees' State Insurance Corp (1996)2 SCC 682; Bandhua Mukti Morcha v. Union of India AIR 1984 SC 802, Para 10; Occupational Health and Safety Association v. Union of India AIR 2014 SC 1469; L/C of India v. Consumer Education & Research Centre and Ors.(1995) 5 SCC 482).

[77] INDIA CONST.art.39(e).

[78] JOGINRA VATI, PRINCIPLES & PRACTICE OF NURSING MANAGEMENT & ADMINISTRATION FOR BSC & MSC NURSING 422 (Jaypee Brothers Medical Publishers (P) Ltd 2013).(An Occupational injury can be defined as 'any injury, impairment or disease affecting a worker or employee during their course of employment. Occupational hazards which are familiar to nurses working in hospitals include Biological risks which arise due to infectious agents such as bloodborne pathogens, bacteria, viruses, fungi, infectious waste, and infestations that cause acute and chronic infections to healthcare workers, which can be transmitted from patient to staff through airborne, skin contact exposure and exposure to infectious fluids; Physical hazards such as burns, injuries arising from ionizing radiation and extreme temperatures; Psychological Hazards due to shifting work, call duty, high workload; verbal abuse from intoxicated patients and hospital management; and Chemical hazards such as asbestos, formaldehyde, lead, methylene chloride and glutaraldehyde. It is reported that the use of cytotoxic/chemical drugs is also likely to irritate skin, eyes, and mucus membrane. Biological hazards exist throughout all healthcare settings and include airborne and blood-borne pathogens such as the agents that cause tuberculosis, severe acute respiratory syndrome (SARS), hepatitis, and HIV infection/AIDS). *See* also Rennie Joshva,Suja Karkade, *A Review on Occupational Health Hazards and its consequences among nurses*, 4 IJNRP 30(2017).

nursing shortage and exacerbates nursing workforce issues. Protecting the health and wellbeing of nurses has extensive positive outcomes for the individual nurse, patients, families, and communities, as well as healthcare organizations and systems……"[79]

The availability of Personal Protective Equipments to safeguard against hazardous substances and exposures is highlighted by the Council.[80] The increasing demand for Personal Protective Equipments by the health care providers, especially nurses who directly deal with patients affected by Covid19, is one of the best example. Medical masks, gowns, gloves, and eye protection (goggles or face shields) are included within it.[81]

Based on the petition filed by the United Nurses Association,[82] requesting immediate directions to formulate a comprehensive policy for the welfare and safety of the healthcare workers who are serving COVID-19 patients, the Supreme Court in *Jerryl Banait* v. *Union of India*,[83] the court once again reminded 'the State and the Police Administration to provide necessary security to Doctors and medical staff when they visit places where patients who have been diagnosed corona virus-positive or who have been quarantined are housed.'[84] It also directed the State take necessary actions against those persons

[79]INTERNATIONAL COUNCIL OF NURSES, OCCUPATIONAL HEALTH AND SAFETY FOR NURSES (15 Oct. 2020), https://www.icn.ch/sites/default/files/inline-files/PS_C_Occupational_ health_safety_ 0.pdf.
[80] *Id.*
[81] RATIONAL USE OF PERSONAL PROTECTIVE EQUIPMENT FOR CORONOVIRUS DISEASE 2019, WORLD HEALTH ORGANIZATION (17 Oct. 2020),https://apps.who.int/iris/bitstream/ handle/10665/331215/WHO-2019-nCov-IPCPPE_use-2020.1-eng.pdf.
[82] United Nurses Association of India v. Union of India, (15 Apr. 2020), https://indiankanoon.org/doc/56700454/.
[83] Jerryl Banait vs. Union of India (08.04.2020 - SC Order): MANU/SCOR/24152/2020.
[84] *Id.*

who obstruct and commit any offense in respect to the performance of duties by Doctors, medical staff and other Government Officials deputed to contain COVID-19".[85]

The right to Just and human conditions of work is yet another fundamental right of nurses.[86] The constitution of India obliges the State to ensure the welfare of workers by framing relevant legislation in this regard.[87] Labour legislation in India is the best example. Various enactments under the labour laws apply to nurses (especially working in the private sector) due to the decision of the Supreme C*ourt in Bangalore Water Supply & Sewerage Board, etc. v. R.Rajappa,*[88] which includes hospitals within the definition of 'Industry.' Here, nurses are regarded as Workman.[89]They enjoy rights such as the right to the 'amicable settlement of Industrial disputes',[90]through 'Grievance Settlement Authorities'[91]or 'Grievance Redressal Committee';[92]right to 'Wages'[93]including 'minimum wages';[94]and 'wages for overtime work';[95]right

[85] *Id.*
[86] INDIA CONST. art.42.
[87] INDIA CONST. art.43.
[88] Banglore Water Supply v. A. Rajappa(AIR 1978 SC 548) (A seven Judges' Bench of the Supreme Court considered the scope of industry and reiterated the test laid down in State of Bombay v. Hospital Mazdoor Sabha (AIR 1960 SC 610).
[89]Industrial Disputes Act, 1947, §2 (s), No.14,Acts of Parliament,1947, (India).(It reads "workman" as any person (including an apprentice) employed in any industry to do any manual, unskilled, skilled, technical, operational, clerical or supervisory work for hire or reward, whether the terms of employment be express or implied, and for the purposes of any proceeding under this Act …….").
[90]Industrial Disputes Act, 1947, No.14, Acts of Parliament,1947 (India).(It deals with Authorities under the Act such as the Works Committee, Conciliation Officers, Board of Conciliation, Courts of Enquiry, Labour Courts, Tribunals and National Tribunals).
[91] Industrial Disputes Act, 1947, §9 C, No.14, Acts of Parliament, 1947 (India). (It deals with Setting up of Grievance Settlement Authorities).
[92] The Industrial Relations Code, 2020,§4, No.35, Code of Parliament, 2020 (India).
[93] The Payment of Wages Act, 1936,§3 (1),No.4, Acts of Parliament, 1937 (India).
[94]The Minimum Wages Act,1948, §12, No.11,Act of Parliament, 1948 (India). *See also* The Code on Wages, 2019, §5.No.29, Acts of Parliament, 2019 (India).

to 'eight hours of work in a day and 48 hours of work a week';[96] right to 'weekly holidays';[97] right to 'annual leave with wages';[98] right to 'equal remunerations';[99] right to payments such as 'provident fund';[100] 'gratuity';[101] 'bonus';[102]and 'subsistence allowance';[103] right to 'insurance provisions';[104]

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[95]The Minimum Wages Act, 1948,§ 14 (1), No.11,Act of Parliament, 1948 (India) *See also* The Code of Wages, 2019,§ 14,No.29, Code of Parliament,1948(India); The Occupational Safety, Health and Working Conditions Code, 2020, § 27,No.122, Code of Parliament, 2020 (India).

[96] The Kerala Shops and Commercial Establishment Act, 1968, § 4, No.34, Act of Parliament, 1968 (India); *See also* The Occupational Safety, Health and Working Conditions Code, 2020; Chapter VII, § 25(1) No.122, Code of Parliament, 2020 (India).

[97] The Kerala Shops and Commercial Establishment Act, 1968, § 11(2), No.34, Act of Parliament, 1968 (India); *See also* The Occupational Safety, Health and Working Conditions Code, 2020; §.26(1) No.122, Code of Parliament, 2020 (India) .

[98] The Kerala Shops and Commercial Establishment Act, 1968, §13, No.34, Act of Parliament, 1968 (India). *See also* The Occupational Safety, Health and Working Conditions Code, 2020; § 32(1) No.122, Code of Parliament, 2020 (India).

[99]The Equal Remuneration Act, 1976, No.25, Act of Parliament,1976 (India). (This Act provides for the payment of equal remuneration to male and female workers and for the prevention of discrimination on the ground of sex against women in the matter of employment for matters connected therewith).

[100] The Employees' Provident Funds Scheme,1952,§1 [(1)] , No.19, Act of Parliament, 1952 (India).(The Central Government may, by notification in the Official Gazette, frame a scheme to be called the Employees' Provident Fund Scheme for the establishment of provident funds under this Act ……"). *See also* The Code of Social Security, 2020 – §15 & 16, No.36, 2020, Parliament of India, (2020).

[101] The Payment of Gratuity Act, 1972,§4,(1),No.39, Act of Parliament, 1972 (India). (Gratuity shall be payable to an employee on the termination of his employment after he has rendered continuous service for not less than five years,- (a) on his superannuation, or (b) on his retirement or resignation, (c) on his death or disablement due to accident or disease: Provided that the completion of continuous service of five years shall not be necessary where the termination of the employment of any employee is due to death or disablement: The Code of Social Security, 2020- § 53(1) Gratuity shall be payable to an employee on the termination of his employment
after he has rendered continuous service for not less than five years,—
(*a*) on his superannuation; or
(*b*) on his retirement or resignation; or
(*c*) on his death or disablement due to accident or disease; or
(*d*) on termination of his contract period under fixed term employment; or
(*e*) on happening of any such event as may be notified by the Central Government).

[102] Payment of Bonus Act, 1965,§8, No.21, Act of Parliament, 1965 (India). (This Act provides for the payment of bonus to employees on the basis of profits or on the basis of productivity and for matters connected therewith).

right to 'protection against occupational injury and accidents including occupational safety, health and working conditions';[105]right to 'welfare facilities';[106]including the right to a 'weekly holiday for night shifts';[107] right to the 'prohibition of overlapping shifts';[108] right to get 'notice periods of work';[109]and right to 'compensation for accident and occupational diseases'.[110]

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[103] The Kerala Payment of Subsistence Allowances Act, 1972, §3, No.27, Act of Parliament,1972(India).

[104] The Employees State Insurance Act, 1948, No.34, Act of Parliament, 1948 (India). (It provides for certain benefits to employees in cases of sickness, maternity and employment injury). *See also* The Code of Social Security, 2020,§28, No.36, 2020, Parliament of India, (2020).

[105] The Factories Act, 1948, No.63, Act of Parliament, 1948 (India).(It provides detailed provisions relating to the health, safety and welfare measures, namely cleanliness, level of ventilation, diversion of dust and fumes, provision of artificial humidification, sanitation, fencing of machinery, among others). *See also* Employees Compensation Act, 1923, Sec 3; The Occupational Safety, Health and Working Conditions Code, 2020,§ 23,No.37, Parliament of India, (2020).

[106] The Occupational Safety, Health and Working Conditions Code, 2020,§24(1) No.122, Code of Parliament, 2020 (India). (It provides welfare provisions such as separate bathing places; place of keeping clothing ; facilities of canteen ; medical examination of the employees……..; first-aid boxes……..; and (viii) any other welfare measures which the Central Government considers……for decent standard of life of the employees).

[107] The Occupational Safety, Health and Working Conditions Code, 2020,§28,No.37, Code of Parliament, 2020 (India). (It reads "Night Shifts as Where a worker in an establishment works on a shift which extends beyond midnight,— (a) for the purposes of §26, a weekly holiday for a whole day shall mean in his case a period of twenty-four consecutive hours beginning when his shift ends; (b) the following day for him shall be deemed to be the period of twenty-four hours beginning when such shift ends, and the hours he has worked after midnight shall be counted in the previous day").

[108]The Occupational Safety, Health and Working Conditions Code, 2020, §29(1) No.122, Code of Parliament, 2020 (India).(The work shall not be carried on in any establishment by means of a system of shifts so arranged that more than one relay of workers is engaged in work of the same kind at the same time).

[109] The Occupational Safety, Health and Working Conditions Code, 2020; §31(1) No.122, Code of Parliament, 2020 (India). (There shall be displayed and correctly maintained in every establishment a notice of periods of work, showing clearly for every day the periods during which workers may be required to work in accordance with the provisions of this Code).

[110] The Occupational Safety, Health and Working Conditions Code, 2020; §73(1) No.122, Code of Parliament, 2020 (India).

The recent legislation, titled the Epidemic Diseases (Amendment) Act, 2020, can also be regarded as a good step from the part of the State to afford protection to nurses against violence during the spread of the COVID-19 epidemic.[111]

Trained Nurses Association of India v. *Union of India,*[112] is an important case in which the Supreme Court has entertained as writ petition filed by the Trained Nurses Association of India on ventilating the grievances on the working conditions of nurses in private hospitals. The petition sought to issue guidelines for improving the working conditions of nurses in hospitals. As per the Judgement, Prof. Jagdish Prasad Committee was constituted in 2006, and it made recommendations as to the payment of minimum wages to nurses as per hospital-bed ratio and application of same working conditions to nurses working in government and private sector[113].

[111] The Epidemic Diseases (Amendment) Act, 2020, No.34, Act of Parliament, India (2020). (§3(b) defines "healthcare service personnel" as a person who while carrying out his duties in relation to epidemic related responsibilities, may come in direct contact with affected patients and thereby is at the risk of being impacted by such disease, and includes— (i) any public and clinical healthcare provider such as doctor, nurse, paramedical worker and community health worker……"§31A (a)defines "act of violence" includes any of the following acts committed by any person against a healthcare service personnel serving during an epidemic, which causes or may cause— (i) harassment impacting the living or working conditions of such healthcare service personnel and preventing him from discharging his duties; (ii) harm, injury, hurt, intimidation or danger to the life of such healthcare service personnel, either within the premises of a clinical establishment or otherwise; (iii) obstruction or hindrance to such healthcare service personnel in the discharge of his duties, either within the premises of a clinical establishment or otherwise; or (iv) loss or damage to any property or documents in the custody of, or in relation to, such healthcare service personnel").

[112] Trained Nurses Association of India v. Union of India,(29 Jan.2016), https://indiankanoon.org/doc/189389715/.

[113] JAGDISH PRASAD COMMITTEE RECOMMENDATIONS, GOVERNMENT OF INDIA (26 July 2018),https://www.tnaionline.org/cms/gall_content/2016/10/2016_10$file08_Oct_2016_094519157.pdf.

In *Association of Healthcare Providers (India)* v. *Government of NCT, Delhi*,[114]the Delhi High Court again reiterated the mandatory compliance with the recommendations of the committee by all private hospitals and nursing homes.

As the majority of nurses are females, they are entitled to 'special provisions relating to their employment',[115] such as the 'prohibition of employment in certain kinds of arduous work',[116] 'maternity leave',[117]and 'payment of maternity benefit',[118] 'maternity bonus',[119] 'nursing breaks',[120] 'crèche facility',[121] and 'other benefits' .[122]

[114] Association of Healthcare Providers (India) v. Government of NCT, Delhi (24 July 2019), https://indiankanoon.org/doc/152416598/.

[115] The Occupational Safety, Health and Working Conditions Code, 2020,§ 43 No.122, Code of Parliament, 2020 (India). (It reads Special Provisions Relating to Employment of Women as Women shall be entitled to be employed in all establishments for all types of work under this Code and they may also be employed, with their consent before 6 a.m. and beyond 7 p.m. subject to such conditions relating to safety, holidays and working hours or any other condition to be observed by the employer as may be prescribed by the appropriate Government).

[116] The Occupational Safety, Health and Working Conditions Code, 2020,§59(1) No.122, Code of Parliament, 2020 (India).

[117] INDIA CONST. art. 42 ; *See also* The Occupational Safety, Health and Working Conditions Code, 2020, §59, No.122, Code of Parliament, 2020 (India).

[118] The Maternity Benefit Act, 1961, §5(1), No.53, Parliament of India (1963). (Subject to the provisions of this Act, every woman shall be entitled to, and her employer shall be liable for, the payment of maternity benefit at the rate of the average daily wage for the period of her actual absence immediately preceding and including the day of her delivery and for the six weeks immediately following that day. *See also* The Occupational Safety, Health and Working Conditions Code, 2020,§60, No.122, Code of Parliament, 2020 (India).

[119] The Occupational Safety, Health and Working Conditions Code, 2020,§64, No.122, Code of Parliament, 2020 (India).

[120] The Occupational Safety, Health and Working Conditions Code, 2020, §66, No.122, Code of Parliament, 2020 (India).

[121] The Occupational Safety, Health and Working Conditions Code, 2020,§67, No.122, Code of Parliament, 2020 (India).

[122] The Occupational Safety, Health and Working Conditions Code, 2020, §4, No.122, Code of Parliament, 2020 (India).(It reads Special Provisions Relating to Employment of Women as Women shall be entitled to be employed in all establishments for all types of work under this Code and they may also be employed, with their consent before 6 a.m. and beyond 7 p.m. subject to such conditions relating to safety, holidays and working hours or any other

Right to Protection against Sexual harassments at Workplace can be regarded as another significant right that is applicable to nurses.[123]

Research studies also pointed out the chance of nurses being exposed to sexual harassment or violence easily[124]. As they are emotionally and physically close to patients, they face the highest rate of sexual harassment than any other professionals. Harassments may be from their colleagues, other staff, patients, patient relatives, and visitors. Sexual harassment may be physical, verbal, non-verbal, and psychological, with different forms in a sexual nature.[125] The shocking incident that happened to nurses named Aruna Ramchandra Shanbaug,[126] can be cited as the most horrifying incident which a nurse can ever undergo at the workplace. One of the central issues in India is that most of the sexual harassment cases against nurses are unreported due to the fear of ridicule or retribution.[127]

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condition to be observed by the employer as may be prescribed by the appropriate Government).

[123]The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013,§4, No.14,Act of Parliament, India, (2013).(It deals with the constitution of Internal Complaints Committee for redressal of complaints of sexual harassment at workplace).

[124]Kahsay,W.G & *"et al."Sexual harassment against female nurses: a systematic review* BMC NURS.19, 58 (2020); Meena Ganapathy, *Is Sexual Harassment of nurses an ice berg in India? Are our student nurses and nurses free from harassment?* 7 IJ NUR.SC.PR II (2021); Paramita Chaudhuri, *Experiences of Sexual Harassment of Women Health Workers in Four Hospitals in Kolkata, India* (2 June 2021),https://www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2807%2930319-4.

[125] *Id.*

[126] Aruna Ramchandra Shanbaug v. Union of India, (1994) 3 SCC 394. (Aruna Ramchandra Shanbaug was a nurse in the King Edwards Memorial Hospital in Mumbai. In November 1973, she was assaulted by ward boy, Sohanlal Bhartha Valmiki, of the same hospital. He strangulated Shanbaug with a dog chain around her neck. The attack cut off oxygen supply from her brain leaving her blind, deaf, paralyzed and in a vegetative state for the next 42 years. From the day of the assault till the day she died on 18 May 2015, Aruna could only survive on mashed food. She could not move her hands or legs could not talk or perform the basic functions of a human being).

[127] *Id.*

In *Vishaka* v. *State of Rajasthan,*[128] the Supreme Court held that sexual harassment of a woman at her workplace amount to violation of her rights of gender equality and right to life and liberty. Based on this decision, the Sexual Harassment of Women at Workplace (Prevention Prohibition and Redressal) Act, 2013, was passed. This Act protects against sexual harassment of women at the workplace and guarantees the prevention and redressal of complaints of sexual harassment.[129] Under the Act, every employer of a workplace is entitled to constitute an Internal Complaints Committee.[130]Nurses, both in the government and private sector, are entitled to get protection under this Act.

Right against exploitation is another right guaranteed by the Constitution of India.[131] Nurses are entitled to protection against forced labour and bonded labour. In *Peoples Union for Democratic Rights* v. *Union of India,*[132] it is held that no one shall be forced to provide labour or service against his will even though it is under a contract of service. It is held that a person who provides labour or service to another for remuneration, which is less than minimum wages, amounts to forced labour.

[128] (1997) 6 SCC 241.
[129]The Sexual Harassment of Women at Workplace (Prevention , Prohibition and Redressal) Act, 2013.
[130] *Id.* at §4. (It reads as "Constitution of Internal Complaints Committee.(1) Every employer of a workplace shall, by an order in writing, constitute a Committee to be known as the "Internal Complaints Committee").
[131]INDIA CONST.art.23 (1).(Traffic in human beings and begar and other similar forms of forced labour are prohibited and any contravention of this provision shall be an offence punishable in accordance with law).
[132] AIR 1982 SC 1943.

In *Seenath Beevi* vs. *State of Kerala,*[133] the Kerala High Court directed the hospital authorities to introduce three-shift systems, wherein the staff nurses were compelled to work for fourteen hours a day for six days consecutively. The court also upheld the continuing system as illegal and unconstitutional. It is observed as:

> *"The nature and quality of service with which we are concerned here are not one to be performed mechanically but with full application of mind. It is a matter concerning public health and those in distress. Hence such a service has to be done with compassion and confidence in contradistinction to the indifferent service rendered by a person with a tired and irritated mind. Deficiency in service in this kind of work is tantamount to disservice because what is dealt with is human life. No person running a hospital would be justified in providing deficient service, and no responsible Government can turn Nelson's eye to the harm caused to or injury suffered by its employees and its citizens".* [134]

Thus, all these rights are so relevant for nurses to meet the obligations attached to their profession. The observations made by the judiciary are also notable for protecting the rights of nurses to ensure quality patient care.

5.4 Conclusion

One of the unfortunate facts is that India has not ratified the Nurses Personnel Convention, which mentions the fundamental human rights of nurses. Another issue in India is that nurses do enjoy any special rights as

[133]Seenath Beevi vs. State of Kerala,2003 (3) KLT 788.(In this case, the Petitioner, a Head Nurse working in the Taluk Head Quarters Hospital, Thirroorangadi in the Health Services Department of the State has approached this Court with the grievance that she is required to do continuous duty for 14 hours at a stretch for 6 days consecutively).
[134] *Id.*

'health care professionals.' Neither the Central legislation nor the State laws mentions it. The inclusion of hospitals within the definition of 'industry' impliedly keeps nurses within the meaning of workmen.

It is also vital to notice that some of the rights of the nursing profession are not recognized in the legislative framework. Rights such as the right to handle emergencies, right to take part in policy decisions related to health, right to receive training and refreshment courses related to professional matters, right to question unethical orders of doctors, right to whistle blow, etc., are not recognized.

Thus, the need of the hour is separate legislation recognizing the rights of nurses as healthcare professionals. Guaranteeing rights to nurses without imposing obligations does not aid the profession in achieving its goal. Attention shall also be given to the manner of performance of duties by nurses, which requires 'duty of reasonable care. A balanced approach must be maintained about their rights as well as their duties. Thus, recognition of rights and regulation of responsibilities needs to be done to enhance their professional dignity to achieve the ultimate aim of quality health care.

CHAPTER VI

DUTIES AND RESPONSIBILITIES: DUTY OF CARE AND NURSES

Introduction

It is often said that doctors are Gods and nurses are Angels. When doctors cure the disease, nurses care for the patient. Both are vital for a successful treatment. As the direct-care takers of the patient, nurses are required to serve the patient with utmost devotion and care. As advocates of patient's rights, they are obliged to respect the human rights of the patient, such as the right to get adequate care and treatment, right to be treated with respect, right to informed consent, right to confidentiality, right to dignity, right to privacy; right to get information about treatment and so on.[1] As actual executors of treatment, they ought to aid the doctors in safeguarding the best interests of the patient. As skilled and specially trained health care providers, they are expected to uphold their professional standards and are accountable for their acts.[2] The chapter analyses the duties and responsibilities of nurses and

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[1]INTERNATIONAL COUNCIL OF NURSES (20 Apr. 2018), https://www.icn.ch/nursing-policy/position-statements.

[2]NIGHTINGALE PLEDGE (20 Jun. 2018),https://www.truthaboutnursing.org/press/ pioneers/ nightingale_ pledge.html#gsc.tab=0,I (It reads as "*I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed o f my keeping, and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and as a 'missioner of health' I will dedicate myself to devoted service to human welfare"*).

the concept of nursing negligence. Some of the significant judicial decisions dealing with the negligence of nurses are also included.

6.1 Duty: The Conceptual Analysis

Philosophers have defined the concept of duty in various ways. Some relate it to the obligations that a person has to fulfill morally, whereas others relate it to legal rights. The term 'duty' is derived from the French word 'due,' which means 'owing to.'[3] Webster's New World College Dictionary provides various meanings to duty such as "a conduct based on moral or legal obligation; or any action, task, etc. required by or relating to one's occupation or position; or a sense of feeling of obligation." [4] Hence, duty can be related to those moral and legal commitments that one owe to others. Black's law dictionary explains duty as an obligation that has a related right.[5]

John Austin classifies duties as absolute and relative, of which only relative duties correlates to rights. He observes:

> *"A relative duty is an incumbent upon one party, and correlates with a right residing in another party….it are a duty to be fulfilled towards a determined person, or determinate persons, other than the obliged, and other than the sovereign imposing the duty…."*[6]

[3] 1 WEBSTER'S NEW WORLD COLLEGE DICTIONARY 444 (4th Edition, 2007).
[4] 1 WEBSTER'S NEW WORLD COLLEGE DICTIONARY 444 (4th Edition, 2007).
[5] 9 BLACKS' LAW DICTIONARY 580 (Thomas Reuters, 2009). (It defines duty as "legal obligation that is owed or due to another and that needs to be satisfied; an obligation for which somebody else has a corresponding right").
[6] JOHN AUSTIN, THE PROVINCE OF JURISPRUDENCE DETERMINED 298 (Universal Law Publishing 2010).(Absolute duties do not corresponds with rights in the sovereign. It includes duties as being (1) towards self,(2) towards persons indefinitely, or towards the sovereign; (3) duties not regarding persons, but regarding God or the lower animals).

According to him, every right supposes a duty incumbent on a party or parties other than the party entitled. Through the imposition of that corresponding duty, the right was conferred. Throughout the continuance of that corresponding duty, the right was conferred.[7] Likewise, the rights of patients can be said to be protected only when nurses are continuously observing their duties.

Another interpretation of the correlation between duties and wrongs is made by John William Salmond. He explains duties as :

> *"An obligatory act, that is to say, is an act opposite of which would be wrong. Duties and wrongs are correlatives. The commission of wrong is the breach of duty, and the performance of a duty is the avoidance of wrong".*[8]

He classifies duties as moral as well as legal. Only legal duties are enforced by the state.[9] Thus, in the broader sense, it can be regarded as those acts that we perform or refrain from doing to protect the rights of those affected by it. Here, duties are imposed on nurses to protect the rights of the patient to ensure quality healthcare.

6.2 Duties of Nurses

Duties play a significant part in the profession of nursing. Upholding the patient's best interest is the primary objective of all duties that are imposed on nurses. Generally, nurses' tasks can be discussed under separate heads, such as duties towards patients, duties towards physicians, and duties towards hospital

[7] *Id.* at 158.
[8] SIR JOHN WILLIAM SALMOND, JURISPRUDENCE: OR THE THEORY OF LAW 181(Stevens and Haynes 1907).
[9] *Id.*

authorities. All these duties have an essential goal of achieving quality health care.

Nurses are expected to abide by the professional etiquettes that are reflected in the 'Code of Ethics' formulated by the International Council of Nurses (first adopted in 1953 and revised in 2012).[10] A nurse has four fundamental responsibilities: promoting health, preventing illness, restoring health, and alleviating suffering.[11] The code depicts the essence of the nursing profession. It symbolizes nurses as holders of human values and human rights. It obliges nurses to promise a strict adherence to the highest standards of nursing care and professional conduct. The assurance of nurses to respect the rights of the patients,[12] to improve practice through continual learning,[13] to

[10]THE INTERNATIONAL CODE OF ETHICS FOR NURSES 1953 (17 Aug. 2017) http://www.icn.ch/images/stories/documents/about/icncode_english.pdf.

[11] *Id.*

[12] *Id.* ("Nurse and People" reads as "The nurse's primary professional responsibility is to people requiring nursing care. In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected. The nurse ensures that the individual receives accurate, sufficient and timely information in a culturally appropriate manner on which to base consent for care and related treatment. The nurse holds in confidence personal information and uses judgment in sharing this information. The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations. The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services. The nurse demonstrates professional values such as respectfulness, responsiveness, compassion, trustworthiness and integrity").

[13] *Id.*("Nurses and practice" reads as "the nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning. The nurse maintains a standard of personal health such that the ability to provide care is not compromised. The nurse uses judgment regarding individual competence when accepting and delegating responsibility. The nurse at all times maintains standards of personal conduct which reflect well on the profession and enhance its image and public confidence. The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people. The nurse strives to foster and maintain a practice culture promoting ethical behavior and open dialogue").

abide by an ethical standard of practice,[14] and to work harmoniously towards their co-workers.[15]

6.3 Duties of nurses in India

6.3.1 Code of Ethics in India

In India, the duties of nurses are reflected in the State legislation and the Code of Ethics for Nurses. The Indian Nursing Council adopted the Code of Ethics in 2006. Similar to the International Code of Ethics, obligations such as respecting the rights of patients, co-workers' rights to maintain quality nursing care, and professional dignity is mandatorily prescribed in this code.[16]

6.3.2 Duty to Register

All the state laws in India mandates compulsory registration of nurses, and all nurses are duty-bound to give notice to the local supervising authority before starting practice.[17] An unregistered person is prohibited from practicing

[14] *Id* . ("Nurses and the profession" reads as "the nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education. The nurse is active in developing a core of research-based professional knowledge that supports evidence-based practice. The nurse is active in developing and sustaining a core of professional values. The nurse, acting through the professional organization, participates in creating a positive practice environment and maintaining safe, equitable social and economic working conditions in nursing. The nurse practices to sustain and protect the natural environment and is aware of its consequences on health. The nurse contributes to an ethical organizational environment and challenges unethical practices and settings").

[15] *Id.* ("Nurses and co-workers" reads as "the nurse sustains a collaborative and respectful relationship with co-workers in nursing and other fields. The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person. The nurse takes appropriate action to support and guide co-workers to advance ethical conduct").

[16] APPENDIX IV, THE CODE OF ETHICS FOR NURSES IN INDIA 2006 (23 Mar. 2018).

[17] Andhra Pradesh Nurses, Midwives , Auxiliary Nurse-Midwives and Health Visitors Act, 1926,§10 (1), No.III, Acts of Andhra Pradesh State Legislature, 1926, (India). Bengal Nurses Act, 1934,§27, No.10, Acts of Bengal State LEgisltaure,1926 (India). Gujarat Nurse, Midwives and Health Visitors Act, 1968,§18 (1), No.24, Acts of Gujarat State Legislature, 1968 (India); Goa Nursing Council (Amendment) Act, 2014,§29 (1), No.23, Acts of Goa State Legislature, 2014 (India); Haryana Nurses and Nurse-Midwives Act, 2017, §31, No.3,

as a nurse. In most state laws, a fine of not exceeding one hundred rupees for posing as a registered nurse is prescribed as a penalty.[18]

6.3.3 Duties towards Patients

Upholding the patient's best interest is the primary obligation of the nurses. Known as advocates of the patient, nurses are responsible for protecting the rights of patients. They should protect the best interests of the patient.[19] In

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Acts of Haryana State Legislature, 2017(India); Himachal Pradesh Nurses Registration Act, 1977, §22 (3) ,No.15, Acts of Himachal Pradesh State Legislature, 1977 (India); Karnataka Nurses, Midwives and Health Visitors Act, 1961,§18(1), No.4, Acts of Karnataka Legislative Assembly, 1961; Madhya Pradesh Upcharika,Prasavika,Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, §16(2), No.46, Acts of Madhya Pradesh Legislative Assembly, 1972; Maharashtra Nurses Act, 1966, §28 (1), No. 40, Acts of Maharashtra State Legislative Assembly, 1966; Manipur Nursing Council Act, 2005,§ 17, Acts of Manipur State Legislative Assembly, 2005;Meghalaya Nursing Council Act, 1992,§14, No.5, Acts of Meghalaya State Legislative Assembly, 1992; Odisha Nurses and Midwives Registration Act, 1938, §14, Acts of Odisha State Legislative Assembly, 1938; Sikkim Nurses, Midwives and Health Visitors Act, 2008, §20 (1), No. 4, Acts of Sikkim State Legislative Assembly, 2008; Tamil Nadu Nurses and Midwives (Amendment) Act, 1960,§ 10, No.26, Acts of Tamil Naidu State Legislative Assembly, 1960;Tripura Nursing Council Act, 1986; No.13, § 21, Acts of Tripura Legislative Assembly, 1986.

[18] Andhra Pradesh Nurses, Midwives , Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §14, No.III, Acts of Andhra Pradesh State Legislature, 1926, (India); Telegana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §14, No.3, Acts of Telegana State Legislative Assembly, 1926; The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972, §28, No.46, Acts of Chattisgarh Legislative Assembly, 1972; Punjab Nurses Registration Act, 1932, §24, No.15, Acts of Punjab State Legislature, 1932; Maharashtra Nurses Act, 1966, §. 34, No. 40, Acts of Maharashtra State Legislative Assembly, 1966; Gujarat Nurse, Midwives and Health Visitors Act, 1968,§27, No.24, Acts of Gujarat State Legislature, 1968 (India);Himachal Pradesh Nurses Registration Act, 1977,§30,No.15, Acts of Himachal Pradesh State Legislature, 1977 (India);Sikkim Nurses, Midwives and Health Visitors Act, 2008, §29,No. 4, Sikkim State Legislative Assembly, 2008; Tripura Nursing Council Act, 1986, §19, No.13, Acts of Tripura Legislative Assembly, 1986; Karnataka Nurses, Midwives and Health Visitors Act, 1961,§27, No.4, Acts of Karnataka Legislative Assembly, 1961; The Uttar Pradesh Nurses, Midwives Assistant Midwives (Auxiliary, Nurse- Midwives) and Health Visitors Registration Act, 1934, §28, No.XV, Acts of UP State Legislative Assembly, 1934;Rajasthan Nurses, Midwives, Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964, Proviso to §32 (2), No.15, Acts of Rajasthan State Legislative Assembly, 1964; Manipur Nursing Council Act, 2005,§ 3, Acts of Manipur State Legislative Assembly, 2005; Haryana Nurses and Nurse-Midwives Act, 2017, §34, No.3, Acts of Haryana State Legislature, 2017(India);Goa Nursing Council Act, 2012,§ 37, No.28, Acts of Goa State Legislature, 2014 (India); Odisha Nurses and Midwives Registration Act, 1938, § 22, Acts of Odisha State Legislative Assembly, 1938.

[19] *Id.*

the words of Florence Nightingale, "what nursing has to do is to put the patient in the best condition for nature to act upon him". [20]

The nurse's role is significant in safeguarding human values and the rights of the patients. They are obliged to provide adequate care and are accountable for preserving the human rights of patient. Moreover, a nurse must maintain the highest standards of nursing care and professional conduct. They shall respect cultural rights of the patient such as the right to life and choice, the dignity of the patient, and treat the patient with responsibility.

Apart from this, the Charter of Patients rights, 2018 imposes certain obligations on nurses.[21]This includes the duties they need to perform in assistance with the doctors and hospitals authorities for protecting the rights of the patient. Duties such as the duty to assist doctors in providing information to the patients about their illness,[22]duty to disclose their identity and professional status to the patients,[23]duty to ensure that the hospital authorities protect the right of the patient to access reports and records,[24]duty to assist hospital

[20]FLORENCE NIGHTINGALE, NOTES ON NURSING: WHAT IT IS, AND WHAT IT IS NOT 8(D. Appleton, 1860).

[21]CHARTER OF PATIENT'S RIGHTS, 2018 (9 Oct. 2019), http://clinicalesta blishments.gov. in/ WriteReadData/8431.pdf.

[22]*Id.* (Right to Information - Every patient has a right to adequate relevant information about the nature, cause of illness, provisional / confirmed diagnosis, proposed investigations and management, and possible complications To be explained at their level of understanding in language known to them. The treating physician has a duty to ensure that this information is provided in simple and intelligible language to the patient to be communicated either personally by the physician, or by means of his / her qualified assistants).

[23] *Id.*(Patients and their caretakers also have a right to know the identity and professional status of various care providers who are providing service to him / her and to know which Doctor / Consultant is primarily responsible for his / her care. The hospital management has a duty to provide this information routinely to all patients and their caregivers in writing with an acknowledgement).

[24] *Id.* (The relatives / caregivers of the patient have a right to get discharge summary or in case of death, death summary along with original copies of investigations. The hospital

authorities in providing emergency medical care,[25] duty to help the hospital authorities to uphold the human dignity of every patient in all situations,[26] and duty to assist hospital authorities in ensuring that patients are provided treatment in a non-discriminatory manner.[27]Thus, in brief, ensuring quality healthcare to patients through a cordial and coordinated relationship with the doctor and the hospital authorities is mentioned in the code. Here, nurses act as an intermediary between the patient and hospital authorities, including the physician.

6.3.4 Duty towards Physicians

It is said that the Doctor, Nurse, and Patient are the three key components of medical practice. The nurse acts as an intermediary between the doctor and patient- a catalyst of doctor-patient communication. As doctor's assistants, nurses are expected to execute their instructions, and as patient advocates, they are required to convey their sufferings to the doctor. Patient-centered health care, an essential criterion of quality health care, can be fruitful only through a cordial –collegial relationship between nurses and doctors. The mutual trust and cooperation they maintain with the patients, and each other are vital in assessing the effectiveness of medical care. The nurse and physician are

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management has a duty to provide these records and reports and to instruct the responsible hospital staff to ensure provision of the same are strictly followed without fail).

[25]*Id.* (It is the duty of the hospital management to ensure provision of such emergency care through its doctors and staff, rendered promptly without compromising on the quality and safety of the patients).

[26]*Id.* (The hospital management has a duty to ensure that its staff upholds the human dignity of every patient in all situations. All data concerning the patient should be kept under secured safe custody and insulated from data theft and leakage).

[27] *Id.* (The hospital management has a duty to ensure that no form of discriminatory behavior or treatment takes place with any person under the hospital's care. The hospital management must regularly orient and instruct all its doctors and staff regarding the same).

engaged in a 'symbiotic relationship,' in that nurses require doctor's orders and doctors rely on nursing care for treating patients.

A strong relationship between the physician and the nurse is a significant factor contributing to patient outcomes and quality patient care.[28] The ability to work as a team to provide health care can be regarded as a vital factor to improved outcomes, error and risk reduction, and optimum care.[29] As stated

> *"Without a doubt, patients are better served through a union of nurses and doctors working collaboratively... Neither nursing nor medicine can 'do it all today, as the patient demands for health care is too broad in scope, the curative techniques are too complex, and no one specialist (medical or nursing) can be expected to generate all the potential possibilities for delivering health care today."*[30]

The physician–nurse relationship can be defined as "the professional interaction, cooperation, communication and collaboration that exist between physicians and nurses".[31] It includes their responsibilities to patients and professional relationships.[32]The physician-nurse relationship can be categorized into five such as 'Collegial,' which is characterized by 'equal trust,

[28] Carbo, Alexander, *Let's Talk : Building Better Physician: Nurse Collaboration* , (12 Jan. 2019),https://www.rmf.harvard.edu/~/media/Files/_Global/KC/Forums/.../forumMay2008.pdf
[29] Clough, Jeanette, *Collaboration between Physician and Nurses : Essential to Patient Safety*, (12 Jan.2019), https://www.rmf.harvard.edu/~/media/ Files/_Global/KC/Forums/ .../forumMay2008.pdf.
[30] Erickson, Ives, Jeanette, *Building a Foundation for Nurse-Physician Collaboration* (20 Jan.2019), https://www.rmf.harvard.edu/~/media/Files/_ Global/KC/Forums/.../forumMay 2008.pdf.
[31] *Id.*
[32] *Id.*

power, and respect between the physicians and nurses';[33] 'Collaborative' in which 'mutual trust exists between the physician and nurse to co-operate with one another';[34] 'Guidance' which includes the element of 'teaching or guiding either of them by the other who is experienced or specialized in that field';[35] 'Neutral' which contains the 'exchange of formal pieces of information';[36] and 'Negative' in which 'anger, verbal abuse, actual or implied threats or resignations are common occurrences'.[37] Among them, the 'negative' relationship is the worst one. It is likely to produce inferior outcomes and an unsatisfied working atmosphere, wherein nurses are compelled to perform their duties without their rights.

In India, the legislative framework that deals with a doctor-nurse relationship is mainly dealt with in the Code of Conduct that regulates the

[33] *Id.* at 12 (Collegial relationships is described as excellent relationships. The core ingredient in these relationships is "different but equal "power and knowledge. It means that physician's value and respects the knowledge that working with nurses will create the best care plan which can help to decide whether to discharge a patient or to insert a central line. Physicians and nurses often regard themselves as peers or colleagues in describing these relationships. In other words, physicians values nurse's opinion on the wellbeing of the patient).

[34] *Id*. (It can be described as "good" or "great "relationships. Care plan is designed by the physician together with the nurse. The principle guiding the relationship is based on "mutuality" and not "equality", the physician is still superior).

[35] *Id.* at 13.(Here, the teacher can be either the physician or the nurse. These can be seen when a physician deemed to be well experienced and knowledgeable and willingly explains and teaches the nurse. However, the case of a nurse teaching can occur when physician attending a medical case not in his or her own specialty. Therefore, they would rely upon the nurse's competence and experience in that field in teaching and guiding them).

[36] *Id.* at 13. (Neutral-relationship can also be called as a friendly-stranger relationship. It is characterized by the exchange of formal information and the conversations are neutral. Here, communication is limited, formal and sometimes even absent).

[37] *Id.* at 14. (It can be illustrated in the following excerpt: "Physicians are sharp; they snap at you, is not just when they are tired but all the time". It is more prevalent among older physicians than younger which, relates to gender issues, power gaps, hierarchical traditions and an attitude that nurses are their handmaidens rather than valued professional collaborators).

doctors[38] and the Code of Conduct drafted together by the Medical Council of India and the Trained Nurses Association of India[39].

The Code of Conduct published by the Medical Council of India to regulate the professional conduct of Physicians mentions nursing as a profession. It reads as

> *"Physicians should recognize and promote the practice of different paramedical services such as pharmacy and nursing as professions and should seek their cooperation wherever required."* [40]

The Code of Conduct issued by the Indian Medical Association and the Trained Nurses Association of India reflects the idea of a partnership between the Doctor and the Nurse to increase quality care and patient safety[41]. The Code of Conduct mandates doctors and nurses to strictly adhere to their respective ethics, regulations, and code of professional conduct. It is asserted that the goal of the doctor-nurse partnership shall be based on shared responsibility and accountability for increasing quality care and patient safety. The code tries to promote a friendly environment where nurses and doctors can assertively make decisions[42]. It grants a voice to nurses to question doctors' orders that are against the patients' interests. It states that

[38] INDIAN MEDICAL COUNCIL(PROFESSIONAL CONDUCT, ETIQUETTE AND ETHICS) REGULATIONS 2002 (19 Oct. 2019), https://www.nmc.org.in/rules-regulations/code-of-medical-ethics-regulations-2002/.
[39] THE TRAINED NURSES ASSOCIATION OF INDIA, CODE OF CONDUCT: DOCTOR NURSE PROF ESSIONAL RELATIONSHIP (8 Dec. 2018), http://www.tnaionline. org/news/ Announcement/ code-of-conduct-doctor-nurse-professional-relationship/112.html).
[40] INDIAN MEDICAL COUNCIL,*supra* note 38,Regulation 5.3.
[41] TRNA , *Supra* note 39.
[42] *Id.*

> *"Although the nurses carry out Doctor's prescription as part of their job, at the same time the registered nurse is duty-bound to contradict with the same in case the same interfered with standards of patient care and professional nursing practice."* [43]

Additionally, the code reminds doctors about their ethical obligation to stay away from compelling nurses to follow their orders contrary to the set standard of good ethical, medical, and nursing practice. The code extends the role of nurses to take prompt actions in emergencies in cases where the treating doctor is not immediately available. The protection assured by the Indian Penal Code under General Exceptions for 'acts done in good faith the benefit of a person without consent' is applicable in such cases.[44] Thus, this code assures a voice to nurses to act and take independent decisions whenever required to protect the safety of the patient. Besides that, it is a positive move towards affirming a strong bond between doctors and nurses.

6.3.5 Duty towards Hospital Authorities

As discussed in an earlier chapter, nurses are treated as labourers or workmen in the hospital. As an employee of the hospital, they are expected to abide by the policies and rules of the hospital. The hospital functions through a healthcare team in which nurses forms the central part. Here, nurses are expected to ensure maximum cooperation and coordination with other team members. Obligations such as to comply with the internal standards of care as defined by the policies of the hospital or procedure manuals and the duty to

[43] *Id.*
[44] Indian Penal Code, 1860 No.45, §92, British India (1860).

keep patient's records or documentation of patient's information relating to treatment are the significant functions expected from a nurse working inside a hospital.

6.3.6 Duty to Document Records

Documentation of the patient records is one of the prime functions of nurses. It can be defined as anything written or printed that is a record or proof of activities.[45] It is the written evidence of nursing practice.[46]Quality documentation includes all the processes of nursing care such as 'assessment, interpretation of findings, plan of care, implementation and evaluation of the care plan.'[47]All communications made with the family, health education or psychological support provided, the process used to get informed consent, and the identification of the signed consent form are included in it.[48]

Briefly, documentation reflects the entire picture of the client and details on the care provided from the time the client entered the hospital till the time of his or her discharge.[49]Notably, misleading, false, illegible, or untimely documentation may lead to jeopardize the legal rights and defenses of both patients and healthcare providers, putting healthcare organizations and

[45] THE BOARD OF NURSING, A NEW TEXTBOOK FOR NURSES IN INDIA 74 (B I Publications 2008).
[46] Aaron Mtsha, *Documentation of Nursing Care Current Practices and Perceptions of Nurses in a teaching hospital in Saudi Arabia* (4 June 2021). https://core.ac.uk/download/pdf/37323574.pdf.
[47] *Id.*
[48] COLLEGE OF REGISTERED NURSES OF MANITOBIA, DOCUMENTATION GUIDELINES FOR REGISTERED NURSES (15 Jun. 2021), https://www.crnm.mb.ca/uploads/ck/files/ Documentation% 20Guidel ines%20for% 20 Nurses%20-%20web%20version.pdf.
[49] Papathanassiou I, Kotrotsiou S, Bletsa V, *Nursing documentation and recording systems of nursing care*, 4 HEALTH SCI.J 2007.

providers at the risk of liability.[50]Though there are no guidelines regarding recording documents, ordinarily, it is recorded briefly and legibly at the time when relevant incidents occur.[51] Written documents are also called by the name 'Medical records or records of the patient'.[52]

Legally, patient records or documentation of nurses can be used as evidence of quality nursing care and saves nurses from unnecessary allegations connected with patient care. It is also notable that inaccurate and incomplete records are evidence of negligent nursing care provided.[53]

A rule made by the South African Nursing Council under the Nursing Act, 2005 is a good example that mentions the omission or failure to record nursing care as a negligent act.[54] The rule empower the nursing council to take disciplinary actions against registered nurses who fail to keep accurate records of nursing care provided to the patient.

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[50]AMERICAN NURSES ASSOCIATION, PRINCIPLES OF NURSING DOCUMENTATION (12 June 2020),http://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf.

[51] NURSE'S KEY, REPORT WRITING : CONFIDENTIALITY OF AND ACCESS OF PATIENT RECORDS, (2 July 2021), https://nursekey.com/report-writing-confidentiality-of-and-access-to-patient-records/.

[52] *Id.*

[53] Aaron Mtsha, *Documentation of Nursing Care Current Practices and Perceptions of Nurses in a teaching hospital in Saudi Arabia*, Assignment presented in partial fulfillment of the requirements for the degree of Master of Nursing at Stellenbosch University,(4 Jun.2021),https://core.ac.uk/download/pdf/37323574.pdf.

[54] SOUTH AFRICAN NURSING COUNCIL, R.387 (8 Aug. 2020), https://www.sanc.co.za/r386/. (Chapter 2 of the regulation reads as "……the acts or omissions set out in this chapter, are deemed to be acts or omissions in respect of which the council can take disciplinary steps against a registered nurse……..."§5. reads as "Wilful or negligent omission to keep clear and accurate records of all actions which he performs in connection with a patient").

The case *McCabe* v. *Auburn District Hospital,*[55] illustrates the importance of proper record-keeping by nursing staff. Pointing out the inadequacy of the nursing notes in the case, it is observed that *"……..inadequacy of the...nursing notes……. must have been a major fact in bringing about a situation which allowed the patient's condition to deteriorate …. without timely remedial treatment".* [56]

In *Spasovic v. Sydney Adventist Hospital,*[57] a patient's health record was used as significant evidence by the hospital authorities to rebut the allegations leveled by the patient. The patient asserted that nurses employed at the hospital who cared for him failed to exercise reasonable care in assessing and treating complaints made and symptoms he exhibited, which were caused by a small cerebral hemorrhage. He claimed that they failed to evaluate and treat him; and he was discharged from the hospital and later suffered a major cerebral hemorrhage, which caused him to have permanent severe disabilities. The hospital authorities relied on the health records as evidence, and the court upheld the evidence as reliable. This case is an excellent example regarding the manner of recording patient records and how it can be used as a piece of evidence to rebut pointless allegations.

[55]McCabe v. Auburn District Hospital (NSW) ,Grove J, No. 11551 of 1982, 12 May 1989).(The young man's mother sued the hospital and its staff for negligence in the case of her son and sought compensation for loss of income of dependence under the compensation to Relative Act, 1897 (NSW) . Bases on the facts and evidence, it is found out that nursing staff were negligent in properly reporting the condition of the patient. The judge upheld the claim against the hospital and the hospital was held vicariously liable for the negligence of its staff).

[56] *Id.*

[57][2003]N.S.W.S.C. 791(12 Sept. 2003).

6.3.7 Duty to follow Nursing Standards of Care

The employer in the health industry put in place many policies and procedures designed to ensure that employees are required to follow a safe and recognized standard of clinical practice. If a nurse fails to abide by the hospital procedure, it can be held to be having been done in a negligent manner**.** Nursing standards of care are mandatory principles or policies that every nurse is obliged to follow while performing their functions. They provide guidelines for "how a nurse should act, and what they should and should not do in their professional capacity".[58] It includes both objective factors (e.g., the actions to be performed) and subjective factors (e.g., the nurse's emotional and mental state).

A nurse is usually judged against the standards established within the professional area of practice. Ensuring quality patient care is the primary aim of these standards.[59]They can be used as the best method for evaluating nurses' performance of their functions.[60] There are two types of standards- external and internal standards.[61] External Standards include nursing standards developed by Nurses Associations, the guidelines set by other nursing specialty practice groups.[62]Internal standards include nursing standards defined in hospital policy and procedure manuals that relate to the nurse in the particular institution.[63] The nurse's job description and employment contract are examples of internal

[58] *Id.*
[59] *Id.*
[60]*Id.*
[61]JOSEPH T. CATALANO, NURSING NOW! TODAY'S ISSUES, TOMORROW'S TRENDS 196 (F.A Davis 2019).
[62]*Id.*
[63]*Id.*

nursing standards. Also known as standards of practice, they are usually set out in the legislation dealing with nurses, regulations, policies, or codes of ethics.[64] It is also notable that any deviation from these standards leads to disciplinary actions, and they can be held liable for negligence.[65] Whenever the nurse deviates from the standard of care expected as part of her professional duty and injures a patient, we can assume negligence. Hence, they are expected to take reasonable care to prevent harm to their patients.

6.3.8 Duty of Care

The duty to take care is an essential quality which every nurse must possess for ensuring safe healthcare. The concept of 'duty of care can be explained as an obligation that a person must meet when performing some tasks. It is that care or anticipated concern which we are required to make before we perform some tasks. Sam Willis & Roger Dalrymple explains it as "an obligation incumbent on an individual to take care of, and prevent harm occurring to another individual".[66]

Donoghue v. Stevenson,[67]is the landmark case in which Lord Atkin set out the concept of duty of care. He explains it as

[64]H.G ORG LEGAL RESOURCES, STANDARDS OF CARE IN NURSING (19 Aug. 2020), https://www.hg.org/legal-articles/standards-of-care-in-nursing-6237.

[65] HERMAN WHEELER , LAW, ETHICS AND PROFESSIONAL ISSUES FOR NURSING: A REFLECTIVE AND PORTFOLIO (Rutledge 2011).

[66]SAM WILLIS, ROGER DALRYMPLE, FUNDAMENTALS OF PARAMEDIC PRACTICE: A SYSTEMS APPROACH 62 (Wiley Black well 2015).

[67] Donoghue v.Stevenson [1932]A.C.562.(In this case, the court held House of Lords held that the manufacturer of ginger beer owed a duty of care the ultimate consumer, even if the consumer had not purchased the ginger beer directly and so had no direct contact with the seller manufacturer).

> *"You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbor. Who then-in-law is a neighbor? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question".*[68]

Thus, the principle of foreseeability of the possible results of the action can be found in it. Law expects each person to foresee the (possibility of) injury that may result from their conduct (act or omission). Hence, to avoid consequences of injury, the law presumes everyone to abide by certain precautions and standards. This can be called a 'duty to care. It is also presumed that whenever a person deviates from this duty of care or precautionary measure which he is expected by law to abide by while performing a task, negligence happens. Likewise, the nurse is expected to take sufficient care while performing their duties; they shall foresee the possibility of injury that may result from their acts.

6.4 Negligence: The Concept

In an ordinary sense, negligence can be defined as an omission to abide by a reasonable standard of care expected from an ordinarily prudent man. Similar principles of negligence apply to all, without any difference as to ordinary man and professional person.[69] 'Legal duty to take reasonable care is its basic notion. Negligence is a term that originated from the Roman law word

[68] *Id.*
[69] *Id.*

'*culpa and negligent, which means culpable carelessness'*. [70] It can be defined as the failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation.[71]

Negligence involves three meanings,[72] such as a state of mind which can be contrasted with intention,[73] as a conduct of a careless type,[74] and the breach of duty to take care imposed by either common law or statute.[75]It can be defined as an 'independent tort' having three vital elements as a legal duty on the defendant's part towards the plaintiff; breach of that duty by the conduct of the defendant;[76] and harm resulting to the plaintiff as a consequence of that breach.[77]

A similar explanation of negligence is provided *in Blyth* v. *Birmingham Water Works Company*,[78]as "The omission to do something which a reasonable

[70] *Id* .at 1133-1134.
[71]9 BRYAN A. GARNER, BLACK'S LAW DICTIONARY 1133(Thomas Reuters 2009).
[72] 12 CHRISTOPHER WALTON, CHARLESWORTH & PERCY ON NEGLIGENCE 124 (Sweet & Maxwell 2010).
[73]*Id.* (Negligence arises where someone either fails to consider a risk of particular action, or having considered it, fails to give the risk appropriate weight. A fine example provided by them is If a man thoughtlessly leaves open the gate of a field enclosing cattle, the likely interference is that he has failed to turn his mind to the risk they will escape).
[74]*Id.* (Negligence in the second sense simply means careless conduct on the part of the claimant in preventing consequences of another person's breach of duty to take care. ex:-a person who in broad day light falls into an unfenced hole in the highway, as a result of not looking where he is going, may be unable to succeed because of his failure to take reasonable care for his own safety).
[75]*Id.* (The third meaning of negligence is based on the principle of liability. It incorporates the idea that the party complained of should owe to the party complaining a duty to take care, and that the party complaining should be able to prove that he has suffered damage in breach of that duty").
[76]*Id.* (He explains negligence as consists in conduct in which there is, on the part of the defendant, usually either no advertence or insufficient advertence to the nature of the conduct and/ or its consequences. In this conduct, whether there is such inadvertence or even full advertence- though this is rare-there is at least no desire for the consequences, and this distinguishes negligent harm from internal harm).
[77]Percy H. Winfield, *Duty in Tortuous Negligence*, 34 CLR 41,41-66(1934).
[78](1856) 11 Ex. 781 at 784.

man guided upon those considerations which ordinarily regulates human affairs would do, or doing something which prudent and reasonable man would not do."

Thus, whenever a man fails to take that reasonable care expected from a 'reasonably prudent man in performing a particular task, and it results in injury, the tort of negligence arises.[79] Thus when applied to the case of nurses, negligence happens whenever the nurse does any act which is harmful to the patient or fails to perform their duties to the patient. It is noteworthy that there is no difference in the type of behavior expected from a professional and a prudent man.[80] As observed, 'no distinction is drawn between the negligence of a doctor, plumber or window-cleaner.[81] However, concerning the degree of 'standard of care required to perform a 'skilled task,' the law presumes its performance by those with the required professional expertise, skill, and knowledge.[82]

[79] Unknown, *Professional Negligence*, 121 U.PA.L.REV.637 (1973).(It is firmly established that the professional is not required to exercise ordinary care. *See* also CHARLESWORTH & PERCY ON NEGLIGENCE 480(Sweet & Maxwell, 2006). (For example, a surgical operation must be performed in the way that a skilled surgeon, who is accustomed to perform that operation, would perform it. it would be no defense, where damage ensued, as a result of unskillful performance that the unskilfulness arose from the operators lack of a surgical qualification or from any other cause).

[80] Dr. LILY SRIVASTAVA, LAW & MEDICINE 72 (Universal Law Publishing Co. 2013).

[81] *Id.*

[82] CHARLESWORTH & PERCY ON NEGLIGENCE 479-480 & 551 (Sweet & Maxwell 2006). (The standard is that of an ordinary competent person in the same calling. For example, a surgical operation must be performed in the way that a skilled surgeon, who is accustomed to perform that operation, would perform it. it would not be defense, where damage ensued, as a result of unskillful performance that the unskilfulness arose from the operator's lack of surgical qualification or from any other cause. It is for the judge at first instance to determine, what , in all the circumstances of the case , is a reasonable standard of care .

This is clearly explained by McNair J, in *Bolam* v. *Friern Hospital Management Committee*,[83] as

> *"Where you get a situation which involves the use of some special skill of competent, then the test as to whether there has been negligence or not is not the test of the man in the top of a Clapham omnibus, because he has not got this special skill…the test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art".*[84]

A distinct version of professional negligence involving the concept of morality and confidentiality' is given by Jackson & Powel.[85] According to them

> *"Practitioners are usually committed, or expected to be committed, to certain moral principles, which go beyond the general duty of honesty…they are expected to provide a high standard of service for its own sake. They are expected to be particularly concerned about the duty of confidentiality. They also, normally, owe a wider duty to the*

[83] Bolam v. Friern Hospital Management Committee [1957] 1 W.L.R. 582, 586.During the course of electro-convulsive therapy [E.C.T] treatment administered to him at the defendant's mental hospital, the plaintiff, a voluntary patient, sustained bilateral "stove-in" fractures of the acetabula. E.C.T treatment consisted in the passing of an electric current through the brain of the patient, which, when given unmodified, i.e., without the prior administration of a relaxant drug, resulted in violent muscular contractions and spasms, attended with a known, though slight, risk of bone fracture. In accordance with his normal practice the doctor treating the patient had given the E.C.T unmodified, and without applying any form of manual restraint other than to support the plaintiff's chin and holds his shoulders, nurses being present on either side of the couch in case the plaintiff fell off. The plaintiff claimed damages, alleging, inter alia, that he defendants were negligent. Held that the doctor who had acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment in question was not guilty of negligence merely because there was a body of competent professional opinion which might adopt a different technique).

[84] *Id.*

[85] 4 JACKSON & POWELL ON PROFESIONAL NEGLIGENCE 3 (Sweet & Maxwell 1997).

community, which may on occasion transcend the duty to a particular client or patient….". [86]

Thus, what are expected from a practitioner are the standards of the ordinary competent practitioner in that particular field.[87] On the standard of skill and care, a professional person is required to exercise that degree of skill and care ordinarily exercised by reasonably competent members of the profession, who have the same rank and profess the same specialization (if any) as the defendant.[88]

Notably, the Civil Liability Act, 2002 prevalent in Western Australia, is an excellent example of the standard of care expected from health professionals.[89] It provides that an act of a health professional is not negligent if it is performed according to the usual practice generally accepted by the members of the profession.[90] It is also mentioned that a health professional is

[86]*Id.* at 2.(According to them, practitioners usually belong to a professional association, which regulates admission and seeks to uphold the standards of the profession. Such associations commonly set examinations to test competence and issue professional codes on matters of conduct and ethics. Most professions have a high status in the community. Some of their privileges are conferred by the Parliament. Some are granted by common consent.

[87] MICHAEL A. JONES, MEDICAL NEGLIGENCE 229 (Thomas Reuters 2020).

[88]POWELL, *supra* note 85.
(Also argues that "the professional person should be judged by reference to the standard of skill and care appropriate to his profession generally". Jackson and Powell discussed the reasons for expecting duty of care form a professional man . According to them, the advisory nature of their work; the status enjoyed by the professional in the society and the expectations of the society that the professional will uphold the required standards are the major reasons for such observations).

[89] Civil Liability Act, 2002, No.22, N.S.W. (Act of Parliament) New South Wales (21 Dec. 2020),www.legislation.wa.gov.au/legislation/ prod/filestore.nsf/FileURL/ mrdoc_ 29637.pdf /$FILE/Civil%20Liability%20Act%202002%20-%20%5B04-e0-00%5D.pdf?OpenElement.

[90]Civil Liability Act, 2002, §.5 PB, No.22, N.S.W. (Act of Parliament). (New South Wales (2002) reads "Standard of care for health professionals as (1) An act or omission of a health professional is not a negligent act or omission if it is in accordance with a practice that, at the time of the act or omission, is widely accepted by the health professional's peers as competent professional practice. (2) Subsection (1) does not apply to an act or omission of a health professional in relation to informing a person of a risk of injury or death associated with — (a) the treatment proposed for a patient or a foetus being carried by a pregnant patient; or (b) a

liable for negligence if he acts or omits to do something which is "in the circumstances of the particular case, so unreasonable that no reasonable health professional in the healthcare professional's position could have acted or omitted to do in accordance with the practice".[91]

Concerning the liability of the professionals, the Supreme Court of India has made a similar observation in *Indian Medical Association* v. *V.P Shantha.*[92] It is observed that

> *"In the matter of professional liability professionals differ from other occupations ……. professions operate in spheres where success cannot be achieved in every case and very often success or failure depends upon factors beyond the professional man's control.…the approach of the court is to require that professional men should possess a certain minimum degree of competence, that they should exercise reasonable care in the discharge of their duties".*[93]

procedure proposed to be conducted for the purpose of diagnosing a condition of a patient or a foetus being carried by a pregnant patient. (3) Subsection (1) applies even if another practice that is widely accepted by the health professional's peers as competent professional practice differs from or conflicts with the practice in accordance with which the health professional acted or omitted to do something. (4) Nothing in subsection (1) prevents a health professional from being liable for negligence if the practice in accordance with which the health professional acted or omitted to do something is, in the circumstances of the particular case, so unreasonable that no reasonable health professional in the health professional's position could have acted or omitted to do something in accordance with that practice. (5) A practice does not have to be universally accepted as competent professional practice to be considered widely accepted as competent professional practice. (6) In determining liability for damages for harm caused by the fault of a health professional, the plaintiff always bears the onus of proving, on the balance of probabilities, that the applicable standard of care (whether under this section or any other law) was breached by the defendant").

