“Convince Your Patients and You Will Convince Society”: Career Decisions and Professional Identity Among Nurses in India

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Abstract
This article reports on the results of qualitative research to investigate the career plans of Indian nurses working in the southern Indian city of Bangalore. The globalized health care market in Bangalore has generated opportunities for an increasingly diversifying profession, many of whose members are keen to pursue global careers, work in specialized clinical settings, and pursue further education, and whose sense of professional identity is strongly influenced by these career choices. The research drew upon interviews with 56 nurses employed across six sites, including public and private health facilities. Decision-making related to the setting of nursing work and the negotiation of boundaries between medical “treatment” were of analytical interest in understanding career drivers and the professional identity of nurses working predominantly in the context of hospital care. Lateral trajectories were found to be important to the construction of a career in nursing—where the extent to which nurses could demonstrate competencies in clinical skill and knowledge and maintain professional control over the practice of nursing are key aspects in constructing a career. The renegotiation of nursing’s public image is at the heart of professionalizing strategies being adopted by nursing’s leaders and is also evident in the accounts presented by hospital nurses in their depictions of nursing practice and career plans. The findings suggest that greater attention to the professional project of nursing in India and the construction of nursing careers would benefit the development of more responsive human resource policies around the retention of nurses.

Keywords
nurses, careers, professional identity, India

Introduction
Nurses are the largest group of health providers in most countries and are vital to the efficient functioning of health services. Nurse shortages have been reported in countries around the world, including India (Castro-Lopez, Guerra-Arias, Buchan, Pozo-Martin, & Nove, 2017; Hawkes, Kolenko, Shockness, & Diwaker, 2009; Walton-Roberts et al., 2017). Studies looking at the extent of shortages of health workers, including nurses, have examined factors that contribute to attrition in the health workforce, such as migration, geographic and organizational maldistribution, employment conditions, poor governance, and weak health infrastructure (Aluttis, Tewabech, & Frank, 2014; Buchan & Campbell, 2013; Goel et al., 2016; Ono, Lafortune, & Schoenstein, 2013).

The emergence of Western nursing in India came about through the introduction of missionary medicine to the subcontinent along with the expansion of European trading routes. The bulk of the training of Indian nurses during the colonial period, therefore, took place in mission hospitals overseen by missionary nurses (Fitzgerald, 1997). Studies tracing the history of nursing in India frequently examine the cultural context that has given rise to the historically low social position of Indian nurses through analyzing the effects of religion, caste, and class on notions of appropriate work for women (Abraham, 1996; Somjee, 1991). In particular, concerns around providing physical care to the bodies of others is tainted by traditional caste prejudices in South Asia, in which such forms of labor were seen as exclusively the preserve of the lowest rungs of the Hindu caste system; thereby characterizing nursing as low status work. More recent sociological studies have reexamined the social status of Indian nurses in light of migration opportunities (Nair, 2012; Nair &...
The following article examines the construction of nursing careers in the Indian context and the main career drivers. It highlights the key themes that emerged from the data analysis, including decision-making related to the setting of nursing work, the negotiation of boundaries between medical “treatment” and nursing “care,” the institutional context (public vs. private sector), and the choice of clinical specialty. It also discusses the perceived benefits of seeking employment abroad and the career profiles of prospective migrant nurses. Finally, the article highlights the importance of the professionalizing strategies being promoted by representatives of national nursing bodies to achieve greater social and economic rewards for Indian nurses as key players in a globalized health care market.

Method

Study Location

The study was undertaken in the city of Bengaluru (Bangalore) in the state of Karnataka, south India, that has a population of approximately 8.4 million people and is the third largest city in the country (Government of India, 2011). Industries based in Bangalore include aerospace and aviation, manufacturing, biotechnology, and Information Technology. This has made Bangalore an important internal labor destination for people from different parts of the country, particularly the surrounding states of Kerala, Tamil Nadu, and Andhra Pradesh. Due to its range of medical and research facilities, including super specialty hospitals and biotechnology companies, Bangalore is also considered to be a key “medical hub” and a preferred location for a globalizing health workforce—particularly nurses (Johnson, Green, & Maben, 2014).

Like other metropolises in India, Bangalore has a mix of private- and government-run health facilities, as well as private and government nursing schools and colleges. The size and profiles of hospitals in the city also vary widely and include corporate “high end” hospitals catering to wealthy Indian and foreign clients, small private clinics and nursing homes, faith-based “mission” hospitals, and government hospitals accessed mainly by middle and lower income patients from Bangalore and surrounding areas. Interviews were conducted across eight different sites (private hospitals, government hospitals, a mission hospital, and a privately operated outpatient clinic) so as to reflect the diversity of health facilities in the city and to include the perspectives of nurses working in different settings.

In this urban setting, nurses are able to actively engage with the possibilities brought by globalization, particularly through the construction of new “hi-tech” corporate hospitals catering to the upper and middle class as well as foreign “medical tourists” to India, many of which have ties to hospitals and medical institutions in Western countries. Such
international networks thus foster another important feature of globalization, that is, the possibility for “mobility” and the prospects of a global nursing career.

**Design**

It is well recognized that qualitative research methods are best suited for studies that seek to explore the texture and nuances of the social world in an in-depth manner (Green & Thorogood, 2014). As the study examined the ways in which nurses construct a professional identity, an inductive, qualitative approach was viewed as the most appropriate means by which to elicit data on meanings and experiences identified with membership in the nursing profession. In-depth interviews with nurses were core sources of data where the purpose was to examine nurses’ presentation of their working lives and conceptions of work and career.

The author also attended a two-day state-level nursing conference, a workshop held at a nursing college and visited a nursing hostel during the course of the research. In addition, approximately 20 hr of observation were undertaken across the sites and included “shadowing” nurses on rounds and observing events, conversations, and interactions. This enabled the examination of some aspects of nurse–patient and nurse–doctor interaction and to get a feel of nursing life outside a formal interview environment. Articles on Indian nurses in Indian newspapers were used as data on recent developments in nursing and to follow up current issues of interest to the study, such as developments in nursing education and trends in overseas migration. The research took place over 9 months and included a preliminary site visit for 2 months in April-May 2007, 6 months of field work between January and June 2008, and a visit from December 2009 to January 2010 for follow-up.

