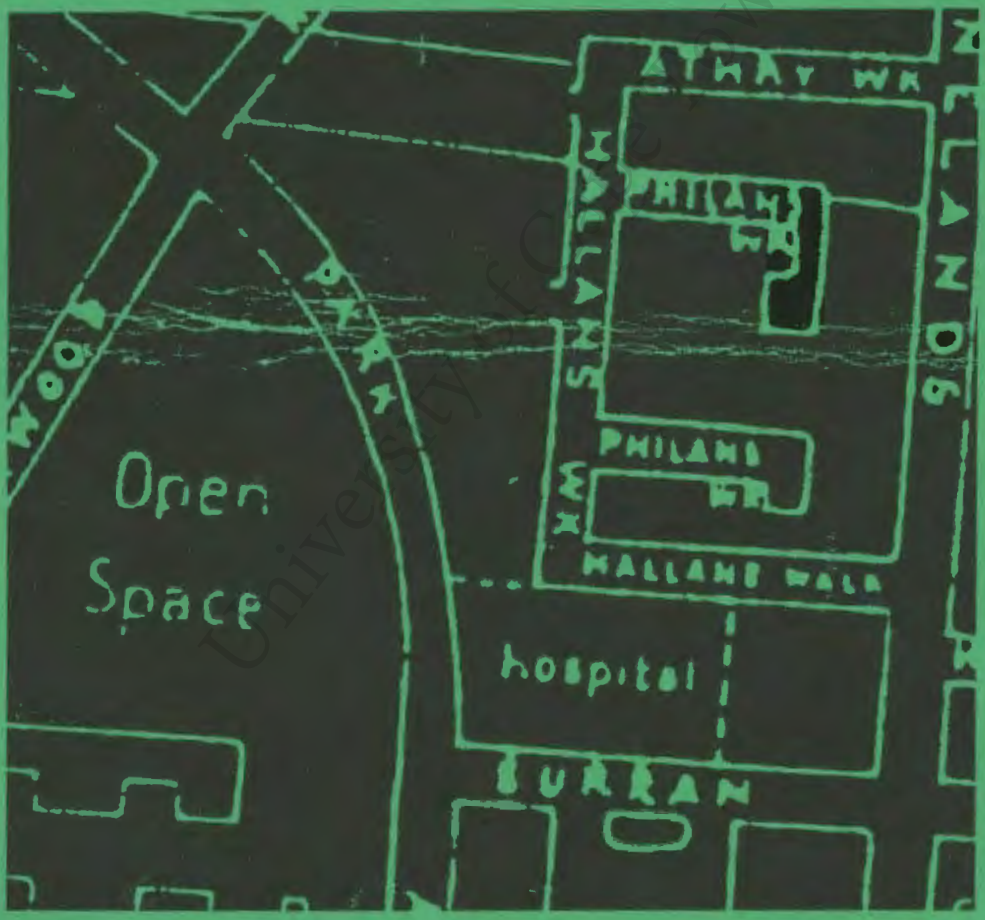
The Geography of the Clinic

Spatial form, meaning and practice at a Western Cape Community Health Centre

Lauren Muller



Submitted in partial fulfilment of the requirements for the degree of Master of Arts (Clinical Psychology)
University of Cape Town

March 1999

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ABSTRACT

This is an ethnographic study which seeks to understand the functioning of a Western Cape primary health care facility, the Hanover Park Community Health Centre, in terms of the space it occupies, transforms and utilises. The study aims to demonstrate that space as an object of inquiry may provide valuable insights into the structuring and interpreting of clinical activity and identity. Fieldwork was undertaken at the community health centre and varied forms of data gathering were used to reflexively observe the manner in which the CHC's space was planned, used and interpreted by staff, and to a lesser extent, patients. Space was understood and examined in the following ways: a) Disciplined and ordered space as an intrinsic component of modern biomedical functioning; b) The role and interpretation of multiple spaces within the staff's cultural construction of the clinic, c) The orthodox and unorthodox use of space as a strategic resource in a context of gang violence and health service crisis. The architectural design of the clinic was analysed in terms of the international criteria and logic for PHC facility design. Unique local features were understood as socially and political contingent. Spatial disorder and insecurity was demonstrated to impact directly upon clinical functioning and social identity. Current changes in health policy, service deterioration and community conflict have amplified staff's anxieties regarding real and metaphoric clinic boundaries and integrity. Staff and patients sought to appropriate and reinterpret spaces as a strategy of power and authority. The Trauma Unit was examined as a particularly vulnerable site where unorthodox forms of power were taken up by staff and patients in a performance facilitated by the uniquely public and chaotic nature of this clinical space. The study concludes practically by stressing the necessity of a spatial understanding in health service management and policy development.

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Abbreviations used in the study

C.H.S.O.	Community Health Service Organisation (PAWC)
CHC	Community Health Centre
DIC	Doctor-in-Charge
E.N.	Enrolled Nurse
F.N.	Field Notes
G.A.	General Assistant
G.P.	General Practitioner
L.A.	Local Authority
M.O.	Medical Officer
M.O.U	Maternity and Obstetrics Unit
N.A.	Nursing Assistant
N.G.O.	Non Governmental Organisation
O.P.D.	Out Patient Department
P.A.G.A.D	People Against Gangsterism and Drugs
P.A.W.C.	Provincial Administration of the Western Cape
P.H.C.	Primary Health Care
PAWC	Provincial Administration of the Western Cape
S.A.S.O.	Special Auxiliary Service Officer
S.I.C.	Sister-in-charge
Sr.	Sister
V.S.P.	Voluntary Severance Package
W.H.O.	World Health Organisation

CHAPTER ONE
INTRODUCTION

> The clinic is carefully sign posted from the entry road. It is one storey and not particularly conspicuous. What marks it out most clearly from its surrounding buildings is the high barbed wire fence with razor wired edges alive with plastic packets flapping in the wind...I am struck by all the security features - security guards, prison door on all large entrances, thick burglar bars and high fences. The paradox of needing to be accessible to and yet protected from the community. How do they negotiate this? Dr. A [the Doctor-in-charge] said it was a result of the gangs in the area. How does spatial access differentiate between gangster and patient? (Initial visit, Fieldnotes,)

1.1 Setting the scene

"I would like to take a big eraser..and start from scratch - start from new!" exclaimed the tired Sister-in-Charge (SIC) of Hanover Park Community Health Centre as we sat discussing the clinic in her "office"[1]. She describes unrealistic managerial demands on staff to cope with extra work and higher patient loads, while not "taking into consideration that staff are less". The facility is changing, "most staff are thinking of leaving,..I no longer do nursing duties", she says. Managing the clinic is a full time job which requires that she become "a police man". The clinic has many problems, gangsterism has increased and there is "no clear cut respect" from the community. "Roles have gone astray" she continues, "I am sick of people insulting me!" When asked why she says this is a "cultural, political thing". Part of the problem, she tells me, is the easy access to the "Day Hospital for gangsters and mothers. People in Hanover Park abuse it, it's too convenient and free of charge, its accessible for nonsense." "People should think twice" she explains, " before coming to a Day Hospital". She thinks that this would make it "fairer on other patients" from outside the areas. Its "scary" for these patients to enter this area to seek care, "most go to Wynberg [CHC]", as "this place is in the centre of the gang area!"[2]

1.2 Locating and grounding: Introducing space

This study sets out to explore "space" as an object of enquiry. In doing so it has asked if "space" can provide useful insights into the problems a specific health institution is facing, and more broadly, an understanding of how the social realities and the functional capacity of organisations are created. Put another way, I shall explore *how* a biomedical institution, a primary health care facility, functions, and *why* it copes with crises in a particular way, by asking *where* this service and crisis is occurring. This study shall therefore ask how personal, social and organisational realities are created in, and through space, and the strategies used by social agents resist and transform these realities. In order to accomplish this, I examine the everyday located material and spatial worlds of an embattled community health centre (CHC) in Hanover Park, an urban working class, "coloured" township in the Western Cape.

This ethnography of a clinic[2a] at a particular moment in history when it and the health service is struggling with social and institutional change and conflict. Hanover Park CHC is an established and respected primary health care institution in crisis. This peripheral biomedical facility is currently caught in the maul of interrelated destructive processes - the internal pressures of policy change and rationalisation, and the external illegality and violence that has come to dominate the Cape Flats. Historically these institutions have privileged rigid authoritarian management with little capacity to devolve power or adapt to changing circumstance (Mgoduso and Butchart, 1992). These conditions have created insecurity, fatigue, and antagonism among, and between the clinic's staff and patients. Health care in the area has potentially been compromised and poorer populations and communities who must rely on the capacities of the public health service. Everyday material conditions in such locations create vulnerable citizens, communities and potentially institutions, with access to limited social choices and resources.

In this study everyday and material practices have been understood within a range of multidisciplinary discourses that articulate the notions of social space, spatial practices and the manner in which these are used and interpreted by embodied social actors (Bourdieu, 1977, Lefebvre, 1991). The Community Health Centre is represented here as an arena or field of competing players and forces such as staff, patients, local communities, state power and global biomedicine. The space of the clinic is therefore saturated with spatialised forms of power and resistance, which "like a coloured dye [is] diffused through the entire social structure" (Turner, 1997, pxii). These forms of power are produced and reproduced in spatialised daily practices and social identities (Bourdieu, 1977, Armstrong, 1993).

The ongoing construction of social structure and reality is a ubiquitous yet scarcely overt or conscious process (cf. Garfinkel, 1967, Laclau, 1990). Social space or material social reality tends to be taken for granted, remaining invisible in our analyses of social action and institutions. Lefebvre (1991) called this the "illusion of [the] transparency" of space, which "goes hand in hand with the view of space as innocent, as free of traps or secret places" (p27-28). Furthermore, the fundamental spatial nature of biomedicine tends to be erased in official positivistic or instrumental discourses which locate the power of biomedicine in abstract scientific truth and moral superiority. Yet, biomedical spaces such as hospitals, clinics, health districts, or indeed the spatiality of the human body (Foucault, 1976, Armstrong, 1995) are not merely empty functional containers, but sites for the production and reproduction of biomedical power and identity.

> To speak of producing space sounds bizarre, so great is the sway still held by the idea that empty space is prior to whatever ends up filling it (Lefebvre, 1991, p.15).

Biomedicine has played a pivotal role in the social construction of the modern body, and subjectivity, and the biopolitics that helps govern the modern state (Foucault, 1976, Turner, 1995). Indeed biomedicine may be said to have succeeded as a powerful discourse in the twentieth century precisely due to its capacity to invent, secure and master an authoritative material presence within the world. Ideology requires form,

> ..any `social existence' aspiring to be `real', but failing to produce its own space, would be a strange entity, a peculiar kind of abstraction unable to escape the ideological or even the `cultural' realm. It would fall to the level of folklore and sooner or later disappear (Lefebvre, 1991, p.53).

Biomedicine therefore needs biomedical spaces to be powerfully immanent in modern society. This utilisation of differentiated and defined spaces gives rise to a (hidden) dependence upon the integrity of biomedical space or territory. Biomedicine is profoundly spatial, this is its strength and vulnerability.

It has become increasingly popular within (loosely designated) post-modern scholarship to examine the role of the body in the construction and representation of identity, discourses and subjectivities (Pile, 1996).

> The body, at the very heart of space and of the discourse of power, is irreducible and subversive. It is the body which is the point of return (Lefebvre, 1976, quoted in Gregory, 1994, p.405)

Space has increasingly entered this discourse as both the concrete and conceptual framing for the body - a body which is often represented as the locus of diffuse and disciplining power (cf. Foucault, 1977). Furthermore, within a post-modern ontology, identities and subjectivities are theorised as being contingent, multiple, fragmented and non-essential (Dear, 1997).

Biomedical roles and identities, namely the binary of doctor-patient, or more broadly staff-patient, structure and define the biomedical encounter and their institutions (Lupton, 1995). Although these are often presented apriori identities, biomedical identities, like racialised or gender identities (Moore, 1996, Foster, 1997) may be shown to be spatially constituted, and dialectically rebound on biomedical space. The notion of the spatial construction of biomedical identities is at the heart of this study, that is, the spaces of the clinic are instrumental in the contextual and ongoing construction of local biomedical identities of staff and patient. These identities are therefore fluid and unfixed (Dear, 1997),

> And it is here that our concepts of spatiality enable an engagement with the space of politics. For if spatiality is to offer a vocabulary for understanding the politics of identity, a fixing and singular spatiality would offer an account of stable and certain, perhaps pre-given identity. *But spatiality which is*

> *understood as constantly changing, unstable and multiple offers a powerful vocabulary for understanding identities as only ever precariously secured*" (Robinson, 1995, p6, emphasis mine).

Thus, the space of the clinic may be understood to be profoundly related to the formation and maintenance of the multiple social identities within it. The heterogeneous nature of these identities is related to the heterogeneity of the spaces within (cf. Lefebvre, 1991, Robins, 1998). For the staff and patients living and working in the clinic, this place, as I will explain, consists of multiple symbolic systems, namely that of biomedicine and the more unruly world of the home, family and street (Harries, 1995, Young, 1989). Social space, according to Lefebvre (1991) acts as a mediator between these different, and sometimes contradictory, social orders, levels and ontological realms (cf. Jensen and Turner, 1997, Young, 1989). These realms are complex and interact spatially in a manner which requires ongoing redefinition and contest, and which defies the apparent stability of physical boundaries (Young, 1989, Harries, 1995). As such space also holds a key to exploring the tension between structure and agency, and the limits and choices that pre-existent material and cultural realties impose upon us (Giddens, 1984).

1.3 The Clinic and the problems

I had not visited Hanover Park or its Community Health Centre prior to this research, although I was conducting research at similar township CHC at the time. It is both familiar and yet unfamiliar, and as a white South African it was quite common to have avoided such areas within this spatially segregated apartheid city. Furthermore, Hanover Park is considered "unsafe" and before I visited Hanover Park and its CHC, I was regaled by extraordinary tales of its gangster infested crime, the "Cape Flats War" and my own personal vulnerability[3]. What I found, however, were far more mundane spaces and struggles between clinic staff, management and patients and the public – including the local gangs.

Staff and patients do not talk overtly about "space" within their accounts of troubles and complaints. They spoke of messy, rude, abusive patients, their fear of violent attack, long waits for treatment, insufficient staff and the slow, seemingly irreparable loss, due to resignations in their close-knit staff body. But, verbal and physical abuse from patients (and staff) does not occur everywhere in the clinic. It is *not* generalised. It occurs in specific sites which have become socially marked as danger zones. Abuse was also directed at some staff members more that others. Professional power and status within the clinic can be translated into different access to certain spaces and differential mobility within and without the clinic (cf. Massey, 1996).

These accounts of "mess", patient abuse and staff counter abuse, reveal a less heroic narrative of an institution whose very capacity to function as a health care facility has been undermined. A staff member noted,

> I observe, I observe.. I mean the way the doctor talks to the patients..in the the tone which he is using. His whole expression, body language, everything dissatisfied, because of the conditions they work under. An now they take it out on the patients. Sometimes the patient come to me here, okay they are new, but they even are more ill when they go home! Because of the treatment!

1.3.1 The place

> Before any choices there is this 'place', where the foundations of earthly existence and human condition establish themselves (Dardel, 1952, quoted in Eyles and Litva, 1998, p.260)

Hanover Park Community Health Centre is a single story, prefabricated squat building without obvious entrance, bounded on two sides by open derelict building sites and the two main roads[4]. The building is orientated with its back to the small commercial centre, so that its public entrance is located on a domestic cul-de-sac. The staff entrance is a guarded gate overshadowed by the growing taxi rank and fruit sellers on the adjacent road.

The clinic is an unremarkable structure, and would blend into the mundane fabric of the small commercial centre were it not for the rather bizarre accent provided by a halo of plastic bags caught in its perimeter barbed fence. *This public clinic is the most fortified building in the neighbourhood.* Open twenty-four hours a day, *the clinic is also the most accessible place in this community.* It is one of the few sites in this "inhospitable" and "peripheral place"[5] which receives a stream of visitors from outside its carefully delineated boundaries.

The CHC is therefore intimately related to the built environment of Hanover Park. Here, repeated uniform low-rise blocks of flats point to the historical origins of a place carved out, not by successive generations of residents, but through the authority and power of the state (Pinnock, 1984, Holston, 1989). Planning and architectural form reflects a modernist vision, which, among other features, challenges the traditional delineation of private and public spaces (Holston, 1989). The Urban Project Research Unit (1981) noted that in Hanover Park the net result of this apartheid appropriated design is that,

> the definition of private/public interface has broken down completely in places, particularly in the flat area. The result is an ambiguity about what is private and public domain. (Urban Projects Research Unit, 1981, p.31).

Pinnock (1984) describes how these ambiguous public spaces become colonised by gangs who continuously perform their appropriation and ownership of this (artificially created) territory through gang posturing and violence.

Figure 1.1 The Main entrance to Hanover Park CHC

Figure 1.2. The Main Gate (behind standing figures) of the CHC onto Hallans Walk, a small domestic road.

Hanover Park is a place born of violence and is a violent place. Forced removals dislocated and excluded people in a bid for social and racial order and control. The net result of this essentially spatial act was the creation of racially designated, homogenous, and healthy[6] governable spaces (Goldberg, 1993). Hanover Park is formally "coloured" area[7], although difference is further etched into place by vigilant gangs who carve out territories and identities within (cf. Pinnock, 1984).