[91] *Id.*

[92] 1995 (6) SCC 651.

[93] *Id.*

Thus, from these, it is clear that the expected standard that is required by law is that of an ordinary competent man in a similar calling…all that any skillful person could reasonably be expected to do in such a case.[94]

A professional can be made liable for negligence in two situations, such as when he fails to possess the requisite skill needed for the performance of the particular task or; if he fails to exercise the skill he possesses with reasonable competence in the given case.[95] Likewise, nurses are also expected to have sufficient competency and skills that are required.

In *Roger* v. *Whitaker,*[96] the court discussed the standard of care that are expected from nurses. In this case, it is held that "in the course of carrying out his or her professional activities, a nurse is required to exercise the skill and care that, objectively, would be accepted by one's professional peers as competent professional practice".[97]

6.4.1 Nurses Negligence

As health care professionals, nurses are expected to possess the knowledge and skill required by their profession.[98] They shall observe the standard of care which a reasonable person with ordinary prudence will use (under similar circumstances) while performing their functions.[99]

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[94] CHARLESWORTH & PERCY ON NEGLIGENCE 480 (Sweet & Maxwell 2006).
[95] 2 Y.V RAO, LAW RELATING TO MEDICAL NEGLIGENCE 21(Asia Law House 2010).
[96] Roger v. Whitaker (1992) H.C.A. 58; 175 CLR 479.
[97] *Id.*
[98] Nathan Hershey, *The Law and the Nurse: Student, Instructor, and Liability,* JSTOR (2 Jan. 2019) https://www.jstor.org/stable/3453130-.
[99] 3 RICHARD GRIFFITH, CASSAM TENDNAH, LAW AND PROFESSIONAL ISSUES IN NURSING 46. (Sage Publications 2014); *See* Nathan Hershey, *The Law and the Nurse: Student, Instructor, and Liability,* JSTOR (2 Jan. 2019) https://www.jstor.org/stable/3453130-; *See also* Kathy

Halsbury explains the liability of medical negligence as:

"The general principles set out in the texts apply to physicians and surgeons are equally applicable to nurses, midwives and all others who give medical advice or treatment……. a person, who holds himself out as ready to give professional advice or treatment, impliedly undertakes that he is possessed of the skill and knowledge required for the purpose……Whether or not he is a registered medical practitioner, such a person who a patient consults owes him certain duties, namely a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give, a duty of care in his administration of that treatment and a duty of care in answering a question put to him by a patient in the circumstance in which he knows that the patient intends to rely on his answer".[100]

It is stated that the care expected from a nurse is a particular kind-professional care. The nurse is charged at all times with the responsibility of conducting herself reasonably and prudently without limit as to time, condition, or circumstances.[101]Whether there can be a liability on the part of the nurse is determined by how she discharge her duty to the patient to provide reasonable and prudent nursing care, regardless of whether she does this act as an

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Graves Ferrel, *Legal Clinic : Documentation, Part 2 : The Best Evidence of Care*, JSTOR (2 Jan. 2019) https://about.jstor.org/terms.

[100] 26 HALSBURY'S LAWS OF ENGLAND 31(Lexis Nexis, 2016). (A person, who holds himself out as ready to give professional advice or treatment, impliedly undertakes that he is possessed of the skill and knowledge requisite for the purpose. Whether or not he is a registered medical practitioner, such a person who is consulted by a patient owes him certain duties , namely a duty of care in deciding whether to undertake the case; a duty of care in deciding what treatment to give, a duty of care in his administration of that treatment and a duty of care in answering a question put to him by a patient in circumstance in which he knows that the patient intends to rely on his answer).

[101] Loric Lorice Ede, *Legal Relations in Nursing*, OCC.HEALTH NURS.1969 (2 Jan.2019) https://journals.sagepub.com/doi/pdf/10.1177/216507996901701201e Ede.

employee, an independent contractor, or an agent.[102] If any action of the nurse harms the patient, the patient can make the nurse liable for negligence.

The standard expected from the nurse is generally, what a reasonable and prudent nurse would have done is defined and measured against a standard: what would a nurse with her training and experience who is doing similar work in a similar setting under similar circumstances in the particular geographical area be expected to do in the specific situation.[103]

Norton v. *Argonaut Insurance Company* [104] is an important case regarding the standard of care that is expected from a nurse in administration of medications. In this case, a nurse was held liable for negligence in attempting to administer a drug that was not familiar to her. While discussing the standard of care which is expected from a nurse while administering medications, it is observed that

> *"…… While we concede that a nurse does not have the same degree of knowledge regarding the drugs as is possessed by members of the medical profession, common sense dictates that no nurse should attempt to administer a drug under the circumstances shown in the case at bar. Not only was Mrs. Evans (the nurse here) unfamiliar with the medicine in question, but she also violated what is the rule generally practiced by the members of the nursing profession in the community and which rule, we might add, strikes us as being most reasonable and prudent, namely*

[102] *Id.*
[103] *Id.*
[104] Norton v. Argonaut Insurance Company, 144 So. 2d 249 (La. Ct. App. 1962).(In this case a nurse had been sued in a wrongful death action where a three-month old infant was administered a fatal intramuscular dose of digitals).

*the practice of calling the prescribing physician when in doubt about an or*der for medication".[105]

Langley v. *Glandore PTY LTD (IN Liquidation),*[106] is another critical case that discussed the standard of care expected of staff nurses in operation theatres. In this case, the Court made specific reference to the Australian Council of Operating Room Nurses Standards, which prescribes procedures for which nurses are responsible in operating rooms. The swabs and instrument count standard were those used to assess the requisite standard of care. Holding nurses liable for the negligence in improper counting of swabs, it is observed that ".…….the nurses, under the procedure described, had the primary responsibility for making an accurate count ensure that all of the sponges used had been recovered from the plaintiff's body……".[107]The court allocated a proportion of the damage to be paid by the nurse's employer.

Elliott v.*Blckerstaff,*[108] is another case that discusses the negligent actions of the nursing staff. In this case, Dr.Elliott was made liable for the negligent act of leaving the sponge in the patient. Later on, it was found from the evidence that the procedure of counting the sponge is a routine surgical procedure that is part of the standard of care followed by nursing staff.

[105] *Id.*
[106] Langley v. Glandore PTY LTD (IN Liquidation) [1997] Q.C.A. 342.(In this Queensland Court of Appeal case, two surgeons appealed against a jury decision finding them negligent in their failure to ensure the removal of a surgical swab from the abdomen of a patient undergoing a hysterectomy. The surgeons appealed on the ground that, as the surgical swab was left in the womb, the swab count must have been incorrect. Therefore, finding there was no negligence on the part of the scrub nurses or the circulating nurses, and thereby, the hospital, should be made overturned. Later, at the trial of the case, it becomes clear that the scrub nurse had made error in counting the swabs).
[107] *Id.*
[108] Elliott v.Blckerstaff [1999]NSWCA 453.

Dr.Elliott, who has already confirmed with the nurse about the count of swabs and sponges, has followed his normal procedure, and the nurse subservient to him was found to have made the misconduct, which caused harm to the patient. Accordingly, the court observed that:

> *"In the manner in which the surgery of the kind undergone by the respondent is performed, the patient receives the attention of a team: the surgeon, the anesthetist, and theatre staff. There is divided responsibility. The surgeon can be regarded…….…..as the master of ceremonies, but he is nonetheless a member of a team and reliant on the due discharge of their responsibilities by the other members of the team. He should be able to concentrate on his skilled task without shouldering the responsibilities of other members of the team".*[109]

Thus, nurse's negligence can be defined as the failure to provide care that meets current standards of practice.[110] To prove negligence on the part of the nurse, the plaintiff has to prove four elements such as the nurse' duty towards him; breach of that duty; causation (direct) link that nurse's act to the patient's injury and damage,[111] which means 'catastrophic injuries' suffered by the patient as a result of the nurse's negligence.[112]

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[109] *Id.*

[110] N. Genell Lee, *Legal Issues : Proving Nursing Negligence*, JSTOR (5 Mar.2019), https://www.jstor/stable/3522264, (It is also observed that to determine these standards, a nurse should find out what her institution's policies are, what her professional nursing organization has published on this subject, and what the literature says, and she can ask herself what another prudent nurse would do under similar circumstanced).

[111] *Id.*

[112] Edie Brous, *The Elements of a Nursing Malpractice Case, Part 1 : Duty* ,119(7) Am j Nurs. 64-67(2019).

Nurses negligence can be divided into 'categories',[113]such as failure to follow a standard of reasonable care as to avoid harm to the patient;[114]failure to use equipment responsibly according to the usage recommendations of the manufacture;[115]failure to communicate with the physician on time and to communicate with a patient (for example, discharge instructions);[116]failure to document a patient's progress and response to treatment;[117]failure to implement a plan of care;[118] and failure to act as a patient advocate, including an inability to question incomplete or illegible medical orders and provide a safe environment.[119]

Another aspect that requires clarification is the distinction between professional negligence and malpractice committed by nurses. Though the terms 'negligence and malpractice' are used synonymously for professional misconduct, they refer to different wrongdoing attached to professional behavior. Usually, malpractice refers to the existence of a professional standard of care and a deviation from that standard of care.[120] It is more severe than

[113] Eileen M. Crooke, *Nurses, Negligence and Malpractice*, 103 (9) Am. J.Nurs.57-60, 57 (2003).
[114]*Id.*at 58.
[115]*Id.*
[116]*Id.*at 59.
[117]*Id.* at 60.(It includes a patient's injuries, pertinent nursing assessment information (for example, drug allergies), a physician's medical orders, information on telephone conversations with physicians, including time, content of communication between nurse and physician , and actions taken).
[118]*Id.* at 59.
[119]*Id.* at 60.
[120]8 JOSEPH T. CATALANO, NURSING NOW ! TODAY'S ISSUES, TOMORROW'S TRENDS 183 & 187 (F.A Davis 2019). (Some of the professional malpractices includes actions such as leaving foreign objects inside a client during surgery; failing to follow a hospital standard or protocol; not using equipment in accordance with the manufacturer's recommendations; failing to listen to and respond to a client's complaints; not properly documenting phone conversations and orders from physician; failure to question physicians orders at when indicated such as too large medication dosages, inappropriate diets, failing to clarify poorly written or illegible

negligence as it indicates professional misconduct or unreasonable lack of skill in performing professional duties.

Negligence is a form of conduct caused by the heedlessness of carelessness that constitutes a departure from the standard of care generally imposed on reasonable members of society.[121]It can occur when, after considering the consequences of an act; a person does not exercise the best possible judgment; when one fails to guard against a risk that should be appreciated; or when one engages in behavior expected to involve unreasonable danger to others,[122] whereas, Malpractice means negligence of a professional person (e.g., nurse practitioner, pharmacist, physician, physician's assistant).[123] It is stated that any person can be negligent, but only a professional person may be accused of malpractice.[124] It is also noted that nurses are held to be professional persons employed to exercise their calling on their responsibility under the general direction of the physician in charge and are grouped with

physician orders, failing to assess and observe a client as directed, failing to obtain a proper informed consent, failing to report a change in a client's condition, such as vital signs, circulatory status and level of consciousness, failing to report another health-care providers incompetence or negligence, failing to take actions to provide for a client's safety such as not cleaning up a liquid spill on the floor that causes a client to fall, failing to provide a client with sufficient and appropriate education before discharge. According to Joseph catalano, even the abandonment of the client will becomes malpractice if it is done without adequate notice).

[121]GEORGE D. POZGAR, PATIENT CARE CASE LAW: ETHICS, REGULATIONS AND COMPLIANCE 459(Jones & Bartlett Learning 2013).

[122]*Id.*

[123]*Id.*at 459.(He explains both negligence and malpractice as the unintentional omission or commission of an act that a reasonably prudent person would or would not do under given circumstances).

[124]JANET PITTS BECJMANN, NURSING NEGLIGENCE : ANAYSING MALPRACTICE IN HOSPITAL SETTING, 13(Sage Publications 1996).

physicians and surgeons and not with cooks, chambermaids ., etc., employed in purely ministerial and administerial functions.[125]

Standards of care serve as guidelines for quality assurance in rendering patient care and thereby hold the nursing profession responsible and accountable to the consumer for the quality of its services.[126]Nursing malpractice occurs when a patient is harmed because the nurse fails to provide or render nursing care that departs from the prevailing professional standard.[127] It includes instances such as administering the wrong medication, administering the wrong dosage of a medication, administering medication to the wrong patient, performing a surgical procedure without patient consent, performing a surgical procedure on the wrong patient or body part, performing the wrong surgical procedure, failure to conduct a thorough history and physical examination, failure to access and reassess a patient's nutritional needs, failure to administer medications, failure to order diagnostic tests, failure to follow up on abnormal or critical test results and so on. Instances such as failure to follow physician instructions, failure to recognize the change in patient's conditions, failure to follow discharge procedures, failure to report patient's conditions or professional misconduct, failure to follow procedures or

[125]Barbara R. Benninger, *Nursing Malpractice –The Nurse's Duty to Follow Orders*, 90 W.VA.L.REV. (1988) 1293-1297.
[126]*Id.*
[127]BECJMANN ,*supra* note 124, at 13(Standard of care are broad in scope and are established by the nursing profession. They serve as guidelines for the assurance of quality in rendering patient care and thereby hold nursing profession responsible and accountable to the consumer for the quality of its services).

track vital signs, etc., come under negligence acts of nurses.[128] Thus, these areas of function are so important that a reasonable prudent nurse must observe the standard of care to avoid negligent acts.

6.5 General Principles of Negligence

Certain general principles can be applied to nurses, too, while fixing their liability for negligence.

6.5.1 Duty to Possess Requisite Skill & Knowledge

Like any other person, a nurse is also personally liable for negligent performance of their duties.[129] As the real executors of doctors' instructions, nurses are expected to perform this task carefully. Initially, the courts have taken the view that nurses should follow that standard of a practice prevalent in the community. Later, the court has expanded the idea that nurses must possess the skill, knowledge, and care possessed by the nursing profession members. So here, the court has taken a professional approach by which nurses are expected to possess the 'knowledge and skill' required for performing their functions.[130] The expansion of the functions of nurses from mere ministerial to

[128]GEORGE D. POZGAR, PATIENT CARE CASE LAW: ETHICS, REGULATIONS AND COMPLIANCE 462(Jones & Bartlett Learning 2013); *See also* Frank J. Cavico, Nancy M. Cavico, *The Nursing Profession in the 1990's : Negligence and Malpractice Liability*, 43 CLEV.ST.L.REV. 557(1995) .

[129] P M Bakshi, *Nurses and the Law*, 36 JILI 288, 285-291(1994).

[130]Strangways-Lesmere v. Clayton [1936] (2 K.B.(It is one of the leading case in which two nurses were held personally liable for administering an overdose drug, due to which the patient lost his life). *See* Parry v. North West Surrey Health Authority[1994]5 Med.L.R 259. (Wherein a Midwife was held liable for failing properly to monitor the progress of the plaintiff's birth, so as to detect that there were difficulties, and for failing promptly to summon a doctor when the plaintiff's distress became apparent). *See* also Voller v. Portsmouth Corporation (1947) 203 L.T.J. 264(nurses allowed operating equipment to become infected).

medical was pointed out as one of the primary reasons for the extension of nurses' liability in negligence.[131]

The West Virginia Nurse Practice Code explains the expected skill and knowledge of a registered professional nurse. It defines 'Practice of registered professional nursing' or 'registered professional nursing' as

> *"…..any service requiring substantial specialized judgment and skill-based on knowledge and application of principles of nursing derived from the biological, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the facts, or the supervision and teaching of other persons concerning such principles of nursing, or in the administration of medications and treatments as prescribed by a licensed physician, a licensed dentist or a licensed advanced practice registered nurse, or the application of such nursing procedures as involve an understanding of cause and effect to safeguard life and health of a patient and others".* [132]

6.5.2 Principles of Vicarious Liability

The second principle is that liability can be invoked based on the relationship between the persons such as master-servant, principal-agent, partnership-firm, employer-employee, and so on. In all these relationships, the liability rests with the persons under whose control the act is performed. Legal

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[131] The Medicinal Products : Prescription by Nurses Act,1992, § 1,c.28,Acts of Parliament, United Kingdom (1992) Prescription only drugs etc.: authorisation of registered nurses, midwives and health visitors (9 Sept. 2020), http://www.legislation.gov.uk/ukpga/1992/28/contents.

[132] WEST VIRGINIA LEGISLATURE, West Virginia Nurse Practice Code, art. 7,§30-7-1 (9 Sept. 2020), http://www.wvlegislature. gov/Bill_Status/bills_text.cfm? billdoc=HB4156% 20SUB% 20ENR.htm&yr=2018&sesstype=RS&i=4156.

maxims such as *respondeat superior,*[133](Latin for 'let the master answer,'this principle holds that an employer is responsible for actions performed by an employee in the course of employment) and *'Qui facit per alium fait per se,'* (which means that a man is responsible for any wrongful act done by his agent or subordinate, provided such action is within the reasonable scope of their employment) is are based on this principle. Halsbury explains it as "The principal is responsible, jointly and severally with the agent, if a wrongful act is committed by the agent in the course of his employment as agent or within the ostensible scope of his authority when his ordinary duties are considered".[134]

Equally, this can be applied to Physician-Nurse relationships. Physicians are liable for those negligent acts performed by nurses under their control/instructions. The principle of vicarious liability has also been regarded as one of the best defenses available to nurses to avoid their liability. As pointed out by Alec Samuels, "acting under instructions of a doctor, unless those instructions are patently erroneous will normally provide a defense for the nurse".[135] Even though the doctor does not authorize the negligent act, the doctor is liable as long as the act is done within the scope of the doctor's authority. Thus, under the doctrine of *respondent superior,* the employer can be held liable for the actions of the nurses under three circumstances such as,[136] nurse is acting within the scope of their employment; the alleged negligent

[133] It is based on the principle that "he who expects to derive advantages from an act which is done by another for him must answer for any injuries which a third person may sustain from it".
[134] *Id.*
[135] *Id.*
[136] Edie Brous, *The Elements of a Nursing Malpractice Case, Part 1:Duty* ,7 (119)Am j Nurs 64-67 (2019).

actions occurred during the course and scope of the nurse's employment, and the nurse's actions were in furtherance of the employer's interests. However, this doctrine will not be applicable in cases where nurses violate employer policies, break the law, exceed the scope of practice, or engage in actions for personal gains.[137] In all these cases, the employer can claim immunity from liability.

Perionowski v. Freeman[138], is an authoritative decision in which the court pointed out the "control" test to determine the liability of the doctor. It is held that surgeons cannot be held liable for the negligent acts of nurse whom they have every reason to believe to be competent, in the performance of ordinary nursing duties, unless doctors are present at the performance of the act and can exercise control. Mc Kinney v. Tromly[139], is another important decision wherein the suregeon is held liable for nurse's negligence. Sellers, J observed that "*We have no difficulty in finding that the nurse, although in the general employ of the hospital , was under the facts of this case an employee of Doctor Tromly while in the operating room and under his control"*.

[137] *Id.*

[138] Perionowski v. Freeman, 4 Fost. & F. 977, 176 Eng. Rep. 873 (1886).

[139] Mc Kinney v. Tromly, 386 S.W.2d 564 (1964) in this case, the nurse administer ether to the patient. When the surgeon began to operate using an electrical instrument, the consequent explosion resulted in the patient's death. At the trial the nurse was found to be negligent, but the surgeon was not held liable. On appeal the court held that the surgeon was liable for the nurse's negligence.

6.5.2.1 Doctor-Nurse Relationship

One of the primary responsibility of the nurse to execute the orders given by the physicians.[140]Any failure to execute the physician's orders constitutes a breach of duty on the part of the nurse.[141] However, a nurse is not required to follow those orders, which are likely to cause substantial harm to the patient.[142] Some authors have pointed out the obligation of the nurse to report and disobey those harmful decisions, if any, made by the doctors. Nurses are also duty-bound to seek authoritative clarification before following an inaccurate order.[143]

In *City of Somerset* v. *Hart*, [144] the court observed that "*...unless the orders are so obviously improper that the ordinary prudent nurse would not obey them…..the nurse is exculpated from liability for harm which resulted when these orders are followed…*".

In the case *Toth* v. *Community Hospital*,[145] it is held that the primary duty of a staff nurse is to follow the physician's order. Here, the nurses administered oxygen at a rate over the physician's specific orders, harming the premature infant twin patients to suffer blindness. Regarding the duty of nurses, it is observed that,

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[140] Barbara R. Benninger , *Nursing Malpractice –The Nurse's Duty to Follow Orders*, 90 W.Va.L.Rev.1293-1295 (1988).
[141]*Id.* (It doesn't means that nurses have to execute any improper orders that may result in harm of the patient.
[142]*Id.*
[143] Alec Samuels, The Legal Liability of the Nurse-the lawyer's, 33 (4) MED SCI LAW 305-9 (1993);*See also* Nathan Hershey *He Can't Take the Responsibility* ,66 AM.J. NURS. 1054(1966).
[144] *Id.*
[145] Toth v. Community Hospital, 22 N.Y.2d 255.

> *"Nurses are not authorized to determine for themselves what a proper course of medical treatment is. They may not invade the area of the physician's competence and authority to overrule his orders…similarly, the nurses could not impunity fail to give oxygen if directed to do so even if some institutions never used the oxygen therapy for premature infants".*[146]

Abille v. *The United States,*[147] is another case wherein the court held that nurses are generally expected to follow physician's orders. In this case, the nurse on duty negligently left a patient who required extra supervision, believing that the physician had altered the position of the patient to that one who requires low supervision. Once the nurse left the ward, the patient committed suicide. Here the court held that the nurse must follow the physician's order and observed that "even a good faith belief is not an excuse for failing to comply with the physician's order…..".[148]

It is notable that following physician's orders do not always discharge nurses from liability for negligence. *Czubinsky* v. *Doctor's Hospital,*[149] is one of an important cases in this regard. In this case, a physician insisted a nurse to leave a post-operative patient to assist him. Though the nurse initially rejected to go with the physician (as she was aware of the hospital policy that requires a surgical team with a post-operative patient) she later left with him due to the continued insistence from the part of the physician. Meanwhile, the patient suffered a cardiac arrest, which resulted in severe brain damage. The court held

[146] *Id.*
[147] Abille v.United States,482 F. Supp.703 (1980).
[148] *Id.*
[149]Czubinsky v. Doctor's Hospital,(1983) 139 Cal.App.3d 361.

the nurse liable for negligence as she failed to abide by the hospital policy. It is observed that

> *"…..the nurse's absence from the operation room was patent, the proximate efficient cause of the injuries suffered by the plaintiff. She was the second most skilled person present. Her presence and skill should have led to a prompt observation of the preliminary warning signs of vital function failures…."*.[150]

Utter v. *United Hospital Centre,*[151] is another critical case that discusses nurses' duty to question improper orders and treatments of the physician. In this case, the nurse failed to report the irresponsive behavior of the doctor, which worsened the patient's condition. Even though she once informed the physician about the need for taking immediate action (treatment) for the patient, she remained silent, following the physician's reaction. In upholding the negligence of the nurse, it is held that

> *"In evaluating the evidence concerning the actions or omissions of the nurses who treated the plaintiff and to determine their duties and responsibilities, it is necessary to consider the declared hospital policy……if a registered professional nurse has any reason to doubt or question the care provided to any patient or feels that appropriate consultation is needed and has not been obtained, she shall direct such question of doubt to the attending practitioner. If……the question has not been resolved, she shall call this to the attention of the Departmental Chairman...."*[152]

[150] *Id.*
[151] Utter v. United Hospital Centre, 36 S.E.2d 213(1977).
[152] *Id.*

A similar subject of nurse's duty to question careless conduct of the physicians arose in *Darling* v. *Charleston Community Memorial Hospital.*[153] Time and again, the court reminded nurses about their duty to take sudden actions once the physician failed in their duty to provide reasonable care to the patient. Nurses are required to report such events of inactions by the physician to the hospital authorities to save the patient from further injury.

Blyth v. *Hospital,*[154] is a critical case in which the court held that nurses are not ordinarily liable for executing the orders of the physicians, but in cases where an order of a physician is found to be negligent as to lead to any reasonable person to anticipate that substantial injury would result to the patient by the execution of such order. The nurse must report it.[155] Thus, this decision provides an insight regarding the manner of execution of orders by nurses. Instead, executing the order blindly, nurses are expected to apply their knowledge and judgment.

In *Byrd* v. *Marion General Hospital,*[156] the Court again discussed the application of the doctrine of respondent superior in the nurse-physician relationship. In this case, a nurse employed by a hospital but acting under the direction of an attending physician injured a patient. The court held that, as long as the nurse acts under the dictation of the physician, she will not be ordinary liable, unless it is so obvious that the orders of the physician are likely

[153] Darling v. Charleston Community Memorial Hospital,33 III.2d 326 (1965).
[154] Blyth v. Hospital, (1856) 11 Ex Ch 781.
[155] *Id.*
[156] Byrd v. Marion General Hospital,202 N. C. 337, 162 S. E. 738 (1932).

to cause substantial injury to the patient. Brogden explains the liability of the physician, J as

> *".. if the physician [referring to the attending physician who was not joined] is present and undertakes to give directions, or ... stands by, approving the treatment administered by the nurse, unless the treatment is negligent and dangerous, ... in such event the nurse can then assume that the treatment is proper under the circumstances. Such treatment, when the physician is present, becomes the treatment of the physician and not that of the nurse".*[157]

In *Browning* v. *Hoffman,*[158] it is held that a nurse must know when to call a doctor. As observed, "It is within the province of the nurse to determine the necessity of the physician's attendance in point of time".[159] Again, the court discussed the need to apply knowledge, skill, and judgment by nurses.

Striano v. *Deepdale General Hospital*,[160] is another case wherein the court discharged the physician from liability for the nurse's negligence when she failed to follow the physician's instructions. It is observed that, in general, *"a surgeon may not be held vicariously liable for the negligence of the nurse not in his employ unless the act giving rise to the injury is one requiring close supervision and instruction".*[161]

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[157] *Id.*
[158] Brownig v. Hoffman ,86 W. Va. 468,103 S.E. 484 (1920).
[159] *Id.*
[160]Striano v. Deepdale General Hospital ,54 A.D.2d 730, 387 N.Y.S.2d 678(N.Y.App.Div.1976) (In this case, the nurse was negligent in ordering and serving hot water to the child (patient) which was against the diet prescribed by the physician).
[161] *Id.*

The same principle is applied in *Rosetta Banks* v. *George A. Barkoukis,*[162]wherein the plaintiff was injured by a nurse who acted outside the physician's authority.

Thus, all these cases discussed the relation of nurse and physician in invoking the principles of vicarious liability and the extent of its application.

6.5.2.2 Liability of the Hospital Authorities

The third principle is concerning the liability of the hospital authorities for the negligence of nurses; it is reflected that for a long time, the hospital authorities were held liable only for the negligence of their staff for the performance of purely ministerial or administrative duties such as attendance of nurses in the wards, the summoning of medical aid in cases of emergency, the supply of proper food and so on .[163]They can escape their liability where their

[162]Rosetta Banks v. George A. Barkoukis , 231 A.D.2d 598, 647 N.Y.S.2d 814 (N.Y.App.Div.1996). (In this case, the plaintiff was struck by the nurse in the face and eye while she was adjusting surgical light. It is found that she acted outside the control of the physician).

[163] Hillyer v. Governors of St.Bartholomew's Hospital, [1909]2 K.B 820. (In this case, the plaintiff brought an action against the management of the hospital for damages for injuries alleged to have caused to him during an operation by the negligence of some members of the hospital staff. It is held that the action was not maintainable. Kenndy L.J held that the hospital authority is legally responsible to the patients for the due performance by their servants within the hospital of their purely ministerial or administrative duties, such as, for example, the summoning of medical aid in case of emergency, the supply of proper food, and the like. The management of a hospital ought to make and does make its own regulations in respect of such matters,, and it is in my judgement legally responsible to the patients for their sufficiency, their propriety and observance of them by the servants". The hospital authority is not liable in matters of professional skill in which the governors neither do nor can properly interfere, either by rule or supervision. But in other matters, the hospital is liable , as the employer, for the nurses' acts. The act of the nurses in administering the drug was within the ordinary scope of their employment of the hospital, and for that act the hospital , as the employer is not liable. *See* also Hall v. Lees [1904] 2 K.B. 602, In this case, a patient who underwent an operation in her own home is engaged a nurse from a philanthropic association to take care of her afterwards. While she was still under the effects of the anesthetic she was burnt by a hot-water bottle due to the negligence of the nurse. The Master of Rolls explains that the liability of the association is determined by the terms and conditions of the contract it had made with the patient. If the association agrees to nurse the patient, then it will be liable to the patient for the negligence of the nurse. On the other hand, if the assurance of the association is only to

staff commits negligence in performing professionally skilled functions.[164] The liability of the hospital authorities was limited only to the extent of assuring the appointments made by them (that the authority exercised care and skill in the selection of an employee's/medical attendants); especially the nurses were duly qualified. Beyond that, they are not held liable.[165]

A judicial shift happened in the case of *Gold* v. *Essex County Council,*[166] wherein the court upheld the liability of a local authority carrying a public hospital for the negligence of its servant. The servant is engaged in a work that involves exercise of professional skills on his part.

Cassidy v. *Ministry of Health,*[167]is another case where the Court of Appeal confirmed the vicariously liable of the hospital authority for the

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provide a competent nurse, then its liability ends with the selection of a competent nurse for the patient).

[164]Hillyer v. Governors of St.Bartholomew's Hospital [1909]2 K.B 820.

[165] Hillyer v. Governors of St.Bartholomew's Hospital [1909]2 K.B 820. (Also See Evans v. Liverpool Corporation [1906]1 K.B.160), A child with scarlet fever was sent to the infectious diseases hospital maintained by the Liverpool Corporation under the Public Health Act, 1875. The boy was discharged by the visiting physician while he was still in an infectious condition, and when he got home gave scarlet fever to three other children of the family. The jury found that the visiting physician, in discharging the child, had not shown a degree of skill and care which was reasonable in the circumstances-that is, that he had been negligent. This visiting physician was an officer appointed by the Liverpool corporation to act under the general direction of the Hospital committee, and the rules provided that he should be responsible for "the treatment of the patients from the beginning to the end of their stay, and also for their freedom from infection when discharged". Court discharged the Liverpool Corporation from its liability and held that the legal obligation of the Liverpool Corporation extended only to the provision of selecting reasonably skilled and competent medical attendants for the patients. The Corporation had made no absolute undertaking, nor was it under any absolute obligation to see that no patient should be discharged by the visiting physician while still in a condition which might cause infection).

[166] Gold v. Essex County Council [1942] 2 K.B 293. (In this case, a patient was injured by the negligence of a competent radiographer, who was a whole-time employee of the hospital. Court upheld the liability of the local authority (Lord Greene M.R, Mackinnon and Goddard L.JJ).

[167] Cassidy v. Ministry of Health [1951]2 K.B.343. (In this case, two figures of left hand of Cassidy were operated upon and bandaged to a splint for fourteen days. The operation was carried out by a whole-time assistant medical officer. The patient complaint of severe pain

negligence of all their staff, even though appointed on a contract of service or contract for service. Lord Denning, L has explained the principles as

> *"When hospital authorities undertake to treat a patient, and themselves select and appoint and employ the professional men and women who are to give the treatment, they are responsible for the negligence of those persons in failing to give proper treatment, no matter whether they are doctors, surgeons, nurses or anyone else….The hospital authorities are responsible for all of them. The reason is that, even if they are not servants, they are the agents of the hospital to give the treatment".*[168]

The court's primary reasoning centered on the duty towards the patient rather than the mode of their appointment. It is the 'course and scope of employment' that decade the authorized acts of an employee, even if such authorized acts are performed in an incorrect and unauthorized way.[169] For example, if a nurse administered medications contrary to authorized hospital procedure and protocol and, in doing so, negligently gave the wrong drug, and the patient suffered damage, the hospital would be vicariously liable.[170] The fact that she offers medications in an unauthorized way contrary to the

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during bandaged condition and the doctor gave sedatives but never examined the hand to know the cause of the pain. After the splint and the bandages were removed, all four fingers were found to be stiff and he could not move his hand. Lord Denning L J held that "when hospital authorities undertook to treat a patient, and themselves select and appoint and employ the professional men and women who are to give the treatment, then they are responsible for the negligence of those persons in failing to give proper treatment, no matter whether they are doctors, surgeons, nurses, or anyone else….where the doctor or surgeon, be he a consultant or not, is employed and paid, not by the patient but by the hospital authorities, I am of the opinion that the hospital authorities are liable for his negligence in treating the patient. It does not depend on whatever the contract under which he was employed was a contract of service or a contract for services).

[168]Cassidy v. Ministry of Health [1951] 2 KB 343.

[169]PATRICIA STAUNTAON & MARY CHIARELLA, LAW FOR NURSES AND MIDWIVES 119 (Elsevier 2020).

[170]*Id.*

organization's policy does not allow the hospital to escape its liability.[171] It is also notable that whenever a nurse performs an unauthorized act and a patient suffers damage. It could be argued that she had gone outside the course and scope of employment, and the hospital could not be vicariously liable for the damage caused.[172] But this has exceptions in emergencies, wherein the hospital protocol authorizes nurses to save the patient from further medical complications.[173]

The liability of hospitals for the negligence of their staff was again mentioned in the case of *Roe* v. *Minister for Health.*[174] The court observed that

> *"…….the hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors but also for the anesthetists and surgeons. It does not matter whether they are permanent or temporary, resident or visiting, whole-time or part-time. The hospital authorities are responsible for all of them. The reason is that, even if they are not servants, they are the agents of the hospital to give the treatment. The only exception is the case of consultants or anesthetists selected and employed by the patient himself…."*[175]

Dulling v. *Bluefield Sanitarium,*[176]is another critical case where the court discussed the liability of the hospital for the negligence of nurses. In this case, the duty nurse failed to check and report the patient's deteriorating condition (even after repeated requests from the patient's mother), due to which

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[171] *Id.*
[172]*Id.* at 124.
[173]*Id.*
[174] Roe v. Minister for Health,[1954] 2 All ER 131.
[175] *Id.*
[176] Dulling v. Bluefield Sanitarium,142 S.E.2d 754 (W.Va.1965).

the patient died. Confirming the liability of the hospital, it is observed that "*a private hospital, conducted for profit, owes to its patient's such reasonable care and attention for their safety, mental and physical condition, if known, may require. The care to be exercised should be commensurate with the known inability of the patient to take care of himself*".[177]

6.5.2.3 Contractual Liability of Nursing Associations

Another notable point is the liability of the nursing association for negligence on the part of nurses, which they make available. *Hall and Wife* vs. *Lees,*[178] is an authoritative decision in this regard. It is held that the liability of the association that supplied nurses depends upon the terms and conditions of the contract which they entered into. In this case, a patient who took a nurse from a nursing association (to take care of her at home) was burnt by a hot-water bottle due to the nurse's negligence. The court discharged the association from its liability. It is held that the contract of association was merely to procure a duly qualified nurse; the nurse who was supplied by the association will work as if he was employed by the person who engaged her and not as the servants of the association.

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[177] *Id.*

[178] Hall and Wife vs. Lees and Others,[1904] 2 K.B.602.(In this case, the regulations provided for the exercise of certain supervision over the nurses by a superintendent appointed by the association, but , with regard to the work of a nurse while engaged in nursing a patient, it was provided that , while so engaged, she should not be absent herself from duty without the permission of the patient's friends, and that she should implicitly follow the instructions of the patient's medical man. A form , which was sent out by the association upon supplying nurses, indicated to the person applying for the nurse that, while engaged in nursing the patient, the nurse was to be regarded as employed by the person. While nursing the female plaintiff, an injury was occasioned due to the negligence of the nurses).

In *Lavelle* v. *Glasgow Royal Infirmary*, [179] the plaintiff was burned by the ultra-violet rays due to the nurse's negligence in allowing her to be exposed for forty-five minutes. The regular period was ten minutes. The court discharged the liability of the defenders (an infirmary that was engaged in charitable purposes). It held that the defenders did not treat the patients but merely procure them the services of persons of skill to give them treatment. "In most cases, the agency is an agent to find works for the nurses, which charges the patient a commission.[180] If engaged in such a way, a nurse should maintain their indemnity insurance policy-particularly if engaged to work in the patient's own home.[181] In such cases, the liability for a negligent act causing damage would rest with the nurse, who would pay any damage for which they may be found personally liable.[182] In such cases, nurses have to rely on professional indemnity insurance policies. This is not applicable in cases wherein agency nurses were employed by the hospital authorities to perform works unsupervised in an area in which the nurse was not competent to work, such cases, the hospital would be vicariously liable.[183]

[179] Lavelle v. Glasgow Royal Infirmary,1[932].S.C.245.
[180] PATRICIA STAUNTAON & MARY CHIARELLA, LAW FOR NURSES AND MIDWIVES119 (Elsevier 2020).
[181] *Id.*
[182] *Id.*
[183] *Id.*

6.6 Relevance for Insurance Protection for Nurses

It is always an erroneous belief that the doctrine of vicarious liability will absolve nurses from personal liability for negligence.[184] Nurses are personally liable for negligence caused while performing functions within their standard of practice. In those cases, nurses have to bear all the litigation costs and expenses personally. Malpractice Insurance Coverage affords protection to nurses in those cases to aid them to meet all the expenses.

The Health Practitioner Regulation National Law (NSW)[185] is a good example that mandates all health practitioners to take professional indemnity insurance if they wish to practice.[186] Physicians, nursing professionals, and other healthcare providers are included under it. It affords protection to healthcare professionals from civil and tortuous liabilities. However, disciplinary proceedings which are taken against nurses are outside the purview of insurance coverage. It covers matters which cover the payment of compensation to patients as a result of negligence on the part of the nurse.[187] It is also to be noted that the amount of coverage of insurance policies depends on

[184] JOSEPH T. CATALANO, NURSING NOW! TODAY'S ISSUES, TOMORROW'S TRENDS 201 (F.A Davis 2019)**;** George F. Indest III & Jason L. Harr, *Why Nurses Should Buy Malpractice Insurance*, HEALTH LAW FIRM (12 Mar. 2021), https://www.thehealthlawfirm.com/ resources/health-law-articles-and-documents/malpractice-insurance-for-nurses.html.

[185]The Health Practitioners Regulation National Law ,2009 Queensland No.86 , Parliamentary Counsel (12 Mar. 2021), https://www.legislation.qld.gov.au/view/pdf/inforce/ current/act-2009-hprnlq.

[186]The Health Practitioners Regulation National Law, 2009 Queensland No.86 , §129 (1) , Parliamentary Counsel Queensland (12 Mar. 2021), https://www.legislation.qld.gov.au/view/ pdf/inforce/current/act-2009-hprnlq. (It reads as "A registered health practitioner must not practice the health profession in which the practitioner is registered unless appropriate professional indemnity insurance arrangements are in force in relation to the practitioner's practice of the profession").

[187]AHPRA, PUBLIC CONSULTATION PAPER , NURSING AND MIDWIFERY BOARD OF AUSTRALIA (15 Jan. 2021,) https://silo.tips/download/public-consultation-paper.

the scope of their practice or the nature of the functions performed by nurses, more coverage for more risk attached to the work. The primary condition is that the nurse must have performed acts within their scope of employment and not under supervision.[188]

6.7 Liability for Medical Negligence in India

As far as India is concerned, the aspect of the personal liability of nurses is an area that is yet to develop. Most of the cases are filed against doctors and hospital authorities by invoking the vicarious liability principle. Only a few cases are filed against nurses.[189]However, a person can file suits against medical negligence under Civil law and Criminal law. Under civil law, the patient or his relatives can file a lawsuit in a civil court for compensation for the injury or death of the patient. It may arise either under the law of Tort or under 'Consumer Protection law in India'.[190]The same principles as stated

[188]*Id.*

[189]Sudhakar v. Gowri Gopal Hospital, 2004(1)CPJ 329(AP SCDRC).(A boy died due to wrong administration of injection by the staff nurse. The hospital, the nurse and the doctor was held liable for compensation). M.Jeeva v. R.Lalitha,1994(2) CPR 517(NC) (In this case, unskilled treatment of a high risk pregnancy at Jeeva Hospital at Tanjore Road near Tiruchirappalli in Tamil Nadu (1994), resulting in the death of the foetus). A M Mathew v. Director, Karuna Hospital,(1998(1) CPR 39 (Ker)(Partial disablement of leg, caused due to administration of injection by an unqualified nurse in 1995 at Karuna Hospital in Trivandrum). Harjot Ahluwalia (minor) through parents v. Spring Meadows Hospital,1997(3) CPR1 (NC) (The national commission for consumer disputes redressal commission upheld the liability of the hospital for the negligence of the nurse. In this case, the unqualified nurse administered wrong injection than that was prescribed by the doctor, thereby causing brain damage to the patient).

[190] An aggrrieved person can file a case against the medical practitioner and hospital. In *Indian Medical Association vs. V.P. Santha ,* the Hon'ble Supreme Court observed that the medical practitioners are covered under the Consumer Protection Act, 1986 and the medical services rendered by them should be treated as services under §2(1) (o) of the Consumer Protection Act, 1986. Similarly under the new Consumer Protection Act, 2019, the medical services shall fall under the ambit of services as mentioned in §2(42) of the new Act. Any matter in medical negligence on the part of the service provider will be considered as

above, such as the reasonable care test and the standard, apply in the case of tort law. The reasonable care test as founded by Justice Mc. Nair in Bolam test is accepted in India by the Court in *Dr. Lakshman Balkrishna Joshi* v. *Trimbak Bapu Godbole.*[191] In this case, the court again held that whoever gives medical advice is expected to have the required skill and knowledge and must exercise a reasonable degree of care as per the situation of the case.

In *Jacob Mathew* v. *State of Punjab,*[192] Court reaffirmed the reasonable care and standard test. It is observed that non-compliance of requisite skill and care principles by a professional will lead to negligence.

Indian Medical Association v. *V.P.Shantha,*[193] is the first case in which the court extended the application of consumer protection law for fixing the liability for medical negligence. It is held that service rendered to a patient by a medical practitioner (also where doctor renders service free of charge or under a contract of service) by way of consultation, diagnosis, and treatment, both medical and surgical, would fall within the ambit of the definition of 'service' under the Consumer Protection Act.

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deficiency under §42(11) of the new Consumer Protection Act, 2019.Any aggrieved person can claim damages for medical negligence against a doctor or a hospital. §69(1) of the Consumer Protection Act, 2019 lays down the time limit within which a complaint for medical negligence must be filed as 2 years from the date of injury).

[191] Dr. Lakshman Balkrishna Joshi v. Trimbak Bapu Godbole, 1969, AIR 128, at 131, 132.

[192] Jacob Mathew v. State of Punjab, 2005 (6) SCC 10.(It is held that "……..a professional may be held liable for negligence on one of two findings either he was not possessed of the requisite skill which he professed to have possessed, or, he did not exercise, with reasonable competence in the given case, the skill which he did possess….the standard to be applied for judging, whether the person to be charged has been negligent or not, would be that of an ordinary competent person exercising ordinary skill in that profession").

[193] Indian Medical Association v. V.P.Shantha 1995(6) SCC 651.(On issue whether a medical practitioner can be regarded as rendering 'service' under §2 (1)(o) of the Consumer Protection Act, 1986).

The majority of the decisions in India discuss the liability of doctors in medical negligence. However, these principles can be applied to nurses as they are also expected to care for the patent with reasonable care and diligence. In *Achutrao Haribhau Khodwa* vs. *State Of Maharashtra,*[194] the court again retreated M P Shantha's case. It is held that medical practitioners are required to perform their duties with due care and must act according to acceptable standards of the medical profession.

Dr. Balram Prasad v. *Dr. Kunal Saha,*[195]is another vital case wherein the Supreme court of India has again reiterated the right to health as a fundamental right under Article 21 of the Constitution. Fixing an amount of ten lakhs rupees as compensation, the court upheld the rights of the patients to be treated with dignity and the duty of the doctors on upholding it.

In *Maharaja Agrasen Hospital* v. *Rishabh Sharma,*[196]the Supreme Court, held the hospital vicariously liable for the negligence of its doctors. Hospitals are vicariously liable for those negligent actions carried by staff nurses within the scope of the hospital's authority, and harm occurs to patients. Regarding the vicarious liability of hospitals, it is held that the hospital is vicariously liable for the negligence acts of the doctors who are working under

[194]Achutrao Haribhau Khodwa vs. State Of Maharashtra And Ors, 1996 SCC(2)634.
[195]Dr. Balram Prasad v. Dr. Kunal Saha and Ors, (2014)1SCC 384.
[196] Maharaja Agrasen Hospital and Ors. vs. Rishabh Sharma and Ors. (16.12.2019 - SC): MANU/SC/1749/2019.

its contract of employment.[197] The hospital is expected to take proper care while delivering healthcare.

As far as criminal law in India is concerned, 'all rash or negligent acts endangering the life or personal safety are made punishable'.[198] All those acts that cause 'hurt or grievous hurt to the life or personal safety come under it.[199] It also covers those acts, where 'death of a person is caused due to rash or negligent act not amounting to culpable homicide'.[200] However, 'acts done in good faith with consent for a person's benefit',[201]are done in good faith for the benefit of a person without consent. Communication made in good faith is outside the purview of criminal negligence. The court has explained the degree

[197] *I d.* at Para 11.4.17.

[198] Indian Penal Code, 1860 No. 45, § 336, British India (1860). (It reads as "Acts endangering life or personal safety of others.—Whoever does any act so rashly or negligently as to endanger human life or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to three months or with fine which may extend to two hundred and fifty rupees, or with both".)

[199] Indian Penal Code, 1860 No. 45, § 337, British India (1860). (It reads as "Causing hurt by act endangering life or personal safety of others.—Whoever causes hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine which may extend to five hundred rupees, or with both"; *See* also §338IPC. (It reads as Causing grievous hurt by act endangering life or personal safety of others. Whoever causes grievous hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine which may extend to one thousand rupees, or with both).

[200] Indian Penal Code, 1860 No. 45, § 304A, British India (1860). (It reads as "Causing death by negligence- Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both).

[201] Indian Penal Code, 1860 No. 45, § 88, British India (1860). (It reads as "Act not intended to cause death, done by consent in good faith for person's benefit.— Nothing, which is not intended to cause death, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied, to suffer that harm, or to take the risk of that harm"…Illustration A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under the painful complaint, but not intending to cause Z's death, and intending, in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence).

of negligence under criminal and civil law in *Dr. Suresh Gupta* v. *Government of NCT of Delhi*. [202] It is that an act can be as a criminal only when there is 'gross lack of competence or inaction' on the part of the medical professional.

Thus, all these principles of medical negligence as applied to doctors apply to nurses also. Even though they can claim exceptions under vicarious liability principles for those actions within the scope of employment, they can be made personally liable for all those actions within the nursing standard of practice or care.

6.8 Conclusion

So far as the negligence of nurses is concerned, nurses are treated in same line with doctors. All the aspects of professional negligence applicable to them are extended to nurses also. But the problem in India is the absence of a prescribed standard of practice for nurses. The legislative framework in India lacks a definite standard of practice that is to be followed by nurses. The lack of role description of nurses and standard of practice usually ousts nurses from liability for medical negligence.

The National Accreditation Board for Hospitals and Healthcare Providers (NABH) has issued standards for nursing professions working within the organizational setup.[203] However, compliance with these Standards is made

[202] Dr. Suresh Gupta v. Government of NCT of Delhi, AIR(2004) SC 4091 at 4095.

[203] STANDARDS OF NURSING EXCELLENCE, NATIONAL ACCREDITATION BOARD FOR HOSPITALS AND HEALTH CARE PROVIDERS (12 Jun. 2021), https://nabh.co/NABH Standards.aspx. (Standard 1 Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation. Standard 2. Diagnosis The registered nurse analyzes the assessment data to determine actual or potential diagnoses, problems, and

mandatory only for every healthcare organization for getting accreditation.[204] It is to be noted that out of the total number of 69,265 Hospitals in India (including the States and Union Territories),[205]only 798 hospitals are accredited with NABH.[206] In contrast, in the State of Kerala, out of 3,342 Hospitals, only 56 hospitals are accredited with NABH. Though these standards are framed to ensure quality patient care, most staff nurses (who are working in the healthcare institutions having NABH accreditation) raised their concern of having overburdened with paper (clerical) works which in turn reduces quality time spent on patient care. Lack of sufficient staff (human resources) is pointed out to be a significant issue that hinders the proper implementation of these standards.

Further, fixing the standard of practice of nurses will also help nurses to identify their functions and save them from unnecessary tasks which are

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issues. Standard 3. Outcomes Identification The registered nurse identifies expected outcomes for a plan individualized to the healthcare consumer or the situation. Standard 4. Planning The registered nurse develops a plan that prescribes strategies to attain expected, measurable outcomes. Standard 5. Implementation The registered nurse implements the identified plan. Standard 5A. Coordination of Care The registered nurse coordinates care delivery. Standard 5B. Health Teaching and Health Promotion The registered nurse employs strategies to promote health and a safe environment. Standard 6. Evaluation The registered nurse evaluates progress toward attainment of goals and outcomes).

[204] NABH guidelines are optional. It is mandatory only for getting accreditation purpose.

[205] Geetanjali Kapoor Aditi Sriram Jyoti Joshi Arindam Nandi Ramanan. Laxminarayan *Covid-19 in India : State-Wise Estimates of Current Hospital Beds , ICU Beds, and Ventilators*, CENTRE FOR DISEASE CENTER FOR DISEASE DYNAMICS, ECONOMICS & POLICY, (June 12, 2021), https://cddep.org/publications/covid-19-in-india-state-wise-estimates_ of-current-hospital-beds-icu-beds-and-ventilators/.(In Kerala there are 1,280 number of hospitals in the public sector and 2,062 number of hospitals in the private sector, thus 3,342 hospitals).

[206]NATIONAL ACCREDITATION BOARD FOR HOSPITAL AND HEALTH CARE PROVIDERS, ACCREDITED HOSPITALS IN STATE OF KERALA
(12 Jun. 2021), https://www.nabh.co/frm ViewAccreditedHosp.aspx,ventilators_24Apr 2020.pdf.

outside their purview.[207] The need is felt to have proper legislation concerning fixing the liability of nurses as they have become one of the prominent sectors of the health care industry in India.

Though the code of ethics drafted by the International Council of Nurses reflects the importance of ethical behavior in nursing, it lacks enforceability. No action is taken in cases where the code is disregarded. Personal interviews conducted by the researcher reveals that a majority of the staff nurses are unaware of the code and its principles.

It is also a fact that most medical negligence cases against nurses go unreported or is settled indoors by the hospital authorities. Though in some cases, disciplinary proceedings in the form of dismissals from the hospitals (or termination of the contract of employment) are inflicted, still, the real incident goes unreported in the public domain.

Another aspect is the inclusion of provisions dealing with the assessment and monitoring of nurses. The State Nursing Council must review the performance of nurses, and actions shall be taken against those who act unethically. The employment of unqualified and unregistered persons as nurses is another issue that points to the need for regulation of private hospitals. Employing unqualified and unregistered persons as nurses for redressing the staff shortage will have an adverse effect on the integrity of the nursing profession as well as quality of care.

[207] From personal interview conducted by the researcher, it is found that most of the staff nurses are overburdened with non-nursing functions which are not directly connected with patient care.

Staff shortage is another vital issue that often leads to issues of negligence by nurses. Personal interviews with staff nurses reveals incidents of negligence committed by staff nurses due to job-related stress and overload work. Thus, only through a proper regulatory framework for reviewing and monitoring the hospitals, the nursing staff can make the health system function smoothly and accountably, ensuring quality health care.

CHAPTER VII

REGULATION OF NURSING PROFESSION IN INDIA

Conceive and claim a world in which regulation, as positively defined, is a powerful instrument for the good of nursing and health visiting-the world of the twenty-first Century. This is the vision! And this is the challenge.[1]

Introduction

Promoting safety of public and maintaining discipline or accountability of the profession are the two primary goals of all regulations. It can be considered as one of the best means to ensure professional accountability and standards of practice. The International Council of Nursing defines regulation as "all of those legitimate and appropriate means governmental, professional, private and individual whereby order, identity, consistency, and control are brought to the profession".[2] It includes powers such as regulating the entry to practice and the power to ensure that practitioners conform to a standard of practice responsibly.[3]

In India, the standards of education and practice of nurses are regulated by the central law and the state enactments. The constitution of the Nursing Council at the Central and State level is the primary aim of both these legislations. Compared to the central Act, the state laws provide detailed

[1] WORLD HEALTH ORGANIZATION, NURSING AND MIDWIFERY: A GUIDE TO PROFESSIONAL REGULATION (*2* June 2020), *applications.emro.who.int/dsaf/dsa189.pdf* .
[2] *Id.*
[3] TRACEY L. ADAMS, REGULATING PROFESSIONS: THE EMERGENCE OF PROFESSION SELF-REGULATION IN FOUR CANADIAN PROVINCE 6 (University of Toronto Press 2018).

accounts on the standards of practice. The chapter analyses the regulatory framework of the nursing profession in India. The role and functions of the Nursing Councils are analyzed to know how far they are empowered to regulate the standard of practice of nurses and take disciplinary actions in cases they adhere to unethical standards of practice.

7.1 Legislative Framework in India

Under the constitution of India, only States have the exclusive jurisdiction to enact a law on matters like "public health, sanitation, hospitals, and dispensaries."[4] However, the Central government is empowered to legislate in technical education, medical education, and other professions that come under the concurrent list of the constitution.[5] In India, nurses' standards of practice and education are dealt with by two sources such as the central legislation and state enactments.

7.1.1 Central law

The Central legislation titled the Indian Nursing Council Act, 1947 is mainly concerned with the constitution of an Indian Nursing Council to establish a uniform standard of training for nurses, midwives, and health visitors.[6]The Central Government is authorized to constitute the Indian Nursing Council consisting of three members such as ex-officio, elected, and nominated

[4] INDIA CONST. Sch.vii, List ii, Item 6.
[5] INDIA CONST. Sch.vii, List iii, Item 25 & 26.
[6]The Indian Nursing Council Act, 1947, No.48, Act of Parliament (India). It was passed by an ordinance on 31 Dec.1947 (10 Aug. 2016), https://www. Indiannursing council.org/ pdf/inc-act-1947.pdf.

members.[7] The ex-officio members consist of the Director-General of Health Services; the Chief Principal Matron, Medical Directorate; the Chief Nursing Superintendent office of the Director-General of Health Services; the Director of Maternity and Child Welfare, Indian Red Cross Society; the Chief Administrative Medical Officer of each State, and the Superintendent of Nursing services from each of the States mentioned the Act.

Elected members include representatives from the State Nursing Council (a nurse and a midwife or auxiliary nurse-midwife who is registered in the State register; heads of institutions (two members) imparting training to nurses and health visitors (one member) (for obtaining a university degree in nursing or respect of a post-certificate course in the teaching of nursing and nursing administration recognized by the Council); Medical Council of India (one member elected); Indian Medical Association(one member from the Central council); Trained Nurses Association of India (one member elected by its council); and members elected by the Parliament (two members from Lok Sabha and one from Rajya Sabha). Apart from this member, the Act empowers the Central Government to nominate four members from amongst the nurses, midwives, or health visitors enrolled in the State register and an experienced educationalist.

The President of the council shall be elected by the members of the council from themselves.[8] The election to the councils will be conducted as per

[7] The Indian Nursing Council Act, 1947, No.48, §3, Act of Parliament (India).
[8] The Indian Nursing Council Act, 1947, No.48, §3 (2), Act of Parliament (India).

the rules made by the central and state governments.[9] The elected or nominated members hold the office for a term of five years.[10] The Act empowers the Indian Nursing Council to be a body corporate having perpetual succession and a common seal, acquiring property both movable and immovable.[11]

As mentioned earlier, recognizing qualifications for practice as nurses, midwives, and health visitors is the primary function of the council functioning at the central level. The Act provides for the maintenance of an Indian Nurses Registrar containing the names of nurses, midwives, auxiliary nurse-midwives, and health visitors who are enrolled on any state register by the Council.[12] There is also mention regarding the duty of the Secretary of the Council to keep the Indian Nurses Register following the provisions of the Act, to revise and publish it in the Gazette of India.[13] Even though the Act was amended in 1957, it does not expand the scope of the Act.[14] The latest amendment to the Act was made in 2006, whereby qualified nurses from privately recognized nursing institutions were permitted employment in government hospitals.[15] The Act failed to go beyond the formality of registration.[16] It does not deal with disciplinary proceedings for misconduct on the part of the nurses.[17] Explanations as to the duties and responsibilities of nurses are absent in this

[9] The Indian Nursing Council Act, 1947, No.48, §5, Act of Parliament (India).
[10]The Indian Nursing Council Act, 1947, No.48, §6, Act of Parliament (India).
[11] The Indian Nursing Council Act, 1947, No.48, §4, Act of Parliament (India).
[12]The Indian Nursing Council Act, 1947, No.48, §15 A, Act of Parliament (India).
[13] The Indian Nursing Council Act, 1947, No.48, §15 A (2), Act of Parliament (India).
[14]The Indian Nursing Council Act, 1947, No.48, §11(2), Act of Parliament (India).
[15]The Indian Nursing Council Act, 1947, No.48, §3, Act of Parliament (India) Amendment Bill, 2016 (Aug. 20, 2018),http://164.100.24.219/BillsTexts/RSBillTexts/AsIntroduced/LXXIX_2006.pdf.
[16] P M Bakshi, *Nurses and the Law*, 36 JILI 288, 285-291(1994).
[17]*Id.*

Act. The Act also fails to prohibit the practice of nursing by unregistered persons.[18]

7.1.2 State laws

As stated above, in India, the States have the exclusive jurisdiction to enact legislation regulating the standard of practice of the nursing profession. Compared to the Central Act, state law covers a broader area about the regulation of standard of nursing practice such as the constitution of State Nursing Council in the respective states, mandatory registration of nurses, grounds for taking disciplinary actions against professional misconduct, prohibition of acts which are against the obligatory rule of registration for practice.

A historical insight into the state nursing councils in India reveals that the first step towards the establishment of registration councils was taken in Bombay, wherein July 1903, the surgeon-general with the government of Bombay put up approval to his government for the establishment of nursing service, nursing reserve and for the appointment of an experienced nurse to be at the head of the service and respond to the surgeon-general.[19] Even though the proposal was not accepted for a long time, it finally led to the establishment of the Bombay Presidency Nursing Association in December 1909.[20]

[18] *Id.*
[19] NAVDEEP KAUR BRAR & H C RAWAT, TEXTBOOK OF ADVANCED NURSING PRACTICE 37 (Jaypee Bothers Medical Publishers 2015).
[20] *Id.*

The first state registration council was passed in 1926 by enacting the Madras Nurses and Midwives Act.[21] Later, other states enacted their legislation. It is noteworthy that some states in India, such as Andhra Pradesh and Telangana;[22] Jharkhand and Bihar;[23] Madhya Pradesh and Chhattisgarh;[24] Uttar Pradesh and Uttarakhand;[25] shares the same legislation. Currently, all the states (except the State of Nagaland, where the Nursing Council Bill, 2019 is pending) have their law to regulate the standard of practice of the nursing profession.[26]

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[21] Suresh K Sharma, *Nursing Practice Act : Current Scenario and Future Needs of India*, 108 NJI 250-166 (2017).

[22] Andhra Pradesh Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §10 (1), No.III, Acts of Andhra Pradesh State Legislature, 1926, (India). (In force in the combined State, as on 02.06.2014, has been adapted to the State of Telangana, under the Andhra Pradesh Reorganization Act, 2014 (Central Act 6 of 2014) Vide. The Notification issued in G.O.Ms.No.80, Health, Medical and Family Welfare Department (F1) Department, dated 26.09.2015).

[23] The Jharkhand Nurses were registered under the Bihar and Orissa Nurses Registration Act, 1953, §2(f), No.1, Acts of Bihar State Legislature 1953 (India).

[24] The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972, §3(2), No.46, Acts of Chattisgarh Legislative Assembly, 1972(India). (It reads as "…The Council shall be a body corporate by the name of the Madhya Pradesh Nurses Registration Council…").

[25] UTTAR PRADESH NURSING COUNCIL, Notification No.1520/M-2-200/2002, dated 7 Nov. 2002(2 Mar. 2019), https://www.upnursescouncil.org/Static/Act.aspx. (It states that …"AND, WHEREAS, Rules framed by the Uttar Pradesh State Government under sub-section (2) of § 33 of the Nurses, Midwives, Assistant Midwives (Auxiliary Nurses Midwives) and Health Visitors Registration Act, 1934 (U.P Act XV of 1934) , is in force in the State of Uttaranchal under § 86 of the Uttar Pradesh Reorganization Act, 2000.
Now, THEREFORE, in exercise of the powers conferred under §87of Uttar Pradesh Reorganization Act, 2000(Act no. 29 of 2000), the Governor is pleased to direct that the Rules framed by the U.P State Government under sub-section (2)of §33 of the Nurses, Midwives, Assistant Midwives (Auxiliary Nurses Midwives) and Health Visitors Registration Act, 1934 (U.P. Act XV of 1934), shall have applicability to the State of Uttaranchal subject to the provisions of the following order.
UTTARANCHAL [RULES FRAMED BY THE U.P STATE GOVERNMENT UNDER SUB-SECTION (2) OF § 33 OF THE NURSES, MIDWIVES, ASSISTANT MIDWIVES (AUXILIARY NURSES MIDWIVES) AND HEALTH VISITORS REGISTRATION ACT, 1934 (U.P ACT XV OF 19340] ADAPTATION AND MODIFICATION ORDER, 2002").