**Sampling**

Apart from state registration statistics, employment data of nurses at central and state level is not comprehensive. In addition, limited information is available on human resources and staffing in the private sector. It is therefore possible that many nurses who are registered with the Karnataka Nursing Council (KNC) are not currently working or have emigrated. Therefore, in the absence of a secondary data set from which to draw a random sample of nurses, a purposive convenience sampling approach was utilized.

In-depth interviews were conducted with 56 nurses, including 51 nurses working in hospital practice and two nursing superintendents and one member of staff in two private nursing colleges. In addition, the author interviewed a retired nurse and her daughter, also a nurse, who had left India to work overseas. Nurses were informed of the research by the nursing matron and invited to participate. A wide age range of participants was desired so as to capture the experiences of nurses of different ages, as well as any generational differences in perceptions of work and career. Participants were recruited to the study after consultation with the hospital medical director and nursing superintendent to inform them of the study’s aims and methods, to request permission to interview onsite, and to ensure that recruitment procedures were appropriate and in line with hospital protocols.

**Data Collection**

The interviews typically lasted between 45 min and 1 hr. Questions were open-ended and structured around a topic guide. The questions covered topics such as the decision to choose nursing, descriptions of daily work, relationships with medical colleagues, future plans for work or study, preferred locations of employment, and international migration. Although recording dialogues provides access to verbatim quotes, as recordings do not capture nonverbal communication they do not reproduce the interview setting in its entirety. Therefore, to complement data from the interviews, notes were made on the interviews in the author’s field journal. These included observations of the interview encounter, impressions of the interview, as well as emerging lines of enquiry. The interviews were predominantly carried out in English. A small number of interviews (four) were carried out in a mixture of Kannada and English by a research assistant in the presence of the author. Four interviews were conducted with doctors.

The interview discussion was followed up with a few “questionnaire” style questions to collect some demographic information about the participants. This information was important to understand more about the participants in the study and was also helpful in observing any differences or similarities across the accounts. Nurses were also asked about the nursing qualifications that they currently held.

**Data Analysis**

The main approach to data analysis drew upon the “grounded theory” method. An appealing characteristic of grounded theory is its “funnel approach,” whereby the initial research questions and hypotheses are fairly broad and then progressively defined according to information emerging from the data. In the grounded theory tradition, data collection is guided by emerging theoretical categories in which researchers gather data to expand on or to eliminate preliminary analytical leads (Charmaz, 1990, 2006; Glaser & Strauss, 1967).

One of the disadvantages of the grounded theory approach is that achieving saturation of categories can require a great amount of time. In the case of this research, it was not possible to undertake the theoretical sampling approach outlined by Glaser and Strauss (1967) where sampling is determined purely by the emerging theory, as this would involve an indefinite length of time collecting data. The time lag between data collection, analysis, and further collection of data through theoretical sampling
Ethical Considerations

Ethics approval for the study was received from the ethics committee of the London School of Hygiene and Tropical Medicine. To ensure that participants understood and agreed to participate in the study, each nurse was given an information sheet to read and invited to ask any questions. After explaining that participation was voluntary and confidential, the author asked whether she could proceed with the interview and orally recorded permission from each participant. Participants were informed that they could end the interview at any time and that all recordings and transcripts were being given an interview number so as not to identify individuals by name. Consequently, all names that are included in this article are pseudonyms.

Findings

Demographic Background

The final sample was overwhelmingly female (49/56 nurses) and is indicative of the larger overall number of women in nursing in India. Seven male nurses participated in the study, where five worked in private health facilities, one worked in the central government–managed hospital, and one was a nursing principal. However, in India, as in other countries, men are increasingly being trained as nurses. For example, in one college visited, male students accounted for almost 50% of the student body. This suggests the increasing popularity of nursing as a choice for boys—largely due to the prospects of employment both in India and overseas.

In terms of the age range of nurses interviewed, the youngest nurse was 22 years old and the oldest was 80 years old and retired. The nurses at both government hospitals were generally older than those interviewed in the private sector. At the first government site, the nurses ranged from 30 to 59 years and the second from 32 years to 57 years, whereas in the first two private hospitals visited, most nurses were in their 20s.

Out of the 56 nurses, 26 were Christians, 29 were Hindus, and one was a Muslim. Although the study size is too small as to provide a representative picture of the religious background of nurses in India, the large number of Hindus in the sample indicates that nursing is increasingly being taken up by Hindus. The almost negligible presence of Muslims indicates that nursing was and still is not a popular choice among the Muslim community. When nurses were asked if they worked alongside Muslim nurses, their response was that this was “rare,” and that only a few of their colleagues were Muslims.

Out of the 29 Hindu nurses interviewed, most were from historically disadvantaged Hindu castes, where six were from what the Indian Government classified at the time of the study as “scheduled castes” (SC), two were from the “scheduled tribes” (ST), and 11 were from the category “other backward castes” (OBCs). A further two were from the Naidu community, formerly classified as OBC, found in different states in the South. Five nurses were from “forward Hindu castes,” particularly Nairs (Kerala) and Lingayats (Karnataka) and one nurse was from the Nagarathar caste (Tamil Nadu). Specific caste data were not obtained from three of the Hindu nurses, although one indicated that she was from a high caste family. An important note with regard to caste is that the list of castes identified as OBC, ST, and SC is flexible and often updated with castes added or removed according to social, economic, and educational indicators. They may also be classified as OBC or SC in one state and not in another. Historically, caste was intimately connected to the occupational hierarchy, with higher castes having better access to higher status and higher income occupations and assets than lower castes. Although caste does
have an important place in the study of Indian occupations, there is evidence of a loosening of the caste–occupation relationship (Desai & Dubey, 2011).

