

Civil servant and professional – understanding the challenges of being a public service doctor in a plural health care setting in rural South Africa

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This work is dedicated to Großmutter and Tante Mukka.

Abstract

Using insider-ethnography the study is an exploration of the experiences of public sector doctors in a rural hospital in KwaZulu-Natal. In the context of a complex policy environment as well as a stressed public sector struggling to meet its constitutional obligations, the daily work of public sector doctors is at the civil service professional intersection. Engagement at this intersection is strongly influenced by the local context of the individuals and communities served. Interactions are also shaped by the local plural health care system where public sector doctors, private general practitioners and traditional healers form complex networks that are largely informal and dependent on personal relationships.

The study uses Lipsky's street-level bureaucracy as a theoretical framework to understand and explore the challenges of being a professional, a bureaucrat and a public official in the public health care sector. In interpreting the rules of their various roles they make many complex decisions that require considerable discretion. In this, their daily work as civil servant doctors remains largely regulated and managed locally by the doctors themselves.

The convergence of the roles of professional and civil servant provides public sector doctors leverage to synergistically use discretion individually and collectively within their daily work. While discretion is abused at times, in the setting of a larger system struggling to deliver services, many of public sector doctors voluntarily align their activities and practices with the ideals of providing a high quality care to the population served. In this discretionary practice is vital for the service to function.

While bureaucratic and professional standards of practices create distance and detachment from the people they serve, in their interaction with colleagues and the public care and caring is evident. Critically, caring is contingent on the space that discretion provides doctors to engage. These findings have considerable implications for how the work of public sector doctors is conceptualized, planned and managed.

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV's	Antiretrovirals
CBO's	Community-based organisations
COPC	Community-oriented primary care
GP's	General Practitioners
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
NGO's	Non-governmental organisations
OPD	Out-patients department
PHC	Primary Health Care
RWOPS	Remunerative work outside of the public sector
SASSA	South African Social Security Agency
STI	Sexually-transmitted illness
TB	Tuberculosis

Chapter 1: Introduction

“I was based at clinic Site B in Khayalitsha during the second half of my community service. I saw about 50 patients a day in quick succession. I processed them as quickly as I could, treating their symptoms with whatever medication was available.

Along with anger, frustration became my constant companion. I wanted to help, but sometimes felt that my medical training, with its strong emphasis on the scientific method and curative approach, was inadequate to give my patients what they really needed. Often they came to me not with medical problems but because I was the last resource.

When the man walked into my consulting room I instinctively straightened up. He reminded me of someone’s uncle. He had that uprightness that marked him as a respected member of the community.

“What can I do for you, tata?” I began when he was seated.

“Doctor, I am not working,” he responded. “My children are hungry, doctor,” he said.

“I am sorry to hear that, tata,” I said, but he did not seem to register it.

“I am asking you for a grant, doctor” he said and produced a carefully folded application form from one of his coat pockets.

“A disability grant?” I asked.

I’d had this conversation dozens of times in the months I’d been at the clinic. In desperation, patients come to ask to be declared disabled so they could claim a government grant. The application required a doctor’s assessment and a declaration that the patient’s condition precluded him or her from performing work in the future.”(1)

In the above quote from “Postmortem – the doctor who walked away” Maria Phalime(1) outlines some of the difficulties of practicing medicine at the forefront of the public sector. The experience she describes, as will become evident in this study, is not an exception. Doctors’ practice encounters in the public sector are overlaid with culture, history, economics and poverty – the larger societal context that medicine is practiced in. Yet in working as a doctor in

the public sector, one is asked to meet specific expectations from patients, colleagues and managers, which shape how one works and how one makes sense of the work.

This is the terrain of the doctor as civil servant.

Little studied, the workplace of public service is where a substantial part of service delivery in South African society actually takes place.(2) Public service is the physical and personal interface between civil servants and citizens. It is a set of interactions that shape the experiences of citizens accessing public sector services.

While the work of civil servants is only poorly understood, the working context of the doctor is further shrouded in professional mystique that arises from professional codes of practice, including doctor-patient confidentiality and long-established legal and social traditions that remove these interactions from the public eye. Where there is an enquiry, as in the classic text by Balint(3), it engages the doctor-patient relationship from a therapeutic perspective and does not explore it as part of the work of the civil servant.

Although the workplace of state doctors is the public sector, their work context is a plural health care system that includes private allopathic and traditional medicine service providers. Precisely how these services interface with public service doctors is under-researched. What is known is that the people served use a range of services, including those of the public sector. The use of multiple services in the plural health care system also influences the way public sector doctors engage with other segments of the larger system and how they approach the care they provide.

Public health care services are part of the state.(4) In the act of accessing public health care services patients realize their rights as citizens.(5, 6) Doctors in the system simultaneously act as professionals and as agents of the state, making the interactions between patients and doctors one between citizens and the state. From his work on how frontline state workers experience and make sense of their work in the public services, Lipsky(7) conceptualized the way they implement policy as street-level bureaucracy and civil servants as street-level bureaucrats.

Aim of study

The aim of this study is to investigate the experiences of public sector doctors in a rural hospital in the context of a plural health care system. Using Lipsky's concept of street-level bureaucracy, the study focuses on doctors' daily decision making and routines and the way they manage their work in the public health care services, as well as their interactions with other arms of the plural health care system. The study is conceptualized within the framework of health systems research and policy implementation, as an empirical qualitative enquiry into healthcare delivery at the interfaces between the clinician as professional and bureaucrat and patients, the public, other health care professionals practitioners and bureaucrats.

Relevance of the study

Post 1994 the challenge of transforming and expanding the public sector to integrate and achieve an equitable system resulted in a stressed and volatile health care system. Important system level changes notwithstanding, service delivery depends on the interactions of public sector doctors with patient-citizens within the wider health care system. This fact and a weak understanding of how street-level bureaucracy works has led to the call for research into this area of enquiry in health systems policy research.(8, 9) No other studies exploring the experiences of doctors as street-level bureaucrats in developing countries were found in the literature.

The study of the experience and functioning of doctors as civil servants is an aspect of health systems research and policy implementation. It also encompasses a wide range of disciplines and sub-disciplines, including public administration (Lipsky), the sociology of work,(2) policy research,(10, 11) human rights research,(12) and the study of professionalism.(13), as well as medical education and training, as the latter concerns the extent of doctors' preparedness for their roles.

Outline of the thesis

Following this introduction (Chapter 1), Chapter 2 briefly explores the background of medical professionalism, the context of post-apartheid public sector development and the current state of the public sector. I also set out a theoretical framework, which focuses on Lipsky's theory of street-level bureaucracy as the conceptual tool that I use to explore doctors as civil servants.

Chapter 3 describes some of the historical, geographic and contextual background of the area where the study was conducted, followed by the chapter on the description of the methodology and research methods used in this study. The chapter covers the processes involved in data collection, analysis as well as some of the methodological and ethical considerations for the study. Chapters 5, 6 and 7 set out the main research findings and describe public sector doctors in three key intersecting roles.

Chapter 5 explores public sector doctors' role as professionals. The professional identity of being a doctor is based on social norms and legal frameworks; yet in the experience of working as a rural public sector doctor, the application of the rules is not straightforward and requires considerable discretion in order that locally relevant choices can be made. Within the public sector, doctors have considerable freedom to arrange their work, develop local rules and make the arrangements that shape their daily routines.

Chapter 6 explores public sector doctors' role as bureaucrats. Doctors are required to fulfil social and other functions that extend beyond a clinical, medical care remit. As state functionaries they regulate the extent of citizens' access to resources and to a lesser extent how this access is structured.

Through the example of the disability grant application process, Chapter 7 explores the role of public sector doctors as officials in the public sector who act on behalf of the state. Chapters 8 and 9 explore their relationship to two key arms of the plural health care system –the private sector and traditional medicine. These two key arms exist in symbiotic tension with public health care services, both competing with and complementing them.

Chapter 10 discusses the key findings of the study, drawing the main argument of the thesis together. It explores the nature of discretion from the perspective of tasks, rules and values and reflects on the nature of the work of the public sector doctor.

The final chapter (Chapter 11) concludes the thesis.

Chapter 2: Background

Introduction

Doctors find they function both as a specific group in the state and often parallel to private medical practitioners and traditional healers as part of the larger, plural health care system. In this chapter I look at some key issues related to doctors as professionals, the function of the public sector and that of the plural health care system.

Doctors as a professional group

As a professional group, doctors enjoy high social status. In South Africa, as in many regions of the world, the profession is believed to have high ethical standards, a high degree of independence and autonomy, and is assumed to draw its practices from sound scientific evidence.(13-15) Further, it is believed that philanthropy frames the profession's work ethic (13, 16, 17). Yet, the profession finds itself under threat(18) and its standing is challenged globally by a multiplicity of complex factors, including the limits of its own influence.

In South Africa, as in many other countries of the world, the profession is regulated by legislation. Doctors are required to actively register with the Health Professions Council of South Africa (HPCSA) in order to practise and by so doing they are expected to meet the practice standards that have been developed and are enforced by the HPCSA. Many of the principles of professional practice that doctors are expected to uphold are construed as universal truths, to be applied irrespective of place and context.(14, 17)

Besides regulations on registration and continuing professional development, the HPCSA is a scientific bureaucracy(19) that creates, disseminates and regulates the implementation of what are considered to be scientific standards through protocols and treatment guidelines. In line with the way that the profession understands itself, the gold standard of practice is largely defined by evidence-based medicine. The HPCSA also plays an important role in upholding ethical standards and responding appropriately to the way practitioners practice.

The medical profession has all the characteristics of professions in general.(20) As such it is held to be a calling or vocation that has a distinctive and evolving knowledge base, determines its own standards, and is self-regulating. A key component of medicine is that the profession is

guided by ethical principles and the ideal of being accountable, particularly to patients and the profession itself.(14) Under the broad banner of biomedicine, the profession is often portrayed as homogeneous. In fact, however, it is both heterogeneous and complex. Many divergent approaches and philosophies coexist, often uncomfortably, between and even within different disciplines and specialisations. Despite this fact, within the profession there remains a fundamental subscription to the idea of being a doctor and the social and ethical dimensions that such a designation implies.(13)

Family Medicine and Rural Health

The discipline of Family Medicine has recently been legislated as a specialist discipline in South Africa and has steadily gained in status within the medical profession. Family Medicine focuses on the person with an illness rather than on a disease process.(21) Accordingly, medical practice centres on the patient-doctor relationship in the context of their family and community lives and regards the doctor as resource for both patients and the communities where they work.(21) Community-oriented primary care (COPC) in particular, initially developed by Sydney and Emily Kark,(22, 23) explicitly links clinical care with community-level engagement. It moves the action of the doctor from being limited to the hospital or practice to also engaging in the social drivers of health and disease.

This paradigm within family medicine resonates with approaches in rural health (24) and in a number of countries family medicine-based approaches are central in how services are delivered to rural populations (e.g., the United Kingdom Canada or Australia). At the time of the research, however, COPC had still to be incorporated as an approach to primary care in the formal health care system.

In resource-limited settings the role of doctors in rural health has also received extensive attention.(25-28) While family medicine has provided an important theoretical context for rural health, the discourse has shifted beyond strictly family medicine and included human resource issues,(27, 29-31) health professional education(32) and health systems issues.(33, 34)

The public sector and the doctor employed by the state in South Africa

In South Africa, doctors provide clinical services at all levels of the public health care system – and in most cases are employed specifically for the clinical service and specialist function that they perform. At the regional and tertiary levels most of the medical services are structured around medical specialist disciplines.

At the district level – and particularly in rural areas – most doctors work as generalists. Even though the range of skills required of them extends beyond the way the discipline of family medicine has been conceptualized, the underlying principles resonate in rural public sector settings. The importance of the doctor-patient relationship(21) is congruent with the approaches advocated in the White Paper, “Transforming Public Service Delivery”.(35) Furthermore, the principles of the district health care system and the primary health care approach taken by the South African Government (35, 36) are based on much more holistic conceptions of health as well as the response of the health care system.(37, 38)

The scope of skills that is required for functioning as a generalist within the public sector at district level goes beyond clinical skills(39). Fields such as leadership, engaging with communities and managing community-level interventions become critical in the successful functioning of the system. Even the clinical engagement needs to be context sensitive and be understood in terms of the referral systems and being or tailoring clinical decisions to a particularly resource constraint.

Within the public sector, doctors form an integral part of the team of frontline workers or agents in the public health care sector that interact with the citizenry and play a key role in providing a service. The tension between the clinical process (as professionals) and what is perceived to be a bureaucratic process (as agents of the state) leaves doctors often frustrated and feeling helpless.(40) This complexity has been described as a ‘double-bind’ for doctors working within the perceived constraints of the public health care system.(41)

Background in understanding the public sector

A particular interest in this study is the role of the doctor working within the public sector.

Michael Lipsky(7) coined the term street-level bureaucracy to describe the context of the front-

line officials in the public services. The street-level bureaucrats are public officials that interact directly with the people that make use of the service – such as social welfare workers or police officers.(7) Doctors interacting directly with the patients using the public health care sector therefore fit this definition. Lipsky argues that the street-level bureaucrats are faced with a dilemma that revolves around a policy imperative that guides the objectives of the public service they are working in, and a situation that is too complex and context specific for regulations and policies to be applied uniformly.(7) Lipsky explores the nature of the dilemma of street-level bureaucrats extensively, including the inherent contradictions of some policies and working in a situation where the resources are limited and where the demand outweighs the available services or resources for the policy imperatives to be fulfilled.(7, 42) He also recognizes that much of the implementation of a seemingly sterile policy takes place in the context of human relations and interactions, where street-level bureaucrats respond to the human needs beyond the confines of the policy.

Lipsky argues that street-level bureaucrats attempt to resolve the dilemma by using their discretion in interpreting policy regarding how the services and resources are to be allocated in the local context.(43) Discretion, as defined by the Oxford Dictionary is “the freedom to decide or act according to one’s own will or judgment”.(44) Hill and Hupe(45) referring to the tension around discretion for public officials in the legal field, describe the nature of discretion as “the extent to which behaviour of public officials can and / or should be precisely prescribed by laws, or conversely about the extent to which officials need to use their discretion to interpret and under some circumstances modify the impact of the law” (pg. 38-39).

In the daily decisions that street-level bureaucrats face, they need to apply their discretion to manage the tension between the generalized rules and the specific local situations that demand a flexible response.(46) This use of discretion, Lipsky argues, implies that the street-level bureaucrats ‘make policy’(7) (p.13).

The character of the street-level bureaucracy as described by Lipsky came out of a particular context of welfare services in the US and Europe in the second half of the twentieth century,(47-49) where the public service was characterized as technocratic and hierarchical,

with a long tradition of top-down policy implementation.(46, 49, 50); Lipsky's theory, however, has been found to be useful and relevant in many different settings and in a range of different public sector structures and management processes.(42, 43, 47, 51-55) The underlying tenet of the dilemma of the street-level bureaucrat in the implementation of policy in context seems to remain relevant. However, there is a very limited literature on street-level bureaucracy in the setting of health services in the public sector of developing counties.(56, 57)

Public sector in post-apartheid South Africa – policy context

In South Africa, the apartheid state had used the public administration as a tool to develop and maintain its divisive policies that entrenched inequity.(58, 59) The engagement with the public sector formed the basis of how citizens experienced the unjust policies of the state.(60)

In the new democratic dispensation, the public sector has a fundamentally different obligation.(61, 62) The rights-based constitution requires the state to progressively realize the socio-economic rights as expressed in Section 27 of the Constitution(63) and the public service is the main vehicle through which the state aims to fulfil its mandate.(64, 65)

Many of the policies translating the constitutional imperative to provide services to all citizens have been hailed as exemplary worldwide.(59) The challenge facing the public sector policies was not only to transform the service delivery, but also to expand the public service from its fractured and inequitable base to reach all citizens in an equitable manner.(65, 66) The focus of much of the reforms post-1994 has been to establish a unitary public sector out of the multiple and fragmented public administrations under apartheid, as each homeland in South Africa at the time had its own administration as well as national, provincial and local levels of government.(67) Post-1994, the public sector went through a process of rationalisation and transformation,(68) focusing more on a developmental approach and attempting to improve efficiency and service delivery.(69, 70)

Accountability and citizenship

The public service needs to be understood in the context of the governmental structures that are outlined in the constitution of the country. The three spheres of government – national, provincial and local – each have different mandates and responsibilities for the delivery of an

array of services. The public sector is structured to align itself with the spheres of government to deliver on the specific mandate. In health, the national Department of Health has an oversight and policy mandate, while the implementation of health care services mostly rests with the provincial departments of health (except for some environmental health components that rest with local government).(71)

The accountability structure of the post-apartheid public sector is complex and is characterised by a dual accountability centring on the implementation of the policies – to the public and to the politicians.(70) In each sphere of government, the various public sector departments are accountable to the political head. In local government this political head is the mayor, in provincial government by the Members of the Executive Council (MECs), who are in turn accountable to the premier of the province. At national level, the public sector Department of Health is accountable directly to the National Minister of Health.

Participation of citizens and community

Besides the accountability to the political head, the South African constitution emphasises the state's and the public sector's accountability to the citizens and communities of the country. The constitution implies that the relationship of the state to its citizens is characterised by an attempt to transform the procedural democracy into participatory democracy.(72, 73) In relation to the public service, this is reflected in the Batho Pele^a principles(74) that are aimed at a citizen-centered approach to the public service. The principles emphasise improved service delivery and accountability to individual 'users' of the service and communities.

However, exactly what constitutes community and how communities actually participate in the decision-making process is not clear beyond the procedural democracy of the individual citizen. Policies in the public health care system are particularly open to community responsiveness and have the potential of a high degree of participation and control.(75) However, this translates into an expectation of "much higher capacity of agency"(76) , which places a greater burden on the citizens both as individuals acting at community level (in the drive for volunteerism such as home-based care) and collectively as communities. In order to engage effectively with the

1 'Batho Pele' is translated as *People first*

state, individuals and communities require extensive knowledge and understanding of regulations. However, in this light the concept of community at times translates into unfunded (or under-funded) self-help of already impoverished populations.(77) And so the rhetoric of a participatory government and engagement with the needs of the citizens has in many instances become hollow, with a rigid and inefficient bureaucracy not tolerating much real participation.(61, 66, 78) Those in power lapse into procedure, those not in power clamour for participation. The process of this conflict influences the expectations and understanding of the roles and responsibilities that citizens have: from passive recipients of services in a welfare state to active participants in determining and co-providing of service delivery.(61)

At an individual level, being a patient (a person who is ill and seeks help within the public sector) also shapes a particular state of citizenship.(41) The role is actively constructed(79) where social- and economic status to some degree determine the type of care that the ill person receives. An extension of this is the concept of biological citizenship where the specific illness and disability determines the person's/citizen's relationship with the state(80) and/or his/her citizenship within the community.(5) A striking South African example of this is the state's changing response to HIV/AIDS and how people with HIV define themselves in relation to the state.(65, 81)

For the street-level bureaucrat a number of tensions that concern accountability are evident. The accountability to the top-down policies and how politicians interpret the policy is juxtaposed to the accountability to communities and patients. The Batho Pele principles(74) are aimed at a citizen-centered approach to the public service and emphasise improved service delivery and accountability to individual 'users' of the service and communities. The expectation of public servants has changed from simple service provision to an expectation of continuous examination (and correction) of barriers to access and utilisation of that service.(65, 70) The rhetoric of the service being responsive to the needs of individuals and communities(61) articulates a new value system that the public service is expected to reflect.(76)

Complex policy environment

The fairly straightforward policy imperative of health care provision to the population of South Africa needed to be articulated in the larger context of post-apartheid development of a new state(59). The notions of the new democracy in South Africa determine the relationship of the state to its citizens, creating a contested terrain. Piper(76) argues that these developments resonate with the notion of progressive governance where the governance of service delivery is not exclusively a state responsibility; rather, the degree of direct influence the state has on implementing state policies is tempered by citizens' and communities' interest and engagement. This can be seen in the social mobilisation and political subjectivity around HIV/AIDS.(81)

Yet, beyond the state's relationship with its citizens, there is a complex environment of external drivers, competing demands and divergent expectations that influence the nature of the public service. The public sector has been seen as an instrument of policy implementation not only at the level of the service that it renders, but also in how the transformation of the public service itself would assist the agenda of the new political dispensation.(60)

One such policy has been to focus on racial redress within the public sector,(66) in an attempt to correct the structural drivers of the racist policies of the previous government. This also was linked to political deployment in critical positions by the newly ruling party as a strategy of transforming the ethos and ideology of the public sector. The effect of this has been that a loss of organizational memory and capacity, which has negatively impacted the public sector.(82)

A further policy initiative influencing the nature of the public sector was the shift toward neo-liberal approaches of government. These policies affected the public sector well beyond health care.(59, 69, 83-85) A range of regulations and pieces of legislation were introduced that supported the corporatization of the management of the public sector. Furthermore, a range of services was outsourced to the private sector and systems and processes instituted within the public service were modelled after those of the private sector.(60, 61, 69) Many of the processes were not supported by the structures or authority that would be required to implement the system meaningfully. For instance, an incentive-based performance

management system that was introduced throughout the public service was difficult to implement when provinces controlled promotion and remuneration centrally.

The process of corporatization of the services influence how the citizen or the patient is seen in relation to the service: rather than being a person that is in the care of a clinician (a patient) the person is described as a consumer, user or client of the service. Case in point: the language of the Mental Health Act(86)referring to ‘mental health users’. The impact of being a ‘consumer’ or ‘user’ rather than a patient implies a commodification of the service (84) and changes the relationship that the service provider has with the recipient of the care.

The multitude of policy initiatives that impacted on health care services appears to be contradictory: public service needed to expand to meet its constitutional obligations of serving the whole population rather than a small elite, while at the same time was expected to shrink, privatize and become more cost effective; it was expected to transform racially and simultaneously retain its capacity and organizational memory of how to manage services; it was expected to implement top-down policy directives but be locally accountable and develop participatory decision-making processes.

Assessment of public sector functioning

The public health care sector is still perceived to be a poor service, bureaucratic and third rate.(40, 87) It appears that the bureaucratic institutions in the newly democratic state frustrate the implementation of participatory democracy.(72) The performance indicators confirm that the public health service is stressed and struggles to meet the expectations of the public.(65, 88, 89)

Limited capacity within the public sector to manage the current service and to implement new policy has been identified as a key component underlying the deterioration of service delivery.(61, 89, 90) Capacity-limitations were also coupled with a failure of governance and meaningful oversight.(67) Within the national and provincial Departments of Health there had not been any comprehensive transformation plan at the time of the study(89, 91) and insufficient attention had been given to actual implementation and improvement of coverage

and quality of health care service. The South African health care system seems to be dysfunctional and failing.(40, 89)

The provincial Department of Health in KwaZulu-Natal in particular has been plagued by poor service delivery, corruption and inefficiencies.(89, 91) The provincial department is characterized by a hierarchical structure and overly centralized decision-making processes with poor levels of accountability or transparency. Financial, supply chain and human resource management has been found to be generally poor, failing to adequately support the implementation of services.(89)

Unfortunately, inefficiencies and failures of the bureaucracy have not only been evident within the provincial structures. The relationship between the provincial structures and hospital management has promoted 'over-adherence to rules'(92)and the management of public sector hospitals has also been described as dysfunctional.(2, 93) There is a limited capacity to effectively respond to the demands of managing profoundly complex systems.(94)

Plural health care system: private and traditional health

Up to now I have described the public sector and its obligation to the citizens of the country. However, the public sector functions in a larger system of health care and is certainly not the only provider of services.(95) When someone becomes ill, the health-care-seeking process involves a complex decision-making process that includes a number of role players cutting across traditions, services and providers. There seems to be a high level of variation of utilization of services with a wide range of possible configurations.(95-97) These can include concurrent or sequential use of multiple public sector services at different points of service delivery, the private sector (again, multiple providers possible), traditional and spiritual healers, and home remedies and over-the-counter medications from pharmacies and other commercial outlets.(98, 99)

An implication of the concurrent treatment of patients is that private practitioners and traditional healers treat essentially the same population as public sector doctors. In a study from Northern KwaZulu-Natal,(100) based on 1200 verbal autopsies, it was found that the vast majority of people that died had consulted the public health care system. On top of that, of the

sample, 90% of people who had consulted a public sector clinic had also visited a private doctor and 50% had also consulted traditional healers.(100)

This pluralistic health care system is driven by the health-care choices of patients and their families. These choices are influenced by a range of factors, including cultural and historical reasons, the ability to pay for services as well as the availability of services. It is widely recognized that many patients have a syncretic worldview – holding a traditional worldview while at the same time accepting scientific or social explanations of diseases and treatments. In this manner, patients often access a range of services concurrently.(67, 101, 102) The use of concurrent health care services provides a particular interface in the public-private sector relationship that is central to how public sector doctors experience the private sector.

Private health care

The private health care sector in South Africa prides itself in the service standards it offers users.(103) The clinical outcomes, particularly when analysed in relation to procedural interventions, are comparable with medical services in industrialized countries that are deemed leaders in health care.(98) The private health care sector in South Africa is also able to rapidly take up new and internationally recognized technological advances and developments and make these available locally. A number of highly specialized units (such as transplant units, assisted reproduction or neurosurgical units) are available in all the major urban centres of the country. In medical terms, the focus of the private sector is on the use of technology, curative services as well as the hotel and comfort aspects of care. (98) However, the private sector is not homogeneous in terms of models for service provision and funding. A wide variety of arrangements exists with all the parties concerned, which include patients, doctors, medical aid schemes, employers, the state and unions to mention a few. The common models from the perspective of the health care providers include ‘contracted-in’ and ‘contracted-out’ medical aid provisioning, group practices and private hospital companies, single-owner practices and cash practices.(103)

The public-private interface

The relationship of the private health care sector with the state is ambiguous. The degree of regulation by the state is often interpreted as interference and over-regulation, while the state

views its role as one of stewardship of the private health care sector.(104) In the literature, public and private health care systems are portrayed as being separate or even competitive. This portrayal is reflected to some degree in the attitudes of both private and public sector doctors as well. Yet, both in terms of actions and certainly in terms of patient choices, the terrain is much more nuanced and complex. What kind of service is going to be accessed by how many people is often determined by individuals' insurance status.(105) Since as many private practices insist on cash payments and do not apply the fee structures suggested by the medical insurance companies, the actual utilization of private health care services is more complex than existing data on insured populations suggest.

Most of the comparisons between the private and public sector have been at the level of resourcing and funding.(11, 105-108) While there is a paucity of accurate data regarding the public/private distribution of resources, in terms of human resources and staffing, it is estimated that in 1998-1999 about 72.6% of general practitioners and 75.2% of the medical specialists worked in the private sector.(11) Similarly, the ratio of medical practitioners per population served in the public sector in 2007 was estimated to be 1/4219 while in the private sector it was estimated to be 1/601.(11)

In comparison to the distribution of health care workers, the pattern of financing of the health care system shows similar inequity. While South Africa spends approximately 8.3% of its GDP on health care (2002 figures), approximately 50% to 60% of the expenditure is within the private sector, of which the majority is paid to private hospital groups via medical aid financing.(109) It was estimated that the private health care sector provided care for less than 20% of the population of South Africa yet utilised 65% of the funds spent on health care in South Africa.(107) This trend has only shifted only marginally over the past decade.(67, 108)

At a policy level, much of the interaction between the public and private sector at a policy level is viewed from the perspective of resourcing – in particular, public-private partnerships. Most examples of such partnerships are found in the technology-intensive tertiary care settings focusing on co-financing of expensive equipment between the state and private sector investment.(110) Most of the central hospitals in the public sector have such ventures as part

of their funding model. A few initiatives focus on such public-private partnerships, but overall there is no consistent integration of public and private health care.(11, 67, 110)

Besides public-private partnerships there is some degree of contracting of services, mostly in the form of locums by the public sector from doctors otherwise in private practice. Similar to this practice an increasing number of private doctors do sessional work (for a set number of hours per week) since the remuneration rates in the public sector have improved dramatically as part of the Occupational Specific Dispensation framework. Sessional work has become more widespread also in rural areas, particularly for the cover of after-hours work.(11)

The private sector in primary care

As mentioned, the private sector has a strong focus on high-tech medicine and offers a much greater range of specialist services than the public sector. It is much easier to access specialist care in the private sector,(11) as specialist care can be accessed directly, without referral from a generalist.