[26] Andhra Pradesh Nurses, Midwives , Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §10 (1), No.III, Acts of Andhra Pradesh State Legislature, 1926(India); Arunachal Pradesh Nursing Council Act, 2011, § 23, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011(India);The Assam Nurses, Midwives, Health Visitors Registration Act,

Moreover, it is notable that among the union territories except the National Capital Territory of Delhi, all others share nursing councils of other states. Union Territories of India such as Puducherry and Andaman & Nicobar share the common council with Tami Nadu, Chandigarh, and Jammu Kashmir with Punjab Nursing Council, Daman, and Diu & Nagar Haveli, and Daman & Diu with Gujarat Nursing Council. Among them, the Union Territory of Delhi

1944, Act No.2, Legislative Assembly of Assam,1944(India); Bengal Nurses Act, 1934,§ 27, No.10, Acts of Bengal State Legisltaure,1926 (India);The Bihar and Orissa Nurses Registration Act, 1953, No.1, Acts of Bihar State Lgisltaure,1953 (India); The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam,1972,No.46, Acts of Chattisgarh Legislative Assembly, 1972(India); Goa Nursing Council Act, 2012, No.28, Acts of Goa State Legislature, 2014 (India); Gujarat Nurse, Midwives and Health Visitors Act, 1968, No.24, Acts of Gujarat State Legislature, 1968 (India); Haryana Nurses and Nurse-Midwives Act, 2017, §31, No.3, Acts of Haryana State Legislature, 2017(India); The Himachal Pradesh Nurses Registration Act, 1977,No.15,Acts of Himachal Pradesh Legislative Assembly, 1977 (India); Jammu and Kashmir Nursing Council Act, 2012, No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India); Karnataka Nurses, Midwives and Health Visitors Act, 1961, No.4, Acts of Karnataka Legislative Assembly, 1961(India);Madhya Pradesh Upcharika,Prasavika,Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam,No.46,Acts of Madhya Pradesh Legislative Assembly, 1972(India); The Kerala State Nursing Council Act, 1953, No.X, Acts of Kerala State Legislative Assembly, 1953(India); Maharashtra Nurses Act, 1966, §28 (1), No. 40, Acts of Maharashtra State Legislative Assembly, 1966(India); Manipur Nursing Council Act, 2005,§3, Acts of Manipur State Legislative Assembly, 2005(India); Meghalaya Nursing Council Act, 1992,§ 14, No.5, Acts of Meghalaya State Legislative Assembly, 1992(India);The Mizoram Nursing Registration Act, 1990(India);Odisha Nurses and Midwives Registration Act, 1938, Acts of Odisha State Legislative Assembly, 1938(India); The Punjab Nurses Registration Act, 1932 (as amended on 2006) (India); Rajasthan Nurses, Midwives , Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964, No.15, Acts of Rajasthan State Legislative Assembly, 1964(India); Sikkim Nurses, Midwives and Health Visitors Act, 2008, §20 (1),No.4,Sikkim State Legislative Assembly, 2008(India); The Tamil Nadu Nurses and Midwives Act, 1926, No.3, Acts of Tamil Naidu State Legislative Assembly, 1926(India); Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act,1926,§14,No.3,Acts of Telangana State Legislative Assembly, 1926(India);Tripura Nursing Council Act, 1986,No.13, Acts of Tripura Legislative Assembly, 1986(India);The Uttar Pradesh Nurses, Midwives Assistant Midwives (Auxiliary, Nurse-Midwives) and Health Visitors Registration Act, 1934, No.XV, Acts of UP State Legislative Assembly, 1934(India).

and Jammu Kashmir have their legislations governing the regulation of nurses.[27]

7.1.2.1 Definition of Nurse

The first and the central part which clarifies the intention of the legislature is the definition part. The extended scope of the practice, the required qualifications, and the categories of persons to whom it applies are mentioned in it. As far as state legislations are concerned, there is no uniformity in the term 'Nurse'. When some states define 'nurses' in terms of the educational qualifications from any institutions recognized by the Council,[28] others describe them as inclusive of various other categories of persons such as an auxiliary nurse, dais, public health nurses, midwife, auxiliary nurse-midwives, and health visitor.[29] A gender-based definition of the nurse as inclusive of their male counterparts can also be found in some state laws.[30]

[27] The Delhi Nursing Council Act, 1997, No.3,Delhi State Legislative Assembly, 1997(India); Jammu and Kashmir Nursing Council Act, 2012, No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India).

[28] The Bihar and Orissa Nurses Registration Act, 1953,§2(f),No.1,Acts of Bihar State Legisltaure,1953 (India); Goa Nursing Council (Amendment) Act, 2014,§2 (k), No.23, Acts of Goa State Legislature, 2014 (India); Himachal Pradesh Nurses Registration Act, 1977, §2(g),No.15,Acts of Himachal Pradesh Legislative Assembly,1977(India); Punjab Nurses Registration Act, 1932, ,§2(e),No16,Acts of Punjab State Legislature (India);Sikkim Nurses, Midwives and Health Visitors Act, 2008, §20 (l) ,No. 4, Sikkim State Legislative Assembly, 2008(India); Karnataka Nurses, Midwives and Health Visitors Act, 1961,§ 2(k), No.4, Acts of Karnataka Legislative Assembly, 1961(India); Rajasthan Nurses, Midwives , Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964, Proviso to §2(e), No.15, Acts of Rajasthan State Legislative Assembly, 1964(India); Manipur Nursing Council Act, 2005,§2 (10), Acts of Manipur State Legislative Assembly, 2005(India);Haryana Nurses and Nurse-Midwives Act, 2017,§2(f),No.3, Acts of Haryana State Legislature, 2017(India);Goa Nursing Council (Amendment) Act,2014,§2,No.23,Acts of Goa State Legislature,2014 (India); Odisha Nurses and Midwives Registration Act, 1938, §2(f), Acts of Odisha State Legislative Assembly, 1938(India).

Most of the definitions are not clear as to the role and functions of nurses. A perusal of the various state laws shows that nurses are explained only in terms of their educational qualifications without defining their functions or role. Except, the Arunachal Pradesh Nursing Council Act, 2011, all the other state legislations lack clarity regarding the definition of the role and boundaries of practice they have to perform.[31] The State of Arunachal Pradesh law specifically points out the boundaries within which each category of nurses carries out their functions. For example, the Act classifies an "Auxiliary-Nurse-cum-Midwives" with that of the Female Health Workers or Auxiliary Nurse-cum-Midwives in the Health Centre of the community having qualified for training in two years courses of Auxiliary Nurse-cum- Midwife with

[29] Meghalaya Nursing Council Act, 1992, §2(d),No.5, Acts of Meghalaya State Legislative Assembly, 1992(India); Manipur Nursing Council Act, 2005,§2(g),Acts of Manipur State Legislative Assembly, 2005(India).

[30] Andhra Pradesh Nurses, Midwives , Auxiliary Nurse-Midwives and Health Visitors Act, 1926,§1(c), No.III, Acts of Andhra Pradesh State Legislature, 1926(India); The Assam Nurses, Midwives, Health Visitors Registration Act, 1944, Act No.2, §2 (f) Legislative Assembly of Assam(1944); The Jharkhand Nurses were registered under the Bihar and Orissa Nurses Registration Act, 1953, §2(f), No.1, Acts of Bihar State Legislature 1953 (India).

[30] The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972, §3(2), No.46, Acts of Chattisgarh Legislative Assembly, 1972(India);Gujarat Nurse, Midwives and Health Visitors Act, 1968,§ 2(j), No.24, Acts of Gujarat State Legislature, 1968 (India);Haryana Nurses and Nurse-Midwives Act, 2017, §2(f), No.3, Acts of Haryana State Legislature, 2017(India);Madhya Pradesh Upcharika,Prasavika,Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, §16(2), No.46, Acts of Madhya Pradesh Legislative Assembly, 1972; The Tamil Nadu Nurses and Midwives Act, 1926,§2(c),No.3,Acts of Tamil Naidu State Legislative Assembly, 1926;Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §1(c), No.3, Acts of Telangana State Legislative Assembly, 1926.

[31]Arunachal Pradesh Nursing Council Act, 2011, §2(f), No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011.

essential qualification of All India Secondary School Examination (AISSE) or equivalent.[32]

Similarly, the Act defines “Health Visitors” as a person employed as Lady Health Visitors after completing two years Lady Health Visitors Course or Auxiliary Nurse-Cum- Midwives with Lady Health Visitor training with a minimum qualification of All India Secondary School Examination (AISSE) or equivalent.[33] They shall be employed as Supervisors in the Main-Centre / Primary Health Centre. They shall be responsible for the supervision of Female Health Workers /Auxiliary Nurse-cum-Midwives of the Sub-Centre within the jurisdiction of the main concerned centre.[34] Like-wise, a “Health worker” (Female)' is defined as a person employed to perform the duties of Female Health Worker after successfully completing one and half year training course of Health Worker with minimum qualification of Secondary School Leaving Certificate or equivalent. They shall be employed as Female Health Workers in the Sub-Centre.[35]

Similarly, a "Nurse-Midwife" is described as a person appointed to perform the duties of a Nurse Midwife who has completed six months duration of a Midwifery course after completing the prescribed Nursing Course. They

[32] Arunachal Pradesh Nursing Council Act, 2011,§2(b),No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011.
[33] Arunachal Pradesh Nursing Council Act, 2011, §2 (b),No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011.
[34] Arunachal Pradesh Nursing Council Act, 2011,§2(d),No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011.
[35] Arunachal Pradesh Nursing Council Act, 2011,§2(e),No.1, Acts of Arunachal Pradesh .State Legislative Assembly, 2011.

shall be eligible for employment as Staff Nurse.[36] Thus the Act expressly mentions the role and jurisdiction of each category of nurses.

The table below points out various definitions used in the state legislations to define the term 'nurse' .

Name of the State Legislation	Definition of Nurse
Arunachal Pradesh Nursing Council Act, 2011	Nurse means persons (male and female) appointed to perform the duties of a nurse who have completed a Nursing Course of three years or above with minimum qualifications of Higher Secondary School Leaving Certificate, All India Higher Secondary Certificate Examination, or equivalent. They shall be eligible for employment to various nursing posts.[37]
Assam Nurses, Midwives, Health Visitors Registration At, 1944	The nurse includes a male nurse.[38]
Bihar and Orissa Nurses Registration Act, 1953	A nurse means a person who holds a certificate in nursing from any institution recognized on this behalf by the State Government.[39]
Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972	The nurse includes a male nurse.[40]
Delhi Nursing Council Act, 1997	Nurse means a person who possesses a certificate in nursing and midwifery from any institution

[36]Arunachal Pradesh Nursing Council Act, 2011,§2(g), No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011.
[37] Arunachal Pradesh Nursing Council Act, 2011, §2(g), No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011.
[38] The Assam Nurses, Midwives, Health Visitors Registration At, 1944,§2(f),Act No.2, Legislative Assembly of Assam(1944).
[39] The Bihar and Orissa Nurses Registration Act, 1953, §2(f), No.1,Acts of Bihar State Legisltaure,1953 (India).
[40] The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam,1972,§2(b),No.46, Acts of Chhattisgarh Legislative Assembly, 1972.

	recognized on this behalf and registered with the Council.[41]
Goa Nursing Council (Amendment) Act, 2014	Nurse means a person possessing- a) A Bachelor's Degree in Nursing; b) A Diploma in General Nursing and Midwifery; or c) A Diploma in General Nursing and such other qualifications as may be recognized by the Indian Nursing Council instead of Midwifery; or Such other equivalent qualifications as may be recognized by the Indian Nursing Council, from a recognized university/Institution.[42]
Gujarat Nurse, Midwives and Health Visitors Act, 1968	The nurse includes a male nurse and an auxiliary nurse.[43]
Haryana Nurses and Nurse-Midwives Act, 2017	A nurse means a person who holds a certificate in nursing granted by an institution and shall include a male nurse.[44]
Himachal Pradesh Nurses Registration Act, 1977	Nurse means a person who holds a certificate in nursing from any institution recognized on this behalf by the Council or one who has been registered under the Act.[45]

[41] Delhi Nursing Council Act, 1997, §2(k),No.3,Delhi State Legislative Assembly, 1997.
[42] Goa Nursing Council (Amendment) Act, 2014,§2(k), No.23, Acts of Goa State Legislature, 2014 (India).
[43] Gujarat Nurse, Midwives and Health Visitors Act,1968,§18 (1), No.24, Acts of Gujarat State Legislature, 1968 (India).
[44] Haryana Nurses and Nurse-Midwives Act,2017,§2(f),No.3, Acts of Haryana State Legislature, 2017 (India).
[45] Himachal Pradesh Nurses Registration Act, 1977, §2(g),No.15, Acts of Himachal Pradesh State Legislature, 1977 (India).

Jammu and Kashmir Nursing Council Act, 2012	The nurse includes male nurse.[46]
Bihar and Orissa Nurses Registration Act, 1953	A nurse means a person who holds a certificate in nursing from any institution recognized on this behalf by the State Government.[47]
Karnataka Nurses, Midwives and Health Visitors Act, 1961	A nurse means a person who holds a certificate in nursing from any institution recognized on this behalf by the Council.[48]
Kerala State Nursing Council Act, 1953	The nurse includes a male nurse.[49]
Madhya Pradesh Upcharika, Prasavika, Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972	The nurse includes a male nurse.[50]
Maharashtra Nurses Act, 1966,	The nurse includes male nurses, auxiliary nurses, public health nurses, midwives, auxiliary nurse-midwife, and health visitor[51]
Manipur Nursing Council Act, 2005	Nurse means a person who possesses a certificate in Nursing and Midwifery from an Institution recognized for the purpose and registered[52]

[46] Jammu and Kashmir Nursing Council Act, 2012, §2(f), No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India).
[47] The Bihar and Orissa Nurses Registration Act, 1953, §2(f),No.1, Acts of Bihar State LEgisltaure,1953 (India).
[48]Karnataka Nurses, Midwives and Health Visitors Act, 1961,§2(k), No.4, Acts of Karnataka Legislative Assembly, 1961.
[49] The Kerala State Nursing Council Act, 1953, §2(d),No.X, Acts of Kerala State Legislative Assembly, 1953.
[50] Madhya Pradesh Upcharika, Prasavika, Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam,§2(b),No.46, Acts of Madhya Pradesh Legislative Assembly, 1972.
[51] Maharashtra Nurses Act, 1966, §2(k),No.40,Acts of Maharashtra State Legislative Assembly, 1966.
[52] Manipur Nursing Council Act, 2005,§2(x),Acts of Manipur State Legislative Assembly, 2005.

Meghalaya Nursing Council Act, 1992	The nurse includes a general nurse in auxiliary nurse midwife and a health worker[53]
Odisha Nurses and Midwives Registration Act, 1938	Nurses mean a person who holds a certificate in nursing from any institution recognized on this behalf by the Provincial Government[54]
Punjab Nurses Registration Act, 1932	A nurse means a person who holds a certificate in nursing from any institution recognized on this behalf by the Council or one who has been recognized under the Act[55]
Rajasthan Nurses, Midwives , Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964	A nurse means a person who holds a certificate in nursing granted by any authority recognized on this behalf by the Council [56]
Sikkim Nurses, Midwives and Health Visitors Act, 2008	A nurse means a person who holds a certificate/diploma/degree in nursing from any institution recognized on this behalf by the council[57]
Tamil Nadu Nurses and Midwives Act, 1926	Nurse means a male nurse[58]
Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926	The nurse includes a male nurse[59]
Tripura Nursing Council Act, 1986	"Registered Nurse or Midwives or

[53] Meghalaya Nursing Council Act, 1992,§2(d),No.5, Acts of Meghalaya State Legislative Assembly, 1992.
[54] Odisha Nurses and Midwives Registration Act,1938,§2(f), Acts of Odisha State Legislative Assembly, 1938.
[55] Punjab Nurses Registration Act, 1932, §17, No.15, Acts of Punjab State Legislature, 1932.
[56] Rajasthan Nurses, Midwives, Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964, §2(e), No.15, Acts of Rajasthan State Legislative Assembly, 1964.
[57]Sikkim Nurses, Midwives and Health Visitors Act, 2008,§2(k),No.4, Sikkim State Legislative Assembly, 2008.
[58]The Tamil Nadu Nurses and Midwives Act, 1926,§2(c),No.3, Acts of Tamil Naidu State Legislative Assembly, 1926.
[59] Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §2(c), No.3, Acts of Telangana State Legislative Assembly, 1926.

	Multipurpose Worker (Female) or Multipurpose Supervisor (Female) or Health Visitor" means a Nurse or Midwife or Multipurpose Worker (Female) or Multipurpose Supervisor (Female) or Health Visitor registered under the provisions of this Act[60]
Nurses, Midwives, Assistant Midwives (Auxiliary Nurses Midwives) and Health Visitors Registration Act, 1934	The nurse includes a male nurse[61]
Nurses, Midwives, Assistant Midwives (Auxiliary Nurses Midwives) and Health Visitors Registration Act, 1934	The nurse includes a male nurse[62]
Bengal Nurses Act, 1934	Not defined in the Act

Thus, the various definitions of the term "nurse" provided in the State legislations reveal the need for a uniform definition to classify them according to the functions they perform.

7.1.2.2 Constitution of State Nursing Council

As stated above, the constitution of the state nursing council to regulate the standard of practice of the nursing profession is the major aim of all state laws. The state nursing council constituted under the state laws acts as the regulatory body to maintain the register of nurses and to take disciplinary actions for professional misconduct. In conformity with the central law, the state nursing

[60] Tripura Nursing Council Act, 1986,§2(g), No.13, Acts of Tripura Legislative Assembly, 1986.
[61] The Nurses, Midwives, Assistant Midwives (Auxiliary Nurses Midwives) and Health Visitors Registration Act, 1934 (U.P. Act XV of 1934), §2(c),No.3,Acts of U.P State Legislative Assembly, 1926.
[62] The Nurses, Midwives, Assistant Midwives (Auxiliary Nurses Midwives) and Health Visitors Registration Act, 1934(U.P. Act XV of 1934),§2(c), No.3, Acts of U.P State Legislative Assembly, 1926.

council incorporates the Ex-officio members, the elected members, and the nominated members in its constitution. However, the representatives included in each state nursing council vary from state to state.

Director of Health Services or the Medical Services or Public Health Services or Medical Education of the concerned state are usually appointed as ex-officio members of the State Nursing Council. Other ex-officio members included in the council represent's distinct positions such as Director of Health Care (state government); Joint Director of Nursing Services (Government); Dean of General Hospital (state), Principal of the Government Nursing Colleges/institutions; Deputy Director of Nursing Services (Government); Matron of significant hospitals of the concerned State, Joint director of nursing services – Sikkim, Nursing Superintendents (General Hospital of the concerned State), Superintendent (Government Hospital of the concerned State), The Assistant Director of Public Health (Maternity and Child Welfare) concerning State and so on.[63]

[63]Andhra Pradesh Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §3, No.III, Acts of Andhra Pradesh State Legislature, 1926, (India); Arunachal Pradesh Nursing Council Act, 2011, §4, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011; Bengal Nurses Act, 1934,§4, No.10, Acts of Bengal State Legisltaure,1926 (India); The Bihar and Orissa Nurses Registration Act, 1953,§3,No.1, Acts of Bihar State Legisltaure,1953 (India); The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972, §4, No.46, Acts of Chattisgarh Legislative Assembly, 1972(India);Goa Nursing Council (Amendment) Act, 2014,§ 3, No.23, Acts of Goa State Legislature, 2014 (India); Gujarat Nurse, Midwives and Health Visitors Act, 1968, §2, No.24, Acts of Gujarat State Legislature, 1968 (India); Haryana Nurses and Nurse-Midwives Act,2017,§4, No.3, Acts of Haryana State Legislature, 2017(India); Himachal Pradesh Nurses Registration Act,1977, §3,No.15, Acts of Himachal Pradesh State Legislature, 1977 (India); Jammu and Kashmir Nursing Council Act, 2012, §3, No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India); Karnataka Nurses, Midwives and Health Visitors Act, 1961,§3, No.4, Acts of Karnataka Legislative Assembly, 1961; Madhya Pradesh Upcharika,Prasavika,Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, §4, No.46, Acts of Madhya Pradesh Legislative Assembly, 1972; Maharashtra

The State Government nominates members of the Council from various fields such as Officers of the Public Health Department of Government; Medical Practitioners, Teachers in Nursing Colleges, Officers of the Medical Department of Government; Registered Medical Practitioners; Registered nurse, registered midwife or Auxiliary Nurses-Midwife and registered Heath Visitor; Non-officials, Nursing Superintendents of the hospitals training candidates for any of the examinations conducted by the council, Person nominated or elected by of the Indian Medical Association, Matron from Medical College Hospitals, etc.[64]

Again, the state laws shows that the state of Haryana sets the best example for the inclusion of more academically acclaimed persons in its Nursing Council. The inclusion of the Director of Medical Education and Research, the Additional Director of Medical Education and Research; the Principal, Government College of Nursing; the Principals of the Government Nursing Institutions; Nursing Educationist having a minimum teaching experience of 10 years teaching in B.Sc. Nursing or Post B. Sc Nursing or M.Sc. Nursing in its council shows that the Act is well-drafted to serve the

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Nurses Act, 1966, §3, No.40,Acts of Maharashtra State Legislative Assembly, 1966; Manipur Nursing Council Act, 2005,§3,Acts of Manipur State Legislative Assembly, 2005; Meghalaya Nursing Council Act, 1992,§ 4, No.5, Acts of Meghalaya State Legislative Assembly, 1992; Odisha Nurses and Midwives Registration Act, 1938,§3,Acts of Odisha State Legislative Assembly, 1938; Punjab Nurses Registration Act, 1932,§2,No.15,Acts of Punjab State Legislature, 1932; Rajasthan Nurses, Midwives Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964, Proviso to § 4, No.15, Acts of Rajasthan State Legislative Assembly, 1964; Sikkim Nurses, Midwives and Health Visitors Act, 2008, §3, No.4, Sikkim State Legislative Assembly, 2008; The Tamil Nadu Nurses and Midwives Act, 1926,§ 30,No.3, Acts of Tamil Naidu State Legislative Assembly, 1926;Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, § 3, No.3, Acts of Telangana State Legislative Assembly, 1926; Tripura Nursing Council Act, 1986, §3, No.13, Acts of Tripura Legislative Assembly, 1986.

[64]*Id.*

significant purpose of the legislation, which is nothing other than the regulation of training and qualification of the nursing profession. It is also noteworthy that some States, such as Haryana and Jammu, and Kashmir, incorporate representatives from private nursing institutions of the concerned State in their Council.[65]

Even though the inclusion of representatives from various fields promotes more transparency in the function of the state nursing councils, still how much the state legislation promotes the self-regulatory character to the nursing profession is often doubtful. The inclusion of too many representatives from the medical profession and public health often doubts the self-regulatory character of the nursing profession. The current evidence also shows that nurses often remain mere spectators in policy tables where the major healthcare decision are taken.

7.1.2.3 Registration of nurses

Registration is the major aim of all the state laws. It is the standard that is prescribed as mandatory for practice as a nurse. A comparative analysis shows that the state laws have entrusted either the state nursing council or the registrar to maintain a State Register.[66] It requires those persons who have undergone

[65]Jammu and Kashmir Nursing Council Act, 2012, §2(k),No.41,Acts of Jammu & Kashmir Legislative Assembly 2012 (India); Haryana Nurses and Nurse-Midwives Act, 2017, § 4(xi), No.3, Acts of Haryana State Legislature, 2017(India).

[66] Andhra Pradesh Nurses, Midwives , Auxiliary Nurse-Midwives and Health Visitors Act,1926, §5, No.III, Acts of Andhra Pradesh State Legislature, 1926, (India); Arunachal Pradesh Nursing Council Act, 2011, §13&14, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011;Bengal Nurses Act,1934, §27, No.14, Acts of Bengal State Legisltaure,1926 (India); The Bihar and Orissa Nurses Registration Act, 1953,§10 ,No.1, Acts

the course of training as prescribed by the Indian Nursing Council, or have passed the examination as prescribed or who was at the time of commencement of the Act already employed or is practicing in the State to make an application to the register for the entering their name into the register.[67] Applicants of

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of Bihar State Legisltaure,1953 (India); The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972, §14, No.46, Acts of Chattisgarh Legislative Assembly, 1972(India); Goa Nursing Council (Amendment) Act, 2014,§3,No.23, Acts of Goa State Legislature, 2014 (India); Gujarat Nurse, Midwives and Health Visitors Act, 1968,§12, No.24, Acts of Gujarat State Legislature, 1968 (India); Haryana Nurses and Nurse-Midwives Act, 2017, §17, No.3, Acts of Haryana State Legislature, 2017(India); Himachal Pradesh Nurses Registration Act, 1977, §18 ,No.15, Acts of Himachal Pradesh State Legislature, 1977 (India); Jammu and Kashmir Nursing Council Act, 2012, §11, No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India); Karnataka Nurses, Midwives and Health Visitors Act, 1961,§12 &13, No.4, Acts of Karnataka Legislative Assembly, 1961; Madhya Pradesh Upcharika,Prasavika,Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, §14 & 15, No.46, Acts of Madhya Pradesh Legislative Assembly, 1972; Maharashtra Nurses Act, 1966, §17, No. 40, Acts of Maharashtra State Legislative Assembly, 1966; Manipur Nursing Council Act, 2005, §13 & 15, Acts of Manipur State Legislative Assembly, 2005; Meghalaya Nursing Council Act,1992, §9 & 13, No.5, Acts of Meghalaya State Legislative Assembly, 1992; Odisha Nurses and Midwives Registration Act, 1938, §10, Acts of Odisha State Legislative Assembly, 1938; Punjab Nurses Registration Act, 1932, §14, No.15, Acts of Punjab State Legislature, 1932; Rajasthan Nurses, Midwives , Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964, Proviso to §12, No.15, Acts of Rajasthan State Legislative Assembly, 1964; Sikkim Nurses, Midwives and Health Visitors Act, 2008, §14 (1),No.4, Sikkim State Legislative Assembly, 2008; Tamil Nadu Nurses and Midwives (Amendment) Act,1960, §5 & 6, No.26, Tamil Naidu State Legislative Assembly, 1960; Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §5, No.3, Acts of Telangana State Legislative Assembly, 1926; Tripura Nursing Council Act, 1986, §14, No.13, Acts of Tripura Legislative Assembly, 1986

[67] Andhra Pradesh Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, § 5, No.III, Acts of Andhra Pradesh State Legislature, 1926,(India); Arunachal Pradesh Nursing Council Act, 2011,§17, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011 ; Bengal Nurses Act, 1934, §14, No.10, Acts of Bengal State Legisltaure,1926 (India); The Bihar and Orissa Nurses Registration Act, 1953,§10, No.1, Acts of Bihar State Legisltaure,1953 (India); The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972, §14, No.46, Acts of Chattisgarh Legislative Assembly, 1972(India); Goa Nursing Council (Amendment) Act, 2014, § 3, No.23, Acts of Goa State Legislature, 2014 (India); Gujarat Nurse, Midwives and Health Visitors Act, 1968,§ 12, No.24, Acts of Gujarat State Legislature,1968 (India);Haryana Nurses and Nurse-Midwives Act, 2017, §17, No.3, Acts of Haryana State Legislature, 2017(India); Himachal Pradesh Nurses Registration Act, 1977, §18 ,No.15, Acts of Himachal

registration are required to pay the prescribed fee and present their degree, diploma, or certificate along with the application. According to the State laws in Jammu & Kashmir, Himachal Pradesh, persons already registered as a nurse, midwives, auxiliary nurse-midwife, or multipurpose health workers by an association recognized by the Council is also entitled to be registered.[68]

One of the significant drawbacks of the provision is its failure to provide for the mandatory renewal of registration and the inclusion of additional qualifications acquired by nurses on the register. The inclusion of a registration certificate with photo identity is another requirement.

A comparative study shows that most state laws prohibit unregistered persons from practicing as a nurse. The disabilities of an unregistered person to hold

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Pradesh State Legislature, 1977 (India); Jammu and Kashmir Nursing Council Act, 2012, §12 & 33, No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India); Karnataka Nurses, Midwives and Health Visitors Act, 1961,§12 & 13, No.4, Acts of Karnataka Legislative Assembly, 1961(India); Madhya Pradesh Upcharika, Prasavika, Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, §14 & 15, No.46, Acts of Madhya Pradesh Legislative Assembly, 1972; Maharashtra Nurses Act, 1966, §17, No.40, Acts of Maharashtra State Legislative Assembly, 1966; Manipur Nursing Council Act, 2005,§13 &15, Acts of Manipur State Legislative Assembly, 2005; Meghalaya Nursing Council Act, 1992, §14, No.5, Acts of Meghalaya State Legislative Assembly, 1992; Odisha Nurses and Midwives Registration Act, 1938,§10, Acts of Odisha State Legislative Assembly, 1938; Punjab Nurses Registration Act, 1932, §14, No.15, Acts of Punjab State Legislature, 1932,; Rajasthan Nurses, Midwives , Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964, §12, No.15, Acts of Rajasthan State Legislative Assembly, 1964; Sikkim Nurses, Midwives and Health Visitors Act, 2008, § 14 No. 4, Sikkim State Legislative Assembly, 2008; Tamil Nadu Nurses and Midwives (Amendment) Act, 1960, §5 & 6, No.26, Tamil Naidu State Legislative Assembly, 1960; Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §5, No.3, Acts of Telangana State Legislative Assembly, 1926; Tripura Nursing Council Act, 1986, §19, No.14, Acts of Tripura Legislative Assembly, 1986.

[68] Jammu and Kashmir Nursing Council Act, 2012, §18(b), No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India);Himachal Pradesh Nurses Registration Act, 1977, §18(b) No.15, Acts of Himachal Pradesh State Legislature, 1977 (India).

any appointment as a nurse in any hospital, infirmary, dispensary, asylum, blood bank, medical laboratory maternity or child welfare centre, or any other medical or public health institution is mentioned in almost all the state laws.[69] It is interesting to note that the law in the State of Arunachal Pradesh extends the prohibition to private health Institutions.[70] It is also noteworthy that the state laws also prohibits unauthorized conferment of any degree, diploma, license, or certificate, implying that the holder is qualified to practice the profession of a registered nurse, midwife, health visitor, or auxiliary nurse-midwife.[71]

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[69] Andhra Pradesh Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §10 (1),No.III, Acts of Andhra Pradesh State Legislature, 1926, (India); Bengal Nurses Act, 1934,§27, No.10, Acts of Bengal State Legisltaure,1926 (India); Gujarat Nurse, Midwives and Health Visitors Act, 1968,§18(1), No.24, Acts of Gujarat State Legislature, 1968 (India); Goa Nursing Council (Amendment) Act,2014,§29(1),No.23, Acts of Goa State Legislature, 2014 (India); Haryana Nurses and Nurse-Midwives Act, 2017,§31, No.3, Acts of Haryana State Legislature, 2017(India); Himachal Pradesh Nurses Registration Act, 1977, §22(3),No.15, Acts of Himachal Pradesh State Legislature,1977(India); Karnataka Nurses, Midwives and Health Visitors Act,1961,§18(1), No.4,Acts of Karnataka Legislative Assembly, 1961; Madhya Pradesh Upcharika,Prasavika,Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, §16(2), No.46, Acts of Madhya Pradesh Legislative Assembly, 1972; Maharashtra Nurses Act, 1966, §28 (1), No. 10 (c), Acts of Maharashtra State Legislative Assembly, 1966;; Manipur Nursing Council Act, 2005,§17, Acts of Manipur State Legislative Assembly, 2005; Meghalaya Nursing Council Act, 1992, §14, No.5, Acts of Meghalaya State Legislative Assembly, 1992; Odisha Nurses and Midwives Registration Act, 1938, §2(f), Acts of Odisha State Legislative Assembly, 19388; Sikkim Nurses, Midwives and Health Visitors Act, 2008, §20 (1),No. 4, Sikkim State Legislative Assembly, 2008; Tamil Nadu Nurses and Midwives (Amendment) Act, 1960, §10, No.26, Tamil Naidu State Legislative Assembly, 1960; Tripura Nursing Council Act, 1986, §21, No.13, Acts of Tripura Legislative Assembly, 1986.

[70] Arunachal Pradesh Nursing Council Act, 2011, §27, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011 reads as "After the expiration of seven years from the commencement of this Act, no Government or private Health Institution, Hospital, Dispensary, Infirmary or lying-in-Hospital shall employ any category of Nurse, Nurse-Midwives, Lady Health Visitor, Female Health Workers or Auxiliary Nurse-Cum-Midwives , unless he or she is registered under this Act".

[71]Arunachal Pradesh Nursing Council Act, 2011, §25, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011; Tamil Nadu Nurses and Midwives (Amendment) Act, 1960, §12 A, No.26, Tamil Naidu State Legislative Assembly, 1960; Tripura Nursing Council Act, 1986,§20, No.13, Acts of Tripura Legislative Assembly, 1986; Manipur Nursing Council Act, 2005,§ 3, Acts of Manipur State Legislative Assembly, 2005; Haryana Nurses and Nurse-Midwives Act, 2017, §33, No.3, Acts of Haryana State Legislature, 2017(India).

Although the prohibition of unregistered persons is the primary goal, the provisions lack a uniform nature, especially those employed in private hospitals. It is also notable that the penalties prescribed in the State laws for dishonest use of the certificate for procuring registration and for posing as a registered nurse vary from state to state.[72]Except for law in Haryana,[73]other states prescribe only a meager fine not exceeding two hundred and fifty rupees as the penalty for dishonest use of the certificate for procuring registration. A fine of not exceeding one hundred rupees for posing as a registered nurse is prescribed in all most all the state laws.[74]

[72] Arunachal Pradesh Nursing Council Act, 2011,§29 & 30, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011.

[73] Haryana Nurses and Nurse-Midwives Act, 2017, §31, No.3, Acts of Haryana State Legislature, 2017(India). It reads as "§33, No.3, Acts of Haryana State Legislature, 2017(India)……. Any person who acts in contravention of this section shall on conviction be punishable, -) in the case of a first offence with imprisonment for a term which may extend to six months and with fine which may extend to fifty thousand rupees; and(b) in the case of a second or subsequent offence, with imprisonment for a term which may extend to one year, but which shall not be less than three months and with fine which shall not be less than two lakh rupees which may extend to five lakh rupees.

[74] Andhra Pradesh Nurses, Midwives , Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §14, No.III, Acts of Andhra Pradesh State Legislature, 1926, (India); Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, § 14, No.3, Acts of Telangana State Legislative Assembly, 1926. The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972, §28, No.46, Acts of Chattisgarh Legislative Assembly, 1972(India);Punjab Nurses Registration Act, 1932, §24, No.15, Acts of Punjab State Legislature, 193; Maharashtra Nurses Act, 1966, § 34, No. 10(c), Acts of Maharashtra State Legislative Assembly, 1966; Gujarat Nurse, Midwives and Health Visitors Act, 1968,§ 27, No.24, Acts of Gujarat State Legislature, 1968 (India); Himachal Pradesh Nurses Registration Act, 1977, §30, No.15, Acts of Himachal Pradesh State Legislature, 1977(India);Sikkim Nurses, Midwives and Health Visitors Act, 2008, §29,No. 4, Sikkim State Legislative Assembly, 2008,Tripura Nursing Council Act, 1986, §19, No.13, Acts of Tripura Legislative Assembly, 1986; Karnataka Nurses, Midwives and Health Visitors Act, 1961,§ 27, No.4, Acts of Karnataka Legislative Assembly, 1961; Sec 28 of the UP Act, Rajasthan Nurses, Midwives , Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964, Proviso to §32 (2), No.15, Acts of Rajasthan State Legislative Assembly, 1964; Manipur Nursing Council Act, 2005,§ 28, Acts of Manipur State Legislative Assembly, 2005; Haryana Nurses and Nurse-Midwives Act, 2017, §34, No.3, Acts of Haryana State Legislature, 2017(India); Goa Nursing Council (Amendment) Act, 2014,§ 37, No.23, Acts of Goa State Legislature, 2014 (India); Odisha Nurses and Midwives Registration Act, 1938, § 22, Acts of Odisha State Legislative Assembly, 1938.

Legislation in the State of Jammu & Kashmir and Haryana illustrates an exception. Legislation in the State of Jammu & Kashmir imposes a penalty of fine not exceeding ten thousand rupees and imprisonment that may extend to one year. The law in the State of Haryana mentions an enhanced penalty of fine which may extend to fifty thousand rupees and fine which may extend to two lakh rupees for the subsequent or the second offence.[75]The need for uniformity is also felt about the inclusion of private institutions or hospitals and penalties to be imposed on unregistered persons.

Some of the good provisions can be found in the provisions of the State of Jammu& Kashmir, Arunachal Pradesh, and Meghalaya. Maintenance of an annual list of registered persons and the authorization of the register with the power to inspect any hospital or dispensary to ascertain the registration of all those practicing nurses is the provision that makes the laws in these states unique.[76]

7.1.2.4 Disciplinary Proceedings

About the registration of any person as a nurse or as other categories of nurses, the council is also authorized with the power to take disciplinary actions against nurses and remove their names from the register. The state laws have a uniform procedure to be followed by the state councils before taking

[75] Jammu and Kashmir Nursing Council Act, 2012,§3, No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India); Haryana Nurses and Nurse-Midwives Act, 2017, § 26, No.3, Acts of Haryana State Legislature, 2017(India).

[76] Jammu and Kashmir Nursing Council Act, 2012, §16& 17, No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India); Arunachal Pradesh Nursing Council Act, 2011, §22 & 31, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011.

disciplinary actions. The state councils must make sufficient inquiries and provide opportunities to the concerned persons before taking disciplinary actions. The States such as Jammu and Kashmir, Chhattisgarh specially mention the requirement of a two-thirds majority of the members present and voting at the council to convict a person guilty of the offence.[77] The duty to remove fraudulent and incorrect entries from the register is also entrusted to the council.[78]

Furthermore, the councils are empowered to remove the name of any nurse, midwife, health visitor, auxiliary nurse-midwives in the register or restore the names so removed.[79] State laws also made it clear that Persons whose name was removed from the register on the grounds of any professional misconduct or other misconduct are not entitled to enter his name in the register[80]. An analysis of the state laws shows that grounds for invoking disciplinary proceedings are not uniform. Opportunity to show cause is prescribed as a mandatory condition to remove such persons' names from the register.[81]

[77] Jammu and Kashmir Nursing Council Act, 2012, §13, No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India), The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972, §17(b), No.46, Acts of Chattisgarh Legislative Assembly, 1972(India).
[78] Jammu and Kashmir Nursing Council Act, 2012,§14, No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India).
[79] Tamil Nadu Nurses and Midwives (Amendment) Act, 1960, §7, No.26, Tamil Naidu State Legislative Assembly, 1960;The Uttar Pradesh Nurses, Midwives Assistant Midwives (Auxiliary, Nurse- Midwives) and Health Visitors Registration Act, 1934, §18,No.XV, Acts of UP State Legislative Assembly, 1934(India).
[80] Maharashtra Nurses Act, 1966,§20, No. 40, Acts of Maharashtra State Legislative Assembly, 1966.
[81] Gujarat Nurse, Midwives and Health Visitors Act, 1968, §14 (1), No.24, Acts of Gujarat State Legislature,1968 (India); Tripura Nursing Council Act, 1986, §19, No.16, Acts of

The grounds for taking disciplinary actions against nurses in various state legislations vary from state to state. In some States, the council is empowered to take disciplinary actions, whereas, in other states, the Registrar is empowered to take disciplinary actions. The different grounds provided in various state legislations for the removal of names from the state register or the grounds barring registration are provided in the table below.

Name of the State Legislation	**Grounds barring registration**
The Andhra Pradesh Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926	i) any offence including a breach of any law which provides that such breach shall be deemed to be an offence for the purpose of this rule, ii) professional incompetence, or contravention of methods ordinarily included in the course of training of Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors, iii) defect in character which in the opinion of the Council would render the entry or retention of her name on the register undesirable.[82]
The Arunachal Pradesh Nursing Council Act, 2011	i)that he or she has been sentenced by any Court of law for any non-bailable offence, or sentence not having been subsequently reserved or quashed; ii)that he or she has been convicted by a Court of law for any offence involving moral turpitude; iii)that he or she has been guilty of professional misconduct, professional

Tripura Legislative Assembly, 1986; Karnataka Nurses, Midwives and Health Visitors Act, 1961,§ 14, No.4, Acts of Karnataka Legislative Assembly, 1961; Rajasthan Nurses, Midwives , Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964, Proviso to §22 (1), No.15, Acts of Rajasthan State Legislative Assembly, 1964; Goa Nursing Council (Amendment) Act, 2014, §24 (6), No.23, Acts of Goa State Legislature, 2014 (India); Meghalaya Nursing Council Act, 1992, Proviso to §11, No.5, Acts of Meghalaya State Legislative Assembly, 1992.

[82]Andhra Pradesh Nurses, Midwives , Auxiliary Nurse-Midwives and Health Visitors Act, 1926, Rule 40,No.III, Acts of Andhra Pradesh State Legislature, 1926(India).

	incompetence, negligence of duty, or lack of integrity or professional ethics[83]
Assam	a) Conviction for any offence involving moral turpitude; b) Guilty of misconduct, negligence of duty or lack of integrity or professional ethics, or (c) Defects in character which may render the retention of its name in the register undesirable[84].
Bihar	Conviction of any offence which implies any defect in character as would render him unfit for duty; guilty of professional misconduct[85]
Chhattisgarh	Sentenced for imprisonment for an offence which indicates a defect in the character; found guilty of infamous conduct in any professional respect[86]
The Goa Nursing Council Act, 2012	Guilty of misconduct such as (a) conviction of a registered nursing personnel by a criminal court for an offence which involves moral turpitude, and which is cognizable within the meaning of the Code of Criminal Procedure, 1973; (b) conviction under the Army Act, 1950 of a registered nursing personnel, subject to the military law, for an offence which is cognizable within the meaning of the Code of Criminal Procedure, 1973 ;or (c) any conduct, which in the opinion of the council, is infamous in relation to the nursing profession, and under, any Code of Ethics

[83] Arunachal Pradesh Nursing Council Act, 2011,§19(1),No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011.
[84] Meghalaya Nursing Council Act, 1992,§11,No.5,Acts of Meghalaya State Legislative Assembly, 1992.
[85] The Bihar and Orissa Nurses Registration Act,1953,§12,No.1,Acts of Bihar State Legisltaure,1953 (India).
[86] The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972, §17(b), No.46, Acts of Chattisgarh Legislative Assembly, 1972(India).

	as prescribed by the Council in this behalf or by the Indian Nursing Council[87]
Gujarat Nurses, Midwives and Health Visitors Act, 1968	Not mentioned
The Haryana Nurses and Nurse- Midwives Act, 2017,	(a)If his name has been entered in the register by error or on account of misrepresentation or suppression of any material fact; (b) he has been convicted of any offence under this Act or has been guilty of the infamous conduct in the profession which, in the opinion of the Council, render him unfit to be on the rolls of the register; or (c) It has been established that the certificate, diploma has been obtained through a fraudulent method or false certificate.[88]
Himachal Pradesh Nurses Registration Act, 1977	Conviction of any offence which in the opinion of the council implies, any defect of character which would render him unfit for duty; guilty of any professional misconduct or infamous conduct or not have been possessing satisfactory professional qualification.[89]
Jammu and Kashmir Nursing Council Act, 2012	Sentenced by any court for any non-bailable offence and the sentence not subsequently reversed or quashed, found guilty of any offence which , indicates professional incompetence, negligence or contravention of regulation included in the performance of the duties of nurses; defects in character which would render the entry or retention of his/her name undesirable.[90]
Jharkhand	Shares the grounds Bihar and Orissa Nurses Registration Act, 1935
The Karnataka Nurses, Midwives and Health Visitors Act, 1961	Not mentioned

[87] Goa Nursing Council (Amendment) Act, 2014,§24(Explanation), No.23, Acts of Goa State Legislature, 2014 (India).
[88] Haryana Nurses and Nurse-Midwives Act 2017,§24,No.3, Acts of Haryana State Legislature, 2017(India).
[89] Himachal Pradesh Nurses Registration Act, 1977, Proviso to §18 (2) (b)(ii),No.15, Acts of Himachal Pradesh State Legislature, 1977 (India).
[90] Jammu and Kashmir Nursing Council Act, 2012,§13,No.41, Acts of Jammu & Kashmir Legislative Assembly 2012 (India).

Kerala	Has committed any offence including a breach of any regulation which provided that such breach shall be deemed to be an offence for the purpose of the Kerala Nurses and Midwives Rules, 1972; for professional incompetence , negligence or contravention of methods ordinarily invocated in the course of training of nurses, midwives, auxiliary nurse-midwives or health visitors; or if he has been sentenced by any criminal court for any offence involving moral turpitude such sentence not having been reversed and a period of three years has not elapsed from the date of the expiration of the sentence.[91]
The Madhya Pradesh Upcharika,Prasavika,Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972	Has been sentenced by a criminal court to imprisonment for an offence which in the opinion of the council. Indicates....a defect in the character as would render the enrolment of his name in the register undesirable or guilty of an infamous conduct in any professional respect.[92]
Maharashtra Nurses Act, 1966	Guilty of 'misconduct' such as Conviction for an offence which involves moral turpitude; or any conduct which is infamous in relation to the nursing profession, and under any Code of Ethics prescribed by the Council.[93]
The Manipur Nursing Council Act, 2005	Not mentioned
The Meghalaya Nursing Council Act, 1992	a) Conviction for any offence involving moral turpitude; b) Guilty of misconduct, negligence of duty or lack of integrity or professional

[91] Rule 69 provides elaborate provisions or details with regard to the manner of removal of person from registration such as enquiry-opportunity of hearing etc.

[92] Madhya Pradesh Upcharika,Prasavika,Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, §14 & 15, No.46, Acts of Madhya Pradesh Legislative Assembly, 1972 (India).

[93] Maharashtra Nurses Act, 1966,§23,No.40, Acts of Maharashtra State Legislative Assembly, 1966(India).

	ethics, or (c) Defects in character which may render the retention of its name in the register undesirable.[94]
Mizoram	a) sentenced for any non-bailable offence, or sentence not having been subsequently reversed or quashed; b)guilty of any offence which indicates professional incompetence, negligence or contravention of regulation ordinarily included in the performance of the duties of Nurses, Nurse-Midwives, Health Visitors, Auxiliary Nurse cum-Midwife or Health Workers; c) defects in his character which render the entry or retention of his name on the register undesirable; d) Nurse, Nurse-Midwife, Auxiliary Nurse-Cum-Midwife, Health Visitors or Health Workers fails to apply for registration within five years from the date of passing.[95]
Nagaland	Council not yet constituted.
The Odisha Nurses and Mid-wives Registration Act, 1938	Convicted for any offence which in the opinion of the council implies any defect of character which would render him unfit for duty , or after an enquiry, has been held by the council to be guilty of professional misconduct or does not possess satisfactory professional qualification.[96]
The Punjab Nurses Registration Act, 1932	Convicted of any such offence as implies in the opinion of council any defect of character such as would render him unfit for duty or who, after an enquiry, has been held by the council to have been guilty of any professional misconduct or

[94] Meghalaya Nursing Council Act, 1992, §9 & 13, No.5, Acts of Meghalaya State Legislative Assembly, 1992(India).
[95] The Mizoram Nursing Registration Act,1990,§19,Mizoram Nursing(Registration) Act, 1990 (India).
[96] Odisha Nurses and Midwives Registration Act, 1938, Proviso to § 10 (2)(b)(ii), Acts of Odisha State Legislative Assembly, 1938 (India).

	not to possess satisfactory professional qualifications.[97]
The Rajasthan Nurses, Midwives, Health Visitors and Auxiliary Nurse-Midwives Registration Act, 1964	(a)He has been convicted of any such offence as implies in the opinion of the Council any defect of character which would render him unfit for duty, or(b) that he has been found by the Council to be guilty of any offence which indicates of professional incompetence, negligence or contravention of regulations, ordinarily included in the performance of his duty; or(c) that he has been found by the Council to be guilty of professional misconduct or infamous conduct in any professional respect; or (d) that there are defects in his character which, in the opinion of the Council, would render the entry or retention of his name on the register undesirable.[98]
Sikkim	Not mentioned
Tamil Nadu Nurses and Midwives Act, 1926	Not mentioned
The Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926	Any offence including a breach of any law which provides that such breach shall be deemed to be an offence for the purpose of this rule; professional incompetence, or contravention of methods ordinarily included in the course of training of Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors, defect in character which in the opinion of the Council would render the entry or retention of her name on the register undesirable.[99]
The Tripura Nursing Council Act, 1986	(a) name has been entered in the register by error or on account of misrepresentation or suppression of a material fact; (b) conviction of an offence; or (c) Guilty of any offence

[97] Punjab Nurses Registration Act, 1932, Proviso (ii) to §14(2)(b),No.15, Acts of Punjab State Legislature, 1932 (India).
[98] Rajasthan Nurses, Midwives, Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964, §19 (1), No.15, Acts of Rajasthan State Legislative Assembly, 1964 (India).
[99] Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926,Rule 40, No.3, Acts of Telangana State Legislative Assembly, 1926(India).

	which indicated professional incompetence, negligence or contravention of regulations ordinarily included in the performance of , the duties of nurses, midwives or health visitors.[100]
Bengal Nurses Act, 1934	Non-bailable offence or Guilty of any offence which indicates professional incompetence, Negligence or contravention of regulation included in the performance of duties of nurses, or Defects in the character of the nurses which would render the entry or retention of his name on the register undesirable.

7.1.2.5 Licensing authority: its role

Almost all the state legislation mentions the functions of the authorities that supervise and control nurses. Some of the illustrations can be found in the legislation of the states such as Sikkim, Maharashtra, Gujarat, Delhi, Karnataka, Manipur, Goa which explains the role of licensing authority to exercise supervision and control of nurses, midwives, auxiliary nurse-midwives, and health visitors within the area under its jurisdiction[101]. It is also notable that in the state legislation of Karnataka, it is mentioned that in case of a municipal area, the Municipal Corporation or municipal council established

[100]Tripura Nursing Council Act, 1986,§16, No.13, Acts of Tripura Legislative Assembly, 1986 (India).

[101] Sikkim Nurses, Midwives and Health Visitors Act, 2008,§22,No.4,Sikkim State Legislative Assembly, 2008(India).
The Delhi Nursing Council Act, 1997,§20, No.3, Delhi State Legislative Assembly, 1997 (India); Gujarat Nurse, Midwives and Health Visitors Act, 1968,§20, No.24, Acts of Gujarat State Legislature,1968 (India);Maharashtra Nurses Act,1966,§30,No. 40, Acts of Maharashtra State Legislative Assembly,1966 (India); Manipur Nursing Council Act,2005,§3, Acts of Manipur State Legislative Assembly, 2005(India);Goa Nursing Council Act, 2012,§20,No.28, Acts of Goa State Legislature, 2012 (India).

for such area, and in the case of any other area, the Zila Parishad or taluk development board established for such area acts as the licensing authority.[102]

The state government can specify any other authority as licensing authority for such area. In some state laws, it is also prescribed that every person registered under the Act shall notify the licensing authority of his or her intention to practice in the concerned area.[103] It is notable that in the State of Arunachal Pradesh, the District Medical Officer and the Health Officer act as the licensing authority and supervise all nurses, nurse midwives, Auxiliary Nurse-Midwives, and the Female Health Worker.[104] Additionally, some states like Bihar, Punjab, Odisha, and Himachal Pradesh empower the local authority to prohibit unregistered persons from practicing as nurses, health visitors, and midwives within the area subject to its jurisdiction.[105]

Furthermore, it is noteworthy that in some states such as Sikkim, Maharashtra, Gujarat, Karnataka, and Goa, special mention is made about the regulation of nursing establishments. A 'Nurses establishment' is defined as

[102]Karnataka Nurses, Midwives and Health Visitors Act,1961,§2 (g), No.4, Acts of Karnataka Legislative Assembly, 1961(India).

[103] The Delhi Nursing Council Act,1997,§21, No.3, Delhi State Legislative Assembly, 1997(India);Maharashtra Nurses Act, 1966,§31,No. 40, Acts of Maharashtra State Legislative Assembly, 1966(India);Gujarat Nurse, Midwives and Health Visitors Act, 1968,§21,No.24, Acts of Gujarat State Legislature,1968 (India); Karnataka Nurses, Midwives and Health Visitors Act, 1961,§21,No.4, Acts of Karnataka Legislative Assembly, 1961(India); Manipur Nursing Council Act, 2005,§ 21(2), Acts of Manipur State Legislative Assembly, 2005(India); Goa Nursing Council Act, 2012, §32, No.28, Acts of Goa State Legislature, 2012 (India).

[104] Arunachal Pradesh Nursing Council Act, 2011,§26, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011(India).

[105]The Bihar and Orissa Nurses Registration Act,1953,§14,No.1, Acts of Bihar State Legisltaure,1953 (India); Punjab Nurses Registration Act, 1932, §17,No.15, Acts of Punjab State Legislature, 1932(India); Himachal Pradesh Nurses Registration Act, 1977,§22 ,No.15, Acts of Himachal Pradesh State Legislature,1977 (India);Odisha Nurses and Midwives Registration Act, 1938,§14,Acts of Odisha State Legislative Assembly, 1938(India).

any establishment, whether carried on for gain or not, which provides for or is intended to provide the services of persons to act as nurses, midwives, auxiliary nurse-midwives, or health visitors to those requiring such services.[106] It is also mentioned that any person who desires to carry on any nurse's establishment shall apply to the licensing authority for a license.[107]

7.1.2.6 Self-regulation

One of the characteristic features that define a profession is its power to make regulations and rules. All the state legislations have provided the state nursing council with the power to make regulations and by-laws for conducting its activities. Matters such as the maintenance of the State register; Supervision and regulation of the practice of the profession by persons who are registered in the State; Prescribing rate of fees to be charged for registration; summoning meetings of the council; expenditure of the council; prescribing the causes for removal of persons from the register; appointment of the registrar are entrusted with the councils.[108] It is noteworthy that in the State of Arunachal Pradesh,

[106] Maharashtra Nurses Act,1966,§2(l), No.10(c),Acts of Maharashtra State Legislative Assembly, 1966 (India); Gujarat Nurse, Midwives and Health Visitors Act, 1968,§2(k), No.24, Acts of Gujarat State Legislature, 1968 (India); Karnataka Nurses, Midwives and Health Visitors Act, 1961,§ 2(1), No.4, Acts of Karnataka Legislative Assembly, 1961(India)

[107] Sikkim Nurses, Midwives and Health Visitors Act, 2008,§24, No. 4, Sikkim State Legislative Assembly, 2008(India).
Gujarat Nurse, Midwives and Health Visitors Act, 1968,§18(1), No.22,Acts of Gujarat State Legislature, 1968 (India); Karnataka Nurses, Midwives and Health Visitors Act, 1961,§ 22 & 14, No.4, Acts of Karnataka Legislative Assembly, 1961(India);Goa Nursing Council Act, 2012,§35, No.28, Acts of Goa State Legislature,2012(India).

[108] Andhra Pradesh Nurses, Midwives , Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §12, No.III, Acts of Andhra Pradesh State Legislature,1926, (India); Arunachal Pradesh Nursing Council Act, 2011,§35, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011; Bengal Nurses Act, 1934,§14, No.10,Acts of Bengal State Legisltaure,1926 (India); The Bihar and Orissa Nurses Registration Act,1953,§100,No.1,Acts of Bihar State Legisltaure,1953 (India);The Chhattisgarh Upcharika, Prasavika, Sahai, Upcharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, 1972, §14, No.46, Acts of Chattisgarh

Maharashtra, Haryana, Meghalaya, and Goa, the council is given broader power to draft a Code of Ethics for regulating the professional conduct of nurses.[109]Besides,some states like Haryana and Goa entrusts the nursing council with the power of a civil court.[110]

7.1.2.7 The Kerala State Nursing Council Act 1953

As this thesis also analyses the real-work life situation of nurses in the State of Kerala, a close look at the State legislation is desirable. Like other state legislations, the Kerala State Nursing and Midwives Act, 1953 aims to register

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Legislative Assembly,1972(India);Goa Nursing Council Act, 2012,§3, No.28, Acts of Goa State Legislature,2012(India);Gujarat Nurse, Midwives and Health Visitors Act, 1968,§12,No.24, Acts of Gujarat State Legislature,1968(India); Haryana Nurses and Nurse-Midwives Act, 2017,§17,No.3,Acts of Haryana State Legislature, 2017(India); Himachal Pradesh Nurses Registration Act,1977,§18,No.15, Acts of Himachal Pradesh State Legislature, 1977 (India): Jammu and Kashmir Nursing Council Act, 2012,§11,No.41,Acts of Jammu & Kashmir Legislative Assembly 2012 (India); Karnataka Nurses, Midwives and Health Visitors Act, 1961,§12 &14, No.4, Acts of Karnataka Legislative Assembly, 1961; Madhya Pradesh Upcharika,Prasavika,Sahai Upacharika-Prasavika Tatha Swasthya Paridarshak Registrikaran Adhiniyam, §14 & 15,No.46, Acts of Madhya Pradesh Legislative Assembly, 1972; Maharashtra Nurses Act, 1966,§17,No.10(c),Acts of Maharashtra State Legislative Assembly, 1966; Manipur Nursing Council Act, 2005,§13& 15, Acts of Manipur State Legislative Assembly, 2005; Meghalaya Nursing Council Act, 1992,§.9 & 13, No.5, Acts of Meghalaya State Legislative Assembly, 1992;Odisha Nurses and Midwives Registration Act, 1938, §10,Acts of Odisha State Legislative Assembly, 1938; Punjab Nurses Registration Act, 1932,§14,No.15,Acts of Punjab State Legislature,1932, Rajasthan Nurses, Midwives , Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964,§12, Rajasthan Nurses, Midwives, Health Visitors and Auxiliary Nurses-Midwives Registration Act, 1964; Sikkim Nurses, Midwives and Health Visitors Act, 2008,§14,No.4, Sikkim State Legislative Assembly, 2008; Tamil Nadu Nurses and Midwives (Amendment) Act, 1960, §5& 6, No.26, Tamil Naidu State Legislative Assembly,1960;Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §12, No.3,Acts of Telangana State Legislative Assembly, 1926; Tripura Nursing Council Act, 1986, §14, No.13, Acts of Tripura Legislative Assembly, 1986.

[109] Arunachal Pradesh Nursing Council Act, 2011,§35(o),No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011;Maharashtra Nurses Act,1966,§3,No.10(c),Acts of Maharashtra State Legislative Assembly, 1966; Haryana Nurses and Nurse-Midwives Act, 2017, §41(1)(g), No.3, Acts of Haryana State Legislature,2017(India); Goa Nursing Council Act, 2012, §10(c), No.28, Acts of Goa State Legislature, 2012(India); Meghalaya Nursing Council Act, 1992, § 22 (g), No.5, Acts of Meghalaya State Legislative Assembly, 1992.

[110] Haryana Nurses and Nurse-Midwives Act, 2017,§38, No.3, Acts of Haryana State Legislature, 2017(India); Goa Nursing Council Act, 2012,§24(7), No.28, Acts of Goa State Legislature, 2012 (India).

and train nurses, midwives, health visitors, and auxiliary nurse-midwives.[111] In uniformity with the central and the state laws, the Kerala Nurses and Midwives Council incorporate ex-officio, nominated, and elected members in its council.[112] It is noteworthy that the Act provides separate registers for nurses, midwives, auxiliary nurse-midwives, and health visitors known as Part A and Part B.[113] Part A contains the name of all nurses who have completed the required training and examination are eligible for registration. Part B consists of names of those persons who had been in regular practice as a nurse or midwife for not less than three years preceding the first day (April) of the commencement of the Nurses and Midwives (Amendment) Act, 1964.

[111]The Kerala State Nursing Council Act, 1953,§2 (d), No.X, Acts of Kerala State Legislative Assembly, 1953 (India).

[112]The Kerala State Nursing Council Act, 1953,§3,No.X,Acts of Kerala State Legislative Assembly, 1953(India).(The Council shall consist of the following members, namely:- (a) The Director of Health Services, the Professor of Gynecology, Medical College, Trivandrum, the Professor of Gynecology, Medical College, Kozhikode [the Professor of Gynecology, Medical College, Kottayam, the Assistant Director of Health Services (maternity and Child Health)], the Superintendent, Women and Children's Hospital, Trivandrum and the Superintendent Women and Children's Hospital, Kozhikode, to be ex officio members; (b) One member elected by the members of the Medical Council from among themselves; (c) three registered nurses nominated by the Government, two of whom shall be Superintendents of nursing schools and the third shall be the Matron – Superintendent of a Major Hospital; (1)[(d) six members elected by the registered nurses from among the nurses registered in Part A of the register of nurses, of whom at least one shall be a member of the Trained Nurses Association of India registered in the State of Kerala, one a member, of the Kerala Government Nurses Association and one a nurse working in a private hospital in the State;] 1[(e) three members elected by the registered midwives of whom one shall be from among the midwives registered in Part A of the register of the midwives, and two from among the auxiliary nurse-midwives registered under this Act;] 4[(f) one member elected by the registered health visitors from among the health visitors registered in the register of health – visitors]).

[113]The Kerala State Nursing Council Act, 1953, §18,No.X, Acts of Kerala State Legislative Assembly, 1953(India).

The Act specifically mentions the grounds of disqualifications for registration.[114] Factors such as the age of minority, unsoundness of mind, non-residence in the State of Kerala, un-discharged insolvency, unsoundness of mind (declared by a competent court), deafness, dismissal from service under any Government, removal of the name registered under the Kerala State nursing council register, etc. are the primary grounds of disqualifications.[115] Like other state legislations, any person who wishes to register with the council is obliged to pay an application fee of rupees ten along with the application form to be forwarded to the register.[116] Nurses, midwives, auxiliary nurse-midwives, or health visitors already registered in any other state in India can also be registered as nurses, midwives, auxiliary nurse-midwives, or health visitors under the Act.[117]

Notably, the Act promotes practice by registered nurses. However, it mandates those nurses to obtain prior permission from the local supervising authority showing their intention to commence practice in any local area.[118] How far the Act intends the right of nurses to practice is doubted. A similar duty is also imposed on them in case of any change of address.[119]

[114]The Kerala State Nursing Council Act, 1953,§20(3),No.X, Acts of Kerala State. Legislative Assembly, 1953(India).
[115] The Kerala State Nursing Council Act, 1953, §6, No.X, Acts of Kerala State Legislative. Assembly, 1953(India).
[116]The Kerala State Nursing Council Act, 1953, § 21, No.X, Acts of Kerala State Legislative Assembly, 1953(India).
[117] The Kerala State Nursing Council Act, 1953, §22, No.X, Acts of Kerala State Legislative Assembly, 1953(India).
[118] The Kerala State Nursing Council Act, 1953, §29(1), No.X, Acts of Kerala State Legislative Assembly, 1953(India).
[119] The Kerala State Nursing Council Act, 1953,§29(2), No.X, Acts of Kerala State Legislative Assembly, 1953(India).

Like other legislation, this Act disables unregistered persons from practice.[120]A meager amount of fine of fifty rupees is imposed on the defaulter. Similar to other Acts, activities such as dishonest use of certificate of registration, unlawful assumption of the title as 'registered nurse', instrumental manipulations for delivery, unauthorized conferment of certificates, diploma, or license is also made punishable.[121]Furthermore, the Act specifically mentions the need for compulsory registration by nurses before they starts practice.[122]

7.2 The National Nursing and Midwifery Commission Bill, 2020

The most recent initiative from the part of the central government is the introduction of the National Nursing and Midwifery Commission Bill, 2020[123] The Bill intends to repeal the Indian Nursing Council Act, 1947 and to establish the National Nursing and Midwifery Commission to regulate and maintain the standards of education and services by nursing and midwifery professionals. It is provided that

> *"A Bill to provide for registration and maintenance of standards of education and services by nursing and midwifery professionals, assessment of institutions, maintenance of a Central Register and State Register, and creation of a system to improve access, research and*

[120]The Kerala State Nursing Council Act, 1953,§30, No.X, Acts of Kerala State Legislative Assembly, 1953(India).
[121]The Kerala State Nursing Council Act, 1953, §31, 33, 34, 34A, No.X, Acts of Kerala State Legislative Assembly, 1953(India).
[122] The Kerala State Nursing Council Act, 1953, § 32(1), No.X, Acts of Kerala State Legislative Assembly, 1953(India).
[123]MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA, DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020(2 Dec. 2020), https://main.mohfw.gov.in/ newshighlights-21.