Of the 56 nurses interviewed, 16 were from Kerala, 34 were from Karnataka, four were from Tamil Nadu, one was from Andhra Pradesh, and one was originally from Bihar, but whose parents had settled in Karnataka. Consequently, the data set presented an overwhelming picture of nurses from the south of India. It is difficult to ascertain the numbers of nurses from north India working in Karnataka as comprehensive employment data from the private sector is limited, but that the sample consisted entirely of nurses from the southern states was not unexpected. Apart from the strong tradition of nursing in the south of the country, the difference in language and culture between the south and the north of India may present a formidable barrier for Hindi and other northern language speakers.

All the Keralite nurses interviewed in the study were in the private hospitals. In both the public hospitals, the sample consisted overwhelmingly of “local” Kannadiga (Kannada speaking) nurses and a handful of nurses from Tamil Nadu. It was not possible to ascertain how many Keralite nurses are working in government hospitals in Karnataka. Although some nurses in the government hospitals mentioned that they worked alongside a few nurses from Kerala, it appears that comparatively few Keralites work in government facilities in Karnataka, as employment is mainly reserved for “local” state nurses or those from other Indian states who have settled permanently in Karnataka and thus satisfy the residency requirements for working as a state government employee.

**Educational Qualifications**

The majority of nurses across the hospital sites held a Diploma in General Nursing and Midwifery (GNM). A smaller number of participants held BSc and MSc nursing degrees, some of whom had upgraded from a GNM Diploma after undertaking a 2 year postcertificate baccalaureate course. The decision to undertake a BSc or GNM program was determined by a number of factors. Those commonly mentioned by nurses at the hospital sites included the availability of BSc programs at the time of entering nursing training, obtaining the required examination marks, having undertaken a major in science subjects in the last years of secondary school, and the cost of the course.

A BSc nursing degree is a higher qualification than a GNM Diploma and is required for entry into MSc and doctoral programs, as well as to join teaching faculty in nursing schools and colleges. Nurses interviewed in the nursing colleges therefore held MSc and PhD qualifications. For the BSc nurses, a degree course was purposely selected so as to provide more flexibility in career opportunities, such as being able to follow a teaching path or to enter MSc and PhD nursing programs.

In expressing satisfaction with their choice of nursing qualification, diploma nurses frequently highlighted a “glass ceiling” associated with a GNM diploma. GNM nurses were mainly limited to clinical settings unless they opted to undertake a 2 year “postbasic” nursing course to upgrade to the equivalent of a BSc degree thereby opening up the possibility of entering nursing education. GNM nurses also reported finding it more difficult to obtain nursing management posts and therefore remain staff nurses for much of their careers. A few of the nurses interviewed had worked for more than 20 years as a staff nurse before being promoted to more senior “in-charge” positions. Although GNM nurses can receive specialized “in-service training” in their hospitals, as was the case in one of the sites, this is not a formal qualification as such but rather an internal requirement of the hospital. Nurses holding GNM diplomas therefore often expressed their desire to undertake the postbasic certificate course to convert their GNM qualification to a BSc.

Of the nurses interviewed, relatively few had climbed significantly up the nursing hierarchy. Most promotions were from staff nurse to an “in-charge” post, where nurses took on administrative and/or managerial duties and supervised nursing care in one or more wards. Nurse Matrons or Superintendents were not always drawn from among senior nurses within the internal hierarchy, but were frequently hired from other hospitals.

Consequently, for most nurses, career pathways mainly involved a lateral succession of posts in different hospitals and teaching institutions, clinical settings, and for some, stints abroad. Consequently, these lateral trajectories were found to be important to the construction of a career in nursing in the study setting for both female and male nurses. While the sample of male nurses in the interviews was too small to draw conclusions as to whether male nurses were able to secure senior positions more easily than their female peers, it did appear that male nurses leaned more toward careers in nursing management and education. Senior faculty in nursing colleges were frequently male, as were many of the keynote speakers at nursing events attended during the course of the research. The relative ease of male nurses in climbing the career hierarchy into senior management both in hospitals and in nursing education was raised by some female nurses as an issue of “internal sexism” in nursing in which male nurses become managers of predominantly female care provision.

The context and nature of nursing work was particularly important to conceptions of a satisfying work biography—particularly the potential to undertake more clinical tasks and achieve higher levels of skill and autonomy in nursing practice. Investigating the relationship between nursing and medicine in the study setting was a means through which to generate information on nurses’ understandings of their role in patient care and the importance of this role to the development of a strong professional identity in nursing and forging a meaningful career.
Negotiating Professional Boundaries

The analysis of power dynamics between health professions forms a key part of literature on interprofessional relationships within hospital settings and the construction and negotiation of professional boundaries (Allen & Hughes, 2002; Liberati, 2017; Miers, 2010; Niezen & Mathijssen, 2014). The way in which the occupational jurisdiction between medicine and nursing was depicted in the narratives, as well as the extent to which nurses could “cross-over” from care into treatment, contest doctors’ opinions regarding the management of patients and maintain professional control over the practice of nursing were found to be key aspects in constructing a career.

During the site visits, nurses were observed engaging in a variety of functions that related to their area of nursing specialty (e.g., cardiology, psychiatry, obstetrics) as well as to the wards in which they were posted (e.g., delivery room, casualty, ICU, psychiatric ward). Consequently, nursing duties ranged from the transfer and monitoring of a patient following heart surgery, the antenatal care, and delivery of uncomplicated pregnancies managed by the nurses working in the maternity hospital to the counseling and recreational activities conducted by psychiatric nurses.