General practitioners, some private pharmacies, and a small number of independent primary health care nurses offer Private Primary Health Care (PHC) services. PHC services include treatment of common illnesses and, particularly in the case of the pharmacies, screening for common illnesses, immunization services and health promotion and prevention.

There is a large non-governmental- and not-for-profit sector in South Africa that also falls outside of the public service. In some cases there is greater impetus for this sector to share its services with the public sector, rather than remaining separate.(111) Many of these organisations offer relatively specific services, such as specific programmatic interventions like prevention of mother-to-child transmission (PMTCT) of HIV or nutritional support for malnourished children.

The trend in private care, however, is to focus on the aspects of health care that have higher financial returns; community-level services are generally more resource intensive for a lower financial return. Even if the preventative return is greater in the long run, this does not

translate easily into financial returns and therefore is less attractive to profit-driven endeavours.

Private care in rural areas

In South Africa, as elsewhere around the world, there are much fewer private health care facilities in rural areas than in urban centres.(33) More specifically, the concentration of private hospitals in rural provinces is dramatically lower than in the urban provinces. For instance, in 2002 the number of private hospitals per 100 000 persons was 0.11 in Limpopo, 0.32 in the Eastern Cape and 0.35 in the Northern Cape, while in the provinces with the largest urban populations it was 7.39 in the Western Cape and 22.72 in Gauteng.(33)

The majority of private health care services in rural areas are general practices and most are a mixture of a small number of medical aid-insured patients with the majority of income arising from patients paying cash.(111) This reflects the economic base for the private service. As a result, general practitioners in rural areas have fewer local options for referrals for specialist opinions, radiological examinations or options for admission to private hospitals. The private general practitioners therefore refer either to the local public sector hospital unless the patients are insured unless they can afford to be referred to urban centres for specific medical conditions.(33) The reliance on the public sector as a first stop for health care further increases the interaction between the public and private sectors.

Traditional healers

Traditional healers are ubiquitous in southern Africa, as throughout the world.(112) The number of people using traditional healers in South Africa is often quoted as being up to 80% of the population(113) but this has been challenged by empirical studies, with use of traditional medicine varying according to location, the condition and local practices. A study conducted in the Bergville area in 1990(114) focused on the use of 'isihlambezo' (a traditional medicine/tonic consisting of a range of mostly herbs that is used during pregnancy). The Bergville study found the use of 'isihlambezo' was around 75% for patients delivering at the clinics. Another study at Emmaus Hospital in 2008(115) assessed the use of traditional medicines among HIV-positive patients and found that 36.7% of patients initiating ARVs were ingesting herbal medicines. This

percentage remained fairly constant a year later.(115) In the analysis of verbal autopsies in Umkhanyakude in Northern KwaZulu-Natal, as mentioned earlier(100) , the use of traditional healers was 50% and in the household survey of Statistics South Africa only 0,4% of respondents indicated that they used traditional medicine.(116) It is evident from the literature that it is critical to understand the definition of traditional medicine used within the specific study, and that the local context in which the data is collected influences the reported findings.

Traditional healing practices are based on the culturally specific understanding of health and disease, which places spiritual, social and individual factors centrally in the concept of causation and treatment of disease.(113, 117) The use of traditional medicine is dependent on the worldview as well as the meaning attached to the symptoms that a person may have.(118, 119) The illness is understood not only as a physical condition but also often involves personal and family aspects, as well as social, political and ecological dynamics.(113, 120, 121)

Historical perspective of traditional medicine

Indigenous healing traditions, including African traditional medicine, have a long history that predates colonial times.(112, 113, 118) These traditions were actively suppressed during the colonial domination of many regions of the world. In the colony of Natal, as in many other parts of the world under British colonial rule, traditional healing was outlawed.(122, 123) The belief system underpinning the traditional healing approaches were seen to be primitive and backward, maintaining indigenous culture and, as such, seen to be a threat to colonial power(124) and schooling. Christianization and legislation were used to discredit African traditions and knowledge systems.(113, 122, 125)

Traditional healing practices were also in competition with rapidly expanding biomedical approaches in the late 19th and early 20th century. Biomedicine was identified as a tool for colonial control and was, furthermore, behind the rationale for licensing herbalists in the late 19th century in the Natal colony.(124) Additionally, the support of missions and their establishment of schools and hospitals was seen as a means of ‘modernizing’ the African cultures and the marginalization of traditional medicine and healing practices were central in this.(125, 126)

The political transition toward apartheid in the mid-20th century further suppressed traditional healing approaches.(102, 122) The process of cultural domination that initiated under colonial rule was continued by the apartheid government,(102) including the use of legislation to criminalize cultural practices. A number of pieces of legislation were passed that explicitly prohibited particularly diviners to practice.(102) The legislation did not differentiate between traditional healing practices and witchcraft. The herbalists falling outside of the definitions of ‘witchcraft’ were controlled via a range of licensing requirements that were restrictive on their expansion and innovation.(124)

Despite the oppressive legislation, traditional healers continue to flourish throughout the 20th century, often in the form of African-initiated churches and are becoming increasingly unregulated.(113) Despite the lack of a legislative framework, a number of local, regional and national traditional healers associations and organizations established themselves in order to promote traditional healing.(123, 125) Some of the associations developed formal structures to regulate and manage their membership. The process of regulatory structures reflects an increased professionalization among the traditional healers(123, 124)

Traditional healers often have a high status within their local communities and function at both individual, family and community levels. These attributes are seen (by some public health specialists) as opportunities for targeting traditional healers as promoters of health and disease-prevention messages, as has been seen in the fight against HIV/AIDS where a much greater acceptance of its cultural dimension is evident.(127-129) However, the impact on the experience of the individual healers – negotiating a life as migrant workers, making a living under the apartheid laws,(97) negotiating the ambiguity of being locally recognized and at the same time deemed to be participating in illegal practices—has for the most part been challenging and debasing.

Global and local policy framework for traditional medicine

The changes in the political terrain in South Africa in the early 1990s also caused a shift in how the state engaged with traditional healers.(123) The Department of Health the need for dialogue as well as regulation of the traditional health sector.(102) The increased engagement

of the state with traditional healers took place in a context where since the mid 1990's international policy recommendations have promoted a greater recognition of the important role of traditional healing. The World Health Organization (WHO) sought to provide a policy framework for approaching traditional health systems within countries(112) during which time the WHO and its member states moved to promote the use of traditional medicine for health care.

In line with the international trend, the post-apartheid government sought to regulate and promote the traditional health sector and introduced the Traditional Health Practitioners Act, Act 35 of 2004, which was challenged in the constitutional court on the grounds that there had been insufficient consultation in the drawing up of the Act. Following a consultative process, a new Act was promulgated in 2007.(120, 130) The Act stipulates the local, district, provincial and national structures regulating the registration and practice of traditional health practitioners(123) and also deals with the training of traditional healers. The Act provides a legal structure for the professionalization of traditional health practitioners. The Traditional Health Practitioners Act applies to specific categories of traditional health practitioners, which include diviners, herbalists, traditional birth attendants and traditional surgeons.(130)

The Act defines traditional medicine specifically to be based on “a traditional philosophy that includes the utilization of traditional medicine or traditional practice”(130)with the aim of diagnosing, treating or rehabilitating a person. It also explicitly includes “physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death”(130) and so foregrounds the cultural role that traditional healers play. The Act also explicitly “excludes the professional activities of a person practicing any of the professions” that are defined by the various pieces of legislation regulating the health professions as well as “any other activity not based on traditional philosophy”.(130)

This taxonomy of traditional health practitioners and the definition of traditional health practice exclude a number of healing traditions that span other practices and approaches that may be common in communities, particularly faith healing using a range of mediums from holy

water to prayer. Many of these practices are common in the Africanist Churches and are considered by many as part of an African healing tradition.(131)

This said, many traditional healers have an ambiguous relationship with the state, which they view with suspicion,(113, 132) and feel alienated from the formal public sector health care system.(97) The degree to which traditional health practitioners would interact with other strands of the health care system or what the nature of the relative jurisdictions are of the regulatory councils in practice has remained unclear in the Act.

The process of the professionalization of traditional medicine systems has been slow and circuitous.(123) While the Act profoundly redefines the relationship that healers as individuals and collectively have with the state),(132) the effect of the Act had limited impact at the time of the study. Experiences from other countries in Africa showed similar trends(133) and, as an example, the professionalization of traditional healers in Zimbabwe has not changed their status or reputation in any significant way over the past 20 years.(134)

Working with traditional healers

The majority of biomedical practitioners remain sceptical about engaging with traditional healers.(101) They have remained mostly critical of the unregulated environment of traditional medicine, which is reflected by the scathing articles written about the ‘non-scientific’ basis of the ‘charlatans’ and the toxic effects of many of the traditional medicines and practices.(135, 136) The differences in cosmology and cultural distance, including language barriers, have been given as examples of the difficulty in finding common ground.(128)

However, there are very few attempts within the public sector to work with traditional healers(132) and even fewer that go beyond paternalistic attempts to teach traditional healers some biomedical concepts or utilise them as health educators.(129, 137) The interactions between the traditional healers and biomedical health care systems have certainly not been an exchange between equals.(128)

As in many other parts of the world, traditional medicine and biomedicine essentially coexist side by side with limited interaction.(114, 118) Despite this openness at the policy level for

greater collaboration and cooperation within the health care system, traditional medicine has continued to struggle with having its legitimacy recognized and has remained largely separate. The long history of conflict and animosity between biomedicine and traditional healing(124) still influences the currently held positions. Yet, in the context of the legal and regulatory developments, the WHO's call for greater integration of the traditional health practitioners into the formal health care system(112) has been echoed locally.(120, 128, 138).

Chapter 3: Local context

The local context influences is more than a back drop to the implementation of policies and delivery of services.(139) The geography, history and current economics influences how the community engages with the government and the public service.

The study was located geographically in the Okhahlamba Local Municipality around the towns of Bergville and Winterton in the Northern Drakensberg Mountains of KwaZulu-Natal. The area includes the villages of Bergville and Winterton, the Traditional Authority areas of the Amangwane, Amazizi and Amaswazi, the nature reserve areas of the World Heritage Site of the Drakensberg, as well as large tracts of commercial farming. The tourism industry related to the World Heritage Site is a major source of employment; however a large proportion of the population is characterised by high degree of poverty and unemployment, poor general service infrastructure and migrant labour. It scores within 10% of most deprived local municipalities in the country.(140)

Historical and ecologic context: Okhahlamba

There has been evidence of occupation in the northern foothills of the Drakensberg Mountains for at least half a millennium. It is assumed that both the San/Bushmen(141) occupied the area, as there are some archaeological findings of human settlement in caves in the Northern Drakensberg foothills, bordering on Lesotho of the Amazizi dating back to the 1500s.(142) The mid-1800s was a tumultuous time along the eastern seaboard of southern Africa with an increasing number of colonists exploring the interior of the land, the remnants of slave trade, particular from Delagoa Bay and extensive movements of particularly the Nguni clans and tribes.(143, 144) This period is often referred to as the 'mfecane' and the Amangwane were one of the clans associated with extensive movements until they finally settled between the Mweni and the Maponjwane rivers in what came to be known as the upper Tugela location (close to Bergville) in the mid-1800s. More recent analyses of the time period also recognise the complex interactions between the migration of Dutch settlers, British colonial expansion, and

the establishment of missions in the interior of the country, which contributed to the tumultuous time and the settlement of clans and tribes in specific areas. (143, 145)

The upper Tugela location was affected by the political and economic developments of southern Africa in a similar manner to many other rural areas in South Africa. Particularly, the establishment of the diamond and gold mines in Kimberly and around Johannesburg around the turn of the 20th century had a major impact through the need for cheap labour. Many legislative and economic factors created a migrant labour population and increasing rural poverty.(146)

In the second half of the 20th century, the apartheid state built on the foundations laid by the colonial government and further restricted access to land for the Amazizi, Amangwane and Amangwe. The current traditional authority areas around Winterton and Bergville were made part of KwaZulu Homeland. The population density in the homeland areas made large-scale farming impossible, and poverty and malnutrition were endemic.(147)

The traditional authority areas were included in the homeland of KwaZulu that was headed up by Buthelezi from the Inkatha Freedom Party (IFP). There was considerable tension among the Amangwane around support for the IFP (the head of the Homeland of KwaZulu government). The IFP focused strongly on the maintenance of cultural values and promoted self-determination and embraced the apartheid-government's policy. It was viewed with suspicion by many in the area due to this cooperation with the apartheid government at the time.

Following the unbanning of the African National Congress (ANC) in 1990, a complicated power struggle between the IFP and the ANC(148) affected the Bergville community, with considerable violence erupting in the run up to the 1994 democratic elections. The support for different political parties – and factions within political parties continued to be represented in the local politic of the area. The local community leaders as well as the traditional leadership were equally active in supporting and aligning themselves to political parties and factions.

The local population has therefore reflected regional, national and international dynamics for the past few centuries. This has strongly shaped the notions of state, legitimacy and participation in decision-making in the local population.

Emmaus Mission and Emmaus Hospital

The early years

As part of an approach to governing Natal in the mid-1800's, Sir Theophilus Shepstone proposed the development of reserves to assign areas for settlement of specific clans.(149) The Amangwane had been highly mobile in the time prior to this(149, 150) and during the Chieftaincy of Zikhali settled in the area of the Upper Tugela Location.

As part of Shepstone's strategy(151) for settling clans in specific locations, he allocated missions to tribes and clans. The Natal Colonial Administration approached the Berlin Mission Society to establish a mission in the area outside Bergville and allocated land in 1847/8 in the vicinity where the current Emmaus Hospital is situated. It was located on the edge of the area that was populated by the Amangwane.

The Emmaus mission station was founded by Reverends Posselt and Gldenpfennig.(152) Emmaus Mission was the first of the Berlin Mission stations outside of Durban in the colony of Natal. In the 1920s a seminary was established at Emmaus Mission which played an important part in the training of a cadre of lay preachers who were instrumental in the mission's strategy for engaging with the local populations.(145)

Missions in the colonial histories had a deeply ambiguous role. They saw their role as civilising the local population, yet also were explicitly a mechanism of colonial expansion control.(145) In some instances, missions were directly linked to the slave trade or reinforcement of government policies (such as landownership) and in the imperial/colonial mind there was little contradiction of this.(145, 151) Many of the missionaries were seen to be rather nave, though their humanist intentions were often real and operated in a complex space between state and community. The missions engaged within this tension more critically in the second half of the 20th century.(145) Particularly the medical mission work was part of an increasingly systematic approach of integrating a more holistic developmental agenda into mission work.(153, 154)

Brief history of Emmaus Hospital

In 1948 the missionary Reverent Bernhard Schiele was posted to Emmaus with his wife Magdalene Schiele, a medical doctor. Together with the assistance of Hilda Prozesky, who later became the first matron of Emmaus Hospital, they slowly developed a medical service.(152) In the initial phase of setting up the hospital there was very little assistance from the Berlin Mission Society, which in the post-war period was struggling financially and organisationally.(145) Over time though, the hospital expanded and by the time the Schieles left in 1968 the hospital had expanded to approximately 300 beds that included a large tuberculosis (TB) section. The hospital had also received a subsidy from the South African government and the Berlin Mission Society was actively supporting the hospital.(152)

In the mid-1970s most rural mission hospitals in the country were nationalised.(154) At the time, virtually all health services to rural black populations were provided by mission societies. While the state subsidised these services, they were not under the control of the state. However, it was not strongly resisted by many missions, as the hospitals were costly and in many instances the provisioning of a medical service was not the primary mandate of the missions. Furthermore, the missions had a limited mandate over the health care system as a whole, and a more integrated and primary care focus was potentially possible under the homeland government.(58, 154)

As with most other rural mission hospitals after nationalisation, Emmaus maintained its mission character, with the chapel being used for services and many traditions in the hospital (such as morning prayer held in the wards) were continued from mission days. The hospital remained relatively small and through the 1980s and 1990s continued to serve the KwaZulu homeland population, including developing a large number of primary health care clinics. Some of these were initially started by the doctors at Emmaus Hospital while it was still under the mission, but the number as expanded considerably in the KwaZulu homeland areas.

Recruiting and retaining professional staff remained a critical challenge for rural hospitals. The government posted a number of doctors doing their national military service to the rural hospitals.(153) The scope of services was dependent on the skills of the doctors available at any

given time and varied considerably – from cataract surgery to extensive abdominal and orthopaedic surgery. The hospital aimed to reach out into the community, which work included providing directly observed treatment for TB, nutrition programmes for children with malnutrition and income-generation projects for women’s groups.(155, 156)

The mid-1990s were characterised by considerable instability and unrest within Emmaus Hospital. The hospital was affected by labour unrest and the closed for a few days. This left the management at the hospital feeling vulnerable and lacking authority to implement policy directives. The dynamic at Emmaus Hospital echoed similar workplace transitions within the public sector in the post-1994 period, with complex relationships between unions, the public sector and government that resulted in considerable loss of discipline and ability to affect management within state hospitals.(2, 93)

In the 2000s the Hospital followed a relatively typical course of events for a small rural hospital. Budgetary constraints and regular overspending, staffing crises and poor administration created a difficult context for the delivery of services.(91) The HIV pandemic was evident in the daily routine of the hospital, stretching the services to their limits. In the absence of ARVs the mortality rate in the Hospital was exceptionally high and services struggled to cope with the demands placed on them. The hospital developed a name for itself in the community: a place where someone goes to die.(97)

Despite a shortage of doctors and nurses, ARVs were introduced in 2006 and changed the practice at the hospital considerably. The ARV programme was rolled out to the clinics relatively rapidly along similar lines to other rural ARV programmes (in particular Mseleni), which was in direct contravention of provincial guidelines at the time.(157) As a direct result of the rollout to Primary Health Care level care, the capacity to increase the ARV enrolment grew considerably and by the end of 2007 the 2011 targets of the HIV&AIDS and STI Strategic Plan for South Africa(158) were being met.(157)

Health care services in Okhahlamba at the time of the study

Public health care services in the Okhahlamba Local Municipality where the study was conducted were part of the uThukela Health District. The services provided included Emmaus

Hospital, which at the time functioned as a district level hospital with 160 beds, (decreased from the time of the mission). There were also five primary health care clinics, three mobile primary health care clinic teams and community-level interventions, including a community health worker programme and environmental health. There were 10 fulltime doctors employed at Emmaus Hospital. The local hospital management at Emmaus Hospital was accountable for the hospital as well as the PHC clinics reporting to the uThukela Health District Office, situated in Ladysmith 70 kilometres away.(156)

Epidemiologically, the population is characterised by high HIV rates, estimated at 12% to 16% of the total population based on estimations from national prevalence studies(159) The area also has an extremely high TB incidence and prevalence (estimated at nearly 1000/100 000 population at the time of the study) and poor nutrition rates(160). The health indicators tell a story of extensive poverty, which was further confirmed by the deprivation Index (measuring a combination of material and social indicators) where, at 3.57, the uThukela District had the 10th highest index in the country(161) at the time.

Private health care

In the private health care sector, a total of seven general practitioners were practising in the two villages in the Municipality that were largely based on cash practices. There were two private pharmacies operating in the area (one in each village) and both provided basic PHC services. Most of the clients at both the private practitioners and the pharmacies were cash-paying clients, rather than relying on a medical aid.(156)

Among the seven general practitioners, there was considerable variation of skills and focus. All treated minor ailments and chronic conditions, while two practitioners had ultrasound equipment, with one focusing strongly on antenatal care. This practitioner also had a delivery suite in his practice but was not able to perform caesarean sections.

Besides the ultrasound equipment, other imaging services in private health care were very limited in the area. The nearest private radiography/radiology service was in Ladysmith and included x-rays and CT scans. Ladysmith also had a private hospital where most of the private doctors in Ladysmith were admitting patients.

A number of private laboratory services had couriers collecting samples at the surgeries and delivering results on a daily basis – the laboratory was based in Ladysmith, but samples would be sent as far afield as Durban or Johannesburg, depending on the investigation requested.

Non-Governmental Organisations

In the geographic area of the Okhahlamba Local Municipality a number of non-governmental organisations (NGO's) are active in the extended health field, including Philakahle/Wellbeing (an NGO supporting people with HIV and TB as well as orphans), the Okhahlamba Area Development Project (a World Vision project involved in supporting orphans, child sponsorship programmes, disability and church awareness around HIV/AIDS), home-based care projects and a church-based orphan-feeding project. Around Winterton an alliance of churches support a home-based care project around the Khethani housing development. A number of local churches, youth groups and women's groups are active as community-based organisations (CBOs).

Traditional Healers

The traditional healers are a heterogeneous group of diviners ('izangoma') herbalists ('izinyanga') and faith healers ('abathandazo'). A local Okhahlamba Traditional Healers Association has been organising traditional healers in line with recent legislation requiring the creation of local structures. They are affiliated with the uThukela District Traditional Healers Council and the KwaZulu-Natal Traditional Health Practitioner's Council at provincial level. The Okhahlamba Traditional Healers Association has been active in recruiting traditional healers to participate in the organisation, but many traditional healers seem reluctant to join in uncharted and uncertain times and there are competing organisations recruiting these healers.(97)

Conclusion

The every-day work of the doctor as a street-level bureaucrat takes place in a complicated macro-environment and is influenced by the local context of the community and the health care system. It is the backdrop for the exploration of the professional in the bureaucracy of a rural hospital and how the work and relationships are shaped.

Chapter 4: Methodology

This is a qualitative ethnographic study that explores the experience of rural public sector doctors as civil servants placed in a particular context.

Methodological considerations

The central question of the study is the experiences of public sector doctors working in a plural health care service environment. Qualitative methods were used to understand the meanings of being both civil servant and professional, as well as the relationship to the plural health care service and patients.

Qualitative research is characterised as involving:

- 'A detailed engagement/encounter with the object of the study
- Selecting a small number of cases to be studied
- An openness to multiple sources of information (multi-method approach)
- Flexible design features that allow the researcher to adapt and make changes to the study where and when necessary.'(162)

Ethnography, as a qualitative research method, is particularly suited to detailed explorations of social interactions(163) in order to uncover the 'contextual, taken-for-granted, tacit knowledge'(164) (p. 492) that creates the social meaning of situations and experiences.(165)

Ethnography is becoming more common and relevant in the health care setting.(166-168) Examples of such work include a number of hospital and clinic ethnographies,(87, 169-173) understanding dynamics between patients and health services,(174) Mol, patients' experience of illness(175, 176) and cross-cultural communication and care.(177, 178) It is an approach that has been used extensively in the area of traditional healing practices(121, 179, 180)) as well as in the study of the plural health care system.(96) Increasingly ethnographic research has also begun to explore specific issues, such as the management and evaluation of a wide range

of services,(181-184) reflecting an increasing interest in understanding the complexity of the health care in its naturalistic setting.

Ethnography is particularly well suited to examining the experiences (47, 49, 185) and meaning making of policy implementation of frontline workers, as in Lipsky's concept of street-level bureaucracy. Yet very little research has been published on this topic outside of the developed countries.

Insider ethnography

This study has been conducted through insider-ethnography(186, 187) using the self-in-practice as a point of entry into the field. As the self-in-practice is part of the field of enquiry, it includes what has been termed auto-ethnography(188), where the enquirer him or herself is the subject of enquiry. Having been immersed in the study context for more than a decade, the researcher is capable of carrying out what has been termed "deep insider research".(189) As the researcher, I have been able to bring both tacit knowledge and organisational memory into the enquiry. Deep insider ethnography gives the researcher access to codes, insider information and established routines that may not be readily accessible to people on the outside of the milieu.(187, 189)

Study Design and Research Methods

As described in the previous chapter on the local context, this study was conducted within the geographical area of Okhahlamba Local Municipality in the northern Drakensberg area of KwaZulu-Natal. The specific sites at Emmaus Hospital include the wards, the outpatient department, meeting rooms as well as a number of sites outside of the hospital, such as meeting areas with the traditional healers and practices of the private doctors.

Selection and overview of participants

To conduct this enquiry, purposive, non-random sampling techniques were used in order to select the role-players critically implicated in the topic under consideration. Participants included three groups of practitioners: all full-time public service doctors working at Emmaus Hospital; all private practitioners that practised in the local municipality of Okhahlamba at the time of the study; and a group of traditional healers (one group of 24, plus 10 key informants).

At the time of the study all 14 doctors were working in the public sector (excluding myself) were approached to participate in the study. They included the community service doctors on placement at Emmaus Hospital for the duration of one year. Of the group, four were considered to be senior doctors based on skill-mix and length of service, and ten doctors were considered to be junior. In terms of origin, ten were South African-qualified doctors and four were foreign qualified. During the period of data collection, three doctors left and three new doctors joined Emmaus. The new doctors included two community service doctors. All doctors that joined were introduced to the study and invited to participate. In all, 11 doctors agreed and three doctors declined to take part in the study, without explanation

All five private general practitioners working in the Okhahlamba Local Municipality were approached and consented to participate. All were South African graduates.

In terms of traditional healers, the study involved the participants at the regular meetings of the Okhahlamba Traditional Healers Association, who all consented to participate in the study as a group. Data was collected at the six meetings that were held during the study period. In addition, ten members of the Okhahlamba Traditional Healers Association were approached to be key informants and agreed to participate in in-depth interviews. Four, who were on the executive leadership of the Traditional Healers Association, were selected on the basis of their involvement in local leadership. The remaining six were selected to get a broad understanding from people who were more or less linked to both the formal health care sector and the traditional healers association. Of the six, two only occasionally participated in traditional authority meetings and had no link with the formal health care sector, while the other four participated in their association's meetings more frequently and had a variety of links to public and private allopathic health care.

My role at Emmaus Hospital

At the time of starting the research at Emmaus Hospital I had been working in the area for about 9 or 10 years, the prior 7 years at Emmaus Hospital itself. I was one of the longest serving doctors and a senior member of the medical team at the Hospital. As I already had a range of roles within the hospital that were outside of the dominant singular role of clinician, I was able

to gain access to other participants both as a member of the clinical team as well as in my other non-clinical roles within and beyond the hospital.

As part of my daily work at the hospital I worked with a few NGOs active in the area, met with traditional healers, and was involved in setting up the antiretroviral treatment (ART) programme in the years prior to the research. I had worked with a large home-based care program in the community visiting many homes and areas in the larger Okhahlamba municipality. Many of these engagements focused specifically on building stronger linkages between the public health care service (the clinics and the hospital) and community-level structures. I had a detailed knowledge of the geography of the area, and many patients were surprised when I knew their neighbours or the colour or name of shop nearest to their house. I was interested in gaining an understanding of the local history of the people of the area.

I also was involved with the Rural Doctors Association of Southern Africa and as an honorary Lecturer in Family Medicine at the University of KwaZulu-Natal I had participated as a local coordinator in the area in an Human Sciences Research Council study led by Karl Peltzer in 2007.(115) The multiplicity of roles enabled me to include research into the routine of my workday interactions.

Reflecting on gaining entry and becoming a researcher

The research project was positioned in the daily lives of rural public sector doctors, seeking to explore their experiences as civil servants. I was conscious of the tension between being an insider practitioner and an outsider observer,(189, 190) being both researcher and part of the team of doctors.

As a researcher inside the study my challenge was not one of entry and familiarisation of the context.(191) Rather it lay in having to develop an observing ethnographic ‘outsider’ perspective – to see the familiar as strange and with new eyes; and to observe, interview and analyse what was going on around me.(190) I prepared myself to do this in a number of ways, including entering the hospital on foot, rather than by car; walking into the hospital ‘as if it was for the first time’, observing closely what I noticed; and sitting in spaces with closed eyes, to hear sounds (such as the air-conditioning from the TB ward that otherwise was a familiar white

noise in daily activities). Through these and other acts of distancing, I forced myself to step out of my established patterns and practices at the hospital. I repeated some of these techniques during the course of the research, particularly after periods of not observing-and-recording (see below under limitations) in order to re-immense myself in the process of research and to take a step back from my role as doctor within the hospital.

Formally, the study and my role as a researcher were established through several meetings. At Emmaus Hospital I convened a meeting with the doctors to introduce the research, describe the study purpose and methods and to create an agreement with them about the procedures I would follow in respect of their decisions regarding participation as well as their professional practice. (Field notes 22/04/08)

I initiated individual meetings with the private practitioners in the Okhahlamba Local Municipality where I followed a similar process.