> *development, and adoption of latest scientific advancement and for matters connected therewith or incidental thereto.*[124]*"*

The Bill defines Nurses as Professionals "having obtained any recognized nursing professional qualification, registered with the Commission and as defined as in Schedule I" of the bill[125]. The Bill provides an elaborate discussion about the scope of practice of Nursing Professionals such as

> *" provide nursing education, treatment, support, and care services for people who are in need of nursing & midwifery care due to the effects of ageing, injury, illness or other physical or mental impairment, or potential risks to health, according to the practice and standards of modern nursing& midwifery, assume responsibility for the planning and management of the care of patients, including the supervision of other health care workers, working autonomously or in teams with medical doctors and others in the practical application of preventive and curative measures in clinical and community settings, and, who have obtained any recognized nursing qualification and are registered with the Commission.*[126]*"*

Thus, this bill is a good step towards conferring professional autonomy to nurses expanding their scope of practice[127] from bedside nursing to community nursing, including planning, management, supervision, working collaboration with doctors for the prevention of diseases. Thus, "nursing care

[124]DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020 (2 Dec. 2020), https://main.mohfw.gov.in/ newshighlights-21.
[125] *Id.* DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL,§2(X).
[126]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020, SCHEDULE 1).
[127]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§2(w) reads "Nursing Practice" refers to the scope and range of roles, functions, responsibilities and activities which a registered nurse may deliver as part of the services and as specified by the regulations under this Act).

provided to a patient/client in all healthcare settings by a nursing professional"[128]is included.

The bill includes various kinds of nursing within its purviews, such as Clinical Nursing[129], Community Health Nursing/ Public Health Nursing[130], Nursing Care Assistant[131], and Nursing Associate.[132]

Elaborate discussion on the constitution and functions of the National Nursing and Midwifery Commission and the State Nursing and Midwifery Commission are provided in the Bill.[133] The National Nursing and Midwifery Commission consists of representatives from Nursing Profession (as its

[128]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§2(y) defines "Nursing Services" means nursing care provided to a patient/client in all health care settings by Nursing & Midwifery Personnel).

[129]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§2(c) defines "Clinical Nursing" means safe, effective and high-quality nursing services in hospital units or nursing care delivered elsewhere, such as clinics, ambulances. Nursing services from tertiary hospitals to health posts in remote communities designated by acuity (emergency, intensive care), condition (cancer, cardiac, gastrointestinal), intervention (surgery) or population (pediatrics, obstetrics), and diagnostic services (laboratory and imaging).

[130]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL,2020,§ 2(e)defines "Community Health Nursing/ Public Health Nursing" means primary healthcare and nursing practice in a community setting for promoting and protecting the health of the population using knowledge from nursing, social and public health sciences with an aim to provide health services, preventive care, intervention and health education to community and population).

[131] *Id.* (DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§ 2 (g) defines "Nursing Care (including Home-based Personal Care) Assistant" means a person as defined in Schedule I and having the requisite nursing care (including home-based personal care) assistant qualification, as prescribed by the Nursing and Midwifery UG Education Board").

[132]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§2(o)defines "Nursing Associate" means a professional having obtained any recognized nursing associate qualification, registered with Commission and as defined in Schedule I; Schedule I reads as Nursing Associate Professionals provide basic nursing and personal care for people in need of such care due to effects of ageing, illness, injury, or other physical or mental impairment, provide health advice to patients and families; monitor patients' conditions; and implement care, treatment and referral plans usually established by medical, nursing and other health professionals, and who have obtained any recognized nursing associate qualification and are registered with the Commission. Multi-purpose Health workers is an example).

[133] *Id.* (DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§3 & §24).

commission)[134], Department of Health and Family Welfare (Govt. of India)[135], Ministry of Defense and Military Nursing Services[136], National Medical Research[137], National Medical Commission[138], Directorate of Health Services[139], Indian Medical Research[140], Chief Nursing officers from selected hospitals[141], Principal of selected Nursing Institutions[142], representatives from

[134]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL,2020,§4(1)(a) reads as "a person having an outstanding ability, proven administrative capacity and integrity and possessing a postgraduate degree in nursing and midwifery profession from any University with experience of not less than twenty–five years in the field of nursing and midwifery, out of which at least ten years shall be a nursing & midwifery leader to be appointed by the Central Government– Chairperson").

[135]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§4(1)(b)(b) reads as "Additional Secretary to the Government of India in the Department of Health and Family Welfare in charge of nursing and midwifery– ex officio member; (c) Nursing Advisor to the Government of India in the Department of Health and Family Welfare – ex officio member").

[136]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL,2020,§4(1)(d) reads as "One representative of the Ministry of Defense not below the rank of Additional Director General, Military Nursing Services to the Government of India in the Directorate General of Armed Forces Medical Services - ex officio member; (e) One representative of the Directorate G").

[137]*Id.* (DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL,2020,§4(1)(f) reads as "One representative of the Indian Clinical Medical Research not below the rank of Additional Director General - ex officio member").

[138]*Id.* (DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL,2020,§4(1)(g) reads as "One person representing the National Medical Commission not below the rank of Deputy Secretary to the Government of India – ex-officio member").

[139]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§4(1)(e) reads as "One representative of the Directorate General of Health Services not below the rank of Additional Director General - ex officio member").

[140]*Id.* (DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020, §4(1) (f) reads as "One representative of the Indian Clinical Medical Research not below the rank of Additional Director General - ex officio member").

[141]*Id.* (DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§4 (h) reads as "Five persons representing out of the following on biennial rotation basis in alphabetical order, not below the rank of Chief Nursing Officer or Nursing Superintendent of the hospitals of the below listed Institutes, ex officio member. All India Institute of Medical Sciences, New Delhi; ii. Armed Forces Medical College, Pune iii. Banaras Hindu University, Varanasi; iv. Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry; v. King George Medical University, Lucknow; vi. Madras Medical Colleges, Chennai; vii. National Institute of Mental Health and Neuro-Sciences, Bangalore; viii. North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences, Shillong; ix. Post Graduate Institute of Medical Sciences, Chandigarh; x. Regional Institute of Medical Sciences, Manipur; xi. Sree Chitra Tirunal Institute for Medical Sciences and Technology, Thiruvananthapuram; xii. Tata Memorial Hospital, Mumbai; Provided that the Commission may add an Institute of repute/excellence to the above list with the approval of Central Government").

State Nursing Commission[143], Nursing members of eminence[144], and members nominated by the Central Government from midwifery professionals[145], charitable institutions[146] and other professions.

The National commission enjoys the power to frame policies and regulations of matters such as regulation of nursing education, educational institutions, standards of nursing faculty, ensuring policies and codes to

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[142]*Id.* (DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§4 reads as "(i) Five persons of the rank of Dean/ Principal on biennial rotation basis in alphabetical order, from the following colleges of nursing attached to the institutions listed below under the Ministry of Health and Family Welfare- ex-officio member: i. All India Institute of Medical Sciences, Delhi; ii. Rajkumari Amrit Kaur College of Nursing, Delhi; iii. ESI Hospital, Bangalore; iv. Vardhaman Mahavir Medical College (College of Nursing, Safdarjung Hospital), Delhi; v. Dr RML Hospital; vi. Lady Harding Medical College; vii. Regional Institute of Paramedical and Nursing Sciences (RIPANS), Aizawl; viii. Bhopal Memorial Hospital and Research Centre, Bhopal; ix. Central Institute of Psychiatry, Ranchi; x. Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry; Provided that the Commission may add an Institute of repute/excellence to the above list with the approval of Central Government").

[143]*Id.* (DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§4(j) reads as "One person from each of the six zones, not below the rank of Chairperson who should be a nursing and midwifery professional, representing the State Commissions on biennial rotation in the alphabetical order as per the zonal distribution of State and Union Territories – ex-officio member").

[144]*Id.* (DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§4 (k)reads as "Twelve nursing members of eminence, two from each of the six zones of nursing and midwifery profession to be nominated by the State Governments, of outstanding ability, proven administrative capacity and integrity, possessing a postgraduate degree in any discipline of nursing and midwifery from any University and having experience of not less than fifteen years in the field of nursing and midwifery out of which at least seven years shall be as a nursing& midwifery leader - member; Provided that at least one member from each zone should be dean nursing & midwifery or principal of nursing & midwifery institute").

[145]*Id.* (DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§4 (l) reads as "Eight nursing& midwifery members of eminence, of which at least two should be midwifery professionals and at least one should be from each of the six zones, to be of nursing and midwifery profession to be nominated by the Central Government, of outstanding ability, proven administrative capacity and integrity, possessing a postgraduate degree in any discipline of nursing and midwifery from any University and having experience of not less than twenty years in the field of nursing and midwifery out of which at least ten years shall be as a nursing & midwifery leader – member").

[146]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§4 (c) "one person, possessing outstanding qualifications and experience of not less than twenty-five years in the field of management or law or economics or science and technology, to be nominated by the Central Government in such manner as may be prescribed – Member; and (d) the Secretary to the Government of India in charge of the Ministry of Health and Family Welfare, to be the Convenor –Member").

observe professional code of ethics, framing guidelines for the functioning of the commission, and other related activities.[147]

Notably, the bill empowers the central government to constitute autonomous boards such as the Nursing UG Education Board and Nursing PG Education Board, Nursing Assessment and Rating Board, and Nursing and Midwifery Ethics and Registration Board.[148] The Nursing Assessment and Rating Board has the power to grant permission to establish and carry out inspections to new nursing institutions.[149] The Nursing UG Education Board and Nursing PG Education Board are empowered to take appropriate measures to improve and regulate nursing education at the undergraduate and postgraduate levels.[150]Finally, the Nursing and Midwifery Ethics and Registration Board is empowered to maintain the central register for all registered professionals, approve or reject the application of registration of nurses, and regulate the professional conduct of the nursing professionals.[151]

The State Nursing and Midwifery Commissions are entrusted with the power to regulate nursing education and enforce the professional conduct, code of ethics, and etiquette to be observed by nursing professionals, including taking disciplinary actions in cases of professional misconduct.[152] It is also expected to ensure standards of nursing education, maintenance of the State

[147] *Id.* DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§10(1).
[148] *Id.* DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§11.
[149] *Id.* DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§20.
[150] *Id.* DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§18 & 19.
[151] *Id.* DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§21& S.25.
[152] *Id.* DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§ 24.

Register for Professionals, and to support the National Nursing Commission in its functions.

Another necessary provision of the Bill is the Introduction of National Examinations such as the National Nursing and Midwifery Entrance Test for admission to the undergraduate nursing education and the National Exit Test for granting registration to nurses.[153] Any person who qualifies for the National Exit Test has the right to register and enroll in the Central Register or State Register.[154] The introduction of these exams are a good step ahead for bringing uniformity in nursing education and is expected to ensure quality and transparency. Notably, only those enrolled with the State Register for professionals or the Central Register are allowed to practice as nurse.[155]Thus, the bill expressly bars the practice of the nursing profession by an unregistered person.

Though the bill is a good attempt, it is not free from criticisms. One of the major criticisms is the inclusion of midwifery along with the nursing profession. Need for considering both as a separate discipline has been argued by the critiques. Another issue is the lack of a definite explanation of the scope of nursing practice, including the functions and role boundaries of nursing practice.

The Bill elucidates various nurses without clearly explaining their qualifications and functions. The expanded scope of nursing practice such as

[153] *Id.* DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL 2020,§28 &§29.
[154] *Id.* DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§26.
[155]*Id.* DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020,§27.

Nurse Practitioner, Palliative Care Nursing, and Home Nursing (including their qualifications) is not discussed in the bill, thereby limiting the scope of nursing practice.

Other issues includes the non-representation of nursing associations, especially the Trained Nurses Association of India, the private nursing educational institutions and hospitals, the State Commission's and Women's commissions in nursing councils.

Further, the aspects of rights and liabilities of nurses are not included in the bill. The need for inspections into private hospitals to ensure quality in nursing practice, power to penalize institutions employing unqualified persons as nurses, the nurse-patient ratio that is to be followed in all healthcare settings, matters such as salary and working conditions of nurses, in-service education, and training facilities, method of recruitment to private hospitals, promotional avenues, the job description of each category of nurses, manner of taking disciplinary actions inside private healthcare institutions, etc. are not included in the Bill. The inclusion of home nurses into the nursing category as provided in the bill is problematic as most home nursing institutions function without proper regulations and employ unqualified staff for delivering home care.

There is no discussion about the standard of practice that is required to maintain quality of nursing. Need for clarity as to the punishment imposed for

unregistered practice is needed[156]. The need for a grievance redressal mechanism for nurses is another requirement which shall be included in the bill. In most cases, nurses don't reveal their grievances due to fear of losing their job. Maters of renewal of license by nurses and the need to keep proper data about their migration are other needs that shall be included and entrusted with the autonomous boards described in the bill.

7.3 Conclusion

Thus, the comparative analysis of all the State legislations in India points out the need for uniform legislation regarding the standard of practice of nursing professionals. Though items such as 'Public health, Sanitation, Hospitals, and Dispensaries" falls exclusively within the State list (Item 6), where the States can only frame legislation, still the possibility of the Central government to legislate under the concurrent list (entry 28) concerned with "medical and other professions" cannot be ignored.[157]

The first and foremost requirement is a uniform definition which explains the definition, role as well as the boundary of performance of each category of nurses such as the 'auxiliary nurse,' 'nurse-midwife,' 'midwives,' 'lady health visitors,' 'public health nurses,' 'auxiliary nurse-midwives and so on. As mentioned earlier, the law in the State of Arunachal Pradesh expressly

[156]*Id.*(DRAFT THE NATIONAL NURSING AND MIDWIFERY COMMISSION BILL, 2020, § 27 (2) reads as"Any person who contravenes any of the provisions of this section shall be punished with imprisonment or fine or both as per the regulations").
[157]P M Bakshi, *Nurses and the Law*, 36 JILI 288, 285-291(1994).

provides such clarity as to the role and functions which each category of nurses must perform.

Another important aspect is the constitution of the State Nursing Council. As discussed above, the power of 'self-regulation' is one of the primary criteria which distinguish a 'Profession' from other occupations. As part of an emerging and full-fledged 'health care profession', nurses shall be able to regulate their state of affairs independently. Even if, an exclusive inclusion of the council with participation from nursing alone is not possible, a balanced approach shall be followed. Representation from medical and health care service sectors with the inclusion of academically inclined and experienced persons shall be thought off. As mentioned earlier in the chapter, the legislation in the State of Haryana is a good example, wherein the State nursing council includes the combination of persons who are well versed in theory as well as practice. The inclusion of representatives from the private sector is another urgent need to be addressed in the legislation.

Another area of concern is the renewal of registration and inclusion of additional qualifications in the State register. The information collected from the Kerala State Council through Right to Information is an instance. It is found that real statistics of nurses who are actively in practice are not available. Updated information about nurses who have completed the higher qualification in nursing (such as M.Sc nursing or Ph.D. in nursing) is lacking. Information as to registered nurses who have migrated to foreign countries is also not available with the state nursing council.

Penalties that are imposed as a part of disciplinary proceedings are another matter which requires an enhancement. A comparative analysis shows that the State of Haryana and Goa have better regulations regarding it. On this behalf, it is also important to note that information about the details of persons against whom disciplinary proceedings are already taken is again missing with the State Nursing Council.

Need is also felt for uniformity about the grounds of disciplinary proceedings that can be taken against nurses. The mechanism to monitor and supervise the registration of nurses shall be made more vigilant as to its mandatory compliance. An additional point that could be added here is regarding to the Professional Code of Nurses ethics. A personal interview conducted with the staff nurses reveals the ignorance among them regarding the code of nursing ethics that is prevalent in India. Urgent need is felt to provide awareness regarding professional code of ethics among nurses.

The representation of nursing professionals in significant policies and debates wherein significant health issues are discussed are an additional aspect that requires consideration. The legislations in India are silent on these aspects. Special mention about the same is needed in the State legislations. Thus, from all the analysis and discussions made here, it can be concluded that the urgent need of the hour is to redefine the standard of nursing practice in India. Their rights, duties, scope of practice, boundaries of practice etc. need to be addressed by the legislation.

CHAPTER VIII

LEGISLATIVE FRAMEWORK OF NURSING EDUCATION IN INDIA

Introduction

Education can be regarded as the significant yardstick by which the fitness and competency of the health care professionals to provide quality professional services with ethical and professional values can be measured.[1] It can be regarded as the significant factor which has a direct impact on the quality of healthcare.[2] It can also be termed as the most worth element which sanctions a 'Professional status to nurses' by transferring tacit knowledge.[3] WHO has identified certain guiding principles such as 'Purpose[4],' 'Universality,' 'Relevance,' 'Coherence,' 'Consistency'[5], 'Flexibility,' 'Quality'[6], and 'Collaboration'[7], as the guiding principles which sets the

[1]A GUIDE TO NURSING AND MIDWIFERY EDUCATION STANDARDS, WORLD HEALTH ORGANISATION (25 Jan. 2019), http://applications.emro.who.int/ dsaf/EMROPUB_2015 _EN_ 1866.pdf.

[2]GLOBAL STANDARDS FOR THE INITIAL EDUCATION OF PROFESSIONAL NURSES AND MIDWIVES, WORLD HEALTH ORGANISATION (2 Sep. 2019), https://apps.who.int/ iris/bitstream/ handle/10665/44100/WHO_HRH_HPN_08.6_eng.pdf;jsessionid=FF0BEBFB6BCAAFEF02 7AF9A42C9555E6?sequence=1.

[3] Henny M. Olsson & Mats T. Gullberg, *Nursing education and importance of professional status in the nurse role. Expectations and knowledge of the nurse role*, 25 IM.J.NURS.STUD 293,293-298 (1988).

[4]WHO, *supra* note 1.(Education standards should ensure that education programmes prepare graduates who are capable of critical thinking and problem–solving, and capable of functioning as competent, ethical care providers. In addition the educational experience should promote the capacity to become a self-directed, life-long learner).

[5]*Id.*(Programmes and other educational experiences maintain their integrity by using consistent processes. The components of a programme (curriculum, mode of delivery, the student) should support and build upon other parts, thereby promoting the achievement of educational outcomes).

[6]*Id.*(A continual quality improvement system, combined with regular internal and external review of the institution and the programmes, serves to strengthen the management and quality of the educational process and outcomes, and provides a check on the level of adherence to the required standards).

[7]*Id.* (The educational process (e.g. in standard-setting; supervision; in the governance process; provision of clinical learning sites) should involve key stakeholders –the profession itself,

standards of nursing education. The chapter examines the historical developments and legislative framework of nursing education in India.

8.1 Historical Glimpses

The history of institutionalized nursing education in India began in colonial times and is intertwined with the history of the clinical nursing sector.[8] The growing awareness about nursing care in the health sector has shot up the demand for nursing professionals. It ultimately paved the way for the initiation of nursing education in India.[9] The first school to train women for nursing in military and civil hospitals was set up at the General Hospital Chennai in 1854.[10] The influence of Florence Nightingale towards the development of nursing education is reflected in her efforts to prepare a draft bill (1865) to improve the nursing system in Indian hospitals. This was followed by coming of trained graduate nurses from Nightingale School of Nurses (St. Thomas Hospital, England) to start nursing schools in India. In 1867, Indian Women began receiving training from St Stephen Hospital, New Delhi.[11] A separate school for nursing in India was set up in the Government General Hospital in Madras in 1871.

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government, the public, employers, educational institutions, students and other health professions – in appropriate and timely ways. Appropriate participation by these groups in standard setting is desirable).

[8] Sreelekha Nair, S Irudaya Rajan, *Nursing Education in India Changing Facets and Emerging Trend*, 24 EPW 38 (2017).

[9] Shivendra Sing & R K Mahapatra, *Nursing Education in India*, RESEARCH GATE (12 Aug. 2020).https://www.researchgate.net/publication/269045335_Nursing_Education_in_ India/citation/download.

[10] NAIR,*supra* note 8.

[11] *Id.*

The role of Christian missionaries in training nurses across Indian Provinces, especially Travancore and Chennai, is notable in the development of nursing education. Around 75 listed schools in South India were run by Christian missions during this period.[12] Influences from abroad forces such as the Rockefeller Foundation based in the United States,[13] and the American nursing experts working with the International organizations in India and USAID (United States Agency for International Development),[14] were also mentioned in pieces of literature dealing with the history of nursing in India. The major centres of excellence were the Christian Medical College, Vellore in Tamil Nadu, and St.Stephen's in Delhi.[15] Regularization and standardization of nursing training is also an essential concern of this period.

During the post-independence period (even though the general social attitude towards nursing remained unchanged), few developments in terms of institutions for medical care took place.[16] More educational institutions came up in different states affiliated to various universities such as Leela Bai Thaker (LBT) College of Nursing, Bombay, (1952), College of Nursing, Indore,(1960), College of Nursing, SMS Hospital, Jaipur (1963), College of Nursing, AFMC, Pune, (1964), College of Nursing, Fort, Bangalore, (1972), College of Nursing, CMC, Ludhiana, (1972), College of Nursing, Calcutta,

[12] *Id.* (Nurses from the West defended this on the grounds that higher-grade certificate courses required higher standards of education, while lower-grade certificate courses were conducted in vernacular languages).
[13] They made a clear distinction between a university setting for the training of women in nursing and traditional hospital-based training programmes. Vellore in South India and Delhi in North India were the major sites of their activities.
[14] USAID helped in the development of degree colleges in Hyderabad, Indore and Jaipur.
[15] NAIR, *supra* note 8.
[16] *Id.*

(1974) and College of Nursing, Vishakhapatnam, (1979).[17] In 1953, Post essential degree program was started in Trivandrum.[18] The Master's Degree program in Nursing was started in 1959 at Rajkumari Amrit Kaur College, Delhi. The program was designed to run for full two years duration.[19] In 1986, the MPhil program was started in the Rajkumari Amrit Kaur College. In 1991, the first Doctoral program in nursing was established in the Institute of Nursing Sciences, M V Shetty Memorial College, and Mangalore.[20] Thus nursing education slowly developed in India with more specializations and branches in various parts of the country.

8.2 Legal Framework in India

The significant change to nursing education in India occurred with the Indian Nursing Council Act, 1947.[21] The Indian Nursing Council was established by this Act. Bringing a 'uniform standard of training nurses' is its primary purpose of the Act.[22] The Act assigns the Indian Nursing Council with the power to grant recognition of qualifications for nursing education.

Some of the powers include:-

[17] SING, *supra* note 9.
[18] K P NEERAJA,TEXTBOOK OF COMMUNICATION & EDUCATION TECHNOLOGY FOR NURSES 129 (J P Medical Ltd 2011).
[19] SING, *supra* note 9.
[20] *Id.*
[21] India Nursing Council Act, 1947, No.48, Acts of Parliament, 1947 (India).
[22] India Nursing Council Act, 1947, No.48, Acts of Parliament, 1947 (India). (Preamble of the Act read as "An Act to constitute an Indian Nursing Council. ……WHEREAS it is expedient to constitute an Indian Nursing Council in order to establish a uniform standard of training for nurses, midwives and health visitors").

8.2.1 Powers & Functions of Indian Nursing Council

The qualifications that are recognized by the Council are provided in the Schedule to the Act. The Schedule deals with the 'recognized qualifications' and 'recognized higher qualifications'.[23] Both contain a list naming the authorities by whom the Certificates (including the senior and junior certificates), Diplomas or Degrees in General Nursing; Post-certificate course in Public Health Nursing or B.Sc. (Nursing) Degree or M.Sc.(Nursing) degree is granted. Any authority recognized by the state government can apply to the council to recognize qualifications that are not included in the schedule but are granted by the authority.[24] Once a declaration to that effect is granted by the council, the qualification will attain the status of 'recognized qualification. The power of the council to enter into negotiations with any authority in any territory of India to which the Act does not extend or foreign country for the recognition of qualifications is mentioned in the Act.[25] Recognition of qualifications will not be provided unless the law and practice of the foreign country permit persons domiciled or who originated in India with the right to enter and practice the nursing profession in that country.[26]

Possession of qualifications recognized by the council is a prerequisite for being enrolled in the State register.[27] Those enrolled in any State register before the commencement of the Act are allowed to enroll in the state register,

[23]India Nursing Council Act, 1947, § 10(1) No.48, Acts of Parliament, 1947 (India).
[24]India Nursing Council Act, 1947, § 10(2) No.48, Acts of Parliament, 1947 (India).
[25]India Nursing Council Act, 1947, § 10(3) No.48, Acts of Parliament, 1947 (India).
[26]India Nursing Council Act, 1947, proviso to §10(3) No.48, Acts of Parliament, 1947 (India).
[27] India Nursing Council Act, 1947, §11(1)(a)(b), No.48, Acts of Parliament, 1947 (India).

though they do not hold any recognized qualifications.[28]All others, including those 'entitled to be enrolled in any State register immediately before the commencement of the Act but was not enrolled,' are required to give an application for enrolment in the register.[29] The same applies to any person holding a 'recognized higher qualification.' They are allowed to enter the qualification as a supplementary qualification in any State register they are enrolled in.[30] Furthermore, the council enjoys the power to grant the enrolment of any Indian citizen possessing foreign qualifications in a State register.[31] Temporary enrolment in the State register can be granted to non-citizens employed as nurses in any hospitals or institutions in India.[32]

Another important power of the council is about the withdrawal of recognition of qualifications. The council can send a statement to the concerned State government in cases where the course of study or training, or examination is not in conformity with the regulations and if the institutions recognized by the state council for training nurses do not fulfill the essential requirements needed for recognition.[33]

The maintenance of an Indian Nurses Register containing the names of nurses who are enrolled on any State register is another important function that is entrusted with the Council.[34] The Secretary of the Council is duty-bound to

[28]India Nursing Council Act, 1947, § 10(1) No.48, Acts of Parliament, 1947 (India).
[29]India Nursing Council Act, 1947, Proviso to §.11(1)(a)(b), No.48, Acts of Parliament, 1947 (India).
[30] India Nursing Council Act, 1947, §.11(1), No.48, Acts of Parliament, 1947 (India).
[31]India Nursing Council Act, 1947, §.11(2)(a), No.48, Acts of Parliament, 1947 (India).
[32] India Nursing Council Act, 1947, §.11(2)(b), No.48, Acts of Parliament, 1947 (India).
[33]India Nursing Council Act, 1947, §14(1)(a)(b), No.48, Acts of Parliament, 1947 (India).
[34] India Nursing Council Act, 1947, § 15 A, No.48, Acts of Parliament, 1947 (India).

maintain, revise, and publish the Indian Nurses Register.[35]

The Act also specifically mentions the power of the council to constitute an Executive Committee to carry out inspections of institutions that impart training to nurses and to attend examinations held to grant recognized qualifications.[36] Additional powers of the council such as the power to require information as to courses of study and training and examinations;[37] power to make regulations about the matters mentioned in the Act;[38] and the power to elect a Vice-President, appoint or nominate such other officers and servants of the council are mentioned in the Act.

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[35]India Nursing Council Act, 1947, § 15A (2), No.48, Acts of Parliament, 1947 (India).
[36]India Nursing Council Act, 1947, § 13, No.48, Acts of Parliament, 1947 (India).
[37]India Nursing Council Act, 1947, § 12, No.48, Acts of Parliament, 1947 (India).
[38]India Nursing Council Act, 1947, § 16, No.48, Acts of Parliament, 1947 (India). (It reads "Power to make regulations as (*1*) The Council may make regulations not inconsistent with this Act generally to carry out the provisions of this Act, and in particular and without prejudice to the generality of the foregoing powers, such regulations may provide for—
(a) the management of the property of the Council and the maintenance and audit of its accounts.

(b) the manner in which elections referred to in sub-section (*2*) of section 5 and in clause (*a*) of sub-section (*2*) of section 8 shall be conducted.

(c) the summoning and holding of the meetings of the Council, the times and places at which such meetings shall be held, the conduct of business thereat and the number of members necessary to constitute a quorum.

(d) prescribing the functions of the Executive Committee, the summoning and holding of meetings thereof, the times and places at which such meetings shall be held, and the number of members necessary to constitute a quorum.

(e) prescribing the powers and duties of the President and the Vice-President.
7[(*f*) prescribing the tenure of office and the powers and duties of the Secretary and other officers and servants of the Council.
(*ff*) prescribing the powers and duties of inspectors;].
(g) prescribing the standard curricula for the training of nurses, midwives and health visitors, for training courses for teachers of nurses, midwives and health visitors, and for training in nursing administration.

(h) prescribing the conditions for admission to courses of training as aforesaid.

(i) prescribing the standards of examination and other requirements to be satisfied to secure for qualifications recognition under this Act.

(j) any other matter which is to be or may be prescribed under this Act").

Thus, though the Act appears to be enriched in provisions needed for promoting practical training to nurses, some of them are still not free from ambiguities. The provision that mentions the withdrawal of qualifications does not go beyond the council's power to send a statement to the concerned state government. It failed to provide a detailed account of the procedure that is to be followed in case the institutions fail to follow the required qualifications or regulations.

8.2.2 Powers & Functions of State Nursing Council

The recognition of institutions offering nursing courses is the primary function of the state nursing councils. Additionally, it is entrusted with various functions such as conducting examinations, granting certificates, conducting the periodical inspection of schools of nursing, giving advice on the maintenance of standards by the schools of nursing, preparing, publish and prescribed text-books and publishing statements of prescribed courses of study, to award stipends, scholarships, certificates of merit, medals, prizes, and other rewards, and to require such institutions to furnish such information as may be necessary.

Apart from these, the state nursing councils are also entrusted with certain powers by various state legislations. Some of the essential powers relate to the constitution of an Examination Board for conducting examinations in the concerned state;[39]providing instructions as to matters of training of nurses in

[39] Goa Nursing Council (Amendment) Act, 2014,§12, No.23, Acts of Goa State Legislature, 2014 (India).

the concerned state;[40] inspecting concerned nursing educational institutions (at least once in two years) and hospitals for ascertaining its standards and registration of nurses;[41] withdrawal of recognition to nursing institutions (based on an adverse report received);[42] prohibition of unregistered institutions from issuing the certificate of diploma and degree of nursing,[43] and the power to make rules relating to other matters of nursing education such as manner of admission, manner of examinations process and so on.[44]

8.3 Present Structure of Nursing Education in India

Currently, there are six levels of nursing education in India like the Multipurpose Health Worker (Female) training (ANM or MPHW-F); Female Health Supervisor training (HV or MPHS-F), General nursing, and midwifery; B.Sc. Nursing; M.Sc. Nursing; M.Phil and Ph.D.

[40] The Assam Nurses, Midwives, Health Visitors Registration (Amendment) Act, 1953, Act No.2, §22(1) Legislative Assembly of Assam, 1944(India); Arunachal Pradesh Nursing Council Act, 2011, §21, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011(India).

[41] The Assam Nurses, Midwives, Health Visitors Registration (Amendment) Act, 1953, Act No.2,§22(1) Legislative Assembly of Assam,1944(India); Bengal Nurses Act, 1934,§23(1), No.10, Acts of Bengal State Legislature, 1926(India);The Kerala State Nursing Council Act,1953,§ 26,No.X, Acts of Kerala State Legislative Assembly,1953(India).

[42]The Assam Nurses, Midwives, Health Visitors Registration (Amendment) Act, 1953, Act No.2,§23 Legislative Assembly of Assam, 1944(India).; Arunachal Pradesh Nursing Council Act, 2011, §23, No.1, Acts of Arunachal Pradesh State Legislative Assembly,2011(India); Meghalaya Nursing Council Act, 1992,§17, No.5, Acts of Meghalaya State Legislative Assembly, 1992(India);Bengal Nurses Act, 1934,§23(2), No.10, Acts of Bengal State Legislature, 1926 (India).

[43] The Assam Nurses, Midwives, Health Visitors Registration (Amendment) Act, 1953, Act No.2,§25, Legislative Assembly of Assam,1944(India); Bengal Nurses Act, 1934,§25, No.10, Acts of Bengal State Legislature, 1926 (India), Arunachal Pradesh Nursing Council Act, 2011, §25, No.1, Acts of Arunachal Pradesh State Legislative Assembly, 2011(India).

[44]The Assam Nurses, Midwives, Health Visitors Registration (Amendment) Act,1953, Act No.2,§23,Legislative Assembly of Assam,1944(India);Andhra Pradesh Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act,1926,§11 (b),No.III, Acts of Andhra Pradesh State Legislature, 1926 (India);Telangana Nurses, Midwives, Auxiliary Nurse-Midwives and Health Visitors Act, 1926, §11(b), No.3, Acts of Telangana State Legislative Assembly, 1926(India).

The courses certified by the India Nursing Council are shown in the table below:-

Nursing Programs	Training Duration	Examination	Registration
Auxiliary Nurse & Midwife	Two years	Nursing Examination Board	R.ANM
General Nursing & Midwifery	3 and 1/2 years Three years from 2015-2016	Nursing Examination Board	R.N & R.M
B. Sc (Basic)	4 years	University	R.N & R.M
B.Sc (Post Basic)	Regular: 2 yrs Distance: 3 yrs	University	Additional Qualification
M. Sc.	Two years	University	Additional Qualification
M. Phil	One year (Full time) 2 years (part time)	University	Additional Qualification
Ph D	3-5 years	University	Additional Qualification

Source: Indian Nursing Council: Admission and Conditions of for School/College of Nursing Revised from 2012-2013 Academic year .[45]

According to the Indian Nursing Council, the primary objectives of the undergraduate level nursing education is "to generate competent nurses with

[45]INDIAN NURSING COUNCIL (2 Apr.2019),http://www.indiannursingcouncil.org/nursing-programs.asp? show=prog-type.

critical thinking skills who are caring, motivated, assertive and well-disciplined responding to the changing needs, healthcare system; to take responsibilities as professional, competent nurses in providing promotive, preventive, curative and rehabilitative healthcare services in the hospital or public health settings; develop the ability of nurses to take independent decisions in nursing situations within the scope of practice, protect the rights of individuals and groups and conduct research in the areas of nursing practice and apply evidence-based practice and to prepare nurses to assume the role of the practitioner, teacher, supervisor, and manager in clinical or public health settings."[46]

8.4 Distribution of Nursing Educational Institutions in India

Currently, the Schools of Nursing and the College of Nursing provide training in nursing education in India. When the Schools of Nursing imparts three-year diploma training in General Nurse Midwife course; the College of Nursing imparts training in four-year B.Sc Nursing degree. The distribution of nursing educational institutions in India, which the India Nursing Council recognizes as of 31st March 2018, is given in the table below:-

States	ANM	GNM	B.Sc. (N)	P.B.B.Sc. (N)	M.Sc.(N)	P.B.D.P
Andaman & Nicobar	1	1	0	0	0	0
Andhra Pradesh	39	162	149	32	33	14

[46] *Id.*

Arunachal Pradesh	7	7	1	0	0	0
Assam	34	52	12	4	5	2
Bihar	110	23	9	2	0	3
Chandigarh	1	0	2	1	1	0
Chhattisgarh	5	84	94	19	20	6
Dadra & Nagar Haveli	0	0	1	1	1	0
Daman & Diu	0	0	1	0	0	0
Delhi	10	20	11	4	7	14
Goa	2	1	3	1	1	0
Gujarat	118	143	89	16	15	10
Haryana	87	84	38	28	9	8
Himachal Pradesh	9	41	26	8	5	0
Jammu & Kashmir	14	16	14	4	3	0
Jharkhand	67	28	10	5	1	2
Karnataka	27	487	319	183	157	54
Kerala	20	186	131	46	63	39
Madhya Pradesh	95	404	190	72	59	10
Maharashtra	552	268	104	55	38	40
Manipur	8	15	7	1	0	0
Meghalaya	2	7	2	1	1	0

Mizoram	4	6	2	0	0	0
Nagaland	2	5	1	1	0	0
Orissa	131	80	21	6	10	3
Pondicherry	7	10	15	7	7	7
Punjab	175	218	108	91	35	8
Rajasthan	29	175	168	46	26	2
Sikkim	1	2	2	0	1	0
Tamil Nadu	41	210	180	72	82	33
Telangana	17	91	85	16	24	13
Tripura	3	5	4	1	2	0
Uttar Pradesh	239	280	94	34	17	7
Uttarakhand	21	29	20	7	8	2
West Bengal	31	75	23	11	12	15
Grand Total	**1909**	**3215**	**1936**	**775**	**643**	**292**

Source: Indian Nursing Council[47]

8.5 Nursing Education at New Heights

Nursing education is reaching its new heights in India. This is evident from the 14 specialty courses that are approved and attached to its post-graduation course (M.Sc. Nursing).[48] The clinical specialties offered to nurse includes subjects such as (both theory and practice) "Medical-Surgical Nursing, Critical Care Nursing, Oncology Nursing, Neurosciences Nursing, Nephro-

[47]INDIAN NURSING COUNCIL(2 Apr. 2019),http://www.indiannursingcouncil.org/nursing-programs.asp? show =prog-type.

[48]INDIAN NURSING COUNCIL, SYLLABUS AND REGULATIONS(2 Apr. 2019), http://www.indiannursingcouncil.org/pdf/M.Sc.-Nursing-syllabus_0108.pdf.

Urology Nursing, Orthopedic Nursing, Gastro Enterology Nursing, Obstetric & Gynecological Nursing, Child Health (Pediatric nursing), Mental Health (Psychiatric) Nursing and Community Health Nursing".[49] Thus, the courses and specializations offered at the post-graduation level highlight that the nursing profession has reached a new realm of knowledge and expertise.

Another important advancement of nursing education in India happened with the introduction of the postgraduate program for nurses titled the "Nurse Practitioner in Critical Care" in 2016.[50] The course is planned to extend nursing service in tertiary care settings.[51] It is expected to enhance the role of registered B.Sc nurses for advanced practice roles such as clinical experts, managers, educators, and consultants, leading to M.Sc. degree in Critical Care.[52] The program includes various courses of study based on strong scientific foundations, including evidence-based practice and management of complex health systems.[53] Upon completing the program and registration, they can independently administer drugs and order diagnostic tests, procedures, medical equipment, and therapies as per institutional protocols.[54] The program is yet to implement in India. Studies and experts in nursing expect that this program, if

[49] *Id.*
[50] INDIAN NURSING COUNCIL, SYLLABUS & REGULATIONS NURSE PRACTITIONER IN CRITICAL CARE POST GRADUATE RESIDENCY PROGRAM, 2016 (2 Apr. 2019), https://www. tnmgrmu.ac. in/images/Syllabus-and-curriculam/Allied-HealthSciences/msc%20nursepracincc%20syllab-03112017.pdf.
[51] *Id.*(The special feature of this programme is that it is a clinical residency programme emphasizing a strong clinical component with 20 per cent of theoretical instruction including skill lab and 80 per cent of clinical experience. After the completion of the course, the 'Nurse Practitioners' (NPs) will be able to provide cost effective, competent, safe and quality driven specialized nursing care to patients in a variety of settings in tertiary care centres).
[52] *Id.*
[53] *Id.*
[54] *Id.*

implemented, will have a far-reaching impact in ensuring quality health care and raising the status and opportunities of nurses, especially for those who have completed post-graduation in nursing.

Another significant change is the introduction of the Single Entry Level for Nursing in India. It phased out GNM courses from India by the year 2020-21.[55] The resolution reads as

> *"To ensure the quality of nursing education, the implementation framework seeks to merge GNM schools with B.Sc.(N)and have a single, entry-level qualification as B.Sc.(N) for nurses by redesigning the B.Sc. curriculum as practical based and by phasing away from the GNM courses".*[56]

Thus, this single, entry-level nursing education has mainly two study schemes – the B.Sc nursing and the ANM course.

Another vital attempt from the Union Minister for Health and Family Welfare is the launch of Two New Nurse Practitioner Courses in 2016- a two-year residential master's in science programs in Critical care; and a one-year diploma in Primary healthcare. The former course is implemented in the Manipal College of Nursing. However, the implementation of the later course can be found in the form of "the Bridge Programs in Community Health Nurse for Nurses." The primary intention of this course is to provide training to qualified B.Sc/GNM qualified nurses in public health & primary care through suitably designed 'Bridge Programs on Certificate in Community Health,' to

[55]INDIAN NURSING COUNCIL, NOTIFICATION (2 Apr.2019), https://www. Indiannursing council.org/pdf/singleentry_28.pdf.
[56] *Id.*

enable them to function as 'Mid-Level Health Care Providers' also known as 'Community Health Officers".[57] They are expected to be "posted at health sub-centers; which could be developed as 'Health and Wellness Centres.[58] In India, the Government of West Bengal (Directorate of health services) has initiated this program and issued orders as to their role and responsibilities related to Administration; Health Care Services and Supportive Supervision.[59] This is a good step that provides an enhanced role to nurses.

[57] *Id.* (Course Objectives: Based on the gaps identified through curriculum mapping between B.Sc (CH) and GNM & BAMS courses, the program would broadly cover the following: Introduction to National Health Programs & Health Systems and adherence to national protocols of treatment and care, development of leadership and management skills for effective functioning of H&WCs. Public Health Competencies such as understanding the history & evolution of public health in India, analysis of health profile of district, state & country, methods to improve health seeking behavior, health promotion, nutritional assessment, promotion, education and rehabilitation, use of basic epidemiological tools, morbidity and mortality profiling of community/district, reproductive and child health, understanding concepts of primary and comprehensive health care, health planning and management. Teaching on primary care of common conditions will lay emphasis on covering the gaps identified in the course mapping as well as the package of 12 services that has been identified for preventive, promotive and basic curative service delivery for comprehensive primary care – these include the areas of maternal and child health, family planning, communicable diseases, screening for non-communicable diseases, management of acute simple illnesses, basic management of eye, ENT, dental, screening for mental health and provision of basic palliative care and care for the elderly, with a mechanism for prompt and effective referral where appropriate. The course would cover all essential competencies required by a MLHP to deliver care at the Health and Wellness Centers (HWCs). The course would lay extra emphasis on key areas such as Drug Pharmacology, Diagnostic skills including Physical examination, and use of drugs. Basic skills of leadership and management will also be covered in the course).

[58] *Id.* (The Certificate Programmes will be rolled out by IGNOU. Theory classes and hands-on Practicum training will be organized at Program Study Centers and Health Centers (District Hospitals, CHCs, PHCs, Sub Centers, etc.) identified and accredited by IGNOU. In addition to this there would be community visits by students for field-based assignments and research projects).

[59] GOVERNMENT ORDER ARCHIVE, GOVERNMENT OF WEST BENGAL, HEALTH AND FAMILY WELFARE DEPARTMENT (12 Apr. 2019) https://www.wbhealth.gov.in/ pages/gov_order _archive; *See also* GOVERNMENT OF WEST BENGAL (DIRECTORATE OF HEALTH SERVICES) , DUTIES AND RESPONSIBILITIES OF COMMUNITY HEALTH OFFICER (CHO) (2 Apr. 2020), https://www.wbhealth.gov.in/uploaded_files/go/Ng578.pdf.

Another vital course initiated by the Ministry of Health and Family Welfare is the Nurse Practitioner Course in Midwifery Training.[60] The purpose of this program is to post Nurse Practitioners in Midwifery in 'Midwifery-led Care Units,' Primary Health Centres and Urban Primary Health Centres conducting deliveries.[61] This course has been implemented in the State of Gujarat.[62] Thus, Nurse Practitioners in Midwifery Services are expected to act as initial service providers (in primary or community healthcare levels) and a suitable mechanism especially to cope with the shortage of doctors in India.

8.6 Reforms and Other Challenges

The latest revised Basic B.Sc Nursing has raised many issues regarding the minimum educational qualification required for applying. The controversy is regarding the provision that allows entry to arts stream students to B.Sc

[60] MINISTRY OF HEALTH AND FAMILY WELFARE MIDWIFERY SERVICES IN INDIA(12 Aug. 2020), https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf. (In order to be selected for the NPM training programme the candidates must: \ Have a GNM (General Nursing and Midwifery) diploma from a recognized institute/B.Sc Nursing degree from a recognized university \ Be a registered nurse and registered midwife (RN & RM) \ Have at least two years of experience of conducting deliveries or experience of working in the concerned field \ A midwife from other countries must obtain an equivalence certificate from INC before admission to this course For post basic 18-months residential Midwifery Training Programme, staff nurses from the regular/in-service cadre shall be prioritized. While the regular staff is away during the 18-month course work, replacement with a contractual staff shall be considered so that healthcare services at the level of facility are not compromised. The current one year NPM course would be revised to 18 months in accordance to the ICM standards. INC would undertake this exercise in consultation with the MoH & FW. The Nurse Practitioner in Midwifery course curriculum would be approved by INC and MoH & FW before roll out of the programme. Training curriculum would be based on the "Essential Competencies for Midwifery Practice (2018 Update)" defined by ICM. Training would comprise of theory, simulation as well as practical sessions in clinical areas. The training duration would be of 18 months and it would be a strictly residential training).

[61] *Id.* at 14.

[62] Bharati Sharma & Dileep Mavalankar, *Health policy processes in Gujarat : A case study of the Policy for Independent Nurse Practitioners in Midwifery*, INDIAN INSTITUTE OF MANAGEMENT(7 June 2020), http://vslir.iima.ac.in:8080/xmlui/ bitstream/handle/11718/ 11385/2012-08-01.pdf?sequence=1&isAllowed=y.

nursing. [63] The primary concern is about their ability to learn science subjects. Students of Nursing are expected to study anatomy, physiology, and microbiology. They must have a thorough knowledge of the subject to be able to carry out their functions.[64] It is also argued that the new syllabus is a move to disgrace the dignity of the nursing profession itself. The syllabus structure of B.Sc nursing provides a clear vision that supports this argument and raises doubts about the ability of arts stream students to learn the most science-oriented course. [65]

The mushrooming rate of private institutions imparting nursing education is yet another primary concern that affects the quality of nursing education. It is noted that around 88% of nursing education in India is provided by the private sector.[66] It is also reported that fake colleges with the promise of a job and overseas opportunities to students, especially from rural areas, have eroded the quality of nursing education.[67] The lack of proper infrastructure for

[63] B.SC NURSING REVISED SYLLABUS (2 June 2020), http://www. indiannursingcouncil. org/pdf/BSCSyllabus_2019-20.pdf .(Students who studies humanities group at the Plus Two Level is allowed to apply for B.Sc Nursing. The terms of admission reads as "Candidate with Science/Arts/ Humanities/Commerce who have passed the 12th Standard examination (10+2) and must have obtained a minimum of 45% marks in the core/elective/academic subjects taken together and passed English individually).

[64] R.Sujatha, *Indian Nursing Council Syllabus permits arts stream students, upsets professionals and academics*, THE HINDU (20 Jan. 2020), https://www.thehindu.com/ news/national/tamil-nadu/indian-nursing-council-syllabus-permits-arts-stream-students-upsets-professionals-and-academics/article30607637.ece.

[65]INDIAN NURSING COUNCIL REVISED B.SC SYLLABUS (20 Jan.2020), http://www. Indiannursingcouncil. org/pdf/BSCSyllabus_2019-20.pdf .

[66] Kaveri Mayra, Sabu S. Padmadas, Zoe Mathews, C*hallenges and needed reforms in midwifery and nursing regulatory systems in India : Implications for education and practice,* 16(5) PLOS ON (20 Jan.2020), https://doi.org/10.1371/journal.pone.0251331.

[67] Deepa Kurup, *Nursing Colleges need some care,* THE HINDU (10 Feb. 2010), https://www.thehindu.com/news/cities/bangalore/Nursing-colleges-need-some-care/article16462386.ece.

providing clinical training is one of the major issues faced by students in private nursing colleges.

Clinical training is so relevant to nursing students to cope with society's current health care needs.[68] Most of these institutions also lack facilities as to higher education in nursing, especially post-graduation courses. It is to be noted that all the nursing educational institutions must mandatorily attach to a hospital for giving practical knowledge in the form of training programs to nursing students. Still, most of the studies show that this practical learning facility is lacking in private nursing institutions.[69]

The geographical imbalances in nursing education in India are another significant issue in India. Most of the nursing institutions are present in the Southern States of India, especially Andhra Pradesh, Karnataka, Kerala, Maharashtra, Tamil Nadu, Kerala, and Pondicherry, which represents only 31% of the Indian population, whereas nursing institutions account only for 9 % in the most populous Northern States of India such as Madhya Pradesh, Rajasthan, and Uttar Pradesh.[70]

Other issues such as non-compliance of the accreditation standards issued by INC by the Sub-standard institutions, inadequate monitoring and governance at the State level, teaching staff shortage, lack of continuing

[68] Vjayashree Yellappa, *A Sector that needs to be nursed backed to health*, THE HINDU(14 Oct. 2020),https://www.thehindu.com/opinion/lead/a-sector-that-needs-to-be-nursed-back-to-health/article33322153.ece.

[69] R.Sujatha, *The hands-on edge*, THE HINDu (6 Feb. 2012), https://www.thehindu.com/features/education/the-handson-edge/article2865467.ece.

[70]Catron Evans,Rafath Razia and Elaine Cook, *Building nurse education capacity in India: Insights from a faculty development program in Andhra Pradesh* ,12 BMC NURSING (2013) (2 Jan. 2020),https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3637284/pdf/1472-6955-12-8.pdf.

professional development for faculty, poor physical infrastructure, lack of professional opportunities for faculty, including the scope of practice as a nurse, disorder curriculum, reliance on didactic teaching approaches, poor student living accommodation, poor links between clinical areas and educational institutions and inadequate clinical experiences, etc. have been pointed out by research studies.[71]

The increasing cost of education is another problem that needs a uniform regulation between the government and private institutions' fee rates.[72] Most of the research studies and personal interviews conducted by the researcher reveal the concerns of the nursing students about the affordability of nursing education and the need for a balance between the fee structure and the salary which they receive once they start their career. [73]

The need for more advanced opportunities for nursing students significantly increasing seats in post-graduation courses, new advanced curriculum with more specializations, and the integration of diploma (G.N.M) and degree (B.Sc) courses are raised in most of the studies relating to nursing education in India.[74]

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[71] CIVILSDAILY ISSUES RELATED TO NURSING SECTOR IN INDIA (12 Oct. 2020), https:// www.civilsdaily.com/news/a-sector-that-needs-to-be-nursed-back-to-health/.

[72]GOVERNMENT OF KERALA PROSPECTUS FOR ADMISSION TO PROFESSION DEGREE COURSES IN NURSING(20 Jun. 2020), https://www.lbscentre.in/ parmedeg2019/downloads/prospectus. Pdf. (A comparative analysis of fee structure of B.Sc nursing course shows, the normal fee charged B.Sc nursing course offered by Government nursing institutions is Rs.20,000/- whereas the private institutions charge Rs.64,000/-as annual fee for both the merit seat and management seats).

[73] Deepa Kurup, *Nursing Colleges need some care*, THE HINDU, (10 Feb. 2010), https://www. thehindu.com/news/cities/bangalore/Nursing-colleges-need-some-care/article16462386.ece.

[74]Meenal Aravind Rane, *Host a healthy community*, THE HINDU, (23 Jan. 2021), https://www.thehindu.com/education/host-a-healthy-community/article33641787.ece.

8.7 Conclusion

Educating nurses with proper standards, syllabus and infrastructure facilities will improve their quality in delivering health care and enhance their professional status and dignity. Though high fee demanded by private nursing institutions has always been a concern, it can cope by uplifting their job opportunities with a safe and secured remuneration package. Leaving these few criticisms, it is also appraisable that there are still excellent institutions in India effectively imparting nursing education, complying with the recommendations of the Indian Nursing Council. They provide practical clinical training to nursing students and provide opportunities to enhance their theoretical and practical knowledge. One positive fact that the researcher noted is that most of the respondents in this study are satisfied with the education they received. It is notable that most of them are aware of the advancements in nursing education and its specializations. The misery begins once they start practicing. It is also shocking that the researcher could notice from its empirical study that the majority of the nurses who participated in the empirical study were reluctant to suggest their profession to their children and family members. The stigma attached to the profession (low status and low payment) often de-motivates them from passing the glory of brightness which the lamp holds to the upcoming generations. However, migration opportunities always keep the profession from losing its charm.

CHAPTER -IX

REGULATION OF NURSING PROFESSION: A COMPARATIVE STUDY OF INTERNATIONAL LEGISLATIVE FRAMEWORK

Introduction

The chapter analyses the regulatory framework of the nursing profession in selected jurisdictions of the world. The increasing tendency of nurses to migrate from India is the reason behind the study. Matters such as nurses' status, role, standards of practice, functions, and powers are analyzed to know the best practices followed by these countries and adapted to India.

9.1 Migration of Nurses

The migration of nurses from India, especially from the State of Kerala, is known worldwide. As per the WHO report, nurses trained in India form many internationally educated nurses working overseas.[1] It is also pointed out that "over 30% of nurses who studied in Kerala work in the United Kingdom or the United States of America, with 15% in Australia and 12% in the Middle East".[2]As per these statistics, "an estimated 33,147 nurses from India were working in OECD countries in 2016.[3] Countries such as Australia, Bahrain, Canada, Kuwait, Saudi Arabia, the United Arab Emirates, and the United Kingdom are other significant destination areas. Acceptance of nursing

[1] WHO, MIGRATION OF NURSING AND MIDWIFERY WORKFORCE IN THE STATE OF KERALA, 2017(12 Aug.2019),https://www.who.int/workforcealliance/brain-drain-brain-gain/migrat ion-of-nursing-midwifery-in-keralawho.pdf?ua=1.
[2]*Id.*
[3]*Id.*

education in India at a global level is the major contributing factor that aids nurses in migrating easily to other countries. Better working condition with a fair salary is the major attraction for migration. The table below shows the percentage of migration of nurses in 2016.

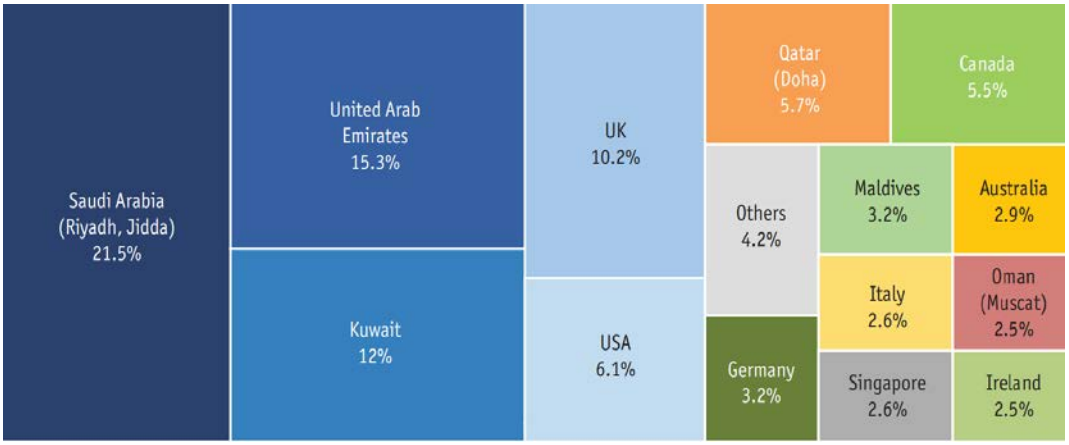

Figure 9.1: Migration of Nurses and Nurse Assistants ;Source: WHO.[4]

The legislative framework prevalent in countries such as the United Kingdom, United States, Canada, Australia, South Africa, the Philippines, and the Middle East are analyzed.

9.2 United Kingdom

As nursing originated from the United Kingdom, a look into its legislative framework is inevitable. In the United Kingdom, the Nursing and Midwifery Order 2001 (latest amendment on 2018) framed under the Health Act 1999 deals with the regulation of nurses.[5] Similar to India, aspects such as functions of the Nursing and Midwifery Council, registration, fitness to

[4]FROM BRAIN DRAIN TO BRAIN GAIN , MIGRATION OF NURSING AND MIDWIFERY WORKFORCE IN THE STATE OF KERALA, WORLD HEALTH ORGANIZATION (12 Dec. 2020), https://www.who.int/workforcealliance/brain-drain-brain-gain/Migration-of-nursing-midwifery-in-KeralaWHO.pdf?ua=1.

[5]The Nursing and Midwifery Order 2001, No.253, UK(5 Dec. 2020), https://www.nmc.org.uk/about-us/governance/our-legal-framework/.

practice processes, and educational standards and training are covered by the Order. It classifies functions into 'principal' and 'over-arching objectives.

Ensuring standards of education, training, conduct, and performance of nurses, midwives, and nursing associates are the principal functions,[6] and Protection of the public is the overarching function of the Council.[7] 'Over-arching functions' are regarded as a means to protect, promote and maintain the health of people; public confidence in the profession; proper professional standards and conduct for members of those professions.[8]

Two committees titled the 'Investigating committee' and the 'Fitness to Practice Committee, function under the Council.[9] Investigation of all the allegations made against those registrants (nurses who have registered under the Order) is entrusted with the Investigating Committee.[10] The committee can order the removal of names from registration in cases where the allegations are correct.[11] The practice committee is empowered to decide all matters referred to by the investigating committee related to the fitness to practice.[12]

Like India, provisions as to the role of the Council and the registrar are mentioned in the Act[13]. The council is empowered to publish standard of practice to which every nurse is obliged to comply. The council also enjoys the power to ensure the compliance of the required standard of education and

[6] *Id.* The Nursing and Midwifery Order 2001, No.253,UK,art. 3(2).
[7] *Id.* The Nursing and Midwifery Order 2001, No.253,UK, art. 3(4).
[8] *Id.* The Nursing and Midwifery Order 2001, No.253, UK, art.3(1)(4) A.
[9] *Id.* The Nursing and Midwifery Order 2001, No.253, UK, art.3(9).
[10] *Id.* The Nursing and Midwifery Order 2001, No.253, UK,art.26.
[11] *Id.* The Nursing and Midwifery Order 2001, No.253, UK ,art.26(7).
[12] *Id.* The Nursing and Midwifery Order 2001, No.253, UK,art.26 D.
[13] *Id.*The Nursing and Midwifery Order 2001, No.253, UK, art.4.

training by the universities and other bodies in the United Kingdom.[14] The power to withdraw approval or refuse approval of courses, qualifications and institutions are entrusted with it.[15]

The council is also entrusted with the power to make rules about the post-registration training to registrants for continuing professional development.[16] This is a good provision that assures professional advancements and progress. The council is again empowered to review the registrants' standards of conduct, performance, and ethics.[17] From time to time, guidance's by the council to registrants, employers, and other persons on matters relating to standard of education and performance are also mentioned in the code. Grounds such as misconduct, lack of competence, a conviction for a criminal offense (conviction by Court Martial), physical or mental impairment, lack of knowledge in the English language, and fraudulent procurement of registration are grounds for removal or withdrawal of name from the register.[18]

The Order empowers the registrar to grant temporary registration to those competent persons in case of emergencies involving loss of human life or human illness.[19]This Act can be justified in meeting its objective of assuring safe public health through good nursing practices.

[14]*Id.* The Nursing and Midwifery Order 2001,No.253, UK, art. 15.
[15]*Id.* The Nursing and Midwifery Order 2001,No.253, UK art.18.
[16]*Id.* The Nursing and Midwifery Order 2001,No.253, UK. art.19.
[17] *Id.* The Nursing and Midwifery Order 2001,No.253, UK, art. 21.
[18]*Id.* The Nursing and Midwifery Order 2001,No.253, UK ,art.22.
[19]*Id.* The Nursing and Midwifery Order 2001,No.253, UK ,art. 9 A.

Another relevant legislation in the United Kingdom is the Medicinal Products: Prescription by Nurses ….etc, Act 1992.[20] It grants the power to prescription to registered nurses. Persons such as Community practitioner nurse prescribers,[21]Nurse independent prescribers,[22] and Nurse Independent/Supplementary prescribers,[23] are granted the power to prescribe

[20] Medicinal products: prescription by nurses etc, act 1992**,** (18 Jun. 2020)http://www.legislation.gov.uk/ukpga/1992/28/introduction Prescription only drugs etc.(Authorization of registered nurses, midwives and health visitors (1)In section 58 of the M1 Medicines Act 1968 (medicinal products on prescription only) in subsection (1) (which specifies who are to be appropriate practitioners in relation to specified descriptions or classes of medicinal products) at the end of paragraph (c) there shall be inserted "and (d) Registered nurses, midwives and health visitors who are of such a description and comply with such conditions as may be specified in the order").

[21]NURSING AND MIDWIFERY COUNCIL STANDARDS FOR PRESCRIBING PROGRAMS(18 Jun. 2020),https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/prescribing/programme-standards-prescribing.pdf.(Standards for Prescribing Programmes defines Community practitioner nurse or midwife prescriber This refers to a registered nurse (level 1), midwife or SCPHN who has an annotation next to their name on our register confirming that they are qualified to prescribe drugs, medicines and appliances from the Nurse Prescribers' Formulary for Community Practitioners in the current edition of the British National Formulary).

[22] Amendment of the national health service (charges for drugs and appliances) (wales) regulations 2001 (18 Jun. 2020), http://www.legislation.gov.uk/wsi/2003/2624/regulation/4/made**. (**§4(2) (a) defines ""independent nurse prescriber" means—(a)a person whose name is registered—(i) in Part 1 or 12 of the nurses and midwives' professional register and has a district nurse qualification additionally recorded in the nurses and midwives' professional register pursuant to rule 11 of the Nurses, Midwives and Health Visitors Rules 1983, or (ii) in Part 11 of the nurses and midwives' professional register as a health visitor, and against whose name is recorded in the nurses and midwives' professional register an annotation signifying that he or she is qualified to order drugs, medicines and appliances from the Nurse Prescribers' Formulary for District Nurses and Health Visitors in Part XVII B(i) of the Drug Tariff; or (b) a person— (i) whose name is registered in Parts 1,3, 5, 8, 10, 11, 12, 13, 14, or 15 of the nurses and midwives' professional register, and (ii) against whose name is recorded in the nurses and midwives' professional register an annotation signifying that he or she is qualified to order drugs, medicines and appliances from the Nurse Prescribers' Extended Formulary in Part XVIIB (ii) of the Drug Tariff").