The interview and observational data across the sites indicated that medicine was largely responsible for major decisions regarding a patient’s course of treatment. For example, doctors decided which patients were to be admitted as inpatients, the types of treatment required, and when patients could be discharged. Nurses worked alongside doctors in functions such as assisting in emergency cases and surgery, undertaking admissions and discharge procedures, giving medicine, administering IVs, preparing patients for diagnostic procedures or surgery, checking fluids and electrolytes, monitoring vital signs, recording medical history, and updating clinical charts. Ward sisters at the sites who were responsible for one or more wards instructed and supervised the work of orderlies, cleaners, and housekeeping that assisted nurses in carrying out activities related to feeding patients and maintaining cleanliness and hygiene. Nurses also provided counseling support and health information to patients and their families.

The interview narratives of nurses across the hospital settings indicated a clear distinction between “medicine” and “nursing” and a subsequent distinction between the functions of doctors and nurses with regard to patients. As has been found in other contexts, nurses’ testimonies defined the boundary between medicine and nursing through highlighting a “treatment/care” divide (Bridges et al., 2013; Churchman & Doherty, 2010; Reeves, Nelson, & Zwarenstein, 2008). Nurses frequently referred to providing “care” as the main role difference between themselves and their medical colleagues. Doctors were seen more as “treatment providers” who came into contact with patients predominantly during their rounds or when called for medical assistance, whereas nurses’ “care” was described as a “24 hr activity” that involved attending to patients’ various medical, psychological, and social needs during their stay at the hospital. Nursing care was thus viewed as advancing a “holistic” approach in the management of patients as opposed to the “disease-oriented” approach of the medical profession. As Parvati, a nurse working in a central government hospital, explained,

In medicine you are only treating the patient, but you are not close to the patient, the joys and sorrows you are not able to share properly with them. Of course, that kind of profession is different from nursing. I think that nursing has got closer attachment to the patient.

At the same time, while nurses were responsible for carrying out treatment instructions laid out by doctors, many were able to conduct their own management of conditions not seen as requiring immediate medical attention—such as management of fever and administering analgesics for pain relief. Doctors intervened based upon the monitoring and assessment of nurses, including nurses’ observations of patients’ responses to treatment. Nurses’ observations were also included in “nurses’ notes” that were handed over to subsequent nursing shifts and frequently accessed by doctors.

The boundary between doctors’ “treatment” and nurses’ “care” was frequently blurred in the daily routine of nursing practice. For example, boundary overlaps often occurred in response to the urgency of “time” and the proximity of the attending doctor to the patient. Many nurses reported taking on medical tasks as required by the situation, such as administering IV antibiotics or inserting nasogastric tubes when doctors were busy or unavailable, as well as performing emergency resuscitation while waiting for the doctor to arrive. This type of boundary crossing was seen as necessary and unavoidable to respond to the needs of patients who were assessed by nurses as requiring immediate attention.

Evidence of different boundary settings between medicine and nursing also emerged in the work histories of nurses. Some nurses complained that in former appointments, hospital regulations meant that they were able to do limited clinical tasks and had to follow doctors’ orders even to undertake routine nursing functions. For instance, Sister Deidre gave the following account of her experience when accompanying her husband for admission at a well-known private hospital in Bangalore:

See, for example, from my own personal experience I will tell you. When my husband was admitted to Hospital X, to give a steam inhalation the nurse was asking for a doctor’s order. I told her “Excuse me. This is purely a nursing function. Why do you need a doctor’s order for this?” The nurses who are working in the corporate set-up, they feel that they have to follow only doctors’ orders. They will not do anything independently. Even to give a steam bath, you don’t need a doctor’s order!
In some hospitals therefore, the setting of boundaries follows a more formal division of labor between medicine and nursing, where hospital management and staff adhere more strictly to professional and hospital regulations. In other hospitals, nurses reported being able to demonstrate greater autonomy over decision-making regarding patients than their nursing colleagues working elsewhere. However, even within contexts with more regulated boundaries between medicine and nursing, nurses were not lacking in agency. Three key features of the work environment across the hospital settings were found to influence nurses’ ability to secure greater autonomy in nursing practice. These were the institutional context in which medical/nursing care is organized—particularly the division of labor between government and private facilities, the clinical setting of nursing work, and the strength of interpersonal relationships between nurses and doctors. Although both institutional and clinical settings can be seen as structural conditions of the work context and in a sense are less negotiable than interpersonal relationships, these conditions were found to create an environment that facilitates the agency of nurses to cross the traditional boundary between medicine and nursing.

**Rival Work Cultures: Private Versus Public Nursing**

Across the interview set, common perceptions emerged that were related to the choice of institutional setting within which to locate a nursing career. The often polarized views of the benefits of a working life as “public sector nurse” or a “private sector nurse” were particularly striking with these institutional contexts being presented as “rival work cultures.”

In the narratives of private sector nurses, government hospital nursing was characterized by lower levels of hygiene, limited equipment, and a generally poor work environment. A career in government hospitals would result in less exposure to modern medical and nursing techniques and equipment than that found in the private sector:

> I am giving preference to private hospitals because hi-tech technology is there. Government hospital means nothing will be there. Nothing will be there. They will not provide proper materials, proper medicines also. How can we manage with those things? (Thomas, 24 years, private hospital)

The limited technology and equipment associated with government hospitals was not only seen as a disadvantage in terms of gaining new knowledge, but could affect nurses’ “job satisfaction” through limiting their ability to provide effective care to patients. A number of private nurses interviewed had undergone their training in government hospitals and were therefore familiar with the environment and set-up of the public sector. For example, Santosh, a 25-year-old male staff nurse working in the operating theater of a private hospital, recalled being able to get a lot of “practical experience” during his hospital training in a government hospital. However, he also described how the lack of facilities and high patient load in government hospitals led him to feel that he was unable to provide high standards of nursing care:

> It is because of the facilities that they provide. If you are a nurse, you are bound to give the maximum care to the patient. But it is not only in your hands. It is also the facilities you have been provided in your position. If you want to carry out your duty, you need a lot of things. With bare hands you can’t do it, you can’t do anything. So, when you don’t find anything to do for your work, you’re helpless. That’s what happens in the government job.