Following ethical clearance, I similarly requested and was given permission to introduce the study at a regular meeting of traditional healers that I attended. The group was enthusiastic about the research and gave consent for me to use meetings for the research. At this meeting I also invited the ten traditional healers to be key informants.

In doing insider ethnography, I observed that establishing myself, as a researcher with private doctors and traditional healers was made easier by the social and professional distance between them and myself. The role was clearer and needed to be negotiated less.

Data for this study was collected over a 13 month period, from May 2008 to the end of June 2009. Throughout the study period my role in the medical team did not change significantly, with these longer-term relationships providing significant stability to how I functioned in the hospital.

To conduct this research I used participant observation, in-depth interviews, and field notes supplemented by documentation to collect data. These different data-gathering methods provided a more comprehensive approach to the questions and issues posed.

Participant Observation

I used participant observation to generate a thick description (162, 192) of the everyday activities of doctors in the public sector at Emmaus Hospital. The observations took place in the wards and outpatient department, in discussions and in meetings while I was working within the catchment area of the Hospital. Events, meetings and incidents as well as comments made in the context of work were recorded directly at the time they took place, for the most part, although occasionally they were recalled and recorded after an event.

I took care to regularly record the everyday work activities of public sector doctors. This ranged from ward rounds or the routine in the operating theatre, to incidental interactions and conversations between doctors walking to and from clinical activities, in the library or during their breaks. In this, my focus was on the mundane and the usual rather than the exceptional or dramatic. Observing in this way enabled me to capture comments or observations of events that are significant to doctors' understanding of themselves and their work.

As colleagues and other staff members were aware of my study I openly took notes during meetings, the ward rounds, and at the nurses' station in my role as a researcher. I recorded individual encounters as soon as possible after their occurrence.

I did not participate in or observe any consultations or patient interactions with any private practitioners or traditional healers.

In-depth interviews

I conducted open-ended in-depth interviews with all consenting study participants to explore their experiences and understanding of and feelings about the work they were doing and their place and the place of others in the local health care system. I used an interview guide (see Appendix 3) to direct the discussion, but allowed the interaction to flow in a dynamic way. The length of the interviews ranged from 24 minutes to 2 hours: 17 minutes.

In-depth interviews with public sector doctors took place in the library or the boardroom at Emmaus Hospital. In-depth interviews with the private doctors took place at their practices during or at the end of the workday, except for one that took place after work at the hotel in Bergville.

The in-depth interviews with traditional healers took place at their homesteads, either in their consulting areas or homes. These interviews were conducted in isiZulu, of which I have a basic understanding. I enlisted the assistance of Mr Nicolas Madondo as interpreter.

Mr Madondo was active in a local farmers' collective in the Potshini area, close to Emmaus Hospital. He had initiated home gardens and rainwater harvesting projects and had participated in fieldwork done by the Farmers' Support Group from the University of KwaZulu-Natal, with whom he had links. He was well known in the local community. His knowledge of the language and local custom as well as his experience in doing research fieldwork ensured that my questions were correctly translated and the interactions were well understood.

All in-depth interviews were audio-recorded. I transcribed all the interviews with doctors, and a research assistant translated and transcribed interviews with traditional healers.

Discussions and focus groups

Early in data collection it became apparent that many of the questions that were being explored as part of the study were being discussed frequently in both formal and informal meetings among the doctors. I used the opportunity of these meetings to pose questions and record the ensuing group discussion. In total, I recorded seven doctors' meetings/group discussions in detail, some of which took place in the informal spaces of sitting together waiting for a meeting to start or continuing conversations at the end of the meeting, before dispersing.

Despite repeated efforts, the envisaged focus group discussion scheduled with the private practitioners did not take place. It appeared that there was not much cooperation between the private doctors in the area. One of the private doctors also indicated a reluctance to engage with the other private doctors. This left a critical gap in the process of gathering data regarding the interaction between the public and private sectors in the area.

I conducted one formal focus group discussion with the group of traditional healers at a regular meeting. The questions I raised in the focus group discussion subsequently became a part of regular meeting discussions, as traditional healers continued to make reference to or elicit

discussion around some of the questions I had raised. These subsequent discussions were recorded through field notes, rather than audio recordings.

Field notes of events

Throughout the data-collection period, I kept a chronicle of events, placing the interviews and the participant observations in chronological order. In the chronicle, I also linked the collected data to the local context. Through the field notes I created a detailed timeline of meetings, incidents, interviews, and events.

I conducted a total of 6 group discussions and 27 in-depth interviews. I also made 88 participant observation entries and a further 73 field notes about events and interactions, which were not part of the participant observation process, as well as additional reflections. Twelve of the notes on participant observations were excluded as they involved or substantively referred to participants that had not given consent to participate. These were destroyed.

Data Analysis

In ethnography, the process of data collection itself simulates considerable reflection. As I started to make sense of the information I was collecting, I also recognised that I needed to distance myself from it. This distancing(187)would enable me to start to analyse the data critically, recognising the inconsistencies between what people say and do and mean, and how these inconsistencies themselves made meaning. I found the process of exiting the field and moving to analysis much more difficult than expected. Despite a number of attempts, I found it taxing to engage with the data at an analytical level, particularly as I continued to work in the context, immersed in the same routines and dynamics that I had recorded.

Only when I relocated and took on a new position was I able to begin the process of analysis. Over a period of time, I engaged with the data by reading and re-reading it, arranging the pieces of data and exploring inconsistencies between what had been observed, what had been said and what the intention seemed to be.

A thematic analysis was conducted of the data generated and the themes and concepts related to each other based on the research objectives. A re-reading of the observations and field

notes, interview transcripts and archival data generated a global picture of the experience of rural public sector doctors.

An inductive process of viewing the data according to a number of theoretical viewpoints placed the local experience in a more global context. A variety of approaches were tried and I found a particularly good fit with Lipsky's framework of street-level bureaucracy. The framework explicitly focuses on frontline workers in the public sector – such as the doctors delivering a service – and thus assisted me in theorising about the experience and decision making of the civil servant doctors at Emmaus. Few other approaches to understanding work at the frontline have explored the professional/public servant intersection, the focus point this study. I reflected on critiques of Lipsky's work and also the applicability of the framework in the context of working as a professional in the South African public sector. Although his ideas derived from another time and context, I found that his insights and particularly the centrality of discretion in his theory to be a particularly useful starting point for viewing the data.

Making sense of the data using the theoretical notion of street-level bureaucracy entailed iteratively moving between the data and texts. Reading the data through the lens of key thematic areas: being a professional, being a bureaucrat and being a public official assisted me to distil and clarify narratives from the wealth of data that were derived from the context where they were collected.

Limitations

Being part of the team of doctors myself, I had access to every aspect of the work. I continued to work as part of the team and continued to see patients and fulfil my duties. The workload at times was overwhelming and at times I found being-and-doing while simultaneously observing-and-recording difficult. This meant that recording of the participant observations fluctuated, being more or less regular depending on the work pressures.

Despite the access that being an insider afforded me to the day-to-day work of the rural doctor, being part of the team and working at the hospital also had limitations. Being so deeply immersed – and being deeply re-immersed as the workload increased - for instance, reduced my space to stand back from and view the work with an ethnographic eye.

In terms of the research, two central concerns with insider research and insider ethnographies are the potential for bias and the problem of validity. Essentially, how authentic the representation of the research is remains a persistent question. The method by definition entails a high degree of subjectivity.(193) Yet it is this very subjectivity of the method that allows for insight into the subject – the meaning making that doctors and others make of rules and practices in a health care system delivered in a particular context. The method allows the researcher (myself) to access a deep understanding of experience in a range of settings in the everyday.(187, 189)

I applied a number of strategies to improve upon the accuracy and authenticity of the data, including:

- Using multiple data collection methods and triangulating between the sources of data to reduce bias.(162)
- Encouraging participants to view transcripts of their interviews to ensure that these conveyed their intention. I also requested them to provide further information and I included their reflections in field notes. This generated some discussion in two instances, with one participant excluding a number of paragraphs from the interview.
- Collecting data over an extended period, thereby decreasing the likelihood of a single event or a peculiar incident to dominate the interpretation of the context.
- Doing extensive participant observation, which generated recurring themes and explanations. These aided the thick description of the everyday life of doctors at Emmaus Hospital at the same time as ensuring that what was observed reflected more than once-off incidents or idiosyncratic processes.

Physical and temporal limitations

The study is located in a specific context at a particular time. The study is limited to the geographic area of Okhahlamba Local Municipality. It is also limited by the time in which data was collected (13 months) and period in which it was collected (May 2008-June 2009).

Methodological limitations

The study findings are not generalizable to any other doctors working in the public sector in any other setting, or even at a different time. The qualitative nature of the study of gaining a deep- and context-sensitive understanding implies that the findings are valid only within the local context. However, the issues raised may have more universal resonance and generate hypotheses that may be explored in future studies.

Limitations of scope

The study focused particularly on the experience of the public sector doctors. Other dynamics that may well contribute to their experience were not explored, as they were not part of the study's scope. While the study contributes to how we understand the doctor as a street-level bureaucrat in a particular context, it does not provide a comprehensive picture of the problem.

Limitations of participation

A number of key role players in the public sector who impact on doctors' practices and experiences, in particular as regard management, were not included in the study.

The doctors who declined to participate in the study may have added to the study. Their decisions may have limited the exploration of particular perspectives in the study and potentially have biased the findings.

Ethical considerations

The study complied with ethical principles outlined by international declarations(194) and local legislation.(36)

Permissions and review of ethics board

The research proposal was submitted to the research ethics committee of the Pretoria University for consideration and was approved (No7/2008; 29/02/2008 - see Appendix1).

Permission to conduct the study was obtained from the local management at Emmaus Hospital and the provincial health authorities in Pietermaritzburg, KZN (see Appendix1).

Participation in the study

Participation in the study was voluntary and no coercion or manipulation was used to entice individuals to participate in the study. There were no payments offered for participation in the

study. Informed consent was obtained from all participants using the information leaflet and consent form attached (Appendix 2).

As much of the participant observation took place in the day-to-day milieu of the hospital, a large number of other persons formed part of the observations. All of these persons were kept anonymous in the recording of the observations, as well as in the write-up of the study. A number of persons that would be identifiable by virtue of their position were excluded as far as possible. They were not the primary focus of the study. In the write up of the study, assigning random initials to them further anonymized the names of the doctors who participated.

As mentioned previously, of the doctors at Emmaus, three doctors declined to participate in the study. They were not interviewed and any reference to them in the meetings or field notes was deleted or destroyed and not used.

Conclusion

The study allowed me to reflect deeply on the work that we as doctors in a public sector hospital in some remote rural areas were engaged in. The way we were making sense of our actions in a peculiar local and historical context is what I sought.

Chapter 5: Doctors' experiences of being professionals in the public sector

In this chapter I will explore how we, as rural doctors in the public sector understand and experience ourselves as professionals. The rural setting is considered to be resource poor – a fact that serves as a starting point for exploring the experience of working in such a context as a professional and how a local sense of being a professional is formed.

The professional in rural South Africa

Despite a constitutional right to health that is backed by current law and policy, severe inequities continue to exist in the rural health care systems of the new democratic order in South Africa (195, 196). This is starkly captured in the geographical distribution of health care practitioners between urban and rural areas. Although 43% of the population lives in rural areas only 12% of doctors and 19% of nurses practice in rural areas. (33)

The experience of working as a professional is not only shaped by the set of rules and regulations of the profession, but also by the context of the practice. (197) In their exploration of the dimensions of professional life, Wagner *et al.* (198) identified character virtues, knowledge/skill and relationship to patients as key categories of professionalism among generalists I will use these to explore the experience of being a professional at Emmaus Hospital.

Character virtues of rural doctors

In individual interviews and group discussions as well as during meetings, it was repeatedly said or implied that working at the rural hospital had intrinsic value. This value, it was felt, reflected the doctor's commitment to the context. Working in a rural hospital, rather than in better resourced settings, i.e. 'being out there' (FT interview) had intrinsic value. It meant that professionals had to deal with situations where investigations like CT scans or some blood tests were not available and "one had to make do with less". (WT interview)

The value of choosing to work in this context relates not only to fewer resources being available in the hospital, but also to the poverty of the community living in the area. In addition to not being able to afford private care, most people in the area also have fewer health service

options. Doctors felt that by providing a service to this community, they also contributed to improved equity and access to care.

Over and above an acknowledgement of the context being resource poor, some doctors at Emmaus had an explicit commitment to improving the quality of care to the community (interviews with IC, CW, CF, EW). The understanding of their professional practice related to the outcomes of health in the community. Our approach to the treatment of TB was related to the overall incidence of TB in the area and whether our individual treatment efforts were having an effect on the epidemic (CF interview). Similarly, working in the children's ward, Dr EW explained this in terms of his desire, over time, to see less malnutrition in children. In other words, doctors were interested in not only being present to treat individuals but also in contributing to an improvement in the care and the health outcomes in the community.

Personal commitment

The personal conviction of working in a place like Emmaus is an important dimension of how virtue ethics were understood. There is a very individual and personal trajectory that influences both the decision to choose to work in a rural hospital and then to stay and continue to work there. Especially for junior doctors, working in rural hospitals represents adventure and "going out there" (interviews with IC, FW and EW) and has a finite limit in terms of the time that they expect to be there. Some community service doctors deliberately chose Emmaus hospital for its proximity to the Drakensberg Mountains and the outdoor activities that this environment offers (WT interview).

Yet, invariably a number of factors combine to inform each individual's decision. For some, family dynamics and choice of residence in the area (CW interview) or working in a context that suit the family arrangements (FT interview) is one important influence. For others, their choice is informed by their childhood experiences, which in turn was part of their motivation to study medicine in the first place. These early influences were identified as the origins for wanting to care for and serve the poor. For another, the decision to work in a rural hospital arose out of sentiments of idealism such as a political conviction to overcome apartheid injustices or as a way of "giving back". (CF interview)

For a few doctors a similar idealism arose out of a religious commitment that was offered as an explanation for wanting to work at Emmaus, which also resonated with the Hospital's missionary roots and former ethos. (UT interview) Much of the ethos was still evident in the daily routines of the hospital, where in each ward the nurses, together with the patients would jointly say a short morning prayer and sing a hymn as the nursing staff for the day came on duty. The religious commitment was not evident in the doctors' meetings or in discussions around service planning.

My own decision to work at Emmaus hospital and commitment to staying there for some time arose out of a mixture of family history, professional-, moral- and political commitment to health care provision for the disadvantaged and a strong sense of home and belonging in the area.

The rich fabric of personal motivation of working at Emmaus is interwoven with how we see ourselves as professionals. Ideas of professionalism are interlinked with the personal convictions and motivations for working at Emmaus. Although they often feel unacknowledged by the system, as one doctor put it, they can see the value of their presence: "No one can ever say it out loud that we are here, we are actually here. And I look around and see what is being done and how we work and the patients that we see and how we treat them and where we refer them. I really feel that the rural doctors here are doing a very good job". (CW interview)

Knowledge and skills of rural doctors

As discussed in the background, the context of a rural hospital requires a wide range of skills and knowledge. On any given day, as field notes of my own day's record, a doctor would be expected to perform a wide variety of tasks and work in a range of clinical settings. My day on 30/10/2008 looked as follows:

We met in the morning in the courtyard (as usual) and everyone was there early. We talked briefly about today. Dr TI checked what everyone was doing and where we would do the joint ward round on the timetable we had drawn up last week Friday. I was allocated to theatre with Dr TC, and he had phoned the ward already to hear how many cases there were. We agreed on the time when we would meet there. Dr TI also asked

who would like to go to some courses. There was one course for how to do triage, and another one for medico-legal work – particularly how to treat people that have been victims of crime. Dr CW and Dr FW volunteered.

In Female ward we saw the patients, one by one, starting at the front where we usually start. The first was a woman who is on ARVs and has developed a weakness in her legs. Initially it was thought to be a peripheral neuropathy from D4T but she was changed to AZT a few months ago – but the weakness was progressive and now she had also developed some loss of sensation. She is being investigated for ‘TB arachnoiditis’ or some other spinal chord lesion. She was booked for a MRI and Dr FW was going to speak to a Dr at Greys again about transferring her there. There was some good discussion and reflections from some of the other doctors that came on the joint ward round and similar cases were shared, particularly patients that had similar symptoms and what was found in the end.

As the ward round continued, we saw a range of patients; some patients were discharged. We had a long discussion about a young woman who was booked for a CT scan and booked for a cardio-thoracic clinic who had a cavity or lung abscess. Another patient had poor renal function and there was a discussion regarding her calcium levels and parathyroid function, due to severe cramps that she was complaining about.

At the end of the ward round we all went to the different wards to do the ward rounds. I first went to the nursery as I am covering for Dr FT who had taken the day off. I saw a small child that was born prematurely and the mother is really looking after the child very well. The child is being ‘kangaroo cared’ – i.e. tied to the mom’s chest for most of the time, except for feeding and the times that the mom washes etc. The child is growing well and looked well. The mom is very patient and obviously enjoyed being praised for what a good job she is doing with the child. The next child I saw was a premature who was delivered at home. I had seen the mom at the Antenatal high risk clinic as she has a cardiomyopathy and should not strain too much for delivery. She had 7 previous deliveries! The child had mild respiratory distress but otherwise was fine. She

had gone into labour quite quickly and also did not have any transport to be able to come to the hospital quickly. I followed up with her on a discussion I had at the antenatal clinic with her regarding family planning and a tubal ligation. She had discussed this with her husband and they were very keen not to have any more children.

I then went to theatre and together with Dr TC did 4 'evacs' (Dilatation of curettage of the uterus) – 3 were TOP's and one came from maternity. We took turns in doing the anaesthetic and surgery, as Dr TC was not so confident with the anaesthetic, and we used this opportunity for him to have some supervision. The theatre staff was great and we could work quite fast.

After theatre I went to paed's ward where I did the ward round. Half-way through the ward round the one child I had not yet seen had a fit and I needed to administer valium, take a lumbar puncture. The child was already on the correct antibiotics for meningitis, but did not have a lumbar puncture taken when admitted. The notes did not reflect why the lumbar puncture was not taken before starting antibiotics, despite suspecting meningitis.

I then went to the ARV clinic to see patients there. The queue was not as long as I had expected. Besides the reviews I was doing, I started 2 people on ARV's, changed the medication for one woman who was pregnant while she was on Efavirenz. One man came to ask for a grant, even though he does not qualify for it. We talked about the rules from the Department of Welfare regarding who can get a grant and he seemed quite accepting of this. (Field notes 30/10/08)

My work day, like that of my colleagues required that I move through a range of procedural and clinical skills and engaged in a range of complex relationships – teacher, colleague, and doctor – required of each specific situation. The range of skills of each of the doctors also determined to some degree where they were working and what role they played there. Not all doctors would teach skills to other doctors, not all doctors would work in need of supervision for doing evacuations of the uterus in theatre. At Emmaus the practice demands covered a wide range of conditions, including those more typical of rural settings, such as treating agricultural poisoning

or snakebites. Indeed, some senior doctors had developed considerable expertise in treating such conditions.

Many of the new doctors during their introduction and orientation at the hospitals were very surprised and at times overwhelmed by how much responsibility rested on individual doctors in the system of service provisioning at Emmaus. They were the frontline doctors, who needed to make decisions about patients, rather than follow the instructions of senior doctors that would take the responsibility. While advice was available, the responsibility rested upon the frontliners. But not only were they required to make a decision about whether a woman needed to have a caesarean section, but they would also actually perform the operation with the assistance of a second doctor. And the inherent expectation that was in how doctors functioned also required (particularly after hours) doctors to make decisions and perform procedures at a similar level for a wide scope of disciplines and conditions.

Exploring the weight of the responsibility that doctors found difficult, one factor was the lack of prior training for performing specific procedures or tasks that many doctors had to undertake. As a result the doctors felt unprepared to perform at this level. One of the doctors said that she started to doubt whether she was actually a doctor (TW interview), as her medical training had not covered many of the procedures that were expected of here at Emmaus. In many other settings, a much narrower set of skills and knowledge would be more than sufficient to be able to function as a competent clinician. In the rural context, a more narrow set of skills seems inadequate. As the scope of knowledge and skills is part of how a professional defines himself or herself, the number of skills required to be considered a competent professional differs between rural and urban clinicians.

A further area that doctors found difficult was the sense of being alone in the work they did. In the description of my working day set out above, much of the time I worked without other doctors and needed to rely on my clinical judgement to make decisions. I would decide when I needed additional advice or to discuss a patient with a colleague. While I would involve the nurses in decision making and discuss patients with them, there was no other doctor with me to act as a sounding board. For particularly junior doctors that were used to working in an

environment where there were a number of more senior doctors always around, working alone and taking much greater responsibility was something new. As one doctor put it at Emmaus: “You are it”. (EW interview)

The expectation to perform such a wide variety of tasks and working in relative isolation at the same time was described as being an “Über-doctor” by one of the doctors working at Emmaus. (CF interview) However, among us at Emmaus it was acknowledged that not everyone can be an “Über-doctor” – not everyone can perform all the tasks or has all the skills required to cover the whole scope of practice in the hospital. Some doctors focused much more on HIV care, or paediatric care, others preferred procedural care or obstetrics. Yet there was an ongoing discussion regarding gaining new skills and expanding the current skill set of all doctors. Particularly for new doctors, a detailed discussion and assessment using a structured assessment tool assisted in identifying the skills and gaps in skills that a doctor had. Based on this a plan for increasing skills capacity would be developed and discussed among the doctors at one of the weekly meetings. (Field notes 17/6/08 – interviews with TC and TW)

The expectation of extending their scope of skills was not always met with enthusiasm by the doctors at Emmaus. Despite the (at times) extensive arrangements made to teach new skills, some doctors exhibited passivity and even open resistance to learning new skills. When Dr TW arrived she identified that she had virtually no procedural and anaesthetic skills. She joined a more senior doctor repeatedly in theatre, learning to do the spinal anaesthetic. Owing to the relatively low number of procedures being done at Emmaus, her exposure was limited. An arrangement was made that she would be called for all of the caesarean sections to initially give the anaesthetic under supervision as a strategy to increase her exposure and accelerate her learning. While this arrangement was discussed and agreed to with all doctors in the meeting, this was not adhered to, with a multitude of reasons given by Dr TW including work pressure (for instance, that OPD was still too full) or just not arriving on time. (Field notes 21/08/08)

Once doctors had learnt new skills, it was expected that the doctor would take on additional responsibilities. In the example above, Dr TW would be expected to be able to perform

anaesthetics when she was on call. After one of the calls when an additional doctor had to come out to assist with the anaesthetic, Dr TW was asked by one of the other doctors how her skills development was going and she responded “I am not ready yet”. (Field notes 21/10/08)

Dr CW felt that doctors often did not want to learn a new procedure, as they would then be expected to perform it the next time, rather than write the referral letter and ‘get rid’ of the patient. (Comment by CW, field notes 01/09/08).

The implications for the patient (in terms of time, travel, discomfort, delay in having the problem addressed etc.) did not seem to be part of the consideration.

Commitment to quality of care

The knowledge and skill required to work as a professional in the hospital was to provide the best quality of care possible. The way that quality of care was understood by the doctors at Emmaus was placed into a local context of being resource limited. It was articulated in the tension between what the ideal care doctors expected should be provided and that care which was rendered. The tension was often discussed among the doctors during the joint ward rounds, doctors meetings and many less formal interactions.

The doctors at Emmaus also compared themselves and the service with other hospitals and services, which gave a sense of the quality of the care provided. For instance, in a number of wards, in particular maternity ward and the children’s ward, regular mortality and morbidity review meetings would be held. During such review meetings the local mortality rates or cure rates of diseases were compared to the targets set by the Department of Health, as well as compared to other hospitals or national or provincial averages. The process of the review meetings reflected on the outcomes of the service provided, which was seen to be a direct indicator of the quality of care that was offered at Emmaus.

Another comparison of the standard of care seemed to be related by individual doctors to previous experiences of working in mostly urban centres and, in some instances, working

abroad.^b Particularly junior doctors often compared Emmaus to previous hospitals in terms of access to investigations as well as opinions of specialists, implying that those factors constituted better quality of care. (Interviews with WT and EW)

However, there were also more operational aspects of care in terms of how the actions of the doctors managed patients within the local context. There was considerable divergence in interpretations and expectations of what was possible and how quality of care was constituted. It became evident in the difference of the attention to detail, speed of working and thoroughness of investigations between doctors.

During a ward round in a female ward, a patient was seen, who had been admitted four days earlier. She had arrived being fairly ill and distressed, but with vague symptoms that were difficult to pin down: some abdominal pain, loss of weight, general body pains and was quite pale. At the time of admission, one of the doctors (Dr FT) discussed the patient with a more senior doctor (Dr TR), who suggested investigating for HIV and TB (including extra-pulmonary TB), investigating the probable anaemia and reviewing the results. Even though these examinations were ordered, on the ward round it became clear that the blood results were not in the file, a number of investigations, including an ultrasound of the abdomen, had not yet been done, including the HIV test. “What is the point?” was the wry comment of the senior doctor, who had been asked for an opinion when the patient had been admitted. The junior doctor working in the ward (Dr FW) pointedly ignored the comment. (Field notes 07/08/08)

The junior doctor in charge of the patient clearly did not complete or follow up on any of the investigations that had been ordered or suggested by the senior doctor. He did not seem to seem to have a sense of urgency – or, perhaps, even the responsibility – to ensure that the investigations were completed. He viewed his responsibility in the rendering of care to be limited to the examination and the ordering of the investigations. In this instance he took no responsibility for what happened after the investigation had been ordered.

^b The idea of quality therefore seemed to be something universal, as if it was context-free. Similar to the professional rules that are presented as if they are universal and absolute and merely need to be implemented, the idea of the quality of care is something that simply should be implemented by all doctors.

The junior doctor's view of his responsibility was in contrast to the expectation of the senior doctor, who implied that ensuring that the investigations actually get done and results get back is included in professional practice and good care for the patient. The responsibility of the professional was understood to be the actual care that the patient receives, rather than having completed all the forms and filled in the applications. It implied a wider responsibility for how the overall system of health care delivery functioned. A number of doctors viewed limiting the scope to only clinical parts of the work negatively. In the words of Dr UT: "There is considerable laziness and shoddiness here". (UT interview)

Compliance with Guidelines

A common approach in the Department of Health in standardising quality of care is the use of guidelines and treatment protocols. Among the doctors at Emmaus, compliance with guidelines was seen to be an important part of how good care was understood. It was best articulated in conflict situations, when one doctor would challenge a colleague for not 'sorting out' a patient. This again indicated different ways of understanding what being a professional entailed and how this related to clinical competence and working within a system to deliver care.

A patient was admitted with head injury following a motor vehicle accident. The admitting doctor wrote in the notes "For CT scan mane (in the morning)" (which is in line with the guidelines for the treatment of head injury. But Dr CW got very irritated during the ward round because during the night the admitting doctor had not made any arrangements with the CT scanner in Ladysmith, arranged for transport or filled in the forms. Also, to perform a CT scan, informed consent had to be obtained and the family members were no longer around (they were present during the night). Dr CW would now need to fill in all the forms, arrange transport and get emergency consent and the patient was delayed. If this had been arranged during the night, the patient would have left for Ladysmith already. (Field note 30/04/09)

The fact that doctors differ in their opinions of what constitutes adequate compliance with the guidelines was clearly a source of considerable tension in the team. For Dr CW the clinical acumen of understanding that the patient needed a CT scan was clearly not enough. The

decision would need to be followed with a range of decisions that were implied in the guidelines (like obtaining consent, arranging transport or completing the required forms) in order for the patient to have a CT scan in the morning. Yet the guidelines were not explicit about these steps that would constitute adequate care for Dr CW, in the context of working at Emmaus. Dr CW's view reflected a common perspective among the doctors – that quality of care was a function of individual effort of the doctor.

The peer review in the joint ward round

At Emmaus the regular joint ward round acted as a peer review process to improve the quality of care.

The Joint Ward Round was held in the Maternity ward. We started in the antenatal ward where a young woman in the third trimester of her pregnancy was presented by a senior doctor (UT). He had admitted her the previous afternoon with pregnancy-induced hypertension and he had prescribed anti-hypertensive medication for her. The senior doctor outlined all the results that were available from the tests that had been taken the day before, reviewed the results from the ultrasound examination that she has had and there was a brief discussion about what further investigations should be sought.