[23]NURSING AND MIDWIFERY COUNCIL STANDARDS FOR PRESCRIBING PROGRAMS(18 Jun. 2020),https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/prescribing/programme-standards-prescribing.pdf. (This refers to a registered nurse (level 1), midwife or SCPHN who has an annotation next to their name on our register confirming that they are able to work in partnership with an independent prescriber (such as a doctor or dentist) to implement an agreed patient/client-specific clinical management plan with the patient/ client's agreement. In order to obtain independent/supplementary prescriber status, a registered nurse, midwife or SCPHN must successfully complete an independent/ supplementary prescriber preparation programme. This is sometimes known as a 'V300 course', from the code that is used to enter the annotation onto the NMC register indicating that a nurse or midwife has successfully completed an NMC approved prescribing programme

medicines.[24]The nurses can enjoy powers subject to the standards of prescribing programs issued by the Nursing and Midwifery Council.[25]It is notable that nurses are allowed to prescribe drugs that are mentioned as 'Controlled drugs',[26] in the regulations. The aspect of public protection, procedures for investigation by the committees on allegations against nurses, and the privilege to prescribe can be regarded as some of the novel provisions which can be incorporated into the legislative framework of India.

Further, it is also pertinent to note that the Nurses and Midwifery Council in the UK has drafted the Code on 'Professional Standards of practice and behavior for nurses'.[27] As stated in the legislation, the protection of the public is the primary aim of the Code. The code contains the standard of practice that every registered nurse is bound to uphold while providing care to individuals, groups, or communities.[28] The code includes four main headings: prioritize people, Practice effectively, Preserve safety, and Promote professionalism and trust. Registered nurses shall abide by the code; any failure

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that gives them independent/ supplementary prescriber status, allowing them to prescribe any drugs (except certain controlled drugs) appropriate to their scope of practice).

[24]THE NURSES AND MIDWIVES (PARTS OF AND ENTRIES IN THE REGISTER)AMENDMENT ORDER OF COUNCIL 2006 (12 July 2020), http://www.legislation. gov.uk/uksi/ 2006/ 1015/ made.

[25] NURSING AND MIDWIFERY COUNCIL STANDARDS FOR PRESCRIBING PROGRAMS,(18 June 2020),https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/prescri bing/ programme-standards-prescribing.pdf.

[26]Misuse of Drugs Regulations 2001 (18 Jun. 2020),http://www.legislation. gov.uk/uksi/2001/3998/ contents/made. (Nurse Independent prescribers is permitted to prescribe any Schedule 2, 3, 4 or 5 Controlled Drugs. Community practitioner nurse prescribers can prescribe all appliances listed in Part IX of the Drug Tariff as they are included in the Nurse Prescribers' Formulary for Community Practitioners). See also, AN INTRODUCTION TO PART IX OF THE DRUG TARIFF (18 Jun. 2020) https://www.nhsbsa.nhs.uk/sites/ default/files/2019-04/DT%20Guidance%20v4.9.pdf.

[27]NURSING AND MIDWIFERY COUNCIL, THE CODE (2 Sep. 2020), https://www. nmc.org.uk/ globalassets/sitedocuments/nmc-publications/nmc-code.pdf.

[28]*Id.*

to follow its principles is expected to invoke disciplinary actions on the part of the nursing council. Punishment may include the removal of names from the register.

9.2 United States of America

A comparative study is made with the United States to ascertain how the States designs their legal framework incorporating the powers of nurses and regulatory framework of their State of Practice. Most of the States in the USA have enacted the Nurse Practitioner Act. Usually, under the legislation, three kinds of practice are allowed to Nurse Practitioners such as the entire practice, reduced practice, and restricted practice.[29] In the entire practice, nurses are allowed to evaluate patients, diagnose order and interpret diagnostic tests and initiate and manage treatments.[30] Prescription of medications of controlled substances/drugs is also allowed to be performed by them.[31] Nurse Practitioner Act and regulations enacted by the States such as Alaska,[32] Arizona,[33] Colorado,[34]Connecticut,[35] District of Columbia,[36] Hawaii,[37] Idaho,[38] Iowa,[39]

[29]AMERICAN ASSOCIATION OF NURSE PRACTITIONERS (5 Sept. 2020), https://www.aanp.org/advocacy/state/state-practice-environment.
[30]*Id.*
[31]NURSE PRACTITIONER, SCOPE OF PRACTICE (22 Jun. 2020), https://www.nursepractitionerschools. com/faq/how-does-np-practice-authority-vary-by-state/.
[32]AK NURSING STATUTES (5 Nov. 2020),https://www.commerce.alaska.gov/web/portals/5/pub/Nursing Statutes.pdf.
[33] AZ NURSING STATUTES, AZ NURSE PRACTICE ACT(25 June 2020),https://www.azbn.gov/laws-and-rules/statutes.
[34] CO BOARD OF NURSING LAWS (12 Apr.2020), https://www.colorado.gov/pacific/dora/Nursing_Laws.
[35] CT NURSE PRACTICE LAWS (12 Sept. 2020),https://portal.ct.gov/DPH/Public-Health-Hearing-Office/Board-of-Examiners-for-Nursing/Board-of-Examiners-for-Nursing.
[36]DC NURSE PRACTICE ACT (12 Oct. 2020),http://doh.dc.gov/sites/ default/files/dc/sites/doh/publication/attachments/DC%20Nurse%20Practice%20Act:.pdf.
[37] HI NURSING STATUTES (2 Dec.2020)http:// cca.hawaii. gov/pvl/ boards/ nursing/ statute_rules/ .

Maine,[40] Maryland,[41] Minnesota,[42] Montana,[43] Nebraska,[44] Nevada,[45] New Hampshire,[46] New Mexico,[47] North Dakota,[48] Oregon,[49] Rhode Island,[50] Vermont,[51]Washington,[52] and Wyoming,[53]follows full practice.

In reduced practice, the advanced nurse practitioners are allowed to practice in collaboration with a physician.[54] A formal relationship exists between them.[55]

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[38]ID NURSE PRACTICE ACT (18 Dec.2020),https://legislature.idaho.gov/statutesrules/idstat/Title54/T54CH14/ .
[39]IA NURSE PRACTICE ACT (22 Dec. 2020),https://nursing.iowa.gov/nursing-practice
[40]ME NURSE PRACTICE ACT (12 Nov.2020),http://legislature.maine.gov/statutes/32/title32ch31sec0.html.
[41]MD NURSE PRACTICE ACT (4 Nov.2020),http://www.dsd.state.md.us/comar/subtitle_chapters/10_ Chapters.aspx.
[42] MN NURSE PRACTICE ACT (18 Nov. 2020),https://mn.gov/boards/nursing/laws-and-rules/nurse-practice-act/.
[43]MT NURSE PRACTICE ACT (12 Aug.2020),https://leg.mt.gov/bills/mca/title_0370/chapters_index.html? pk_vid=d4d1611717c03af61592389015f69b59.
[44]NE NURSING REGULATIONS & STATUTES (12 Aug. 2020), http://dhhs.ne.gov/Pages/ DHHS-Regulations.aspx.
[45] NV NURSE PRACTICE ACT (21 Aug. 2020),https://nevadanursingboard.org/practice-information/.
[46]NH NURSE PRACTICE ACT (21 Aug. 2020), hhttp://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXX-326-B.htm.
[47] NM NURSE PRACTICE ACT (22 Aug. 2020),http://nmbon2015.sks.com/forms.aspx.
[48]ND NURSE PRACTICE ACT (19 Nov.2020),https://www.ndbon.org/ RegulationsPractice/NursePracticesAct.asp.
[49]*Id.*NURSING RULES & PROCEDURES(12 Dec.2020),https://secure.sos.state.or.us/oard/ displayChapterRules.action?selectedChapter=16.
[50]WEBSERVER (10 June 2021),http://webserver.rilin.state.ri.us/Statutes/TITLE5/5-34/INDEX.HTM.
[51] VERMONT GENERAL ASSEMBLY (2 Aug. 2021), https://legislature. vermont.gov/ statutes/chapter/26/028.
[52]WASHINGTON STATE LEGISLATURE (3 June 2021),http://app.leg.wa.gov/rcw/default.aspx?cite=18.79.
[53]STATE OF WYOMING, 66TH LEGISLATURE (2 June 2021),http://legisweb.state.wy.us/LSOWEB/wyStatutes.aspx.
[54]ADVANCED PRACTICE NURSING-COLLABORATIVE PRACTICE, http://www.alabamaadministrativecode.state.al.us/docs/nurs/610-X-5.pdf (28 Dec.2020). The Alabama Board of Nursing Administrative Code defines collaboration as "The term collaboration does not require direct, on-site supervision of the activities of a certified registered nurse practitioner or a certified nurse midwife by the collaborating physician. The term does require such professional medical oversight and direction as may be required by the rules and regulations of the Board of Nursing and the State Board of Medical Examiners").
[55] *Id.*

The performance of reduced practice by registered nurses depends upon the approval of the Board of Nursing and State Board of Medical Examiners.[56] The prescription power is also limited to the restrictions imposed.[57]

[56] *Id.*

[57] *Id.*(Prescriptions and Medication Orders by Certified Registered Nurse Practitioners(1) Certified registered nurse practitioners engaged in collaborative practice with physicians may be granted prescriptive authority upon submission of evidence of completion of an academic course in pharmacology or evidence of integration of pharmacology theory and clinical application in the certified registered nurse practitioner curriculum. (2) Certified registered nurse practitioners practicing under protocols approved in the manner prescribed by Code of Ala. 1975, §.34-21-80 et seq. may prescribe legend drugs to their patients, subject to the following conditions: (a) The drug shall be included in the formulary recommended by the Joint Committee and adopted by the Board of Nursing and the State Board of Medical Examiners. (b) The drug type, dosage, quantity prescribed, and number of refills shall be authorized in an approved protocol signed by the collaborating physician and the certified registered nurse practitioner. (3) A certified registered nurse practitioner shall not initiate a call-in prescription in the name of a collaborating physician for any drug, whether legend or controlled substance, which the certified registered nurse practitioner is not authorized to prescribe under the protocol signed by the collaborating physician and certified registered nurse practitioner and approved under this section unless the drug is specifically ordered for the patient by the physician, either in writing or by a verbal order which has been transcribed in writing, and which has been signed by the physician within seven working days or as otherwise specified by the Board of Nursing and the State Board of Medical Examiners. (4) A written prescription for any drug that the certified registered nurse practitioner is authorized to prescribe may be called in to a pharmacy, provided the prescription is entered into the patient's record and signed by the certified registered nurse practitioner. (5) The certified registered nurse practitioner in collaborative practice with prescriptive privileges shall not engage in prescribing for: (a) Self. (b) Immediate family members. (c) Individuals who are not patients of the practice, except in cases where a certified registered nurse practitioner is prescribing for the sexual partner(s) of a patient in accordance with an Expedited Partner Therapy (EPT) protocol for the prevention of transmission and spread of sexually transmitted disease(s). (6) The certified registered nurse practitioner who is in collaborative practice and has prescriptive privileges may receive and sign for samples of legend drugs that are authorized in the approved formulary for the collaborative practice, provided the certified registered nurse practitioner complies with all applicable state and federal laws and regulations. (7) When prescribing legend drugs a certified registered nurse practitioner shall use a prescription format that includes all of the following: (a) the name, medical practice site address, and telephone number of the collaborating physician or covering physician. (b) The name of the certified registered nurse practitioner. (c) The medical practice site address and telephone number of the certified registered nurse practitioner if different from that of the collaborating physician. (d) The certified registered nurse practitioner's registered nurse license number and identifying prescriptive authority number assigned by the Board of Nursing. (e) The words "Product Selection Permitted" printed on one side of the prescription form directly beneath a signature line. (f) The words "Dispense as written" printed on one side of the prescription form directly beneath a signature line. (g) The date the prescription is issued to the patient).

Legislation on Nurse Practitioner Act and regulations enacted by States such as Alabama,[58] Arkansas,[59] Delaware,[60] Illinois,[61] Indiana,[62] Kansas,[63] Kentucky,[64] Louisiana,[65] Massachusetts,[66]Michigan,[67] Mississippi,[68] New Jersey,[69] New York,[70] Ohio,[71] Pennsylvania,[72] South Dakota,[73] Utah,[74] Virginia,[75] West Virginia,[76] and Wisconsin,[77]follows the practice of reduced practice.

Restricted Practice is the third kind of practice allowed by State laws and regulations. State practice and licensure laws allow Nurse Practitioners to

[58]ALABAMA BOARD OF NURSING, ADMINISTRATIVE CODE (12 Aug. 2020) http://www.alabamaadministrativecode.state.al.us/docs/nurs/610-X-5.pdf.
[59]ARKANSAS STATE BOARD OF NURSING (16 Nov. 2020), https://www.arsbn.org/nurse-practice-act.
[60]THE DELAWARE CODE (12 Aug. 2020), https://delcode.delaware.gov/title24/c019/index.shtml.
[61]ILLINOIS GENERAL ASSEMBLY (18 Oct. 2020), http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1312&ChapterID=24.
[62]INDIANA PROFESSIONAL AGENCY (18 Oct. 2020), http://www.in.gov/pla/files/ISBN.2011_EDITION.pdf.
[63] KANSAS PROFESSIONAL AGENCY (18 Oct. 2020), http://www.ksbn.org/npa/npa.pdf .
[64]KENTUCKY BOARD OF NURSING (22 Oct.2020),https://kbn.ky.gov/ practice/Pages/default.aspx.
[65]LOUISIANA STATE BOARD OF NURSING (15 Oct. 2020), http://www.lsbn.state.la.us/NursingPractice/Laws,Rules.aspx.
[66]MASSACHUSETTS BOARD OF NURSING (19 June 2020), https://www.mass.gov/service-details/laws-regulations-board-of-registration-in-nursing.
[67]MICHIGAN GOVERNMENT, NURSING FAQ (21 Oct. 2020),https://www.michigan.gov/lara/0,4601,7-154-89334_72600_72603_27529_27542-295888-,00.html.
[68] MISSISSIPPI BOARD OF NURSING (25 Oct. 25, 2020), https://www.msbn.ms.gov/Documents/NursingPracticeAct.pdf.
[69]NEW JERSEY BOARD OF NURSING LAW (18 June 2020), https://www.njconsumeraffairs.gov/Statutes/nursinglaw.pdf.
[70]NYSED.GOV. (25 Oct. 2020), http://www.op.nysed.gov/prof/nurse/nurselaw.htm.
[71]OHIO BOARD OF NURSING (20 Sept. 2020), https://nursing.ohio.gov/Law_and_Rule.htm.
[72]PENNSYLVANIA CODE & BULLETIN (28 Sept.2020), https://www.pacode.com/secure/data/049/chapter21/subchapCtoc.html.
[73]SOUTH DAKOTA LEGISLATURE (25 Oct.2020) https://sdlegislature.gov/Statutes/Codified_Laws/DisplayStatute.aspx?Type=Statute&Statute=36-9A.
[74]UTAH BOARD OF NURSING (8 Oct. 2020), https://dopl.utah.gov/nur/index.html.
[75]VIRGINIA BOARD OF NURSING, (15 Oct. 2020), http://www.dhp.virginia.gov/nursing/nursing_laws_regs.htm.
[76]WEST VIRGINIA CODE, (28 Oct.2020),http://www.legis.state.wv.us/WVCODE/code.cfm?chap=30&art=7#1.
[77]WISCONSIN. GOV. (18 Oct.2020),https://dsps.wi.gov/Pages/RulesStatutes/Nursing.aspx.

engage in only one element of Nurse Practitioner practice.[78] It requires career-long supervision, delegation, or team management by another health provider for the Nurse Practitioner to provide patient care.[79] One of the best illustrations can be found in the Nursing Practice Act prevailing in the State of California, which restricts the scope of practice of Nurse Practitioners to Ordering of Drugs (Prescription) alone. The law also requires supervision of the nurse practitioner by a Physician and Surgeon under a collaborative effort. [80] States such as California, Florida, Georgia, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas follow the restricted practice.

About the legislative framework in the USA, it is essential to note the Nursing Practice Act prevalent in the State of California, which provides a clear explanation as to the practice of nursing without overlapping with that of the physicians.[81] It includes functions that range from primary health care to direct and indirect patient care ensuring safety and protection of patients, administration of medications, the performance of skin tests including immunization techniques, withdrawal of human blood from veins, observation of signs and symptoms of illness, including reactions to treatment and initiation and implementation of emergency procedures as per standardized procedures.[82]

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[78]NURSE PRACTITIONER (19 Oct. 2020), https://www.nursepractitionerschools.com/faq/how-does-np-practice-authority-vary-by-state/.

[79]*Id.*

[80]CALIFORNIA BUSINESS AND PROFESSIONS CODE, §2834-2837,art. 8.(10 June 2020), https://law.justia.com/codes/california/2005/bpc/28342837.html#:~:text=2005%20 California %20 Business %20and% 20Professions, Nurse%20Practitioners &text=2834.&text= No%20 person%20shall% 20advertise%20or,practitioner%20established%20by%20the%20board.

[81]CALIFORNIA NURSING PRACTICE ACT,2013,art.2 (19 July 2020),https://www.rn.ca. gov/pdfs/ regulations/npr-i-15.pdf.

[82]*Id.* (Article 2 reads as scope of regulations (b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with

This is also another necessary provision that can be adapted to the Indian legislative framework. Concerning the Standard of Practice, the American Nurses Association has drafted Standard of Practice for All Registered Nurses (2010).[83]

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difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following):
(1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.
(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.
(3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.
(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

[83] AMERICAN NURSES ASSOCIATION, SCOPE AND STANDARDS OF PRACTICE(2 Oct. 2020), https://oysconmelibrary01.files.wordpress.com/2016/09/website-ana-2010 nursing-scope-and-standards-of-practice.pdf.(Standard 1. Assessment The registered nurse collects comprehensive data pertinent to the healthcare consumer's health and/or the situation. Standard 2. Diagnosis The registered nurse analyzes the assessment data to determine the diagnoses or the issues. Standard 3. Outcomes Identification The registered nurse identifies expected outcomes for a plan individualized to the healthcare. The graduate-level prepared specialty nurse or advanced practice registered nurse provides consultation to influence the identified plan, enhance the abilities of others, and effect consumer or the situation. Standard 4. Planning The registered nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes. Standard 5. Implementation The registered nurse implements the identified plan. Standard 5A. Coordination of Care The registered nurse coordinates care delivery. Standard 5B. Health Teaching and Health Promotion The registered nurse employs strategies to promote health and a safe environment. Standard 5C. Consultation The graduate-level prepared specialty nurse or advanced practice registered nurse provides consultation to influence the identified plan, enhance the abilities of others, and effect change. Standard 5D. Prescriptive Authority and Treatment The advanced practice registered nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations. Standard 6. Evaluation The registered nurse evaluates progress toward attainment of outcomes. Standard 7. Ethics The registered nurse practices ethically. Standard 8. Education The registered nurse attains knowledge and competency that reflects current nursing practice. Standard 9. Evidence-based Practice and Research The registered nurse integrates evidence and research findings into practice. Standard 10. Quality of Practice The registered nurse contributes to quality nursing practice. Standard 11. Communication The registered nurse communicates effectively in all areas of practice. Standard 12. Leadership

Another notable aspect regarding the legislative framework in the United States is the prevalence of regulations for nurse staffing and patient care,[84] through which hospitals are regulated by ensuring quality health care. Some examples include the Nurse Staffing Standards for Patient Safety and Quality Care Act of 2013, prevalent in California.[85]

The Act provides for a staffing plan in hospitals in the form of Application of Minimum Direct Care Registered- Nurse-To-Patient Ratios. Under the program, a direct care registered nurse is not expected to take care of more than the provided number of the patient at a time.[86]The Act prohibits

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The registered nurse demonstrates leadership in the professional practice setting and in the profession. Standard 13. Collaboration The registered nurse collaborates with healthcare consumer, family, and others in the conduct of nursing practice. Standard 14. Professional Practice Evaluation The registered nurse evaluates her or his own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules, and regulations. Standard 15. Resource Utilization The registered nurse utilizes appropriate resources to plan and provide nursing services that are safe, effective, and financially responsible. Standard 16. Environmental Health The registered nurse practices in an environmentally safe and healthy manner).

[84] Juh Hyun Shin, Jung Eun Koh, Ha Eun Kim, et al. *‚Analysis of professional health provider need in east Nusa Tenggara until 2015,* 5 HEALTH SYST POLICY RES. 2 (2018).

[85] NURSE STAFFING STANDARDS FOR PATIENT SAFETY AND QUALITY CARE ACT, 2013 (Oct. 18, 2020),https://www.congress.gov/bill/113th-congress/house-bill/1907/text.

[86]*Id.*(NURSE STAFFING STANDARDS FOR PATIENT SAFETY AND QUALITY CARE ACT, 2013, § 3401 (b) (1) “(1) IN GENERAL.—Except as provided in paragraph (4) and other provisions of this section, a hospital’s staffing plan shall provide that, at all times during each shift within a unit of the hospital, a direct care registered nurse may be assigned to not more than the following number of patients in that unit:
“(A) One patient in trauma emergency units.
“(B) One patient in operating room units, provided that a minimum of 1 additional person serves as a scrub assistant in such unit.
“(C) Two patients in critical care units, including neonatal intensive care units, emergency critical care and intensive care units, labor and delivery units, coronary care units, acute respiratory care units, post anesthesia units, and burn units).
“(D) Three patients in emergency room units, pediatrics units, step-down units, telemetry units, antepartum units, and combined labor, deliver, and postpartum units.
“(E) Four patients in medical-surgical units, intermediate care nursery units, acute care psychiatric units, and other specialty care units.
“(F) Five patients in rehabilitation units and skilled nursing units.
“(G) Six patients in postpartum (3 couplets) units and well-baby nursery units.”).

imposition of mandatory overtime requirements to meet the direct care registered nurse-to-patient ratios.[87]

The California Nurse-to-Patient-Ratio law provides the minimum registered nurse-to-patient ratios for hospitals.[88]This ratio reflects the maximum number of patients assigned to a registered nurse during one shift. The law also prohibits unlicensed persons from performing nursing functions.

The safe staffing for quality care act 2013,[89] prevalent in New York, explains the nurse-patient ratio to be followed in hospitals.[90] The Act explains the need for a nurse-patient ratio as a means to ensure quality patient care. It is mentioned that "to ensure the adequate protection of patients in health care settings, qualified registered nurses be available to meet the needs of the patients ….and the basic principles of staffing in the healthcare setting must be based on patient care needs……..".[91]Under this law, the direct care nurse can refuse a work assignment against the safe staffing requirements.[92]

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[87]*Id.*NURSE STAFFING STANDARDS FOR PATIENT SAFETY AND QUALITY CARE ACT, 2013, §340199(3)(B).
[88]CALIFORNIA LEGISLATURE, ASSEMBLY BILL, 394 (1999-2000) (29 Oct. 2020), https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=199920000AB394
[89]NEW YORK LEGISLATIVE ASSEMBLY BILL 2954(18 Sept.2020) https://www.nysenate.gov/ legislation/ bills/2019/a 2954 https://www.nysenate.gov/legislation/bills/2019/a 2954.
[90]*Id.*(NEW YORK LEGISLATIVE ASSEMBLY BILL 2954, § 2826.3 reads "Minimum Staffing Requirements as(a) the documented staffing plan shall incorporate, at a minimum, the following direct-care nurse-to patient rations :- (1) One nurse to one patient :Operating room and Trauma emergency units and all critical care areas including emergency critical care and all intensive care units and maternal/child care units ……(ii) one nurse to two patients : Maternal/child care units for the first stage of labor…….(iii) one nurse to three patients: antepartum, emergency room, pediatrics, …….(iv) one nurse to three patients : post-partum mother/baby couplets…… (v) one nurse to four patients : non-critical antepartum patients, and medical/surgical and acute care psychiatric units; (vi) one nurse to five patients: rehabilitation units; and (vii) one nurse to six patients : well-baby nursery units……..").
[91]*Id.* (NEW YORK LEGISLATIVE ASSEMBLY BILL 2954,§.2823 A).
[92]*Id.* (NEW YORK LEGISLATIVE ASSEMBLY BILL 2954,§.2832. 2).

The other States, such as Massachusetts, Connecticut, Illinois, Nevada, Texas, Vermont, and Washington, also have laws regulating the nurse-patient ratios, thereby ensuring the availability of sufficiently qualified nurses as per the patient's needs.[93] Thus, these laws are good examples that can be adopted in the Indian legislative framework for ensuring quality patient care.

9.4 Canada

Canada is another State which provides an elaborate discussion about the regulatory aspects of nurses. Jurisdiction of Canada is selected to know those provisions which grant more independent status to nurses within a well-defined regulatory framework. Similar to India, Canada follows the federal structure of governance.

The Nursing Act, 1991 and the Regulated Health Professionals Act, 1991 deal with the regulation of nurses in Canada. One of the notable aspects is that the regulatory bodies constituted in each province are entrusted with the power to regulate the conduct of their members. Apart from that, there is no national license for nurses in Canada.

A broader scope of practice to nurses as inclusive of activities related to the promotion of health is provided by the Nursing Council Act, 1991.[94] The Act defines the practice of nursing as "the promotion of health and assessment of the provision of care for and the treatment of health conditions by

[93] Juh Hyun Shin, "et al.",*Analysis of professional health provider need in east Nusa Tenggara until 2015*, 5 HEALTH SYST POLICY RES. 2 (2018).

[94]ONTARIO REGULATIONS 275/94 & 799/93 (20 June 2020), http://66.135.122.117/en/what-is-cno/regulation-and-legislation/legislation-governing-nursing/.

supportive, preventive, therapeutic, palliative and rehabilitative means to attain or maintain optimal function".[95] Compared to India, the provincial nursing council in Canada provides enhanced representations to nurses. Around twenty-one persons, of whom fourteen (elected by) from among members who are registered nurses and seven (elected by) from among members who are practical nurses.[96]

The Ontario regulations enacted under the Nursing Act, 1991 deal with the aspect of registration and professional misconduct of nurses. Differs from India, this Act provides more detailed procedures for registration as nurses, such as successful completion of a baccalaureate degree in nursing, training program in nursing, national registration examination, and nursing jurisprudence examination.[97]

The Act classifies registered nurses' certificates into six classes such as general, extended, temporary, particular assignment, emergency assignment, and non-practicing.[98] Except for the extended class of certificates, a registered

[95] *Id.*
[96] *Id*,§9 (1).
[97] *Id.*(ONTARIO REGULATIONS 275/94, Rule 2(1).
[98] *Id.*(ONTARIO REGULATIONS 275/94, Part II, Rule 1 reads "General Class — Most of the College's RNs and RPNs are registered in this class. Extended Class—RNs in this class are Nurse Practitioners. They have met additional competency requirements beyond those required in the General Class. There are three specialty certificates in the Extended Class: NP-Adult, NP-Pediatrics, and NP-Primary Health Care (a fourth specialty certificate, NP-Anesthesia, is not available at this time). Temporary Class — RNs and RPNs in this short-term class are recent graduates, or applicants from outside the province, who have met all entry-to-practice requirements except successful completion of the registration exam. They practice as an RN or RPN subject to specific terms. Special Assignment Class — A short-term, nonrenewable registration for RNs and RPNs, usually from outside of Canada, who have an appointment or assignment with an approved facility in Ontario. They practice as an RN or RPN subject to specific terms. Emergency Assignment Class — RNs and RPNs, usually from outside of Ontario, are registered in this class when the provincial government has asked the College to issue certificates of registration in this class. Non-Practicing Class —

practical nurse enjoys the right to hold all the other registration certificates.[99] The members of the Council enjoy the right to use titles as a nurse, nurse practitioner, registered nurse, or registered practical nurse.[100]

The Nursing Act, 1991 provides a list of 'authorized acts',[101] which can be performed under the guidance of physicians,[102] such as making communication with the patient about the diagnosis made for prescribing drugs; performance of procedures that are permitted; administration of injection; prescription and dispensation of drugs as per regulations,[103] and 'controlled act' which a registered nurse can perform as long as they possess

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Available to current and previous members of the College's General or Extended classes, members in this class are not allowed to practice, or represent themselves as qualified to practice, nursing in Ontario").

[99]ONTARIO NURSING ACT 1991,§1.1(28 Oct.2020),https://www.ontario.ca/laws/statute/ 91n32.

[100]*Id.* (ONTARIO NURSING ACT 1991,§11(1).

[101] *Id.* (ONTARIO NURSING ACT 1991,§4).

[102]*Id.* (ONTARIO NURSING ACT 1991,§5 &5.1(2) ,3,4, 5,6)

[103]*Id.* (ONTARIO NURSING ACT 1991,§4.1 reads as" In the course of engaging in the practice of nursing, a member who is a registered nurse……. authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Communicating to a patient or to his or her representative a diagnosis made by the member where the purpose of that communication is for prescribing a drug as authorized under paragraph 5.
2. Performing a prescribed procedure below the dermis or a mucous membrane.
3. Administering a substance by injection or inhalation.
4. Putting an instrument, hand or finger,
   i. beyond the external ear canal,
   ii. beyond the point in the nasal passages where they normally narrow,
   iii. beyond the larynx,
   iv. beyond the opening of the urethra,
   v. beyond the labia majora,
   vi. beyond the anal verge, or
   vii. into an artificial opening into the body.
5. Prescribing drugs designated in the regulations.
6. Dispensing a drug.
7. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning").

the requisite skill, knowledge, and judgment that are required for its performance.[104]

Another significant aspect of the Act is its clarity in defining the powers of nurses in a detailed manner. Some of the powers such as the power to perform authorized acts, power to prescribe medications, power to register, and power to dispense, sell, and compound medicines are mentioned in the Act. The nursing regulation enacted under the Act empowers the registered nurse in the extended class with powers to prescribe, to dispense, to sell, and to compound drugs. These conditions must be satisfied before a registered nurse can prescribe medications,[105] as there must exist a nurse-patient relationship; drug must be specified for therapeutic purposes only; the registered nurse is obliged to record information's relating to prescription such as the name and address of the person to whom the drug is prescribed; the name, strength, and quantity of the medication that is specified with the direction to use; the name, address and registration number, the title of the registered nurse who prescribes it with signature; and the date on which the drug is prescribed. Similar conditions are also specified for enjoying the right to dispense,[106] compound,[107] and sell drugs.

Thus, the legislative framework in Canada provides broader wisdom to nurses so far as their powers are concerned. Thus, regulatory framework is

[104] ONTARIO NURSING ACT 1991, Rule 15(1)(3)(4).
[105] ONTARIO REGULATIONS 275/94,Part II, Rule 17(20 June2020),http:// 66.135.122.117/ en/what-is-cno/regulation-and-legislation/legislation-governing-nursing/.
[106] *Id.*(ONTARIO REGULATIONS 275/94, Rule18).
[107] *Id.* (ONTARIO REGULATIONS 275/94, Rule19).

well-framed to preserve and maintain the significant purpose of quality healthcare and public protection.

It is essential to note the Nursing Act, which is prevalent in Nova Scotia (Canada).[108] The Act defines nursing services in a detailed manner which includes

> *"as an application of specialized and evidence-based knowledge of nursing theory, health and biological, physical, behavioral, psychosocial or sociological sciences inclusive of principles of primary health care, in a variety of roles including clinical services to clients, research, education, consultation, management, administration, regulation, policy or system development relevant to such application, and such other services, roles, functions, competencies, and activities for each nursing designation that are related to and consistent with the foregoing, including those (a) described in Section 174 or prescribed by the regulations;[109] (b) taught in an approved education program; (c) authorized for practice under federal or Provincial legislation; and (d) generally accepted as constituting the practice of nursing".[110]*

[108]NURSING ACT, 2019, NOVA SCOTIA LEGISLATURE (12 Dec.2020)https://nslegislature.ca/sites/default/files/legc/statutes/nursing.pdf .

[109]*Id.* (NURSING ACT, 2019, §174 reads as (2) Until such time as regulations made under this Act are effective, the scope of practice for a nurse practitioner means the application of advanced nursing knowledge, skills and judgment in addition to the scope of practice for the registered nurse designation under this Act, including all modifications to such scope of practice as approved under the *Regulated Health Professions Network Act*, in which a nurse practitioner may, in accordance with standards for nurse practitioners, do one or more of the following: (a) make a diagnosis identifying a disease, disorder or condition; (b) communicate the diagnosis to the client and other health care professionals as appropriate; (c) perform procedures; (d) initiate, order or prescribe consultations, referrals and other acts; (e) order and interpret screening and diagnostic tests; (f) recommend, prescribe or reorder drugs, blood, blood products and related paraphernalia, including research, education, consultation, management, administration, regulation,policy or system development relevant to clauses (a) to (f).

[110]*Id.* (NURSING ACT, 2019, § 2 defines nursing services).

This definition clearly explains the broader ambit of the nursing profession. It can be considered as a good example that can be adapted to the Indian legislative framework.

9.5 South Africa

As a developing State which can be comparable with India, the legislation in South Africa is looked into. Alike with other developed countries, South Africa also grants a professional practitioner status to nurse professionals.

The Nursing Act, 2005 regulates the profession of nursing in South Africa.[111] The definition of 'Nursing Service' as 'any service within the scope of practice of a practitioner'[112] itself shows the wider ambit which the nursing professionals enjoy as a practitioner.

Like the legislation in the UK, the Nursing Act, 2005 explains 'Protection of the public and Maintenance of professional standard of practice' as the primary objective of the nursing council.[113]A professional nurse is defined as "a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice".[114] Registration is a pre-requisite for practice as a professional nurse, midwife,

[111]NURSING ACT, 2005, NO.33, PARLIAMENT OF REPUBLIC OF SOUTH AFRICA (19 June 2020), https://www.gov.za/sites/default/files/gcis_document/201409/a33-050.pdf.
[112]*Id.*(NURSING ACT, 2005, § 1, NO.33, PARLIAMENT OF REPUBLIC OF SOUTH AFRICA (2005).
[113]*Id.*(NURSING ACT, 2005, § 3, NO.33, PARLIAMENT OF REPUBLIC OF SOUTH AFRICA (2005).
[114] *Id.*

staff nurse, auxiliary nurse, and auxiliary midwife.[115] Experience in community service for one year is a mandatory condition before registration.

Another notable aspect is the detailed descriptions of the scope of practice of registered and enrolled nurses in a detailed manner by defining each of their boundaries.[116] Activities such as diagnosing of a health need of the patient; execution of a program of treatment; treatment and care; administration of medicine; prevention of diseases; promotion of health; prescribing hygiene and physical comfort; promotion of exercise, rest and sleep of a patient; facilitation of body mechanics'; supervision of patient; and other related activates are provided in the regulations attached to the Act.[117] Likewise, a list of activities that an enrolled nurse can perform is provided in the regulations.

Thus, the legislation promotes clarity as to the functions and responsibilities expected from a registered nurse. The powers enjoyed by registered nurses includes matters such as to perform certain acts such as physical examination of any person; the diagnosing of any physical defect, illness, or deficiency in any person; the keeping of prescribed medicines, administer in specified conditions; the promotion of family planning in cases

[115] *Id.*(NURSING ACT, 2005,§31(1),NO.33, PARLIAMENT OF REPUBLIC OF SOUTH AFRICA) (2005).
[116] SOUTH AFRICAN NURSING COUNCIL, REGULATIONS RELATING TO THE SCOPE OF PRACTICE OF PERSONS WHO ARE REGISTERED OR ENROLLED UNDER THE NURSING ACT,1978 (9 Aug. 2020),https://www.sanc.co.za/regulat/Reg-scp.htm.
[117] *Id.*

where the services of a medical practitioner or pharmacist are not available is another important feature of the Act.[118]

The South African Nursing Council also enjoys vast powers as to the regulation of education, training, and standard of practice of nurses. Notably, the nursing Council consists of twenty five members, out of which fourteen represent the nursing sector. They are included based on their expertise, education, practice, community health, primary health care, occupational health, and mental health.[119] Similar to other countries, the council also enjoys the power to hold an enquiry and disciplinary actions against unprofessional conduct from the side of nurses.[120]

9.5 Australia

The Health Practitioner Regulation National Act, 2009 is the primary legislative framework that sets out the standards for registration and accreditation of health professionals in Australia.[121] The definition provided in the Act incorporates nursing into the framework of health professionals along with medical and paramedical professionals. The Nursing and Midwifery Board of Australia regulates the profession by adhering to these standards and guidelines. The law has classified nurses into 'registered' and 'enrolled' nurses. Registered nurses belong to the category of practicing nurses who have

[118] NURSING AM ACT, 2005,§38A ,NO.33, PARLIAMENT OF REPUBLIC OF SOUTH AFRICA(2005) (July 9, 2020),https://www.sanc.co.za/pdf/Nursing%20Act%201978.pdf .
[119] *Id.*(NURSING AM ACT, 2005,§5)
[120] *Id. (*NURSING AM ACT, 2005, §46).
[121] HEALTH PRACTITIONER REGULATION NATIONAL LAW ACT, 2009,NO.101 PARLIAMENTARY COUNCIL, AUSTRALIA(10 Aug.2020),https:// www.legislation.act. gov.au /View/a/db_ 39269/ current/ PDF/db_39269. PDF .

completed the required education, and enrolled nurses are usually students undergoing the approved program of study.[122] All the other guidelines relating to continuing professional development of nurses, for applying for endorsement as a nurse practitioner, the standard of practice of nurses, safety, and quality guidelines for nurse practitioners are provided by the Nursing and Midwifery Board.[123]

Like the USA, the standard of nurse practitioners is accepted in the Health Practitioner Regulation National Law Act, 2009.[124] Usually, nurse practitioners are expected to make assessments based on diagnostic capability; plan care and engage others; prescribe and implement therapeutic interventions; evaluate outcomes by improving practice.[125] They are granted the power to prescribe medicines under the 'Continuing therapy model' and the 'Shared care model.' In the former one, the treatment of patients and prescribing of medications is initiated by the doctors but continued by the nurse practitioner.[126] In the later model, care is shared between a nurse practitioner and a medical practitioner in a formalized arrangement with an agreed plan to manage the patient in a patient-centered model of care.[127] Thus, the attachment

[122]*Id.* (HEALTH PRACTITIONER REGULATION NATIONAL LAW ACT, 2009).
[123]NURSING & MIDWIFERY BOARD OF AUSTRALIA, NURSE PRACTITIONER STANDARDS OF PRACTICE(10 Jan.2021).https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards/nurse-practitioner-standards-of-practice.aspx.
[124]HEALTH PRACTITIONER REGULATION NATIONAL LAW ACT, 2009, §95, NO. 89A, PARLIAMENT OF QUEENSLAND 2009 (2 June 2020) https://www. legislation.qld. gov.au/view/whole/html/ inforce/current/act-2009-045.
[125] NURSING & MIDWIFERY BOARD OF AUSTRALIA, NURSE PRACTITIONER STANDARDS OF PRACTICE (10 Jan. 2021),https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards/nurse-practitioner-standards-of-practice.aspx.
[126]*Id.*
[127]*Id.*

of Professional Practitioner status to nursing can be regarded as one of the distinct features of the law and the guidelines.

The nature of regulation and rights that are guaranteed to nurses by the selected jurisdictions which are discussed above are provided in a table below:-

Name of the State& the Legislation	**Major regulations mentioned in the legislation**	**Powers enjoyed by nurses**
United Kingdom The Nursing and Midwifery Order, 2001	i. Scope of practice defined ii. Investigating Committee and Fitness to Practice Committee iii. Periodical review of nurse's performance by the Council	Power to prescribe
United States of America	i. Scope of practice defined ii. Qualification for licensure iii.Disciplinary proceedings that may be taken in case of non –compliance with rules	Power to prescribe
Canada The Nursing Act, 1991	i. Scope of Practice defined- Lists out authorized acts to be performed by a registered and registered practical nurse ii. Certification of registration mandatory for practice and non-practice iii. List of 37 acts mentioned as falling under Professional misconduct iv. Quality Assessment included for ensuring nurse quality	Power to perform "Authorized and Controlled acts." Power to prescribe, dispense, sell and compound drugs (subject to conditions mentioned)
South Africa	i. Mandatory registration ii. Grounds for taking disciplinary actions	Power to perform specific activities (in the absence of medical practitioners) mentioned in the legislation

India	Registration & grounds for taking disciplinary actions by the council. No Scope of practice defined No Standard of practice defined	No specific powers

Apart from the above-discussed legislations in the selected jurisdictions, the legislation in the Philippines is also discussed here to know the role of the State in regulating the profession of nursing.

9.7 Philippines

Some of the special provisions relating to nurses in the law of the Philippines prompted the researcher to analyze them here. The legislation is titled the 'Philippine Nursing Act, 2002'.[128] Creating a more responsive nursing profession is the primary purpose of the Act. One of the notable provisions in the legislation is the responsibility entrusted to the State to improve the nursing profession.[129] It is explained that

> *"It is hereby declared the policy of the State to assume responsibility for the protection and improvement of the nursing profession by instituting measures that will result in relevant nursing education, humane working conditions, better career prospects, and a dignified existence for our nurses…. The State hereby guarantees the delivery of quality basic health services through an adequate nursing personnel system throughout the country".*[130]

[128] PHILIPPINES NURSING ACT, 2002, NO.9173, REPUBLIC ACT (PHILIPPINES), 2002(29 June 2020), https://www.ilo.org/dyn/natlex/natlex4.detail?p_isn=67377.
[129] *Id.*
[130] *Id.*

Another significant provision is the detailed explanation of the scope of nursing practice, which includes individual nursing services performed in collaboration with other healthcare providers.[131] A wide range of activities is included within their practice, such as nursing care ranging from conception, delivery, childhood, preschool, adolescence till old age. It is also important to note the definition of nursing care. Nursing care is defined as

> *"Nursing care includes, but not limited to, traditional and innovative approaches, therapeutic use of self, executing health care techniques and procedures, essential primary health care, comfort measures, health teachings, and administration of written prescription for treatment, therapies, oral, topical and parenteral medications, internal examination during labor in the absence of antenatal bleeding and delivery……a nurse is also required to establish linkages with community resources and coordination with the health team……provide health education to individuals, families and communities; Teach, guide and supervise students in nursing education programs including the administration of nursing services in varied settings such as hospitals and clinics; undertake consultation services; engage in such activities that require the utilization of knowledge and decision-making skills of a registered nurse; and Undertake nursing and*

[131] *Id.* (PHILIPPINES NURSING ACT, 2002, No.9173,§ 28, REPUBLIC ACT (PHILIPPINES), 2002 reads Scope of Nursing as "A person shall be deemed to be practicing nursing within the meaning of this Act when he/she singly or in collaboration with another, initiates and performs nursing services to individuals, families and communities in any health care setting. It includes, but not limited to, nursing care during conception, labor, delivery, infancy, childhood, toddler, pre-school, school age, adolescence, adulthood and old age. As independent practitioners, nurses are primarily responsible for the promotion of health and prevention of illness. As members of the health team, nurses shall collaborate with other health care providers for the curative, preventive, and rehabilitative aspects of care, restoration of health, alleviation of suffering, and when recovery is not possible, towards a peaceful death").

health human resource development training and research, which shall include……..……the development of advance nursing practice".[132]

Special provisions as to the salary of nurses, funding for a nursing specialty program, Incentives, and Benefits of nurses are included in the Act.[133] Thus, this Act can be regarded as a good model so far as the State is responsible for the welfare of the nurses.

9.8 Middle East Countries

As the migration of nurses from India to Middle East Countries is on the rise, the regulatory framework of the nursing sector in Saudi Arabia and the United Arab Emirates is looked into.[134] In Saudi Arabia, the legislation issued by the Ministry of Health titled 'Law of Practicing Health Professionals' deals with the regulation of nursing. It is vital to note this is the sole legislation

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[132] *Id.*(PHILIPPINES NURSING ACT, 2002, No.9173,§28(2)REPUBLIC ACT (PHILIPPINES), (2002).

[133]*Id.* (PHILIPPINES NURSING ACT, 2002, No.9173, §32,REPUBLIC ACT (PHILIPPINES), 2002 reads Salary as " In order to enhance the general welfare, commitment to service and professionalism of nurses, the minimum base pay of nurses working in the public health institutions shall not be lower than salary grade 15 prescribed under Republic Act No. 6758, otherwise known as the "Compensation and Classification Act of 1989": Provided, That for nurses working in local government units, adjustments to their salaries shall be in accordance with Section 10 of the said law..Philippines Nursing Act, 2002, No.9173,§.33, Republic Act (Philippines), 2002v read Funding for the Comprehensive Nursing Specialty Program as "The annual financial requirement needed to train at least ten percent (10%) of the nursing staff of the participating government hospital shall be chargeable against the income of the Philippine Charity Sweepstakes Office and the Philippine Amusement and Gaming Corporation, which shall equally share in the costs and shall be released to the Department of Health subject to accounting and auditing procedures: Provided, That the Department of Health shall set the criteria for the availment of this program". Philippines Nursing Act, 2002, No.9173, § 34 Republic Act (Philippines), 2002 reads Incentives and Benefits as "The Board of Nursing, in coordination with the Department of Health and other concerned government agencies, association of hospitals and the accredited professional organization shall establish an incentive and benefit system in the form of free hospital care for nurses and their dependents, scholarship grants and other non-cash benefits. The government and private hospitals are hereby mandated to maintain the standard nurse-patient ratio set by the Department of Health").

[134] MINISTRY OF HEALTH, LAW OF PRACTICING HEALTH PROFESSIONS ISSUED BY THE ROYAL DECREE No.(M/59), 04/11/1426 H-6 DECEMBER, 2005 (20 Aug. 2020), https://www.moh.gov.sa/en/ Ministry/Rules/Documents/Executive-Regulations-of-Health-Practice-Law-Ar.pdf.

dealing with the regulation of the healthcare profession, which consists of physicians, dentists, and other paramedical professionals. The legislation deals with their license to practice, duties to society and patients, and professional liability in cases of professional malpractices. Even though there is no special legislation exclusively for nurses, this legislation itself explains the status of nurses they enjoy along with other healthcare professionals with the responsibilities they have to maintain quality health care.

In the United Arab Emirates, the Health Authority of Abu Dhabi, Dubai, and the Northern Emirates regulate the nursing sector. Though UAE lacks a definite legislative framework for Nursing, there are clear regulatory and licensing standards for nursing.[135] The UAE Nursing and Midwifery Council regulates the nursing sector to protect and promote the health and safety of the public.[136] It includes the functions, responsibilities, and activities that a nurse can perform and is accountable for.[137] Ensuring quality care to the patient is the primary aim of these standards.

9.9 Conclusion

Thus, Public Protection by promoting safe and quality nursing practice is the primary objective of all these legislations. The clarity maintained by each legislative framework on the role and function of registered nurses is a good example that can be adopted in India. The assurance of self-governing powers

[135] Brownie SM, Hunter LH, Aqtash S, Day GE, *Establishing Policy Foundations and Reg ulatory Systems to Enhance Nursing Practice in the United Arab Emirates* 16 Policy Polit Nurs Pract 38-50 (2015); *See* also UAE NURSING AND MIDWIFERY COUNCIL, NURSING AND MIDWIFERY SCOPE OF PRACTICE USER GUIDE (2015) http://www.uaenmc.gov.ae/ Data/Files/ 2016June/ User%20Guide%20SOP.pdf .
[136] *Id.*
[137] *Id.*

to the nursing councils shows how much independence the profession enjoys in regulating matters such as taking disciplinary proceedings, ensuring mandatory registration for practice, and adherence to professional etiquette and standards.

The mechanisms adopted to ensure public protection by assuring the quality and registration of nurses, which is prevalent in the United Kingdom, the more comprehensive explanation as to the functions, role and patient ratio of nurses in the legislative framework of the State of California, the power of nurses to do acts which are classified as 'authorized,' the broader definition of nursing service from individual care to the care of the whole community which is prevalent in the Philippines and the obligation imposed on the State to protect nursing professionals are good provisions that can be adapted to India from other countries. Nurses' expanded scope of nursing practice and titles such as nursing assistants, registered nurses, nurse educators, nurse practitioners, clinical nurse specialists, licensed practical nurses, and advanced practice registered nurses with their expanded scope of practice are other examples that can be included within the legislative framework of India.

It is also notable that the researcher came across repeated suggestions for introducing the Nursing Practitioner course in India from those staff nurses who aspire to pursue higher education in nursing. It is expected to give more avenues and expand the horizons of nursing. Thus, the role and recognition of nurses as 'professional practitioner'is the major characteristic feature that distinguishes the legislations of other countries from India.

CHAPTER X

ANALYSIS AND FINDINGS OF THE EMPIRICAL STUDY

Introduction

Nursing is often described as one of the noblest professions, but how far nurses enjoy recognition is still a debated issue in India. In India, nursing is always treated as a low-status occupation. Issues related to their working conditions such as long working hours, low salary, lack of occupational status, workplace violence and harassment, exposure to work-related infections, and lack of social security measures have always followed the nursing profession as a curse. Though the nurses working in the government sector enjoy better working conditions when compared to the private sector, the 'healthcare professional' status is still missing. Though labour legislation in India extends a broader range of social security benefits, proper implementation of the same to nurses, is doubted. Even if many studies have been conducted on nurses' working conditions and recommendations have been made, their situation remains without much change. In this chapter, an empirical/field study is done by distributing a questionnaire to nurses working in the government and private sector in the State of Kerala to know the actual factual situation regarding the need for a legislative framework.

This study attempts to know how far the social security benefits assured by the labour legislation in India are implemented. The study is also relevant as far as the State of Kerala is concerned to know how far the government of Kerala and primarily the private hospitals have implemented the significant

recommendations made by the two committees Balaraman Committee (2012) and the Veerakumar Committee (2013), that are constituted to study the conditions of nurses working in private hospitals in the State of Kerala. Although an effort is also made to know how far the rights of nurses in the State of Kerala conform with the Nursing Personnel Convention, 1977 (No.149) as adopted by the International Labor Organization.

Information collected through the right to information, especially the government orders, is also included in the chapter. Mainly such information is collected from the Indian Nursing Council, the Kerala Nursing Council, and the Health and Labour Welfare departments in Kerala.

The information was collected through personal interview techniques and questionnaires, including telephonic conversations and field visits conducted among nurses working in private hospitals and government hospitals (medical colleges). Out of 300 staff nurses interviewed, 150 nurses were employees of the selected three Govt. Medical Colleges and 150 nurses were employees of private hospitals, employed in selected districts of the State of Kerala.

10.1 Details of the Empirical Study

10.1.1 Type and Sources of Data

This study relies on primary data collected from the specific populations selected using designated sampling tools and methods. The study was organized based on structured questionnaires. The total number of registered

nurses in Kerala is 2,33,502,[1] distributed unequally among fourteen districts. The primary classification of the population was done based on the public and private sectors.

10.1.2 Sample Selection

The universe of study is nurses in India, and the population for sampling was selected from the State of Kerala. The sample size was chosen by using multi-stage random sampling. In the first stage, the 14 districts of Kerala were divided into geographic zones such as Northern Zone, Central Zone, and Southern Zone. Then, one district from each zone is selected, such as Calicut from the Northern Zone, Ernakulam from the Central Zone, and Trivandrum from the Southern Zone. In the Second Stage, hospitals in these three districts were classified into private and government hospitals. Using a multi-stage random sampling method, government medical college hospitals and five private hospitals from each selected district were selected. Finally, 50 staff nurses from each government hospital and 50 staff nurses from private hospitals were randomly selected from selected districts were included based on the convenience sampling method, thus comprising a total of 300 staff nurses, 150 nurses from the government sector, and 150 nurses from the private sector.

[1] SEE APPENDIX V, NURSES REGISTERED WITH THE KERALA NURSING COUNCIL FROM 01/01/2008 TO 31/08/2019 (Information obtained from the Application filed under Right to Information Act, 2005).

10.1.3 Sample Size

A questionnaire containing 46 questions is distributed to 150 staff nurses employed in government medical college hospitals and 150 staff nurses employed in private hospitals of the concerned districts.

10.1.4 Sampling Method

Appropriate methods of sampling were used at distinct levels of study. The sampling methods used include convenient Sampling, multi-stage sampling, and purposive sampling for selecting a specific population and unit size. The population was again classified based on the private and public clinical establishment. The information from this population was collected based on a designed and structured questionnaire.

10.1.5 Data Collection (Tool Frame)

A total of 300 questionnaires with '46 questions'[2] are distributed to staff nurses from government and private hospitals, randomly selected from the population. Each question is framed to know the issues of nurses employed in government and private hospitals. They were allowed the freedom to conceal their name as well as the name of the hospital. Only the nature of the hospital, whether government or private, has been asked to reveal.

The gender of the informant, their qualification, registration status, nature of the hospital, intention to work abroad, amount of salary received, staff-patient ratio, hours of work, hours of job interval, number of holidays

[2] APPENDIX VI, QUESTIONNAIRE USED FOR CONDUCTING THE EMPIRICAL STUDY.

availed, payment of social security measures such as maternity benefit, minimum wages, gratuity, pensions, bonus, etc. are included in the questionnaire.

10.1.6 Data Analysis and Interpretation

1. Gender wise classification

The study begins with the information as to the gender of the respondents. As expected, among the 300 staff nurses interviewed from the government and the private sectors, only a limited number of male nurses could be found. This shows the dominance of the nursing profession by females. Out of the 150 staff nurses interviewed from the government sector, around 125 nurses were females, and 25 nurses were males. Among the 150 staff nurses interviewed from the private hospitals, 140 nurses were females, and 10 were males.

Table: 1

Classification based on Gender	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Male Nurses	25	16.66%	10	6.66%
Female Nurses	125	83.33%	140	93.33%
Total	150	100	150	100

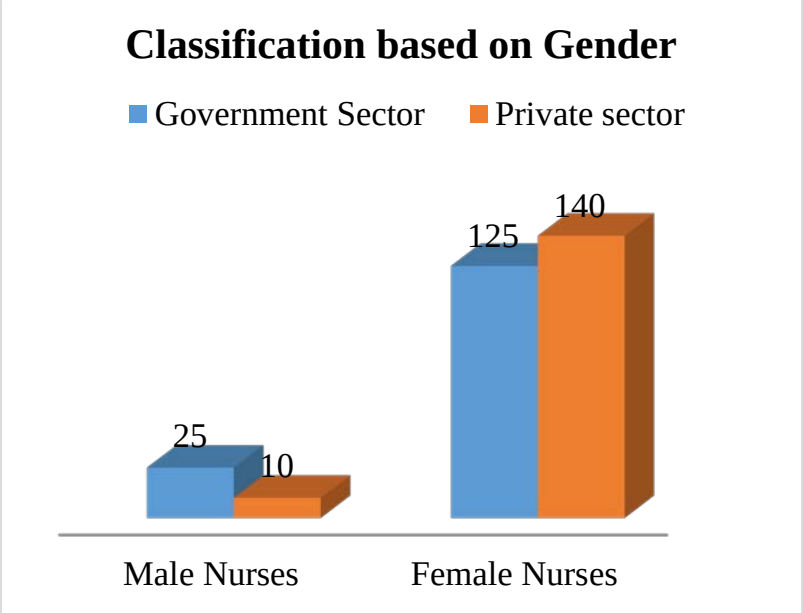

Fig: 10.1

2. Age-wise classification

Age-wise classification is used to know the age group of the highest number of staff nurses employed in the government and private sector. Of the total 150 staff nurses interviewed from the government sector, 25 nurses were aged below 30 years, 90 nurses were aged between 31 and 40 years, 25 nurses were aged between 41 and 50 years, ten nurses were above 50 years. Out of the total of 150 staff nurses interviewed from the private sector, 20 nurses were aged below 30 years, 120 nurses were aged between 31 and 40 years, ten nurses were aged between 41 and 50 years and none can be found above 50 years.

Table: 2

Age-wise classification	Government Sector		Private Sector	
	Number	Private	Number	Percentage
Below 30 years	25	16.66%	20	13.33%
Between 31-40 years	90	60%	120	80%
Between 41-50 years	25	16.66%	10	6.66%
Above 50 years	10	6.66%	0	0
Total	150	100	150	100

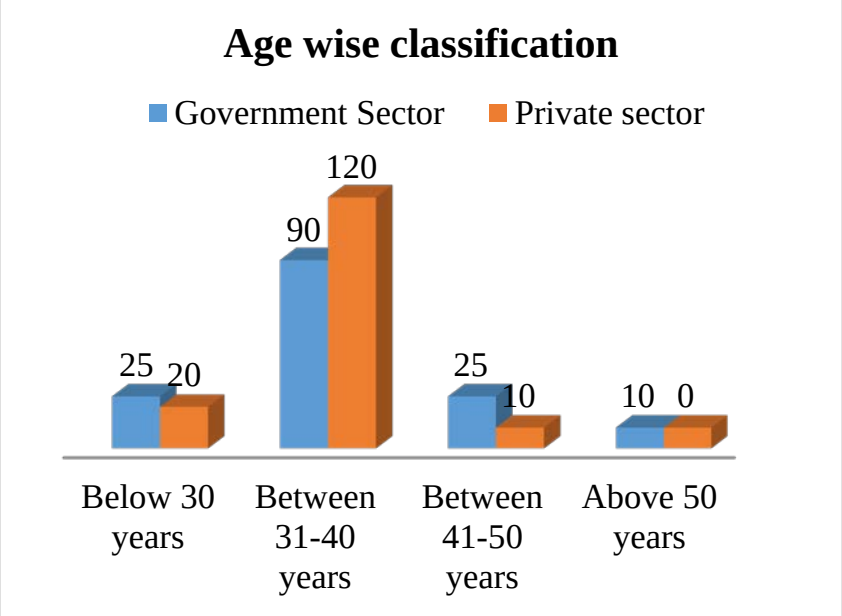

Fig: 10.2

3. Qualification

Qualification-wise classification is selected to know the educational qualification possessed by staff nurses belonging to both sectors. Of the total 150 staff nurses interviewed from the government sector, 90 nurses belong to the General Nurse Midwife category, 50 staff nurses belong to the B.Sc

category, and ten belong to the M.Sc category. Among the total 150 staff nurses interviewed from the private sector, 100 nurses interviewed possess B.Sc qualification, and 50 staff nurses have GNM qualification.

Table: 3

Classification based on Qualification	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
M.Sc	10	3.33%	0	0
B.Sc	50	33.33%	100	66.66%
GNM	90	60%	50	33.33%
Total	150	100	150	100

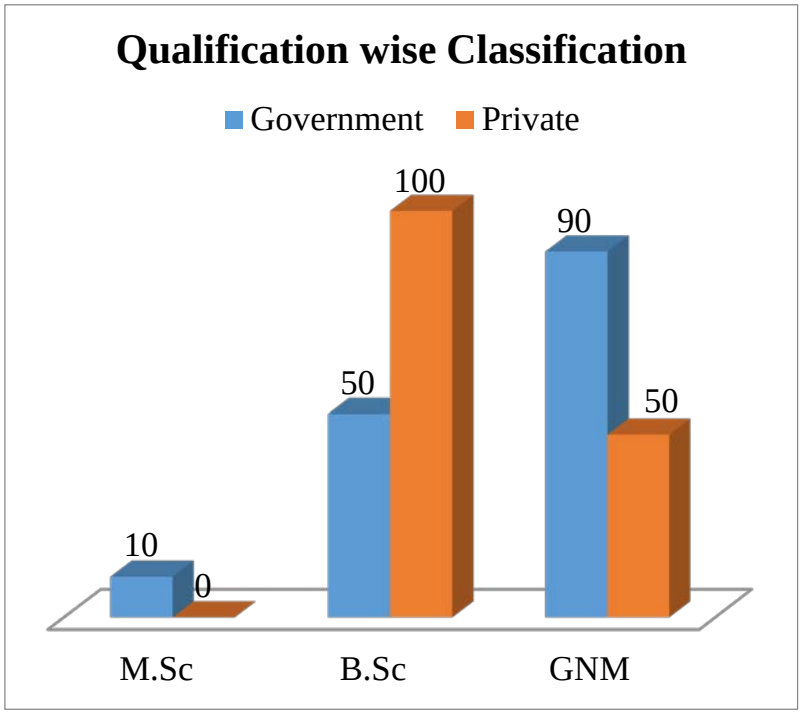

Fig: 10.3

4. Registration

The question as to registration is included to know whether nurses are aware of its importance. Out of the 150 staff nurses interviewed from the government sector, 150 nurses are aware of registration. Out of the 150 staff nurses interviewed from the private sector, 150 nurses are registered. Thus, it is found that the majority of the staff nurses are aware of the registration process, and it is a pre-requisite for practice. Since nurses employed in government medical colleges are selected based on the examination conducted by the Kerala State Public Service Commission, they have compulsorily gone through the registration process.

Table 4

Awareness regarding registration	**Government Sector**		**Private Sector**	
	Number	**Percentage**	**Number**	**Percentage**
Yes (Registered nurses)	150	100%	150	100%
No (Unregistered nurses)	0	0%	0	0%
Total	150	100%	150	100%

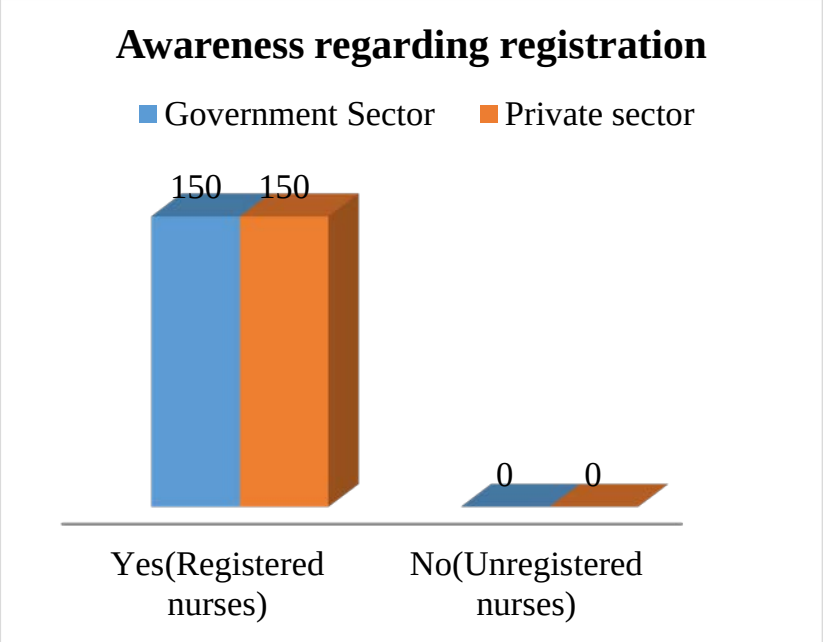

Fig: 10.4

5. Security of Employment

One of the significant problems which the researcher could identify from the study is the nature of the employment of nurses who are working in both sectors. For this study, only those staff nurses who are appointed permanently are selected from the government hospitals. In the private sector, around 80 staff nurses were appointed on a contract basis, 40 nurses were appointed on an internship basis, and 30 staff nurses were employed permanently. Thus, the permanency of the job is a factor that distinguishes the private from the government sector.