Although nurses praised the work environment of private hospitals with reference to the higher levels of hygiene, medical care, and equipment, many felt that a career in the private sector was insecure and that there were fewer financial incentives. Most of the critique leveled at government hospitals was focused more on the work environment rather than the employment benefits available to government nurses. In this respect, the majority of nurses across the sites acknowledged that the biggest incentive to work in government hospitals was the “job security.”

> In the government sector it is a very secure life. So that’s what I wanted. Because outside you will be football, you will be thrown from this institution to that institution. (Parvati, 34 years, government hospital)

Nursing in government facilities was seen as offering “lifet ime” security as nurses would be able to receive a state pension, health insurance as well as housing and other benefits. In addition, for nurses across government and private sites, further education in nursing was seen as very important, being key to career progression and to ensuring a high standard of nursing care. Nurses in the government sector were more able to pursue these opportunities as part of their professional careers than private nurses as they are supported by government scholarships or bursaries that cover fees and related expenses. For nurses working in the private sector, as the costs of further study are not typically borne by private institutions, further education has to be financed by nurses themselves. Some private sector nurses therefore highlighted that though they would like to undertake a post-basic certificate to upgrade to a BSc qualification, they could not afford the time or the costs of the program. Manjula, a 24-year-old GNM nurse working in a private teaching hospital, recounted:

> In government training, scholarship is available, like they provide stipend, it is government training. Since I was doing in government training, I received a stipend, but now we do not receive, for government staff they can pursue further training with salary for free . . . as we are in private, not in government, we have to pay money.
Consequently, while some private sector nurses demonstrated no desire at all to construct a career in the public sector, for others, the perceived benefits of a career in the public sector through the incentives of better salaries, the potential for further study, and “life security” were a powerful motivator to seeking employment in this institutional context.

“Expert Knowledge” and the Clinical Setting of Nursing Care

Nurses favored placements according to the level of clinical experience and “learning on the job” that they offered. Respondents with GNM and BSc qualifications highlighted their desire to “specialize” rather than becoming a “general nurse,” a term that was used to describe essential adult nursing care. Although in one site (a private teaching hospital) nurses were routinely transferred to different clinical areas every few years, most respondents felt that acquiring specialized nursing skills through training and experience in one clinical area was more valuable than “split nursing duties”—a term used by some nurses to describe a mixture of ward and specialist nursing duties such as working in the operation theater or ICU or moving between two or more clinical areas. Soraya, a 22-year-old staff nurse who worked in one of the private hospitals, explained,

Speciality working is better no? Than working in all other combination, speciality means we will come to know better. If other, all, it means it will be come to be like a mixture. This thing, that thing, we will not come to know in detail. Speciality means we can come to know regarding that case. We can handle individually. If others, means the cases will be together like cardio, nephro, neuro, everything will be together.

This view was supported by the Nursing Superintendent of a large multispeciality private hospital in Bangalore who encouraged her students to consider specialization in a clinical area to avoid becoming what she termed as “a jack of all trades and master of none.” The choice of speciality was often related to the perception of opportunities abroad, so that speciality areas such as obstetrics and gynecology were not as popular as areas such as cardiology or psychiatric nursing that were considered to be much more “in demand” overseas.

The choice of nursing speciality also revealed the gendered pathways through nursing in India. For example, male nurses were directed toward specialties such as psychiatric, emergency nursing, and orthopedic nursing which were seen as more “suitable” for men. Although male nurses also undertake training in midwifery as part of both the GNM and BSc curriculum, none of the male nurses interviewed considered obstetrics and gynecology to be an appropriate career path for male nurses due to cultural sensitivities around male–female interaction in India.

Forging a meaningful career in nursing also included working with greater professional autonomy. The ability to conduct independent assessments of patients, undertake certain medical tasks, and demonstrate higher levels of professional responsibility was perceived by respondents to be largely determined by the clinical setting of nursing work, thereby suggesting a hierarchy of desired settings in which to locate a nursing career. Here, general ward nursing was seen at the bottom of this hierarchy in both public and private work settings. Nursing work in this context was perceived as less “technical” and mainly involved essential nursing duties such as bathing, administering medicine, providing meals, and overseeing the general comfort of patients. Consequently, ward nursing duties were typically assigned to junior nursing staff.

Providing essential nursing care on the wards was perceived as the least attractive setting for a nursing career in that it was perceived as low-status work and often described as “boring.” For example, one nurse described providing care on the general adult wards as involving little more than “administering a tablet.” Being assigned to ward duties was also considered to be less marketable in terms of securing employment in other hospitals both in India and abroad. Therefore, a higher premium was placed by nurses on specialized skills that were considered to be in short supply and, thus, “in demand” rather than routine nursing skills that could potentially be undertaken by auxiliary categories of health workers.

At the other end of the spectrum of professional responsibility was the status awarded to nurses working in critical care. The interview narratives with doctors and nurses illustrated that nurses working in the ICU were considered to be the most experienced and skilled nursing staff. For example, in discussing areas of nursing recruitment, the medical director and a visiting consultant in the cardiothoracic hospital explained that they put their “best nurses” in the ICU. The reason for the high professional status awarded to critical care nurses is the level of independent responsibility associated with providing care to critically ill patients. This included questioning physicians over drug prescriptions for patients. As one doctor noted,

I had somebody pointing out to me that this drug might further diminish the white cell count in a patient whose white cell count was already diminished. I was so glad when they came up with that.

As nursing has historically been viewed as a low status occupation in India due to its association with “dirty work, upgrading nursing skills through working in specialized settings or through further education also provides the opportunity to present a ‘skilled’” persona to the public. While nurses predominantly highlighted positive experiences with patients, negative patient encounters were most often linked to behavior reinforcing perceptions of nurses’ social inferiority largely
linked to the public perception of nursing work as “unskilled.” For example, some nurses described being treated “like servants” while others complained that the low status given to nursing work meant that patients deferred medical and treatment related questions to doctors.