The Hanover Park CHC, like its surrounding space, is therefore a contested and ambiguous place. It is both separate yet profoundly embedded within its physical and social context. Its official designation refers to a localised site, and yet it is one of the more cosmopolitan and socially heterogeneous areas in this vicinity. It announces it presence through clear signposting at the mainroad entrance, but yet is proximally signposted and orientated in such a manner that its entrance is hidden and inaccessible in an adjacent domestic road[8]. It lies between the public business hub and the (relatively) quieter domestic streets. Tales of mutual patient/staff or gangster abuse and immanent service collapse are juxtaposed with those of an exceptional dedicated staff body, model service transformation and moments of great warmth and caring between staff and patients. It is paradoxically both open and closed; a place of relationship, and a sterile institution.

1.3.2 Accounts of the gangs

The Hanover Park Day Hospital, as it was originally called, was established in the early eighties by the coloured House of Representatives. Since the early nineties there have been complaints that the clinic has been plagued by the many gangs in the area. These accounts began to emerge in the press from 1994, with the M.O.U nursing staff equating their situation with the political violence then being experienced in the African townships. Nurses began to insist on "danger pay" for the "life threatening situations they face everyday" from the gang members "demanding treatment"(Athlone News, 3.3.1996), or "stray bullets" from gang wars outside.

> They bring dogs and they threaten to get you at the bus stop, and one even threatened to kick the door in (Cape Argus, 3.3.1994)

The clinic has prefabricated walls that offer the inhabitants little protection. In November 1995, the Doctor-In-Charge (D.I.C) was shot in the buttocks while examining a child in his office. A stray bullet which had penetrated the exterior of the building caused the injury. It was apparently fired by gangster fighting in the area around the clinic. The staff were quick to respond by threatening to close the Trauma Unit down unless their provincial management provided a concrete perimeter wall around the property. The press reported that, "The embattled staff of Hanover Park's hospital appealed to the army to be called in to protect them from gun wielding gangsters who regularly overrun the hospital demanding medical care and terrorising patients" (Cape Times, 23.11.1995).

Figure 1.3. A car leaves the staff parking area through the Staff Gate onto Surran Road. The Taxi rank is on the right.

Figure 1.4. Shops at the Hanover Park town centre, opposite the staff entrance

The staff issued a statement for the press on the 17 November 1995 stating that "The gangs surrounding the hospital believe that the facility is for their exclusive use" and that,

> the public makes unfair demands on the [pressurised] staff and ignores the handicaps which impact on service delivery. This unbalanced situation leads to explosive situations which sour relationships between staff and the community (Cape Argus, 17.11.1997)

The staff closed the unit for a few hours on New Years eve 1996 as they were "terrified by gangs fighting and shooting outside the hospital" (Cape Argus, 4.1.1996). This allegedly happened after a doctor refused to treat an injured gangster who "swore and threatened to kill him" (Cape Argus, 5.11.1995).

By late 1997, when the fieldwork for this study was undertaken, the gangs remained an ongoing threat. However, as the Sister-in-charge suggested, the threat the clinic was then facing had broadened and moved beyond the predictable binary of gangs and staff. The antagonists and the parameters of the threats to institutional authority and security had become less clear-cut, and more diffuse. In short the situation was more ambiguous, and thus potentially more ominous.

1.4 The Aim of the study

> Our search for the human takes us too far, too "deep" whereas it is awaiting for us besieging us on all sides [for] the familiar is not necessary the known. (Lefebvre, 1947, quoted in Gregory 1994, p.363).

This study examines the primary material interface of biomedicine and the community, at a time when civil governance and health service resources are threatened. By examining biomedical space, and its spatial practices, the study will focus upon material and mundane sites of social construction and reproduction. The study also describes a community and its health service at risk, and thus also asks how space functions as a resource for spatialised strategies of defence and resistance (Shields, 1997). The specific insight at the heart of this study is the *fragility* of biomedical space and its vulnerability to physical and symbolic appropriation.

By foregrounding space and place in this study, I am therefore seeking a spatialised description or construction of this located biomedical institution, its power (or lack thereof) and its problems. In this sense, following Foucault (1976), I am seeking to raise for myself, the "threshold of the visible and the expressible" (pxii) outside the dominant discourses of social, organisational and clinical psychology. To undertake the task, I have therefore drawn upon fields of enquiry such as anthropology, sociology, and a philosophy of space, within both a modern and postmodern frame.

As a health worker, the problems and functional capacity of such a facility remains a professional and ethical challenge. Therefore this spatial enquiry may produce a helpful practical understanding of how a clinic works and guidance as to ways it could work better (while problematising what this criteria may be). *It is therefore a challenge of this project to show that an understanding of space can be useful and meaningful knowledge* (cf. Lefebvre, 1991). Furthermore, I also seek to translate such knowledge into a pragmatic discourse of health service development, while contributing to a theoretical understanding of the inherent spatiality "the social".

The scope of this project is, by necessity, limited. The spatial is a rich and complex field of enquiry and requires preliminary excursions to broadly map out the terrain. The challenge is to begin to "see" or "feel" the spatial amidst the flux, messiness and familiar representations and constructions of everyday and organisational reality. I am hoping here to place space at the heart of my investigative vocabulary[9]. This requires a cognitive and perceptual shift, a different gestalt, a challenge to familiar binaries of foreground and background, stage and actor (cf. Lefebvre, 1991).

It has therefore been important amidst this disorientation to be grounded in the existing maps of spatial theory. I have drawn heavily in this study upon the spatial models of two theorists[10], Henri Lefebvre and Michel Foucault, whose work will be briefly outlined below, and applied in greater detail within the text.

1.5 Guides

> Is space indeed a medium? A Milieu? An intermediary? It is doubtless all of these, but its role is less and less neutral, more and more active, both as instrument and as goal, as means and as end. (Lefebvre, 1991, p.410-411, quoted in Soja 1996, p.45)
>
> A whole history remains to be written of spaces - which would be the at the same time be the history of powers ...from the great strategies of geopolitics to the little tactics of the habitat. Michel Foucault in Gordon, 1980, p.149

This study is structured such that relevant theory and literature has been woven into following chapters. In order to master this treacherous theoretical terrain, however, two guides have been particularly helpful to the study.

1.5.1 Disciplining spaces: Michel Foucault

Michel Foucault's (1977) careful description and analysis of the development of modern disciplining space within institutions such as prisons, asylums, factories and hospitals has been vital in understanding how the clinic space is rationally structured in order to accomplish its modern functions. Foucault translated the mechanism of institutional (state) power into specific forms of architectural panoptic design and habitation, which make possible the construction of individualised knowledge of "the patient" and the docile modern subject. Foucault's Discipline and Punish is a

richly detailed guide to the micropolitics of built institutional spaces. Power here is productive and therefore ambiguous, and his analysis remains mindful of the necessary contingency of design for effective modern humanist medical, penal and psychological practices as we know them.

It seems appropriate that another rich vein of spatial analysis has emerged from critical and postmodern geographers such as Harvey (1985), Gregory (1994) and Soja (1989, 1996). These theorists while embracing Foucault have been instrumental in making the original spatial philosophy of Henri Lefebvre (cir. 1910 - 1991) the foundational texts of very grounded and creative spatial exploration(s).

1.5.2 Spaces of domination and imagination: Henri Lefebvre

Lefevbre has been described as one of the most influential figures in the development of French Marxist theory and philosophy from the early thirties to late fifties (Soja, 1989). Soja (1989) describes him as "the most persistent, insistent and consistent of the[se] spatializing voices" (p.16).

Lefebvre's spatiality has roots in the primacy Marx placed upon "material life in the production of thought and action - that social beings produce consciousness rather than the reverse." (Soja, 1989, p.48). Unlike Foucault, his spatial analysis emphasized a political project, although his Marxism has been described as "flexible open and cautiously eclectic" and his academic stance multidisciplinary (*Ibid*, p.48). Lefebvre's micro-spaces are positioned within a broader macro-analysis of capitalistic modes of production with complex centre-periphery relationships (Harvey, 1985). He was therefore a forerunner in perceiving the spatialised nature of power and subjectivity, writing, "Power is everywhere; it is omnipresent, assigned to Being. It is everywhere *in space*" (Lefebvre, 1976, in Soja, 1996, p.31, original emphasis). He linked space to governance and production, seeking to "chart the historical successions and superimpositions of modes of production of space" (Gregory, 1997, p.206).

In order to understand how space is socially produced, and in turn productive, a preliminary question emerges: What space are we referring to? How do we distinguish or differentiate it? Lefebvre (1991) alerted us to the ontologically destabilising notion that *social space could be multiple and differentiated*, and different forms of social space may co-exist in one physical location seemingly even in antagonistic opposition (cf. Allen and Pryke, 1996). Lefebvre (1991) pointed to two forms of social space, namely "Representations of space" and "Spaces of representations" (or "Representational space"). Lefebvre's understanding of multiple and differentiated spaces will be used in the study to understand the complexity of spatial meaning and structure within the study. Finally, Lefebvre (1991) provides the mechanism of spatial production and reproduction by describing "spatial practices".

> The spatial practice of a society secretes that society's space, it propounds and presupposes it, in a dialectical interaction, it produces it slowly and surely as it masters and appropriates it (p.38).

These practices are not therefore arbitrary or unstructured, but require a level of "competence" and "performance" (or one may add inculturation), thus giving "coherence and continuity" to the social fabric (Lefebvre, 1991, p33). In this sense spatial practices are similar to Gidden's (1984) notion of routine and repetitive activities, the "material grounding of ..the recursive nature of social life"(*Ibid*, pxxiii), and Bourdieu's material "social practices" (Bourdieu, 1977).

1.6 The Map of the Study

Following Chapter One, the Introduction, Chapter Two shall outline the ethnographic research methods used in the study. Chapter Three describes the spatialised discourse of Primary Health Care (PHC). Here I shall investigate how PHC ideology and discourse is based on unexamined assumption regarding "where" it is practised and the spatial relations inherent to its specific form of biomedical practice. Explicit and implicit clinic architectural design criteria are described. Chapter Four and Five begin by examining different forms of clinic space through the lenses of Michel Foucault and Henri Lefebvre respectively. In Chapter Four, I describe the production of disciplined biomedical spaces and identities, while Chapter Five describes lived spaces, and real and imaginary spatial boundaries and their symbolic and emotional significant. Chapter Six and Seven are linked, and take these observations one step further. They describe unofficial and unorthodox strategies used by staff and patients as agents to utilise and resist forms of power within the clinic. Chapter Seven focuses specifically upon the functioning and strategies used within the Trauma Unit to manage this dangerous and vital biomedical space. Chapter Eight is the conclusion. Appendix II provides more detailed descriptions of the clinical places and processes.

CHAPTER TWO

METHODOLOGY

> Ethnography is a culture studying culture...It seeks to build a systematic understanding of all human cultures from the perspective of those who have learned them (Sprandely, 1979, quoted in Thomas, 1993, p.10).
>
> We must show that the phenomena described fit the category of the description, and that the information about the phenomena on which the category is based is accurate (Hammersley, 1992, p.71).

2.1 Ethnographic inquiry

This study attempts to ask questions about 'spaces', or more precisely biomedical spaces - a slippery and illusive object, which evades and challenges the inadequate investigative and representational tools of academic discourse. 'Space' is therefore easily squeezed into unhelpful reified concepts which once again elude the world of *lived* space in which the material, symbolic/conceptual and social have been seen as inseparable (Lefebvre, 1991). More abstract or theoretical questions regarding space must therefore be grounded in actual places, in an ethnographic research frame which encourages a dialogue between observation, description, analysis and generalised theory (Hammersely and Atkinson, 1983).

There is however a paucity of descriptive and analytic studies on biomedical space[i]. Space is generally seen as unremarkable, or transparent, a neutral stage or background for the biomedical drama (cf. Lefebvre 1991). Biomedical space is seldom investigated as, a valid object of analysis, l*et al*one a vital constituent of biomedical functioning and identity.

Following Hammersley (1993), a challenge in this study has been to find a category of description to describe the phenomenon of interest, spatial use and structuring in a Primary Health Care (PHC) facility. I have selected conventional ethnography as it has a tradition of fieldwork methods that have found social spacing and its meaning as a valid object of research (e.g. Bourdieu, 1977, Moore, 1996); and, furthermore, has experimented with different means, such as mapping, to capture this, essentially elusive, phenomenon (cf. Crane and Angrosino, 1993). I am also conscious in this process that my conceptualising of this object, and the means I use to capture it, are essentially constructing the very phenomenon I wish to explore (Pollner, 1987). Ethnography offers me a multi-modal research approach which will allow many different constructions of "space", that is in discourse, through naturalistic observations and through graphic and photographic representation, which I hope will ground this research, and mitigate against the unhelpful, vague reification of "space" found in many postmodern texts.

By describing this work as ethnographic, I understand it to mean that I have undertaken reflexive data collection that is both a descriptive and exploratory investigation of on-site "social process in an everyday setting" (Hammersley and Atkinson, 1983, p.24).

In order to capture and depict such processes, I have relied largely on direct observations, interactions and recording of various data sources (Thomas, 1993) such as spoken discourse or media reports, in a multi-vocal approach that also includes collecting "evidence and artefacts" such as official clinical records and statistics (Feldman, 1989).

These observations have been largely unstructured, and I sought to enter the area without preconceived expectations of what I would encounter there. This data gathering has occurred in a specific demarcated context or setting, in which I have attempted to locate myself along a spectrum of various degrees of participation (Hammersley and Atkinson, 1983). Furthermore, I have attempted to capture both "etic" and "emic" material. This emic material was obtained largely through rapport and discussions with informants to get access to an "insiders" view of their experiences and the manner in which they understand and construct meaning in their world (Feldman, 1993).

Ethnography, therefore, as I understand it, is both a methodology that defines its object and its methods. It is not a methodology that psychology has extensively utilised, and its expertise lies in the anthropological, and to a lesser extent, sociological disciplines. There is always a tendency, to simplify and unproblematically utilise extracted methods from another discipline. This occurs without due understanding and reference to the contested, multiple and complex epistemological and methodological debates and developments of those methods or theories in its own fields of origin. Furthermore, it is problematic to present these methods as neutral, scientifically valid techniques devoid of the specific theories. Ethnography has its roots in both a positivist and hermeneutic tradition, to which it makes often contradictory truth claims that have been further problematised with the advent of more postmodern approaches.

2.2 Studying space

> To question `space' is to question one of the axes along which "reality" and truth are conventionally defined (Shields, 1997, p.188).

The study of "space" as a viable object of study is relatively new, especially outside the field of the more spatial sciences such as geography and architecture (Soja, 1989). To locate the spatial within biomedical sites and practice would not be unusual within the applied world of medical architecture, design and ergonomics. Hospitals and clinics are regularly built and there exists a small but authoritative body of literature as to what constitutes good design given the medical

procedures, activities and technologies they must facilitate (e.g. Cammock, 1981, Putnep, 1979). Are these then the spatial factors to which I am referring to in this study? And if not, what is the "object" of this investigation?

Pollner (1987) alerts us to the ontological fallacy of "mundane enquiry" which presupposes that an object under study is *discovered* rather than *constructed* through the investigative mechanisms which generate knowledge. As the dominant epistemological tradition of the sciences, this type of enquiry would seek to define "space" here as a "real" object that pre-exists this enquiry. It needs therefore to be clearly stated at this juncture that "space" in this study is a social construct that has particular and multiple discursive bloodlines which need to be made explicit in order to articulate here what it is that is being sought and observed.

The empirical tradition rests upon the accurate sensory apprehension of its objects for the establishment of its truths (Foucault, 1976), and it has been argued that visible observations and truths have an epistemological privilege (Lefebvre, 1991). Likewise, the broad discursive and postmodern traditions has been fascinated by the text, the word, the fecund universe of language. Modern and now postmodern knowledge, it may be argued, is dominated by a world that is known through sight and reading as opposed to what is *lived* (cf. Lefebvre, 1991). Although, these counterpoints could be easily deconstructed, they point back to more submerged phenomenological or existential and ethnographic traditions which celebrated the constitution of "being" and "meaning" in everyday life (cf. Tuan, 1977).

2.3 Locating the researcher: limitations and responses

Despite the complexity of this debate, I wish to highlight some framing factors for my handling of data and its analyses in this study. Many of these issues trace the tension in this study between theoretical exploration and the desire to construct practical and instrumental knowledge. These factors are relevant here in understanding the specific limitations of this study, and its future directions.

Current models of ethnography highlight the need for reflexive examination of ones subjective interpretations and position *vis a vis* the material or fieldsites. Reflexive enquiry, has been defined as a stance "directive towards explicating the conditions of one's own existence and ideological practices so as to expose one's participation in power relations" (Lupton, 1995, p.13). This reflexivity involves ones social or gender positions (Shields and Dervin, 1993), and role as producer of ethnographic knowledge and narrative. My racial, gender, professional and class positioning impacted on both what I saw, how I felt and the manner in which I was perceived and related to. I have tried to incorporate these responses as a means of understanding the spatialised politics of the clinic, and my participation in this. The following fieldnote illustrates the point:

> I entered through the staff parking entrance. The security guard seemed to inspect me as I drove in, but I am long used to the ease my white skin (?) gives me access to private township clinic spaces...Patients were present in all the waiting room, although the numbers were typical of early afternoon thinning. My white skin, clothing and briefcase always seem to mark me here as another health professional. Is it my imagination that waiting patients' stares always seem imploring - "Is this one of the doctors that is going to see me?" I always feel slightly apologetic in these places because I am not helping to alleviate the queue! I feel like an important person with access to resources, especially as I confidently enter space or talk to staff (in some cases leading them away from seeing patients) which they [the patients] have no access to. Awaiting patients were all coloured and poor. I don't remember much else. (Initial Impressions, 8.7.1997)

2.3.1 Insider/Outsider ontology

Traditional ethnography has positioned the researcher as clearly "outside" the observed culture or ontology, despite the call for relative degrees of participation in the daily practices of the observed community. This is a constant tension within the field, how to get "in" (i.e. access to the informants lifeworlds), while maintaining sufficient distance, so as not to become engulfed in the world of the Other, one cannot be both a "native" and a "anthropologist" (*Ibid.*). Feldman (1989) writes that the ethnographer should gather information about:

1. Peoples understanding of their life worlds.
2. The formation of everyday life practice and beliefs.
3. Shared meanings and codes through which they are expressed.
4. The relations between shared meanings and performed action.
5. The relations between formal (institutional) rules and behaviours and informal actions" (p.20).