Table 5

Security of Employment	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Permanent	150	100%	30	20%
Contract	0	0%	80	53.33%
Internship	0	0%	40	26.66%
Total	150	100	150	100

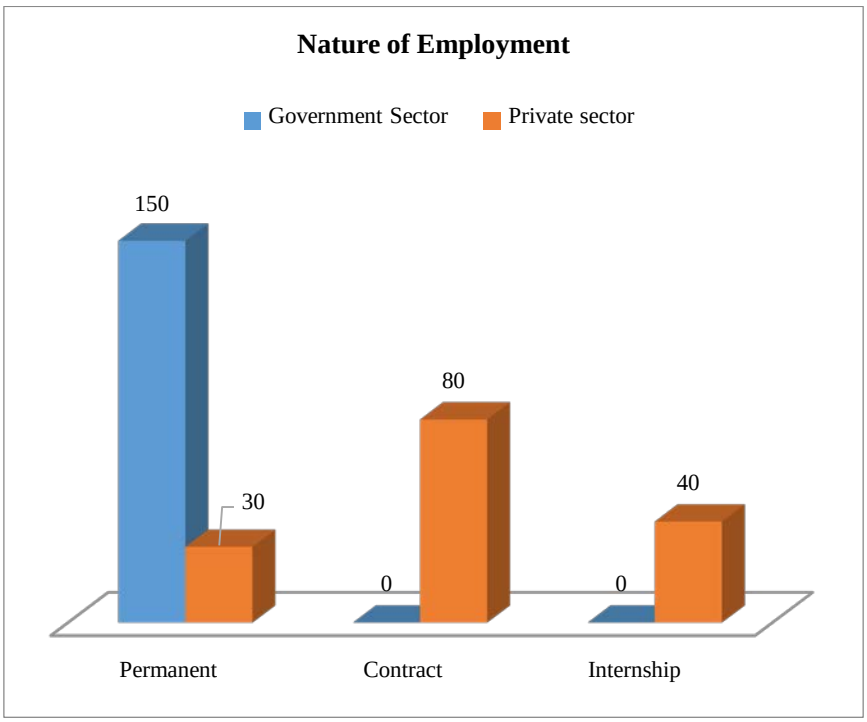

Fig: 10.5

6. Selection Criteria

Another important factor that differentiates the private sector from the government sector is the method of appointment. When examination and interview are conducted to select staff nurses to the government sector through

the public service commission,[3] the same is not applicable in the private sector, which relies mainly on the interview method for selection. Out of the 150 staff nurses interviewed from the government sector, 150 nurses replied as examination with an interview as a method of selection. Out of the 150 staff nurses interviewed from the private sector, 60 nurses responded examination with interview examination as the method of selection, and 90 nurses answered interview alone as a method of selection.

Table 6

Selection Criteria	**Government Sector**		**Private Sector**	
	Number	**Percentage**	**Number**	**Percentage**
Interview alone	0	0	90	60%
Examination with Interview	150	100%	60	4%
Others/ group discussion	0	0	0	0
Total	150	100	150	100

[3] APPENDIX VII, GOVERNMENT OF KERALA NOTIFICATION G.O. (P) NO. 303/2011/H&FWD. 11May 2011.

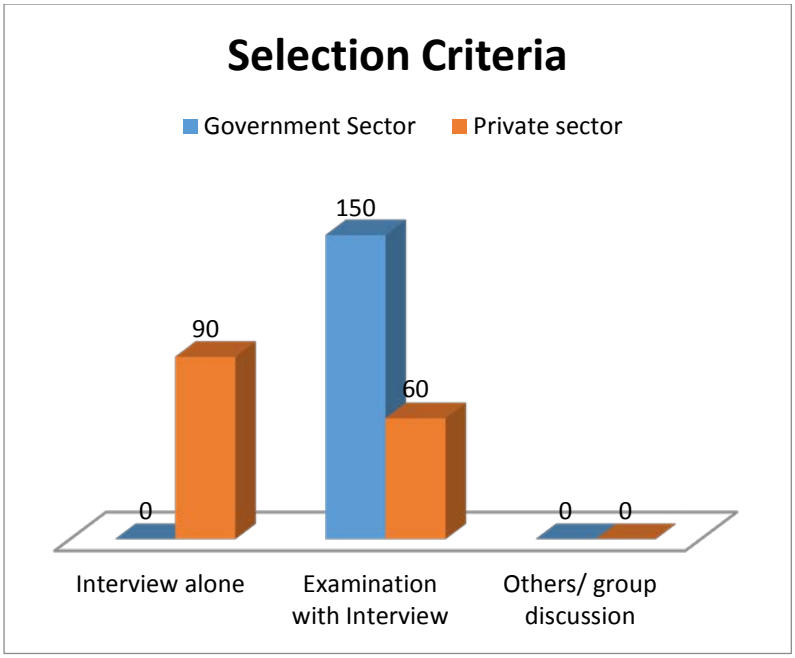

Fig: 10. 6

7. Experience

Out of the 150 staff nurses interviewed from the government, 125 nurses have experienced between 6-10 years, 20 nurses have experienced between 1-5 years, and five nurses have experienced above ten years. Among the 150 staff nurses interviewed from the private sector, 100 nurses have experience between 1 -5 years, 30 nurses have experience between 6-10 years, and 20 nurses have experience above ten years. One of the important factors to be noted here is that most staff nurses in the private sector have frequently changed the hospital or shifted from one hospital to another due to dissatisfied working conditions or harassment from the management side. Lack of permanency in the job or non-renewal of the contract is the primary reason for this.

Table 7

Years of experience of the respondent	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Between 1-5 years	20	13.33%	100	66.67%
Between 6-10 years	125	83.33%	30	20%
Above 10 years	5	3.33%	20	13.33%
Total	150	100	150	100

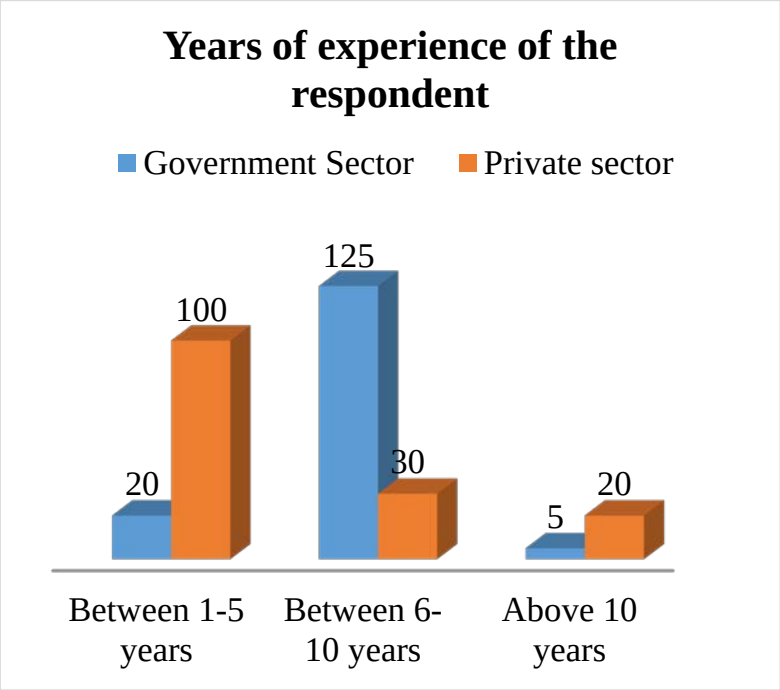

Fig: 10.7

8. Appointment Orders

Out of 150 staff nurses interviewed from the government sector, 150 nurses replied as having received appointment orders. Issuance of appointment Orders is limited in the private sector. When once issued, they lack clarity as to the job tenure or depend on the discretion of the hospital authorities or management. Out of 150 staff nurses interviewed from the private sector, 90 nurses replied as not having received appointment orders, and 60 nurses replied as having received appointment orders.

Table 8

Appointment Order provided	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	150	100%	60	40%
No	0	0%	90	60%
Total	150	100	150	100

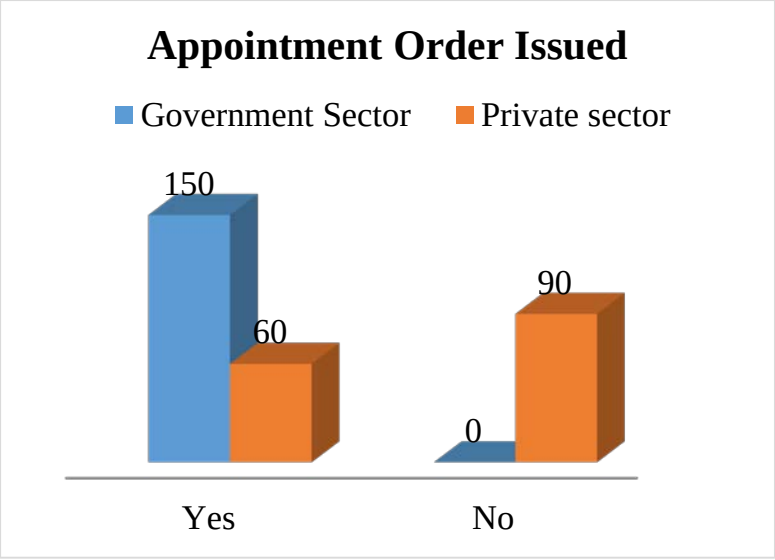

Fig: 10.8

9. Monthly Salary

Having a fixed salary is an essential concern of the staff nurses belonging to the private sector. In most cases, their salary is not specified or fluctuates depending on the hospital authorities' discretion. The non-payment of minimum wages (as fixed by the government of Kerala by government order of Rs. 20,000/-) is another primary concern of staff nurses working in the private sector. In most cases, the payment of minimum wages is often neglected by the hospital authorities.

Of the total 150 staff nurses interviewed from the government sector, it is known that the salary of staff nurses is fixed as per the government order. A staff nurse (grade I) salary is between Rs. 29200-62400/- and a staff nurse (grade II) is between Rs. 27800-Rs.59400/-.[4]

Of the 150 staff nurses employed in the private sector, around 90 replied that they were paid a salary between Rs.15,000-19,000/-; around 40 nurses replied that they were paid a salary between Rs.10,000/-14,000/- and around 15 replied as receiving salary below Rs.10, 000/- and 5 receives salary between Rs. 20,000-24,000/-

[4]APPENDIX VIII.

Table 9

Monthly Salary	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Below Rs.10,000	0	0	15	10%
Between Rs.10,000-14,000	0	0	40	26.66%
Between Rs.15,000-19,000	0	0	90	60%
Between Rs.20,000-24,000	0	0	5	3.33%
Above Rs.24,000	150	100%	0	0
Total	150	100	150	100

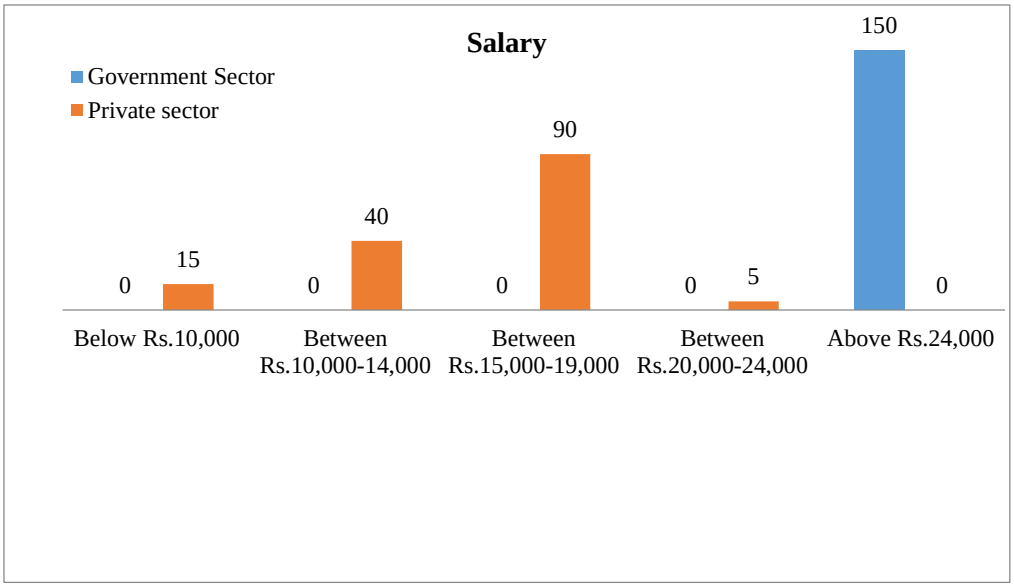

Fig: 10.9

10. Intention to work abroad

Of the 150 staff nurses interviewed from the government sector, none showed their intention to work abroad. Most nurses intend to work in Kerala and are satisfied with their salary compared to nurses working in the private sector. Of the 150 staff nurses interviewed in the private sector, 70 nurses show interest in working abroad. The attractive salary with career opportunities and respectful status are the primary reasons for migration. The United Kingdom, United States were selected as the important place for the destination. However, gulf countries were also preferred by some. The repayment of education loans is one of the significant reasons which pushes nursing graduates for migration.

Table 10

Intention to work abroad	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	0	0	70	46.66%
No	150	100%	80	53.33%
Total	150	100	150	100

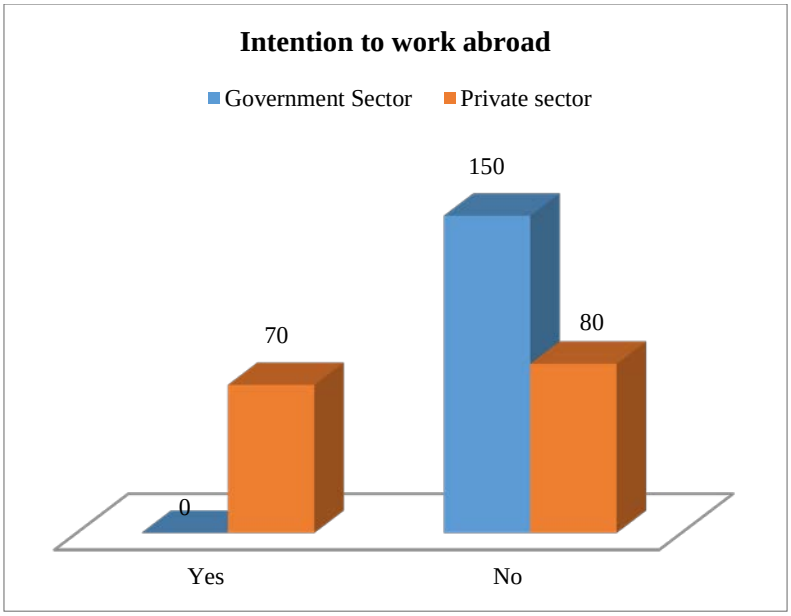

Fig: 10.10

11. Nurse Patient Ratio

Nurse Patient Ratio is another factor that ensures quality patient care. The Nurse-Patient ratio fixed by Indian Nursing Council is 1:6. Usually, 1:6 is the nurse-patient ratio followed in Government Medical College Hospitals in the State of Kerala. No ratio has been fixed by the government departments for the private hospitals.[5] In most cases, it depends on the bed strength of the hospitals, which is often manipulated by the private hospitals for filling the vacancies with a few staff. It is also notable from the personal interviews that both sectors do not follow the same.

Of 150 staff nurses interviewed from the government sector, 90 nurses showed concern about the non-implementation of nurse-patient ratio of 1:6.

[5] APPENDIX IX, NURSE PATIENT RATIO.

None of the hospitals, both in the government and private sectors, conform to the staff nurse ratio of 1:6. It is pointed out that a nurse has to handle 20 patients in some cases, leading to overload work and negligence issues. The non-conformity with the nurse-patient ratio leads to overtime and overstress/overload work for nurses. Out of 150 staff nurses interviewed from the private sector, 150 nurses showed their concern on non-implementation.

Table 11

Nurse Patient Ratio followed	**Government Sector**		**Private Sector**	
	Number of nurses	**Percentage**	**Number of nurses**	**Percentage**
Yes	60	40 %	10	6.66%
No	90	60%	140	93.33%
Total	150	100	150	100

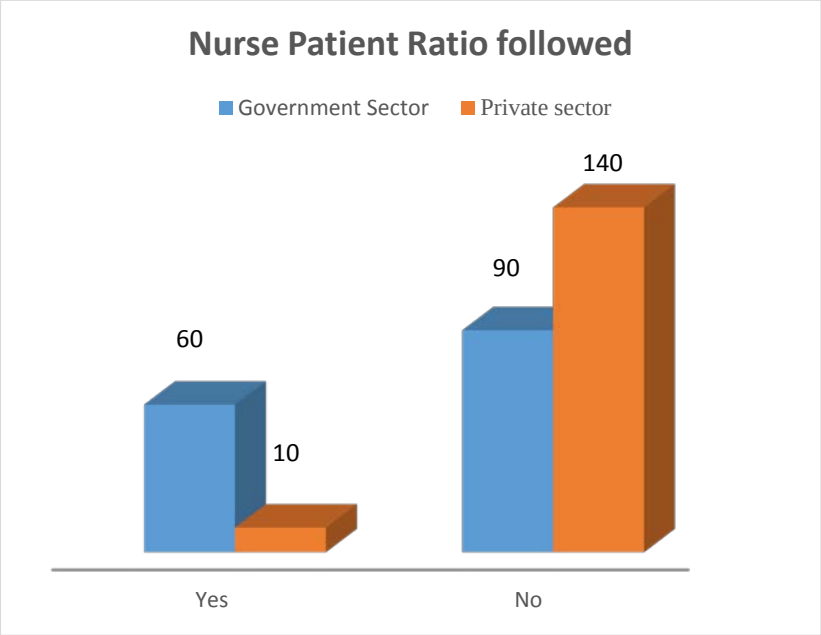

Fig: 10.11

12. Hours of work

Generally, three shift-system of work is the recognized hours of work of a staff nurse in the government sector. Three shift systems such as Morning: 7:30 am to 1:30 pm; Noon: 1:30 pm to 7:30 pm; and Night: 7:30 pm to 7:30 am is accepted in Government Medical College Hospitals.[6] Thus, 6 hours of duty a day is followed by the government hospitals. Out of 150 staff nurses interviewed from the government sector, 150 nurses replied as below 8 hours. Out of 150 staff nurses interviewed in the private sector, 70 nurses replied 8 hours as their working hours at day time; 40 nurses replied as more than 8 hours duty, and 40 replied as below 8 hours, wherein they follow three-shift duty with 6 hours of work.

Table 12

Hours of duty	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
8 Hours	0	0	70	46.66%
Above 8 Hours	0	0	40	26.66%
Below 8 Hours	150	150%	40	26.66%
Total	150	100	150	100

[6] APPENDIX X, HOURS OF WORK.

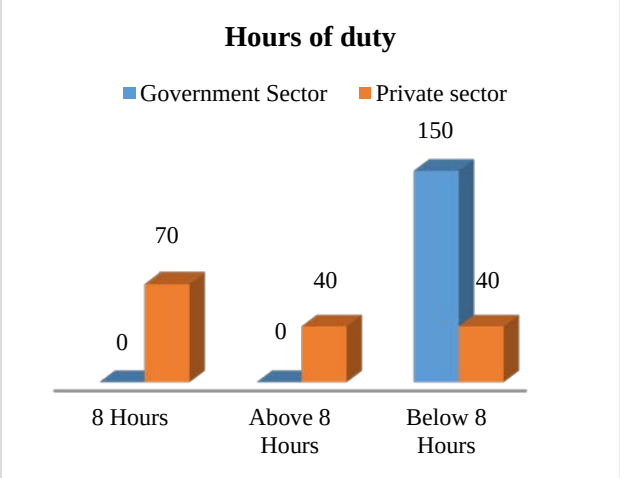

Fig: 10.12

13. Number of weekly holidays

One-day weekly holiday is permitted to all nurses working in government as well as the private sector. Compared to staff nurses working in private hospitals, staff nurses working in the government sector can enjoy all the government holidays (Calendar holidays).Out of 150 staff nurses interviewed from the government sector, 150 nurses replied having one day as a weekly holiday. Out of 150 staff nurses interviewed from the private sector, 150 responded having one day as a weekly holiday.

Table 13

Weekly Holidays	**Government Sector**		**Private Sector**	
	Number	**Percentage**	**Number**	**Percentage**
Yes	150	0	150	0
No	0	100%	0	100
Total	150	100	150	100

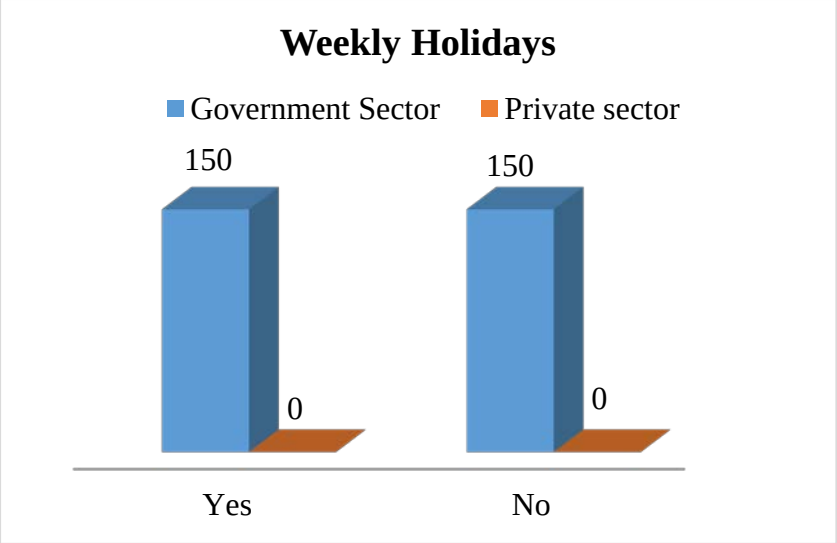

Fig: 10.13

14. Night Shifts

Out of the 150 staff nurses employed in the government sector, 150 nurses replied as having six days night duty in a month. Out of the 150 staff nurses employed in the private sector, 125 nurses replied above six days as night duty (14 days as night duty in a month) and 25 nurses replied as having six days night duty in a month. This shows that there is no uniformity as to the time of night shifts in the private sector.

Table 14

Number of night duty in a month	**Government Sector**		**Private Sector**	
	Number	**Percentage**	**Number**	**Percentage**
Six days	150	100	25	16.66%
Above Six days	0	0	125	83.33%
Total	150	100	150	100

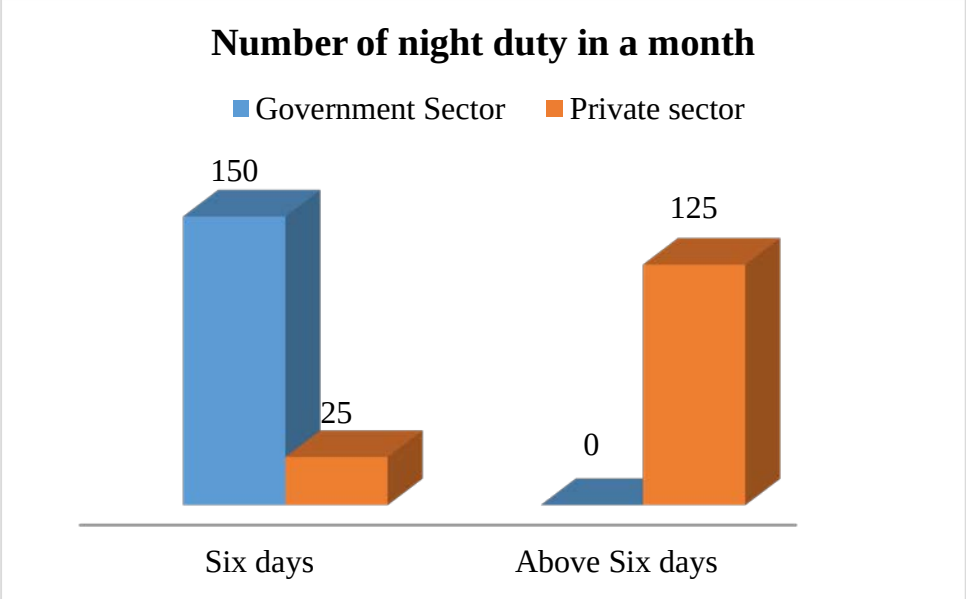

Fig: 10.14

15. Harassments during night shifts

For this study, the Out of the 150 staff nurses employed in the government sector, 110 nurses replied having faced no harassment, ten nurses replied as having faced harassment, and 30 nurses did not respond to the question. Out of the 150 staff nurses employed in the private sector, 20 nurses replied having faced harassment, 80 nurses replied having faced no harassment, and 50 staff nurses did not respond to the question.

Table 15

Harassments during night shifts	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	10	6.66%	20	13.33%
No	110	73.33%	80	53.33%
No response	30	20%	50	3.%
Total	150	150	150	100

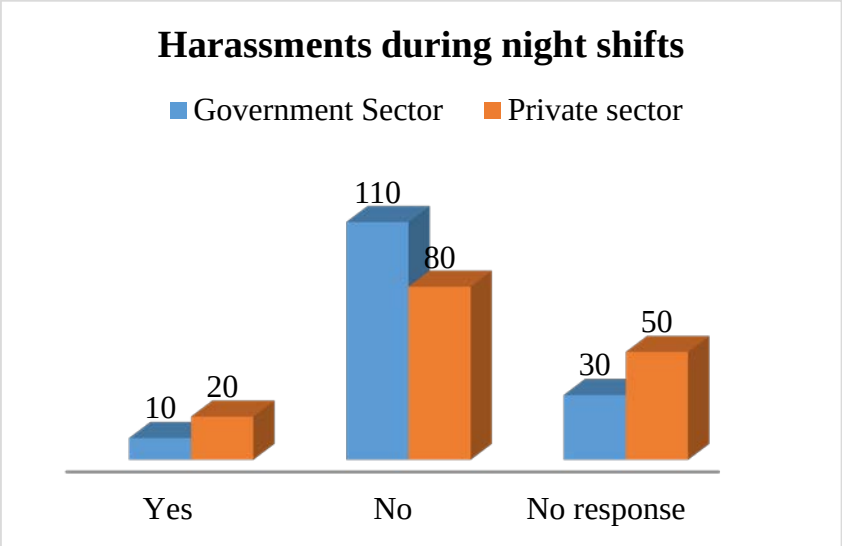

Fig: 10.15

15 A. If yes, who are the perpetrators of violence?

Among the staff nurses who respond as facing harassment, most of them have replied of having faced harassment from the relatives of the patients. Harassments from the side of other hospital staff, including senior nurses and staff, have been reported. Only a few replied of having faced harassment from the side of hospital management and doctors. Out of the 150 staff nurses employed in the government sector, only10 nurses responded as having received harassment from the side of other hospital staff. None of the nurses have replied as having received harassment from the other side.

Out of the 150 staff nurses employed in the private sector, 30 nurses replied as having faced harassment from patients, 45 nurses replied as having faced harassments from relatives of patients, 25 nurses replied as having faced harassments from hospital management, ten nurses replied as having faced

harassment from doctors, and 40 nurses replied as having faced harassments from other hospital staff.

Table 15 A

Persons from whom harassment is experienced	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Patients	0	0	30	20%
Relatives of Patients	0	0	45	30.0%
Hospital management	0	0	25	16.66%
Doctors	0	0	10	6.67%
Other Hospital staff	10	6.66%	40	26.66%

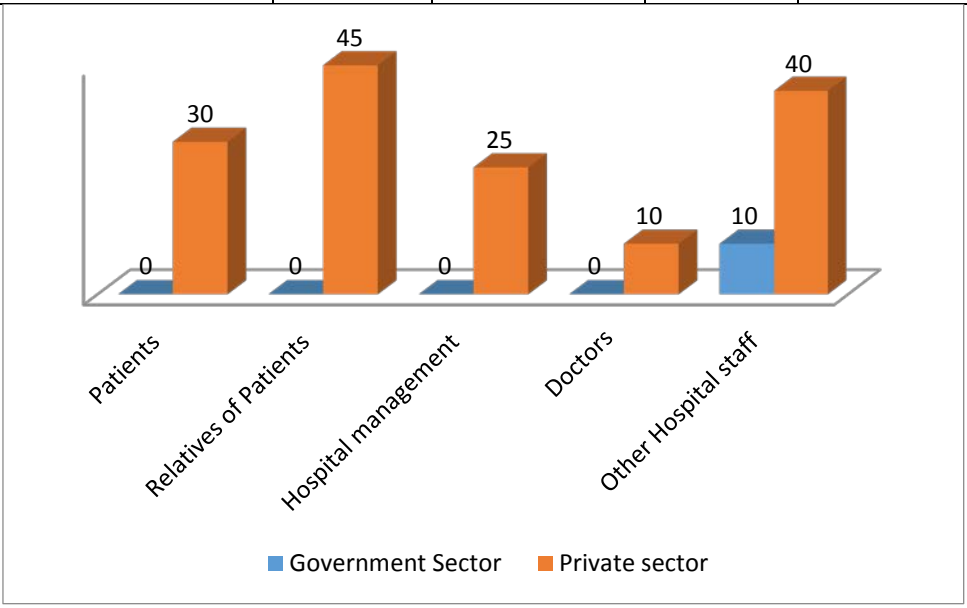

Fig: 15 A

15 B. Type of Harassment

Out of the 150 staff nurses interviewed from the government sector, only ten nurses replied verbal abuse as the primary form of harassment. No responses are received as to other forms of harassment. Out of 150 staff nurses interviewed from the private sector, 40 nurses replied verbal abuse, 20 nurses

answered physical abuse, and 20 nurses replied sexual abuse as forms of harassment they faced. The remaining 70 nurses did not respond to the question.

Table 15 B

Type of harassment	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Verbal	10	6.66%	40	26.66%
Physical	0	0	20	13.33%
Sexual	0	0	20	13.33%
Not revealed	0	0	70	46.66%

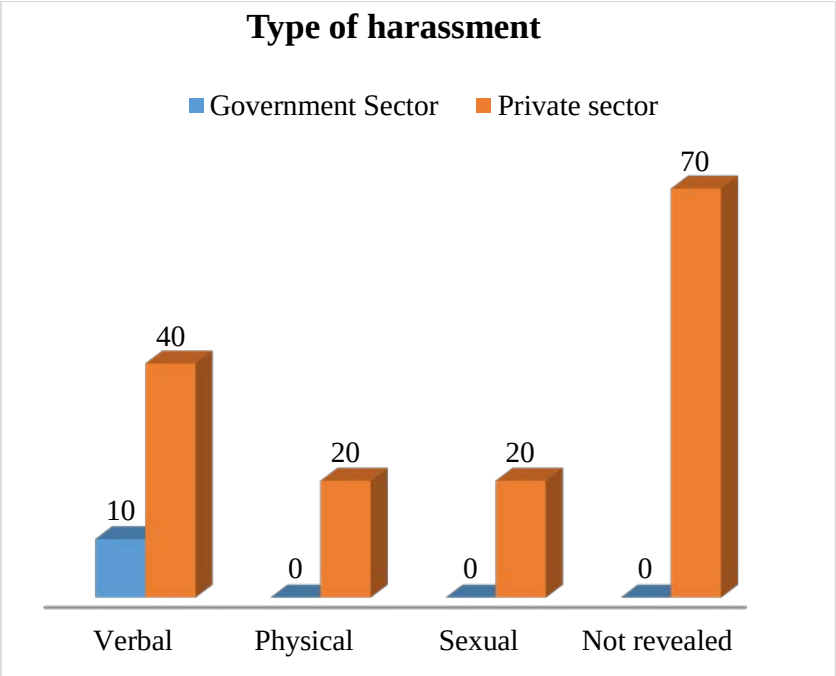

Fig: 10.15 B

16. Transportation facilities

The provision for transportation facilities is lacking in both the hospitals. Staff nurses working in both sectors would have no choice but

depend on private vehicles as a source of transportation. The majority of the nurses find it difficult, especially after night duty hours. Out of 150 staff nurses interviewed from the government sector, 150 nurses replied negatively. Out of 150 staff nurses interviewed from the private sector, 150 nurses responded negatively.

Table 16

Transportation facilities	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	0	0	0	0
No	150	100	150	100
Total	150	100	150	100

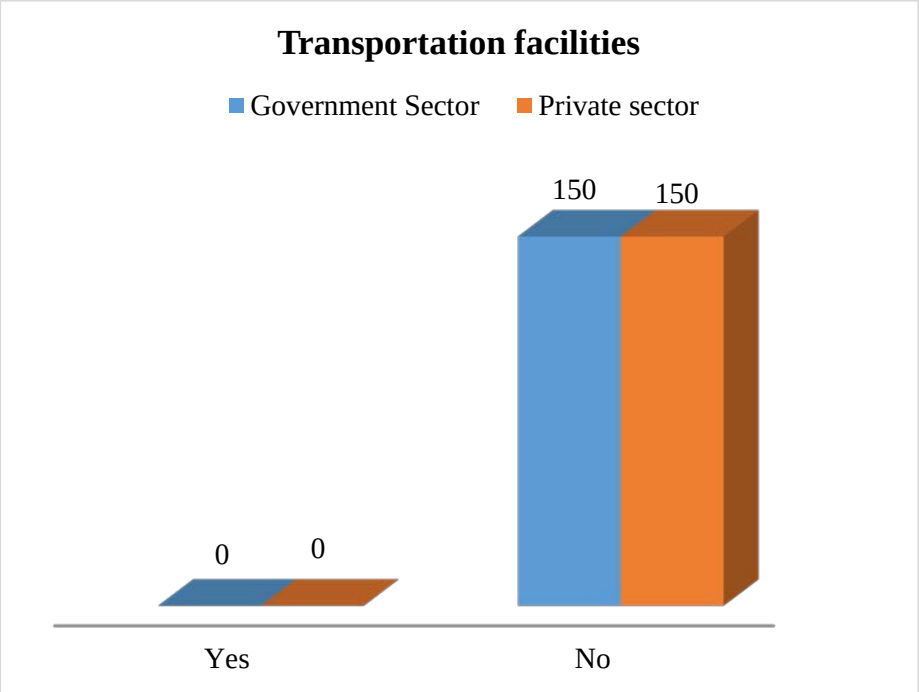

Fig: 10.16

17. Allowances received

Compared to Staff nurses employed in a private hospital, the staff nurses employed in the government enjoy more allowances such as Dearness allowances; Festival allowances (bonus); Mess allowances; Uniform allowances, Housing allowances as enjoyed by all other government employees. Out of 150 staff nurses interviewed from the government sector, 150 enjoyed all the benefits.

Out of the 150 staff nurses employed in the private sector, 150 nurses replied as having received festival allowances. Ten nurses responded having to receive mess allowances, and 150 staff nurses responded as not receiving any benefits.

Table 17

Allowances received	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Dearness allowances	150	100%	0	0
Festival allowances	150	100%	150	100%
Mess allowances	150	100%	10	6.66%
Housing allowances	150	100%	0	0
Uniform allowances	150	100%	0	0

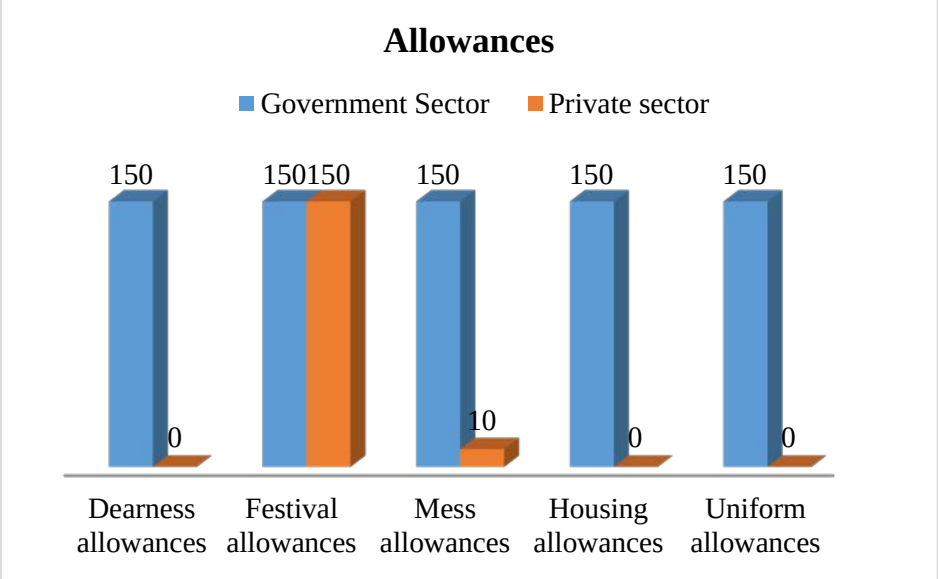

Fig: 10.17

18. Overtime Work

The compulsion to do overtime work is another crucial issue faced by nurses in both sectors. However, it is more rampant in the private sector when compared to the government sector. Shortage of sufficient staff is the primary reason behind it. Out of the 150 staff nurses interviewed from the government sector, 30 nurses replied as having overtime work, and 120 nurses answered having no overtime work. Out of the 150 staff nurses employed in the private sector, 130 nurses replied affirmatively to overtime work and only 20 nurses replied as having overtime work.

Table 18

Prevalence of overtime work	Government sector		Private sector	
	Number	Percentage	Number	Percentage
Yes	30	20%	130	86.66%
No	120	80%	20	13.33%
Total	150	100%	150	100

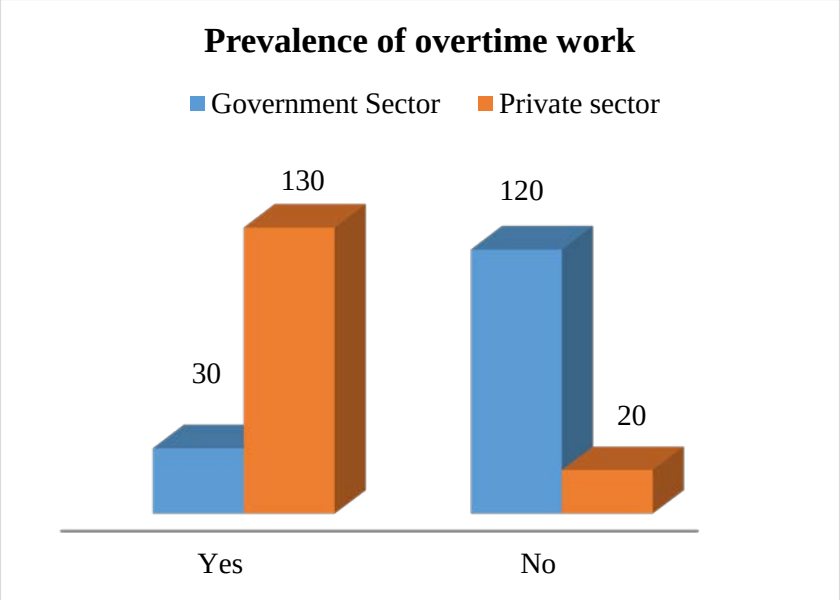

Fig: 10.18

18 A. Provision for Overtime allowances

Lack of payment for overtime work is yet another issue faced by nurses in both sectors. This violates the Minimum Wages Act, 1948, which mandates the employer to pay for every hour worked in excess at the overtime rate. However, staff nurses working in the government sector benefit from special leave for overtime duties performed. Out of the150 staff nurses interviewed in the government sector, 70 nurses replied as having overtime allowances, and

80 nurses responded as not having overtime allowances. Out of the 150 staff nurses interviewed from the private sector, 150 nurses did not have overtime allowances.

Table 18 A

Provision for overtime allowance	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	70	46.66%	0	0
No	80	53.33%	150	100%
Total	150	150	150	100

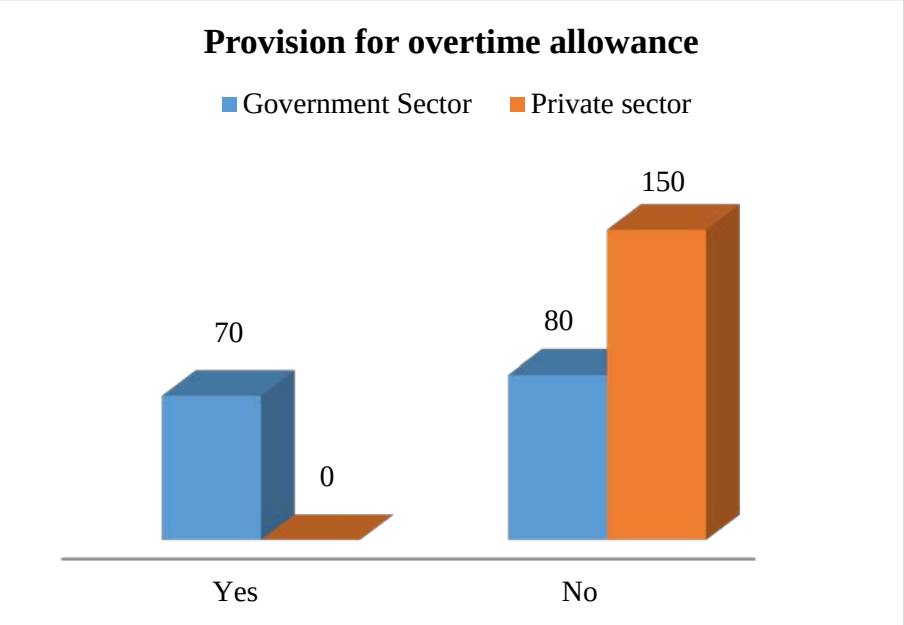

Fig: 10.18 A

19. Paid Annual Leave

Paid annual leave is a benefit assured by the Kerala Shops and Commercial Establishment Act, 1968. The majority of the staff nurses

employed in both sectors answered affirmatively to the availability of paid annual leave for 12 days.

Out of the 150 staff nurses interviewed from the government sector, 150 nurses replied as having paid annual leave. Out of the 150 staff nurses interviewed from the private sector, 120 nurses answered as having received paid annual leave, and 30 nurses replied as not having paid annual leave. However, some nurses who responded positively also showed concern about fatigue during leave days due to a staff shortage or overloading work. So though leave with pay is granted, the compulsion to work during leave days also exists.

Table 19

Paid annual leave	**Government Sector**		**Private Sector**	
	Number	**Percentage**	**Number**	**Percentage**
Yes	150	100%	120	80%
No	0	100%	30	20%
Total	150	100	150	100

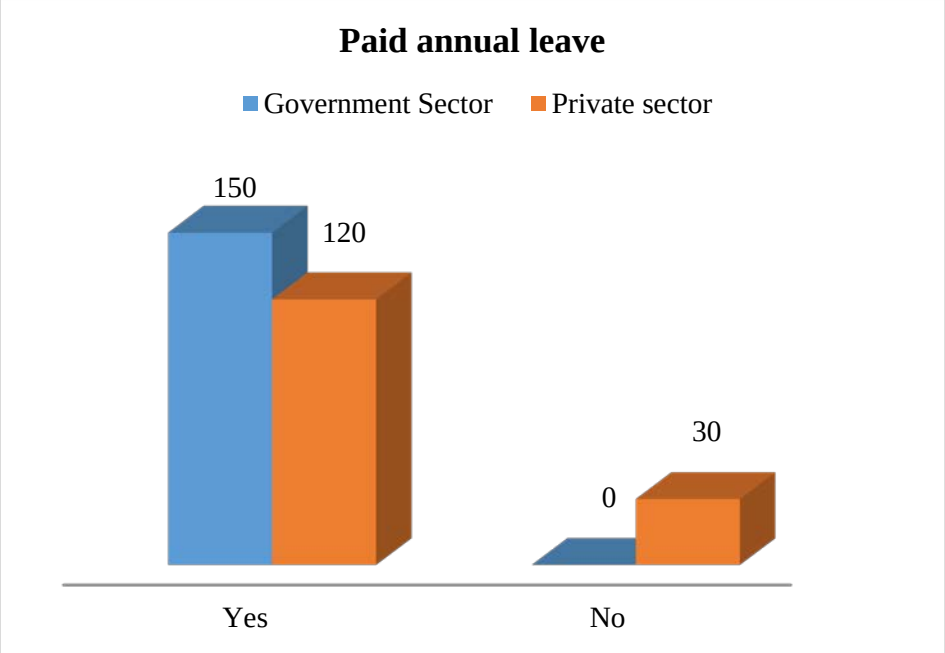

Fig: 10. 19

20. Pension Schemes

Lack of provision for social security schemes such as Provident Fund, Gratuity, and Pension scheme is one of the most critical challenges facing staff nurses working in the private sector. Out of the 150 staff nurses interviewed from the government sector, 150 nurses replied as having received the social security schemes. Out of the 150 staff nurses interviewed from the private sector, 60 nurses replied as having received provident fund, 50 nurses replied as having received gratuity, and none of the nurses replied as having received the pension.

Table 20

Social security schemes provided	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Provident Fund	150	100%	6 0	40%
Gratuity	150	100%	50	33.33%
Pension Schemes	150	100%	0	0

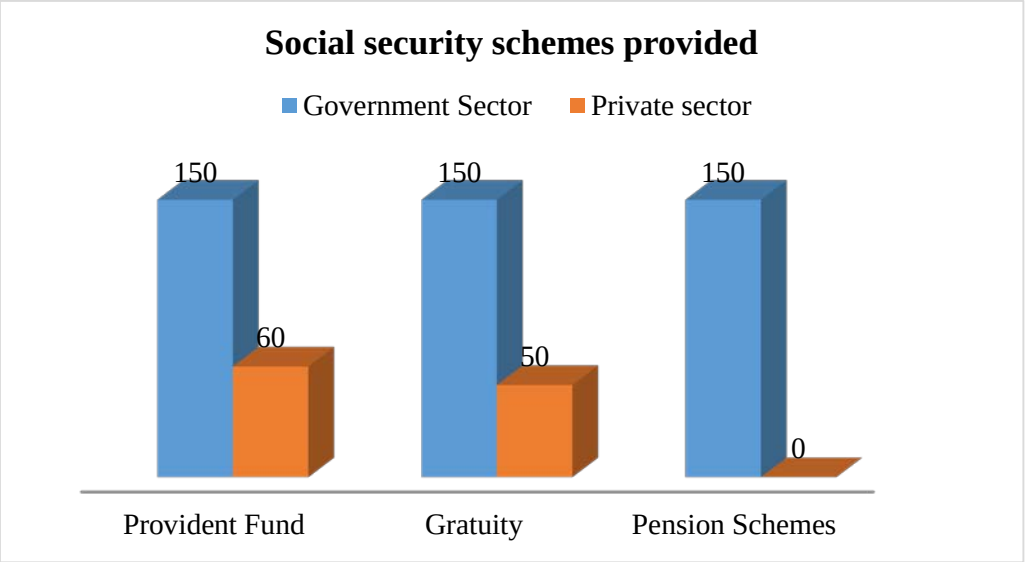

Fig: 10. 20

21. Availability of Leave

Availability of sufficient leave is another challenge faced by staff nurses working in the private sector. Out of the 150 staff nurses interviewed from the government sector, 150 nurses replied with casual and sick leave. Out of the 150 staff nurses interviewed from the private sector, 80 nurses replied with casual and sick leave, and 70 nurses replied with no casual and sick leave.

Table 21

Availability of casual leave and sick leave	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	150	100%	80	53.33%
No	0	0	70	46.66%
Total	100	100	150	100

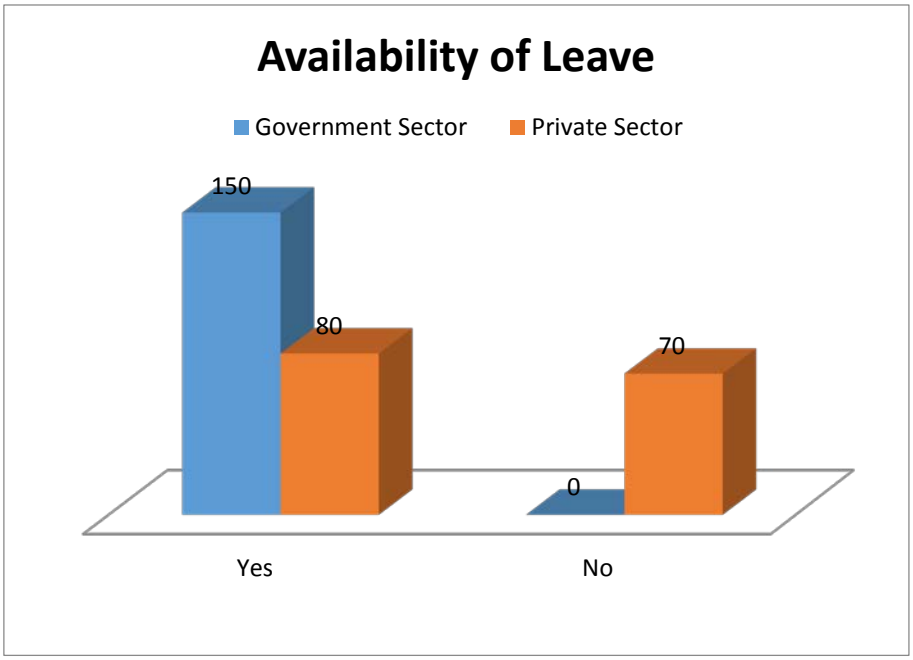

Fig: 10.21

22. Maternity Leave with full wages

As most staff nurses are females, the provision for maternity leave is a matter of grave concern. However, the right is not exercised fully; there will be no full payment in most cases. Out of the 150 staff nurses interviewed from the government sector, 150 nurses replied with maternity leave with full wages. Out of the 150 staff nurses interviewed from the private sector, 150 nurses

replied with six months maternity leave. Out of the 150 staff nurses who answered from the private sector, 60 nurses responded receiving full wages during maternity leave, and 90 nurses replied not receiving full wages during maternity leave.

Table 22

Maternity Leave with full wages	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	150	100	60	40%
No	0	0	90	60%
Total	150	100	150	100%

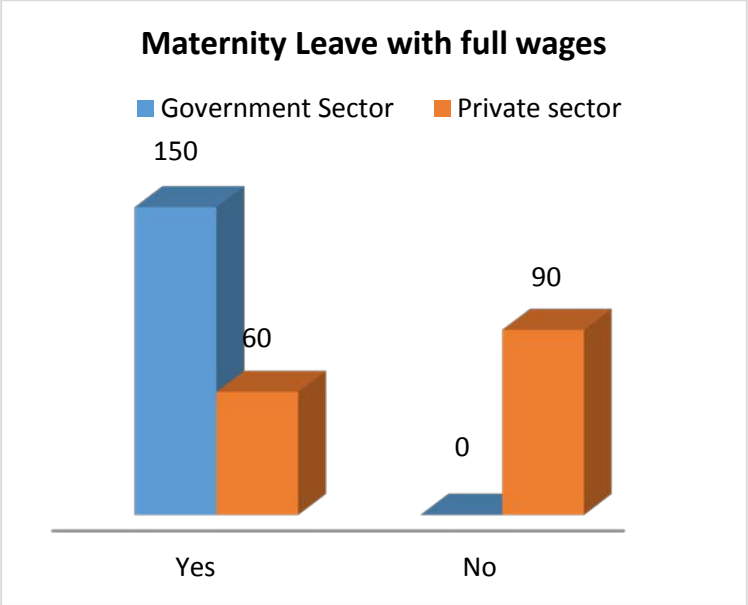

Fig: 10.22

23. Promotion opportunities

When the staff nurses working in government hospitals enjoy a definite structure as to the promotion posts,[7] the same is lacking in the private sector. Out of the 150 staff nurses interviewed from the government sector, 150 nurses replied of having promotion opportunities. Out of the 150 nurses interviewed from the private sector, 150 nurses responded negatively to promotion opportunities.

Table 23

Scope for Promotion	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes (adequate)	150	100%	0	0
No(Not adequate)	0	0	150	100%
Total	150	100%	150	100

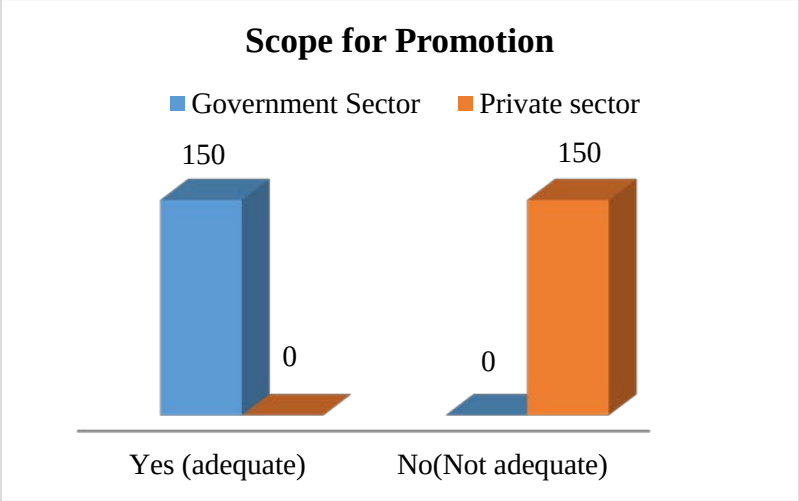

Fig: 10.23

[7] APPENDIX XI, PROMOTION OPPORTUNITIES

24. Crèche facilities for children

The non-availability of crèche facilities attached to hospitals is another issue faced by staff nurses employed in both sectors. Since women dominate the majority of the nursing sector, this issue is relevant. Most female nurses in both sectors have suggested the need for crèche facilities attached to the hospital at a reasonable rate. Out of the 150 staff nurses interviewed from the government sector, 150 nurses replied having no crèche facilities for children. Out of the 150 staff nurses who answered from the private sector, 150 responded with no crèche facilities.

Table 24

Crèche facilities for children	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	0	0	0	0
No	150	100%	150	100%
Total	150	100	150	100

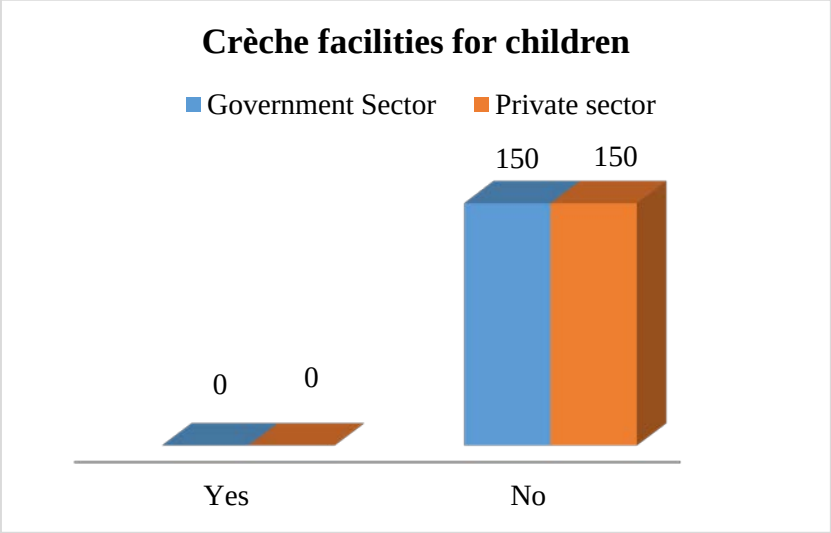

Fig: 10.24

25. Hostel facilities attached to hospitals

Though most of the staff nurses replied positively about the existence of Hostel facilities attached to hospitals, still some raised the issue of non-availability of hostel facilities attached to hospitals. Out of the 150 staff nurses interviewed from the government sector, 100 nurses replied that the availability of hostel facilities attached to hospitals and 50 nurses replied as not having hostel facilities. Out of the 150 staff nurses interviewed from the private sector, 120 nurses responded as to the availability of hostel facilities, and 30 nurses replied as not having hostel facilities.

Table 25

Hostel facilities attached to the hospital	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	100	66.66%	120	80%
No	50	33.33%	30	20 %
Total	150	100	150	100

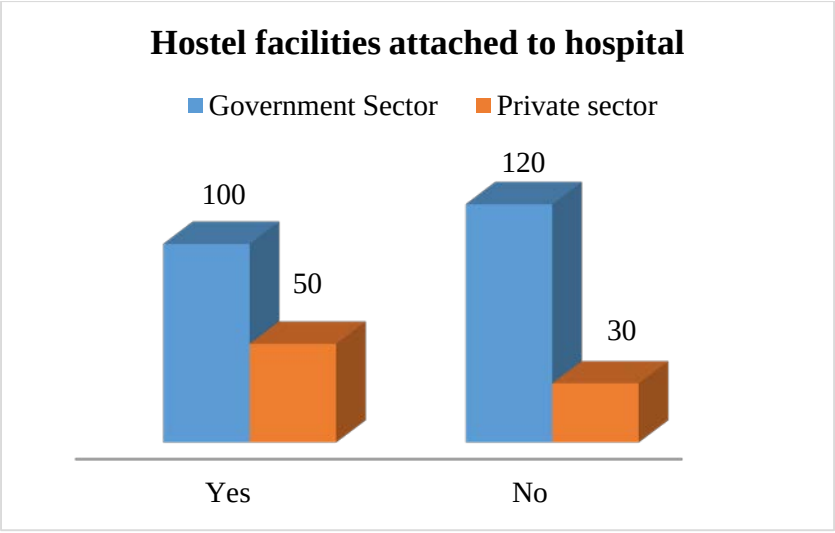

Fig: 10.25

26. Occupational Health hazards

Hazards related to work are yet another issue faced by staff nurses. Hazards in the form of infections, needles tic injury, musculoskeletal pain, latex allergy, transmissible diseases, varicose vein are present in their job. Out of the 150 staff nurses interviewed from the government sector, 50 nurses replied infectious as the significant occupational health hazard,15 nurses responded needle stick injury, 70 nurses replied musculoskeletal pain, ten nurses replied latex allergy, five nurses answered transmissible diseases. Five nurses replied varicose veins as a significant occupational health hazard. Out of the 150 staff nurses interviewed from the private sector, 40 nurses' responded infections, ten nurses replied needle stick injury, 50 nurses replied musculoskeletal pain, 20 nurses replied latex allergy, 20 nurses replied transmissible diseases and ten nurses replied varicose vein as the significant occupational health hazards.

Table 26

Occupational hazards	**Government Sector**		**Private Sector**	
	Number	**Percentage**	**Number**	**Percentage**
Infections	50	33.33%	40	26.66%
Needlestic Injury	15	10%	10	6.66%
Musculoskeletal Pain	70	46.66%	50	33.33%
Latex allergy	10	6.66%	20	13.33%
Transmissible diseases	5	3.33%	20	13.33%
Varicose vein	5	3.33%	10	6.66%
Total	150	100	150	100

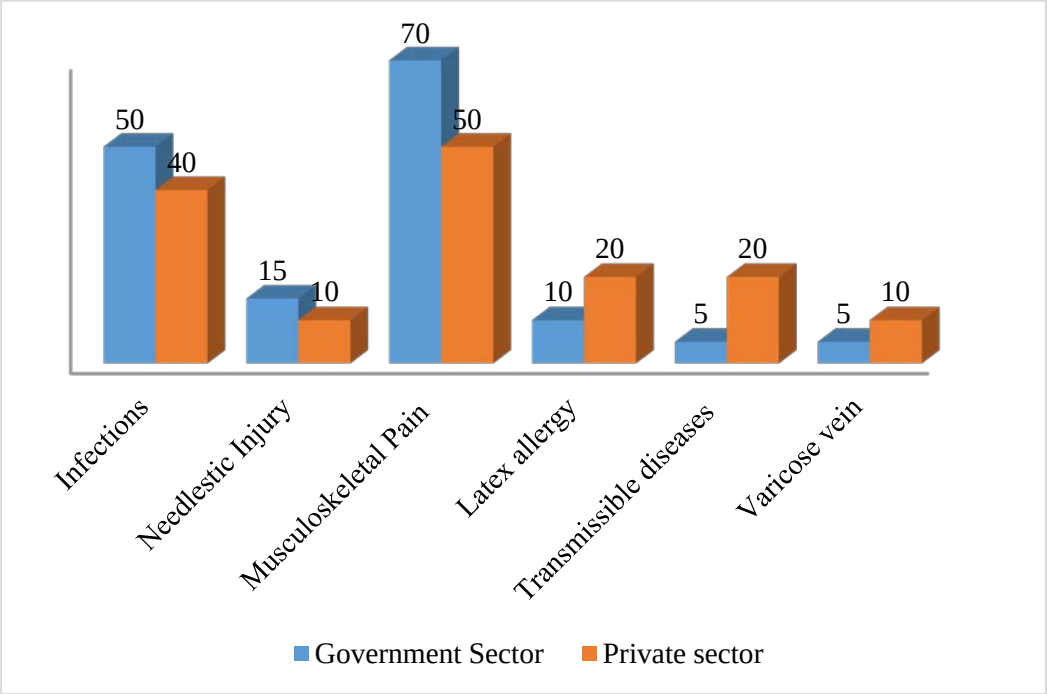

Fig: 10.26

27. Accidents and injuries during duty hours

Needle stick injuries and radiations are the most common type of health-hazardous that staff nurses face. It is revealed that only a few numbers of them have faced injuries or accidents during duty hours. Most of them said that they take sufficient personal protection and care while performing their duties. Out of 150 staff nurses interviewed from the government sector, 15 nurses replied having faced accidents and injuries during duty hours, and 145 nurses responded having not faced accidents and injuries during duty hours. Out of the 150 staff nurses interviewed from the private sector, ten nurses responded having faced accidents and injuries during duty hours, and 140 staff nurses answered not having faced accidents and injuries during duty hours.