The public is not giving that much value for a nurse. See, if we tell the patient “this is the problem, relax, the doctor will come and examine you. We are checking your vitals. Everything is normal, don’t worry.” Sometimes the patients won’t listen to us. “Where is the doctor”? When a nurse comes to attend to them, they are not happy. “Call the doctor, let the doctor come.” (Shalini, 29 years, private outpatient clinic)

The public image of nurses and nursing work was therefore important to nurses in designing their career as well as to strengthening the profession as a whole. Nurses were particularly concerned about the possibility of knowledge “stagnancy” where they would remain in predominantly task-oriented roles with little opportunity for further learning and skills development.

You know, in the medical field every four months, five months there is a new technology and people who are teaching us are not in touch with that. So, they are teaching something that has passed already . . . For doctors . . . they keep upgrading because they constantly have to deal with the patients. But ours, it becomes sometimes like a sort of mechanical job . . . you might be highly intelligent, but if you are not in touch, you tend to forget. So, upgrading skills is really important . . . (Sarita, 37 years, government hospital)

Being bypassed by developments in medicine and nursing and becoming “mechanical” introduces the risk of “de-skilling,” in which nursing functions could potentially be downgraded by hospital management to “basic care” tasks and distributed to other hospital employees. Counteracting the threat of “de-skilling” through acquiring additional skills emerged as a career driver for nurses as well as being of key importance to maintaining occupational closure for the profession of nursing itself.

Across the study sites, almost all nurses highlighted good working relationships with doctors as well as with other health staff such as physiotherapists, dieticians, and technicians. The majority of nurses interviewed described positive working relationships between doctors and nurses, some using the word “family” to describe interprofessional relations. The term “team” was used frequently by psychiatric nurses indicating the interdisciplinary nature of mental health care. For many nurses, years of experience working in one area enabled them both to build up clinical skills and medical knowledge as well good interpersonal relationships with medical staff. This often led some nurses to be labeled as “competent” by doctors and thus trusted to take on a greater range of medical activities.

The interviews demonstrated that age and seniority acted upon the extent to which nurses were given more autonomy in decision-making by doctors. Older and more senior nurses tended to exert a larger measure of professional control than younger nurses, and showed a greater ease of communication with doctors. “Being at ease” with doctors also meant that they were more empowered to question a doctor’s instructions or able to take over certain medical duties without having to specifically request permission. Some younger nurses therefore felt quite disempowered in their relationships with doctors compared with their “seniors” and felt unable to question doctors’ decisions regarding the care of their patients.

**Constructing International Nursing Careers**

For private nurses in particular, a key career decision was whether and when to seek out opportunities for nursing abroad. Analysis of the interviews indicated that the decision to migrate is strongly rooted in the desire for increased earning power and knowledge. Most nurses complained that nursing is not well paid in India and that this was a major incentive to work abroad. Private nurses were found to express higher levels of dissatisfaction with pay and job security than their government sector colleagues and were therefore more likely to express an interest in nursing overseas.

For those nurses interested in migrating, the economic rewards of a foreign salary were seen as key to buying a house, providing support to families, and for female nurses in particular, to putting money aside for marriage as “dowry” payments. Although both male and female nurses expressed an interest in migration, the possibility to seek overseas employment was found to have particular social benefits for women. For example, an overseas salary can enable nurses to save for their marriage and in doing so, also presents them as more desirable marriage partners.

The study found notable differences in the profiles of prospective migrant nurses across the data set. Nurses who articulated an interest in overseas migration were typically in their 20s, working in private hospitals, unmarried, and came from Kerala. Five out of 16 nurses from Kerala were return migrants and six nurses expressed an intention to seek work abroad (n = 11). Of the five nurses who were reluctant to seek work abroad, three felt that such a decision would only have been possible before marriage. The other two nurses from Kerala explained that they had considered working overseas, but decided to stay in India as their husbands were not supportive of the idea.

In their interviews, both male and female nurses from Karnataka typically expressed less interest in migrating abroad than their Keralite colleagues and preferred to stay in India. Of the 34 nurses from Karnataka in the sample, 19 stated that they were not attracted to the idea of seeking nursing employment overseas. An additional nurse (59 years)
explained that she had previously explored the possibility of working abroad but did not pursue these plans due to family reasons. She now felt that it was “too late” in her career as she was close to retirement. Other nurses from Karnataka cited family reasons for their desire to stay in Bangalore, particularly the reluctance to leave parents and children behind and wanting to stay in India. However, eight nurses from Karnataka did highlight an interest in working overseas and mentioned similar reasons to nurses from Kerala, particularly the desire to gain knowledge, skills, and expertise and earning higher pay than in India (Johnson et al., 2014). Four nurses from Karnataka had already migrated abroad, of which three were return migrants and one currently lives in the United Kingdom.

Nurses across the data set frequently described themselves as part of larger social groupings that included family and community. Female nurses in the study often referred to their husbands, parents, and extended family members, including their in-laws, when discussing decisions around where to live and work. These findings reflect gender norms in decision-making processes for women and girls in Indian society. For example, before marriage, a young woman’s family and kin networks are instrumental in making decisions around key areas of life such as education, employment, and marriage. After marriage, decisions are frequently made in consultation with husbands and “in-laws.” For example, Rita, a nurse working in a private outpatient clinic, stated how though she was keen to work abroad, her husband was not willing to leave Bangalore, “He told me very frankly ‘ If you want to go, go! Forget about me.”

Concerns about leaving children in the care of others were also frequently highlighted by female nurses as a barrier to working abroad. Consequently, for many young nurses, migration was an experience to capitalize upon before marriage and family life. This may symbolize a period in nurses’ lives where there is more room for autonomous decision-making. For example, in discussing whether she had considered going abroad, Parvati stated,

Yeah, that was before marriage obviously. But now after having my child, maybe even after my marriage also, I even thought about going abroad. But after the delivery, then I just stopped thinking about going abroad.