One of the other doctors (FW) requested to look over the medication again. The prescription had not yet been initiated (the patient had not received any medication at that point), as the drugs that had been prescribed were not in the ward stock. The reason for this is that they were not the first-line agents according to the standard treatment guidelines or the guideline for maternal care in District Hospitals that was issued by the national Department of Health.

A lively discussion arose, with the senior doctor in the ward defending and advocating for the combination of medications that he chose, quoting instructions from the consultant obstetrician from Ladysmith Hospital (the regional referral hospital), and that there were “numerous journal articles” on the subject matter that supported the medication that had been prescribed.

Dr CW argued that according to her understanding of the disease process the treatment did not make sense, particularly the use of diuretics in pregnancy. This argument was not responded to by any other doctors in the discussion. Dr FW asked whether the drugs prescribed were a good combination of medications if the patient will not receive them in time, as they need to be collected from the pharmacy separately and they were not kept in stock in the ward. “Even if the medication is a rational choice, but the patient does not get it, it will not lower the blood pressure”.

The discussion had started with wide participation from most doctors attending the ward round, offering opinions on the guidelines and the understanding of the disease process, but as Dr UT defended the prescribed medication further, only another senior doctor continued the discussion and asked how a resolution could be found to the arguments that had been put forward. He suggested that the evidence for the different choices to the next perinatal mortality meeting where often issues of protocol and treatment options were discussed and where intermittently representation from the regional hospital participated.

Later in the day I spoke to the pharmacist about an unrelated matter, who (without prompting) raised a concern regarding non-adherence to the treatment guidelines in maternity. “It is just chaos; no one knows what is the correct treatment for the patients”. (Field notes 28/11/08)

The joint ward round in itself is a form of peer review and peer accountability. It was quasi-voluntary and relied on consensus within the group to attend the ward round. The regular joint ward rounds had been established a number of years previously by the team of doctors at the time to have a forum for discussion of management of patients. At the time it was identified as a forum where doctors could present complicated patients or problems that they were stuck with and get additional ideas or assistance. The second function focused on the acknowledgement that ‘we all miss things.’ By presenting and reviewing patients in the ward where one was working, additional opinions, ideas and perspectives could be explored. While a

norming process was implied, this was not explicit. The process of giving support to one another has the effect of regulation and led to a degree of accountability to one another.

To return to the situation described, as part of the joint ward round the prescription and patient management of one doctor was scrutinised and assessed against a number of possible criteria including a number of different treatment guidelines. It was difficult to verify any of the opinions put forward in the ward round itself or to present evidence for the ideas. While the ward round did not offer any resolution or consensus regarding the prescription the authority or evidence was offered as a way to resolution. While the admitting doctor had the discretion to prescribe, through the process of the joint ward round this was judged by peers.

Interpersonal dynamics in the ward round

The interpersonal dynamics during the joint ward round influenced the discussion. While the focus of the discussion was on the work, the relationships between individuals influence how doctors responded to each other. In the described interaction, there was a gradual change from initially all doctors participating in the discussion to only the 2 senior doctors remaining as part of the discussion at the end. While the discussion was focused on the prescription and how appropriate it was, it appeared that junior doctors were not part of the final decision regarding how the challenge of the prescription should be resolved.

The dynamic reflected how seniority within the team has implications not only on how decisions can be challenged but also on how senior doctors needed to account for themselves. Senior doctors' opinions were given greater weight and authority, in part because of their length of experience in clinical practice generally and the fact that they had dealt with many more cases in the particular setting. Drawing from previous experiences in how particular problems were dealt with (that did not necessarily follow the guidelines) senior doctors were afforded greater discretion and this higher degree of discretion lent itself to less accountability. Indeed, the ability to work independently was seen to be a feature of being more senior.

The referral to an authority that was perceived to have higher authority is an important principle in dealing with such disagreements around adherence to guidelines. The Perinatal Mortality Meeting was a more formal clinical governance process than the joint ward round.

Patient relationship in a rural setting

The doctor-patient relationship plays a central role in how doctors understand their professional role. The relationship to patients was often featured in the interviews, observations, meetings and many discussions that doctors had.

I am across the courtyard from OPD and on the side Dr FW is standing in a small circle of people. One of them is a young woman, dressed in the hospital-issue gown; the others are dressed neatly and seem to be relatives of the woman. The doctor is explaining something to the relatives and the woman. As I pass I hear an older woman asking the doctor “And are you going to be here, when we come back with her?” To this the doctor replied, “Yes, I will have everything ready then, just go to OPD and join the queue there, I will see you in OPD...” I don’t hear anything more, as I have passed. As I continue and turn the corner to theatre, I see first the young woman and then the older woman hugging the doctor and then turn with the rest of the relatives and walk to the ward.
(Field notes 21/09/08)

The doctor was conducting a consultation with the patient and presumably the relatives were present, and there was a warmth and humanity in the way they related to each other, particularly evident in the gesture of closeness at the end of the interaction. The interaction moved beyond a rational discussion of clinical results. The discussion regarding arrangements presumably for a follow-up visit was not only about the date and place but also included personal concern and engagement.

It is not only in the Hospital where such interactions take place. Dr IC, who had only been at the hospital for 4 months at the time of the interview, was surprised to be recognised by people in Bergville when she went to do some shopping in town. In rural health the off-duty doctor is not anonymous. As a doctor it is known who you are and where you work and in the little town it is

not uncommon to be stopped by people that had been seen at the hospital and told about how a relative had recovered from the illness, or a family member has died. This occurs in the public space of a shop, at the filling station or when going for a walk in the mountains. It is not unusual to go to a restaurant and be asked for the results of a test by a waitress, or to be approached in the post office for information on the availability of a service from Emmaus Hospital. In these types of interactions, the professional working at Emmaus is being recognised, even though the interaction takes place outside of the environment of work.

During the interviews all doctors professed to have a good relationship with the patients. The criteria that were used to make this assertion clearly varied among the doctors. For some doctors, the quality of the relationship was based on how thorough the medical investigation and treatment were. For Dr CF, quality denoted continuity of care, which was much easier to achieve than in an urban setting. For Dr AM and Dr EW the quality of the relationship was reflected in the degree of emotional engagement. In all cases, the quality of the relationship had an aspect of reciprocity or responsiveness from the patients. (CW interview)

Over the years I had developed a habit when entering OPD. Instead of walking in through the back entrance, where the people sitting in the waiting area would not see me arrive and leave, I entered through the waiting area.

Entering OPD I loudly greeted all the patients collectively 'Sanibonani nonke' (the literal translation of the greeting is 'I see you') at which the group greeted back. I then enquired how everyone was 'Ninjani na?', in the usual pattern of greetings in isiZulu, to which the response was 'Niyaphila' ('We are well'). At this point I joked with them, saying if they are well, they can now go home. They had seen the doctor (pointing to myself) and now they were clearly better. This caused a commotion of laughter and some calling that they are still sick. I then went and start the routine of the OPD work. The reciprocity of the interaction established a context for the interactions that followed in the consultations. I had established some degree of rapport with the patients and was able to move rapidly to explore the reasons for coming to OPD. In many instances the humour of the interaction continued, for instance, when I asked

“Unjani?” (“How are you?”), some patients would say “Ngiyagula” (“I am ill”) and laugh. (Field notes 18/03/09).

The interaction indicated that I acknowledged everyone in the waiting area and the people waiting also acknowledged me. I also acknowledged that the majority of patients spoke isiZulu, and that they were waiting to see the doctor. The humour furthermore acknowledged them as people and, by saying that they are well and go home now I was also implying that they would like to wait a short time.

However, in essence, for the doctors most relationships with the patients coming to the hospital remained superficial. This was, in part, seen to be a function of the sheer numbers of patients seen (interviews CF, UT and CW). A single day often involved a ward round of up to 30 patients in the morning before tea, then either clinic visits or outpatient clinic where 20 – 30 patient consultations would take place. In such a context it is difficult to develop long-term, engaging and meaningful relationships with every single one of the 50-60 patients seen in a day (interviews with CF, FW and FT). The high number of patients is seen to shape the doctor-patient relationship and influences what the possibilities for the relationships are.

Individual patients were also seen to be part of a mass of people that were being seen and within that, patients were often objectified, grouped into collectives and de-individuated.

During a ward round in the TB ward we were discussing a young woman who had intermittent persistent headache. She was completely conscious but seemed to be in pain. Various investigations had been done, including lumbar punctures and other tests. The discussion moved toward whether she had any clinical signs of meningitis when Dr TC walked toward the bed where she was lying down and without any verbal interaction or eye contact, took hold of her head in both hands and moved it forward and backward to assess if she had any stiffness of the neck. The woman cried out, and grabbed Dr TC’s hands, it seems in pain. He let go of her while turning to the doctor leading the discussion and said, “Yes, she does have neck stiffness.”(Field Notes 06/06/2009)

The patient's body is the focus of the attention. The pain that the examination elicits is interpreted as a clinical sign. From the interaction it also appears that Dr TC has access to the patient's body, without having to ask for permission or to negotiate.

None of the other doctors in the ward round intervened or stopped Dr TC in how he had approached the patient in this particular case. The actions by Dr TC are at least tolerated, if not condoned, by the other doctors in the team as well as the nurses. It fits with the pattern of the ward round that I had described earlier, moving from one patient to the next with minimal explanation or engagement with the patients.

Similar sentiments are reflected in the way that patients are referred to in the context of our work. Patients are labelled in terms of their disease process or body parts or their prognosis (often using acronyms) such as "the MDR in bed three" (MDR stands for multi-drug resistance), "the BKA for theatre" (BKA stands for below-knee amputation) or "the gonner in the sideward". Collectively patients become "the queue" or "the ward" (Comments during doctors meeting 23/05/2008), which denote units of work. In most relationships with patients, doctors avoided closeness. "We ask such intimate things, yet remain distant". (FW interview)

Yet, many of examples given already indicate that the alienating abstraction evident in the interaction between Dr TC and the patient with suspected meningitis is by no means the only basis for the relationship between doctors and patients. Doctors have a high degree of choice and discretion in deciding how to relate to patients, but also the type of care patients will receive. The interface between the patient and the doctor is influenced by more factors than the way the profession defines itself.

Professionalism in action

It is clear not only from the professional ideals, but also the range of skills doctors have and the way that the professional patient-doctor relationship is viewed, that the idea of discretion – of being able to use one's judgement – is central to how the process of making daily decisions is conceived. In the incident I describe below, the complex layering of skills and knowledge, personal attitude and professional rules is evident:

The incident occurred over a weekend, when Dr TH was on call. He had been called by the midwife from labour ward for a woman in active labour and diagnosed foetal distress. He explained the situation to the woman in labour and, after obtaining consent, decided to do a caesarean section. He tried to call the doctor on 2nd call. [At the hospital there are usually 2 doctors at a caesarean section, one doing the anaesthetic and resuscitating the neonate, if required, and the other performing the surgery.] Dr TH was not able to contact the doctor on 2nd call on his mobile phone or at his home phone number. He discussed this with the theatre sister and suggested that he would perform both the anaesthetic as well as the surgery, but she refused to scrub with him. Dr TH then tried to call other doctors who may be around who were not on call. He could not find anyone. He discussed this with the theatre sister again, who then reluctantly agreed. Dr TH performed the caesarean section as a solo operator, first giving the spinal anaesthetic with an enrolled nurse observing the patient (under instruction of Dr TH), and then operating on the patient. A healthy baby was born and there were no post-operative complications.

After the weekend, doctors other than Dr TH raised their concerns about the problem presented by the non-availability of the doctor on 2nd call. When I discussed the incident with Dr TH he was nonchalant. He did not offer any explanation for the unavailability of the other doctor on call. Rather, he shrugged it off with the following comment: “There are many hospitals where we worked like this the whole time. That’s just how it is.” (Field Notes 21/07/2008)

The conduct of Dr TH demonstrates how working in an environment where resources are unavailable creates a situation where the doctor is forced to use his discretion in trying to manage the patient. The professional, ethical and institutional rules still require Dr TH to make one decision of many possible ones regarding the management of the patient. What starts as a purely clinical decision (identifying that the woman in labour needed an emergency caesarean section) required extensive engagement with the health care system that moulded what care the woman received in the end.

Dr TH could have decided to refer the patient to the next level of care and put the baby's life at great risk. This would have been a defensible action and been supported by the sister in theatre. Yet he had to weigh up not only the initial decision, but a cascade of decisions that would derive from the first decision – to confront the sister or not, to push for a caesarean section or not, to give in to the implied course of action that the theatre sister preferred (to refer the woman to Ladysmith) or not.

Clearly, Dr TH had experience, knowledge and skill in performing the operation and managing the situation. He had been exposed to such situations before, had treated patients like this before and, presumably, was aware of both the professional imperatives as well as the risks associated with the course of action he chose. He was aware both implicitly and explicitly in the discussion with the theatre nurse that there are possible professional sanctions against such a course of action.

In the incident described above, the theatre sister played a central role in determining the course of action, both through her initial refusal to scrub (which largely remained unchallenged by Dr TH) and then agreeing to scrub. She acted as a limiting factor, who ultimately decided whether the woman was going to go to theatre (and deliver a live baby) or not.

The negotiation with the theatre sister tacitly acknowledged that there were multiple sets of rules, multiple interpretations of the sets of rules and multiple power dynamics at play, even in the simple decision of whether to take the woman for a caesarean section or not. The individual interpretations (influenced by the local arrangements and quasi-rules) end up shaping such life-and-death decisions as to whether to do the caesarean section at Emmaus under imperfect conditions and potentially save the life of the child or to refer the mother in labour to Ladysmith Hospital, with the likelihood that the baby may die.

Even though the rules are remarkably similar in their intent and scope for each of the professions, in the immediacy of the decision making, minor differences, particularly minor differences in interpretation of the rules, can create seemingly unresolvable positions. The discretion both professionals are afforded allows them to have different interpretations and come to different conclusions regarding an acceptable course of action in the situation.

It is clear that Dr TH respected the decision of the theatre sister. He did not call on higher authorities or engage in conflict with the theatre sister, but rather tried to find another colleague to assist. She on the other hand could respect Dr TH's decision, and appreciated the effort he was making in an imperfect situation. This led to an agreement where both, jointly, could find a path of action.

The interaction underscored the interdependence of different professions in working together—but also that the respective professional authority and decisions are taken into account when making decisions. While much of the way that the professions define themselves, the inter-professional interaction is key in how decisions are made and acted upon. This expression of teamwork with unspoken rules of boundaries is an expression of respect and cooperation that requires care and dedication.

While it appears that the relationship with the theatre sister was difficult terrain, there was an open discussion around the decisions that needed to be taken. The relationship with the colleague who was not available seems much less explicit or resolved. As far as I know, Dr TH did not challenge the doctor on 2nd call at any point about the incident. It was absorbed into the general milieu of lack of resources. It seemed to be immaterial whether the lack of resources was due to financial constraints, local mismanagement or individual lack of accountability. On one level this is understandable. In the situation of needing to do a caesarean section, the reason for the non-availability of the second doctor (or third doctor for that matter) seems immaterial. There was a situation of one woman and her unborn baby that needed a caesarean section and that is what needed to be dealt with.

It was particularly interesting for me that Dr TH did not decide even to mention the unavailability of the doctor on 2nd call. Rather, he thought it was 'normal' to engage and negotiate with the sister and ultimately perform the caesarean section and anaesthetic on his own. The unavailability of the 2nd on call (which was never explored or explained) would constitute poor professional conduct. However, this was not followed up or even formally raised in any other context after the incident.

The rural doctor as a professional

So how is a locally legitimate interpretation of being a professional created?

As demonstrated above, being a professional in the context of the rural hospital is formed not only by the external concepts and definitions of what a professional is, but is strongly shaped within the context. In all the dimensions of how a professional can be understood, considerable local application and, therefore, local adaptation is evident. Doctors identify an ideal set of characteristics and values that rural doctors should possess, but differ in their views of what comprises that ideal. Just being here as an expression of commitment contrasted sharply with a deep commitment to doing everything right and being thorough – even where this clearly was also limited by resources.

Similarly, the skills and knowledge required to work as a rural doctor seem to be more than most doctors could muster. Individual doctors' interpretations of the scope of skills a rural doctor should have also varied. Being very skilled was seen as beneficial, but also had negative implications of needing to take on more responsibility and carry a heavier load. Passive resistance to developing more skills in a situation of feeling overburdened and overstretched is an understandable response, but again demonstrates the local response to an ill-defined ideal of what kind of tasks doctors in rural hospitals are expected to perform and, therefore, what skills they should have. The tendency to take on a much wider responsibility within the health care system, not only related to the range of clinical skills, is central to the identity of rural doctors, but not necessarily enjoyed by the doctors working in such a situation.

The process of holding doctors accountable, also when transgressing professional rules in the process of wanting to offer the best possible care for patients is complex. A degree of self-regulation and peer review was in place at Emmaus that resulted in doctors engaging in discussions around the quality of care, yet had limited authority to overrule the decisions of individual doctors. Extensive examples of individual doctors who did submit to the peer review process indicated acceptance of the moral authority of the process.

Conclusion

Within the medical profession as a whole the discretion of how the individual patient is treated is highly valued and defended. It expresses itself as the insistence on professional autonomy within a framework of regulations and ethical imperatives. The professional autonomy, however, is overlaid by the local context of the public sector bureaucracy and its framework of regulations and expectations.

Doctors are active in shaping this milieu and are part of the process of developing a locally acceptable version of being a rural doctor. The legitimacy seems to be based on a moral authority of being a rural public sector doctor that is qualitatively different from working in a different setting. The authority referred to is complex, including a degree of competency, commitment to justice and serving the poor and a sense of the health care system. Despite this formative process, divergent and unstated understanding and meaning is attached to rules – blurring meaning and needing to compromise. This again underscores the degree of discretion that being a professional working in such a setting allows for, and indeed requires.(7)

Professionalism in this analysis is, therefore, a locally legitimate interpretation as opposed to a universal ideal.

Chapter 6: Doctors as bureaucrats

Introduction

In this chapter I will explore doctor roles and sense of themselves as bureaucrat or civil servant through an examination of their daily work and experience as professionals at Emmaus Hospital. The patterns of work and engagement with patients are shaped by the nature of what they do and how they, as street-level bureaucrats, find ways to manage competing expectations.

The larger system protects professional space, both on a macro scale and in the local context. There is little scrutiny or access to this space within the health care system even though the health care system as a whole is arranged around the availability of certain health professionals and services that they are able to offer. In a similar manner to how the access to OPD is regulated and requires referral by other PHC level care (except in emergencies), the regional services and central services require referral from the district-level care in order to gain access to specialist services. This elaborate system limits access of patients to doctors and entrenches the perception that *because* doctors are scarce they have discretion to work the way they do.

The purpose of the arrangements is to be able to provide the service, and is strongly aligned with the technical skill of the different doctors and services in the different levels of the service. The on-going relationship between a health professional and the patient is secondary to how services are provided.

Doctors managing their work

Collectively, doctors at Emmaus Hospital had considerable leeway to arrange their duties in a manner that suited them. Even the decision of when the working day started, was, within limits, left up to the team of doctors themselves. Doctors met routinely every Friday morning in the library to plan the services for the following week. They also began each day with a meeting, usually in the courtyard in front of OPD, to coordinate their day's activities. The planning and coordination meetings shape the working day for the doctors and follow well-established patterns that arrange the doctors in a way to ensure that all the work is covered.

The overall system is arranged around ideas and realities of the scarcity of doctors. This is reflected in many of the processes that are dependent on the professional decision, skill and authority of the doctor. These include activities such as prescription of drugs, which is regulated by legislation or arrangement of the ward rounds as described above, which reflect more inter-professional and local arrangements. A way that the doctors manage the scarcity is to develop a team, where each member is able to work across a number of functions and cover work otherwise performed by other doctors. This is very different from a larger hospital where the responsibility of one section is not readily shared among other sections.

Weekly Planning Meeting

Starting at 07:30, the Friday morning planning meeting allocated doctors to activities for the following week. Generally, core activities were the daily visits that a doctor undertook to the peripheral PHC clinics some 20 to 70 kilometers from Emmaus, theatre work that included anaesthetics and both the scheduled elective surgery and daily *ad hoc* emergency surgery, and the disability grant applications. The planning meeting also covered who was responsible for the ward round in each ward on each day as well as whether other meetings or visitors were expected. A template for a roster had been developed a few years previously with all the major areas of work that needed to be covered and was completed during the meeting. The roster for the following week was then distributed to all the wards, theatre and OPD.

The meeting of 19/06/2008 typifies the process of weekly planning:

Dr FW indicated that Dr KD from Ladysmith would be visiting on the following Wednesday and he wanted to discuss some patients with Dr KD and therefore did not want to be allocated the PHC clinic visit on that day. Dr UT volunteered to go to the PHC clinics instead. Dr CF volunteered for the ARV clinic, and so on until all the duties had been allocated. The doctors' initials were noted on the roster and Dr KD's visit was also entered. (Field Notes 19/06/2008)

A number of doctors also had areas that they wanted to focus on and the allocation process allowed for some flexibility to accommodate interests of individual doctors. In the process of

allocation the team attempted to spread the workload among the doctors while taking a mix of skills, seniority and workload into account.

While some doctors changed wards regularly, others stayed in one ward over a considerable time where they developed greater skills in one area. Dr CF had developed a relationship with patients and staff at one of the PHC clinics and volunteered to go to this clinic most weeks. Dr UT was interested in obstetrics and took charge of the high-risk antenatal clinic. The regular allocation to one service also promoted ongoing engagement and taking greater ownership of the service. The process was felt to support the ability to “make a difference”. (IC interview)

Daily Morning Meeting

Doctors discussed any changes in the plan for the day at the daily meeting. For example, on the 04/06/2009 a doctor scheduled for duty called in sick:

Instead of meeting under the walkway in the courtyard where we usually met, some of the doctors were standing in the sun next to the paediatric ward. When Dr TI arrived, he reported that Dr FE had phoned him in the morning saying that he was ill. As Dr FW was on holiday we were a bit short in OPD now, where Dr FE had been allocated to work. The discussion moved quickly to explore options of who would do the ward round in Dr FE’s ward (male ward) as well as how we would ensure that there were enough doctors in OPD during the day. Dr TC offered to do the ward round in MW after his ward round in TB ward, and would therefore be a bit later in OPD, and Dr IC indicated that she was down for theatre and there were only 2 cases and therefore she would be able to get to OPD earlier.

The day was further fine-tuned, as doctors made arrangements around who went to lunch first or the use of the opportunity of being in theatre together to do some teaching. (Field notes 04/06/2009)

Generally, doctors took collective responsibility to cover the work and ensure mutual cooperation.

OPD

While the weekly and daily planning of activities allocated different areas of work to doctors, within each of the areas of work patterns were established that shaped the interaction between colleagues and patients in a system that relied not only on other doctors but also on a range of other personnel.

The nurses in OPD were expected to manage the queue, ensuring that everyone waited their turn and that patients were orderly. There were many moments that could spark dissatisfaction. If someone tried to 'jump the queue' there was an uproar and unhappiness among the people waiting to be seen. Patient dissatisfaction increased when the queue moved slowly or doctors went to lunch, particularly if there was no doctor in OPD for the whole lunch period. However, whenever there was commotion in the waiting area, doctors would not intervene. Rather, they would instruct the nurses to sort things out. In doctors' and OPD meetings where doctors and nurses met together, doctors generally distanced themselves from responsibility for queue management (doctors' meeting 20/01/2009). By so doing, they were able to focus on the consultation while maintaining a distance between themselves and the organizational issues of waiting patients.

At any one time, several doctors had to work together in OPD in order to attend timeously to all patients. Their work required considerable cooperation and coordination. Doctors, however, responded variously to this requirement. At a doctors' meeting where these issues were discussed (06/01/2009), it was apparent that some doctors were more aware of how full OPD was at any given time and would pace their work accordingly. When it was busy, they would process patients faster or do multiple tasks in order to finish more quickly. Others, however, did not change their pace or pattern of work, even when OPD was full and the queue was long, as the account below illustrates:

On the 18/03/2009 OPD was full – all the chairs in the waiting area were occupied. When I arrived, I saw Dr FW and Dr TW standing in conversation at the entrance of one of the consulting rooms in front of the full waiting room. The nurses were sitting in the consulting rooms that were not occupied also chatting with each other – and there

appeared to be no hurry to do anything. Dr FW and Dr TW were talking fairly loudly about where they were the previous weekend. There seemed to be no urgency to attend to the waiting patients. The patients sat waiting and the two doctors stood there in the corridor, talking. In the meantime, the two other doctors working called patients into their consulting rooms at regular intervals. The queue moved slowly. After observing this for some time, I walked past and asked how OPD was going, to which Dr FW replied: “Eish, it is really full...” pointing to the waiting room. And then he added, “I suppose we must get cracking,” and called the next patient in the queue to his consulting room. (Field notes 18/03/2009)

The issues of cooperation and coordination extended beyond pace of work. When patients needed admission, some doctors tried to ensure that as much of the investigations and completion of forms would be sorted out in OPD, even the reviewing of test results before sending patients to the wards. Others, however, ordered investigations but did not make sure that bloods were taken or investigations performed. Although doctors frequently discussed these and other possible solutions to dealing with staff shortages and streamlining activities, they found it difficult to reach a consensus about exactly what should be done (doctors meeting 06/01/2009) and some were unable to apply the required flexibility and responsiveness to their practice.

Even though doctors purported to share an overall ethos of care that gave them purpose and meaning in a rural setting like Emmaus, high levels of individual discretion around pace and approach to their daily routine resulted in considerable variability in the actual extent to which they cooperated and collaborated with doctors and other members of the health care team.

Ward rounds

Doctors and other health care professionals followed well-established patterns of work in the daily routine as the account of rounds in the female ward illustrates. (Field notes 18/08/2008)

At the time of doing the study the main section of the female ward was arranged in an open dormitory style, with two rows of beds facing each other separated by a wide passage. At each bed there were curtains. They were tied back but when they ran along the railings suspended

from the ceiling, they enclosed the bed in privacy. At one end of the ward was a small office space for the nurses, called the 'nurses' station.' It was enclosed with glass and slightly elevated, making most of the ward visible to the nurses, although patients were not able to follow the interactions that took place in their space.

At the far side of the ward were doors leading to the ablution facilities. Even though the building was old, the ward looked neat and well maintained. The beds in the ward were fairly new. The walls had a new coat of paint.

All parties, including patients, operated by ward rules. Amongst other things, Emmaus patients were required to be in their beds from the start of the doctor's ward round until it was completed. Many other activities in the ward, including cleaning or visiting patients would cease during ward rounds.

I was sitting at the phone in the nurses' station of the ward, waiting for a doctor from the referral hospital to return my call regarding a patient I was referring. From this vantage point I could observe the ward round that was underway. Dr FW, together with the professional nurse, moved along the central passage from one bed to the next. Most patients sat on top of their neatly made beds. The physical setup and procedural arrangements of the ward round allowed Dr FW and the nurse to work rapidly, with maximum access to the patient. The ward round had already started at one end of the ward and had reached the third bed when I had arrived in the ward.

The professional nurse pushed a doctor's trolley along with her. It carried many different forms and papers, a box of latex gloves, some small boxes with various items such as sputum bottles with green tops, one or two books and a clip board with laboratory results on the top level and a pile of x-rays on the lower level. As the doctor came to the next bed, he took the patient's file from the box at the foot end of the bed. He opened the file, paged through it, looked at the last entry, paged to the section on blood results and paged through the results that were in the file. The woman in the bed sat up straight and observed closely what the doctor was doing. Initially she did not speak.

The doctor turned to the nurse and asked her for some of the results from the laboratory and whether a blood specimen had been taken the previous day. The sister started paging through the clipboard and then called to the ward clerk to ask whether the blood results had come back from the laboratory. The clerk in turn responded that she would go and check. In the meantime the doctor had started to look through the pile of x-rays. He found the x-ray he had been looking for and took it out of the large brown envelope. He looked at it against the light of the windows, behind the woman in the bed. He returned the x-ray to the envelope and started writing in the file.