Table 27

Accidents and injuries during duty hours	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	15	10%	10	6.66%
No	145	96.66%	140	93.33 %
Total	150	100	150	100

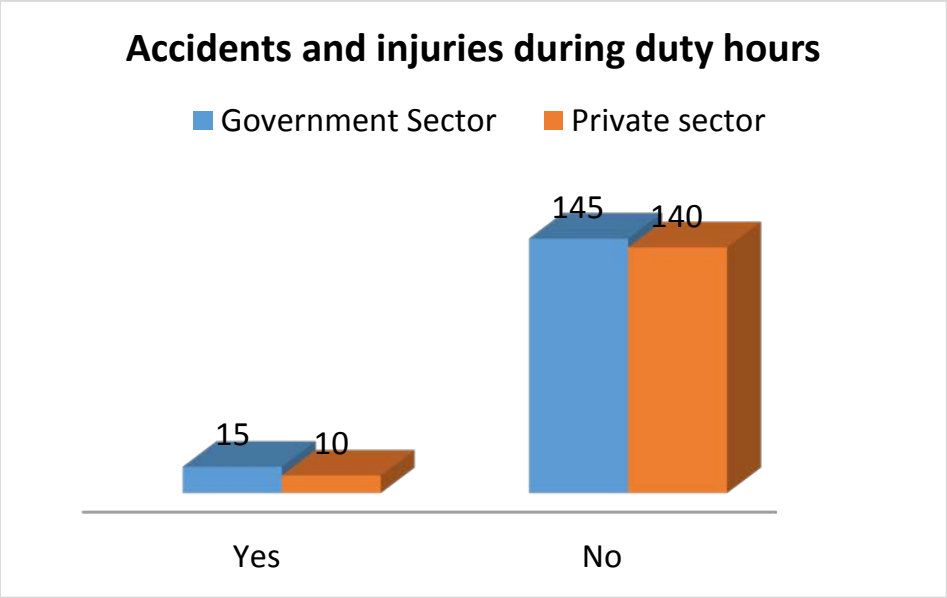

Fig: 10.27

28. Infectious/contagious diseases from the patients

Nurses are easily prone to infectious diseases from the patients due to their job's touch and care nature. As they are aware of it, they consciously take sufficient precautions while treating the patients. Only a few numbers expressed as having been affected by infectious diseases from the patients. Out of the 150 staff nurses interviewed from the government sector, ten nurses

replied as having been affected by infectious diseases from patients, and 140 nurses responded as not having been affected by infectious diseases from patients. Out of the 150 staff nurses interviewed from the private sector, five nurses replied as having been affected by infectious diseases from patients, and 145 nurses responded as not having been affected by infectious diseases from patients.

Table 28

Any infectious diseases from the patients	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	10	6.66%	5	3.33%
No	140	93.33%	145	96.66%
Total	150	100	150	100

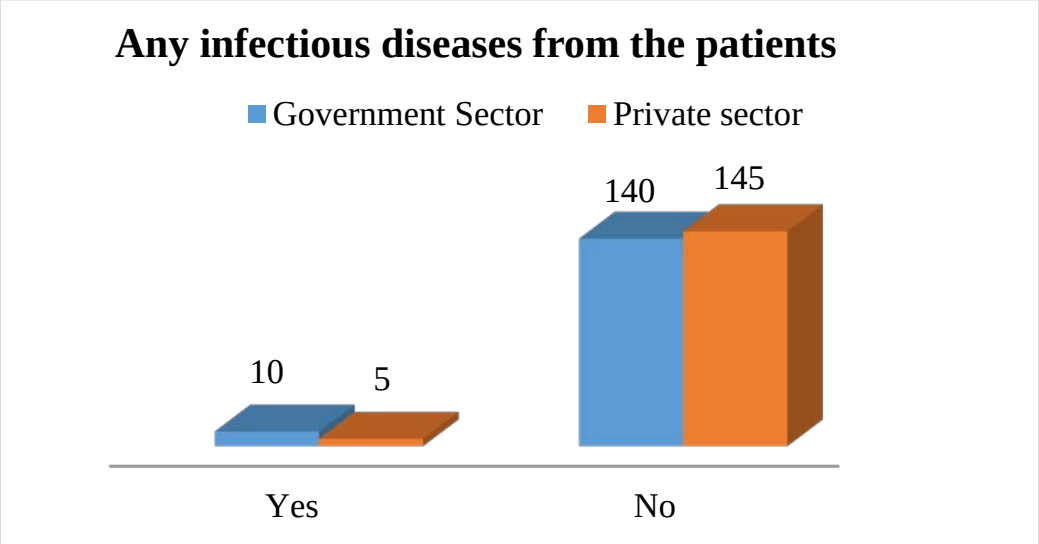

Fig: 10.28

29. Vaccination against infectious diseases

The availability of protective vaccination against infectious diseases in the hospital is vital for the nurses. Out of the 150 staff nurses interviewed from the government sector, 65 nurses replied receiving vaccinations, and 95 nurses replied not receiving vaccinations. Out of the 150 staff nurses interviewed from the private sector, 110 nurses responded having received vaccination, and 40 answered not have the vaccination.

Table 29

Vaccination against infectious diseases	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	65	43.33%	110	73.33%
No	95	63.33%	40	26.66%
Total	150	100	150	100

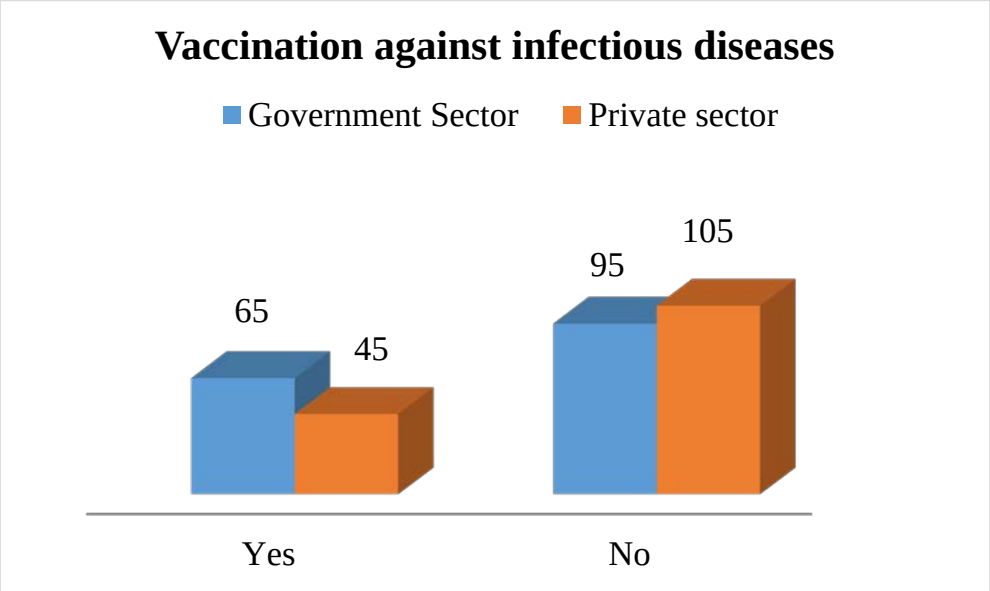

Fig: 10.29

30. Availability of personal protective equipment such as gloves, masks, PP.E kits to safeguard oneself against risks (such as diseases/ Illness)

Concerning the availability of personal protective equipment in the nursing station, all the staff nurses employed in both sectors responded positively. Out of the 150 staff nurses interviewed from the government sector, 150 nurses replied having personal protective equipment in hospitals. Out of the 150 staff nurses interviewed from the private sector, 150 nurses answered having personal protective equipment in hospitals.

Table 30

Availability of Personal Protective Equipment's in hospital	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	150	100%	150	150
No	0	0	0	0
Total	150	100	150	100

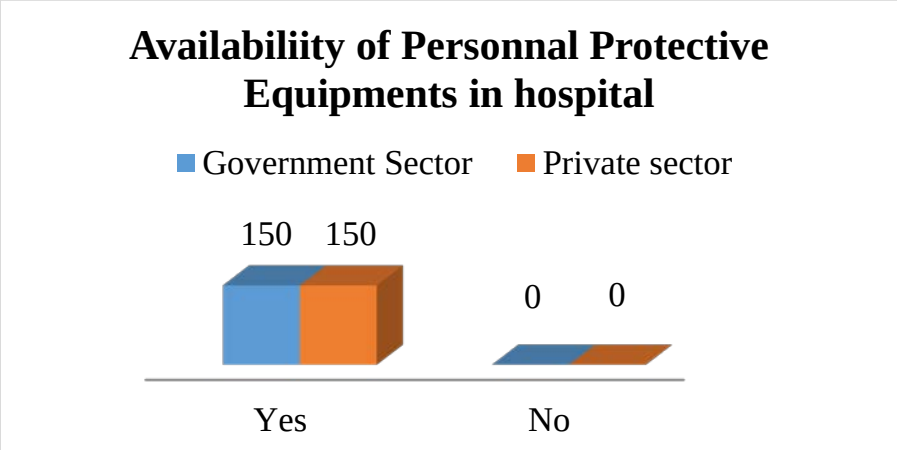

Fig: 10.30

31. Awareness about Internal complaints committee against sexual harassments at workplace

The Internal complaints committee receives complaints about sexual harassment at the workplace. Only a few nurses are aware of the functioning of the internal complaints committee at hospitals. Out of the 150 staff nurses interviewed from the government sector, 130 nurses replied as having been aware of an internal complaints committee against sexual harassment at the workplace. Only 20 nurses replied as not aware of the committee. Of the total 150 staff nurses interviewed from the private sector, 60 nurses are aware of the committee's existence, and 90 nurses are not aware of the committee's existence.

Table 31

Internal Complaints committee	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	130	86.66%	60	40%
No	20	13.33%	90	60%
Total	150	100	150	100

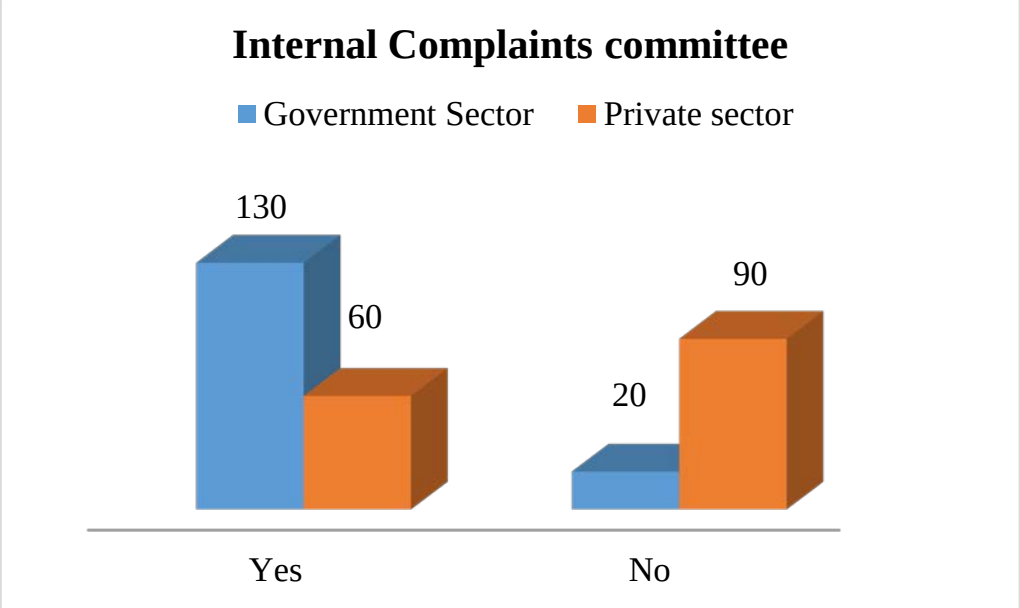

Fig: 10.31

32. Non-nursing duties entrusted

The demarcation of duties to be performed by staff nurses employed in the private sector is one of the primary reasons for the overload of works. Most of the staff nurses in private sectors are entrusted with clerical jobs, which sometimes affect their performance in ensuring quality patient care. In the government sector, there is a definite structure as to the duties and responsibilities of staff nurses.[8] Out of the 150 staff nurses interviewed from the government sector, 150 nurses replied as not having non-nursing works entrusted to them. Out of the 150 staff nurses interviewed from the private sector, 150 nurses answered as having entrusted with non-nursing works.

[8] APPENDIX XII , G.O.(P) NO. 180/2004/H & FWD DATED 6TH AUGUST, 2004 ON DUTIES OF STAFF NURSES

Table 32

Non-nursing works entrusted to nurses	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	0	100%	150	100%
No	150	0	0	0
Total	150	100	150	100%

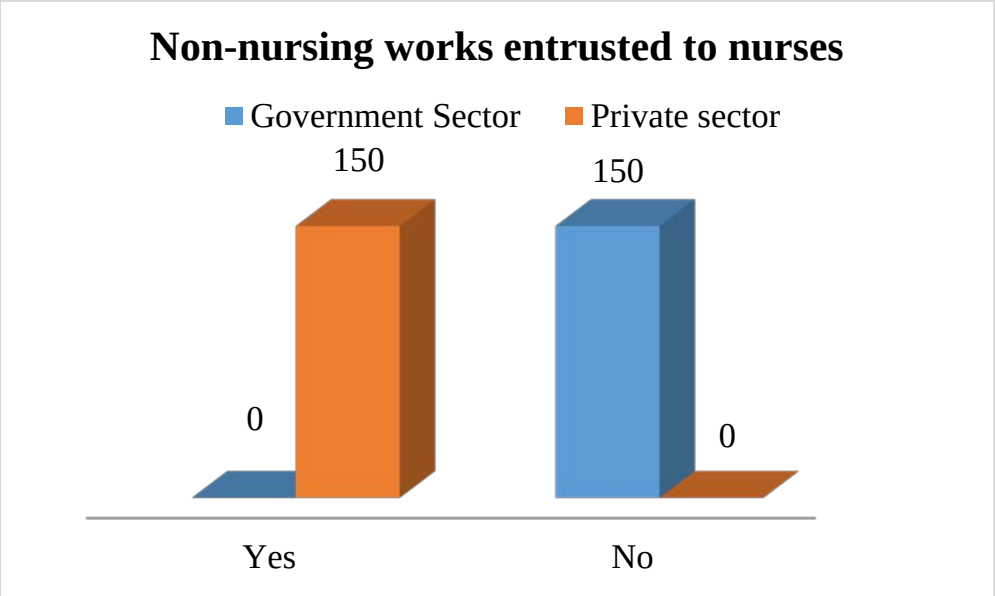

Fig: 10.32

33. The attitude of doctors to nurses

The cordial attitude of doctors to nurses is an essential factor that adds to a healthy working environment. When a cordial relationship exists between nurses and doctors in the government sector, the same is lacking in the private sector. The existence of verbal harassment from the side of doctors and a dominating attitude is expressed by most of the staff nurses working in the private sector. Out of the 150 staff nurses employed in the government sector,

120 nurses replied as having a cordial relationship with doctors. Only 30 nurses responded to the presence of dominating attitude from the side of doctors. Out of the 150 staff nurses interviewed from the private sector, 20 nurses replied as having a cordial relationship with the doctors, and 130 nurses answered the presence of dominating attitude of doctors.

Table 33

Doctor nurse relationship	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Cordial	120	80%	20	13.33%
Dominating	30	20%	130	86.66%
Total	150	100	150	100

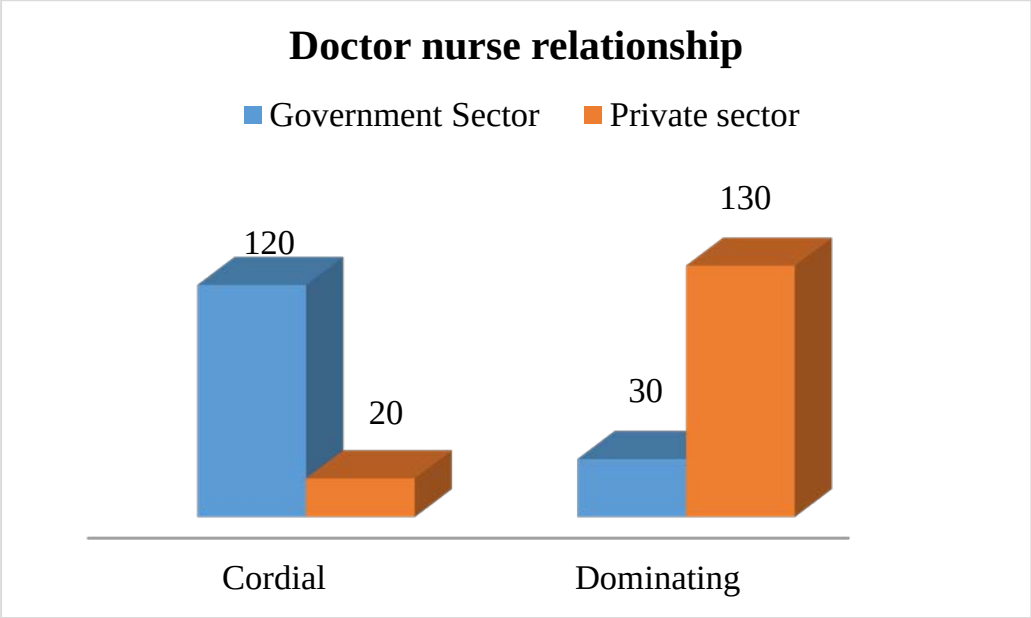

Fig: 10.33

34. Job satisfaction among nurses

Compared to staff nurses employed in the government sector, staff nurses employed in the private sector showed more job satisfaction. Job security with a fixed salary is the primary reason behind this. Still, some staff nurses working in the government sector point out the need for more professional dignity and status. Out of the 150 staff nurses interviewed from the government sector, 100 nurses expressed job satisfaction, and 50 nurses replied as not satisfied with their job. Out of the 150 staff nurses interviewed from the private sector, 30 nurses responded as having job satisfaction, and 120 nurses replied as not having job satisfaction.

Table 34

Job Satisfaction among nurses	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	100	66.67%	30	20%
No	50	33.33%	120	80%
Total	150	100	150	100

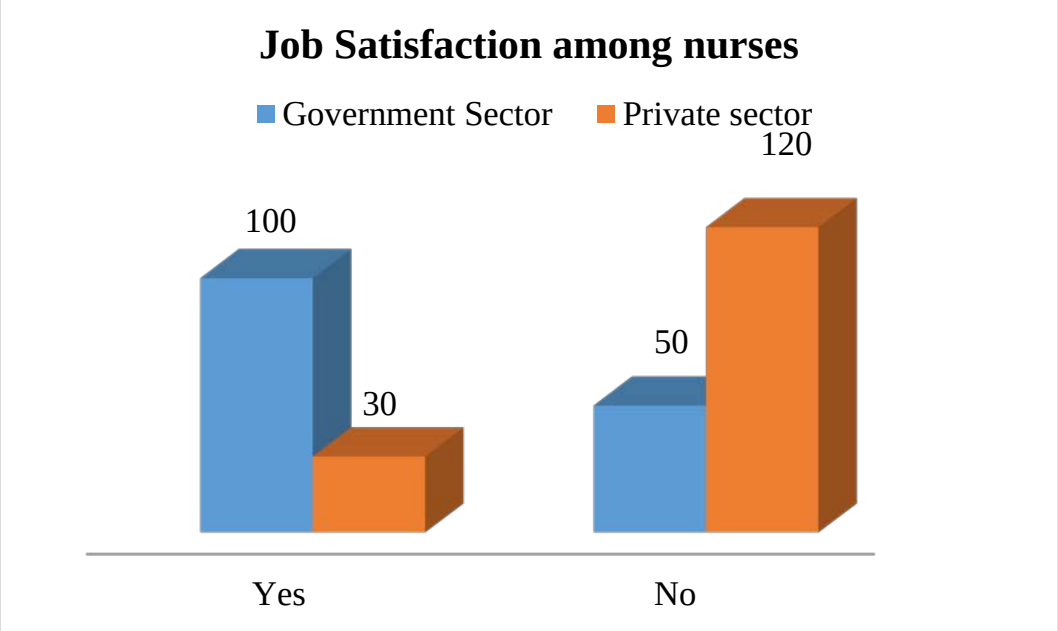

Fig: 10.34

35. In-service education programs

In-service education programs are essential for staff nurses to enhance the quality of their performance. This will help nurses to update their knowledge and develop their skills. The provision for in-service education programs is important for to staff nurses to enhance their knowledge and skill. But the provision for the same is lacking in both sectors. Out of the total 150 staff nurses employed from the government sector, 150 nurses replied as not having in-service education programs. Out of the 150 staff nurses employed from the private sector, 150 nurses responded as not having in-service education programs.

Table 35

In-service education to nurses	Government Sector		Private Sector	
	Government	Percentage	Number	Percentage
Yes	0	0	0	0
No	150	100%	150	100
Total	150	100	150	100

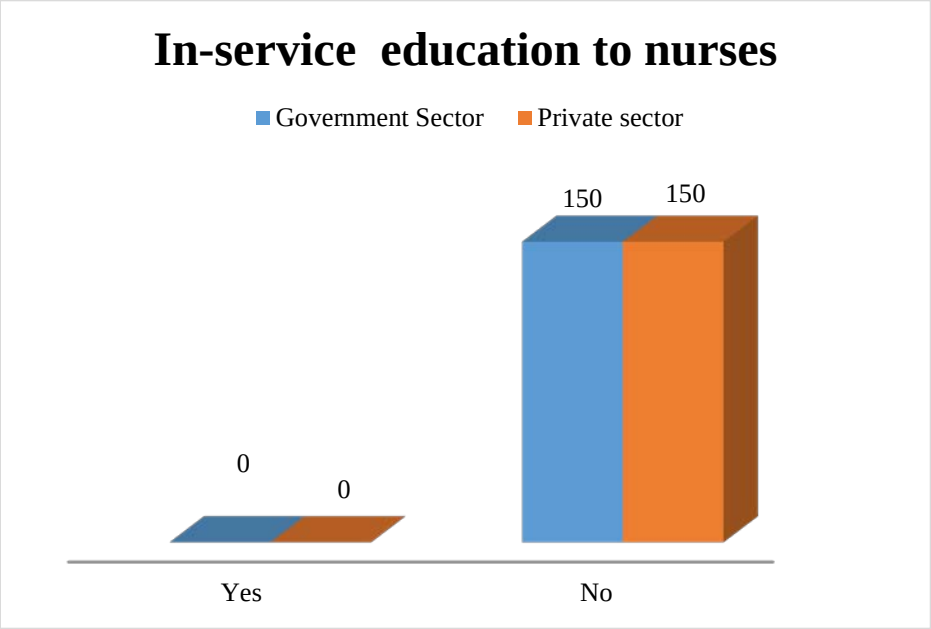

Fig: 10.35

36. Legal literacy classes to nurses

The need for legal awareness among staff nurses is suggested by most post-graduate level qualified nurses. As most nurses are unaware of their rights and the legal mechanism through which they can redress their grievances, the need for legal literacy awareness classes among them has become a prerequisite. Currently, both system lacks a mechanism in this regard. Out of

the 150 staff nurses, 150 nurses replied as not having legal literacy classes provided by the hospitals. Out of the 150 staff nurses employed in the private sector, 150 nurses answered as not having legal literacy classes offered by the hospitals.

Table 36

Legal Literacy classes to nurses	Government Sector		Private Sector	
	Government	Percentage	Number	Percentage
Yes	0	0	0	0
No	150	100%	150	100%
Total	150	100	150	100

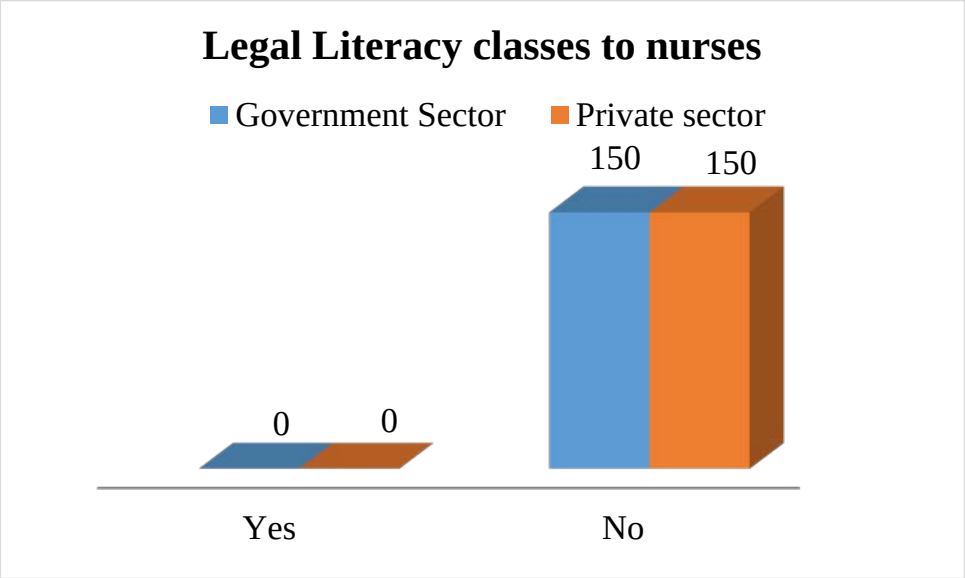

Fig: 10.36

37. Trade Union Membership

Compared to the government sector, the scope of trade union activities are very limited in the private sector. Nurses are reluctant to join trade union activities due to the fear of repercussions from the side of hospital

management. Out of the 150 staff nurses interviewed from the government sector, 130 nurses replied as having membership in nurse's trade unions or associations, and 20 nurses answered as not having membership in nurses' trade unions. Out of the 150 staff nurses employed in the private sector, 60 nurses replied as having membership in nurse's trade unions, and 90 nurses answered as not having membership in nurse's trade unions.

Table 37

Nursing Trade Union Membership	Government Sector		Private Sector	
	Number	Percentage	Number	Percentage
Yes	130	86.66%	60	40%
No	20	13.33%	90	53.33%
Total	150	100	150	100

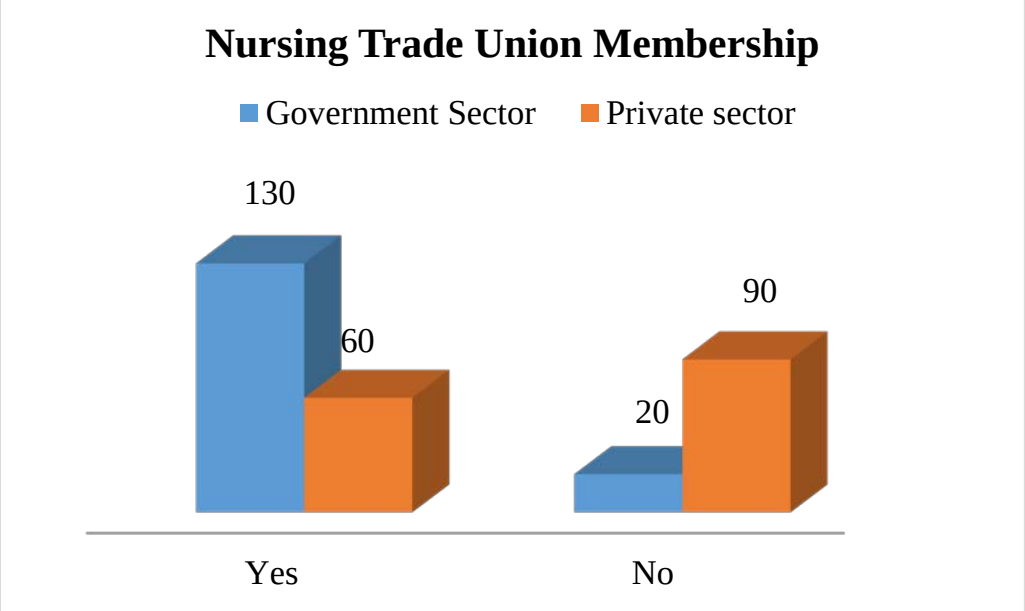

Fig: 10.37

ADDITIONAL QUESTIONS TO NURSES WORKING IN THE PRIVATE SECTOR

38. Execution of Bond

Regarding the execution of Bond between the nurses and the management of the private hospitals, most of the reply received is negative. Out of the 150 staff nurses employed in the private sector, 30 nurses replied as executed bond at the time of joining, and 120 nurses replied as not executed any bond at the time of joining.

Table 38

Execution of Bond at the time of joining	Private Sector	
	Number	Percentage
Yes	30	20%
No	120	80%
Total	150	100

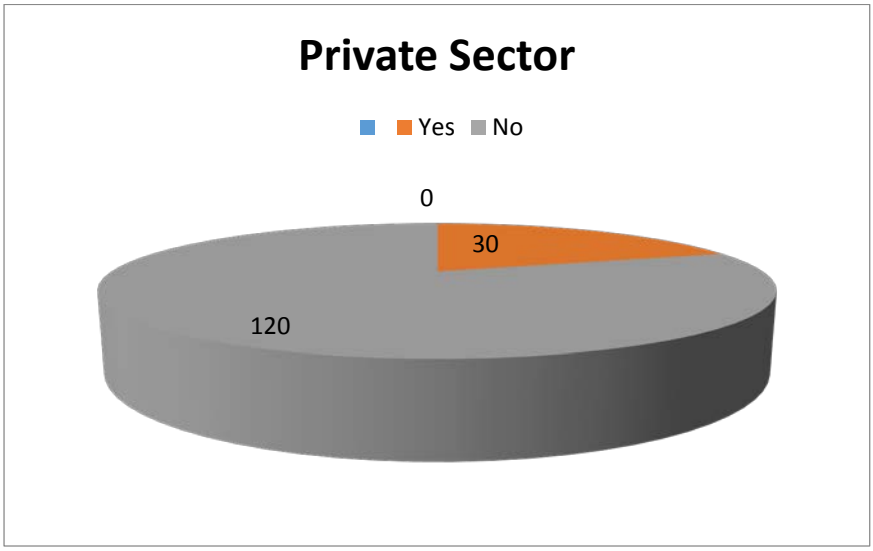

Fig: 10.38

39. Where do you file work-related complaints?

The nurses' awareness about the Grievance Redressal Mechanism constituted under the Industrial Dispute Act, 1947 is examined by this question. Out of the 150 staff nurses interviewed from the private sector, only 30 nurses were aware of the Grievance Redressal Mechanism, 60 nurses replied hospital management as the authority handling work-related complaints, 50 nurses responded to nursing associations as the authority handling work-related complaints, and ten nurses replied nursing councils as the authority handling work-related complaints.

Table 39

Authority handling Work related complaints	Number	Percentage
Hospital Management	60	40%
Grievance Redressal Mechanism	30	20%
Nursing Associations/ Trade union	50	33.33%
Nursing Council	10	6.66%

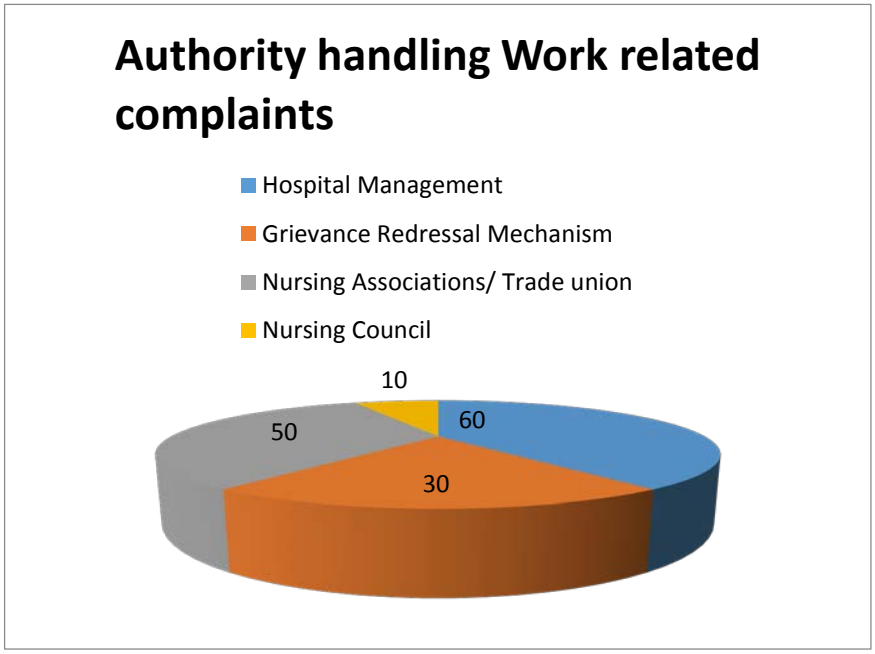

Fig: 10.39

40. Attitude of hospital management to nurses

The harassing attitude of hospital management is revealed by most staff nurses working in the private sector. Out of the 150 staff nurses interviewed from the private sector, 30 nurses replied as having a cordial relationship with doctors, 110 nurses replied harassing nature on the part of hospital management, and ten nurses responded neutral attitude on the part of hospital management.

Table 40

Hospital management nurses relationship	Number	Percentage
Cordial	30	20%
harassing	110	73.33%
Neutral	10	6.66%
Total	150	100

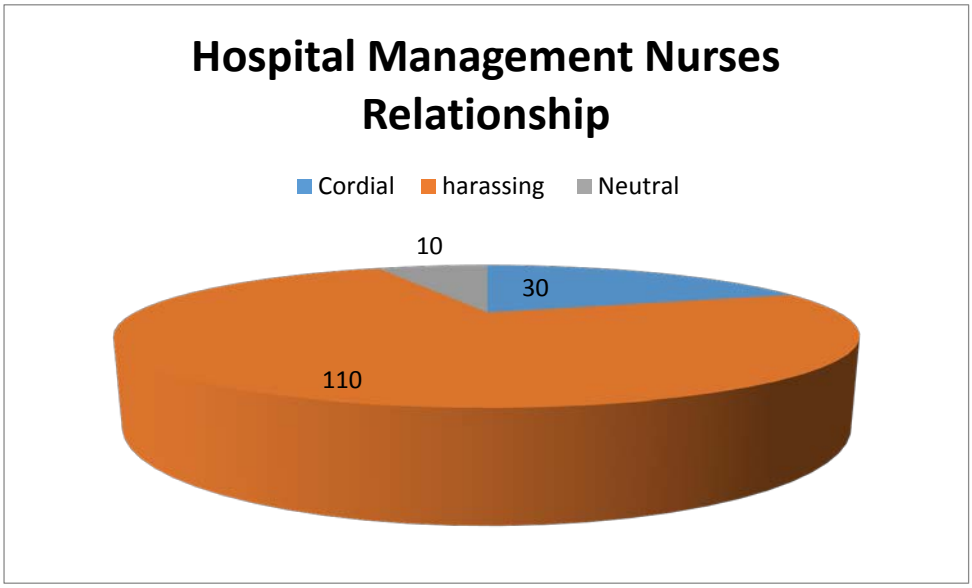

Fig: 10.40

41. Have you faced any disciplinary action from your employer for Union activities and Collective Bargaining?

Though the staff nurses showed their support for trade union activities, most of them are reluctant to participate in trade union activities due to fear of repercussions. As far as the activists are concerned, some have faced warnings and negative behaviors from hospital management. Out of the 150 staff nurses interviewed from the private sector, 60 nurses replied as having faced disciplinary actions from the employer's side for trade union activities, and 90 nurses responded as not facing disciplinary actions from the employer for trade union activities.

Table 41

Disciplinary action from employer for trade union activities	Number	Percentage
Yes	60	40%
No	90	60%
Total	150	100

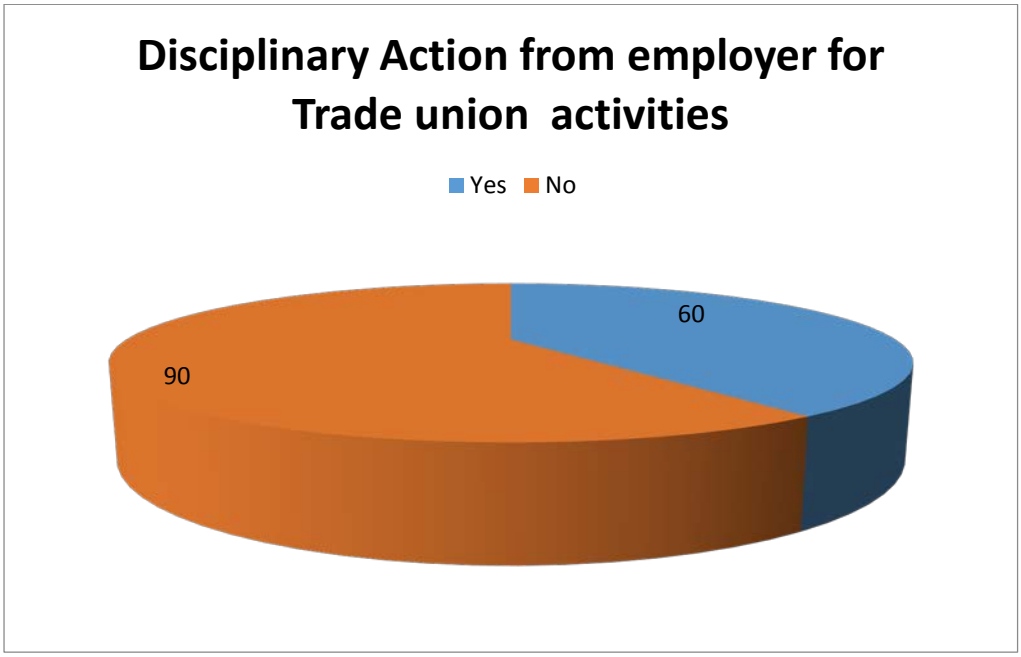

Fig: 10.41

42. Respondent's Suggestions

The researcher has also sought suggestions from the side of the respondents. Improvement in salary is one of the significant suggestions put forth by the staff nurses working in the private sector. Out of the 150 staff nurses interviewed from the private sector, 100 nurses suggested improving their salary.

Likewise, the payment of minimum wages is another primary suggestion. Out of the 150 staff nurses interviewed, 90 nurses suggested the need for implementation of minimum wages. They showed their concern on the need for balancing their salary with their hours of work.

The need for allowing the activities of trade unions in hospitals is another suggestion. Out of the 150 staff nurses interviewed from the private sector, 90 nurses suggested trade union activities in the hospital sector.

As far as nurses from government sector are concerned, their main suggestion is the need for implementation of nurse patient ratio.

Conclusion

The present empirical study shows that staff nurses working in government hospitals are more satisfied than those working in the private sector. Fixed salary and other benefits provided by the government is the primary reason behind this. In the private sector, benefits and other social welfare measures are not satisfactory. In the regulatory sphere, nurses employed in the government sector are well regulated. But in the private sector, the nurses are at dismay. Even though private hospitals have the freedom for

self-regulation, most of them are arbitrary or fanciful. The nurses in private are found unsatisfied with the working conditions. The private hospitals have made self-regulations that are at par with the governmental rules. Still, such regulations failed to attain its fundamental objectives due to lack of implementation. Uniform laws and regulations for the private sector are absent, creating situations of anomalous arbitrary policies that make the sector unregulated. Another issue is the non-implementation of social security measures which are mandated by the constitution and statutes. This issue arises due to the lack of enforcement agencies to monitor the implementation of these laws in the private sector. Therefore, the lack of proper regulation of private hospitals was one of the major problems affecting nursing.

The shortage of staff and the non-implementation of the nurse-patient ratio are other significant concerns that nurses in both sectors have. However, this is rampant in the private sector, and often it leads to overburdening of work and reduces the quality of time which nurses spend with the patients. Most of the nurses belonging to the private sector have shown concern about non-nursing duties such as administrative duties, housekeeping, and messenger services which include transportation of patients, etc., imposed on them.

Nurses belonging to the private sector, especially those with B.Sc nursing qualifications, reveal their intention to work abroad. Enhanced professional status with fair salary or incentives and progressive environment for professional advancement are pointed out as reasons in the study. The lack of promotion avenues and non-implementation of maternity leave with full

wages are significant concerns for nurses working in the private sector. Nurses who have more experience showed their concerns about the need for promotion avenues and a salary increase. Another concern is the lack of job security. Most nurses employed in the private sector are working on a contractual basis and are denied social security benefits, especially the availability of maternity leave with full wages. In most cases, maternity leave for six months is provided without wages.

The attitude of the hospital management and the doctors are other significant concerns shared by staff nurses belonging to the private sector. The harassing and non-cooperative attitude of the hospital management is one of the important reasons which prompt staff nurses to shift from one hospital to another. This behavior on the part of hospital management also reduces the scope of healthy discussions to ensure patient care. Most of the staff nurses employed in the private sector revealed their reluctance in filing complaints to redress their grievances due to fear of harassing attitude from the side of hospital management.

The dominating behavior of doctors is also reported by nurses, especially those possessing B.Sc qualifications. A cordial behavior is expected to ensure more quality patient care.

Both sectors suggest the need for professional status and a uniform department for nursing. The need for a legislative framework to protect and ensure safe working conditions for nurses, especially in the private sector, is reflected in the study. Further, the Personal interviews with B.Sc qualified

staff nurses point towards the need for a wider ambit of law wherein they are guaranteed professional dignity and recognition as ‘professional practices.’ The need for legal recognition as ‘health care professionals’ is also suggested by a few.

CHAPTER XI

CONCLUSION AND SUGGESTIONS

Healthcare is one of the primary obligations of the State. Establishing a Health System consisting of those conditions and facilities needed to achieve the right to health is the first step in this regard. The availability of a sufficient number of well-qualified and well-trained healthcare professionals is an essential prerequisite. Health care providers function as the primary building blocks of the health system. They play a vital role in protecting the rights to the health of the people. They include a team of health care professionals such as physicians, nurses, paramedics, physical and occupational therapists, etc. Among them, the nursing professionals are the direct providers of healthcare. They function near to the people. They are more accessible and act as an intermediary between the physician and the common person.

As a significant voice of the health system, the role of nurses can be found at three levels: the individual or patient-centered level, the community or public health level, and the global level. They play different roles as per their educational qualifications. They include the Registered Nurses, the Licensed Practical Nurses, the Certified Nursing Assistant, the Advanced Registered Nurse Practitioner, Nurse Practitioners, Nurse anesthetist, etc. Their functions range from taking vital signs, dispensing prescribed medications, applying bandages, administering injections, performing therapeutic massage, preparing

patients for surgical procedures, providing health education to patients and families, diagnosing health problems, prescription of medications, and so on.

In India, they play a significant role in the public health care level provided exclusively by the State; and the hospitals level, in which both the State and private entities play the part. In the Indian health system, nurses are known in various names such as the Auxiliary Nurse-Midwife/Female Health Worker, the Male Health Workers, the Lady Health Visitor, the Public Health Nurse, the Auxiliary Nurse Midwives, the Staff Nurse, the Nursing Sister/Ward Sister/Supervisor, the Assistant Nursing Superintendent, the Deputy Nursing Superintendent, the Nursing Superintendent, and the Chief Nursing Officer.

The historical accounts on nursing throw light on the development of nursing as a profession. In olden days, nursing was considered an ordinary task performed by female family members, especially mothers who nurse and nourish their children. Later the Christian Orders of Deaconesses influenced nursing, and the conviction that nurses must be pure in mind and body came to exist. It led to the practice of nursing being performed only by unmarried women or virgins or widows who devoted themselves to the service of others.

Later, the difficulties of wars, especially the Crimean and the Second World War, adds a new shape and order to nursing. Nurses were in massive demand for caring wounded soldiers at war fields. One of the finest examples can be found in the Crimean War (1854-1856), wherein the service of Ms. Florence Nightingale transformed the understanding of nursing itself. The pain

and effort she took to nurse the wounded soldiers with very few amenities brought new insight into nursing as a 'discipline.' She defined nursing as a 'want of a better, which includes the wholesome caring of the patient. She adds new dimension to nursing as a discipline that requires training, skill, and knowledge. She started training schools for nurses in England and worldwide, thereby giving a professional touch to nursing.

This transformation of nursing as a professional sphere can be found in India also. The major shift in nursing happens with the coming of the westerns. The westerners have a tremendous influence on nursing education. They, along with the Christian missionaries, started training schools for Indian nurses. The constitution of Indian Nursing Services for providing nursing care for the soldiers in India is one of the chief milestones laid down by Ms. Floreance Nightingale in India. The present system of training and advancement in Nursing owes its existence to the efforts of westerns. Later, the Westerns in India developed the Military Nursing Service, the Auxiliary Nursing Service, and the School of Nursing Administration. Collaboration of the Trained Nurses Association with WHO and Rockefeller encourages international exposure of nursing in India.

The disgusting reality in India is that the Indian mindset towards nursing never changed, even though there are advancements in nursing education. The notion of pure and pollution theory spread by the Brahmanical period developed prejudices against nursing as it involves direct caring of the patient. The interactive nature of the job, night shift works and living outside the home,

were other major stigmas attached to the profession. Nurses were called 'untouchables' or 'Prostitutes' due to the 'touch and care' nature of their profession. Nursing was viewed as a profession that was unsuitable for women belonging to respectable families. Apart from that, nurses work in a deteriorating atmosphere. Deplorable living conditions of nurse's hostels, poor quality and insufficient food, overcrowding and unsanitary conditions in hospitals, long working hours, and meager salaries were the issues faced by nurses at their workplace. Thus, even though nursing education in India has gained international exposure, the working conditions of nurses remained in awful condition.

The year between 1930- 2016 witnessed the appointment of various committees to study the issues of nurses in India. They made several recommendations for the advancement of nursing. Their suggestions result in the improvement of nursing education in India. However, the working conditions of nurses remain the same. The silence on the part of the State, hostility from the side of medical professionals, dominance of westerns in nursing leadership were pointed out to be the leading cause for this state of affairs.

As the essential workforce of the healthcare industry, nurses are entitled to various rights guaranteed under human rights conventions. Convention such as the Geneva Convention 1949, the Nursing Personnel Convention, 1977, the Nurses Bill of Rights, 2001 were the essential documents that reflect the rights of nurses. In India, nurses are entitled to all the rights guaranteed by the

Constitution of India, such as the right to practice their profession, the freedom to form associations and trade unions, the right to life, the right to health, and the right to be just humane conditions of work.

Apart from these rights, nurses are entitled to all the social security benefits and various rights extended to laborers in an Industry. This is due to the decision of the Supreme Court in *Bangalore Water Supply & Sewerage Board, etc. v. R.Rajappa,*[1] which includes hospitals within the definition of "Industry." Here, nurses are regarded as Workman. They enjoy rights such as the right to the amicable settlement of Industrial disputes through Grievance Settlement Authorities or Grievance Redressal Committee, right to Wages including minimum wages, wages for overtime work, right to eight hours of work in a day, and 48 hours of work a week, right to weekly holidays, right to annual leave with wages, right to equal remunerations, right to payments such as provident fund, gratuity, Bonus and subsistence allowance, right to insurance provisions, right to Protection against occupational injury and accidents including occupational safety, health and working conditions, right a weekly holiday, right to the prohibition of overlapping shifts, right to get notice of periods of work and right to compensation for accident and occupational diseases. However, various media reports and petitions filed before the Supreme Court and High Court reveal that most of these rights are not enjoyed by the nurses. The issues of non-payment of wages, including minimum wages

[1] Banglore Water Supply v. A. Rajappa (AIR 1978 SC 548).

and pathetic working conditions and non-implementation of social security benefits were reported.

It is an undisputed fact that nurses are bound to function as per the doctors' instructions when it comes to administering treatments to patients. However, the discussions on nurses' duties of care show that nurses are expected to perform and possess ‘reasonable care, skill, and knowledge while carrying out the doctors' instructions. Even under the authority of doctors, nurses are expected to perform their duties with the requisite skill and expertise expected out of a professional person. Failing of which, result in negligence on the part of nurses.

Failure to follow a standard of reasonable care to avoid harm to the patient; Failure to communicate with the physician on time and to communicate with a patient; failure to document a patient’s progress and response to treatment, failure to implement a plan of care; and failure to act as a patient advocate, including to- failure question incomplete or illegible medical orders are some examples of nurse’s negligence. However, the principle of vicarious liability, which is invoked in cases of master-servant, principal-agent, partnership-firm, employer-employee relationships, is applied here for fixing the liability of nurse’s negligence. Usually, the physician and the hospital authorities are made liable for negligence arising within the scope of the employment of nurses. Physicians are accountable for those negligent acts performed by nurses under their control/instructions. Likewise, the hospital authorities are vicariously liable for the negligence of their staff nurses.

One of the main difficulties in the Indian legislative framework is the lack of clarity regarding the duties of the nurses. There is an absence of a defined standard of nursing practice. Due to these legal lacunae relating to the role description of nurses and standard of practice, nurses' negligence remains unidentified.

An analysis of the legislative framework shows that the nursing profession in India is mainly regulated by the central law titled the Indian Nursing Council Act, 1947, and the State legislations. The constitution of the Nursing Council at the Central and the State level to regulate the standard of practice and education of nurses is the primary aim of both legislations. On the standard of practice, compared to the central Act, the state laws provide detailed accounts on mandatory registration for practice, conditions for registration, prohibition of unregistered persons from practice, grounds for taking disciplinary actions, the role of nursing councils, and penalties for non-conformity with the prescribed standards of practice.

Viewed critically, the regulatory framework in India reveals the need for a proper definition of the term ‘nurse.’ The state legislations in India define nursing in different ways. Some states define ‘nurses’ as per educational qualifications; others describe them as inclusive of other persons such as an auxiliary nurse, dais, public health nurses, midwives, auxiliary nurse-midwives, and health visitors. The definitions are not clear about the role of the nurse or the duties of the different categories of nurses. The scope of practice and the standards of practice are missing in both the legislations. The provision dealing

with the constitution of nursing councils also needs a re-look due to the lack of adequate representation from the nursing field.

Though the new bill titled the National Nursing and Midwifery Commission Bill, 2020 in India is a good attempt; it is not free from drawbacks. The inclusion of midwifery along with the nursing profession, the inclusion of home nurses (who are usually unqualified) into the nursing category, the lack of definite explanations on the scope of nursing practice including the functions and role boundaries of nursing practice, the non-representation of nursing associations in the Nursing Councils, and the absence of inclusion of the rights and the liabilities of nurses are some of the critical matters of discussion.

One of the strongest stands that support the nursing as a profession is their education, which includes learning medicine-oriented subjects such as anatomy, physiology, microbiology, and clinical training in hospitals. The orientation towards science and medical knowledge invariably provides them with adequate knowledge, training, and skill and inserts them within the framework of a 'professional.' The expanding scope of specializations in post-graduate nursing education is notable. However, the issue of double-entry allowed to nurses who possess a GNM degree or B.Sc nursing into nursing practice is always a matter of concern. Issues such as the mushrooming growth of private nursing institutions without proper infrastructure facilities for clinical training, the presence of geographical imbalances on nursing education within the States of India, non-compliance with the accreditation standards, disparity

in the cost of education between the private and government nursing educational institutions, the demand for more specializations for post-graduate students in nursing including the nurse practitioner course, the recent attempts of the INC to throw open admission of B.Sc nursing to those art stream students, etc. are raised in various studies relating to nursing education in India. Even so, nurses who are graduated from India receive a warm welcome in countries outside India.

One of the points noted in the comparative study of the regulations in countries outside India is the inclusion of nurses as healthcare professionals within their legislative framework. Regulations in these countries are clear regarding the role, definition, duties, and standard of nursing practice. Independent duties that are to be performed by nurses belonging to different categories are explained in a detailed manner along with their powers and privileges enjoyed by nurses. The title enjoyed by nurses such as 'advanced practitioner' and the power to prescribe drugs; the power to perform specific activities in the absence of medical practitioners are good provisions which can be incorporated to India's existing legislative framework. Recognizing their role as healthcare professionals within the legislative framework is such an urgent need of the hour.

In addition to understanding India's legislative framework, the study also tries to know the regulation of the service conditions of nurses working in private and government hospitals in the State of Kerala. An empirical study is conducted among nurses in the State of Kerala to know the real work-life

situation. As a result of the study, it is realized that both sectors have different regulations regarding service conditions. When the staff nurses employed in the government sector have fixed rules and regulations relating to their working conditions, the same is absent in the private sector. The study unveils the issue of non-implementation of social security measures to staff nurses as well as the need for regularization of service conditions, especially in the private sector, is called for with some suggestions for regulating the nursing profession.

Suggestions

1. There is a need for a Central Legislative Framework to regulate the nursing profession in India. The term 'nurse' must be properly defined within the legislative framework with an explanation as to their roles, functions, and scope of practice. Aid can be taken from the Nova Scotia Act, which defines 'nursing' as a science having evidence-based knowledge….."[2] It is a good example that can be adapted to the Indian legislative framework. There shall be clarity about those persons who are included within the definition and capable of giving nursing care and who are excluded from the definition who are not qualified for providing nursing care. This is relevant to avoid the misusage of the term. An example of such misusage can be found in Home nursing, where mostly unqualified persons are delivering care or assistance to those who are in need.

[2] CHAPTER IX, *supra* note p.277.

2. The inclusion of more representatives from the nursing community to the Nursing Councils is an essential prerequisite which can be included within Indian legislative framework. Nurses having practical experiences and high-level academic qualifications can be included in it. The best example can be taken from the legislative framework of the State of Haryana[3]. This will enhance the professional autonomy of nurses. However, the proper balance shall be maintained concerning representatives from other fields such as the Department of Health, medicine, nursing organizations.

3. Duties that nurses are required to perform must be clearly mentioned within the legislative framework. The comparative study of the legislative framework in Canada specifies the "authorized and controlled acts" which can be performed by nurses.[4] This will help to avoid the tendency of overburdening nurses with unnecessary duties and will help to use their time qualitatively for patient care. The legislative framework prevailing in the State of California which explains the duties of nurses ranging from direct patient care to performance of emergency procedures can be taken as a good model.[5] As far as staff nurses working in government hospitals are concerned, government orders are specifying their duties in a detailed manner, whereas the duties of

[3] CHAPTER VII, *supra* note p.207.
[4] CHAPTER IX, *supra* note p.275.
[5] CHAPTER IX, *supra* note p.269.

the staff nurses in private hospitals depend on the whims and fancies of the management.

4. Some additional rights of nurses within the legislative framework such as the right to handle emergencies, right to take part in policy decisions related to health, right to receive training and refreshment courses related to professional matters, right to question unethical orders of doctors, right to whistleblow shall be incorporated into the legislative framework. This will help in ensuring quality healthcare.

5. The standard of the practice of nurses shall be mentioned in the legislative framework. The health of the public shall be given more importance. Without properly defining the standard of nursing practice, the standard of care expected from nurses cannot be ascertained to make them liable for negligence. Guidance can be sought from NABH standards for Nursing Excellence.[6] Proper Implementation of these guidelines is needed.

6. Though registration of nurses is a mandatory provision before practice, the penalty which is imposed for non-registration is too meager. Enhanced punishments shall be imposed on those nurses who practice without registration.

7. The Nursing Councils in the State must be given the power to monitor and review the working conditions of nurses as well as the power to take

[6] CHAPTER VI, *supra* note 203 at p.187.

disciplinary proceedings in cases of unethical conduct. Disciplinary proceedings must be taken only after proper investigation and inquiry into the allegation.

8. The need for more involvement from the part of the State is important in improving the conditions of the nursing sector. The legislative framework of the Philippines which imposes an obligation on the State to protect and improve the nursing profession is an important provision that can be incorporated into India[7]. The State must take appropriate steps to ensure that the rights of nurses are protected in India.

9. Regulation of Private hospitals is one of the urgent needs of the hour. A regulatory mechanism with proper reviews and inspections as to the implementation of legislation is needed. As far as the issues of nursing professionals are concerned, the private hospitals shall be obliged to work in a partnership with the government for ensuring quality health care. The unregulated freedom enjoyed by the majority of the private hospitals in Kerala harms the employee-employer relationship which they maintain with their staff nurses. Issues such as humiliating treatments from the side of hospital management as well as doctors, job stress, non-implementation of staff nurse-patient, work-related hazardous, low promotional avenues, low salary, unpaid maternity leave, unsecured job, etc have been pointed out by staff nurses working in a private hospital. Fixed salary schemes

[7] CHAPTER IX, *supra* note p.283.

with job security and social security benefits shall be provided to staff nurses working in the private sector.

10. Need for a Single Department for nursing is another suggestion. It is notable from the Right to Information availed from the Directorate of Health, State of Kerala that (i) all the information (such as their salary details, the total number) of staff nurses employed in private hospitals are available only with the Labour Department, State of Kerala; whereas the Directorate of Health keeps all the information about the staff nurses employed in government hospitals, state of Kerala. This shows the separate categorization of the departments. Thus, the need for a single department or directorate to deal with the matters of nurses is felt.

11. Implementation of the nurse-patient ratio is the urgent need of the hour in both sectors. The non-implementation of the nurse-patient ratio is a major concern of staff nurses employed in both sectors. The staff-patient ratio will help in improving quality patient care and avoid overstress among staff nurses. The nurse staff-patient ratio provided in the legislative framework of the United States[8]is an example that can be adopted in India. The nurse-patient ratio must be mentioned in the legislative framework. Strict penalties must be imposed on those healthcare institutions which fail to adhere to them.

[8] CHAPTER IX, *supra* note p.275-276

12. Effective collaboration between doctors and nurses is another need of the hour. It's time to think about a change like a relationship that exists between the doctor and the nurse. A professional shift towards a collaborative relationship shall be thought off.

13. Advanced avenues for Post-graduate nurses to practice their profession are another requirement. As the nursing education in India is reaching its new heights with new specializations especially at the post-graduation level (M.Sc); new opportunities in the form of "Nurse Practitioners" as followed by other countries has become inevitable in India.

14. Regulation of private nursing educational institutions is another matter which needs attention. Clinical training of nursing students and proper inspections/monitoring of these institutions are needed for ensuring quality of nursing students.

15. The need for an effective complaint mechanism that protects the rights of nurses especially to redress their grievances shall be encouraged. Their right to file complaints anonymously shall be protected. The Nursing Councils shall be empowered to entertain the complaints and take adequate steps in this regard. The functioning of complaint redressal mechanisms such as Grievance Redressal Committees shall be made mandatory in all private hospitals for getting accreditation and licensing.

16. Implementation of the recommendations of the Committees which were appointed in India for studying the issues faced by nurses is another urgent need. The suggestions pertain to the implementation of social security schemes for nurses as well as the need for regularization of service conditions of staff nurses working in the private sector.

17. Implementation of NABH guidelines is another suggestion for improving the regulatory framework of private hospitals. The guidelines, though issued for accreditation purposes, provide a good framework for improving the conditions of staff and other infrastructure facilities of the hospital. It if implemented properly will surely provide an efficient workspace for nursing professionals to act upon, ensuring their rights as well as obliging them with more responsibilities related to their professional sphere of actions.

18. Besides all this, recognition of the profession is one of the major needs emphasized by the staff nurses who were interviewed for the empirical study. Nurses working in both sectors feel the need for professional recognition of nursing besides their status as a workman. So apart from labour status which is indispensable due to the employer-employee relationship and nature of their functions, a need is felt for professional recognition within the legislative framework. The new bill as well as the comparative study of the legislative framework in countries outside India calls for such a move.

In *toto*, the protection of rights, recognition of nursing as a health care profession with distinct features and regulations by fixing proper standards of practice is the urgent need of the hour, to enhance the dignity of the profession and to reach the goal of quality health care. Thus, as an indispensable part of healthcare, the nursing profession shall be given wings to fly and spread the message of healthcare.

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Break the chain

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Yours faithfully,

Head of the Department
Editor-in-Chief

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IS THAT CLAPPING ENOUGH…?

Abstract

The whole world has become a standstill…covid-19 stretching its arms and causing more and more catastrophe to human race. The battlefield is all set with health care providers as the real warriors, serving and saving others. Among them, nurses provide the face-to-face, hand-in-hand care to the victims of the pandemic. They indulge in greater risks, losing their lives for keeping the patient safe and healthy. Called as 'angels of mercy', nurses are blessed with the magical touch to heal pains and sufferings. As the backbone of the healthcare system, they are regarded as the 'care-takers' of the whole community. The miserable fact in India is that they lack legal recognition and protection as "health care professionals". They are labeled as "labourers or workmen" and hence deprived of their right to professional status and dignity. The paper attempts to critically analyse the existing legislative framework dealing with the rights of nurses. Furthermore, the paper calls for an urgent action to recognize, regulate and rejuvenate nursing profession in India.

I Introduction

At last, Time has come; we clapped, honoring them for their selfless service. We praised and saluted them for their priceless care. But still, is that enough? Don't they deserve more? Nurses as "Voice to lead-Nursing the World to Health" is the motto adopted by the International Council of Nurses (ICN) for this year's nurses day celebrations[1]. The role of nurses as careers, healers, educators, leaders and advocates, has been highlighted by ICN. The call for advancing the role of nurses as practitioners and leaders of policy making related to health are reflected by the report.

The term "Nursing" has always been used as a synonym for the word "care". As a universal service, nursing shares the common goal, "the best interest of the patient". When doctor's cures the disease, nurse's cares the patient to reach his best self. The nearness relationship they maintain with the common men provides them a unique identity, distinct from other healthcare providers. The World Health Organisation regards

[1] International Council of Nurses, *available at:* https://www.icn.ch/news/nursing-world-health-icn-announces-theme-international-nurses-day-2020 (last visited on May 27, 2020)

"Nurses as the "lynchpin of health teams", playing a crucial role in "health promotion, disease prevention, treatment and care" [2]. They execute a wide range of clinical and non-clinical functions necessary for the delivery of healthcare[3]. In the contemporary world, nurses enjoy extended role with titles such as advanced practice nurse, nurse practitioners, clinical nurse specialists and nurse anesthetists.

In India, the major area of nursing service can be seen at two levels of healthcare such as the public health care level which is provided exclusively by the State through health centres; and the hospital level, where both the State and private entities are part. At the public health care level, nurses are classified as Auxiliary Nurse-Midwife/Female Health Worker; Male Health Workers; Lady Health Visitor; Public Health Nurse (Junior); Public Health Nurse (Senior);Public Health Nurse Supervisor and Chief/District Public Health Nurse . Role of nurses at the hospital level are classified as Staff Nurse, Nursing Sister/Ward Sister/Supervisor, Assistant Nursing Superintendant, Deputy Nursing Superintendant, Nursing Superintendant and Chief Nursing Officer.

According to the Statistics of the Indian Nursing Council, there are around, 8, 85,383 Auxiliary Nurse Midwives (ANM), 21, 29,820 Registered Nurses and Registered Midwives (RN&RM) and 56,644 Lady Health Visitors (LHV) in the Country[4]. It is also notable that there exist around 8500 nursing institutions in the country producing about 3 lakh nursing personnel annually[5]. However, studies reveal shortage of trained and skilled nurses in India. According to the Official Statistics available with the Ministry of Health and Family Welfare, Government of India, India stands at the 75th rank amongst around 133 developing countries with regard to the number of nurses in the country[6]. The Nurse

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[2]World Health Organisation, , *available at*: http://www10.who.int/hrh/news/2019/celebrating_nurses/en/ (last visited on March4, 2020)

[3] Rosamma Jose, Leadership for nurses in India : A futuristic perspective, Express Health Care, *available at* : http://www.expressbpd.com/healthcare/life-healthcare/leadership-for-nurses-in-india-a-futuristic-perspective/389253/ (last visited on December 5, 2019)

[4] Indian Nursing Council, *available at* :http://www.indiannursingcouncil.org/ (last visited on March 3,2020)

[5] *Id*

[6] Government of India, Ministry of Health and Family Welfare, *available at* http://164.100.47.194/Loksabha/Questions/QResult15.aspx?qref=10983&lsno=17 (last visited on March 10,2020)

patient ratio in the Country at present is 1.7 nurses per 1000 population[7]. The World Health Organization too points out that need of an additional 2.4 million nurses in India to achieve government's aim of nurse-patient ratio of one nurse per 200 populations[8].