In this research "the people" examined have been largely *the staff* of a biomedical institution, and many of the practices, beliefs, rules and meanings studied, are those generated by this biomedical tradition. The ethnographic tradition has its roots in the colonial and post-colonial studies of cultural others (Clifford, 1997). The question needs to be asked where I positioned my self for this research as both a biomedical professional as an "insider", and as a researcher doing fieldwork in an unfamiliar clinic and area, as an "outsider". Furthermore, it is highly problematic to simply conflate the staff with the area. Most of the staff do not come from Hanover Park, and participate in the construction of the patients and area as "other", or appealed to professional and class similarities between us.

From the onset of my time at the clinic, beginning with formal interviews with senior staff and introductions to staff, I positioned myself as another health professional, who happened to be doing research at their clinic. This, often unconscious positioning, was, I believe, an attempt to appeal to

the legitimacy and status of my professional role to enter many "private" clinical spaces, such as patient examinations. In retrospect I believe this was problematic for an number of reasons: Firstly, ethnographic work yields it best results when researchers allows themselves the uncomfortable position of "not knowing", or in ethnomethodological terms, allowing all to seem "strange" (Garfinkel, 1967). By asserting my position within the clinic ontology, I believe I often closed off opportunities to interrogate processes, which at the time appeared obvious, (e.g. a clinical procedure and the actors participation in this). That is, I assumed the shared (biomedical) meaning that organisational members must be seen to possess (Garfinkel, 1967). However, my entering into this "blindness" of taken-for-granted institutional concepts and truths (Thomas, 1993), has been somewhat mitigated by the research object - space/spacing. Biomedical space is not articulated as an object in general biomedical discourse, and hence its focus forces the biomedical subject to examine the "everyday and unfamiliar" in my midsts (cf. Lefebvre, 1991).

If shared biomedical professional meaning was the first layer of contact inevitable in this research situation, it may have been punctured by ongoing interpersonal contacts that allowed greater access to specific clinic and personal meaning. Although I believe that my time at Hanover Park gave me some insights into the lifeworld of this specific clinic and its clinic culture, there were real problems that made understanding difficult at times. The first was the relatively short time spent at the clinic, which did not allow for deep rapport to be established with the staff. This was often heightened by my specific focus on physical and spatial structuring. Secondly, many of the most informal discussions, in common rooms (etc.) were undertaken in rapid colloquial Afrikaans which was often hard to follow, and very difficult to record. Staff were very busy and overworked, so formal interviews were often very difficult to set up. Furthermore, there was a distinct dislike of taped interview, which may have arisen out of fear and distrust, especially in a time of critical public scrutiny and a perception of unsupportive and punitive management (Muller *et al*, 1998). However, rapport and meaningful participation (as observer) was best accomplished in the long stretches of after hours and night duty. These experiences not only provided valuable, detailed data, but more importantly provided "embodied knowledge" (Moore, 1996) of working in this clinic. This was perhaps the most grounded and valuable insight into embodied spatial experience which lay largely outside the perimeters of official biomedical discourse. It remains problematic however, to articulate this kind of knowledge in an academic study.

Moore (1996) writes of the difficulty in ethnographic narrative of allowing the more embodied aspects of fieldwork "into" the narrative. Likewise there seems little space for the fieldworker's affective and imaginative response - in short the unconscious and emotional responses of the researcher have little epistemological status in this ambiguously empirical discourse. Psychoanalysis on the contrary asserts that what the therapist (or investigator) feels or imagines in an encounter with a client/patient (or organisation) provides "valuable diagnostic clues for

understanding elusive communication from the patient" (Casement, 1990, p.65). Loosely, this response within the clinician is referred to as counter-transference, and can be valuable material in understanding the clients unconscious (and conscious) anxieties (Casement, 1985).

This study is not overtly based in analytic thought or clinical understanding, however it is laced with barely articulated notions of unconscious symbolism, meanings and defensive responses in what I saw and observed (cf. Malan, 1979). Furthermore I am aware of my own anxieties shaping what I perceived, wrote and focused upon in the clinic - what "caught my eye". I wish to highlight these not just to highlight my subjective biases (to use an empirical notion), but as valuable information of central anxieties within the clinic. My own fears and prejudices tend to be evident in the observations made within the clinic.

2.3.2 Private - public spaces

My positioning within the clinic was ambiguous, and as I have stated I made claims to my biomedical professional status in order to manage the anxieties I had about being in the clinic as an observer. Constructing myself as a staff member made it easier to enter the clinical spaces, and be in (some) staff designated places.

Fieldwork requires a degree of violation of boundaries between public and private, often uninvited. My observations in this study focus upon the Trauma Unit in the clinic. Although all other areas were visited and explored, my most prolonged periods of observation and participation were here. No clinical sessions were observed in the doctors rooms. Participation in the Trauma Unit as an ambiguous insider-outsider was easier precisely as the boundaries between private and public spaces were more ambiguous - I felt less anxiety about being there, indeed I often did not even have to explain my presence.

2.3.3 Drama, wounds and exciting entertainment

The Trauma Unit was also a site of heroic, exciting, dangerous action and camaraderie between staff on night duty. I felt less anxious here about my inclusion and invasion. In reflecting on my notes and accounts of those times it is clear that it is the damaged, rather than sick, patients that caught my attention here. This is partly due to the fact that sick or diseased patients were taken behind the curtain by the doctor for examination, while the damaged patients (stab victims, car accidents, broken bones etc.) were treated in a visible public space in which I participated. I was fascinated, repelled and afraid of patients' open wounds and blood (this was consciously related to HIV infection fears). Wounds are visible holes into the interior of the body, stab wounds reveal the interior of the body and the fragility of the skin above. This was seductively fascinating and frightening.

2.3.4 Escaping the Clinic

Generally I did not enjoy visiting the clinic. These were anxious times when I felt uncomfortable about violating certain spaces and watching certain "private" procedures. Sometimes the clinical spaces repelled me, there were smells of urine, unwashed bodies, blood and wounds wrapped in dirty rags. Invariably I breathed a sigh of relief when I left the clinic and often felt guilty about the ease and power I had to come and go, and more importantly, leave when I wanted to, or had had enough. Staff made envious comments often when I left. It was good to get out of there.

2.3.5 The family of informants

The clinic staff treated me with a range of responses from disinterested tolerance to active friendliness, confession and motherly regard. I was afraid of taking something from them (as researcher) and giving little back. Desire for some form of reciprocity made me offer technical advice on occasions (positioning myself as staff) and giving a large thank-you party and gifts at the end of the fieldwork. I envied their close bonds at times and felt excluded from some staff spaces such as the men's common room and the informal staff tearoom, the "love room".

2.3.6 Perilous States[ii]

My fear and anxiety regarding the violence in the clinic is found as a subtext within my fieldwork accounts. The media is also flooded with accounts of the immanent collapse of the health service, but also the apparent chaos and violence within this country. Images of disintegrating nation states, vigilantism, civil war and global economic meltdown appear to have become commonplace. Modern governance and spaces appear to disintegrate into pre-modern chaos. This material produces anxiety about social stability and my own vulnerability which is reflected in this study. Can the clinic survive - can the modern state survive? This personally felt fear and sense of peril is present in this analysis.

2.4 Date gathering

Time available for fieldwork at Hanover Park CHC was limited in this study. I spent three months at the clinic on a part time basis, from July to September 1997, although ongoing contact and visits continued until December 1997. Access and permission to do research at the clinic had been facilitated by other ongoing research work on mental health services in which I am involved (Muller *et al.*, 1998). This broader project is important here as it has provided the vital contextual framing for this clinic case study. As part of this larger project, I have visited and examined the conditions of a cross-section of provincial and Municipal PHC clinics and CHC's in the greater Cape Town area. This information, although not directly found in this study, has greatly assisted me in managing one of the greatest dilemmas facing single-setting ethnographic studies, that is distinguishing between the specific and the more generalisable aspects found in any site (Hammersley, 1983).

Basic data gathering methods therefore included:

a) **Direct observations** of clinical areas in the clinic, accompanied with informal discussions with available staff as to the tasks they were doing and their experiences of this specific work and area. This included clinical, (e.g. nurses and doctors), and non-clinical staff, (e.g. security guards, clerks and general assistants). I attempted to visit all areas, as well as get a sense of their usage across time, for instance weekends and nights at the Trauma unit, or visits to surrounding homes with the District sister.
b) **Personal reflections,** recording my own feelings and responses to the clinic and my time spent here.
c) **Mapping or drawing** of informal floor plans of the clinic, including general building design, placement of objects and general spatial usage and limited cognitive mapping (Thomas, 1993).
d) **Unstructured interviews** with staff members on a formal and informal basis to discuss their experiences and work, or gathering specific factual data about the clinic (e.g. historical space usage and staffing levels). These interviews used various means of data recording, such as formal written notes or audiotaped recording taken during interviews, more informal notes from memory after the event. Limited discussions were also undertaken with waiting patients and escorts. Formal and informal interviews were undertaken with the following clinic and health workers:

1. Nurses: Professional, Enrolled and Nursing assistants. 2. Doctors (Medical officers), 3. General assistants (cleaners, domestics).	4. S.A.S.O.'s 5. Community volunteers 5. Security Guards 6. Ambulance men

e) Collection of **secondary documentation** on the clinic, ie. official clinic architectural plans (Provincial Public Works Department), area maps from the Planning Dept., City Council and clinical statistics (C.H.S.O.), or official clinic staff rosters. Direct examination of clinic statistical records to extract data, e.g. Trauma Unit of residents and descriptive statistical analysis of this.
f) A **photographic record** of the places described in the research.

2.5 Choice of research sites

My aim, from the onset of this study was to select a clinic where I would be able to observe clinical functioning with the greatest ease and access. I did not seek out a specific problem or problem clinic to investigate. Hanover Park was suggested by an ex-staff member within the provincial

management as it had an open policy for research and in many ways was a model clinic. A senior provincial mental health manager described it thus,

> The centre is doing an amazing job. All the staff are motivated and work as a team. It is amazing how they cope with their situation (Comprehensive Health Evaluation Report, 1997)

Hanover Park CHC is in many ways, therefore, an exceptional place. It has a reputation among the local health structures for productivity, cohesion and innovation. I was also attracted to Hanover Park by its more exotic and dangerous reputation and my lack of knowledge about this area. The selection of a "good" clinic for this study was positive here. Staff were generally undefensive and co-operative in tolerating my "researcher gaze". Furthermore, the official frame of the clinic as a site of excellence, mitigates against the tendency to label adaptive but unofficially coping strategies by staff simply as "poor" practices, which would prematurely close down enquiry into the manner in which such activity is central to institutional functioning and survival (cf. Garfinkel, 1967)

CHAPTER THREE

THE SPATIAL DISCOURSE OF PRIMARY HEALTH CARE

> There is, therefore, a spontaneous and deeply rooted convergence between the requirements of *political ideology* and those of *medical technology*..a concerted effort ..[for] the constitution of this new space: the hospitals, which alter the specific laws governing disease, and which distribute those no less rigorous laws that define the relations between property and wealth, poverty and work (Foucault, 1976, p38-39, original emphasis)

3.1 Classifying the space

Hanover Park Community Health Centre is officially a biomedical institution for the provision a community-based primary health care service (Draft Health Bill, 1997). Since Primary health care is the official ideology of the clinic and its management (*Ibid.*), it is vital to begin by examining this official discourse to understand its relationship to the spatial practices within the clinic. The aim of this chapter is therefore to describe some of the explicit and implicit spatialisation of the official discourse and practices of biomedicine and primary health care. Explicit official standardised design principles are also described within the dominant discursive or ideological frame of biomedicine. I shall then explore some of the basic, unarticulated assumptions and unofficial principles of modern space which shape these spatialised practices and discourse.

This chapter will foreground Lefebvre's "Representation of space" (1991), that is the dominant rational, productive social space articulated by modern planning, architecture and technology. Such space seeks to distance itself from the world of the symbolic, affective and imagination, as,

> The dominant spaces in any society and today are best exemplified by the more formal, abstract representations that find their true expression in the rationality of the planned urban location or the meticulous design of an architectural project (Allen and Pryke, 1996, p.179).

3.2 Positioning biomedicine

> What is ideology without a space to which it refers, a space which it describes, whose vocabulary and links it makes use of, and whose code it embodies? More generally what we call ideology only achieves consistency by intervening in social space and in its production (Lefebvre, 1991, p.44).

Biomedicine is a term used to describe globalised western ethnomedicine associated with modern western expansion and ascendancy, along with the modern-western nation state, technology, science. It is and the philosophy of liberal-humanism (Baer *et al*, 1997; Lupton, 1995) a rational, technocist

discourse with a now familiar, mechanistic model of the body which is to be cured from carefully categorised forms of human pathophysiology located in discrete empirically devised structures and systems. The developmental roots of biomedicine cannot be subtracted from the western economic context of industrial capitalism and its forms of production[1] (Baer *et al*, 1997). Biomedical discourse and practises are profoundly implicated in modern western values, cosmology and governance that cannot be subtracted from the basic conditions of modern existence and subjectivity (Foucault 1977, 1984).

Across time, geography and political ideology, biomedicine has developed many local forms and mutations. Its authoritative centre remains the developed West, although it soon followed the trajectory of colonial expansion and later the rhetoric of post-independent states[2] (cf. Mull, 1991). Biomedicine, as part of biopolitics, has thus become part of the political discourse and fabric of modern governance (Lupton, 1995), thus "linking medicine with the destiny of states" (Foucault, 1973, in Gordon 1980, p.34).

Biomedical discourse is therefore neither static or monolithic and takes form and authority from contingent local and global forms of power, the modern state and the local and global market. Biomedicine as a professional discourse distinguishes between, (and one could easily argue hierarchically orders) different sub-disciplines and discourses. Primary health care or community health is one particularly hybrid and potentially subversive version. Secondly, forms of health care will differ along the axis of political economy, global patterns of development and underdevelopment and the sheer brutality that poverty and marginality impose. Biomedicine has therefore been critiqued as a means by which such social inequality is reproduced and sustained, within the folds of a mystifying, seemingly apolitical arena.

3.3 Representations of primary health care

> We will provide an effective, holistic, comprehensive primary health care service. The service will be accessible, equitable and available and will involve community participation Preamble: Hanover Park CHC Mission Statement[3]

3.3.1 Frontiers of state and biomedicine

Primary health care facilities in developing countries are usually built as part of state public health structure (Mull, 1990), thus, such spaces need to be seen as a hybrid mixture of state[4] and biomedical space[5]. Historically in South Africa primary health care has been a progressive discourse which contained socialist and more liberal ideals in as much as it became emblematic of basic rights to (free)

state services and social equity in a participatory democracy. Patients in this overtly politicised discourse are represented as entitled, empowered and active agents in a health process which encompasses broad-based promotive and preventative health aspects. Primary health care discourse embeds its practices within a valorised "community" whose "development" it supports and with whom it seeks to participate[6].

> Primary health care is the *first point of contact* of individuals, the family, and the community with the national health system bringing health care *as close as possible* to where people live and work, and constitutes the first element of a continuing health care process..The people have a right and duty to participate .in the planning and implementation of their health care (Declaration of Alma-Ata 1978, Scott, 1983, p.105, emphasis mine).

PHC care has been constructed as the "nation's first line of defence' in maintaining the health and well being of the people" (Valins, 1993, p.xi). The discourse of broadly defined community based primary health care directly or indirectly refers to this notion of front-line service offered at the level of the local and particular.

Armstrong (1993) argued that within this discourse, the boundary line of biomedicine has become a potent social space by which modern forms of governance is accomplished. Writing on "surveillance medicine" he[7] extends this metaphor to argue that the techniques of health prevention and promotion, hallmarks of official primary care, "recognises that health no longer exists in a strict binary relationship to illness"(Armstrong, 1995, p.400). This results in,

> ..the blurring of the distinction between health and illness, between the normal and the pathological, meant that health care intervention could no longer focus almost exclusively on the body of the patient in the hospital bed. Medical surveillance would have to leave the hospital and penetrate into the wider population (Armstrong, 1995, p.398).

For Armstrong (1993, 1995) the boundary of biomedicine within community health practices remains an elusive problematic. He concludes, "Are they lines or are they spaces, and what mechanism of power maintains their morphology" (Armstrong, 1993, p.409). The question therefore needs to be asked; What is the material reality of this interface or boundary? Can it be perceived as a border, and if so how is this policed and maintained? Is the notion of a boundary or interface accurate in a society where biomedical discourses shape practices and identities far outside the material bounds of the clinic?