Dr FW then looked up and, in English; he asked the patient how she was feeling. The nurse translated his question and the patient responded in isiZulu that she was feeling a little better. The doctor nodded, completed the notes in the file and filled in some of the forms for further blood investigations. He looked up to her and in English said “We’ll carry on with the medicines that we have been giving you in the drip. We are waiting to see if you have TB.”

With that he turned to the next patient and opened the file. The nurse translated into isiZulu what the doctor had said to the woman. The patient listened carefully and then asked the nurse whether she could go home. The nurse responded that the doctor was waiting for the sputum results and that this would take some time.

At that point the doctor turned to the nurse, interrupting her conversation with the patient and said (in English) – “Oh, we also need to do VCT (Voluntary counselling and testing).” He made a further note in the patient’s file and turned back to the file of the next woman. The nurse said to the woman in isiZulu: “We need to wait for the result for the TB – and the doctor wants you to test the blood – the girl will come later to speak to you.” The patient asked “Test for what?” to which the nurse answered “For HIV.” The patient laughed and turned away to the woman in the neighbouring bed and conferred with her softly in isiZulu. (Field notes 18/08/2008)

Reflecting on the field notes I noted that the tests were ordered matter of factly, as part of the routine of the ward round and similar to other administrative issues that needed to attention.

There was little explanation given to the patient. She was not engaged in the reasoning behind the request for the test and her opinion was not solicited. In the case of the HIV test, the nurse informed the patient that “the girl” (a lay counsellor) would engage with her around the test and would explain things, removing pre-and post-test counselling from the practice of the professional nurse of the doctor.

Such interactions with patients were routinely the practice in ward rounds. It was an open interaction in which there was little privacy — even the request for the blood result was called across the ward by the nurse to the ward clerk. The pattern of open interaction between doctors and nurses in full view of patients and with little privacy was repeated as the doctor and the attending nurse went from patient to patient for about two hours reviewing notes, checking blood results or ordering further investigations, until all the patients in the ward had been seen. The focus of activity and attention was on the patients’ notes and prescriptions, on their results and x-rays and on the next set of investigations. The ward round had a ritual of efficiency about it. The roles of the doctor, professional nurse and even the patients were clear. The ward round was arranged around the activities of the doctor. He could ask for forms or results and they would be brought to him. The equipment used for the routine tasks on the ward round was readily available on the trolley that the professional nurse pushed along with her as they moved from bed to bed. Patients only spoke when they were spoken to; the nurse translated.

At the end of the ward round, doctors might need to perform procedures in the ward. The same efficient and systematic approach of the ward round is evident in the pattern of how the procedures are performed. Patients are prepared and positioned and all the required equipment and forms for the procedure are put in place and ready for the doctor.

In the case of the female ward round described above, for example, Dr FW needed to do a lumbar puncture and an ‘ascitic tap’ (drawing fluid from the distended abdomen of a woman with ascites). In both instances, the professional nurse had already instructed one of the staff nurses to prepare for the procedure during the ward round. When the doctor came to do the procedure, he found the equipment, gloves and disinfectant ready and waiting for him.

The staff nurse drew the curtain around the bed and gave brief instructions to the patient regarding what would happen and how the patient would need to be positioned. She held the patient's hand, while the doctor busied himself in preparation for the procedure. For the procedure itself, Dr FW told the woman in isiZulu, when he was going to insert the needle, and that she should remain still. Once he obtained the required fluid and filled it into the correct specimen bottle, he thanked the woman, sealed the specimen bottles, labelled them and completed the forms to go with the specimens to the laboratory. (Field Notes 18/08/2008)

The preparation by the staff nurse with all the equipment laid out and the patient already positioned allowed Dr FW to perform the procedures quickly and efficiently.

In between moving from one patient to the next, he discarded the gloves he used into the bin next to the washbasin, washed his hands and went to the following patient where the nurse had moved the patient into the correct position behind the drawn curtain. (Field Notes 18/08/2008)

When Dr FW performed the procedures, they were done effortlessly, with the nurse, doctor and even the patient all participating with only minimal cues in fairly complex activities. There was seemingly little need to explain, engage or find out more about the person in the bed. It was impersonal and focused on "getting the work done." (CW interview)

Efficiency beyond the ward round

Doctors also function within a larger system. They depend on processes that they may have had some influence over but were not in the sphere of their direct control.

During the ward round in the female ward, Dr WT presented a patient he had admitted the previous day. The patient was post-menopausal and had previously been admitted to the ward with chronic vaginal bleeding. During the prior admission at Emmaus she had had an ultrasound that found a mass in the lower uterus. It was not clear however, whether it was a benign fibroid or a malignancy. After discharge from hospital she had been referred for a pap smear at the PHC clinic. At the time of doing the smear she had

been asked to return to clinic after 4 weeks to review the results with the visiting doctor. At the scheduled follow-up visit she was seen by the doctor. Her test results were not back, however, and the doctor wrote: “Pap smear result not back – TCB [to come back] in 2 weeks,” in the notes. She returned two weeks later, and the subsequent doctor wrote the same note.

When Dr WT saw her at the PHC clinic at her subsequent visit some two months after the Pap smear had been taken, the results had still not arrived. This time, instead of writing “Pap-smear result not back TCB in 2 weeks,” from the clinic he called the cytology laboratory in Pietermaritzburg to trace the pap smear number and in the process learned that there was a backlog of about 5 months for reading routine pap smears. Owing to the high index of suspicion for a malignancy, he asked the laboratory staff to prioritise reading the smear and to give him feedback that same day. He also traced the results of other blood investigations that were taken previously (that also had not been recorded in the notes) and decided to admit the patient so that “things can be sorted out” and “she will not fall through the cracks”. (Field notes 22/07/2009)

Dr WT used discretion to decide whether or not to act on behalf of the patient within the larger system. As he was not directly responsible for the delay in the pap-smear results, quite reasonably he could have waited for them just as other doctors had previously done. Also, although he was not responsible for the female ward where the woman was admitted, at Emmaus it was acceptable practice for him to admit the woman to the ward and discuss what needed to be done with the ward doctor. He, however, had made most of the arrangements even before her admission and followed up on the phone call he made to the cytology laboratory. When he phoned the following day for the pap-smear results they showed malignant cells. The patient needed to be further investigated for cancer of the cervix. Dr WT then arranged her referral to the oncology clinic at the tertiary hospital for an early appointment.

Dr WT managed not only the clinical aspects of the case, but used his understanding of how the larger system functions to assist the patient. He had made multiple arrangements for the

patient, short-circuiting red tape in the system and finding the fastest way to address the woman's clinical problem.

He understood how the different components function and he had worked out how to navigate rapidly through the requirements for each component. He also chose to act on behalf of the patient, using not only his clinical skills and acumen but also his knowledge of the system. His clinical skills enabled him to diagnose the seriousness of her condition, but without his knowledge of the laboratory system, the booking system and even the system of admitting patients to Emmaus, he would not have been able to refer her as rapidly as he did for the care she needed.

Like Dr WT, several doctors took pride in their ability to overcome bureaucratic requirements and inefficiencies by circumventing obstacles and managing loopholes in the system. Amongst others, their strategies involved developing personal relationships with key individuals who could short-cut decisions (such as consultants at the regional or central hospitals) and making themselves familiar with how the booking system worked for specific services. This said doctors were also aware that their efforts did not always pay off for both logistical and subjective reasons. As Dr WT observed "here, you have to be realistic and realize that it takes time to transport the patient, it takes time to report on all the scans by the radiologists in 'Martizburg, for instance.'" (WT interview)

Discretion not only operated positively, in terms of acting for patients in the bureaucracy (like Dr WT) or choosing to increase efficiency and cooperation. It also operated negatively, in terms of using discretion to avoid work, leave work early or avoid taking responsibility. The examples illustrate that not all doctors treated patients or their jurisdiction of responsibility in the same way. At Emmaus it is possible to escape the definitions that are thrown upon you and one does not have to behave in a way that is expected from civil servants. It is possible to be less officious and have a different relationship with the people around you. (CF interview)

Personal relationships and how these formed part of the way doctors made meaning of their work at Emmaus seemed to have a large impact on how some people were being treated. The relationship Dr CF referred to was larger than that of a professional –It pointed to a more

human contact and interaction not regulated by professional or bureaucratic rules of being a doctor in the public sector.

Being a doctor and civil servant

The clinical work performed by the doctors stretches across levels of care, referral systems, waiting rooms and ward rounds. The arrangements enable doctors to work rapidly and efficiently, but they also shape the contact and interaction that they have with the individual patient. In the routine of daily work, many processes are organized around the doctor. Within these processes doctors exert considerable control over the practical organization of their work, both collectively and individually. While the focus of planning is primarily on service delivery and getting the work done, individual doctors manage their own ward rounds, their own pace of work and their interactions with the patient to a considerable degree.

To a large extent, the package of services that should be delivered at a district hospital is dependent on the availability of doctors. In other words doctors are central to the implementation of Department of Health policies. For some doctors, however, the import of this reality is poorly understood. For them, their focus remains on their function as a doctor: “I am a doctor. I don’t think I see the bigger picture of being employed by the government department.” (WT interview)

For others, who may understand their role in realizing Department of Health policy in practice, there is the tension of working in a resource-constrained environment, particularly in rural hospitals. “When you come to work for the government service, you forget about many things. You say, let me put this aside”. (FE interview) They are forced to confront the disjuncture between the many positive aspirations articulated in the policy and the harsh limitations of local service that did not seem to be designed to address these objectives. Doctors (and other health care workers) functioned in the space between the intentions of the policies and the reality that they face in daily work. Despite the freedom by doctors to control much of the work, the limitations of working in the public sector were felt to impact on the quality of care that patients would receive. “We always need more equipment, more time, more staff” (TC).

And so, “there will always be a conflict” (FW interview) between the role of being a doctor and a civil servant.

Conclusion

Working in the public sector raises a range of critical questions about how best to care for patients. While the overall system allows for considerable agency to assist patients, there also are evident loopholes in how doctors interact with the patients that come to see them for help. Working as bureaucrats means they have a range of actions open to them, from hiding behind rules and to creative and responsive engagement with the health care system in order to find the best solution for patients.

Chapter 7: Doctors as public officials

The queue was moving slowly in the general waiting area. Toward the back of the OPD a second queue of people filled the passage. They waited for their turn to see a doctor as part of the disability grant application process.

Doctors are called upon to act in a legal and official sense in a range of circumstances that extend beyond therapeutic care. These functions are regulated by specific legislation that regulates activities that are not strictly therapeutic yet are part of the scope of being a professional. Among other things doctors are required to complete sick leave certificates, carry out medical assessments for insurance purposes and to provide reports for the placement of disabled children in special schools. Doctors also have to provide forensic reports where they suspect abuse of children and to document injuries in cases of alleged rape or where death is possibly due to non-natural causes. The doctors are also a certifying authority in disability grant applications. In this section, I will use the example of their role in disability grant assessments to explore the role of the doctor as a public official.

The administrative process

Unlike other social support grants the disability grant requires medical certification. The applicant has to be assessed by a doctor and found to have a physical or mental disability. The verified condition has to be of sufficient severity and duration for the grant to be awarded. In urban areas the Department of Social Development or the South African Social Security Agency has contracted doctors specifically to perform the disability assessments. However, in rural areas public sector doctors, because of their limited number and historic practices, perform these assessments as part of the general outpatient function at the hospitals.

For the applicant, accessing the grant involves a lengthy and complicated administrative process that needs to be managed across two, often three government departments: Social Development, Department of Health and at times Home Affairs, if identity documents have to be obtained.

I was assisting Dr, FE in the “DG clinic” (disability grant clinic). He had recently joined Emmaus Hospital and was unfamiliar with the process. When we went to OPD at about

11h00, a queue of people waited outside the consulting room in the OPD. They sat separately from those in the patients' waiting room as the nurses had identified who came specifically for the "DG's."

As we prepared to see the first of the applicants, I tried to outline the steps in the process again. Although the process had been discussed in a doctors' meeting and was covered in the documentation that is given to doctors as part of their orientation to Emmaus Hospital, the paperwork and the steps involved were difficult to convey outside of the actual context. The people in the queue were at different stages of the disability grant application process. Depending on their specific situation, different forms would need to be completed.^c

As we saw each applicant, Dr FE and I went through the documentation that was required for each of the steps. The first applicant came with the referral letter from the SASSA offices, indicating that he had been registered into the application process. The forms he came with contained his identification number, fingerprints and a certified copy of his identity document. He also brought his medical records. Together Dr FE we went through the medical assessment form that needed to be completed.

The medical assessment form outlined the components of the assessment under a number of headings. The doctor had to complete sections on the conditions' history, the clinical signs, the treatment provided and the prognosis of the condition. The section on the degree of disability (rather than impairment) required the doctor to specify how disabled and how permanent the disability was. The doctor had to sign the form and add the HPCSA registration number as well as the dated facility stamp. The assessment form was stapled together with all the other documentation brought by the applicant,

^c Points of entry into the disability grant request process were either a doctor or social worker (public or private) who would refer the patient to the SASSA offices. Alternatively the patient could go directly to the SASSA offices to request a disability grant. At the SASSA offices the patient needs to produce a valid identity document, a certified copy of the identity document as well as documentation that they are indigent. Once certain criteria are met (the person needs to be over 18 years of age and under the pensionable age, be indigent etc.) their name is entered in a register. The certified copy of the identity document is attached to a referral letter with a specific reference number and a date stamp and these are given to the patient who must then to be assessed by the doctors at Emmaus.

and placed in an envelope that was taken to the SASSA offices in Bergville by the driver of the Hospital.

Other applicants that we saw were at the initial stage of the application process. They had come to request referral to the SASSA offices so that they could register into the application process. The referral consisted of a standardised letter that needed to bear the official hospital stamp, the date and the doctor's signature.

Some applicants presented with forms that were incompletely filled in or documentation that was missing. . An older woman came with multiple forms that were in no clear order and some of the documentation seemed to have been duplicated. After sifting through and arranging all the paper work in chronological order, it seemed that she had applied for a disability grant more than once. Also the identity numbers on the forms were not consistent. Dr FE and I explored this with her and it turned out that she was making an application for a disability grant for her younger sister who was severely mentally disabled. The sister had received a grant for her disability for a long time but the grant was terminated because she had not come in person to collect it at the grant pay-out point. Her sister now needed to go through the application process again to verify that she was indeed still alive as well as disabled. The older woman had also used her own identity number and the sister's identity number interchangeably on the forms which had caused confusion. The disabled sister was not present and there was no proof of whether she was still alive or not. (Field notes – 23/05/2008)

Reflecting on the field notes, I became increasingly aware of how difficult it was for both the doctors and the applicants to navigate through the bureaucracy. From the Dr FE' perspective, even though the steps in the flow diagram in the orientation documents sounded straightforward, the detail of the context made it increasingly difficult to assist individuals as there were so many additional and exceptions to the rules.

I also was cognisant of the fact that doctors used different strategies to arrange the work, including getting through the paper work. They even differed in how they attended to the first few steps of seeing applicants that came to Emmaus Hospital to apply for a disability grant

(Field notes Dr's meeting 18/05/2008). Dr CF, for example, dealt with each patient in detail one by one to try to clarify which forms were needed and sort out the problems as they arose. She tried to write individual letters for each of the applicants if they were incomplete (CF interview) and felt that whoever came through the door needed to get her full attention.

Dr UT's strategy was to only begin to fill in an applicant's individual forms after going through the whole queue to check their documentation. He would "automatically" (UT interview) turn away people whose forms were incomplete or who did not bring all the required documentation. In the doctors' meeting he was of the view that "They should have been told by SASSA only to come here if all their paperwork is in order." He did not see his role as one of assisting applicants to navigate their way through the process. In his view it was SASSA's responsibility to sort all the paperwork out and to inform each applicant of the processes and requirements for the grant before they came to the disability grant clinic at Emmaus Hospital.

Dr UT then grouped the remaining applicants according to where they were in the application process. He first saw the people who needed a medical assessment form. Then he turned his attention to those who came to request initial referral to the SASSA offices. (Field notes 18/05/2008)

Responding to changes in regulations from SASSA

At Emmaus Hospital confusion around the disability grant process was ongoing. For new doctors, like Dr FE, the process had many nuances and challenges that were not easily understood. In addition, during the data-collection period, SASSA introduced some regulatory changes that we first discovered by default because a number of applicants were sent back to Emmaus with the instruction that their forms were incomplete. Two to three months prior to our efforts to get clarity, SASSA had instituted a rule that two doctors, rather than one, were expected to complete the medical assessment forms. These new regulations further complicated the process, adding to the confusion. In the interim, because doctors were not informed of this change, applicants were sent "from pillar to post, getting contradictory instructions from different officials and doctors and nurses." (CF interview)

The officials at SASSA explained to Dr IC that the changes complied with directives and policies purportedly introduced to improve efficiency and prevent abuse of the system. However, when Dr IC asked for copies of these revised policies and guidelines, SASSA officials could not produce any documentation. Dr IC was unable to establish whether the regulations came from national policy or provincial regulations or indeed if they were just adaptations and interpretations by local officials at the SASSA offices. (Field notes 02/05/2009)

At Emmaus, a lengthy discussion ensued among the doctors to find a solution to the requirements. Dr CW and UT pointed to the impact that any changes in the disability grant application process would have on OPD, as there was an acute shortage of nurses at the time. The requirement of having two doctors assess the disability grant applicant would mean doubling the doctors' workload at the disability grant clinic.

The medical manager proposed that a 'DG clinic' (Disability Grant Clinic) be set up at the SASSA offices in the Department of Social Development in Bergville. This suggestion initially met with a negative response as the doctors worried about its implications, inter alia, additional work coupled with the decrease in doctor availability at the hospital as well as additional transport costs (CW in the doctors' meeting. Field notes 16/5/2009). Also, the day that was proposed for the DG clinic, Fridays, clashed with the day specialists routinely visited Emmaus hospital as part of their outreach service. Doctors felt that the arrangement would mean that one less doctor would benefit from specialist teaching and support.

With time support for the idea a 'DG Clinic' on Fridays at SASSA offices grew, as the doctors weighed the options available to them. Dr UT in particular argued that such an arrangement would enable doctors to take responsibility for the parts that they are trained to do and it would force SASSA to take responsibility for sorting out the paperwork.

Eventually the team at Emmaus agreed to run a 'DG Clinic' at the SASSA offices. The new arrangements were finalised within three weeks and a doctor from Emmaus started attending at the SASSA offices every Friday. The first few DG clinics were somewhat chaotic but the system soon settled down, with the doctor on duty filling in forms without doing any clinical

examinations. Applicants were required to bring all clinical information and they were sent back to the referring clinician where this was insufficient or incomplete. The onus of provision of the clinical information was on the applicant.

Subsequently, SASSA negotiated with Dr IW, one of the local private doctors, to perform assessments on the applicants on Fridays as well. As his offices were within walking distance of the SASSA offices in Bergville, this innovation meant that registers could be completed and applicants could be seen and assessed by two independent on the day of the DG clinic. In other words, it was now possible for the application process for a disability grant to be processed from beginning to end within a single day, board. (IC in Dr's discussion, 28/07/2009)

This solution had multiple additional benefits. By moving the queue of applicants out of the OPD space to the SASSA offices in Bergville it assisted in decongesting OPD at Emmaus Hospital. For SASSA it enabled the assessment process to flow more rapidly and efficiently, as both medical assessments took place on the same day, with completed paperwork ready for submission to the disability grant review. Disability grant applicants also benefited greatly, particularly in terms of transport costs, as all the medical assessments could be completed in one trip to Bergville.

What fuelled the change in the system was the bureaucratic imperative to create 'checks and balances' to combat fraud and objectify decision making that, in turn, translated into significantly more barriers for people with disabilities. Ironically, while it was not the intention, the new process improved access to grants for the people who needed them.

Assessing disabilities

During orientation to the disability grant process, Dr FE asked me – “How do you assess if someone is disabled?”(Field notes 18/05/2008)

This question, at the heart of the role of the doctor as a professional in the disability application process had been discussed at length among Emmaus Hospital doctors as they have grappled with the challenge of a how medical examination or tests could indicate and be used to determine the extent of disability and its consequences. It seemed that SASSA expected that

doctors' interpretations of biomedical indicators would provide them with definitive answers. The guidelines from SASSA outlined that if the condition limited the functioning of a person this constituted a disability. There was no good guidelines however regarding how to assess the severity of the limitation of functioning – and for doctors this was difficult to assess

In order to try to provide more objective measures to justify determining disability or impairment doctors at times would order blood tests, x-rays or other scans. Dr CF gave an example of a patient with extensive joint destruction. The x-ray seemed to be a straightforward way of indicating the severity of the disability yet, in itself, it was not informative of the patient's ability to walk or perform routine tasks. As Dr CF stated, "The diagnosis is generally meaningless with respect to severity of disability." (Field notes 30/05/2008)

At many meetings the discussions around the disability grants focused specifically on biological markers. However clear the argument seemed, the lack of objective measures of a disability was frustrating. One example that came up to illustrate doctors' concerns was the CD4 count of 200 'cut-off' that was used to determine eligibility for a disability grant. The low CD4 count was an indication of disease progression, target organ damage as well as having a prognostic value. Yet, in disability terms, there were many people with a CD4 count of more than 200 that deserved grant support because they had other complications of HIV. Conversely, there were many people with a CD4 count of less than 200 that were very well.

Determining disability in terms of functional capacity to work and social and economic vulnerability fared even worse. It was hoped that occupational therapists and physiotherapists would provide doctors with "a proper assessment of what they can do" (CF interview). Yet when they were drawn into the process, they too were bedevilled by the tension of different models of understanding disability and the requirement of providing clinical assessments to determine the severity of disability. In addition, all health professionals struggled to understand the meaning they should give to the ability to work, given the local social context of high unemployment rates and work opportunities that invariably involved strenuous manual labour.

Doctors nevertheless were required to complete the forms and in the absence of clear criteria to guide their understanding, the main deciding factor was the doctors' discretion. The further the matter was considered, the clearer it became that their decisions were arbitrary and inconsistent, particularly in terms of how they took account of the social contexts of the individuals seeking disability grant relief. (Doctors' discussion 30/05/2008, 04/11/2008, 30/4/2009, 02/05/2009) It seemed that the severity of the disability, the capacity to cope with the disability or the level of individual income had little, if any, bearing on whether an applicant would be given a disability grant.

Medicalization of entitlements

Disability grant applicants want to access resources that the state, as part of its policy and perceived duty, makes available to its citizens. The application process is itself a way of realising entitlements that come with citizenship. The requirement of a medical examination and assessment in order to access the benefits of citizenship influences the nature of the relationship between the applicant and the state. This resonates with the idea of biological citizenship discussed previously.(5, 80)

For the doctor or health professional the engagement with a patient as a disability grant applicant changes the relationship profoundly. In the instant of making the request, the patient engages the doctor as an official arbiter of a non-medical service from the state, rather than as a health professional. This transition is not a choice of the doctor.

The fact that some doctors expect applicants to appropriately self-diagnose and self-refer suggests that these doctors assume that people understand and have internalised the medical dimensions of the qualifying criteria. And indeed many have – whether they have a disability or not.

Fraud

Many of the application requirements – documentation in support of a means test, certification of identification documents and fingerprints – are strategies by SASSA to minimise fraud. The attempts by some applicants to gain access to the grants through deception further support the view that some disability grant applicants know and work the system.

After Dr IC's presentation on the models of disability, several doctors described instances where individuals tried to claim disability grants fraudulently. Dr CW recounted an instance of a patient whom she assessed for a disability grant. When he came into the consultation room he seemed virtually unable to walk or bend. But when she asked him to climb onto the examination couch, he lithely bent over to take off the shoes, and then got onto the couch unassisted. When she started the formal examination, he again was not able to bend his back even a few degrees and groaned in apparent pain. "They are wasting my time if they are not disabled." (Field notes, CW in the doctors' discussion 02/05/2009)

Dr FW told of an applicant already receiving a disability grant who presented with another person's identification papers and medical records. The applicant claimed to have been diagnosed with TBs and HIV. By chance, Dr FW recognised him from a recent admission to the hospital where the diagnosis of both TB and HIV were specifically excluded. During the course of the consultation the applicant realised that Dr FW remembered him and he ran out of the consulting room. (Field notes 04/11/2008)

SASSA's expectation that doctors use their professional expertise to prevent applicants from defrauding the system also casts them as bureaucratic functionaries and model citizens. In practice, some take to both these roles while others do not.

Generally, however, doctors felt that patients who malingered or tried to get grants by deception broke a tacit agreement between themselves and their doctors. They found it awkward to manage the relationship when there was such obvious secondary gain attached to the assessment. "I really don't like being abused like this." (FW interview) Several found the relationship difficult to repair.

Gatekeeping resources

The doctor's role as a gatekeeper of resources in the disability grant process came up repeatedly in Emmaus hospital meetings. The guidelines from SASSA state that the doctor is required to do a medical assessment and that the decision to award a grant is taken by a SASSA-appointed board based on a review of all relevant information. In this, even though

doctors play a critical part in the decision-making process, they are once removed from the outcome.

In the local context, however, the doctor's report is the determinant of an application outcome. When Dr IC visited SASSA the officials informed her that the Board was not functional and had not met once in the preceding 8 or 9 months. As a consequence, they processed applications using doctors' assessments to determine outcomes. Doctors have become de facto arbiters of disability grant awards.

Inevitably, doctors views on the disability grant were influenced by the role they had been assigned as officials – “acting for the state – we are implementing the service-delivery promises of the state” (IC in the report back from SASSA office - Field notes 02/05/2008) – and the attendant responsibility that came with it. They knew that state resources were limited, a fact that they had been reminded of by SASSA.

Some of the doctors questioned the amount of the award. “Why would the state give so much money?” (UT interview) Some felt it created dependency and laziness. “The disability grant makes people lazy and apathetic. If I was given some money for nothing, of course I would rather not work. I would also rather get the money than have to work all day.” (CW in the doctors' discussion, Field notes 04/11/2008)

For others, unease about and even a reluctance to complete disability grant applications by some stemmed from a conflict in imperatives between being a public official and a high-level health professional. “We need to do the best for our patient.” (CF in the doctors' discussion, Field notes 30/05/2008)

Yet, “doing the best for the patient” in the context of the disability grant was itself not a clinical matter. It required an engagement with issues beyond biological markers. These included commitment to performing honest and objective assessments to ensure that the grant was awarded to eligible applicants. In terms of preventing corruption, in line with the SASSA pamphlet, (199) doctors had to make sure that those who were not disabled did not get the grant despite the definition of disability being inadequate. Doing the best for a patient in the

context of high levels of poverty and unemployment also may move the doctor to assist in securing financial assistance.

The tension between public official and health professional was exacerbated because Emmaus doctors knew the patients making the application. “It makes it easier to complete the forms if you know them, their history and their background – but it makes it harder to be objective as you want to make sure that they will get the grant.” The doctors’ dilemma was heightened even further when they were aware of the patients’ social conditions and the extent of their poverty. (CF interview)

Conclusion

“The moment the patient asks me for a DG (disability grant), something has changed.” (CF interview)

In the disability grant application process, doctors interact with patients very differently from the more therapeutic and clinical consultations that characterise many other interactions with patients. The rules and guidelines on how disability grant application forms should be completed are expected to be standardized and should give doctors little or no direction on how to arbitrate over the allocation of state resources. Yet, the complexity of the task, the emersion in the local context as well as ambiguities in interpretation of the rules offers considerable discretion in how the disability forms are completed.

Chapter 8: Public sector doctors relating to private health care

Up to now I have explored how public sector doctors function as street-level bureaucrats from a few perspectives within the public sector. Yet the public sector doctors do not function in isolation of the larger context of how health care is accessed and the different systems of care that exist outside of the public sector. Within this plural health care system, I will explore what the experience of public sector doctors of the private health care system is. In relation to private health care, how do public sector doctors function as street-level bureaucrats? And out of this, how do we understand private and public sectors in the provision of health care to rural populations?

Setting the scene

I was invited by a representative of a private hospital company to attend an exploratory meeting about setting up a private health care facility in the nearby Champagne Valley in the Drakensberg. He billed the meeting as a ‘stakeholders’ meeting’ where a range of key role-players in the health care services in the area were invited to engage with a presentation regarding the proposal. I checked with the other doctors at Emmaus and found that the invitation had been extended to only a few of them. Neither the health district office nor the Emmaus Hospital management had been invited and in the end I was the only person from the public sector that attended the meeting.