Although male nurses appeared to be less constrained by gender norms that act upon women’s ability to demonstrate autonomous career decisions, male nurses also made key life decisions in consultation with their families. For example, young, unmarried male nurses looked to their parents for advice around their careers, many of whom had joined nursing upon the recommendation of their parents. Out of the seven male nurses interviewed in this study, six had joined nursing following the encouragement of their parents. One male nurse from Karnataka stated that he was not considering migrating overseas as his parents were not in favor of this, indicating that male nurses may also seek the approval and support of their families with regard to migration.

The interview narratives also demonstrated the importance of two types of networks in constructing a career in nursing—“social” and “professional.” “Social networks” include family, community, and nurse class mates and are mainly horizontal in that they function as a “news service” about available opportunities in nursing, including possible employment opportunities in Bangalore as well as working overseas. As Santosh described,

It’s a lot of networks because as you know, basically, in this field it’s like 95% Kerala people and it’s a lot of network between the staff, the students, and so, so many people from the same towns. There is a lot of networking, so somehow you come to know which hospital is having vacancies. Rather than coming to know from ads and all, it’s from the network itself.

Many of the younger respondents, in their 20s and early 30s, described how they had submitted their applications to particular hospitals in Bangalore because their friends were working there. The desire to work alongside friends indicated that rather than being a site of “competitiveness,” social networks were cohesive and supportive of individual careers.

Actually my goal is to go abroad. Means Australia or US. Because my friends are working there. They are telling it is a nice place, you come here, please come immediately. (Karthik, 34 years, private outpatient clinic)

“Professional networks” included other nurses and medical professionals who work at the hospitals. These are mainly vertical in that they assist nurses in learning about employment opportunities, writing reference letters, and providing recommendations for vacancy positions. Some nurses described how some doctors, with whom they had good interpersonal relationships within one hospital and who had subsequently moved to other hospitals, also continued to keep them informed of vacancies. Nurses also reported being frequently advised by doctors about potential career paths, such as choosing speciality areas within nursing or the potential for migrating abroad. Some nurses who described being assisted by doctors highlighted how they also came from the same “community,” for example, from the same town or state. Consequently, the reach of community ties within professional networks in hospitals and teaching institutions appeared to be extensive and fundamental to career decision-making.

**Collective Social Mobility and the Professional Project of Indian Nursing**

Given the historical association between nursing and low-status work, professionalizing strategies promoted by nursing’s
For nursing’s leadership, including the national Indian Nursing Council (INC) and its state-level body, the Karnataka Nursing Council (KNC), the low public image of nursing presents nurses with an important collective threat to claims for greater professional status. Professionalizing strategies put forward by nursing’s leaders therefore concentrated upon improving the image of nurses in the hospital environment, where this was perceived to have a “knock on” effect on the perception of nurses in wider Indian society. As a key note speaker at the state nursing conference urged his fellow nurses “Convince your patients and you will convince society!” Student nurses were encouraged to speak in English to their hospital colleagues and were discouraged from speaking in the vernacular which was seen to present a more “local” identity to patients and hospital staff rather than that of an assertive “global” nurse. In Bangalore, as in other large Indian cities, the effects of globalization have underlined the importance of English as a common professional medium of communication.

Among some nurse leaders, there was dismay that the emerging generation of nursing students were rejecting bedside nursing in favor of a career in specialized clinical areas, in hospital administration, and through pursuing further education—areas that would further their career trajectories in a competitive global health care market. For some nurses in the professional associations, the desire to move away from bedside nursing was undermining the traditional role of nurses to provide holistic care to patients. For others, engaging in many of the essential care activities required in bedside nursing was a waste of nursing “skill.” This group promoted specialization as a form of professional prestige and highlighted the importance of developing advanced nursing knowledge and skills in specialty areas as a way to modernize nursing practice and meet the expectations of 21st century health care. In many ways, the debate within nursing in India echoes the debate within nursing in other contexts in which a series of professional dilemmas are posed by the preference for increased specialization and educational qualifications in some quarters and the critique, in others, that these trends are driving nurses further away from the patient and have become a threat to occupational closure (Maben, Latter, & MacLeod Clark, 2007; Nelson, Gordon, & McGillion, 2002).

Diminished control over nursing knowledge was raised frequently as a challenge to professional status, where nursing education was described by many nurses as a “business” that threatened to undermine public confidence. Since the early 1990s, there has been a large increase in the number of private nursing schools and colleges in Bangalore offering nursing courses. The development of private nursing facilities came about largely to meet the demand for nurses both domestically and abroad, particularly in countries such as the United States that were reporting a large shortfall in their nursing workforce. These education facilities have attracted nursing students from surrounding states particularly Kerala—where despite its strong historical roots in Indian nursing has fewer available nursing spaces. The mushrooming of private nursing educational institutions has become a matter of concern for the INC and KNC particularly around the quality of instruction and insufficient facilities. This has resulted in the tightening of controls and the closure of a number of institutions.

Migration, on the other hand, was overwhelmingly depicted by nurses as an important social and economic “asset” for the profession, providing clear “evidence” of the “competency” of the Indian nurse. The perception of nurse migration as a positive development for Indian nursing was also supported by the presence of a Bangalore-based recruitment agency throughout the state level nursing conference. The recruitment agency set up an information stand within the main conference hall, and their representatives gave a presentation to the audience on opportunities for nurse migration particularly to the United States. In addition, while senior nurse managers did highlight the logistical challenges in providing nursing care due to high rates of staff turnover in some hospitals, as well as the difficulties in finding qualified MSc and PhD nursing staff to teach courses and supervise students, they were supportive of their staff members’ plans to apply for overseas positions, often giving them time off to attend interviews or sit the relevant examinations.