3.3.2 Place making

Community health centres are generally found in poorer areas where there is less financial and physical access to private health care services, such as a general practitioner. Such health care facilities are therefore prime sites for the state to interface and intervene directly with poorer communities. They serve therefore as biomedical gateways to limited state resources, usually in sites of poverty and relative insecurity[8]. They are represented as the intimate, familiar and benevolent face of the state in such communities (cf. Armstrong, 1995). It would be inaccurate, however, to see the biomedical boundaries of primary health care as coterminous with the official physical spaces of its clinics or community health centres. PHC discourse encompasses the health related needs of public environments, the home and the individual (Department of Health, 1997). Primary Health Care may be constructed as the boundary of biomedicine, yet the trajectory of this frontier appears to dissolve and blur with the realm of domestic, the familial and ultimately the individual (Armstrong, 1995).

Community Heath Centres, as stable built structures are concrete representations of the state's presence in peripheral spaces, and indeed, it may be argued, stamp legitimacy and permanence on contested or unanchored settlements. Primary Health Care clinics are therefore key points of intersection between the state, biomedicine and "the community". This relationship is discursively constructed in the official names given to clinics which unproblematically correlate these facilities to a specific localised area, e.g. Langa CHC, Retreat CHC etc. Such services therefore assist in the stabilising and production of officially sanctioned community place and identity[9]. For instance, Harries (1996) describes how the local community health centre is woven into peoples personal and community narrative construction at Hout Bay, another smaller Western Cape suburb.

3.4 Contested Definitions

The discussion thus far has focused upon official and dominant versions of biomedical primary health care discourse. It cannot be supposed that this is the official practice of the clinic. It is therefore necessary to briefly outline some of these disjunctions and contradictions.

The first PHC service in Hanover Park remains a small single storey and unmarked brick building across the road from the CHC. Established as a child health promotive and preventative "Baby Clinic", the service was managed by the local municipal structures[10]. Its presence supports Armstrong's (1995) observation that the early and basic forms of community health services focused upon the monitoring of the health and development of infants and the mother-child relationship.

The Community Health Centre was designed and managed by the state as a curative "Day Hospital". The name change here is significant, and has been occurring slowly along with other recent progressive changes along with greater emphasis by a new provincial management on a "community based primary health approach" (Department of Health, 1997)[11]. Staff and patients, however, still refer to the CHC as the "Day Hospital" or "the clinic". Indeed all the signs on the walls of the CHC still announce the "Day Hospital", along with inaccurate times about limited services offered and doctor availability (Figure 1.1).

Furthermore, staff members (notably doctors) can still function within the clinic while either contesting the definition and claiming no allegiance to a primary health care approach.

> Dr. K. is on duty [at the Trauma Unit]. He is a Family Medicine registrar, he has to work in the PHC clinics on night duty. He hates this clinic work, he is angry about the clinical services offered. ..."This is not primary care" he says, "this is not patient care. (Field notes, August 1997).
>
> Dr X admits that he has no particular commitment to PHC philosophy, but that he enjoys working at the clinic as he has space to himself. (Field notes, August 1997).

Hanover Park CHC is by no means alone in this apparent confusion and contestation regarding its actual official functioning or commitment to a primary health care approach, particularly comprehensive PHC services[12] (Muller *et al*, 1998). The official injunction for primary health care to offer a preventative and promotive orientated, comprehensive, primary health care at district level, is a "pure" form of the World Health Organisation's PHC policy. The clinic's actual service delivery is almost entirely traditional, facility-based, curative care, with no structures for community participation. As the clinic's Mission Statement attests, this is the valued and orthodox rhetoric of the clinic staff and its management (C.H.S.O.). The questionable health classificatory status of the centre remains but one of the factors which challenges and destabilises the meaning of this space.

3.5. Design Criteria

> A distinct plan must be provided. Every possible parameter and continuum has to be rigorously planned and systematised, so that a total plan and order can be maintained (Putnep, 1979, p.123).

To what extent has this ideology shaped the architectural design of primary health care facilities? And how is this articulated in spatial form and practice? Lefebvre (1991) argued that ideology must impose and concretise itself in space in order to have effect in the social and material world. This requires that

ideologies develop particular material forms by which they are socially recognised, reproduced and which become the specialised sites for standardised spatial practices, e.g. the rituals and routines of church and a chapel; a hospital and a clinic. Ideology is thus stabilised by standardised and homogenous concrete spatial form, which also acts as a site of power by which spatial practices and identities are enacted. These spaces exist in dominant discourses as reified *abstract places* with accompanying socially sanctified roles and behavioural expectations (Lefebvre, 1991). How is official, biomedical space of the clinic translated into spatial form and practice? These aspects will be discussed below, but first it is important to unpack primary health discourse.

The task of the Primary Health Centre architect, we are told, is to devise an "architectural" or "built solution" to "translate function into coherent form" (Valins, 1993, p.9). Biomedical design discourse is represented as presenting globally applicable criteria[13] although limited local "principles" have been developed (e.g. Rispel, Price and Cabral, 1996). These manuals assert that such criteria are a universal "skeleton" (Cox and Groves 1990, p.25), "factors which can apply across the international spectrum" (Valins, 1993, p.9). Actual form, or "flesh", (Cox and Groves, 1990, p.25) may differ in terms of catchment size and developed or undeveloped nation status[14] (cf. Cox and Groves, 1990). There is therefore a clear orthodoxy implied in these criteria, a means by which core elements of biomedical spatial relations are disciplined, standardised and reproduced in global forms of biomedical practises[15].

The spatial structuring of biomedicine cannot be subtracted from other forms of modern spacing related to urban planning (Mitchell, 1992), or new ways of structuring production and institutional environments (Foucault, 1977, Holston, 1989). Architects have also been explicitly aware of the relationships between built structures and social relations, and may hence consciously, usually along with state policy, use modern elements of design to achieve social change and governance (Holston, 1989). These interventions tend towards modes of spatial ordering which extend the "gaze" or influence of the state from public or civic space into the more private and relational realm of the home and family (Armstrong, 1995), thus loosening the boundaries of private and public domains (Mitchell, 1992, Holston, 1989).

International architecture and design manuals for primary health care facilities articulate this slippage between civic space, and the home. A primary health facility "should be part of the community fabric" (Valins, 1993, p.1). They should be "accessible, welcoming and comfortable" (*Ibid.*). Unlike larger hospitals, they should not "alienate", but be designed on a more "human scale" (*Ibid.* p20). Illustrations of such conceived spaces include the physical props of home or indeed hotel. By providing a shared

space for different professionals to work and interact, they should facilitate teamwork essential to comprehensive care (Cox and Groves, 1990).

Primary health facilities preferably accompanying other civic structures, such as a civic centre, so that they may also function as a "community resource" (Valins, 1993, p.10). They should be sited at accessible, central locations (*Ibid.*), and seek ways to *adapt or articulate* the "cultural" frame and resources of a specific place or community (Cox and Groves, 1990)[16]. Despite essential local variation, these texts assert that the primary aim or criteria of community health centre design remain the same. These official criteria include (1) sequential medical encounters and activities; (2) management of patient flow and circulation; (3) spatial territories; and (4) flexible expansion.

3.5.1 Sequential medical encounters and activities

Valins (1993) states that the design should facilitate the "coming together of a patient" (or group of patients) with a health worker, "within an environment that [also] allows for privacy, confidentiality and dignity"[17] (p.9). Cammock (1981) demystifies this encounter and provides careful descriptions of the precise functional sequences for this "coming together"[18]. Her first principle is that PHC facilities should be adequately designed so as to "house" the vital activity sequences of the clinic (*Ibid.*). Her "activity sequence "of a "Personal Care type session: GP surgery" (Cammock, 1981, p15) is one that any visitor to a private GP will recognise (see Figure 3.1). It is clear that such activity sequences are a range of discrete spatial and functional practices occurring in a preordained, routinised, co-ordinated sequence over time.

3.5.2 Management of patient flow and circulation

Some authors state that the most important design criteria of a health centre is a form which aids the efficient "circulation" and "flow" of staff and patients (Cox and Groves, 1990, Cammock, 1981). This requires "clarity and rationality" (Valins 1993, p.14) so that the building design guides and informs its users.

3.5.3 Spatial territories

Cammock (1981) defines three territories, with the centre whose differentiation must be consciously addressed through design, "The more clearly the building can reflect this distinction the better it will meet the needs of both groups" (Cammock 1981, quoted in Valins, 1993, p.23). These were:

Staff Territory: Record rooms, common rooms, administration office, staff WCs
Public Territory: Patient entrance/waiting room

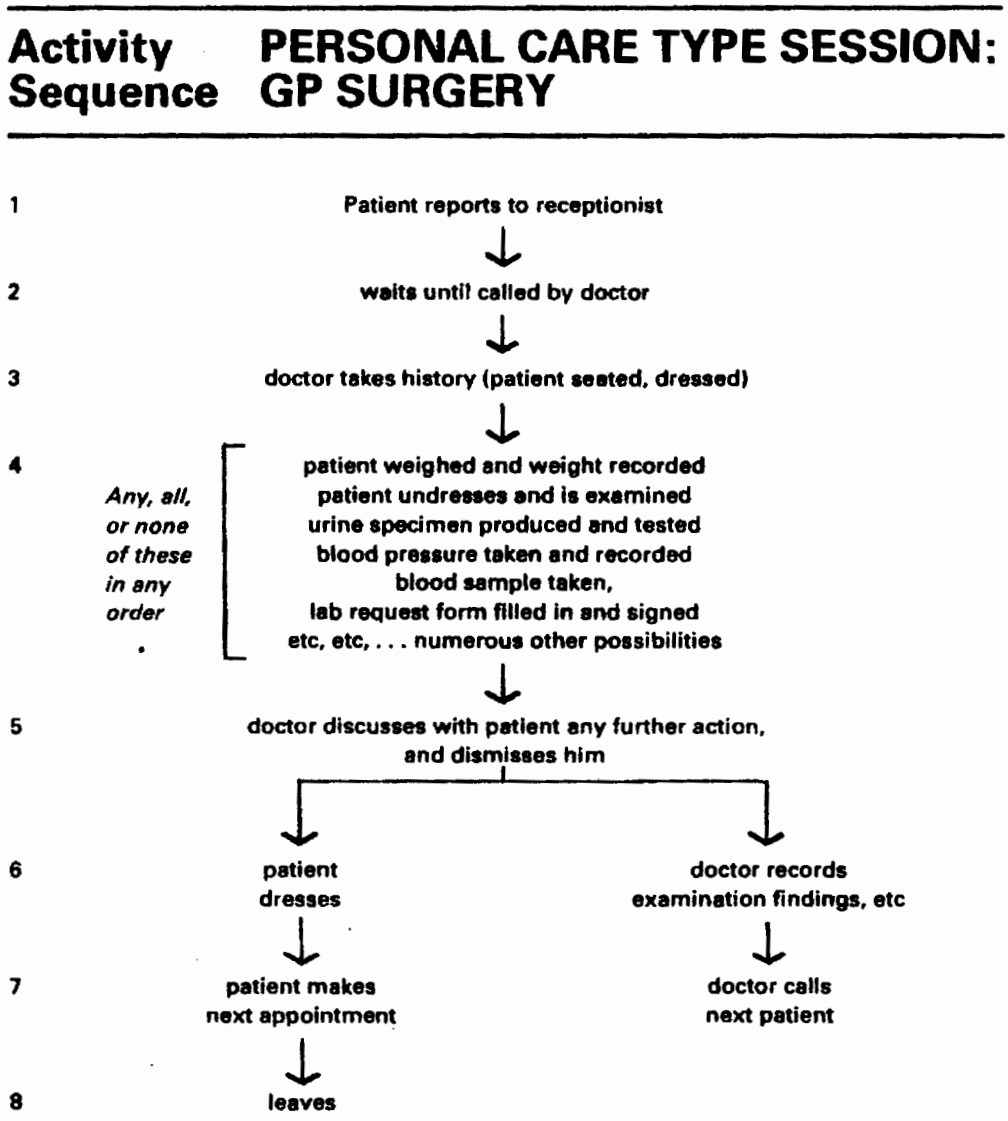


Figure 3.1. "Personal Care type session: GP surgery" (from Cammock, 1981)

> *Patient Care Territory*: Consultation, interview, examination, group space, and any other room used for patient care sessions (Valins, 1993, p.23).

Territory differentiation allows the circulation of staff and patient in ways that maintain the "protection" (*Ibid.* p.24) of staff private space, and the circulation of staff between staff and patient areas without having to enter public space. Patients should also be able to leave the building without having to re-enter the reception area. It is unclear in this scheme what the status of corridors is, as actual design criteria encourages the development of specific staff entrances between clinical and staff spaces so that staff do not have to use the (public) corridor.

3.5.4 Flexible expansion

Design manuals emphasis flexible use of spaces as services expand and spaces may need to be rezoned. This "robust flexibility" (Valins, 1993, p.185), also includes the addition of new elements across time. Therefore, room function should not be "anchored to one particular function" (*Ibid.*, p.24). A closer reading of this and other texts indicates however that rezoning seldom is encouraged between different territories Thus, clinical function may be more free floating, but territorial usage is not.

3.6 The assumptions and unofficial criteria

The design of the clinic is therefore not random or dictated by aesthetics. Official biomedical architectural design criteria and more informal norms are instrumental in the development of buildings such as the Hanover Park CHC. However, such criteria articulate aspects of design which require emphasis or specification, they ignore or merely allude to aspects of designs which structure the fundamental and taken-for-granted form of modern clinical order. These features include the differentiation of biomedical space; spatial rationality, the nature of primary health care patients - that is their ambulatory or more mobile status; and tightly spatial-functional correlates. These unofficial criteria and their significance will be discussed below.

3.6.1 Differentiated public space

Public institutions are designated public spaces, which must be accessible, yet differentiated from surrounding public space. The notion of an intimate community contact or even adaptation (Valins, 1993), is juxtaposed by an evident anxiety with an emphaisis upon clinical order - the rational management of patients and staff within clinic spaces. Even future trajectories of expansion and change are carefully factored into the design, structuring and coding new forms and disciplining unruly morphology.

Thus, primary health facilities must be open to the public, yet separate and differentiated - open, but different form the surrounding public space or the community. An unasked or answered question

remains: How is community proximity managed without and within the clinic, while sustaining the unique character of this biomedical space?

The original studies of biomedical spaces describe closed-off places such as the asylum and sanatorium (cf. Foucault, 1977, Goffman, 1973), which have their origin in the exclusionary rituals of contagion and the confinement and discipline of the prison. As Foucault suggests, there is a kind of enclosed purity to these places. These are total institutions (Goffman, 1973) whose inner spaces may be ordered and sealed off from the outside - whether this be through actual walls or marginal locations.

Hospitals, and then other forms of public institutions began to open outwards, to permit, and then require, the flow and access of the public in-order to function. As Foucualt (1997) describes,

> The old simple schema of confinement and enclosure - thick wall, heavy gate that prevents entering and leaving - began to be replaced by the calculation of openings, of filled and empty space, passages and transparencies. (p.172)

Primary health care, as has been described, incorporated and celebrated this openness and interface with the public or the community. This interface is at the core, rather than incidental, to its functioning. Yet, glaringly absent in this discourse are specifications about exterior boundaries, or even security. Clinics are not presented as defensible space (Knox, 1995), and an open, welcoming and warm relationship with "the community" is the dominant trope.

The construction of internal "territories" (Cammock, 1981), hints at anxieties regarding regional zoning, yet this is never made explicit (cf. Giddens, 1984). Primary health care space must be differentiated territory, yet radically open to "the swarming mass" of the population (Foucault, 1977, p.144). We need therefore to problematise how this is achieved.

3.6.2 Mobile objects

The CHC was never a hospital in the usual sense of the word. Within inpatient hospital care the structuring principle is the ward and "the bed" as the main locus of medical treatment and observation (Prior, 1992). There is a correlation between fixed space, duration of time and individualised patients. Here the patient should be passive, immobile and their bodies cared for in a state of almost infantile regression and control of their bodies (Lupton, 1994).

The clinic was, and is first and foremost, a site for *ambulatory care*[19]. That is, medical out-patient care to patients who were presumably well enough to travel to and from the CHC, wait for care, walk to offices and know where they are meant to be going. Patients must therefore be the mobile sick who can

negotiate the space within and without the CHC. The flow of the public into and out of a Community Health Centre is greater than in a Hospital. The interface between public and clinic is therefore multiple, yet of shorter duration. The sheer mass of new contact, circulation and interaction with the mobile public is therefore considerably greater. In a day, facility people come and go and hence the process of being a patient may vary for the mobile as opposed to bed-based sick (Weir, 1977).

3.6.3 Homogeneous function and area correlates

Mitchell (1992), following Foucault (1977) notes that the hallmark of modern town planning and institutions is,

> ..the precise specification of space and function, the co-ordination of these into hierarchical arrangements, the organisation of supervision and surveillance, the marking out of time into schedules and programmes (p.xii).

Form and function are correlated and differentiated into separate areas or zones, (e.g. clear separation between work and domestic spaces). This correlation between area and function should be clear, legible, rational and fixed (Holston, 1989). The space or locale of the clinic, for instance, should have a homogeneous and fixed official function associated with health care. This function announces the meaning of the space (Goss, 1996), or put another way, the practices that occur in a space are a means of interpreting its social meaning (Bourdieu, 1977).

Staff refer to clinical work stations as "areas" (officially "activity areas"). These different rooms within the clinic are where different health services are offered (e.g. "Preparation", "Treatment", "Injections", "Trauma", "Dressings" and "District"). Nursing staff (and cleaning staff) rotate between "areas" along strictly determined time schedules developed by the sister-in-charge or the housekeeper[20]. This scheduling tightly controls or fixes zones along the axis of both space and time (Giddens, 1984). In nursing and G.A. discourses, your "area" signifies part of the clinic, and hence your task for the next week. Hence, such practices may be said to socially produce and reproduce specific spaces within the clinic in a mutually constitutive manner (Lefebvre, 1991).