The meeting was attended by two of the local general practitioners, one retired doctor residing in the area, representatives of the rate payers association, a few prominent business people and developers, representatives of a local private ambulance service and two volunteer nurses that had been assisting local people free of charge, particularly in cases of emergency. The local government representatives for economic development confirmed their attendance but did not attend on the day.

The meeting comprised a relatively brief presentation followed by a general discussion that was led by the representative of the private hospital company. The presentation outlined a description of the kind of services that could be provided with options for 24-hour emergency care, a short-stay ward and theatre facilities for day procedures and to augment an ambulatory

general practitioner service with specialist care. A business plan with the projected workloads and turnover was also presented, which included projections on the number of service users required for the project to be profitable. It drew on experiences of setting up similar services in other parts of the country, using mostly urban examples.

In their analysis of viability the research that the presenters based the assessment on determined the proportion of the population that would potentially access the facility by combining the number of people in area on medical aid with the envisaged growth in this population segment that was expected to come from multiple up-market housing developments, retirement facilities and hotels frequented by tourists. The focus of the presentation focused on the potential market in the area rather than planning based on population-based need. By the calculations presented, the economic base in this rural community was marginal. The potential financial growth and profit was again compared to similar ventures in urban centres.

The ratepayers association was very supportive of the initiative. Its representative bemoaned the absence of representation from local government for economic development, suggesting that this absence reflected political indifference to local development, even though the potential investors were doubtful of the venture and had given little thought to greater integration with the general economic development planning of the Municipality. At one point one of the presenters asked about other current services available in the Champagne Valley. Besides private general practitioners, the ratepayers' representative mentioned mobile PHC services as well as the PHC clinic running once a week close to the Drakensberg Boys Choir. The services were referred to specifically as a place where some of the older people that could not afford private care could collect their chronic medication. There was no other mentioning of the public sector services such as Emmaus Hospital, the regional services in Ladysmith or the ambulance services.

The public sector services were also not included in the feasibility assessment of the private hospital company that was presented and in the discussions following the presentations the

possibility of linking the private and public services in terms of referrals, or sharing of resources was not considered (Field notes and presentation: "Drakensberg Medicross"– 14/09/2008)

This practice of public and private sectors operating in isolation from one is echoed in much of the literature on the topic. The legislation and policy(36) requires that the district health system should coordinate all health-related activities in a geographically defined population (the district), the planning process was at a relatively advanced stage, with no engagement in the health district structures. Central imperatives in the legislation and policy such as accessibility, equity and progressive realization of rights to access to care were also not included in the presentation of how the analysis was conducted. Although depicted at a policy level as a design response to the needs of insured and uninsured populations, actual utilization of services by patients is complex and nuanced. Generally, all patients use a multiplicity of services in a variety of configurations, combining various layers of public services, private allopathic health care providers, traditional and spiritual healers, over-the-counter pharmacy services and self-medication services.

In fact, the experience of this interface is one of concurrent and sequential use of multiple service providers, as I will illustrate below through the issue of referrals.

Referrals

Within the public sector the formal protocols and policy documents from the National Department of Health or the Provincial Department of Health outline the referral system, which is explicit about the levels of referral.(200) In the private sector the referral arrangements are a lot less formal and the referral between doctors is left much more open.(11) Underlying the loose arrangements of referrals in private health care is the autonomy of the choice of which doctor to refer to. This autonomy is aggressively defended as one of the key features of professionalism and independence in private care. However, the same independence allows for every doctor to have his or her own criteria of when to accept patients and, as the experience of the family and doctor showed, it can become a barrier for a patient accessing care, even if he or she qualifies for the care, financially.(11) The lack of clear and consistent rules and processes regarding who could make what kind of decision (e.g. to give authority to admit the patient to

the hospital, or who would be responsible for the care of the patient) was a barrier to the rapid referral of the patient

Referring from a public sector hospital

A teacher working at a high school in the area was involved in a motor vehicle accident. He sustained multiple injuries, including a fractured femur, as well as possible internal injuries. He received immediate emergency care in the casualty department. The doctor on call temporarily splinted his leg and gave him intravenous fluids and painkillers. He was stable but very ill. He was admitted that same night to the male ward. In the morning, during the ward round Dr EW started preparations to transfer him to Ladysmith Provincial Hospital, a public sector facility where he was to be assessed by the surgeons as well as the orthopaedic surgeons.

When the teacher's family came to visit mid-morning, they requested that he be transferred to the private hospital in Ladysmith, as he had medical aid. The family expected this to be a simple matter. Dr EW phoned admissions at the private hospital where she was told that in order for the hospital to accept the patient a specialist associated with them would have to accept the patient and make a decision whether to admit him or not. On top of the requirement of an instruction from one of the private hospital's specialists, the patient would have to deposit money into their account – R1000 to be assessed in casualty and a further approximately R10 000 to be admitted, in the absence of medical aid authorization. When Dr EW informed the family of these prerequisites, they said they would be able to pay a deposit if it was required, as the teacher did not have his medical aid card with him.

Dr EW then phoned one of the suggested specialists who agreed to take on the patient once the medical aid was settled. She then phoned an orthopaedic surgeon also associated with the private hospital and he too said he would only consider accepting the transfer of the patient if the medical aid cover was confirmed and authorization provided for the patient's admission. He was not interested in a cash deposit or payment. Dr EW again discussed the options with the family and they said they would

arrange to get the card. The patient remained stable. In compliance with his and his family's wishes, his referral to the surgical and orthopaedic services at the Ladysmith Provincial Hospital was delayed.

In the early afternoon the patient's wife returned to Emmaus Hospital with the medical aid card. Dr EW then had to leave OPD to phone the surgeon. Once again he asked about medical aid authorization and Dr EW assisted the teacher's wife get the necessary permission, as she did not know how to go about the process. Dr EW phoned the surgeon again, who finally agreed to the transfer of the patient.

Now that the patient had access to the private hospital Dr EW then had to get him there. She phoned the public sector ambulance services. After some confusion and misunderstandings they indicated that they did not transfer public sector patients to private institutions and that a private ambulance service would need to be called. Having listened to Dr EW's interaction with the medical aid, the teacher's wife was able to give the private ambulance service the relevant admission authorization. The patient left Emmaus after 20h00 and transferred to the private institution. (Field notes 17/08/2008)

During the process Dr EW re-negotiated, wrote referral letters, discussed the patient with the family, and followed up on the instructions of the specialists in the private facility.

The private doctors did not have any formal relationship with Dr EW that would allow them to give her instructions. They were outside of the public health care system and had no line-function responsibilities or even any real recourse to a doctor in the public service. Yet, there were at least 2 levels where they had some authority – the more obvious one was that of gatekeeper – where a number of requirements were set out before the patient would be accepted for a transfer. The criteria were primarily financial (including authorization by the medical aid, which in essence is surety). Not only the private specialist but also the administrators at the private health care facility play this gatekeeping role that is independent of the medical condition of the patient. The second level where the private doctors seemed to have authority in relation to Dr EW, and this was that they were specialists and that they were

more senior than Dr EW. While this may not have been evident to the private specialists, Dr EW was a community-service doctor who is junior, making it much more difficult to challenge the specialists. She assisted the family at each step of the process, making the patient's referral to private care intelligible and accessible to them. The process of accessing private care from the public sector hospital was a convoluted and complex negotiation between the public sector and the private health care professional. There were no institutional protocols that regulated the interactions between the two doctors and so it required each step to be negotiated and agreed on.

While patients may choose the type of service they would like to access, the interaction between public sector and private doctors in such situations depends on the individual doctors involved to a large degree. In this instance, the public sector doctor was proactive and helpful. In similar situations other doctors may have written referral or discharge letters, leaving the family to negotiate the terrain of moving a patient from one institution to the other. Indeed, there are instances where families insist on managing private care referrals themselves, making their own choices of doctors and services.

Referrals from Private Care into the Public Sector

Referrals from private care into the public sector are largely loose and informal. As mentioned in the background, while there are a number of private general practitioners in rural areas throughout the country, the capacity to perform investigations, particularly radiological imaging, and to admit their patients is very limited. While the services in the cities are expensive, the transport adds to the cost of accessing the service. Furthermore, patients without medical aid, or who have exhausted the medical aid benefits, would also request to be transferred from the private general practitioner to the public service as they were not able to pay the private care rates.

There are many referrals from local private general practitioners to Emmaus, such that at day end the desks in the consulting rooms invariably were strewn with the referral letters from private doctors. (Interview with CF, FT and IC) These letters are often poorly prepared, as the case below illustrates.

I was asked to look at a lesion on the leg of an older man by one of the younger doctors (Dr WT) as he was not sure what to do. The doctor indicated that the patient had been referred by Dr IW, a local GP, for further investigations. He was puzzled at what the problem could be and found the referral letter to be “not helpful at all”. The GP’s note read: “Chronic lesion on lower leg – ?diabetic” with no further information.

After introducing myself to the patient, I examined the patient’s leg. I thought the lesion might be malignant and that certainly required further investigations. Dr WT and I discussed how to investigate the patient’s condition further, including checking for diabetes. Dr WT then explained what we had discussed to the patient, including the procedure of taking a biopsy. (Field notes 09/10/2008)

He no longer took account of the private doctor making no reference to the referral note, the possible diagnosis of ‘diabetes’. He also did not enquire regarding any medication or treatment that the patient may have received from the doctor. The patient had become a public sector patient and he had become his doctor.

The referral letter

Patients referred by private practitioners are usually sent with a referral letter to Emmaus Hospital. There, administrative clerks at reception are instructed to refer any patient arriving with a referral letter from another PHC clinic or private practitioner directly to OPD in order to be seen by a doctor rather than a PHC nurse. This is the only formal pathway for referred patients.

With few exceptions, the content of general practitioner referral letters is brief and uninformative, as illustrated above. Many did not indicate whether there has been some ongoing care or whether medication had been prescribed. Most did not indicate any co-morbidity or other medical issues and very few gave indication of patient expectations or contextual issues. The referral letter itself seemed to be regarded as a perfunctory formality to hand patients over to the public sector. The poor quality of the referral letters received from some of the private general practitioners shaped public sector doctors’ opinions of the private sector. Public sector doctors felt they reflected the kind of service the private doctors provided. (Field notes - doctor’s meeting 02/05/2009)

Equally though, referrals back from doctors in the public sector to private GPs were completely absent. While it might seem that GPs did not expect feedback from the public sector, this was not the case. For some private doctors, the absence of feedback on referrals and especially the failure to back-refer was frustrating. (Interview with MT, GK and IW) Many of these GPs had worked extensively in the public sector, and recognized the resource limitations, the challenges of bureaucracy and the overwhelming health care needs of poor populations (Interview IW, GK, MT and NS). They often held the doctors in the public sector in high regard. However, they were critical of the lack of communication. Once they referred a patient to the public sector they were given little if any formal information regarding diagnosis, investigations or procedures. “It is as if you send them into a black hole” (GK interview). They usually had to depend on their patients to remember and understand the care they had received and more exceptionally to take notes or bring some evidence with to their next consultation. The referral letter system itself also did not support continuity of care.

Sometimes, however, communication about the care of patients across the public/private sector divide is influenced by the informal links between private- and public sector doctors who share common social circles or have had previous professional contact.

Dr CW had worked as a private GP before working at Emmaus. In a casual courtyard discussion before a meeting, Dr CW mentioned how Dr GK, a former colleague, had called her to find out what had happened to a young man in severe cardiac failure whom he had referred. She willingly gave him feedback on the patient’s diagnosis (severe pericardial effusion due to TB) and the course of care and treatment he was being given. (Field notes 05/06/2008)

These social circles reach beyond the professionals concerned.

I was called by Dr NS, a private GP, who had seen a woman who had previously been treated for cancer of the cervix but had not attended her follow-up appointments. He asked whether I could assist and re-refer her. She was not on a medical aid but her employer, whom I also knew well socially, had paid for the private consultation. Expecting a call, I incidentally saw the woman’s employer at the shops in town. She also

asked me for advice about getting a referral to oncology. She was very concerned about the health of her employee as she had missed her appointments for a considerable time and did not know how best to get back into the system. I advised her to get the patient a referral from a local clinic or a private GP so that she could come directly to OPD, where she would be able to wait her turn to see me. (Field notes 21/04/2009)

In rural areas where communities are more closely knit such social interactions in informal settings are common and influence the functioning of the health care system. Through the network the doctors –both public and private – become a resource for the community in a manner that less common in urban settings. The advice given and the arrangement made for the employee foregrounds the influence of personal relationships on system functioning in street level bureaucracy. Personal relationships influence how rules of triage and the routine of the work in a place like OPD either assist or prevent a person to be seen rapidly.

Despite the recognition of the resource limitations in the public sector, private doctors acknowledged that relatively expensive investigations (such as TB culture) or services (such as oncology) were potentially available to the poorest sections of the community in the public sector at virtually no charge. They also acknowledged that these were out of reach in the private sector for many of their patients and that engaging with the bureaucracy in the public sector was a small price to pay to get better health care for their clients. A number of private doctors said that they negotiated this access for their clients daily (Interview NS, GK, MT and IW).

Arrangements existed that enabled doctors to practice across the spaces of the private and public sectors. Private sector doctors sometimes work in the public sector. At Emmaus, a number of private GPs from outside of the geographic area, for example, had sessional posts. These required them to work for a limited number of hours a week after hours at Emmaus Hospital. There they assisted with night calls and weekend calls, staying in a rondavel at the Hospital while on call.

While these special arrangements assist with the workload at public sector hospitals, they were not always viewed or experienced positively. While some of the sessional doctors had a very

good reputation in terms of patient rapport, competence and quality of the work and engagement with the staff, the overall attitude at Emmaus toward sessional doctors was negative.

During a discussion of a case of stillbirth at the perinatal mortality meeting, the actions of the different staff members were reviewed in relation to established clinical protocols. It became clear that a number of decisions that were taken did not follow the protocol and these were deemed to have led to complications that contributed to the demise of the baby. In the meeting a senior midwife commented that sessional doctors: “don’t know the protocols; they are never part of any in-service training.” (Field notes – mortality meetings 22/10/2008)

Sessional doctors were not considered to be part of the Emmaus team, despite working at Emmaus for a considerable amount of time. They did not attend any meeting regarding arrangements or planning of services and there was little interaction with them, besides the interactions on the call itself. Importantly, they were not consulted when protocols changed as meetings took place outside their official sessional hours.

Conversely, public sector doctors also worked outside the public sector. This work ranged from volunteering with local NGOs to providing voluntary ongoing care for bed-ridden and terminal patients who they visited regularly, treating friends and neighbours for simple conditions or writing of prescriptions. Serving patients outside the public sector in this way did not fall foul of departmental policy and Emmaus actively supported such engagement with the community.

More obliquely, though, some public sector doctors at Emmaus did locums for private doctors in the area. In terms of the Department of Health policy public sector doctors had to apply to do additional remunerative work and if they did not have official permission, such work was illegal. The Department of Health condoned doing additional remunerative work under certain circumstances.⁽¹¹⁾ Doing locums legally for private doctors was regulated by the Remunerative Work Outside of the Public Sector (RWOPS) policy, which required a formal application that needed to be supported by the manager and then signed off by the HOD of the KZN Department of Health. The agreement included conditions such as the remunerative work

could be done outside of normal working hours only, could not make use of state resources for the work and registration with the HPCSA in the category of independent practice. None of the doctors who qualified to apply for private paid work at Emmaus had, in fact, done so.

Although the doctors' at Emmaus Hospital views towards remunerated locums for private doctors ranged from acceptance to rejection, in practice, locums that were done when doctors were not on call or at weekends were tolerated by both the management and most colleagues. As with the voluntary work, these activities were not actively monitored as long as they did not interfere with the work at the Hospital. Generally doctors were even reluctant to police colleagues even when a few flouted the written and unwritten rules even if it increased the workloads for those remaining in the service, as the examples below illustrate.

During theatre, in the general discussion, Dr CW was recounting an encounter with Dr FW, who came to ask me where a particular doctor was because a patient told him that he had seen him at the private surgery in the morning and had been asked to come and see him at Emmaus Hospital. The doctor in question had phoned the medical manager in the morning that he was not feeling well and would be coming to work late. The story was related in half-jest in front of the nursing staff. The theatre sister said "But everyone knows this" and laughed. (Field notes 15/07/2008, 26/10/2008)

In one of the doctors meetings, Dr CW made a direct reference to a rumour that doctors were doing illegal work during office hours. The doctor suspected of the practice became very angry, demanding proof and the need to stop individual victimization. Observing his strong reaction, most of the doctors present thought that doctor concerned probably was doing illegal locums, but they were reluctant to start policing a colleague.

Generally, doctors have established considerable freedom to engage and work outside of the public sector in a wide range of ways. While official policies regulate much of such interaction, in the local context these regulations are interpreted and applied in a variety of ways and non-adherence to guidelines is largely tolerated. The space between the private and public sectors was no exception to this.

It is worth noting that it is not only doctors that use the space in-between the sectors. Patients also move between services in pursuit of the care they want or need, as the example below illustrates.

I saw Mr M when he came to the outpatient department for a blood test result and a review of his ultrasound report. During the consultation it emerged that he had been on ARVs for about a year. After starting the ARVs he had felt much better and regained his strength until a short while prior to the consultation when he started to lose weight slightly and was not feeling well. He was concerned about TB as he recognized some of the symptoms from the health education that he had received. When he raised the concerns with the PHC nurse at the clinic, she asked him to produce sputum, which he could not do as he was not coughing. She examined him carefully and did not find any signs of TB. The nurse followed the clinical protocol and as his weight loss was minimal she did not refer him for further investigations.

He was not satisfied with the management by the PHC nurse and decided to go to a private doctor for the investigation for TB. The private doctor referred Mr M to the hospital for an ultrasound of the abdomen. A junior doctor saw Mr M in OPD and started the process of investigating extra-pulmonary TB

Nowhere in the letter from the private doctor or the hospital doctor's notes in his file did it indicate that he was HIV positive or that he was on ARVs. This fact only emerged when I asked him to produce the patient-held record from the clinic and I discovered that he had been seen by the PHC nurse. (Field notes 13/04/09)

Even though the PHC nurse at the clinic had correctly followed the clinical protocol of how to investigate a person suspected of having TB, Mr M was not satisfied. He had a private GP refer him directly to a doctor at the public hospital, by-passing the system in order to get what he believed to be a better service. There were some services that were much cheaper in the public sector that patients could not easily access and so, rather than going to a private institution for an investigation, they consulted a private doctor who referred the patient to the hospital and

requested the service or investigation. This allowed the patient to by-pass the PHC clinic, which in many cases performed a gatekeeper function.

Conclusion

Despite the fact that they attend to many of the same patients the private and public health care systems are not formally connected to one another. Instead, they work in parallel and, even where they intertwine, they do so in an uncoordinated and often idiosyncratic way that requires doctors on both sides to negotiate a space for care and the best treatment for patients.

While the referral letter and the relationships between the doctors of the different services were inadequate in providing any real continuity of care, the common ground was the patient. Both services treated the same community – and commonly the same patients. The patient had fixed and separate relationships with the public sector and the private sector doctors. Even the expectations that one may have created of the other (e.g. what tests the doctors at Emmaus would perform) did not translate into any relationship between the doctors of the two services as seen in a number of the observations described.

The differences in resourcing of the private and public sectors are stark and at a formal level the systems seem to function in isolation of each other. Yet, when examined locally in context, the interaction between the two sectors is much more nuanced. Despite the lack of formal arrangements, they are deeply enmeshed in each other. It is difficult to find the divisions and boundaries. The two sectors are intertwined, yet have separate rules and processes. This creates a labyrinth of interactions and diverse possibilities, for both sectors as well as all the individuals concerned.

Some possibilities are explored actively by both private and public sector doctors, but also a range of other stakeholders such as patients or, as in one example, the employer of a patient.

Chapter 9: Traditional healers and the health care system

Introduction

The joint ward round was about to start in the TB ward. We were waiting in the space in front of the bed closest to the nurses' station where we would start. The sister in charge was arranging the trolley for the doctor's round. The clerk had fetched all the patients' files and was placing them on the foot-end of the beds. I became aware of the scent of burning 'mphephu' (*helicrysum spp*) .(201) I recognised it as an herb that is commonly burnt like incense. I turned to Dr EW standing next to me and asked whether she recognised the scent. As I asked the question, an elderly man came around the corner from the far side of the ward, carrying a burning candle, a small branch of a tree and a small bundle of smouldering 'mphephu'. He was murmuring softly, seemingly to himself. Two younger men were with him. They walked solemnly behind him toward the exit without interacting with anyone and soon vanished out of the ward. Dr EW watched the events. She replied to my question, saying that she was not sure. She then remarked that 'maybe once she had seen something like this before in her ward', but did not know what it meant^d.

This ritual is a common cultural practice that is one part of several burial rituals practised in South and southern Africa. It occurs frequently at the hospital. According to local cosmology, when a person dies in hospital or at a place that is not their ancestral home, the soul or spirit of a person is untethered and restless. It is both endangered and dangerous and can only find peace and be appeased when it is brought home by a family member. Usually this task is assigned to an elder in the family or household. 'Mphephu' is burned to clear the air for the ancestors who are then informed of the death and of the funeral arrangements. The emissary of the family travels to the hospital to fetch the spirit. At a place closest to where the family member died, he performs rituals and then calls the deceased by name and clan names, identifies himself by name and family relationship and accompanies him home. He speaks to

^d *Mphephu* (*Helicrysum spp.*) is often referred to as 'Our incense' in the Eastern Cape and KwaZulu-Natal. Bundles of the plants are commonly sold for the purpose in street *Muthi* (medicine) stalls in many parts of South Africa. They are commonly called 'everlastings' in English because of their long-lasting flowers.

the deceased, telling him why he is there and what they are doing. “Come ... come we are going home, let’s go, we are going home’ (“Woza, ... woza, siye’khaya, masihambe, siye’khaya”). From then on the elder does not break contact with the spirit of the deceased, describing every step of the journey. As they leave the ward, for example, the elder may softly say softly ‘we are going through the door, come with us, we are walking down the corridor, come with us, let’s go’. This calling continues without interruption until the elder and the deceased’s spirit reach home.

The biomedical practices and rituals of public sector doctors at Emmaus intersect with traditional healing practices and rituals daily. Yet, Dr EW, like other doctors was exposed to them routinely during the course of her work and she did not understand their underlying cosmology or their implication for diagnosis, treatment or care.

In this chapter I consider how public sector doctors at Emmaus understand and engage with the intersection between biomedical and traditional healing practices.

Noticing traditional medicine

The starting point is to find out whether traditional healing practices are observed and, if so, what sense is made of them in diagnosis, treatment and care.

The admission notes of a child with suspected meningitis reflected that she had ‘umgcabo’-marks over the spine. Dr IC had seen the child the night before. In the morning paediatric ward Dr TW asked about the marks and their significance. The professional nurse said that the mother suspected a condition called ‘ibala’ and that she was very fearful that the child would die. The information from the nurse did not explain the mother’s fear, except to indicate that ‘ibala’ may be a serious condition. But the nature of ‘ibala’ – its cause, its natural history is or what can be done to treat it was not explored further.

The information given by the nurse had little impact on how the doctors engaged with the child. The diagnosis, assessment and treatment options remained the same as that made by Dr IC the previous night. The doctor gave a fairly medical explanation to the

mother regarding the need to continue with the treatment, without acknowledging or responding to the mother's clearly expressed fear of the traditional treatment. (Field notes 17/06/2008)

Dr TW's response is typical, even among more experienced doctors who recognise 'umgcabo' marks and other signs of traditional practices. Generally, doctors do not incorporate the meaning or significance of their observations about traditional healing practices into their treatment and care approach. This response is an artefact of cosmology, ignorance and training (178) where linguistic and cultural literacy, including knowledge of local understanding of diseases is not included in the educational skill set of medical doctors.

During a ward round, the professional nurse and I explored the traditional diagnosis of 'idliso' with a patient in the TB ward. Previously he had defaulted on TB medication and now was admitted for the retreatment regime that included daily injections of Streptomycin. The patient explained that he thought he had 'idliso'. He had consulted with family members and a traditional healer and stopped taking his medication. A few months later, when his symptoms started again, a sputum analysis found him to still have active TB. He was admitted to Emmaus Hospital for the initial phase of the retreatment programme. The conversation took place in isiZulu. (Field notes 20/01/2009)

A visiting medical student commented on how speaking isiZulu made a big difference in being able to communicate and explore treatment options. This observation was generally shared by the doctors at Emmaus who felt that an inability to speak isiZulu was a significant barrier in the doctor-patient relationship. (Interview EW, CF, IC and UT) Nine out of 12 doctors at Emmaus did not speak fluent isiZulu. The link between culture and language is intimate.(202) Yet they required that a translator, usually a nurse, be present to support their work, as many patients knew little English. This disrupted doctor-patient communication on the ward as illustrated earlier in the chapter on the ward round as well as in private consultations.

Although doctors acknowledged the importance of language in professional practice, none of those who did not speak isiZulu were actively learning the language. The process of learning

isiZulu required them to engage with terms and concepts such as ‘ibala’ or ‘idliso’ and the cosmology that that represented. Their lack of language skills reflected a lack of understanding of and a limited interaction with cultural norms and practices (Interview CF, UT and CW) as well as their social distance from the local community. As Dr CF astutely observed, “We are not celebrating with them, ploughing with them or grieving with them.” (CF interview)

Doctors’ perspectives on traditional medicine

Doctors at Emmaus varied in their levels of engagement with and negotiation around cultural issues, particularly around traditional healing. Most engaged with these only when the patient or the patient’s family requested something specific. For example, on an occasion Dr CF asked me for advice before the doctors meeting. He wanted to know what to do as the family of a very ill and weak TB patient had requested a pass out for 3 days to take him to a traditional healer. He explained “I generally have no problem with this, but he is very ill and I am not sure whether he will cope.”

Doctors’ views of traditional medicine were less benign when they came into conflict with actual or intended patient treatment. A number of doctors (EW, IC, and CW) accepted spiritual and cultural rituals as long as the patient did not actually ingest or administer any substances. They expressed a “rule of thumb” that was applied to several treatment regimes, including post-test ART counselling. For them traditional medication was untested and, as a consequence, had the potential of being toxic or producing drug interactions that could be harmful to the patient or difficult to manage. (Doctors’ meeting – 18/09/2008)

The view that traditional medicine could not be trusted was fairly widespread. When a patient was being prepared for starting ART, he or she would need to attend three sessions of adherence training. One of the sessions called “Healthy Lifestyle” covered issues such as promoting exercise, healthy diet and managing stress. During the sessions, items that were identified to be avoided included alcohol, smoking and traditional medicine. Traditional medicine was seen in a similar light to alcohol consumption and smoking. As a way of engaging with traditional medicine in the adherence-training program, patients were advised that traditional medicines that were not ingested or administered were tolerated.

Doctors made repeated reference to the traditional practice of administering enemas(136, 203) in children with diarrhoea.

At a mortality review meeting in the Children's Ward where the regular visiting paediatrician was present, the case of a child who died a few hours after admission was discussed. The child had been admitted with severe diarrhoea and was in shock. In the admission notes the doctor indicated that an herbal enema had been administered and blood results showed severe acidosis and dehydration. In the ensuing discussion, one of the doctors felt that the mother of the child was co-responsible for the child's death because she had administered the enema. More generally, the doctors also speculated about the content of the enema. Dr EW, for example, suggested that such enemas contained "battery acid, toothpaste, bleach" (Dr EW), while Dr CW held that any domestic cleaning agent would be added to the mixture as the enemas are supposed to clean the bowels. Generally, they attributed the death to the traditional practice. By contrast, the consultant's view was that the problem did not lie in the enema or the actions of the mother. Rather it arose from the disease process and the quality of the therapeutic intervention. For him, the problem in all likelihood lay in how sick the child was even before the enema was administered and the inadequacy of the treatment that the child received at the hospital. (Field notes 28/05/2008)

The worry about the unscientific nature of traditional medicine is often generalised by doctors to assumptions about the people who practise or use traditional medicine.