Furthermore, migration was viewed as a key means to improve the professional and social standing of nurses in India. In their testimonies, nurses frequently highlighted the low pay of nurses, stating that their pay levels reflected those of “unskilled” workers rather than medical professionals. A speaker at the nursing conference passionately told the audience, “Let India be empty of nurses and then they will acknowledge us!”—a sentiment which suggests that at the political level, migration functions as a rationale to press for changes in working conditions and salary levels in Indian hospitals. Consequently, as migration offers the potential for individual social and economic mobility for migrating nurses, it is also a strategy to achieve collective social mobility.
Discussion

The confluence of local and global perspectives characterizes the professional project of nursing in contemporary India in which nurses are seeking to carve a new identity both within the Indian medical system and in wider Indian society (Johnson et al., 2014). This research supports other studies that describe the dual function of migration—both as an individual life strategy (Nair & Percot, 2011) and as a collective bargaining tool for the nursing profession (Timmons, Evans, & Nair, 2016). As demonstrated by the interview data, the career paths of nurses into nursing education, advanced nursing practice in specialty areas, and the decision to migrate abroad has resulted in a profession that is increasingly diversifying. For nurses in Bangalore, globalization has introduced the potential for status renewal through the incorporation of new technologies into nursing practice and the prospect of global employment. As reported by Walton-Roberts and colleagues (2017), rather than being a “hidden” process, this research found that migration was discussed openly by Indian nurses. Moreover, the international recruitment of nurses is a profitable industry with tie-ups between overseas and India hospitals in the training and recruitment of Indian nurses, where Bangalore has emerged as one of the three main recruitment hubs in India along with Delhi and Kochi (Khadria, 2007). Consequently, migration to Bangalore is one step along the migratory pathway for many nurses from Kerala who are able to gain work experience in the city’s various private hospitals before applying for positions abroad. For other nurses, Bangalore is a large, cosmopolitan city, and working in Bangalore may be viewed as “equivalent” to moving abroad. These nurses, particularly from rural Karnataka, explained that migrating to Bangalore was itself considered an important transition and that their families would not be supportive of their desire to leave India.

Compared with nurses from Karnataka, the pronounced interest in migration among Keralite nurses is well supported by the literature on nurse migration from India (Nair, 2012; Nair & Percot, 2011; Walton-Roberts et al., 2017). This study found that the decision to migrate is often “communal” and influenced by the existence of overseas community networks, as well as family and spousal support. These features were particularly evident in the narratives of nurses from Kerala, many of whom had relatives and friends already abroad (Johnson et al., 2014). The Keralite community has a long history of international migration in nursing and thus the presence of an international network of friends and family acted as a strong incentive to pursue nursing work overseas.

Where career aspirations of health workers have been examined in empirical research, overseas employment is frequently depicted as the career decision for health workers from low- and middle-income countries. While the findings of this research do concur with studies examining the factors behind nurse migration from India, such as dissatisfaction with employment conditions in Indian hospitals and perceptions of better salaries abroad, the possibility of professional development, and the potential to join family overseas (Hawkes et al., 2009; Thomas, 2006; Walton-Roberts et al., 2017), this study of nurses working in Bangalore is one of the few that embeds the decision of whether or not to seek overseas employment among other career decisions routinely faced by nurses in India during their working lives.

The landscape of global public health is continually shifting, partly as a result of the social and economic changes brought about by globalization, as well political considerations. Since this study was carried out, there have been important geopolitical events including “Brexit” and restrictions on the recruitment of international workers to countries such as the United States that will affect the career plans of health workers, including nurses, looking to work outside their countries of origin. It is too early to anticipate what this may mean for the career trajectories of Indian nurses or for enrolment into the nursing profession itself in India. However, as this study has illustrated, the decision to migrate overseas for nursing employment is one aspect of the career trajectories of nurses in India. While not all nurses wish to migrate, globalization and international migration have important implications for nurses’ professional identity as an occupational group. In addition, urban centers such as Bangalore that are characterized by fast-growing global opportunities offer nurses the possibility to work in large hospital set-ups where they can enter specialty fields, move into nursing education, or gain exposure to new medical technologies, in addition to developing the skills required to seek a nursing position abroad.

The research findings show that the notion of a meaningful career has great resonance among Indian nurses and plays a far more important role in work-related decisions than has been attributed to-date in the literature. Nursing careers in the study setting were not restricted to climbing the nursing hierarchy, but involved a series of lateral work roles in different clinical settings, institutional contexts, and overseas placements. Careers were found to be flexible and agential, where career achievement was characterized by skills acquisition, learning, enjoyment of nursing work, and professional autonomy in addition to material rewards. Career stagnation was found to be a concern of nurses across the data set, where this was characterized by the absence of opportunities for additional knowledge and skills. Whereas policy-level discourses around migration have focused on individual “push” and “pull” factors that encourage international nurse migration, these discourses could be expanded to include concerns around professional autonomy, career incentives, and professional status.

This research is also one of the few that has looked at the negotiation of professional boundaries between nursing and medicine in India and the implications for professional identity. While nurses accepted that medicine was the dominant
paradigm over treatment decisions, they resisted any attempt to bring nursing under the purview of medicine and asserted a distinctive identity. As has been found elsewhere, the treatment/care divide is often more symbolic than functional in that such boundary lines may shift or be unclear when providing health care to patients within a hospital setting (Allen, 2015; Miers, 2010; Niezen & Mathijssen, 2014). As this research was not an ethnographic study, a more detailed “in situ” analysis of nursing practice in Indian hospitals would provide greater insight into boundary negotiation between nursing and medicine.

Finally, the tension observed in the narratives among the profession’s leaders that juxtaposed “holistic” general nursing against fragmented, “specialized” nursing was not seen to be as significant for nurses working in hospital practice. The majority of hospital nurses supported increased educational qualifications and clinical specialization toward building a “professional” image of nursing in India. At the same time, Indian nurses also strongly emphasized the importance of holistic care in their narratives. Therefore, while nursing’s leaders presented a tension between modern and traditional visions of nursing, hospital nurses were found to reconcile both these visions in their descriptions of their daily lives as nurses and in their hopes for the future.

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