Modern efficiency requires that unstructured heterogeneous daily activities be broken up into a rational order of discrete standardised units which are fixed in space (Holston, 1989; Mitchell, 1992). Macro and micro-elements of social activities are rendered into individual units which become regionalised in divided space (Giddens, 1984). Such spaces are encoded with specific (official) social meaning (e.g. Treatment room, examination couch).

The relationship here between standardised activities or practices affixed to standardised space is therefore not merely a matter of practical, but of semantic importance (Bourdieu, 1977, Moore, 1996). In the clinic, as in other biomedical institutions, the official meaning of a place is the official function undertaken here. There is an economy or discipline applied to practice, this results in the streamlining of set tasks and even bodily movements and alignments (cf. Heath, 1986), it also closes down possibilities for alternative functional interpretations (cf. Bourdieu; 1977, Foucault, 1977).

> State space is 'striated' or gridded.. movement in it is confined as by gravity to a horizontal plane, and limited by the order of that plane to preset paths between fixed and identifiable points (Massumi, 1987, quoted in Gibson-Graham, 1997, p.315)

3.6.4 Modern space

I am thus beginning to propose a notion of biomedical space, and especially public or state health institutions, as a particular form or subset of modern space, which has common design features to other institutional sites. Here mobility is controlled, territories sustained and place becomes synonymous with the function undertaken there. I have also proposed in this chapter that primary health care as a particular biomedical ideology is profoundly spatialised, and this spatialisation may become a source of power and influence on the patient, the household, as well as within the community and the state. The next chapter will explore the instrumental capacity of this space further.

CHAPTER FOUR

PRODUCING DISCIPLINED BIOMEDICAL SPACE AND IDENTITIES

> Is it surprising that prisons resemble factories, schools, barracks, hospitals, which all resemble prisons" (Foucault, 1977, quoted in Rhodes, 1991, p.228)
>
> All these institutions were factories of order; like all factories, they were sites of purposeful activity calculated to result in a product conceived in advance, in their case in restoring certainty, eliminating randomness, making the conduct of the inmates regular and predictable - certain - once more". (Bauman, 1995, p.107)

4.1. Regimented and functional biomedical space and identities

Hanover Park Community Health Centre as I described in the last chapter, consists of a building constructed to a clear plan (Figure 6). Here staff provide official daily health care activities which are generally routinized, prescribed and predictable. Patients may also be observed doing mundane patient activities, such as waiting on benches, standing in queues and or smoking in the sun outside. There is a familiar order, a discipline and authority in this biomedical place which, despite the occasional crisis, means that health services are delivered, and work gets done. Indeed the order within the clinic, is the means by which problems are identified, how staff, patients and "the community" know, there is dis-order. The ordered backdrop of biomedicine permits the perception of the abnormal, while providing the mechanistic frame by which modern health services are provided (cf. Foucault, 1976, 1977, Baumann, 1995, 1997).

Order is a relative term, and historically and culturally is structured on varied principles which sustain the dominant social fabric (Moore, 1996). Modern (western) order is a historical product that flowered in the converging forces of industrial capitalism, humanistic philosophy and the empirical science of the nascent European modern age (Butchart, 1995). Biomedicine and the management of the populace, their deviance and productive capacity have an interwoven historical trajectory inscribed in the very morphology of their peculiar forms of power. Michel Foucault has been a key voice in describing how this modern power works, its multiple permutations, and its historical origins. This is a diffuse, encompassing power, referred to by Foucault as "disciplining" (1977), that is structuring and producing our most intimate ontology as modern citizens and selves. This quintessantly modern power is a form of governance whose locus is not enacted through spectacles of punishment upon the human body, as in "sovereign power" (*Ibid.*), but through means which are less repressive, more voluntary and "humane".

> The politics of the modern state were modelled on the method of replacing a power concentrated in personal command, and always liable to diminish, with powers that were systematically and uniformly diffused. The diffusion of control requires mechanisms that were measured rather than excessive and continuous rather than sporadic, working by invigilation, and the management of space (Mitchell, 1992, p.175)

Biomedical spatial discipline needs to be also understood as shaped by current biomedical knowledge and assumptions, for instance who and what constitutes "the patient" (Prior, 1992), or the treatment routine (Comoroff, 1977). This chapter will examine the construction of physically ordered and disciplining space within the clinic. A space shaped and structured according to ordering and disciplining principles which act dialectically, - via the spatial practices they engender - to reproduce its institutional ideology (Lefebvre, 1991). I shall demonstrate here the successful and unsuccessful disciplining principles in the clinic design and usage. I shall also examine the strategies used by staff, within a particular sanctioned set of spatial strategies and modifications, to maintain this spatial form and order through increased security features without and within the clinic. The fortification of the clinic will therefore be understood here as an amplification of pre-existent design principles which are essential to the clinical productive capacity of this space. Modern discipline and order are an inseparable component of modern production. Yet we need to take this one step further in our understanding of "how" the clinic functions. What is produced, and to what extent does this production process produce and reproduce the local and historical construction of class and race. Biomedical order is therefore described as dialectically in relation to biomedical (and other) forms of social identity and relationship (Lefebvre, 1991). Areas covered will therefore be: 1) The plan of the clinic and the trajectory of the patient, 2) The closing off and fortification of space.

4.2 Foucault's Disciplining technology

Foucault traces the historical antecedent of modern disciplining spatial organisation to the Panoptic prison design (1977). Spatial arrangements and methods of surveillance perfected in the modern prison and the reformatory began to be incorporated into more open spaces such as the hospital, school and factory. This shift in institutional site was possible through the perfection of a *spatial technology* based upon principles which enabled the precise control of its inhabitants who are both the objects and subjects of knowledge (Foucault, 1976, 1977). This spatial technology provided an efficient structural and organisational scheme for architectural and town planning projects, ordering all contexts where "one is dealing with a multiplicity of individuals on whom a task or a particular form of behaviour must be imposed" (Foucault, 1977, p.205). The birth of modern medicine cannot be subtracted from

biomedical forms of surveillance and spatial relationships such that generic space was rendered "medically useful", or "therapeutic..space [was] born" (Foucault, 1977, p.144).

Disciplined biomedical space comes into being as not simply the result of architectural enclosure or exclusion, but as a mechanism of *spacing*, micro-spatial and temporal organisations of activity[1], "calculated distributions" of objects, including human bodies and their movements, by which we recognise modern order (*Ibid*, p.219).

The central disciplining mechanism here was the perpetual, yet, unidirectional visibility of the inmate, patient or citizen - "he is seen, but he does not see; he is the object of information, never a subject in communication" (Foucault, 1977, p.200). This *surveillance* is made possible through multiple means of visibility, primarily physical sight, yet al so other kinds of sensory experience and confessional revelation (Foucault, 1976, 1977). Yet it is not simply the ability to see, observe or discover which is the accomplishment of the modern gaze, but the invention of what is seen and the translation of this into new forms of discourse of empirical truth or bureaucratic data. This represents a capacity to raise phenomena to "the threshold of the visible and the expressible" (Foucault, 1976, p.xii). Foucault descibes

> ..this productive relationship between method and object was that of 'disciplining power'..which consists in the techniques by which human bodies are observed, analysed and fabricated as knowable entities possessed of particular attributes and characteristics" (Butchart, 1995, p.ix)

The production of such rational knowledge of the subject is thus intimately linked to the control or discipline over that which is visible and analysed - in primary health care discourse - the patient, the community and their health (Armstrong, 1993, 1995). Furthermore, according to Foucault (1977), such visibility generates forms of self-consciousness or self-monitoring, essentially a subjectivity which ultimately acts upon itself to produce docile, known citizens or patients. This social participation allows that "external power may throw off its physical weight" (Foucault, 1977, p.203)

Such (modern) visibility has few historical or cultural antecedents, it is artificially created and sustained. In order for the people to be the object of such a gaze, they must be extracted out, partitioning off, inserted within ordered grids and discursively recorded, that is individualised from the mass or populace. The individualised "case" is born out of *individualised enclosure* within spaces which facilitate clear background - foreground relations, processes of *normative ranking*, measurement and examination which produce modern bureaucratic and clinical knowledge (Foucault, 1976, 1977).

Foucault (1976) places the microforms of the clinical gaze and spacing between doctor and patients at the centre of modern truth making.

> Doctor and patient are caught up in an ever-greater proximity, bound together, the doctor by the ever-more attentive, more insistent, more penetrating gaze, the patient by all the silent, irreplaceable qualities that, betray, that is reveal and conceal - the clearly ordered forms of disease (Foucault, 1976, p.15-16).

The hospital developed as a "examining apparatus" (Foucault, 1977, p.185). This *examination* was highly ritualised, and always involved a "ceremony of power..an objectification of those who are subjected", and process whereby power is able to "extract and constitute knowledge" (*Ibid*, p184-185). These processes cannot be subtracted from "a system of intense registration and of *documentary accumulation.*" (*Ibid*, p.189). The "power of writing" was at the heart of the disciplinary process, records, statistics and histories, bureaucratic writing processes which weave the whole process together (*Ibid.*)

Foucault has been criticised for presenting uncritically a European, gendered norm, and failing to analyse the specificities of discipline upon social "others", including the colonised (Mitchell, 1992, Rose, 1993). In the following discussion on design and utilisation of the Hanover Park CHC it is valuable to bear in mind that these forms may differ across the racial and class based landscape of the past and current South Africa.

4.3 The Structuring of clinical activity

In order to demonstrate how the clinic space functions within the ambit of Foucualt's disciplining technology, two aspects must be explored here. The first is the original plans of the clinic and its current physical design and spatial usage. The second is to trace the trajectory of the public through this space as they undertake the treatment routine or the process of becoming and being a patient in the clinic (cf. Young, 1989). Both aspects need to be considered here given the modern productive logic of spatialised production and mobility (cf. Foucault, 1977). Ordered and efficient flow through the clinical spaces activates these spaces to undertake their clinical function (cf. Cox and Groves, 1990, Cammock, 1981).

4.3.1 The plan and spatial usage

I will describe here the Hanover Park Community Health Centre in terms of its original architectural design, including aspects which may have been modified in current usage. In terms of its original design, it will also examine more closely the key design anomaly - the Doctor's Doors. The complete architectural plans of Hanover Park CHC are found in Figure 4.1.

The Hanover Park Day Hospital building originally consisted of three rectangular prefabricated single storey structures of varying size, designated on the plan as Block A, B and C. These areas have different functional tasks and are connected by a single interleading corridor. At the time of the research, Block C, the Maternity and Obstetrics unit, was physically closed off from the rest of the clinic and was managed by the provincial hospital services[2].

a) Block A

This makes up the bulk of building, and consists of a set of offices and treatment rooms set on either side of a long central axis. The central axis is a composite structure consisting of four small courtyards (which allow light to pleasantly flood the interior), and three differentiated waiting areas. The junction between Block A and the connecting corridor to Block B is the site of the Sister Office. Waiting areas and corridors act as public areas, with (gendered) public toilets attached to each.

The initial waiting room is the largest and situated at the main public entrance. It is one of five official waiting areas, each furnished with fixed benches and decorated by educational health posters. Each waiting area is associated with a proximal service (e.g. Reception, Preparation, Doctor's rooms and Dispensary). Currently two extra more informal waiting areas have developed in the corridor outside the Trauma unit (T) and outside the psychiatric sisters and social workers office (PS). The divide between public waiting area/corridor and clinical treatment areas is most tenuous in the Preparation and Dispensary areas. Here the space in the designated clinical area is either too small to contain all the activities (Preparation), or the waiting area is utilised as the dispensing site via a hatch in the dispensary room wall. Clinical activities therefore spill out into the waiting and corridor areas creating ambiguous public-clinical areas.

It is clear according to size alone, that it is conceptualised that the largest mass of people is expected to wait in the initial waiting room prior to undergoing administrative procedures at reception. Thereafter people are dispersed throughout the building into smaller aggregates of seated patients and their escorts. It is not clear where people were originally designed to leave the Day Hospital, possibly through the front entrance (AE) or at one of the smaller exterior entrances (AE-BE). .

The Reception area (R) is noteworthy as the only area designed with a permanent physical barrier between public and staff during consultations. Two windows are embedded in the walls of the reception room, one looking onto the Large Waiting room, and the other above a clerical counter which

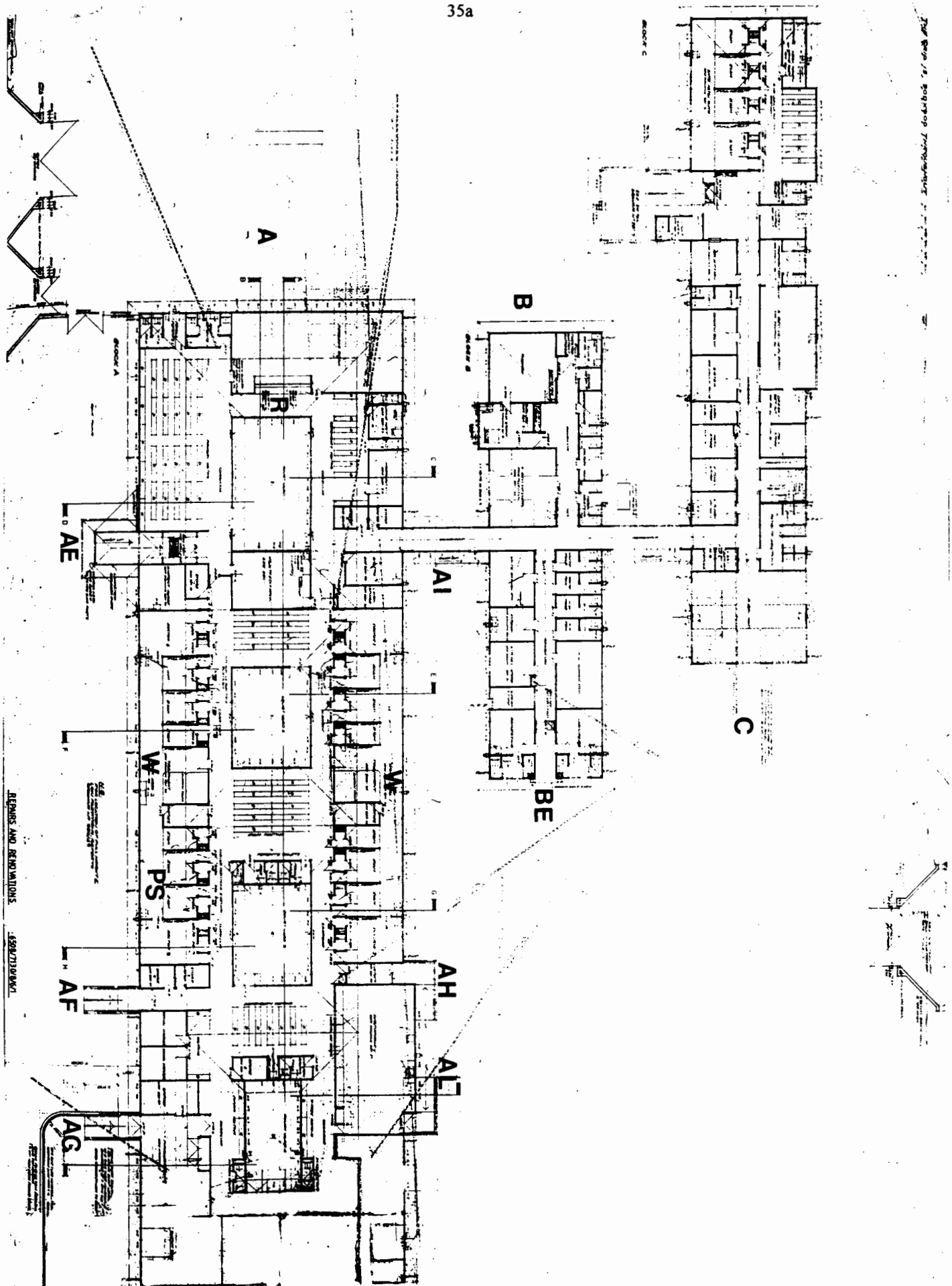


Figure 4.1. Archtectural plan of Hanover Park CHC, showing main blocks and exterior entrances (Legend in the text)