Walking through OPD past the open door of a consulting room, I saw Dr IC consulting a teenager. He was with an older woman whom I recognised as Mrs SM, one of the iSangoma from the regular meetings that I had with the Traditional Healers Association. When Mrs SM saw me, she excitedly jumped up and greeted me loudly with a warm hug. She had brought her epileptic son for a review of his medication. As in my previous encounters with her, she wore a number of items that indicated her status as iSangoma – a dried gallbladder tied with some beads and feathers to her hair over the occiput, white and red beaded anklets and wrist-bands and an array of necklaces made out of

beads and animal skins. I introduced her to Dr IC as one of the iSangoma that I meet with. (Field notes – 12/10/08)

Dr IC was surprised that Mrs SM was an iSangoma despite the fact that the signifiers that identified her as a diviner were openly visible. She wore them in a matter-of-fact manner as if her appearance were not out of the ordinary. They were recognisable to anyone familiar with the culture, not least of all to the nurse who was translating for Dr IC. In recognition of her status she addressed Mrs SM in a respectful and specific manner accorded traditional healers.

The extent of Dr IC's unfamiliarity with local thinking was made even more apparent later that day, when we talked briefly about the incident. Dr IC remarked that she found it interesting that Mrs SM had brought her son to the hospital for medication. She assumed that traditional healers used only traditional medicines and seemed to have no idea that people generally used a multiplicity of health care services in a plural system. Dr IC also assumed that traditional healers' health care decisions did not involve rational thinking. Yet the case of Mrs SM illustrates exactly the opposite.

From previous interactions and discussions I knew some of Mrs SM's son's health background. He had started having seizures when he was about 5 years old. Even prior to the seizures, Mrs SM had noticed that he was not developing at the same rate as other children. When the seizures started, she had used some traditional medications. However, when the seizures became more severe and longer lasting, she saw the visiting doctor at Dukuza Clinic close to where she lived. Her son was started on anti-epileptic treatment but the seizures were not well controlled. The doctor at the clinic subsequently referred her to the neurology clinic in Durban where, after some changes in medication, the seizures were well controlled, although her son remained with developmental delay.

During one of the trips to the clinics I bumped into Mrs SM outside the Tshanibezwe High School on my way to Dukuza clinic. She was dressed in the splendid full regalia of a traditional healer (rather than the few signifiers she wore at the hospital), as she was on her way to attend a function at the school. Mrs SM was a well-known, local dignitary, who was actively involved in a number of community structures, including the parents' committee at school and the

Traditional Healers Association. I reflected on the interaction that she had had with Dr IC and it was clear that in the confines of the consulting room, neither her son's illness nor her life as a traditional healer and member of a larger community was recognised at all.

Yet, there is a long tradition in allopathic medicine of doctors who engage and relate to traditional healing beliefs and practices in a more cooperative and mutually affirming way.(179) Inspired by writings of the Karks(22) and Arthur Kleinman(119, 168) among others, it is a journey that I have taken at Emmaus.

A personal narrative.

Over time my personal exposure to those I have encountered during my daily work at the hospital and clinics has stimulated my interest in the cultural practices of the local community. I learnt much about local history and customs from patients and nurses in the health service.

My understanding deepened significantly, however, when I started to engage in a more structured manner with the traditional healers through a local home-based care organisation, Philakahle. In the course of supporting their work over many years, I encountered home-based carers who were traditional healers.

Particularly before ART became available, the organisation's meetings were filled with lengthy discussions about traditional healing approaches to and alternative therapies for treating HIV. At one point Mrs EK, a member of the home-based care organisation and a traditional healer invited me to share information about HIV with a group of traditional healers who were in the process of forming the Okhahlamba Traditional Healers Association.

I was introduced as "Doctor Bernhard from Emmaus Hospital". After a tentative start I became a regular participant at the meetings of the Okhahlamba Traditional Healers Association that convened roughly every 2 months. As we explored HIV and how it affected the body it was abundantly clear that these traditional healers had a vast experience in and a deep understanding of symptoms and presentations. They were also curious and keen to learn, requesting me to explain many of the terms and biomedical concepts, including the workings of the prevention of mother-to-child transmission.

The Okhahlamba Traditional Healers Association also actively discussed ways of improving health care service collaborate. I was particularly involved with an initiative to link traditional healers into a referral network at community level. Developed in collaboration with the Department of Health, Philakahle and some community structures it sought to strengthen case finding and treatment of TB and included developing a referral pathway from community level to the PHC clinics.

Reflecting on my role in this relationship, I was aware that I significantly influenced the manner in which the traditional healers engaged with the public sector. In a sense I was their bridge into the system, giving explanations, finding solutions and advising on strategies to manage blockages. My 'insider knowledge' of key people and processes, I could advise them how best to navigate the health care system and, in many cases, I directly assisted them in these engagements.

The public health care system did not have policies or regulations to guide the process of working with traditional medicine locally. Although I had little explicit encouragement from hospital management to engage with the traditional healers, I was able to attend meetings during working hours and I reported their results to the medical manager. At the level of the District Management Team, the person responsible for community liaison actively encouraged my engagement.

At a personal level this engagement with traditional healers provided me with an understanding of the community and an insight into the role of traditional healers that I previously did not have and could never have gleaned from working within the confines of the hospital. I also learnt about their experience as practitioners of the interface between the two systems.

Traditional healers' views of and experiences with the health care system as practitioners

The meetings with traditional healers often considered the public sector health service at length. Discussion usually was initiated by concrete examples that arose out of traditional healer practices.

Mrs LH requested clarity regarding the treatment of one of her clients that she was concerned about. She presented a long narrative, with detailed recounting of interactions and conversations. The woman she had been consulting was pregnant and had come to Mrs LH for 'isihlambezo'^e. During her consultation she established a few signs that were of great concern to Mrs LH – decreased foetal movement and swollen feet – Mrs LH said she was very concerned as she feared a serious complication and asked the woman to immediately attend the local clinic. When the woman got to the nearest clinic, she was turned away by the clerk who spoke to her through a window as the door was already locked. The clerk indicated that they close the doors at 11h00 and besides, the antenatal clinic was on a different day. When the woman tried to explain that she needed to be seen urgently, she was apparently asked whether she was hard of hearing.

In an attempt to understand the narrative presented, Mr SS, Mrs KM and Mr TM posed questions to try and clarify clinic practices. “What are the official hours that the clinic should be open?”, “Can it be correct to turn someone away at the door, without examining them, even if the clinic is full?” These prompted a lengthy discussion around poor treatment at the clinics, as well as the lack of accountability of the staff. (Field notes 29/04/2009)

Traditional healers also regularly raised concerns about mistreatment of patients in the public sector with me. Usually an initial query to clarify a service or treatment led to a discussion about individual cases. For example, Mr TM’s question “If someone has been diagnosed with TB, how long should it take before the treatment is initiated?” not only led into a conversation about the diagnosis and treatment of TB but also on to the pathway of a particular young man who had a diagnosis of TB based on sputum results but was turned away at one clinic repeatedly. He started treatment only after he was admitted at Emmaus Hospital. (Traditional healers meeting 26/05/2009)

^e As mentioned in the background, 'isihlambezo' is a generic name for traditional medication that is used during pregnancy as a tonic to assist both maternal and foetal well-being.

Like the doctors at Emmaus, clinic staff in the public allopathic health system had an ambiguous relationship with traditional medicine, as this discussion at one of the traditional healers meetings illustrates. Mrs RH had been part of the home-based carers' network for a number of years. She told of the close relationship she had built up with a particular professional nurse at the nearest clinic doing home-based care activities. However, when the professional nurse found out that Mrs RH was a traditional healer the relationship changed and Mrs RH was no longer provided with home-based care kits. (Traditional healers meeting – 04/11/ 2008)

Despite being critical of how they and their patients were treated in the public health care service, traditional healers did not challenge its worth. On the contrary they had high regard for its healing potential and valued the services that were provided. They considered themselves as active partners in health care. They believed the public sector *had* to be accessed. (Interview EK, TM, RH, MM and SM) Mrs EK had been instrumental in setting up the link between myself and the traditional healers. She participated in community meetings actively advocating for ARVs (EK interview). At one of the regular traditional healers meetings she challenged them to test themselves and send every one of their clients for an HIV test. Her reasoning “if you don't look at everything, you may miss something – asking the ancestors is not enough”, lead to a lengthy discussion about the possibility of traditional healers being allowed to perform rapid HIV tests as part of the traditional consultations. (Field notes 29/04/2008)

Traditional healers were also very open to engaging with the coordination of services. In my discussions with them as part of my work on developing a referral network they expressed a clear desire and commitment to participating in the health care system and welcomed the linkage with the clinic. While their services were poorly coordinated among themselves, they wanted to contribute to the improvement of health care.

Mr TM, for example, suggested that the traditional healers could come to the hospital to treat patients. He said he wanted to see how far we could work together. He said he could imagine that traditional healers and doctors could have consulting rooms next to each other. Patients could choose “where they would go first, to you or to me”. In the discussion I used the example

of 'idliso'^f and TB and how the symptoms would be interpreted by the different practitioners. When I asked him how we would decide who was correct, Mr TM suggested that we treat for both. His response, interestingly, reflected the ethos of the plural health care system, where in practice, patients went to seek treatment for both. (Traditional healers meeting – 02/11/2008)

Mr TM's suggestions starkly revealed the limitations of my level of authority in the Department of Health. As I had engaged with the Department as a doctor from Emmaus Hospital, I could speak on behalf of the Department of Health only within the scope of my work. At my level I had no authority to make formal agreements or implement system-wide changes such as offering consulting rooms to the traditional healers.

The scope for improved intersystem interaction where doctors and healers had the authority to initiate change, however, did exist in the private sector where doctors were open to such possibilities. One of the traditional healers, Mr SS, described how he accompanied patients to the surgery of a local private practitioner. Born of a longstanding relationship between the two practitioners, he was invited in and able to participate in the consultation together with the GP. The GP listened to his assessment and was able to assist (Mr SS interview). This same relationship was also positively described by the private practitioner concerned. He offered biomedical treatment in cases where the traditional healer was not able to treat the patient. He valued the input of the traditional healer because he had only a limited understanding of a traditional medicine system that was a reality in the lives, and illnesses, of the people he treated (GK interview).

Conclusion

All doctors are frequently exposed to traditional medicine in the course of their work. At Emmaus, and more generally in the region, the relationship with traditional practitioners spans collaboration, cooperation and ignoring one another. Doctors' practices are determined both by their levels of understanding and the levels of authority they exercise in their respective

^f Idliso is a traditional diagnosis of (often intentional) poisoning using traditional medicines. The symptoms of idliso have been described to be very similar as symptoms of TB, particularly the loss of weight, loss of appetite, central chest pain and coughing of blood.

systems. This in part accounts for the difference between my interactions and those of Dr P, the private practitioner.

Both their formal training and the public system reinforce doctor ambiguity to traditional healers. Traditional medicine is poorly regulated locally. From the perspective of the traditional healers, the engagements with the Department of Health were frustrating and confusing. The rules they came across were contradictory, changed at a whim and made little sense.

Although there are policy initiatives directed at professionalising and institutionalising of traditional practitioners, the engagement itself is complex and spans a range of approaches and understanding of the interaction between traditional medicine and the public sector. This, in turn, creates space for doctors to use their discretion at street level to determine how patients will be treated.

Chapter 10: Discussion: The doctor in the public sector

Introduction

To understand Lipsky's notion of street-level bureaucracy(7) a three dimensional concept that involves tasks, rules and values(47) provides a useful theoretical framework to examine and understand the everyday experiences of working as a doctor in the public sector in rural KwaZulu-Natal. It enables us to understand the dynamics of how public sector doctors, as front-line professionals and bureaucrats, practice discretion to resolve dilemmas that arise in a local plural health care system. In this chapter I consider street-level bureaucracy as discretionary practice and how it shapes doctors' understanding of patients and the local plural health care system as the initial point of departure.

Tasks

As previously described, doctors at Emmaus undertake a wide spectrum of tasks as part of their daily activities. Most arise from their professional mandate to provide a medical service and it is this mandate that shapes much of the detail of their clinical decisions. The professional context also shapes how doctors understand the range of tasks to be performed and, more broadly, their scope of work, which in a rural context is characteristically expanded.(26)

The consultations, ward rounds and clinical procedures are part of the expected application of their professional body of knowledge within the health care service. Many of the more bureaucratic and official functions, such as attending to disability grant applications, task allocation and arrangement of services also arise out of their professional occupation as doctors in the context of the public sector policies. Indeed in some instances the tasks rely on the legal authority that comes with their professional status.

Some of the tasks that doctors perform are structured through tools, evidenced by the forms that have been developed for preparing a patient for theatre or grant applications. Laid out by a set of questions or tick-boxes the forms define the information required to be collected. No space is given to the doctor to record any additional information. In respect of a disability grant application, for instance, this means that the doctor's tasks of examination and information review are determined by what is deemed important by the Department of Social

Development, in line with policy. Similarly the routine of the preparation of a patient for theatre (as Dr TH followed) structures the tasks that doctors have to perform.

Yet within the constraints of forms and routines, doctors also have discretion in the way they implement professional tasks. Individually doctors determine the pace of their work, when they deem their work is completed and how thoroughly they execute their tasks. In setting their own standards of quality and performance, they create the space to exercise discretion.

I have described several instances of doctors exercising discretion in respect of their tasks in previous chapters. My engagement with the traditional healers, Dr FW's engagement with the family in the courtyard or Dr WT's response to the challenge of resolving a patient in need of cancer treatment by finding the quickest pathway through a complex organizational terrain are all examples of doctors' creating discretionary space in their professional practice. Yet, these examples also show that discretionary practice is not reducible to a mechanistic process. The complexity of discretion in task performance requires doctors to know the extent and the limits of their authority to address clinical or administrative issues and be willing to respect the limits.

In general, many tasks performed by doctors at Emmaus depended on professional expertise at the same time as they relied on bureaucratic processes. In other words to get work done, to do their tasks, doctors had to simultaneously act as professionals and civil servants. They were guided in their actions by rules.

Rules

Street-level bureaucracy is enacted through rules. This involves making rules, enforcing and complying with rules and manipulating or bending rules. At Emmaus, rule-making happened in the course of organizing the working day and week. The process of local coordination and allocation of doctors to medical services were negotiated in meetings among doctors themselves. They made local arrangements that provided the rules of approach for a range of activities. These included the number of doctors expected to be on call at night, procedures of contacting the 2nd on call, the allocation of doctors to the outlining PHC clinics, the organization and management of the ward round, the procedures of preparing patients for theatre or even the process of prescribing medication all. These rules were largely situational and pragmatic.

They were also rarely formalized or even recorded. In making these rules of practice, Emmaus doctors in effect interpreted higher-level policies and tried to create coherence out of the overlap and contradiction of the numerous regulations and policies. The purpose of the rules was to improve efficiency, particularly in the context of the scarce resources and the health care service depended on them to function. It was these pragmatic and situational rules, rather than formal rules and policies that materially determined the scope and coverage of service.

Compliance with formal and informal professional and bureaucratic rules is shaped by context. At Emmaus Hospital, some rules and standards could not be implemented within the existing resources, systems and support. Thus, for example, professional practice requires the presence of three doctors in theatre during a caesarean section. As Emmaus had too few doctors to provide a 24-hour service if this practice was to be enforced, the local arrangement was for two doctors to be present at the caesarean section to ensure a continuous service. Bending the rule reflected a compromise between stopping caesarean sections and referring all patients to the regional hospital, or violating the letter of the professional rule. Clinicians at the referral and other district hospitals and local management and doctors accepted that this rule needed to be modified as its enforcement would significantly increase an already overstretched system. Compromising on the rule points to normalization of different standards of practice and care and the importance of context in making rules, including professional ones. Generally, scarcity of resources requires that rules (and policies) are re-interpreted in order to find practical solutions that can be applied locally.

While there is acceptance of the need to modify rules in accordance with local resources, it raises questions around the boundaries of rule breaking and the latitude of practice that doctors have as professionals. In redefining professional rules, the threshold of when the bending of the rules becomes a transgression becomes blurred. Thus at Emmaus, when Dr TH decided to perform a caesarean section as a solo operator, he made reference to other hospitals where caesarean sections were routinely performed by a single operator 'due to resource constraints'. The discretion of Dr TH had precedent, as many others before him had taken similar decisions. Yet, as a doctor he was unsupported by any explicit rules or policies.

Moreover, because professional rules do exist, when doctors bend them they can and are challenged in their practices by other professionals. A nurse challenged Dr TH's decision to conduct a single-handed caesarean section and a pharmacist queried prescriptions from the maternity ward. Other professionals frequently interpret the malleability of rules differently from doctors and when disagreements arise; the official rules become the point of departure for discussion and further practice. The divergence in interpretation happens largely because alternative, context specific interpretations of the rules are usually was not formalized other than as a tacit understanding or practice.

While consideration of context can justify the need to make rules malleable, rules are also susceptible to manipulation by individual interest and need. Doctors can make and break rules to protect their own interest in the system – be it by controlling the work order and flow, by determining the way they engage with patients, or by doing illegal locums. At Emmaus, when rules were interpreted for individual gain, such discretion often did not benefit patients and invariably impacted negatively on staff and hospital functioning.

Whether professional or administrative, organisations generally put a variety of processes in place to encourage adherence to rules.(204) At Emmaus the more experienced doctors played a central role in articulating the formal and informal rules that shaped daily work. They used the joint ward rounds, new staff orientation and staff mentoring to make rules visible and known. Through these, they repeatedly articulated local approaches and interpretations of policies to guide doctors' practices. This was not always easy, as the example of the disability grant system demonstrates. Not only was it extremely difficult to make sense of the formal rules, but also the only way that they could be applied was by making them responsive to the local context.

The joint ward round in particular, provided opportunities to define standards of care, foster accountability, and create a culture that was upheld and overseen by senior doctors. The discussion about drug choices in the maternity ward, for instance, illustrates how the rules of the profession such as evidence-based medicine were juxtaposed against organizational rules such as the official guidelines so that doctors could weigh what would constitute best practice

in the local context. It revealed the divergent priorities that doctors had in the interpretation of the rules.

The more formalized regular review processes are all examples of peer-reviewed practice that encourage adherence to rules and policies. As part of good practice guidelines for clinical work were applied to some aspects of service at Emmaus. Yet even the formal review processes were not uniformly applied. For instance mortality meetings were routinely run in the maternity and paediatric wards, but the hospital did not have a Hospital Therapeutics Committee.

Review processes stimulate discussion and build consensus, allowing doctors to draw on the authority of evidence-based medicine and to weigh these against national Department of Health guidelines. But for this to happen, they also depend on the moral authority of individual doctors, which exists beyond organizational hierarchy and professional rules of evidence. Thus it was the senior doctor's questioning of and referral for review of a prescription in maternity that prompted a more detailed examination of the prescribing habits that formed part of building consensus of the local norms.

Values

Doctors frequently made reference to a range of values in general discussions. At Emmaus a high degree of shared values informed the allocation of work, local service arrangements and doctors' approaches to treating patients. The shared values also constitute the basis from which they engage in discussions with one another.

One reason doctors' choose to work at a rural hospital like Emmaus is because they want to provide affordable and quality health care to poor, underserved and disadvantaged people. They share the high-level value of philanthropic and pastoral service that is strongly associated with their profession as a calling. It is a value that is congruent with the government's commitment to the creation of a unitary, public health care system, equity and health for all, the country's pro-human rights constitution(63) and its policies to address poverty(59) and redress of historic inequities.(64, 67)

The strong alignment of their professional value of pastoral/philanthropic service with that of the state, as well as the needs of ordinary people, should support doctors' discretion and innovation in the local implementation of policy.(48, 50) Yet this is not always the case. Policy can produce considerable tension when it supports conflicting values. Thus, the policy requirement for three doctors to be in attendance in a caesarean section to ensure patient safety countermands the ideal of providing a service to the whole population in the context of limited resources.(205) The policy and moral tensions posed by working in a resource-poor environment throw values into stark relief. At times, the tension enables doctors to justify poor quality of care - 'we are doing our best' (CW) – with the moral authority of working for the poor and underserved. It reflects a sense of justice and how this was reflected in the service provision in daily life(206) and that the work the doctors is dependent on their own moral work, including the will to act but also a degree of moral skill, beyond the clinical and bureaucratic, to enact care.

At times, it enabled them to selectively choose values to support their day-to-day decision making, be it in the prescribing of medication, planning of services or the engagement with entities outside of the hospital. Various, as the data show, individual doctors take recourse in values associated with philanthropy, health activism, professional autonomy, clinical excellence and addressing public health imperatives.

An inherent tension in values also exists between a profession that focuses on the individual patient and a health system that desires to serve as many people as possible.(7, 55, 207) It is commonly held that individual diagnosis is central to medical practice.(14) Yet, at the same time as it subscribes to this view, the Department of Health also has a population-level public health approach, that focuses on morbidity and mortality rates, coverage rates and population-based targets of service delivery. In practice this tension is played out both in the formal planning of services but also in how doctors decided to spend their time while working. Generally, doctors at Emmaus struggled to balance the time they made available to individual patients and the time they devoted to achieving better coverage and greater service equity. As a group a level of consensus regarding the struggle to find a balance existed, as the doctors

allocated resources to clinics and OPD, yet as individual doctors, they deployed considerable discretion in where they put their time and effort.

This same tension extended to all doctors' working arrangements. Their participation in the provincial Department of Health meetings to plan TB services conflicted with clinical services to patients in the outpatients department. Their engagement with services outside of the hospital took resources out of clinical services, as did their engagement with home-based carers, traditional healers or local NGOs. In practice, efforts to balance competing demands and values remained unresolved both at an individual and collective level at Emmaus.

Despite a formal value convergence of public sector doctors and the Department of Health, doctors at Emmaus Hospital observed that many decisions and practices of the Department of Health negatively impacted on their ability to act on these values in their daily functioning within the organization. Particularly, the level of resourcing and support for rural health services and a bias toward urban and tertiary services conflicted with notions of equity and quality care.(33)

The perception of doctors that the public sector was part of a political agenda (as discussed in the section on the disability grants for instance) reflects an inherent tension in their values as medical professionals, clinicians, and the values of a public service system that casts them in the role of civil servant. This too is a tension that most found difficult to resolve at an individual or collective level.

Private sector medical practitioners

Public sector doctors' perceptions of private medicine are largely negative, despite the high degree of enmeshment between the sectors. A common professional background does little to temper their often-dismissive attitude towards private health care.

The private sector doctors were not affected by most of the policies and regulations that framed the work of the public sector doctors. Yet shared professional values foster a wide range of explicit or implicit cooperation between them. There was wide consensus among doctors at Emmaus that choice of care – i.e. public sector patient use of private health care –

was “a good thing”. Because of this perception and the greater choices offered patients by the private sector Dr EW thought little of the time it took out of his working day to transfer the patient to Ladysmith Hospital.

The fact that private and public sector doctors shared common professional values contributed to private sector doctors being comfortable in their clinical-care interactions with public sector doctors. The private doctors were appreciative of the work of public sector doctors did and generally complimentary of the public sector serving the poorest of the poor. Serving people who cannot afford private care, be they indigent or simply out of medical aid, is not a private business value, even though it is in tension with the private doctors’ professional undertaking. Thus, they do not hesitate to refer patients to the public sector if they are not able to afford private care. Referral arrangements of patients from private to public sector services is generally rudimentary, which, as Schneider points out, reflects a lack of coordination and cooperation between the systems.(208)

Traditional healers and medicine

The values of traditional healers and public sector doctors are both similar and different. Traditional healers, like doctors as professionals, are interested in healing and not doing patients harm. Like public sector doctors, traditional healers serve the members of the community, and like private sector doctors, they do so for recompense. Unlike doctors trained in compartmentalized and specialist care, they value and practice ‘whole person’ medicine. Public sector doctors share many of the disparaging views about traditional medicine that abound in the profession. These in particular relate to treatment practices and the use of potentially toxic medicinal concoctions(135) that are regarded to be harmful. Most Emmaus doctors paid little heed to traditional medicine and were ignorant or dismissive of traditional healers, despite traditional medicine being widely used. However, the few who acknowledged and engaged with traditional healers did so because they sought to practice holistic medicine in context.

Through personal efforts to open a dialogue between local traditional healers and Emmaus doctors, it was possible to create a platform to explore a number of issues of common concern,

including exploring issues of potential harmful practices and possible systems for referral of patients to each other. This interaction opened up the space for a dialogue between the different strands of the plural health care system that gave private and public sector allopathic doctors a deeper understanding of the structure and functioning of the traditional healing system and its cultural location.

Civil service doctors in the public sector

The public sector in South Africa has been characterized as a stressed system plagued by resource limitations, severe inefficiencies and poor performance. This characterization is true for Emmaus Hospital and resonates with the experience of the doctors working in the facility.

It is important to ask how Lipsky's description of street-level bureaucracy fits with and supports our understanding of public sector doctors in a local rural setting more than 30 years after Lipsky's description was first formulated. Born from an analysis of a very different type of public sector(48), since the late 1990's the public sector internationally has undergone substantial reform.(42, 45, 50) Particularly the 'New Public Management ' model conceived and developed in the UK and US with its increased emphasis on corporatization, the privatization of services,(47) and devolved decision making has shaped public sector reform across the globe.(209-212)

In developing countries public sector reform has been driven by stringent conditions of grants from the International Monetary Fund and other global bilateral funding agencies.(212) More often than not, these reforms impact negatively on the public sector in the face of its limited resource base, less established governance of the public sector and complex historical factors, such as the prior colonial relationship with the countries controlling the funding agencies. An ongoing critique of such funding mechanisms has focused on the underlying neoliberal agenda that has commoditized the public sector and its services and transformed citizens into consumers.(60, 84)

The new public management model has directly impacted on South Africa. Here, the public sector has embraced increased corporatization with a high degree of commercialization.(60, 61) In contrast to the classic new public management model, the public sector post-1994

experienced a massive expansion of services to address both welfare and poverty through social services and public works programmes. Public sector reform is also entangled in rhetoric of local accountability(76, 78) as a strategy of public sector reform that in turn has created high levels of expectation in the citizenry.(69)

In public sector health care, the Department of Health has been unable to establish and operationalize key components of the public sector reform. Public sector doctors are left to function in a tempestuous terrain because of, amongst others things, inadequate governance(60, 89) that has contributed to current levels of corruption(61) as well as inadequate human resourcing. The local context for the doctors as street-level bureaucrats is characterized by contradictory and conflicting policies, excessive top-down control that hampers local accountability and local innovation, overwhelming demand that is fuelled by both need and the progressive realization of rights, declining absolute and relative resource allocation, and the demand for population-level outcomes irrespective of individual care.

This public sector context is significantly different from the more classical top-down rule-driven bureaucracy that led Lipsky to his theorizing around the front-line policy-making. Nevertheless, and notwithstanding the specificity of particularly environments or the changes in complexity the notion of public servants, including doctors, the concept of street-level bureaucrats remains useful because it locates them as agents who must actively interpret policies and engage in the spaces of public service in order to practice their profession and deliver services to people. In the tension between the top-down policy implementation and the bottom-up clamour for inclusion, street-level bureaucracy acts as an important terrain for implementation and therefore health system change.

The current context, however, presents doctors with particular challenges. Managing discretion is a major issue in the implementation of the health care because the interactions between doctors and patients were strongly shaped by the merging of doctors' professional and civil service roles.

At Emmaus, managing doctors' discretion involved a number of activities and processes. There was considerable emphasis on adherence to guidelines – national, provincial or even local – in

order to standardize care. Doctors were also involved in a multiplicity of meetings to plan services, discuss patients and review practice. This is typical for street-level policy making. In particular, doctors and allied medical staff developed a degree of accountability for clinical decision making through joint ward rounds. Through one or more of these strategies, while doctors still exercised high levels of discretion in their decision-making and practices, they did not do so in an unconstrained way. Rather, they were required to account for their actions, and especially they were required to account as professionals rather than as bureaucrats.

Managing discretion is made harder by the absence of effective organization in the Department of Health at provincial and district level.⁽⁹¹⁾ Many of the governance structures stipulated in the National Health Act either were not functional or were absent at the time of the study, making regulation and oversight over policy implementation difficult. In effect there were neither top-down controls nor local governance processes to hold doctors accountable. At Emmaus this vacuum of governance was filled by doctors themselves, who through self-regulation and professional accountability⁽¹⁴⁾ created systems and processes to ensure acceptable standards of care.