Increasing tendency of migration among nurses in India is the major reason for this shortage. Better Social status and chances for professional advancements are the main attractions which push nurses overseas. As per the report published by WHO titled as "Migration of Nursing and Midwifery Workforce in the State of Kerala, 2017", "Nurses trained in India form a significant portion of internationally educated nurses working overseas". It is also pointed out that "over 30% of nurses who studied in Kerala work in the United Kingdom or the United States of America, with 15% in Australia and 12% in the Middle East (15)".Countries such as Australia, Bahrain, Canada, Kuwait, Saudi Arabia, the United Arab Emirates and the United Kingdom were reported to be the major areas of destination for nurses.

Though, concerns about nurses are debated nationwide, still the question of recognition as 'professional practitioners of healthcare' remains unsolved. Neither the Central nor the State legislative framework in India defines nursing in terms of a professional sphere of action. Though, forms the largest sector of healthcare, they are still "invisible" and unrecognized.

II Nurses as nourishing

The term 'nurse' is derived from the Latin term *nutricius*, which means nourishing[9]. Various interpretations of nursing ranging from doctor's assistants to professionals having well knowledge and expertise in healthcare can be found. In a simplest sense, nursing can be defined as a process of wholesome nourishment of the patient[10]. An interpretation of nursing as a profession interlinked with medicine is given by the Merriam-Webster Collegiate Dictionary. It defines nurse as "a licensed healthcare

[7] *Id*

[8]Bulletin of the World Health Organisaiton, *available at* : https://www.who.int/bulletin/volumes/88/5/10-020510/en/ (last visited May 8, 2019)

[9]Online Etymology Dictionary, *available at* : https://www.etymonline.com/word/nurse (last visited on May 20, 2020)

[10] Sr.Nancy, Stephanie's *Principles and Practice of Nursing*, 22 (N.R Brother, Indore, 5th edn. 2002).

professional who practices independently or is supervised by a physician, surgeon, or dentist and who is skilled in promoting and maintaining health[11]".

Virginia Henderson[12], the first lady of nursing, regards nursing as a method of entering into the situation of another so as to understand that the other person's desires. She quotes,

"A nurse is to get inside the skin of each of her patients in order to know what he needs"[13]. Her definition explains nurses as "assistants to individuals especially the sick in performing the activities which she or he can do at normal times". She observes[14]:-

> The unique function of the nurse is to assist the individual, sick or well in the performance of those activities contributing to health or to its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge and to do this in such a way as to help him gain independence as rapidly as possible" (1966).

No discussion on nursing is complete without mentioning the contributions made by Florence Nightingale, the founder of modern nursing. Her dedicated services to nurse wounded soldiers at the Crimean war will remain inscribed in golden letters. She cherished the vision of nursing as a "wholesome care of the patient". She explains the basic duty of a nurse as 'to aid patients to become agents for their health care management'. She used the word 'nurse' for 'want of a better'[15]. She defines the role of nurse as"....what nursing has to do is to put the patient in the best condition for nature to act upon him". To her, nursing comprises of the complete caring of the patient', the surroundings which he or she lives is vital. Fresh air, light, warmth, cleanliness, quiet and a balanced diet are factors that nurses have to consider while providing nursing care[16]. She observes

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[11] Marriam-Webster Dictionary, 18 (Marriam-Webster, USA, 11th edn,.2004)

[12] Virginia Henderson (1897-1966) was a nurse, theorist and author. She is known as "The Nightingale of Modern Nursing", and "The 20th century Florence Nightingale", *available at* https://nurseslabs.com/virginia-henderson/ (last visited on April 8, 2019)

[13] Virginia Henderson, *Basic Principles of Nursing Care*, 75(International Council of Nurses, 5th edn., 1997)

[14] *Id*

[15] Florence Nightingale, *Notes on Nursing: What it is and What it is not*,8(D. Appleton Company, New York, 5th edn.,1860)

[16] *Id*

> "Nursing has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet-all at the least expense of vital power to the patient"

An elaborately discussion on the role of the nurses is provided by the International Council of Nurses. First of all, it defines the term Nurse as "a person who has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country."[17]Further, the definition explains nursing as "an autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings"[18]. Activities like "promotion of health, prevention of illness, advocacy, endorsement of safe environment, research, participation in shaping health policy, in patient and health systems management and education" are included as part of nurse's function[19]. Factors such as closeness, patient-centered care, shared decision making, collaboration (with doctors, patients, co-workers), open discussions (with the patient and his family), and strict adherence to professional values offer a unique identity to nurses. Thus in a broader sense, nursing can be defined as a process of nourishment whereby a dignified (healthy) life can be achieved.

Nurses as professional practitioners

The World Health Organiaiton indentifies, Nurses are part of a "Health Care Team which comprise of professionals such as medical practitioners, physical and occupational therapists, social workers, pharmacists, spiritual counselors, as well as family members, who are involved in providing coordinated and comprehensive care"[20]. The International Standard Classification of Occupations (ISCO-08) issued by International Labour

[17]International Council of Nurses, *available at* http://www.icn.ch/who-we-are/icn-definition-of-nursing/ (last visited on February 10,2019)

[18] *Id*

[19] *Id*

[20]Id WHO 2006

Organisation[21], has classified "Nursing Professionals" as Health Professionals.[22] "Different category of nurses like the clinical nurse consultant, District nurse, Nurse anaesthest, Nurse educator, Nurse practitioner, Operating theatre nurse, Professional nurse, Public health nurse and Specialist nurse are included in this category[23].The nature of work performed by nurses in relation to the tasks mentioned in the definition is considered to be the basis of this classification[24]. Compared to India, the titles of nurses are different in other parts of the world. In the USA, nurses were classified into categories such as the Certified Nursing Assistant[25]; Licensed Practical Nurse[26]; Registered Nurse[27],

[21] ISCO-08 is a four-level hierarchically structured classification that allows all jobs in the world to be classified into 436 unit groups. These groups form the most detailed level of the classification structure and aggregated into 130 minor groups, 43 sub-groups and 10 major-groups, based on their similarity in terms of the skill level and skill specialization required for the jobs. According to them, the tasks performed by professionals include : conducting analysis and research, and developing concepts, theories and operational methods; advising or applying existing knowledge related to physical sciences, mathematics, engineering and technology; life sciences, medical and health services, social sciences, and humanities; teaching the theory and practice of one or more disciplines at different educational levels; teaching and educating persons with learning difficulties or special needs ; providing various business, legal and social services; creating and performing works of arts; providing spiritual guidance; preparing scientific papers and reports.

[22] International Standard Classification of Occupations ISCO-08,p. 128 https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_172572.pdf Nursing Professionals provide treatment, support and care services to the people who are in need of ageing, injury, illness or other physical or mental impairment, or potential risks to health. They assume responsibility for the planning and management of the care of patients, including the supervision of other health care workers, working autonomously or in teams with medical doctors and others in the practical application of preventive and curative measures.

[23] Id According to them, "Health Professionals conduct research; improve or develop concepts, theories and operational methods; and apply scientific knowledge relating to medicine, nursing, dentistry , veterinary medicine, pharmacy, and promotion of health According rto them, tasks performed by workers in this sub-major group usually include :conducting research and obtaining scientific knowledge through the study of human and animal disorders and illness and ways of treating them; advising on or applying preventive and curative measures, or promoting health; preparing scientific papers and reports. Competent performance in this group requires skills.

[24] Id

[25]The Certified Nursing Assistant (CNA) is required to undergo state-approved education program and on-the-job training as their educational qualification before enrolling. Their main function is to assist the registered nurses. Only a limited function such as bathing the patient, taking vital signs, dispensing prescribed medications, applying bandages are entrusted with them. Felix Tarcomnico , How to become a Certified Nursing Assistant, Huffpost https://www.huffpost.com/entry/how-to-become-a-certified_b_3720475-

[26]Licensed Practical Nurse (LPN) and Licensed Vocational Nurse requires a diploma in approved educational program often found in technical schools and community colleges. In addition to the duties of Certified Nursing Assistants, they are qualified to administer Injections, perform therapeutic massage, prepare patients for surgical procedures, maintain patient medical records, change bandages and dressings, and sometimes manage intravenous drips. LPNs are also responsible for communicating a patient's needs to medical staff.

Advanced Registered Nurse Practitioners[28], and Nurse Practitioner[29]. Among them, the Advanced Registered Nurse Practitioners and (Nurse Practitioners to a certain extend) can diagnosis patients, manage treatments, order tests, and prescribe medications. A similar role of nurses to the USA can be found in the United Kingdom, where nurses were classified as registered nurses, Licensed Practices nurses, Certified Nursing Assistant, and Advanced Registered Nurse Practitioner. They share more or less similar functions extending from bathing the patient to prescribing medications.

All most all countries have recognized nurses as healthcare professionals in their legislative framework. Nursing Act, 2005 in South Africa is a good example. It defines a "professional nurse" as a "person who is qualified and competent to practice nursing comprehensive nursing in the manner independently and the level prescribed and who is capable of assuming responsibility and accountability for such practice." Another legislation that provides an independent status to nurses is the Nursing Act, 1991, prevailing in Canada. The notable aspect is the inclusion of nurses within the purview of the list titled "Self-Governing Health Professions." Rights including prescription, dispensation, selling, and compounding of drugs are guaranteed to registered nurses by the Act[30].

III Indian Nurses: Labourers or Workmen

It is a miserable fact that nurses do enjoy any special rights as 'health care professionals in India. It is also imperative to note that there is a lack of clarity in India regarding the inclusion of nurses as 'health care professionals.' The Central law, title as the Indian Nursing Council Act, 1947 and the state legislations dealing with the regulation of nurses in India do not deal with nurses' rights. The constitution of Nursing Council at the Central

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Rebecca Le Boeuf, Infographic : Types of Nurses https://www.snhu.edu/about-us/newsroom/2018/05/types-of-nurses-infographic

[27] Id Registered Nurse is required to have an Associate Degree in Nursing (ADN) or Bachelor of Science in Nursing (BSN) In addition to the duties of CNA and LPN, they are qualified to assist in nursing diagnosis and to supervise the works of CNA and LPN

[28] Id Advanced Practice Registered Nurse (APRN) is required to have Master of Science in Nursing as their educational qualification. They can diagnosis patients, manage treatments, order tests and prescribe medications

[29] Id Nurse Practitioner is required to have Master of Science in Nursing or master's degree in a specialty role. They can examine patients, diagnosis health problems, analyse test results and administer medicines and treatments.

[30] Nursing Regulation 275, Part II, Rule 17

and the State level to regulate the standard of practice and education of nurses is the major aim of both legislations.

However, the inclusion of 'hospitals' within the definition of 'industry' by the Bangalore Water Supply Case,[31] impliedly keeps them within the definition of 'workmen' under the Industrial Disputes Act, 1947[32]. As a labour class, they are entitled to all the benefits guaranteed by the labour laws such as the amicable settlement of Industrial disputes[33];Wages[34]including minimum wages[35]; maternity benefits[36]; eight hours of work[37]; payments such as provident fund[38],gratuity,[39]Bonus[40];and compensation of occupational injury and accidents[41]. But in the practical sense, they are curtailed all this rights and benefits. This is evident from the reports submitted by the committees which were appointed to study the working conditions of nurses in India[42]. The increasing rate of petitions filed by nursing associations also highlights major issues relating to work such as health risks, overtime working hours, sexual harassments at workplace and non-

[31] *Bangalore Water Supply* v. *A. Rajappa* (A.I.R 1978 S.C 548)

[32] The Industrial Disputes Act, 1947, s.2 (s)

[33] The Industrial Disputes Act, 1947 s.3 deals with Authorities under the Act such as the Works Committee, Conciliation Officers, Board of Conciliation, Courts of Enquiry, Labour Courts, Tribunals and National Tribunals.

[34] The Payment of Wages Act, 1936, s.3 (1) & 5;

[35]The Minimum Wages Act,1948, s.12 & s.14 (1)

[36] The Maternity Benefit Act, 1961,s.5

[37] Kerala Shops and Commercial Establishment Act, 1968, s.4

[38] Employees Provident Fund and Miscellaneous Provisions Act, 1952,s.1 (1)

[39] Payment of Gratuity Act, 1972,s.4 (1)

[40] Payment of Bonus Act, 1965,s.8

[41] Employees Compensation Act, 1923, s.3(1)

[42] In 2016, Prof. Jagdish Prasad Committee was constituted in India by the judgement of the Supreme Court in *Trained Nurses Association of India v.Union of India & Ors(*2016 SCC online SC 95), The committee recommended the payment of minimum wages to nurses as per hospital-bed ratio and application of same working conditions to nurses working in government and private sector. The need for framing legislations or guidelines by States for implementation of minimum wages by the private hospitals is also high lightened. The report is available at http://nursingmovements.com/doc/Protection%20and%20safeguarding%20the%20interest%20of%20Nurses%20working%2020th%20Sep,%202016.pdf (last accessed on June 22, 2018)

payment of minimum wages[43]. Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 is another important legislation which provides Protection to nurses against workplace harassments[44]. The Act deals with the constitution of Internal Complaints Committee for redressal of complaints of sexual harassment at workplace[45]. Even if the non-implement of these rights is an area of concern, still the question is: Is this treatment under labour legislations enough? Don't they deserve special/exclusive rights for the service they render to humanity?

Though, every state in India has legislation pertaining to nursing, none of them goes beyond registration and lacks clarity as to the rights of nurses. All the state laws define nurses with the framework of their educational qualifications. Different categories of nurses are included without properly defining the boundaries of their practice. The constitution of nursing council is yet another issue. Majority of the state nursing council is dominated by medical professionals without much representation from nursing professionals. The grounds for taking disciplinary actions against nurses are another

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[43] *Jerryl Banait vs. Union of India (UOI)* and Ors (08.04.2020 - SC Order) : MANU/SCOR/24152/2020, Based on the petition filed by the United Nurses Association[43], requesting immediate directions to formulate a comprehensive policy for the welfare and safety of the healthcare workers who are serving COVID-19 patients, the Supreme Court once again reminded 'the State and the Police Administration to provide necessary security to Doctors and medical staff when they visit places where patients who have been diagnosed corona virus positive or who have been quarantined are housed'. *Trained Nurses Association of India v.Union of India & Ors[43]* , is an important case in which the Supreme court has enteratianed as writ petition filed by the Trained Nurses Associaiton of India on ventilating the grievances on the working conditions of nurses in private hospitals . The pettion sought for issuing gudieleienss for improvinsg the working conditions of nurses in hospitals. The need for framing legislations or guidelines by States for implementation of minimum wages by the private hospitals is also high lightened. In Association of Healthcare Providers (India) *v.* Government of NCT, Delhi, decided on 24th July, 2019, (available at https://indiankanoon.org/doc/152416598/, last accessed on December 28, 2019) In this case, the Supreme Court again reiterated the mandatory compliance with the payment of minimum wages by all private hospitals and nursing homes. Aruna Ramchandra Shanbaug v. Union of India, (1994) 3 *SCC* 394, can be cited as the most horrifying incident which a nurse can ever undergo at workplace. Aruna Ramchandra Shanbaug was a nurse in the King Edwards Memorial Hospital in Mumbai. In November 1973, she was assaulted by ward boy, Sohanlal Bhartha Valmiki, of the same hospital. He strangulated Shanbaug with a dog chain around her neck. The attack cut off oxygen supply from her brain leaving her blind, deaf, paralyzed and in a vegetative state for the next 42 years. From the day of the assault till the day she died on May 18, 2015, Aruna could only survive on mashed food. She could not move her hands or legs could not talk or perform the basic functions of a human being.In *Seenath Beevi vs. State of Kerala(*2003 (3) KLT 788) , the Kerala High Court directed the hospital authorities to introduce three shift systems wherein the staff nurses were compelled to work for 14 hours a day for 6 day consecutively. The court also upheld the continuing system as illegal and unconstitutional.

[44] Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013
[45] *Id*,s.4

concern which needs uniformity between state laws. Mechanism for monitoring the implementation of the rights of nurses as well as the observation of ethical standards in clinical practice is other area which needs to be addressed by the legislations.

V. Right, Recognition, & Regulation

The three R's such as –Rights, Recognition and Regulation is the need of the hour. The recognition of nursing as a distinct profession with unique features, ensuring the rights of nurses and fixing proper standards of practice through regulation are the urgent requirements. Recognition of nurses as 'health care professional's' is still in an infancy stage in India. A legislation which recognizes nurses role as 'health care professionals' shall be enacted. The legislation must guarantee the right of nurses to practice their profession. Although the Supreme Court of India has recently upheld the right of nurses to practice their occupation throughout the territory of India, still it does not expand their rights.[46]All the rights related to professional practice such as right to occupational safety and health; right to freedom from workplace harassments and violence; right to form associations or unions; right to refuse orders (physician's as well as) relating to unethical practice; right to enhance professional knowledge and skill through training and other related mechanism; right to get represented in policy decisions relating to healthcare; right to take decisions during the time of emergencies; right to disclose unethical practice at workplace (including unethical orders by physicians); shall be included within it. A balanced approach must be maintained with regard to the rights as well as the obligations of the nurses, and then only nursing will meet its major objective of ensuring 'quality health care'.

VI. Conclusion

Time and again, the recurrent attacks by viruses, in the form as Nipah and Covid-19,have unveiled the truth - Nurses are the real wheels by which the healthcare system moves. Now, it's time to have a re-look and re-fresh ourselves. The Mother-Earth taught us to remain home silently cherishing the realities of life. Covid-19 stretching its

[46] *Private Nursing Schools and Colleges Management* v. *The Indian Nursing Council & Ors*, Civil Appeal No. 958 of 2019 (Arising out of SLP (C) No. 32603 of 2017) decided On: 22.01.2019; *available at* : MANU/SC/0402/2019 (last visited on May20, 2020)

arms -Better stays safe home praying and praising life's blessings. Meanwhile, the mind whispers, "Hey! Nothing to worry about, the warriors are ever-ready… dressed up in their PPE kits, to confront and serve us till their last breath".

APPENDIXES

Appendix I - Dr.Balram committee recommendations & Veerakumar Committee recommendations

Appendix II – Minimum Wages (G.O(P)No.33/2018) LBR

Appendix III – Recommendations of the committee constituted on 24/2/2016.

Appendix IV – Code of Ethics for Nurses in India.

Appendix V – No. of Nurses in the State of Kerala.(Information received through RTI).

Appendix VI – Questionnaire.

Appendix VII – Method of Appointment. (G.O dated 11/05/2011).

Appendix VIII – Salary of Nurses (G.O dated 20/01/2016).

Appendix IX – Nurse patient ratio. (Information received through RTI)

Appendix X – Hours of work. (Information received through RTI)

Appendix XI – Promotion posts of staff nurses. (Information received through RTI)

Appendix XII – Duties of staff nurses. (G.O dated 06/08/2004).

RECOMMENDATIONS OF DR.Balaraman Committee Report

1. The committee recommends that the Government may give strict directions to the hospitals to appoint candidates having prescribed qualification (General Nursing and Midwifery/B.Sc Nursing) and registration with Kerala Nurses and Midwives Council (KNMC) as nurses. Stringent action may be taken against hospital authorities violating these norms.
2. It is desirable to conduct a pre-registration examination by the KNMC for those who have completed their nursing program outside Kerala. The nursing council may be entrusted with this responsibility.
3. The Kerala Nurses and Midwives Council shall issue Identity Card for nurses with RN RM numbers
4. All private hospitals should ensure an organized nursing service department with a qualified and experienced Nursing Superintendent, an administrative office, ministerial staff, equipment, machinery, supplies, communication and documentation system
5. Those nurses having basic qualification may be appointed through a formal written examination, skill test and interview by an expert committee in nursing. The government may adopt steps to make policies of recruitment, selection and placement process of nurses in private sector through an authorized body under the Dept. of Health and Family welfare.
6. The hospital authorities may be directed to issue appointment order specifying the terms and conditions of service
7. Appointment of various nursing personnel such as Nursing officer, Nursing Superintendent , Nursing Supervisor, and Head Nurse may be strictly based on INC norms
8. Appointment of nursing personnel in higher cadre may be based on their qualification, years of experience and performance appraisal.
9. As per INC norms nurses with additional qualification in nursing, may be given weightage in terms of increment. For those with post basic diploma in specialty nursing of one year duration one additional increment, with basic/post basic B.Sc degree in nursing, two additional increments and with post graduate degree in nursing, three additional increments may be given.
10. Considering the existing reservation for admission to GNM programme by INC, twenty percent of the vacancies in a hospital may be filled with male nurses.
11. Availability of senior nursing personnel in each ward may be ensured for guidance and supervision of staff for safe practice and quality assurance.
12. Specific uniform code shall be maintained for all the nurses working in different private hospitals all over Kerala. All other category of hospital staff shall be prohibited from using similar uniform.

13. Urgent steps may be taken by the Government to review the existing job description of various categories of nursing personnel and made available for ready reference of the staff.
14. The eligibility of the nursing staff for the post of Head Nurse shall be minimum 8 years of clinical experience as staff nurse for Diploma nurses (GNM) and minimum 5 years of clinical experience as staff nurse for Graduate nurses.
15. State service rules may be followed for the nurses working in the private hospitals also with regard to regularization of service, declaration of probation, promotion, other service benefits and disciplinary procedures.
16. All institutions shall keep various records of all nursing staff which include personal, professional, health and service records in the Nursing Service Department.
17. The administration shall ensure a harmonious and conducive working environment in the hospital.
18. The nurse- patient ratio shall be maintained as per the INC norms.
19. Three shift systems with maximum 8 hours duty may be introduced immediately and implemented in a full fledged manner within a period of 3 months.
20. Weekly working hours of staff shall be limited to 48 hours and extra working hours may be documented and compensated either by leave or by extra emoluments.
21. The night duty shall be scheduled in such a way that each nurse is assigned not more than 6 days night shift per month with an eligible night off and weekly off
22. Leave benefits shall be ensured: Casual leave -12, Annual leave-12, Sick leave-12 and Public holidays-13 may be sanctioned for all category of nursing staff. Compensatory off shall be given whenever they are engaged on holiday duty.
23. Well equipped nurse's station with adequate supplies, equipment and personal protective equipment shall be made available in the wards for safe practice.
24. Adequate basic facilities such as safe changing room with dining and toilet facilities for male and female staff, sick room, transportation at odd hours of duty shifts, quarters and subsidized canteen facility shall be ensured for nursing staff.
25. All qualified and registered nursing personnel working in the private hospitals may be provided with a basic salary as proposed.

Pay and other allowances proposed for different category of Nurses

SL NO.	CATEGORY	BASIC PAY Rs.	INCREMENT Rs.
	Staff nurse	12900/-	250/-

	Senior staff nurse (3year experience)	13650/-	300/-
	Head Nurse	15180/-	350/-
	Deputy Nursing Superintendent	17740/-	400/-
	Nursing Superintendent	19740/-	450/-
	Nursing Officer	21360/-	500/-

- Basic pay: The basic pay for all the category of nursing staff in all hospitals shall be same irrespective of the location/bed strength/classification of the hospital.
- Dearness allowance: Based on consumer price index.
- HRA and CCA: As per the location of the hospital and rate fixed by the government.
- Uniform allowances: Rs.1000/- per annum
- Bonus: one month salary for the nursing staff drawing basic salary up to Rs.15000/-
- Festival allowance: Rs.1000/- annum for the nurse employee drawing basic salary above Rs.15000/- per month
- Special/risk allowance-Rs.500/- per month.
- Night shift allowance: Rs.50/- per night
- Overtime allowance - Rs.150/- per hour.

26. Monthly salary shall be disbursed through banks before the 5th of every month.
27. If nurses are eligible for ESI and EPF benefits they shall be enrolled on time and communicated to the concerned.
28. Medical benefits - Initial and annual medical checkup, investigations and treatment, protective vaccinations and maternity benefits may be extended to eligible candidates from the same institution free of cost.
29. Incentives and rewards may be given for special achievements and outstanding performances
30. Employee may be allowed to resign and relieve from the institution with one month prior notice.
31. The hospitals shall appoint sufficient number of supporting staff such as nursing assistants, attenders, house keeping staff and other class IV employees and the nurses

shall be completely relieved from non- nursing activities to maintain smooth and efficient patient care services.

32. There shall be specific uniform with colour code prescribed for the supporting staff and they shall wear identity card while on duty.

33. The supporting staff shall be brought strictly under the purview of the Minimum Wages Act.

34. The different categories of supporting staff also require serious consideration with regard to job description, working conditions, medical benefits and remuneration.

35 Orientation/ induction program for 4-6 weeks shall be conducted for newly appointed staff nurses.

36 In-service education program shall be conducted on regular basis by the hospital for the nursing personnel for updating their knowledge and skills to ensure safe delivery of nursing care.

37. Opportunities may be given to attend 30 hours of in-service education per year which is mandatory for the renewal of registration every five years as prescribed by INC.

38. Regular performance appraisal shall be done for all the nursing personnel and supportive interventions and training arranged as required.

39. Bond and posting of nurses as trainee/observer without adequate remuneration is illegal and against INC norms. Such practices existing in some of the hospitals shall be stopped forth with.

40. Government may establish a system for ensuring the compliance to the above recommendations by the hospital authorities.

41. Registration of all health care institutions in the state may be made mandatory. The health care institutions which are under the Kerala Shops and Commercial Establishment Act 1960 and rules 1961 at present have to be brought under the purview of Clinical Establishment Bill which is under consideration of the Government.

42. Classify and Grade the private health care institutions, according to the facilities and services offered to the public.

43. Urgent steps may be initiated to amend Kerala Nurses and Midwives Council Act 1953, the draft of which is under review by the Government.

44. Legislation may be made at State and National level stipulating salary and service conditions of different category of nurses.

45. State and District level Grievance cell may be formed consisting of local members of the public, nurses' association representatives, senior nursing officials, government nominees, and nursing council representatives.

46 Action may be taken to cancel registration/affiliation against those hospitals who appoint staff nurses withholding original certificates, demanding deposits/bond and withholding

experience certificate which is against Hon. Supreme Court Verdict and Nursing Council/ Government directions.

47. Urgent steps may be taken to wipe out unrecognized institutions conducting training and issuing fake certificates in nursing.

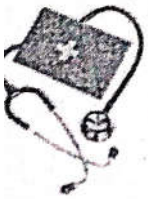
48. The Government may take necessary steps to establish a Nursing Directorate under the Department of Health and Family Welfare, as directed by the Govt. of India to streamline the administrative and academic control, service conditions, remuneration, and career prospects, moral and ethical behavior and practice standards of nurses.

49. The government may take an interim measure for declaring moratorium for the repayment of educational loan at least for one year or till a stable source of income is ensured, to the deserving candidates. The government may also consider waiving off such educational loans or reducing the EMI or make the loan interest free.

50. The committee strongly recommends that the income and expenditure in hospitals shall be properly accounted and audited.

Section Officer

VEERAKUMAR COMMITTEE



CHAPTER IX

Committee – Recommendations

In the light of the observations the Committee put forward the following recommendations to Government for consideration.

1. For the implementation of the working hours the hospitals in the State may be classified into two categories on the basis of the bed strength (Below 100 beds and above 100 beds) instead of classifying them into rural and urban divide.
2. While considering various factors applicable to the situation a three shift pattern of 6-6-12 hours is the most suitable working hours for the nurses in the private hospitals having more than 100 beds subject to the condition that their working hours should not exceed 8hours /day, 48hours / week and 208 hours /month including authorized leave.
3. While fixing the working hours as 6-6-12 pattern the most convenient working hours may be as follows.

Morning shift:	7.30 A.M -1.30 P.M
Evening shift:	1.30 P.M -7.30 P.M
Night shift:	7.30 P.M to 7.30 A.M

However, a half an hour relaxation on either side of the shift can also be permitted if it is convenient for both the parties and they agree for the same.

4. Even though a hospital is having less than 100 beds, if it is a super speciality one, three shift pattern may be implemented for quality patient care. A hospital having less than 100 beds and admitting patients with general conditions, three shift patterns may be implemented in ICUs.
5. The managements of hospitals having less than 100 beds may be allowed to continue the two shift pattern of 12hours /day and 12 hours/ night or let them to have an option to follow the 6-6-12 pattern suggested for other hospitals.
6. While allowing the 6-6-12 pattern, engaging an employee for more than the normal working hours (8 hours /day), hours of overtime (not more than 10 hours of work per day including overtime and total hours of overtime not more than fifty hours in any quarter) stipulated under Section 6 and 9 of the Kerala Shops and Commercial Establishments Act, 1960 respectively require an exemption under the Act.
7. Working hours of Nursing Superintendents and other staff who are not having regular night duty shift should work for minimum 8 hours/day.
8. The managements may also be requested to provide transportation facilities to the nearest bus point and facilities for rest with sufficient toilet facilities to the female nurses in the hospitals.

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Minimum Wages to the Employees in Private Hospital

G.O.(P) No.33/2018/LBR

S.R.O. No. 245/2018 – In exercise of powers conferred by clause (b) of sub-section (1) of section 3 of the Minimum wages Act, 1948, (Central Act 11 of 1948), read with clause (b) sub-section (2) of section 5 thereof and in supersession of the notification issued under G.O. (Ms.) No. 135/2013/LBR dated 5th November, 2013 and published as S.R.O. No. 884/ 2013 in the Kerala Gazette Extraordinary No. 3177 dated 7th November, 2013 the Government of Kerala in consultation with the Minimum Wages Advisory Board and after considering the objections and suggestions received on the preliminary notification issued as 375/E1/2017/LBR dated 16th November, 2017 the Kerala Government hereby revise the minimum rates of wages payable to the employees employed in the private hospital sector.

PART I – OFFICE AND GENERAL CATEGORY

Group – 1 Scale of pay- ₹ 23220-470-25570-520-28170

1. General Manager, 2. Administrative Officer, 3. Secretary

Group – 2 ₹ 22650-460-24950-500-27450

1. Manager

Group – 3 ₹ 22090-450-24340-490-26790

1. Administrative Assistant / Assistant Manager, 2. Chief Accountant / Head Accountant / Accounts Officer 3. Chief Cashier / Head Cashier 4. Internal Auditor 5. Public Relations Officer 6. Maintenance Engineer 7. Floor Manager / Front Officer

Group – 4 ₹ 19040-390-20990-420-23090

1. Assistant Public Relations Officer 2. Computer Programmer Cum Operator 3. Store Keeper Clerk 4. Chief Security Officer 5. Chief Receptionist 6. Ward Secretary

Group – 5 ₹ 18110-370-19960-400-21960

1. Clerk 2. Insurance Assistant 3. Stenographer 4. Accountant 5. Cashier 6. Internal Audit Assistant 7. Security Officer 8. Receptionist cum Tele-operator/ Front Office Assistant / Assistant Store Keeper.

Grooup – 6 ₹ 17230-350-18980-380-20880

1. Electrician / AC Mechanic, Plumber, Tailor, Welder, Typist, Typist Clerk, Telephone Operator, Driver / Ambulance Driver, Cook, Power Laundry Foreman, Data Entry Operator, House Keeper

Group – 7 ₹ 16810-340-18510-380-20410

1. Power Laundry Attender, Pump Operator, Lift Operator / Lift Mechanic, Dhobi, Kitchen Assistant, Waste Treatment Plant Operator, Generator Operator

Group – 8 ₹ 16000-320-17600-360-19400

1. Office Assistant / Attender / Helper, Gate Keeper, Gardener, Watchman / Security, House Keeping Assistant / Sweeper, Assistant Store Keeper.

PART II – REGISTERED NURSES

Grooup – 1 ₹ 22650-460-24950-500-27450

Nurses Manager (M.Sc+5 years experience / B.Sc + 10 years experience) Nurses Director / Nurses Officer

Group – 2 ₹ 22090-450-24340-490-26790

Nursing Superintendent (B.Sc + 5 years experience) Matron (BSC / GNM + 10 years experience)

Group - 3 ₹ 21550-440-23750-480-26150

Assistant Nursing Superintendent / Deputy Nursing Superintendent (B.Sc . +5 years experience / General Nursing +10 years experience)

Group – 4 ₹ 21020-430-23170-470-25520

Head Nurse / Clinical Supervisor / Sister in-charge/ Group Captain/ Leader

Group – 5 ₹ 20550-420-22650-460-24950

Tutor Nurse/ Clinical Instructor (EMT/ Ambulance)

Group – 6 ₹ 20000-400-22000-440-24200

Staff Nurse GNM/B.Sc., Regd. ANM Special Grade (10 years experience)/EMT/Ambulance Nurse

Recommendations of the committee constituted in compliance of Hon'ble Apex Court Judgement dated 29.01.2016 in W.P.(C) 527/2011, vide Ministry's order No. Z-29011/15/2013-N dated 24.02.2016.

Committee examined all the information collected from various states, AIGNF and TNAI and felt that adequate salary and basic facilities are not provided to nurses employed in private hospitals/nursing homes. Their pay and working condition is really pathetic and some steps are required to be taken to uplift the standard of working conditions in respect of nurses. After deliberations and discussions, the committee has made following recommendations:

1. Salary:
   - In case of >200 bedded hospitals, salary given to private nurses should be at par with the salary of State Govt. nurses given in the concerned State/UT for the similar corresponding grade.
   - In case of >100 bedded hospitals, salary given to private nurses should not be more than 10% less in comparison of the salary of State Govt. nurses given in the concerned State/UT for the similar corresponding grade.
   - In case of 50-100 bedded hospitals, salary given to private nurses should not be more than 25% less in comparison of the salary of State Govt. nurses given in the concerned State/UT for the similar corresponding grade.
   - Salary given to private nurses should not be less than Rs.20000/- pm in any case even for <50 bedded hospitals.

2. Working conditions:
   - Working conditions viz. leaves, working hours, medical facilities, transportation, accommodate ion etc. given to nurses should be at par with the benefits granted to State Govt. nurses working in the concerned State/UTs.

3. Steps should be taken by all States/UTs for formulating legislation/guidelines to be adopted for implementation of the above recommendations in case of Nurses working in private hospitals/institutions.

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Code of Ethics for Nurses in India

1.The nurse respects the uniqueness of individual in provision of care - Nurse

1.1 Provides care of individuals without consideration of caste, creed, religion, culture, ethnicity, gender, socio-economic and political status, personal attributes,
or any other grounds

1.2 Individualizes the care considering the beliefs, values and cultural sensitivities

1.3 Appreciates the place of individual in the family and community and facilitates participation of significant others in the care.

1.4 Develops and promotes trustful relationship with individual(s)

1.5 Recognizes uniqueness of response of individuals to interventions and adapts accordingly

2. The nurse respects the rights of individuals as partner in care and help in making informed choices - Nurse

2.1 Appreciates individual's right to make decisions about their care and therefore gives adequate and accurate information for enabling them to make informed choices

2.2 Respects the decisions made by individual(s) regarding their care

2.3 Protects public from misinformation and misinterpretations

2.4 Advocates special provision to protect vulnerable individuals/groups.

3. The nurse respects individual's right to privacy, maintains confidentiality, and shares information judiciously- Nurse

3.1 Respects the individual's right to privacy of their personal information

3.2 Maintains confidentiality of privileged information except in life threatening situations and uses discretion in sharing information.

3.3 Takes informed consent and maintains anonymity when information is required for quality assurance/ academic/legal reasons

3.4 Limits the access to all personal records written and computerized to authorized persons only.

4. Nurse maintains competence in order to render Quality Nursing Care

4.1 Nursing care must be provided only by registered nurse

4.2 Nurse strives to maintain quality nursing care and upholds the standards of care

4.3 Nurse values continuing education, initiates and utilizes all opportunities for self development.

4.4 Nurses values research as a means of development of nursing profession and participates in nursing research adhering to ethical principles.

5. The nurse if obliged to practice within the framework of ethical, professional and legal boundaries- Nurse

5.1 Adheres to code of ethics and code of professional conduct for nurses in India developed by Indian Nursing Council

5.2 Familiarizes with relevant laws and practices in accordance with the law of the state

6. Nurse is obliged to work harmoniously with members of the health team - Nurse

6.1 Appreciates the team efforts in rendering care

6.2 Cooperates, coordinates and collaborates with members of the health team to meet the needs of people

7. Nurse commits to reciprocate the trust invested in nursing profession by society Nurse
7.1 Demonstrates personal etiquettes in all dealings
7.2Demonstrates professional attributes in all dealings

Code of Professional Conduct for Nurses in India

1. Professional Responsibility and accountability - Nurse

1.1 Appreciates sense of self-worth and nurtures it
1.2 Maintains standards of personal conduct reflecting credit upon the profession
1.3 Carries out responsibilities within the framework of the professional boundaries
1.4 Is accountable for maintaining practice standards set by Indian Nursing Council
1.5 Is accountable for own decisions and actions
1.6 Is compassionate
1.7 Is responsible for continuous improvement of current practices
1.8 Provides adequate information to individuals that allows them informed choices
1.9 Practices healthful behaviour

2. Nursing Practice - Nurse

2.1 Provides care in accordance with set standards of practice
2.2 Treats all individuals and families with human dignity in providing physical, psychological, emotional, social and spiritual aspects of care
2.3 Respects individuals and families in the context of
traditional and cultural practices, promoting healthy practices and discouraging harmful practices
2.4 Presents realistic picture truthfully in all situations for facilitating autonomous decision-making by individuals and families

2.5 Promotes participation of individuals and significant others in the care
2.6 Ensures safe practice
2.7 Consults, coordinates, collaborates and follows up appropriately when individuals' care needs exceed the nurse's competence

3. Communication and Interpersonal Relationships -Nurse

3.1 Establishes and maintains effective interpersonal relationships with individuals, families and communities
3.2 Upholds the dignity of team members and maintains effective interpersonal relationship with them
3.3 Appreciates and nurtures professional role of team members
3.4 Cooperates with other health professional to meet the needs of the individuals, families and communities

4. Valuing Human Being - Nurse

4.1 Takes appropriate action to protect individuals from harmful unethical practice
4.2 Considers relevant facts while taking conscience decisions in the best interest of individuals
4.3 Encourages and supports individuals in their right to speak for themselves on issues affecting their health and welfare
4.4 Respects and supports choices made by individuals

5. Management - Nurse

5.1 Ensures appropriate allocation and utilization of available resources
5.2 Participates in supervision and education of students and other formal care providers
5.3 Uses judgment in relation to individual competence while accepting and delegating responsibility
5.4 Facilitates conductive work culture in order to achieve institutional objectives
5.5 Communicates effectively following appropriate channels of communication

5.6 Participates in performance appraisal
5.7 Participates in evaluation of nursing services
5.8 Participates in policy decisions, following the principle of equity and accessibility of services
5.9 Works with individuals to identify their needs and sensitizes policy makers and funding agencies for resource allocation

6. Professional Advancement -Nurse

6.1Ensures the protection of the human rights while pursuing the advancement of knowledge
6.2 Contributes to the development of nursing practice
6.3 Participates in determining and implementing quality care
6.4Takes responsibility for updating own knowledge and competencies
6.5 Contributes to core of professional knowledge by conducting and participating in research

കേരള നഴ്സസ് ആന്റ് മിഡ്വൈവ്സ് കൗൺസിൽ

റെഡ്ക്രോസ് റോഡ് , തിരുവനന്തപുരം - 35

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വെബ്സൈറ്റ്: www.nursingcouncil.kerala.gov.in, www.knmc.org

നമ്പർ.ബി.47936/2019/ ആർ.റ്റി.ഐ /എൻ.സി തീയതി : 06-09-2019

സ്വീകർത്താവ്,

ശ്രീമതി. ആർ. പ്രിയ,

ത്രിവേണി ഹൗസ്,

ബ്ലോസ്സം റോഡ്,

എളമക്കര പി.ഒ

കൊച്ചി - 26

മാഡം,

വിഷയം: കെ.എൻ.എം.സി - വിവരാവകാശ നിയമം 2005 - നിലവിലുള്ള കൗൺസിൽ - വിവരങ്ങൾ നൽകുന്നത് - സംബന്ധിച്ച്.

സൂചന : താങ്കളുടെ 17/08/2019 ലെ അപേക്ഷ.

2005 ലെ വിവരാവകാശ നിയമം അനുസരിച്ച് സൂചന അപേക്ഷ പ്രകാരം താങ്കൾ ആവശ്യപ്പെട്ടിരുന്ന വിവരങ്ങൾ ചുവടെ ചേർക്കുന്നു.

1. 23/05/2008.
2. ഒരാൾ മരണപ്പെട്ടതിനാൽ നിലവിൽ 20 അംഗങ്ങൾ.1953 ലെ നേഴ്സ്സസ് & മിഡ്വൈവ്സ് ആക്റ്റ് പ്രകാരം നിലവിലെ കൗൺസിൽ അംഗങ്ങളെല്ലാവരും യോഗ്യരാണ്. അവരുടെ വിദ്യാഭ്യാസ യോഗ്യതയെ സംബന്ധിച്ചു വിവരങ്ങൾ ഈ ആഫീസിൽ സുക്ഷിച്ചിട്ടില്ല.
3. 01/01/2008 മുതൽ 31/08/2019 വരെ 2,33,502 നേഴ്സുമാർ.
4. ഇല്ല.
5. 2018-19 അക്കാഡമിക്ക് വർഷത്തെ കണക്ക് പ്രകാരം 125 എണ്ണം

എ. ഗവൺമെന്റ്	ഃ 06
ബി. പ്രൈവറ്റ്	ഃ 108
സി. എം.ജി. സർവ്വകലാശാല	ഃ 06
ഡി. സി.മെറ്റ്	ഃ 05

QUESTIONNAIRE- STAFF NURSES EMPLOYED IN PRIVATE HOSPITALS AND GOVERNMENT MEDICAL COLLEGE

Please indicate your response in the appropriate columns

1. What is your gender?

Male	Female

2. What is your age group?

Below 30 years	Between 31-40 years	Between 41-50 years	Above 50 years

3. What is your qualification?

ANM	GNM	B.SC	M.SC

Others please specify:

4. Are you a registered nurse?

Yes	No

5. Nature of your employment?

Contract	Internship	Permanent

6. Selection criteria used for your appointment?

Interview alone	Examination with Interview	Other/ group discussion

7. How long have you been employed in this hospital?

Between 1-5 years	Between 6-10 years	Above 10 years

8. Have you received appointment order for joining ?

Yes	No

9. What is your monthly salary?

Below Rs.10,000/-	Between 10,000/- 14,000	Between 15,000- 19,000	Between 20,000- 24,000	Above 24,000

10. Do you have any intention to work abroad?

Yes	No

11. Whether the hospital follow nurse patient ratio?

Yes	No

12. How many hours of work are you engaged in a day?

8 hours	Above 8 hours	Below 8 hours

13. Do you have weekly holidays?

Yes	No

14. Number of night shifts in a month?

Six days	Above six days

` 15. Have you faced harassments during night shifts ?

Yes	No	No responsed

15.A If yes, who are the perpetrators of violence ?

Patients	Relatives of patients	Doctors	Hospital management	Other hospital staff

15. B. Type of Harassment faced?

Physical	Verbal	Sexual	Not revealed

16. Do you have transportation facilities?

Yes	No

INFORMATION ABOUT SOCIAL SECURITY MEASURES PROVIDED

17. Specify the allowances that are provided by the hospital authorities

Dearness allowances	Festival allowances	Mess allowances	Housing allowances

18. Do you have overtime work?

Yes	No

18 A. Do you have special allowances for overtime work?

Yes	No

19. Do you have paid annual leave?

Yes	No

20. Whether the hospital provides you with pension schemes?

Yes	No

21. Do you have casual leave and sick leave?

Yes	No

22. Do you have maternity leave with full wages?

Yes	No

23. Do you have promotion opportunities?

Yes	No

24. Do you have crèche facilities for children?

Yes	No

25. Do you have residential accommodation/hostel facilities for staff nurses?

Yes	No

26. What are the occupational hazards related to your work?

Infections	Needles tic Injury	Musculoskeletal pain	Latex allergy
Latex allergy	**Transmissible diseases**	**Varicose Vein**	**Workplace violence/ Harassments**

27. Have you faced any accidents and injuries during duty hours?

Yes	No

28. Have you ever contracted any infectious/contagious diseases from the patients?

Yes	No

29. Whether the hospital authorities vaccinate you against infectious diseases?

Yes	No

30. Are there adequate personal protective equipments in the hospital such as gloves, masks, PP.E kits to safeguard oneself against risks or for ensuring protection against occupational hazards/risks)?

Yes	No

31. Do you know about internal complaints committee against sexual harassments constituted in your hospital?

Yes	No

32. Are you entrusted with non-nursing works?

Yes	No

33. What is the general attitude of doctors to nurses?

Cordial	Dominating

34. Are you satisfied with your job?

Yes	**No**

35. Does the hospital authority provide training classes to improve nursing personnel's standard of practice (In-service education and continuing education)?

Yes	**No**

36. Does the hospital authority provide legal literacy classes to the staff?

Yes	**No**

37. Do you have membership in trade unions?

Yes	No

ADDITIONAL QUESTIONS TO NURSES WORKING IN THE PRIVATE SECTOR

38. Did you execute any bond with the management at the time of joining?

Yes	No

39. Where do you file work-related complaints, if any?

Nursing Council	Hospital Management	Grievances Redressal Committee	Nursing Associations	No

40. State the attitude of the hospital management to nurses generally?

Cooperative	Non-approachable	Neutral

41. Have you faced any disciplinary action from your employer for Union activities and Collective Bargaining?

Yes	No

42. Do you have any suggestion for improving the conditions of nurses generally? If yes, please specify it below

© Government of Kerala
കേരള സർക്കാർ
2011

Reg. No. രജി. നമ്പർ
KL/TV(N)/12/2009-2011

KERALA GAZETTE

കേരള ഗസറ്റ്

EXTRAORDINARY

അസാധാരണം

PUBLISHED BY AUTHORITY

ആധികാരികമായി പ്രസിദ്ധപ്പെടുത്തുന്നത്

Vol. LVI / വാല്യം 56 | Thiruvananthapuram, Monday / തിരുവനന്തപുരം, തിങ്കൾ | 16th May 2011 / 2011 മെയ് 16 | 26th Vaisakha 1933 / 1933 വൈശാഖം 26 | No. / നമ്പർ 1027

GOVERNMENT OF KERALA

Health and Family Welfare (C) Department

NOTIFICATION

G. O. (P) No. 303/2011/H&FWD. *Dated, Thiruvananthapuram, 11th May, 2011.*

S. R. O. No. 302/2011.—In exercise of the powers conferred by sub-section (1) of section 2 of the Kerala Public Services Act, 1968 (19 of 1968) and in supersession of all the existing orders on the subject, the Government of Kerala hereby make the following Special Rules for the Kerala Medical Education (Nursing in Hospital Wing) Subordinate Services, namely:—

RULES

1. *Short title and commencement.*—(1) These Rules may be called the Kerala Medical Education Services (Nursing in Hospital Wing) Subordinate Service Rules, 2011.

(2) They shall come into force at once.

2. *Constitution.*—The service shall consist of the following categories, namely:—

Category 1—Head Nurse

Category 2—Staff Nurse Grade-I

Category 3—Staff Nurse Grade-II

3. *Method of appointment.*—Appointment to the categories specified in column (1) of the Table below shall be made by the method of appointment specified against it in column (2) thereof, namely:—

TABLE

Category	*Method of appointment*
(1)	(2)
1. Head Nurse	By promotion from category 2 (Staff Nurse Grade-I)
2. Staff Nurse Grade-I	By promotion from category 3 (Staff Nurse Grade-II)
3. Staff Nurse Grade-II	By direct recruitment through the Kerala Public Service Commission

4. *Appointing authority.*—The appointing authority in respect of all categories shall be the Director of Medical Education.

5. *Reservation of appointment.*—The Rules of reservation of appointment contained in Rule 14 to 17 of Part II of the Kerala State Subordinate Services Rules, 1958 shall apply to the appointments by direct recruitment.

6. *Qualifications regarding age.*—No person shall be eligible for appointment by direct recruitment, if she/he has not completed 20 years of age and has completed 35 years of age as on the first day of January of the year in which the notification for selection is issued with usual relaxation to the candidates belonging to Scheduled Castes/Scheduled Tribes and Other Backward Classes, as per rules.

ചോദ്യം 5 : സ്റ്റാഫ് നഴ്സ് ഗ്രേഡ്-2 വിന്റെ നിയമനാധികാരി ജില്ലാ മെഡിക്കൽ ആഫീസർ ആയതിനാൽ അച്ചടക്ക നടപടി സ്വീകരിക്കുന്നത് അതാത് ജില്ലാ മെഡിക്കൽ ആഫീസറാണ്. സ്റ്റാഫ് നഴ്സ് ഗ്രേഡ്-1 ന്റെ അച്ചടക്ക നടപടി സ്വീകരിക്കുന്നത് വകപ്പ് തലവനാണ്.

ചോദ്യം 6 : ആരോഗ്യ വകപ്പിന്റെ കീഴിൽ unregistered നഴ്സുമാർ ആരും ജോലി ചെയ്യുന്നില്ല.

ചോദ്യം 7 : സ്റ്റാഫ് നഴ്സ് ഗ്രേഡ്-I 29200-62400
സ്റ്റാഫ് നഴ്സ് ഗ്രേഡ്-II 27800-59400
ധനകാര്യ വകപ്പിന്റെ 20.01.2016 ലെ ജി.ഒ(പി) 7/2016 എന്ന ഉത്തരവ് പ്രകാരമാണ് പ്രസ്തുത ശമ്പള സ്കെയിൽ നിശ്ചയിച്ചിട്ടുള്ളത്. ഉത്തരവിന്റെ പകർപ്പ് ധനകാര്യ വകപ്പിന്റെ വെബ്സൈറ്റിൽ ലഭ്യമാണ്.

ചോദ്യം 9 : 3 ഷിഫ്റ്റ് സമ്പ്രദായം നടപ്പിലാക്കിയിട്ടുള്ള ആശുപത്രികളിൽ രാവിലെ 7.30 മുതൽ 1.30 വരെ ആദ്യത്തെ ഷിഫ്റ്റും 1.30 മുതൽ 7.30 വരെ രണ്ടാമത്തെ ഷിഫ്റ്റും 7.30 മുതൽ അടുത്ത ദിവസം രാവിലെ 7.30 വരെ മൂന്നാമത്തെ ഷിഫ്റ്റും പ്രവർത്തിക്കുന്നു. അല്ലാത്ത സ്ഥാപനങ്ങളിൽ 8 AM മുതൽ 1 PM വരെ എല്ലാ പേരും നിർബന്ധമായി ഡ്യൂട്ടിയെടുക്കുന്നു. അവരിൽ ചിലർ സ്ഥാപനത്തിന്റെ ആവശ്യാനുസരണം 1 PM മുതൽ 4 PM വരെയും 4 മുതൽ 6 വരെയും ഡ്യൂട്ടിയെടുക്കുന്നു. വൈകുന്നേരം 6 മുതൽ 8 മണി വരെ നൈറ്റ് ഡ്യൂട്ടിയാണ്. ഇപ്രകാരം ഡ്യൂട്ടി നിശ്ചയിച്ചിട്ടുണ്ടെങ്കിലും സ്ഥാപന മേധാവി ആവശ്യപ്പെട്ടാൽ അധിക വേതനം കൈപ്പറ്റാതെ 24 മണിക്കൂറും ഡ്യൂട്ടിയെടുക്കാൻ KSR I ചട്ടം 14 പ്രകാരം സർക്കാർ ഉദ്യോഗസ്ഥൻ ബാധ്യസ്ഥനാണ്.

ചോദ്യം 11 : Organizational structure of Nursing Service under DHS

1) Addl. Director of Nursing Service (at State level)
2) Deputy Director of Nursing Service (at State level)
3) Assistant Director of Nursing Service (at State level)
4) District Nursing Officer (at District level)
5) Nursing Officer (in major hospital more than 500 bed)
6) Nursing Superintendent Gr.I (Hospitals)
7) Nursing Superintendent Gr.II (Hospitals)
8) Head Nurse (Hospitals)
9) Staff Nurse Gr.I (Hospitals)
10) Staff Nurse Gr.II (Hospitals)

"ഭരണഭാഷ - മാതൃഭാഷ"
(MOTHER TONGUE IS OUR ADMINISTRATIVE LANGUAGE)

Directorate of Medical Education
GOVERNMENT MEDICAL COLLEGE HOSPITAL
P.O. MEDICAL COLLEGE, THIRUVANANTHAPURAM - 695 011
Telephone: 0471- 2444270, 252 8297, 8229, 8462, 8463, 8465. Fax 0471-2442234
Telephone (Medical College Hospital Superintendent): 0471-2528262
e-mail: supdt.mcht@gmail.com

No. G3/12597/2020/G.M.C.H.T.

Date: 01/10/2020

From

Public Information Officer

To

Smt. Priya.R
Thriveni
Blossom Road
Elamakkara P.o
Kochi-26

Sir,

Sub:- GMCHT – General –RTI-2005 information-Staff details-Reg.

Ref:- 1. Application Received on 03/08/2020 through GMCT
2. Reply sent on 03/09/2020.

Remaining details regarding your application is furnished below.

2. Number of bed strength sanctioned -1952
3. Current nurse : patient ratio

In ward	1:4
ICU	1:1
Operation Theatre	1:2

Yours faithfully

Public Information Officer

"ഭരണഭാഷ - മാതൃഭാഷ"
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Directorate of Medical Education
Government Medical College Hospital
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Telephone (Medical College Hospital Superintendent): 0471-2528262
e-mail: supdt.mcht@gmail.com

No. G3. 21509/2019/GMCH/TVPM. Dated : 24/12/2019

From

THE PUBLIC INFORMATION OFFICER

To

Smt.Priya.R
Triveni (H)
Blossom Road
Elamakkara P.O
Kochi-26

Sir,

Sub:-Government Medical College Hospital,Thiruvananthapuram – General-RTI-2005-Information-regarding.

Ref:- Application received on 11/10/2019 through DME

(9) In Government Medical College Hospital,Thiruvananthapuram 3 shift duties are going on (8 hours.)

1. Ist Shift - 7.30 am-1.30 pm
2. 2nd Shift - 1.30 pm-7.30 pm
3. 3rd Shift - 7.30 pm-7.30 pm

In emergency situation the duty time exceeds 8 hours.

(10) Information regarding the details of working hours in private hospital is not available in this office

Yours faithfully,

PUBLIC INFORMATION OFFICER

Appellate Authority
Superintendent
Govt.Medical College Hospital,
Thiruvananthapuram

Copy to:- 1. Public Information Officer, DME
2. File/Stock file

Pa 27/11/19

e-mail : 'dmekerala@gmail.com'
Fax : 0471-2443080

Phone : Office: 2528575
2442126

Director (Personal) :2444011

GOVERNMENT OF KERALA
DIRECTORATE OF MEDICAL EDUCATION
MEDICAL COLLEGE.P.O
Thiruvananthapuram-695 011

No.K2/130325/RTI/2019/DME/567 Date: 5.10.2019

From

The State Public Information Officer

To

Smt. Priya R,
Threveni(H),
Blossom Road,
Elamakkara P.O, Kochi-26

Sir,

Sub:- Medical Education Department - Right to information Act 2005 - details furnishing of - regarding.

Ref:- Your application received on 5/9/2019

I am to invite your attention to the reference cited and to furnish the following available information as per your request,

1) 3269 Nurses are working under Medical Education Department.

2, 4, 6, 8) → not available in this office.

3) 217 nurses have been granted LWA to proceed to foreign countries on various reasons.

5) Director of Medical Education, in respect of Medical Education Department.

7) Salary details are available in the GO(P)No. 07/2016/Fin. Dated: 20/01/2016, and the same is available in the official website of Finance Department, Govt. of Kerala.

9) & 10) Such details are to be collected from Principals / Superintendents of Govt. Medical Colleges.

11) Promotion posts of Staff Nurses -

(entry cadre): Staff Nurse Gr. II - Staff Nurse Gr.I- Head Nurse - Nursing Superintendent Gr.I - Nursing Superintendent Gr.II - Nursing Officer

12) You are requested to remit Rs. 26(13x2) in the Treasury under the head of account 0070-60-118-99. After submitting the chalan you can obtain the copies.

13) Institution wise supervisory authority is Nursing Officer.

14), 15) May be collected from Principals concerned.

16) 1:4

17) Yes.

18) Nurse Practitioner in Midwifery Course is available in Government College of Nursing, Thiruvananthapuram since 2011.

GOVERNMENT OF KERALA

Abstract

HEALTH AND FAMILY WELFARE DEPARTMENT—DUTIES AND RESPONSIBILITIES OF STAFF NURSES AND AUXILIARY STAFF—ORDERS ISSUED

HEALTH AND FAMILY WELFARE (C) DEPARTMENT* G. O. (P) No. 180/2004/H & FWD. Dated, Thiruvananthapuram, 6th August, 2004.

Read:— 1. Government Letter No. 23863/C3/03/H&FWD dated 23-8-2003.
2. Letter No. O & M 4-86408/02/DHS. dated 11-3-2004 from the Director of Health Services.

ORDER

Government are pleased to approve the revised duties and responsibilities of Staff Nurses and Auxiliary Staff of Health Services Department as appended to this order.

By order of the Governor,
M. N. ARAVINDA DAS,
Deputy Secretary to Government.

To

The Director of Health Services/Director of Medical Education, Thiruvananthapuram.
All District Medical Officers (Health).
Stock file/Office Copy.

GCPT. 3/3867/2004/OTP.

STAFF NURSE

Staff nurse is a first level professional Nurse who provides direct patient care, assist in ward management and supervision. The post of staff nurse is directly proportional to the Head Nurse or ward charge nurse. All Staff Nurse should be in uniform at the time of marking their attendance, and should keep punctuality in duty and time.

DUTIES AND RESPONSIBILITIES

Direct Patient Care

1. Carry out the procedures of admission and discharge of the patients.
2. Maintain clean and safe environment for the patient.
3. Responsible for personal hygiene and comfort of the patient.
4. Attend the nutritional need of the patient and supervise dietary services.
5. Attend doctors' rounds and carry out all the treatment and instructions.
6. Maintain safety of the ward equipments and supervise cleanliness of hospital utensil such as sputum cups, urinals, bedpan, kidney trays etc.
7. Perform various technical duties related to nursing care.
   (a) Administration of medications—
   Administer injections and intravenous infusions.
   Administer intravenous blood transfusion under supervision of medical officer in emergencies.
   (b) Assist doctors in various medical and surgical diagnostic procedures by preparing patients and getting ready with required things.
   (c) Performing simple diagnostic procedures viz., urinalysis and estimation of haemoglobin percentage etc.
   (d) Collecting and sending of specimens for diagnostic procedures.
   (e) Recording of vital signs, i.e. temperature, pulse, respiration and blood pressure.
   (f) Performing gastric lavage, giving enema etc.
   (g) Prepare patients for operation and see that he/she is sent to operation theatre with all necessary papers and medications.
   (h) Takes care of eyes, ears, back, bowel, bladder, perineum, etc., whenever needed.
   (i) Observes all patient conditions and take suitable action accordingly and/or report changes to ward in charge/or the doctor.
   (j) Give expert bedside nursing to all patients.
   (k) Dressing of surgical wounds according to the direction of medical officer.
   (l) Accompany very ill patients sent to other departments.
   (m) Impart health education and discharge advices to patient and his family members.
   (n) Meeting emergency situation promptly. Keep every drugs, maintain emergency tray and equipments in the ward.

(o) Administration of oxygen, Ryle's tube insertion for feeding and aspiration and other problem based care to patients.

(p) Filling and maintaining all records such as case sheets, temperature charts, intake output chart, diet sheet, doctor's order sheet, nurse's records.

(q) Care of dying- give the last care, recording death in the register, arrange ambulance.

Operation Theatre Management

1. Maintain aseptic environment of the operation theatre.
2. Ensure autoclaving of articles.
3. Prepare anaesthetic trolley for surgery.
4. Assist the surgeon and anaesthetist in every step skilfully while performing various types of surgery.

Labour Room Management

1. Render comprehensive antenatal care.
2. Conduct normal delivery.
3. Attend & assists doctors in all obstetrical emergencies.
4. Take care of newborn and premature babies.

Management of ICU's

1. Intent & procure all necessary equipments, drugs, oxygen cylinder whichare required for the unit.
2. Operate ECG, cardiac resuscitation and other sophisticated high tech machines whenever needed or assist the doctor in. operating such machines.

Psychiatric Unit

1. Assist the doctors in admission and discharge of patients.
2. Prepares patient for ECT and other procedures and therapies.
3. Assists in management of aggressive, suicidal and grief as other symptoms of patients.

Ward Management

1. Helps the ward in-charge to carry out the work during her absence.
2. Maintain general cleanliness of the ward.
3. Supervise the duties of subordinates.
4. Maintain the scheduled poisonous drug registers.
5. Supervise nursing care and other tasks carried out by the student.

Educational Responsibilities

1. Helps in orientation of new staff and students.
2. Extends co-operation and participate in clinical teaching.
3. Participate in in-service education programme.
4. Plan and implement formal and informal health education programme.
5. Assist and extends co-operation in nursing research programme.
6. Any other duty assigned by nursing superintendent.

STAFF NURSE Gr. I

DUTIES AND RESPONSIBILITIES

1. All the above duties.
2. Duties of Head Nurse in the absence of Head Nurse.
3. Any other duties assigned by the Nursing Superintendent.

HEAD NURSE

Head Nurse is directly responsible to the Nursing Superintendent Gr. I. She/he is accountable for the nursing care management of a ward or a unit assigned to her/him. She/he is responsible for safety and comfort of the patients in the ward/unit to provide high quality of nursing care both in terms efficiency and effectiveness of service.

DUTIES AND RESPONSIBILITIES

Responsibilities of a Head Nurse will be broadly classified .as follows

(a) Supervising the performances of staff and managing the unit efficiently
(b) Supervise/Attend patient care.
(c) Teaching of staff and students.

Direct Patient Care

1. Ensure proper admission and discharge of patients.
2. Assist/Attend direct care of patient as and when required.
3. Assigning duties to the staff.
4. Takes nursing round with staff and students.
5. Accompany the Doctors rounds & ensure doctors instructions concerning patient treatment are carried out promptly.
6. Co-ordinate patient care with other departments
7. Ensure all nursing procedures are carried out promptly & see that total health needs of patient are met.
8. Ensure accurate recording of vital signs and observations.
9. Responsible to ensure therapeutic diet to patients as per doctor's order & supervise dietary services.
10. Ensure that emergency medicines/emergency trolley etc. kept ready.
11. Ensure safety, comfort & good personal hygiene of patient.
12. Ensure smooth healthy communications between nurse-patient, nurse-doctor & other superior officers.
13. Ensure prompt recording of death & any unusual incidents.
14. Ensure timely filling of daily census records.
15. Ensure safe & clean environment for the ward and ascertain the quality of care rendered.

Supervision and Ward Management

1. Implement ward policy.
2. Makes the duty schedule & work assignment.
3. Indenting and procurements of ward supplies, medicines, equipments etc. and keep records.