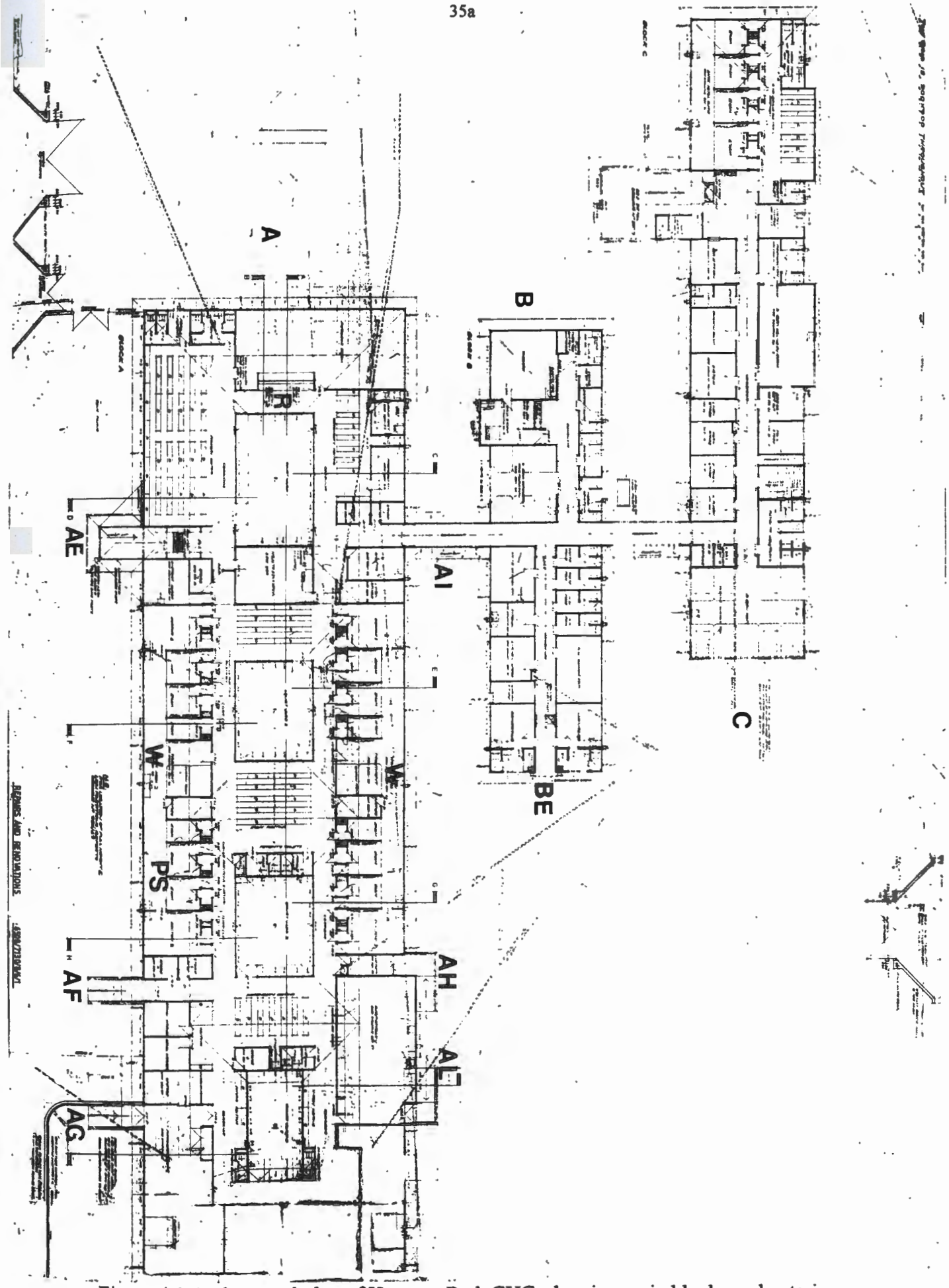


Figure 4.1. Archtectural plan of Hanover Park CHC, showing main blocks and exterior entrances (Legend in the text)

makes up most of the passage between the initial waiting room and the interior clinical spaces of the building. The window onto the Large Waiting is closed off by the staff with a curtain when not in use.

"Work areas" link the two large banks of Examining and Doctors rooms on either side of Block A (W1-2). Following Cammock (1981), they may be observed to act as links between clinical areas, and, only accessible to staff, they therefore act as staff corridors. All the treatment areas, including the official Treatment, Examination and Doctors rooms, are equipped with more private examination areas and couches.

The farthest end of Block A was designed for specialist areas such as the Dispensary and Radiology units, as store and rehabilitation areas. The rehabilitation unit is currently being utilised as student nurses' teaching, demonstration and common rooms. This change is consistent with the observation that rehabilitation has become a rare phenomenon at the primary health care level (Muller, *et al*, 1998). The storeroom has been appropriated by the Sister-in-charge as her (unofficial) office.

b) The Doctors (and Examination) Doors

These doors are the clinic's only real "anomaly" when its original architectural design is compared and evaluated in terms of published international biomedical design norms and ideals[3]. This is best seen in practice by the doors that lead in and out of the three "Doctor's rooms", although features of these are present in the entrances to the smaller semi-private examining cubicles of the Treatment rooms used only for Doctor's or CNP consultations[4]. Doctors's rooms (consisting of both consulting areas such as a desk and chairs) and examination area[5] (i.e. examination couch surrounded by curtain rail) has four doors (Figure 4.2). Although Cammock (1981) proposed separate staff/patients and shared zones, which would require separate entrances which helped demarcate and manage these – four entrances, in a relatively small space, warrants further investigation. Here, one door leads into the Treatment room(s) (this is kept unlocked in most cases), and functions "correctly" as a separate staff entrance (Cammock, 1981). The others serve as patients' entrances between the "shared" consulting room and the "patients" waiting areas. Again this is a "correct" separation, it is the number and form that these entrances take that is anomalous. Staff informed me that two of these entrances are for patients' entrance and one for patient exit. The exit is a single standard door.

The entrances are therefore more complex consisting of three exterior doors (facing the waiting area), two of which act as patient entrances. These each lead directly into a small cubicle partially containing a bench which has an interior door in turn leads into the Doctor's consulting room. In this sense it would perhaps be more accurate to say that there are *six* doors leading in and out of the consulting room - four doors double in two entrances, and two staff entrances, one into the corridor and the other into the treatment workarea. The entrance is therefore staggered between inside and out, with an in-between zone in which the patients could wait before entering[6] The staff doors are of standard design, and the Examination rooms have a slightly less complex form of those found in the Doctor's rooms.

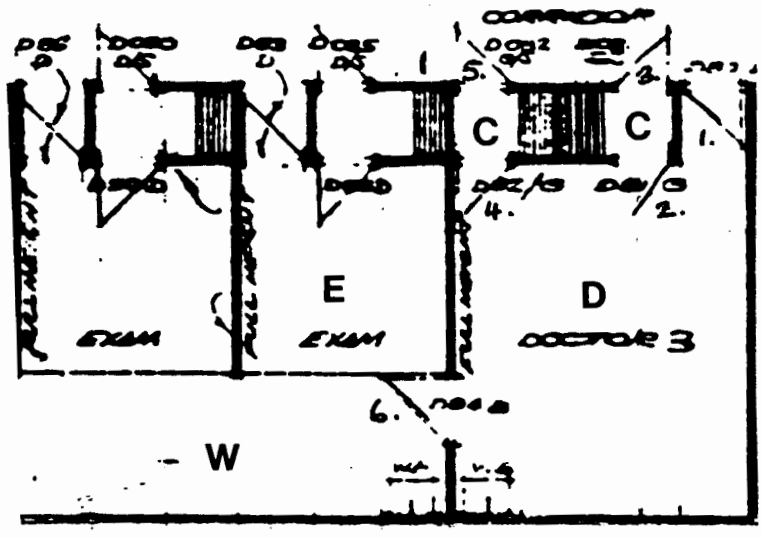


Figure 4.2:The Doctor's Doors

Legend

C. Cubicle 1 and 2
D. Doctor's Consulting Room
E. Examination Rooms (used by Doctors and CNP's)
1-6 Doctor's Doors
W. Work area

These cubicles and multiple doors are a common feature of similar local township clinics, yet theses do not feature in any international guides (e.g. Valins, 1993, Cox and Groves, 1990). I am unaware of the origin and local architectural history of this apparently local innovation, but I have observed, however, that new local PHC facilities do not have these multiple entrances or cubicles.

Currently, among the clinic's doctors', form does not necessarily dictate function. Although older staff still use the entrance cubicle, newer doctors simply view this arrangement with some bafflement. They use the single entrance or the original exit. This is kept at times locked as waiting patients have been known to "burst into" their offices uninvited, demanding attention.

c) Block B

The central structure consists of two distinct areas separated by the long linking corridor.

1. The first is the area reserved for staff rest and domestic duties (Figure 4.3). Facing south are staff toilets and tea-rooms plus areas for "domestic", "kitchen" and "maintenance stores". There is also currently a small "Doctors Room" which was initially designed as a tea-room for "White" staff. The largest tearoom in current use was originally designated on the plans for "Non-white" staff only. Staffs'accounts indicate, however, that tearooms were never racially segregated, not least because white staff at the clinic are a recent phenomenon.

2. The second area was initially designed as an operating theatre and recovery room and its supporting stores and toilets[7]. It was never used as such, and currently functions as the twenty-four hour "Trauma Unit", with its "Trauma" and "Nebulizing" rooms. "Change-rooms" were designated according to "Doctors" and "Sisters" and contained toilets. Currently the "Doctors" toilet functions as a male staff toilet, and the "Nurse's" serves women staff.

Although largely absent in the initial clinic plans, CHC is also surrounded by two distinct, tarred parking areas. These are segregated according to staff and public areas. The staff parking area is constantly monitored and closed off from the main public road by a gate and security guard. A separate prefabricated dental clinic was built in the public parking area, this parking area is accessed only by a small domestic road.

4.3.2 The clinic patient's trajectory

> The production of social space, according to Lefebvre, begins with the "study of natural rhythms and the modification of these rhythms and their inscription in space by means of human action, especially work-related actions..spatial-temporal rhythms" (Dear, 1997, p.56, quoting Lefebvre, 1991).

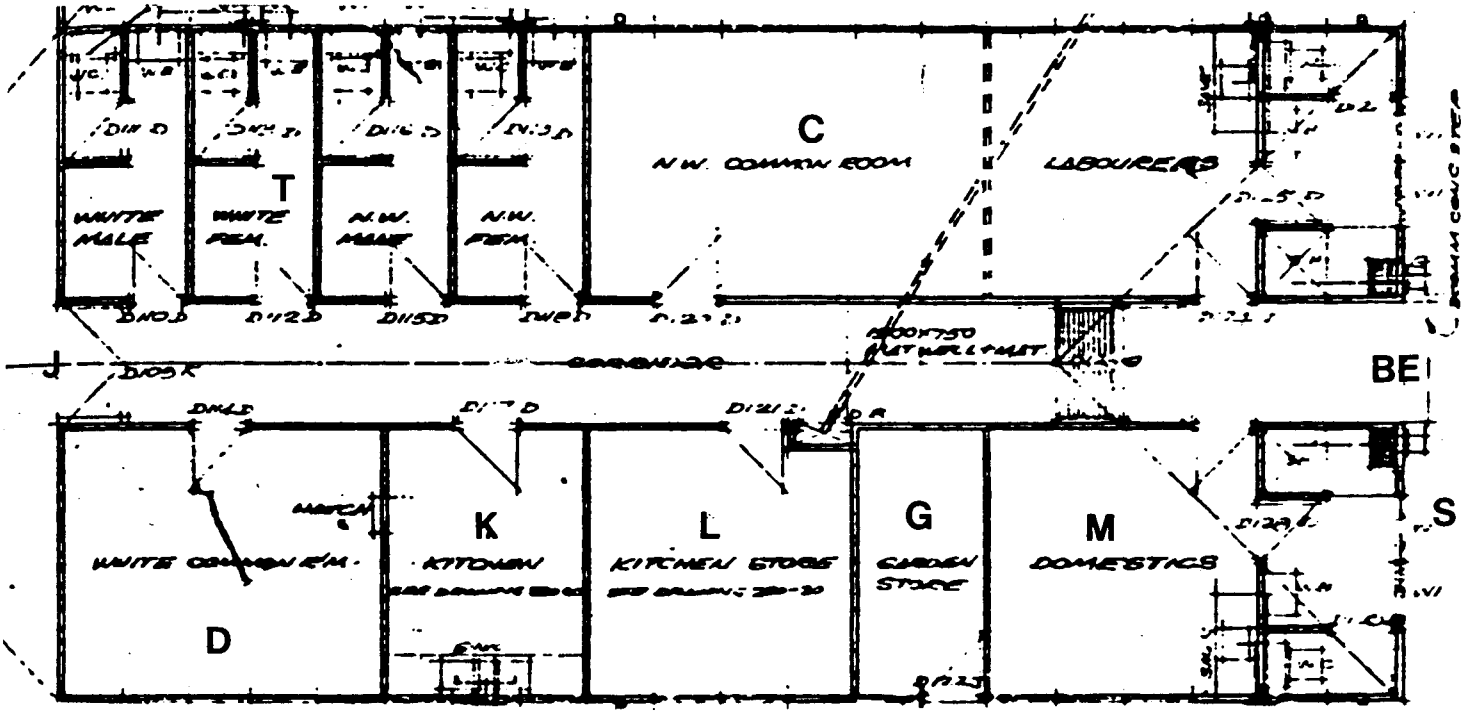


Figure 4.3: Architectural plan of staff amenities

Legend
Current usage (original design in brackets)

C. Tea Room (Non-White and Laborers common room. Note that dividing wall
here was never constructed.
D. Doctor's Room (White Common Room)
G. Garden Store (Garden Store)
K Kitchen (Kitchen)
L. "Love Room" (Kitchen Stores)
M. Laborers and men's common room (Domestics)
S. Staff Parking area
BE. Staff Entrance

a) Steps and stages

Visiting a doctor at Hanover Park Community Health Centre is both similar, yet different to a visit to an average private general practitioner, or the form of first world public health encounter described by Cammock (1981) (Figure 3.1). The *form* this difference takes is seldom articulated in the comparative quality assurance models of differentially resourced health care. Poorer public health patients do not just receive less health care or services. *Public health services are qualitatively different*, a difference which is only fully perceived when the trajectory of such a patient through the clinic functional space is more carefully examined (cf. Comaroff, 1977).

Generic patients visits are of course approximates, yet the path of the clinic's patient described below needs to be compared with Cammock's (1981) GP consultation activity sequence. The described appointment is that of a *booked* patient at the clinic. Despite the delay in accessing care that pre-empted this appointment process, this trajectory is considerably simpler in terms of gaining access via reception for the unbooked patient[8] than described below (see. Appendix II for more detail).

1. Patient waits to report to receptionist
2. Patient reports to Reception.
3. Patient waits until called by nurse.
   Patient waits to be allowed through the security gate along with nine other patients.
4. Patient waits in Prep area until called by nurse.
5. Patient weighed, weight recorded. Temperature taken (and recorded) Urine sample produced and tested (in Prep. area).
6. Patient waits for nurse to collect file and direct her to Doctors rooms.
7. Patient waits outside Doctor's office until called by doctor.
8. Patient waits in Waiting Cubicle (This step may be omitted)
9. Patient sees doctor, examines patient's body, and takes history.
10. Doctor discusses with patient's further action, records referral in file etc and dismisses her or prescribes further tests (e.g. blood samples to be sent to lab.
11. Patient dresses (this may be completed in cubicle), Doctor calls next patient from waiting area (or from waiting cubicle.)
12. Patient heads to Injection room, notifies nurse of presence (file through door) and waits to be called.
13. Patient is called by nurse. Blood sample drawn.
14. Patient returns (with file) to Reception to make next appointment (patient may wait again to be seen by reception staff).
15. Patient leaves building via main entrance and gate.

There is an assumption here that no other services have been provided, such as visit to the Dispensary.

It is clear from this description that Clinic patients undergo possibly the same number of clinic procedures, e.g. urine and blood samples and doctors examination, so where does the difference lie and what is the outcome of this?

Giddens (1984) proposed that different social forms and relationships are born out of routinesed activities of embodied social actors through time-space. It is clear that if the patient's trajectory is examined as a temporal and spatial phenomenon, a very different medical encounter begins to emerge.

4.4 Reflections on design and process:

Two perspectives need to be examined here. What is the fixed, physical design of the clinical spaces, and how are these features activated and possibly experienced by patients passing through them along the structured and prescribed treatment trajectory.

4.4.1 Ordered space

Broadly speaking the interior space of the clinic is a repetition of rectangular rooms built along a central long axis or corridor typical of hospital design (Putnep, 1979). Each room in the clinic has a designated function, and rooms performing a similar function, such as the doctors or examination rooms, are similar in design. There is a tendency to designate, fragment and locate tasks, activities and individuals - staff and patients within serialized, partitioned, and ascribed areas.

The interior is organised in a largely symmetrical manner, with matching entrances and perpendicular lines. There is therefore repetition of standardised spaces, small compartments and cubicles in which only limited numbers of people and activities could be placed. Areas are categorised according to function and identity, and clinical areas resemble multiple divisions of space into which the flow of patients are temporarily slotted. Following Foucualt (1997) we can therefore observe that,

> each individual has his [sic] own place, and each place its individual. Avoid distributions in groups..Disciplinary space tends to be divided into as many sections as their are bodies or elements to be distributed. (Foucault, 1977, p.143)

4.4.2 Partitioning and sequence

The design accent is therefore upon controlled repetition and predictable sequencing of staff and patient placement and activity. The design reflects this sequencing or trajectory such that the patient's movement or trajectory is spatially manifest in a ranked classification of public and clinical space, for instance Waiting room to clinical areas, or - Preparation to Examination rooms.

Thus there is - or should be - a visible congruence between *where* the patient is in the building and what stage in the treatment process they are at (waiting for medication). Put another way, "where" the patient is located also says "what" should now be done for them (e.g. be X-rayed). Foucault (1977) dubbed this the disciplining "art of rank" (p.146) which, combined with bureaucratic paper work – such as the patient's file or admission ticket, allows an hierarchical ordered movement through the clinical spaces,

> rank - a technique for the transformation of arrangements. It individualises bodies in a location that does not give them a fixed position, but distributes them and circulates them in a network of relation. (*Ibid.*, p.146).

4.4.3 Fractured encounters and treatment choreography

The trajectory of the patient is a choreography of movement between discrete spatialised "stations" (cf. Hägerstrand, 1975 in Giddens, 1984). Within a more affluent or private medical encounter, such stations may be micro-adjustments and relocations, for instance merely lifting one's arm, standing up, or moving from chair to examining couch (Heath, 1986). For the clinic patients these steps require not only significant relocation between "areas", but movement through, and waiting within, public spaces punctured by brief task orientated encounters with different health workers.