As a result it is difficult to neatly differentiate professional and civil servant roles in decision-making. Being a doctor and being a civil servant are synergistic in daily work at Emmaus. Both are needed for working effectively in the health care system. This convergence of roles enables considerable agency, as is clearly demonstrated by doctors' ability to leverage the system for patients, arrange their work and be clinically more efficient. The agency that derives from such discretion is also a source of considerable professional satisfaction. Doctors are motivated, as they feel that they are able to make a difference and effect change.⁽²¹³⁾

Role convergence also comes with practical constraints. Bureaucratic processes of the public service limit the role of doctors as professionals. Doctors in the private sector enjoy greater freedom to prescribe and treat, as they do not have to practice within the strictures of essential drugs lists or the limitations of resources that impact on treatment options, which differentiates their context from street-level bureaucracies. Those who run their own practices

also have much greater control over their work and choosing their patients, as well as more direct control over a relatively simpler bureaucracy.

The converse also applies, in that doctors too are a limiting factor within the public health care service. Many processes are dependent on doctors' professional skills and competencies. The scarcity of doctors particularly in rural areas both locally and internationally,(24, 29, 33, 214) directly influences the ability of health care services to implement policy. However, professional limitations on policy extend beyond doctor availability. In the public sector the kind of health care that is provided is also determined by the mix of skills and competencies, as well as the willingness of individual doctors to provide the required services. These kinds of professional limitations at Emmaus made it hard to meet the many policy imperatives of the public sector.

The evidence from Emmaus suggests that these constraints can be overcome where doctors engage with the tensions between the available resources and the policy expectations. Through planning processes, the development of local skills, the orientation of new doctors and the adjustment of rules to provide services they acted as street-level bureaucrats, applying values and modifying tasks and rules. This finding suggests that Lipsky's interpretation of discretion as a mostly negative by-product of the dilemma of implementing policy(215) is at best one-sided and off the mark. In situations like that at Emmaus, services are only provided because doctors are able to find local mechanisms to align their practices with policies through discretion.

In the literature an increased alignment of professional with civil service roles is largely attributed to changes in the model of public service over the past two decades.(45, 47, 50, 216) Budd(50) for instance suggests that the values and intentions of both professionals and the public sector converge in a number of settings. Further, the professionalization of the public sector is an explicit policy imperative. Yet, at Emmaus, how doctors aligned themselves as civil servants was more a personal and collective response to the local context(217) than policy directives.

Relationships in street-level bureaucracy

Doctors function as street-level bureaucrats through relationships that extend well beyond the dyadic doctor-patient relationship of clinical care. As professional practitioners and civil

servants they rely on individual and collective relationships both within and beyond the public sector to enact discretion. This is clearly illustrated at Emmaus, where they were intrinsic to daily functioning in the public sector as well as in the larger plural system. Collectively they engaged entities outside of the hospital, such as referral hospitals or the SASSA office in Bergville, often in formalized agreements and protocols that shaped the delivery of services. At times, even in the absence of formal agreements or delegated authority, doctors represented Emmaus Hospital or even the provincial Department of Health. Thus, for instance, the grant system was coordinated locally through a doctor-driven collective engagement. The arrangements they made with SASSA officials derived from their interpretation of policy that in turn produced a unique service outcome built on mutual cooperation.

Multiple and complex networks individual relationships also directly shaped care pathways within the service. Traditional healers, patients and private doctors all either leveraged their own interpersonal relationships or used intermediaries who had relationships with Emmaus doctors to access public health care and referrals to higher levels of care. Equally, public service doctors brokered access to the plural health care system, be it in respect of welfare, private medical care or traditional healing, through interpersonal relationships.

It is widely acknowledged that the relationship between doctors and patients has therapeutic value⁽³⁾ which is why personal engagement is central to the practice and theory of family medicine.^(21, 218) What is less recognized is that when doctors act as civil servants, they enter the domain of public policy and citizenry. In this terrain, their patients are recast as citizens in need of public services at the same time as they remain patients in need of clinical care. In the process of providing clinical care the doctor enacts the role of the state providing services for the citizen. This may facilitate the doctors to extend their care practices beyond the clinical setting and enter into a different kind of relationship with the people they professionally viewed as patients.

Yet the profession engages with the patient and the public service engages the citizen through its respective bureaucracies. And therefore it can be expected that the inclination to depersonalize interactions between patients/citizens and doctors/civil servants persist beyond

the medical setting. At Emmaus, the very routines created to manage health care and services also served to depersonalize and distance doctors from patients. This insight suggests that the critique of especially biomedicine, as a system of health care that lacks empathy, may be at least in part misplaced. The critique that exceptionalizes biomedicine(219) fails to recognize that bureaucratization and professionalization of practices – be they biomedical or social – create practitioner distance and detachment at the same time as it objectifies and de-individualizes the people being served.

Does this suggest there is no place for caring? The objectification and reductionist abstraction of patient/citizens leaves plenty of place for caring. Kleinman(220) describes the two dimensions of caring as a technical or practical dimension and an emotional dimension ; there is substantial evidence that doctors at Emmaus care. The technical or practical aspects of care are evident in the routines of doctors moving from one patient to the next in the ward rounds, or from one service to the next to ensure that services are being delivered. Dr WT's referral of the patient with the cancer of the cervix is an example of how he made a particular effort and engaged with the problem that the woman was facing. It did not involve a high degree of emotional engagement by the doctor with the patient and, indeed, the patient may not have known of the particular effort made by Dr WT. Yet, when one focuses only on technical-care delivery, the reciprocal relationship with the patient is diminished – and the care is not experienced.

Emotional care, as von Mollendorff(221) has described, has the potential to be transformative and is critical to doctors' sense of service and the meaning they make of their work. Among the doctors at Emmaus the emotional care between doctors and patients that extended beyond the practical demands of care was also evident. Humour, emotional presence and continuity of care all showed a deep commitment by doctors to their patients as people and fellow citizens. The engaged discussion and personal touch during the discussion of Dr FW in the courtyard showed an emotional presence. Even the frustrations with the barriers of cultural and social distance between them and their patients arose from doctors' desire for more personal connectedness to local people.

Generally, empathy and care are central to societal expectations about how doctors should engage with patients.(3) Whether doctors are able to care in practice, however, is a factor of the demands of the system as well as their personal inclinations and capacities as individual doctors. There is rich evidence in the literature on compassion(222, 223) as well as on compassion fatigue and burnout(224, 225) that attests to the centrality of personal engagement in the work of clinicians. The evidence on burnout, stress and anxiety among doctors and other health care professionals points to the emotional exhaustion that the trauma and suffering of others inflict on doctors' wellbeing. The bureaucracy, it must be said, (expressed by hierarchies, obeying orders or the technicalization of caring tasks into procedures) is protective of health care professionals and facilitates their continued functioning in very difficult situations.

Within the public sector – and in its operationalization through the bureaucracy – care is highest amongst its priorities. Most of the objectives and strategies of health care services refer to population-level targets (performance) and the overall improvement of health status (outcomes) rather than the reduction of suffering and improved individual health and wellbeing. Ironically, when health care professionals maltreat or fail to serve patients, both managers and politicians lament the lack or absence of care.

Indeed, the challenges of ensuring individual care pits doctors against the imperatives of the health care system.(221) In this terrain, personal relationships significantly determine doctors' action(43, 226)and increasingly define how street-level bureaucrats function within the system(227, 228) to achieve quality care. In other words the power of public service doctors lies in their engagement with care. Through a unique combination of professional and civil service authority, they are able to negotiate policy and leverage access to medicines, services and other resources in order to provide meaningful care for people, as patients and citizens. Rather than diminishing,

Collectively regulated discretionary practice becomes a vital part of normalizing caring in doctors' professional practice.(9, 183, 227) When this happens care ceases to be exceptional, a characteristic of extraordinary doctors and health care professionals(221). Instead, it becomes

the expected 'normal' professional response to patient care, with doctors "walking a mile in their shoes." (222)

Unconsidered in the work of Lipsky, discretion has been found to play a critical role in facilitating caring. As such it a central, if elusive, component of the doctor-patient relationship.

Implications for the health care system

Increased discretion has both negative and positive implications for the health care system. Some of the negative aspects of increased discretion evident in the study extend from lack of accountability for actions, illegal practices such as the alleged illegal locums as well as wilful deviance from guidelines and prescribing patterns.

More positively, discretion played a critical role in how doctors voluntarily aligned themselves with the overall purpose of the service, rather than mechanistically adhering to guidelines. Their ability to manage patients in situations where resources are limited and many guideline requirements are absent, requires clinicians to use discretion innovatively in patient care. Yet how such a space is managed and related to system-wide engagement to improve services in much less clear.

The capacity of doctors to improve local service depends on them exercising discretion. It is the choice of the local doctor (or any health care worker) to take up an issue or to ignore it. Some systems that are not functioning well may well be tolerated (such as the on-call system when a second doctor cannot be found). Approaches such as quality improvement methodologies (229, 230) rely on the street level bureaucrat involved with the patient care to identify modifiable factors, use the information available and to make plans to improve the local situation. Such behaviour is in keeping with the idea of health care workers as change agents (231) It is also in keeping with calls for greater health care professional activism.(65) as well as system wide transformational changes that empower local decision making, alignment of local action with system-wide direction and improved monitoring and local use of information.(232)

The predominant 'top-down' approach to managing and directing practice in the health care system has little ability to effect change. In a setting like Emmaus Hospital, away from the gaze of head office in the, at times, forgotten periphery, doctors were actively and willingly working toward the goals of the health care system. Such alignment did not happen because of rules. Rather it was made possible because they had internalized and integrated professional and bureaucratic goals while taking into account their context.

Chapter 11: Conclusion

Overview of key findings and conclusions

Discretion

While the local context of Emmaus Hospital was very different in nature to the bureaucracy described by Lipsky, the concept of street-level bureaucracy has been useful to explore the experience of rural public sector doctors. At the centre of the narrative of the doctor as a street-level bureaucrat is discretion. It is evident in the attempts to interpret professional principles in the local context, struggling with standards of care and with resource limitations. It was evident in the transgression of rules in attempts to offer the best care for patients and in exercising the freedom to prescribe the best treatment that a doctor could within the confines of the public sector policies and guidelines.

The role of being a professional working in the public sector merged with being a civil servant into a street-level bureaucrat, using discretion in much of the decision-making and interactions within the wider health care system. The discretion extends further than around decisions relating to patients – it reaches many other aspects of the local decision making of the type and scope of services to be offered. The merged roles of professional and civil servant offers considerable agency and capacity to influence local access to services and care.

Discretion was central to how doctors arranged the health care service – in the allocation of doctors to different aspects of the service and making arrangements so that the majority of services could be covered within the limits of available resources. Doctors developed efficient routines and patterns of working to achieve maximum coverage of services.

With the freedom related to decision making and discretion in the abuse of the freedom was also evident. On a subtle level it occurred in the rather officious behaviour of ignoring waiting patients and, in a more clandestine manner, was the suspected engagement in illegal locums.

Discretion was critical for service to function

At Emmaus hospital doctors worked in a larger system that was considerably stressed. In the organizational vacuum of the public sector as it was described, the efforts made by doctors as

street-level bureaucrats to ensure the local implementation of services were remarkable. This perspective is underappreciated in the literature. (8)

The service delivery to a significant extent depended on doctors' interpretation of both professional values and policy imperatives. The interpretation impacted on both personal and collective arrangements and extended to the interactions with patients and services outside of the public sector. Policy ideals such as inclusion of the private sector, engagement with traditional medicine or even making disability grants available to qualifying individuals are all dependent on the particular interpretation by the doctor as a street-level bureaucrat.

At a collective level (again guided by both their professional imperatives and the interpretation of policy) doctors engaged in complex coordination of services with a range of stake holders such as SASSA and regional and central hospitals. The authority of doctors in doing so did not seem to be questioned – indeed, they were seen to be legitimate representatives of the Department of Health, without ever having any formal delegations or authority bestowed upon them.

From the perspective of the rural public sector doctor, the top-down approach of policy implementation that characterizes the public sector – as well as the arguments for a need for a bottom-up approach in response to articulated needs – is not the only dynamic influencing service provisioning by the public service. Rather, the dynamic engagement of the street-level bureaucrat in providing a service shapes how the needs of patients and communities are being addressed. The street-level bureaucrats play a critical role in the implementation of policy and shaping how services are delivered. The particular way the policy is interpreted and implemented extends to the way accountability could be structured around the role of street-level bureaucrats. It is clear that doctors are critical to the service delivery, particularly clinical services. Yet the real value of their work at Emmaus was the greater voluntary alignment with values expressed in professional and policy imperatives.

Managing discretion

The way discretion was managed among the Emmaus Hospital doctors relied on both formal and informal processes. The group dynamic among the doctors and moral authority of the

individuals among them influenced decisions of the whole group. A more formal peer review process linked more explicitly to the guidelines and targets within the Department of Health. Yet, in both instances, compliance relied on the extent to which doctors collectively aligned themselves with the policy imperatives of the public sector and their profession.

The significant value of the work by doctors at Emmaus arose out of the voluntary alignment with values expressed in professional and policy imperatives. The dynamics underlying such alignment raises implications for how health care services need to be managed.

Relationships

Yet, exploring how public sector doctors function both within the public sector and in the plural health care system demonstrates a complex web of relationships that strongly influenced the decision-making. The relationship with SASSA or doctors at other hospitals impacted on service delivery just as the relationships individual doctors had with patients or entities outside of the public sector such as private practitioners or traditional healers.

Doctors also consistently engaged with individual patients beyond a superficial and technical level. This was despite care and empathy not being foregrounded and prioritized within the public sector or professional bureaucracy. The role of the street-level bureaucrat in offering a caring service is therefore critical. Care is always dependent on personal discretion to engage. Despite policy initiatives and imperatives, care is experienced at the interface between the street-level bureaucrat and the citizen/patient.

The relationships that mediated this care extended beyond the boundaries of the bureaucratic engagements. The discretionary practice that engages with patients in a caring and empathic manner becomes central in forming a basis for how patients can engage with the health care service.

The role of the street-level bureaucrat needs to be explored further – particularly in understanding, planning and managing services in the context of a more responsive and high-quality service. Rather than needing to abolish discretion, it is critical not only for an innovative and responsive public sector, but particularly for care to take place within the public sector. The

type of management that would facilitate such discretion in a constructive manner needs to be explored further.

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Appendix 1: Documentation of Ethical Clearance and Institutional Permission to conduct the study

Certificate from Institutional Ethics Committee, University of Pretoria

The Research Ethics Committee, Faculty of Health Sciences, University of Pretoria comply with ICH-GCP guidelines and has US Federalwide Assurance. FWA 00002567, Approved dd 22 May 2002 and Expires 24 Jan 2009.
IRB 0000 2235 IORG0001762 Approved dd Jan 2006 and Expires 21 Nov 2008.



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Health Sciences Research Ethics Committee

Fakulteit van Gesondheidswetenskappe Navorsingsetiekomitee

Date: 29/02/2008

PROTOCOL NO.	7/2008
PROTOCOL TITLE	Civil Servant and professional – understanding the challenges of being a public service doctor in a rural health care setting in rural South Africa.
INVESTIGATOR	Person: B M Gaede Phone: 036-4881570 Fax: 0866755123 E-Mail: besam@lantic.net Cell: 0827366054
DEPARTMENT	Family Medicine; University of Pretoria, Pretoria
STUDY DEGREE	PhD
SUPERVISOR	Prof T Marcus
MEETING DATE	30/01/2008

The Faculty of Health Sciences Research Ethics Committee, University of Pretoria has considered this Protocol on 27/02/2008 and **approval** herewith given.

*Dr. AG Nienaber (female) BA(Hons) (Wits); LLB; LLM (UP); Dipl. Datametrics (UNISA)
 *Prof V.O.L. Karusseit MBChB; MFGP (SA); M.Med (Chir); FCS (SA); Surgeon
 *Prof M Kruger **Chairperson** (female) MB.ChB.(Pret); Mmed.Paed.(Pret); PhD. (Leuven)
 *Dr N K Likibi MB.BCh.; Med.Adviser (Gauteng Dept.of Health)
 *Snr Sr J. Phatoli (female) BCur (Et.Al) Senior Nursing-Sister
 *Dr L Schoeman (female) Bpharm, BA Hons (Psy), PhD
 *Dr R Sommers (female) MBChB; M.Med (Int); MPhar.Med;
 Mr Y Sikweyiya MPH; Master Level Fellowship in Research Ethics; BSC (Health Promotions)
 Postgraduate Dip in Health Promotion
 *Prof TJP Swart BChD, MSc (Odont), MChD (Oral Path) Senior Specialist; Oral Pathology
 *Dr A P van Der Walt BChD, DGA (Pret) Director: Clinical Services of the Pretoria Academic Hospital
 *Prof C W van Staden MBChB; MMéd (Psych); MD; FTCL; UPLM; Dept of Psychiatry

DR R SOMMERS; MBChB; M.Med (Int); MPhar.Med.
SECRETARIAT of the Faculty of Health Sciences Research Ethics Committee - University of Pretoria

* Members attending the meeting.

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Letter of permission from the Provincial Knowledge Unit, Department of Health in KwaZulu-Natal:



Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
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Pietermaritzburg
3200
Tel.: 033 – 395 2944
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Reference : HRKM011/08
Enquiries : Mr X. Xaba
Telephone : 033 – 395 2805

13 March 2008

Dear Dr Gaede

Subject: Approval of a Research Proposal

1. The research proposal titled **‘Civil servant and professional – understanding the challenge of being a public service doctor in a plural health care setting in rural South Africa’** was reviewed by the KwaZulu-Natal Department of Health. The proposal is hereby **approved** for research to be undertaken at Emmaus Hospital.
2. You are requested to undertake the following:
 - a. Make the necessary arrangement with identified facilities before commencing with your research project.
 - b. Provide an interim progress reports and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to xolani.xaba@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr S.S.S. Buthelezi
Chairperson: Provincial Health Research Committee.

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Institutional Permission to conduct the study at Emmaus Hospital:



HEALTH
KwaZulu-Natal

EMMAUS HOSPITAL

Cathedral Peak Road
Private Bag x 16 , Winterton, 3340
Tel: 036 488 1570, Fax.: 036 488 1330
E- mail.:h030504@dohho.kzntl.gov.za

Enquiries : Mr L.T. Mazibuko
Telephone : (036) 488 8203

06 February 2008

TO: WHOM IT MAY CONCERN

RE: DR. BERNARD GAEDE'S RESEARCH STUDY

Hereby I give permission for the proposed study " Civil Servant and professional- understanding the challenge of being a public service doctor in a plural health care setting in rural South Africa" to be performed at Emmaus Hospital, following approval from an accredited Ethics Committee.

Kind regards


MR L.T. MAZIBUKO
CEO

UMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 2: Participant Information Leaflet and Informed Consent Form

Title:

Civil Servant and professional – understanding the challenges of being a public service doctor in a plural health care setting in rural South Africa.

1) The purpose of the study

Public sector doctors function within a context of other health care systems, particularly the private health care sector and traditional medicine. These systems function largely in parallel – however the different sectors influence how each of us practice and how patients are treated throughout our local area.

The purpose of the study is to explore the particular challenges of being a doctor in the public service and how we relate to private doctors and traditional healers.

2) Explanation of procedures to be followed

This study involves 3 ways of finding information about the topic. The first is to conduct interviews with public sector doctors, private sector doctors and traditional healers in the sub-district. Following the interviews, focus groups will be conducted to discuss some of the issues raised further in the groups. The third way of collecting information will be by conducting ‘participant observation’ of what we do and how we work in the public sector – reflecting on our work as doctors and civil servants.

The interviews will be open ended and the kinds of questions asked will relate to the following themes:

How you came to work in the public sector/private sector/traditional medicine;

Your relationship to the people they treat;

Your experience of the public health care sector;

Your understanding of traditional healing and the relationship of traditional healers to public sector doctors and private practitioners;

Your understanding of the practice of private medicine in the area and the relationship of private medical practitioners to public sector doctors and traditional healers;

Your understanding of how citizenship relates to how we treat people in our professional practice

Your responses will also contribute to the direction of the conversation, since the purpose is to explore critical issues based on your knowledge and experience of doctors in the public sector. It is expected that the interview will last between 60 and 120 minutes.

These interviews will be conducted as far as possible in the language of your choice. They will be audio-recorded and transcribed. You will be able to read your interview and make corrections or additions before it is analyzed, should you wish to do so. Your participation in this study will be anonymous, unless you wish your real name to be used.

3) RISK AND DISCOMFORT INVOLVED.

There are no intrinsic risks in this project. What you say is from your experience.

4) POSSIBLE BENEFITS OF THIS STUDY.

You will not benefit directly from this study. However, at the end of the study, feedback will be given to each of the groups that have participated in the study and an opportunity will exist to decide on whether and how to act on the information presented. The finding of the study will also be shared with the Emmaus Hospital management and the District management in order to assist in formulating procedures and policies.

5) PARTICIPATION IN THE RESEARCH.

Your participation in this study is entirely voluntary. You can choose not to answer questions that you are not comfortable with. And even after the interview, if you decide you don't want to be part of the study, you can withdraw and your interview will not be used.

6) ETHICAL APPROVAL.

The protocol for this research project has received written approval of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

7) INFORMATION.

If you have any questions concerning this study, please contact:

Dr Bernhard Gaede, Emmaus Hospital, Private Bag X16, Winterton 3340, Tel: 036 488 1570, Fax: 036 488 1330 or email: besam@lantic.net

Or Prof T Marcus, Department of Family Medicine, Room 7-31, HW Snyman North Building, Tel: 012-3543293 or tessa.marcus@up.ac.za

8) CONFIDENTIALITY.

All data in this study will be treated as confidential. Unless otherwise agreed the findings of this research will be published or presented in a way that participants remain unidentifiable.

9) SUBMISSION OF THE STUDY

Dr Bernhard Gaede will submit the study towards the completion of a PhD.

10) CONSENT TO PARTICIPATE IN THIS STUDY.

Please give your consent to this study by responding to the following:

- i) I understand the purpose of this study
- ii) I am willing to participate in this study;
- iii) I wish to review /I do not wish to review (**delete as appropriate**) the transcript of my interview.
 - a. If I wish to review the interview, I agree to make amendments and return the transcript of my interview to Dr Bernhard Gaede within three weeks of receiving it. If I do not communicate otherwise, the original transcript will be considered to have been acceptable to myself.
- iv) I wish to remain anonymous/I agree to have my real name used in publication (**delete as appropriate**)
- v) I have read the above information before signing this consent form. The content and meaning of this information has been explained to me. I have been given the opportunity to ask questions and am satisfied that they have been answered satisfactorily.
- vi) I have received a signed copy of this informed consent agreement.

.....
Name of participant Signature Date

.....
Name of investigator Signature Date

.....
Name of witness Signature Date

Appendix 3: Interview guides

1) Interview guide – Public Sector Doctors

Introduction

Research question: - what is the experience of being a doctor in a rural public sector practice?

Possible Prompts:

Tell me about how you became a doctor and ended up at Emmaus – the whole story.

Listen for: Motivation for becoming a doctor
 Experiences (training, private / public, ‘patient’)
 Decisions re: place of work (NGO/state/private)

Possible Prompts:

How did you decide to work at Emmaus?

How does Emmaus compare to other public sector facilities?

**I would like to explore some key relationships that we have – How do you relate to Your
colleagues? Your employer? Your patients?**

How does the administration at Emmaus hospital see patients?

How does management see patients? (dialogue re: difference with your view)

Are the patients getting the best care considering the resource constraints? (why? follow-up responses)

Listen for: Decision for becoming a Dr
 Role of Dr in state
 Influence of bureaucracy / state
 Limits / extension of medicine by state

Possible Prompts:

Besides the public sector, are there any other places / people / services that members of the community access services from? (explore all of the options as indicated below)

What has been your experience of the private Dr’s (GP’s) in this area?

How would you describe the relationship that we have with the GP's in this area?

How do you think patients relate to the GP's in comparison to how they relate to you? (How are GP's different?) Why do people go to GP's?

What has been your experience of traditional healers in this area? How do you think it works?

How would you describe the relationship that we have with the traditional healers in this area?

How do you think patients relate to the traditional healers in comparison to how they relate to you? (how are traditional healers different?) Why do people go to traditional healers?

Listen for: Roles of private / traditional medicine
 Relationships with private / traditional medicine
 Attitudes (moral language) towards private / traditional medicine
 How are public sector Dr's perceived by private / trad medicine

Possible Prompts:

What is your experience of your relationship with your patients? (story to illustrate)

How do patients (and their families) see / experience Emmaus Hospital?

What is the role of Emmaus in the community?

Who do you think is 'the community'? (impact on your work?)

Do you perceive yourself as a 'civil servant'? What does that mean to you?

Listen for: Words used to describe 'patients'
 Values expressed re patients
 Roles of patient / family / community
 Decision-making processes
 Community / patient's influence at the hospital

Reflection / closure

Any closing remarks... anything that you would like to add?

2) Interview guide – Traditional Healers

Introduction

Research question: - what is the experience of being a doctor in a rural public sector practice?

Lead In:

Tell me about how you became a traditional healer and ended up working in this area?

Listen for: Motivation for becoming a traditional healer

Experiences (training, initiation, practising)

Decisions re: place of work

Possible Prompts:

How did you decide to work in this area?

I would like to explore some key relationships that we have –

Are the patients getting the best care considering the resource constraints in this area? (why? follow-up responses)

Listen for: Role of Dr in state

Influence of bureaucracy / state

Limits / extension of medicine by state

Possible Prompts:

Besides your practice, are there any other places / people / services that members of the community access services from? (explore all of the options as indicated below)

What has been your experience of Emmaus Hospital doctors?

How would you describe the relationship that we have with Emmaus Hospital?

How do you think patients relate to the Hospital in comparison to how they relate to you? (How is the public sector different) Why do people come to you or the hospital?

What has been your experience of Private GPs in this area?

How would you describe the relationship that we have with the GPs in this area?

How do you think patients relate to the GPs in comparison to how they relate to you? Why do people go to GPs?

Listen for:

- Roles of public sector / traditional medicine
- Relationships with public sector / GPS
- Attitudes (moral language) towards public sector / private care
- How are public sector Dr's perceived by traditional healers

Possible Prompts:

What is your experience of your relationship with your patients? (story to illustrate)

How do patients (and their families) see / experience Emmaus Hospital?

Who do you think is 'the community'? (?Impact on your work?)

Listen for:

- Words used to describe 'patients'
- Values expressed re patients
- Roles of patient / family / community
- Decision-making processes
- Community / patient's influence at the hospital

Reflection / closure

Any closing remarks... anything that you would like to add?

3) Interview guide – Private GPs

Introduction

Research question: - what is the experience of being a doctor in a rural public sector practice?

Lead In:

Tell me about how you became a doctor and ended up working in your private practice here in Winterton / Bergville?

Listen for: Motivation for becoming a doctor
 Experiences (training, private / public, ‘patient’)
 Decisions re: place of work (NGO/state/private)

Possible Prompts:

How did you decide to work in private care?

How does Emmaus compare to other public sector facilities?

I would like to explore some key relationships that we have –

Are the patients getting the best care considering the resource constraints? (why? follow-up responses)

Listen for: Decision for becoming a Dr
 Role of Dr in state
 Influence of bureaucracy / state
 Limits / extension of medicine by state

Possible Prompts:

Besides the your private practice, are there any other places / people / services that members of the community access services from? (explore all of the options as indicated below)

How do you think patients relate to the Hospital in comparison to how they relate to you? (How is the public sector different) Why do people come to you or the hospital?

What has been your experience of traditional healers in this area? How do you think it works?

How would you describe the relationship that we have with the traditional healers in this area?

**How do you think patients relate to the traditional healers in comparison to how they relate to you?
(how are traditional healers different?) Why do people go to traditional healers?**

Listen for: Roles of public sector / traditional medicine

 Relationships with public sector / traditional medicine

 Attitudes (moral language) towards public sector / traditional medicine

 How are public sector Dr's perceived by public sector / traditional medicine

Possible Prompts:

What is your experience of your relationship with your patients? (story to illustrate)

How do patients (and their families) see / experience Emmaus Hospital?

What is the role of Emmaus in the community?

Who do you think is 'the community'? (?Impact on your work?)

Listen for: Words used to describe 'patients'

 Values expressed re patients

 Roles of patient / family / community

 Decision-making processes

 Community / patient's influence at the hospital

Reflection / closure

Any closing remarks... anything that you would like to add?