Discrete examination activities undertaken by nursing staff in the Prep(aration) room, such as being weighed, taking temperatures and urine samples, have traditionally occurred as part of the doctor's consultation. Likewise, post examination treatment procedures are undertaken by nurses after the consultation in the "Injection" or "Dressing rooms". This "preparation" process is largely *standardised*, and appears to be supported by clinical staff in the interest of clinical thoroughness and efficiency. For instance, Dr. A stressed that this process ensures "*good medicine*" as no vital signs are missed, such as a failure to routinely test patient's urine, as might occur in an unstandardized private general practitioner appointment.

"*Activity areas*", as discussed, are inscribed with official function and meaning. For the patients passing through such areas, this movement results in them being subject to certain clinical processes (within a limited range). Thus, design space-function contingency also acts as a structuring principle for staff by limiting choice and potential error. It has also little need for complex and multiple clinical rules and protocols, and these procedures may therefore be economically undertaken by relatively junior staff (in this case nursing assistants or enrolled nurses). Thus, Bourdieu likened

> this practical mastery of the schemes immanent in practice, to the spatial organisation of the material world. He maintains that *movement through constructed space..acts as a mnemonic and helps to build up practical mastery of these same schemes.* (Moore,1996, p.84).

4.4.4 Multiple public exposures

For the clinic patients, many of these encounters occur in public or semi-public spaces[9]. For instance, in the Prep. area patients undergo basic medical procedures, such as weighing and having their temperature taken with a permanent audience of other patients (often mothers and children) who are at various stages of similar procedures (e.g. waiting to have their urine tested). The lack of staff in the clinic has necessitated conditions that on some days a single professional nurse is alone in this area undertaking a range of procedures, virtually simultaneously. Patients, clutching bottles of urine, move

in and out of the public waiting room, which also serves as the only thoroughfare for patients to move in and out of the clinic.

Other procedures such as wound dressings (and the accompanying discussions with nurses) occur in shared and semi-public spaces such as the Dressing room[10]. Staff are not insensitive to the levels of exposure of patients' bodies in these semi-public areas (e.g. Trauma Unit), and may limit the degree of undress required for a procedure (e.g. rolling up a patient's sleeve rather than removing the entire shirt). The actual consultation with a doctor occurs, however, within his/her "Doctors" office[11] amidst more private conditions (seemingly) not dissimilar from those described by Cammock (1981)[12]. This consultation may now be considerably shorter and technically simplified, utilising the doctor's examination and diagnostic techniques without the need for additional (time-consuming) procedures.

The aim here is not to reinforce bourgeois assumptions about privacy[13] (Elias, 1978), but to draw attention to how these are reproduced in such socially marked spaces. What emerges also is the fluid path between the private and public realms for the clinic patients. This occurs both in terms of treatment within semi-private shared "areas" (such as "Dressings" and "Preparation"). It is also takes place throughout the treatment trajectory which necessitates frequent moves, or "realm shifts" (Young, 1989) between the differently encoded "realms" with varying degrees of (patient) privacy and exposure[14].

4.4.5 Muted objects

The net result of such spatial practices is a fragmented and staggered medical encounter produced by the mobility (and waiting) of the patients between different "areas" where traditional medical procedures are offered, in this case by nursing staff. On a relational level, this trajectory fractures a continuous encounter or co-presence (Giddens, 1984) between clinician and patients, emphasising the technical and task-orientated aspects of the medical encounter. Furthermore, standardised investigations (e.g. temperature and urine analysis) are disconnected from an unfolding clinical interview which may signify their meaning in an individualised diagnostic process. Bodily functions are collected as disconnected signs of physical disease processes. This information is collected and presented to the doctor before the patient actually begins the actual appointment, hence preceding and pre-empting talk and the development of a patient's illness narrative within the actual doctor's interview (cf. Mishler, 1984). Of course, alternative readings are possible here, namely that the reduction of technological procedures enables more time within the clinical interview for clinician availability (Giddens, 1984).

All the staff I spoke agreed, however, that there was a necessary degree of professional distance required from patients in order to function in the clinic. Insufficient adequate distance was related by some to over familiarity and lack of control over patients

> The staff are getting too acquainted with the patients on a first name level, and then when the patient comes here, its like..there is no control, there is no, there nothing where you can draw the line..know what I mean. (G.A interview)

Most staff agreed that they would not like to live locally as this would mean that this social distance could not be sustained. Furthermore, with the current level of dissatisfaction among patients, there is a fear that they would be open to ongoing abuse from their neighbours who are dissatisfied with the service offered. Bonds with the community are seen as dangerous and not conducive to clinical care.

Staff in the clinic talked of consciously limiting talk with patients in order to avoid more informal relationships developing.

> Dr X's patient appointments last from usually 3-6, or even 20 minutes. He feels this is generally long enough, because, although he is "fascinated by the patients stories", he probably "shouldn't hear more" as "too much of a bond develops" between him and the patient, and this "interferes" with the medical work that needs to be done (Doctor B interview)

The erasure and silencing of patients' illness narratives (Kleinman, 1988) and Lifeworlds (Mischler, 1984) within the clinical interview has already been demonstrated (e.g. Mischler, 1984, Muller, 1994). Mizrahi (1986) also describes means by which busy clinicians use and encourage instrumental distancing as a means of efficient technological competence, especially in health contexts of limited resources. Patients emerge from these practices as "muted objects" (Littlewood. J., 1991), removed from the messy world of difficult social circumstances, within a discourse of standardised signs and disciplined symptoms. Furthermore, reduced relational ties reinforce this objectification and the instrumental barriers between staff and patient identities.

In her analysis of an acute psychiatric unit, Rhodes (1991) describes similar processes in which the facility exists with internal contradictions between administrational efficiency and the medical model. This tension is greatest in contexts of limited health resources. This results in forms of "cynical instrumentality" and "objectifications" developing which emphasise the control of *patients movement* through the system resulting in rapid discharge (p.30). She concluded that the primary source of (medical) competency here was speedy efficiency in patient processing and movement. She draws the parallel here between forms of medical and industrial production in the "perception of time as a substance that can be manipulated in the service of production" (p.59).

4.4.6 Surveillance

In terms of public areas, there are differentiated spaces for patient holding, mobility and biomedical clinical and administrative activity. Different areas permit varying degrees and forms of visibility. Devices and modifications have been installed so that patients are seen, rather than see. Corridors run, uninterrupted by solid doors, down the lengths of each block. Treatment rooms open onto these

corridors at fairly regular intervals. These long corridors serve as the (only) thoroughfares by which patients travel to reach the clinical or treatment areas. The corridors function therefore as sites for, largely patient, mobility. The corridors are kept uncluttered and straight easing access between points. The length of the corridors is also visible to those who align themselves along its plane. As Foucault (1977) noted,

> The disciplining mechanism was a machinery of constant inspection, that achieves its hold over the body "according to laws of optics and mechanics, according to the whole play of spaces, lines, screens, beams, degrees and without resources..to excess, force or violence (quoted in Butchart, 1995, p.267).

The key point which allows easy surveillance of the interior space is the reception area. Other points of surveillance are the glass-panelled door in the sister's office along a nodal point of the patient's and staff's routes, and the three axial courtyards. It is clear, however, that the direction and control of observation determines these devices' capacity to function to the staff's advantage. The Sister-in-charge complained that her office was too "*public*" and "*not private*" enough for her to work in, and has withdrawn to an appropriated office space at the back of the building. According to the general assistants, the courtyards used to be places where patients gathered to smoke and "*mess*", and thus remains permanently locked. The courtyards were however also places where patients could gather and observe the clinic's functioning. Staff could thus be observed rather than observe. It is clear that these messy, unruly and ungovernable places have therefore been closed off to the public, despite the need for interior waiting space.

a) Reception: The administrative policing of the boundary

The reception area is organised so that staff can observe and interact with people within the public waiting and reception areas. This initial staff/public interface is thus controlled and secured by a permanent glass-and-counter barrier, and a small curtained window that opens onto the initial waiting area. Staff control the visibility through this window by lowering the curtain most of the day, reportedly to stop waiting patients from watching them. This curtained window thus acts as an asymmetrical surveillance devise, in as much as staff are able to observe patients - even without them knowing it - while patients are unable to do likewise. It is noteworthy that this is the only area adequately structured by panoptic principles, and is located at the foremost, most vulnerable and key staff/public interface.

The official public entry point into the patient trajectory begins not just as they enter the CHC grounds or building, but when they must interact with the clinic bureaucracy and identify themselves as someone seeking health care, that is when they request patient status[15]. In the words of Goffman (1968, in Weir, 1977), the reception is the official entry point into the public primary health care patient's "moral career", of which the official medical encounter is only a part of a more complex framing "people-processing" mechanism (*Ibid.*). The closing down of entrances and the insertion of gates and

security has physically enforced the need for each patient to walk through the reception area, which acts as a bureaucratic processing and observation post. The reception area therefore facilitates a range of systematised booking and sorting processes, in order to control both patient numbers per day and distributing them across time, as well as apprehending obviously "illegal" patients. It is thus seldom that any patients are turned away once they have been screened by reception. Conflicts regarding access to services can sometimes occur at reception, where physical barriers and guards, no doubt assist in asserting reception staff's authority[16].

> Mrs R [the receptionist] tells dishevelled patients: "*Jy gaan nie pille kry nie! Loop! Gaan huis toe. Jy het alweer rondgeloop*". [You are not going to get pills! Walk! Go home! You've already been around here] She justified this by explaining that she knows this patient, he "drinks" and tries to get extra free medication which he sells for cash (Field notes).

The reception area is instrumental in managing the public and administrative interface of any health institution or business. This interface involves not only gates and security (and its concurrent axes of visibility and narrow physical distributions), but also complex bureaucratic writing procedures. In order for each patient to enter the clinical area of the clinic they must each be accompanied by an individualised file in which their personal particulars have been collated and inscribed. Unbooked patients, currently the majority of those who use the service, must also have undergone a brief medical screening early in the morning to assess if they are sick enough, and what are their medical needs, before they are "*admitted*" or given official patient status, with its accompanied file and long wait.

In a public health institution, such as Hanover Park CHC, health care should be financially, physically and even culturally accessible (Department of Health, 1997). This occurs in a context of shrinking and strained health resources. It is thus the task of the reception area not only to facilitate patients entry, but more crucially, to limit, or even restrict it (cf. Rhodes, 1991). Furthermore, an initial screening by a medical officer in order to be "*admitted*", along with an official file, is the method by which a member of the public becomes a legitimate "*patient*". This process can be traced in space, and requires the ordering of space to achieve administrative order which is inscribed here upon the individual.

4.4.7 Classification

Foucault (1977) linked the spatial distribution of patient in hospitals with the spatial construction of classified and tabulated biomedical knowledge. He thus asks us to also read the clinical spatial arrangement as a mechanism for ordering and distinguishing disease and disorder - a spatialised (social) construction of "the disease", and "the patient" (cf. Prior, 1992). Unlike the specialised spaces in larger hospitals, such as infectious medicine or surgery related wards, the space of this clinic reflects the more mixed, or undifferentiated ethic of comprehensive primary health care.

a) Constructing the "psychiatric patient"

In the clinic, this type of differentiated space exits in one area only. Despite the trends towards greater procedural mental health integration, separate waiting spaces largely for psychiatric patients still exist. Patients destined to see the psychiatric nurses are cramped awkwardly into a makeshift waiting area. Indeed interviews with staff indicate much concern with regard to "mixing", "normal and psychiatric patients" (Muller *et al*, 1998). Here, where you wait is also a sign of your pathology - thus inscribing the last stubborn differentiation between the "sane" and "insane" in spatial structuring and practice. Another differentiation, perhaps more difficult to enact, is that between the well and the sick - the constitution of the "real" and thus deserving patient - a dilemma I will continue to examine in Chapter Five.

4.4.8 Privacy and amplified extraction

The shift from public to private spaces within the clinic is largely one of scale, barriers and complexity of access. Public and private spaces appear to be primarily constructed along the trajectory of the masses and the individual. It compromises a movement from the many to the few, the extraction of the individual from the public gaze (Mitchell, 1992). There is therefore an intriguing relationship between cultural expectations of privacy and the individualised biomedical examination.

a) The Doctor's Doors

The medical encounter with the doctor in the "Doctors Rooms" is the most individualised, intimate and private encounter between clinician and patient. The original patient cubicle provided therefore an interstice, an in-between space, between the public and clinical spaces. This may be read as offering greater protection of privacy, a distance to traverse or a time of transition which in some clinic designs is accomplished by corridors between public and examining areas (cf. Valins, 1993). Again, returning to Foucault (1977), other complementary and contesting readings link this space to a greater disciplining logic while challenging a single reading thereof

In examining the trajectory of the public health patient, Comaroff (1977) proposes that the hierarchy of the clinic's space moves from public to treatment to private staff spaces. The architecture of Hanover Park CHC does not support this conjecture. The elaborate entrances into the doctor's rooms appear to reinforce or amplify these places in some manner. The Doctors's doors thus suggest a hyperbolic act, a concern at the heart of the (supposedly) functional rationality of biomedicine.

Young (1989) describes the anxieties associated with the "passages between realms" of biomedicine, which involve the transformation of self from embodied subject to disembodied, medicalised object. Although Young's interpretative frame will be explored more in Chapter 5, we are alerted here to the fine meshing of modern functional or disciplining and symbolic meanings.

The complex physical design of the Doctor's entrances signals that these spaces are key - if not prime - sites of biomedical's productive disciplining power. Biomedical privacy is a site of sanctioned exposure of a "pure", silenced body to the more intimate medical gaze (Young, 1989). The doctor rooms are the point where the examination process is completed and the final stage of the biomedical trajectory - the known and diagnosed patient - has constructed its object (c.f. Holohan, 1977).

The cultural frame for the generative biomedical gaze is physical privacy - that is biomedical exposure within special non-public spaces. The mechanisms to achieve this are spatial enclosure and physical extraction. These key elements of disciplining power involve the partitioning off and individualisation of the body of the inmate or patients from the "multiplicity" (Foucault, 1977, p.220). The waiting cubicles could be read here as a mechanism of extraction, a process of isolation (and solitude) by which the waiting patient is separated out to become an individualised object within the analytical examination space of the Doctor's room[17].

Foucault's analysis has been criticised for its failure to adequately address features of difference, such as gender, race and class, within his understanding of power (cf. Rose, 1993). Could it be that the apparent predominance of doctor's cubicles in older township based clinics also reflects racialised and class based anxieties, related to dominant colonial and apartheid construction of black and coloured people and spaces? The chaotic disorder of poorer black spaces has long been a trope in a racialised ontology (Butchart, 1995), thus suggesting the perceived need to insert more detailed and stringent disciplining mechanisms at this crucial biomedical site. The placement of this mechanism at this most interior point of the clinic - not the current site for security door development - suggests this felt need is more intimate, more related to the individual of the patient than external threats.

Mitchell (1992) writes of the colonial and historical construction of social order that set itself up in opposition to the crowds and "unruly commotion" of the racial, cultural and class "other", (p.115). Foucault (1977) describes how this crowd is historically constructed as the site of "illegality and evil" (p.144). Notions of civilisation and modernity have always been intrinsically embodied and spatial, such that "certain practices involving self and space, order and time, body and mentality were to be adopted" (*Ibid*, p.120).

The spatial extraction of the patient via the elaborate entrance ritual necessitated by the doctor's doors, suggests that within the apartheid period in which these clinics were constructed, the transition point between the masses and the individual patient were conceived as being particularly problematic. This problematic may have been related to the homogenising group and de-individualising discourses of "the masses" by which dominant sectors have constructed the social Other. Thus, the doctors' doors spatially manifest through an elaborate architectural mechanism the problematic interface between the discourse of "the masses" by which working class, Coloured or African people were constructed, and a more individualised biomedical discourse. Disciplining biomedicine must produce the individualised

docile patient, a production process that structures the clinical space, and is best articulated at the final and most potent interface - the point where the last vestiges of the patient's historically specific group identity must to transformed into the civilised and individualised patient.

Thus, we also observe a two-fold movement here linking social extraction and individualisation with a cultural discourse of privacy and biomedical privilege (cf. Young, 1989, Comaroff, 1977). The emphasis placed upon the physical extraction mechanism points to the dominant social construction of the racialised "other" in the apartheid era during which the clinics were designed[18]. Thus, social identity may be read off these social spaces - where spatial relations point to social relations - mapping the peculiar histories of our times and places.

4.5 The Fortification of the Clinic

Since the end of 1996, the staff of Hanover Park CHC have gone to great length, including industrial action and threats of industrial action (i.e. closing the Trauma Unit), to insert more security features within and around the clinic. How do these function and how may they be interpreted?

4.5.1 Multiple openings

Originally the Hanover Park Community Health Centre was designed with seven exterior entrances into the clinic (see Figure 4.1). These included the (1) the main patient entrance (EA); (2) the staff entrance (onto the staff parking area) (BE); (3,4) a staff service doors (AH, AL) onto the staff parking area) and another (5) and (7) entrances on the north side of the building into the social workers office area (AF), an access ramp into the Physiotherapy area (AG); (7) and another access door onto the Trauma room and staff corridor (AI). The indicated Trauma entrance was moved from the original design placement on the East side of the building (Staff area) to the West side (Patient parking area) - thus acting for many years as another entrance for patients into the clinic. Today only one public entrance remains.

Hanover Park CHC originally functioned therefore with four public entrances. These entrances allowed the public multiple access to the interior of the clinic building, as well as many points of exit back into the street. For a member of the public entering the clinic at one of these multiple entrances, different doors not only implied greater access into and out of the clinic interior, but choice in terms if routes or itineraries within (cf. Noyes, 1997).

This openness of the CHC may be read quite literally as a looseness of boundaries, a tolerance of greater liminality or uncertainty between public or community and biomedical space. Harries (1996) describes this blurring of boundaries between community and biomedical space in a smaller less fortified CHC in Hout Bay. She describes how this was accomplished daily through the creative assertion of community, rather than biomedical, social practices within formally designated biomedical

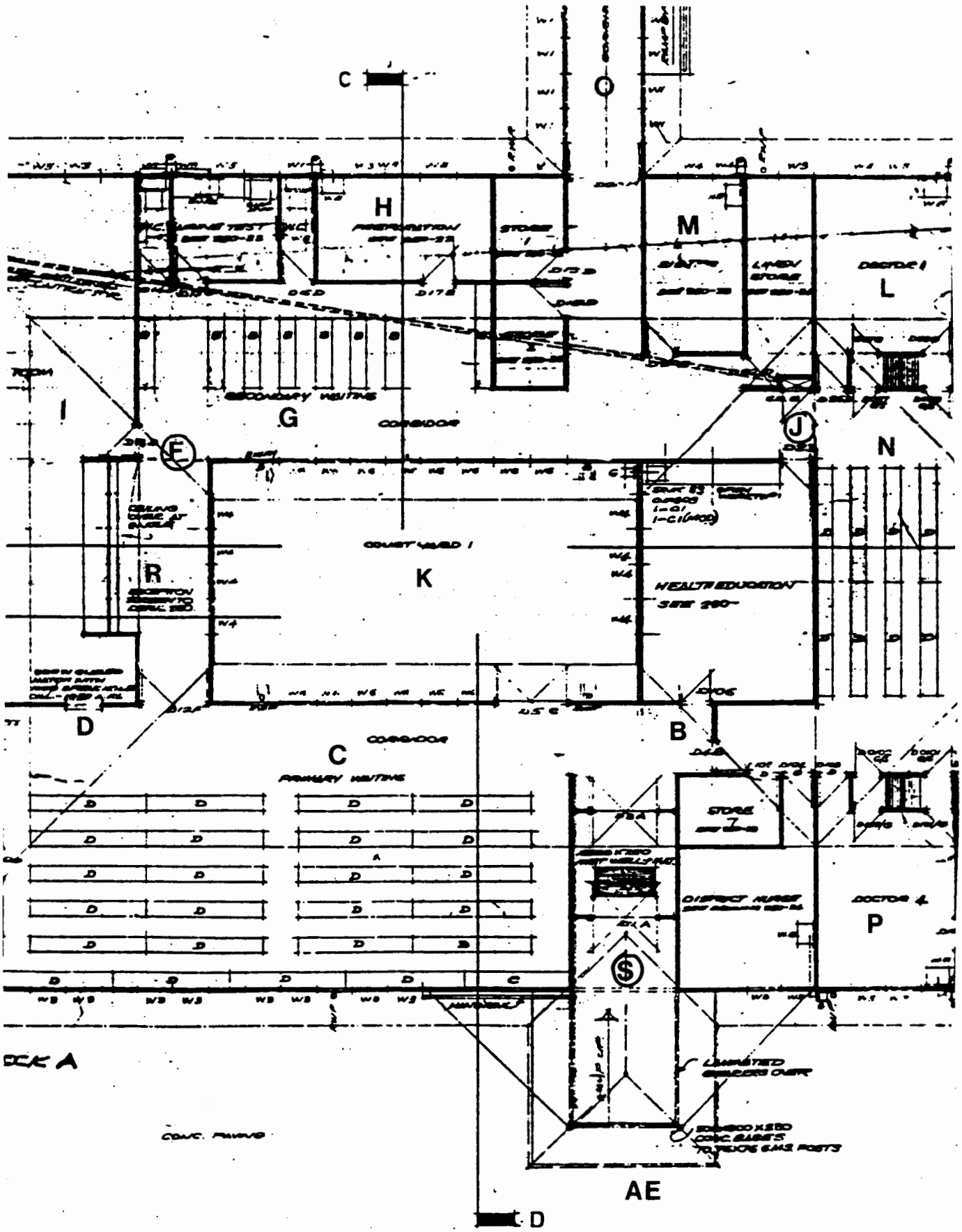


Figure 4.4. Detail from architectural plan of Block A of Hanover Park CHC (legend on page 47b)

Legend for Figure 4.4

AE. The Main Entrance
B. Closed off corridor
C. Primary Waiting Area
D. Windows to Reception area
R. Large glass window and counter for Reception
F. Reception Gate
G. Secondary or. Prep. Waiting room
H. Preparation Room
I. Reception and filing Room
J. Second Gate
K. First Courtyard
L. Doctor's Room 1
M. Sister-in-Charges Office (official)
N. Waiting area for Doctor's Rooms
O. Corridor to Block B (Trauma Unit, Staff Rooms and MOU)
P. Doctor's Room 4
S. Entrance gate

public spaces. She writes about the "re-colonisation" and place making of biomedical space by the community, as

> Visible boundaries such as walls or enclosures give rise to an appearance or separation between spaces where in fact what exists is an *ambiguous continuity* (Lefebvre 1991, quoted in Harries 1996, p.75, Harries' emphasis)

4.5.2 Closing the entrances: securing the perimeter

The clinic is no longer the accessible space it was designed to be. Across time a pattern is clearly emerging here:

1. Entrances have been closed.
2. Those that remain open have undergone a process of fortification.
3. Interior public spaces have been partitioned and closed off by gates, such that interior spaces reflect the fortification of the exterior.

Patient or Public entrances have been reduced to a single Main entrance, which may be monitored and controlled at all times. Currently patient entrances AF and AG are permanently locked. Heavy steel gates have in the last two years closed off the Trauma entrance (AI), so that it is a locked entrance used only for ambulances. This door is also controlled and guarded by security staff located at the street entrance. The only remaining entrance for the public (BE) is the original main entrance, reinforced now by a metal "*prison*" (J) gate and security staff. The staff entrance and the service entrance have remained open, however these too are watched and access is controlled by a security guard at the staff entrance gates, effectively keeping this area accessible only to identifiable staff[19].

These changes have a context and a history which has required the strategic reshaping of the clinic's public/biomedical boundary. The reduction of entrances has been a gradual process which intensified from 1995 with increased gang-related activities. In early 1996 the staff of the CHC were successful in their community lobbying and protest action - quite literally threatening to close the CHC unless their security demands were addressed - and obtained greater security from provincial management. Initially this included a high wire-covered exterior security wall and a professional security firm to guard all entrances.

Thus, the closing down of multiple entrances may be read as an attempt to gain greater control of biomedical space by seeking to assert the disjunction or differentiation between the clinical space and the public community space outside. Quite simply the limiting and control of access into and through a territory is a means of defining and controlling its boundaries (Knox, 1995). This attempt to keep out the community has however, major limitation and core contradictions, namely that primary health care facilities are meant to be accessible public facilities (Dept. Health, 1997). Furthermore, as Harries (1996) describes, it is not access of the public *per se* that is a problem, but a public that refuses to act as

"good" patients, and clinical public spaces for non-clinical activities, such as a social meeting place, which challenges the meaning of the clinical space. As Bourdieu (1977) proposes, the original design and intention of social or culturally inscribed space may be reinterpreted or challenged by people's daily practices (cf. Moore, 1996). Therefore, this attempt to physically reduce and close off the clinic's perimeter boundary may be successful in reducing the risk of stray bullets entering the CHC or stopping the illegal entrance of the public, but it does little to address the legitimate public, the patient, within its walls. Other strategies were therefore adopted.

4.5.3 Remaking the prison

> This place looks like a prison now!" I heard a (familiar) patient joke with the staff (Field notes).

Since June 1997 this fortification has entered a second phase, that is the closing off and guarding of interior spaces. Internal security gates were also added *within* the clinic. These gates have been inserted, at staff's insistence, to "*control the public*" and to stop patients' "*escorts*" especially those who seek to enter the clinics with "*weapons*". The gates were also meant to reduce the number of patients entering the treatment areas at any one time. Gates have also been erected at the junction between the Reception and "Prep" areas (F, see Figure 4.4) and outside the Head Sisters office (J). The staff are pleased with this additional security, although the general complaint is that there is not enough.

As discussed, patients are mobile and service efficacy requires the smooth movement of patients between coded workstations. Currently the clinic is plagued by bottlenecks of patients at certain junctions, such as at the Preparation and Dispensary areas. Staff seek to limit access to these areas and "*distribute*" patients "*to the doctor*" as soon as possible. In the past these areas have thus invariably been sites of conflict and abuse between staff and patients, as nursing staff have sought to impose their authority in controlling and limiting patients - who have complained and resisted.

These guarded gates are used to limit the flow of patients into the interior of the clinic, that is past reception and into the Preparation area during the day. They are also located at key sights of surveillance – the reception area and the Sister's office. At night, Gate J is used to close off the interior of the CHC completely and channel the flow of patients into the Trauma Unit, thus increasing the security of the rest of the unused and unguarded building.

Thus, these gates, which are controlled by security guards, function in a number of ways. They reinforce the role of the reception area in controlling the access into the clinic. This single "lane" reduces choice of movement for staff and patients and canalises movement along a single axis which may be better-controlled and observed at all times. It also allows nursing staff to limit the entrance of ten patients at a time. The initial structure of the clinic, and its modifications, can be seen as a means of managing large numbers of people. Following Foucault (1977), the disciplining technology was based

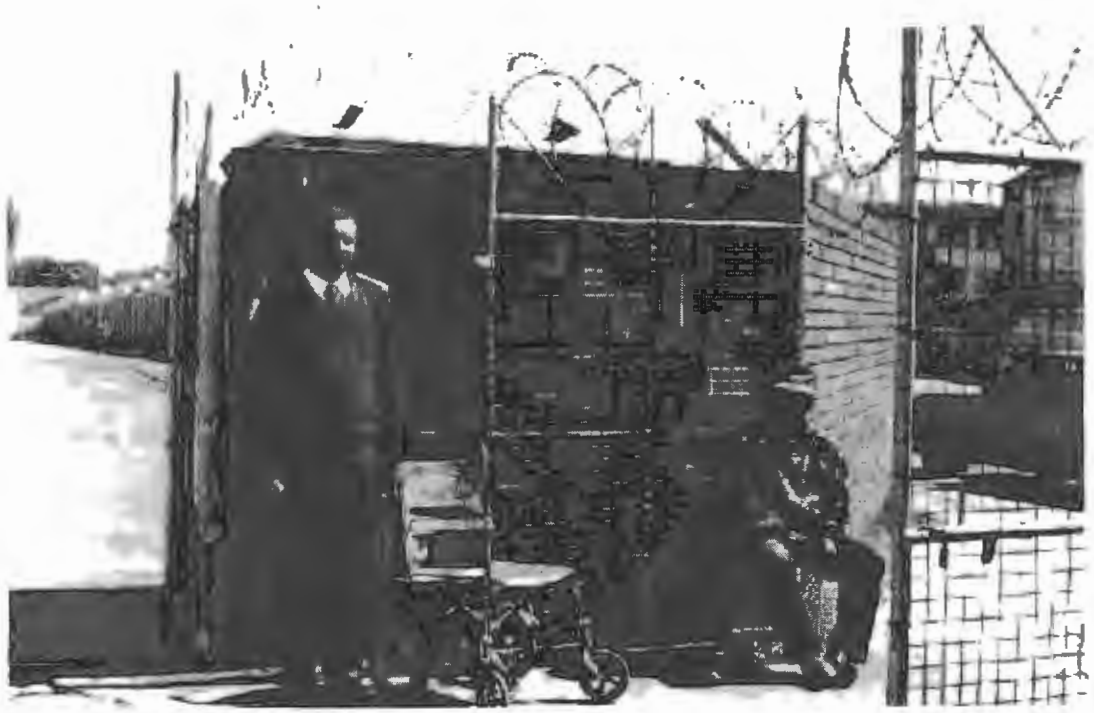


Figure 4.5. A security guard at the Main Gate onto Hallans Walk

Figure 4.6. The Security Gate (J) between the Reception and Preparation Area

upon "regulating movement..clear[ing] up confusion" and "dissipating compact grouping of individuals" creating "calculated distributions" of people in such a way that they became predictable and governable (p.219).

A general assistant explained the benefits of this in terms of increased efficiency and reduced conflict between staff and patients,

> If you take the Prep, that is a critical area, [but] I think now lately it is improving a bit, because they only admit ten patients at a time. Now at first,..there was no limitation. Now I see the nursing assistants, they call 10 patients at a time, they've got to stand there, just to get order and stuff...Then they first sort those ten patients out and distribute them to the different doctors, and then they take another ten. And it takes all that verbal abuse from that nursing assistant as you get quite rude patients. As a result that nursing staff is going off sick, or they get aggressive or what ever.

The gates are therefore designed as a physical means of authority and control which limits the need for staff to exercise direct physical control over the patients body or movement. Thus, there is less need to use the biomedical inscribed interpersonal power of staff-patient to maintain order. This order is sustained by mechanical disciplining methods, and overt security control becomes the onus of the armed security guard. The guard's capacity for violence is latent and secondary to the control of barriers, which act to pre-empt the need for direct violence or conflict to control patients. The placement of gates therefore creates partitions and barriers which reduce the development of crowds of unruly people. Disciplining power, as Foucault (1977) noted, acts by dissipating and dividing the many - reducing unlawful circulations and conglomerations - under the auspices of visibility and bureaucracy. In this clinic, the use of prison-like gates has enhanced this institutional capacity, yet, at the same time, challenging the biomedical definition of the space - it looks more like a "*prison*" than a clinic. A category contradiction I shall examine further in Chapter Five.

The management and limiting of patients, and to a lesser extent staff mobility, throughout the clinic is clearly therefore an act of authority and power sustained and reproduced by the physical structuring of the clinic building and its security additions. We can therefore, like Massey (1996, p.239), assert that "different social groups have distinct relationships to..social mobility: some people are more in-charge of it than others are". Thus, we are able to link power within the CHC to control of mobility, and also the right to occupy and traverse status-inscribed territories.

Furthermore, it has become clearer that power is structured and immanent in the physical forms and spaces which discipline and control placement and movement, and hence also social identity. This points to an understanding of power and identity which is more fluid, contingent and diffuse (Dear, 1997).

Figure 4.7. A patient walks through the security gate (J)

Figure 4.8. Patients sit in the Main Waiting area waiting to be called through Gate F into the interior of the building. The Woman and child on the right is talking to Reception staff through one of the access windows.

4.6 Spatial relations, productive capacities and identities

> If space embodies social relationships, how and why does it do so? And what relationships are they? (Lefebvre, 1991, p.27).

Space defines and concretises makes immanent and "real" the relationships between people and things. The clinic space is therefore adapted to the key polarities of public/private, mobility/immobility and staff/patients. Key biomedical spatial and identity boundaries have been daily enacted and reinforced by carefully designated staff and patients territories, which prohibit and permit the placement, mobility and visibility of differentiated categories of people - primarily staff and patients/public.

Furthermore, staff spaces reflect the professional, racial and class divides at the time of construction, thus, spatially representing social identities in the designated fabric of place (Silby, 1996). Many of the racial and professional boundaries that existed in the original plan, appear, however, never to have been enforced or have been slowly eroded. However, it is clear that other boundaries are being erected and reinforced, pointing to new anxieties regarding identity, mobility and order.

Gates and security guards have been erected at key junctions in order to control the flow of patients (quantity) and limit escorts, especially those deemed potentially threatening (quality). The gates and security in the clinic reinforce therefore the ordering and disciplining capacity of the clinic, which, requires the continuous governance of spaces facilitated by these security features. There is however a convergence of historically contingent dynamics here which link this biomedical productive process to broader forms of specific social identities.

4.6.1 The production of "the patient"

In "Prep" the patient is prepared. At "Doctor" the patient "sees the doctor", at "Injection" s/he gets injected, etcetera. Ordered biomedical activity, across structured biomedical space, marks biomedical productivity. It takes little imagination here to link this staged distribution of the activities enacted on the patient with a conveyer belt of medical objects. Goffman (1968) called this "people processing", a hallmark of modern efficiency and bureaucracy. Some design manuals directly address the "threat" of such perceptions,

> A hospital is not a factory, in which the assembly line dictates all aspects of the design but a community in which the interaction of individuals is fundamental to the successful working of the whole. A hospital is an enormous house. (Weeks in Putnep, 1979)

Patients' subjective accounts of public health reinforce this observation - medical care is impersonal, authoritarian mechanistic and often public (cf. Comaroff, 1981, Wiles and Higgins, 1996). Yet, conveyer belts or assembly lines are efficient and productive in as much as they are ordered and co-ordinated. As modern productive space should function as "..a whole whose separate parts are 'in

harmony'.like a machine, generating effort out of the interaction of its individual parts" (Mitchell, 1992, p.46-47). It is clear that within the clinic this not always the case and "the patient is forever running up and down to the doctor." (Mr P, GA). General assistants also note that many patients find the walking, waiting and potential mistakes tiring,

> Now by the time that the patients have got to the chemist, I mean they're fed up, following this whole procedure. You're so tired and ill, especially old people... it causes anger on the part of the patients (Mr P, G.A).

The medical technology in the clinic is not "high tech". medical equipment or procedures but a mechanism of spatially ordering people in order to produce biomedical products. This mechanism may produce a depersonalised and authoritarian, but relatively efficient biomedical treatment process (cf., Comaroff, 1981), or a slow, chaotic mechanistic process which is experienced as frustrating and abusive by patients and staff alike.

4.6.2 The reproduction of the "Other"

I have discussed here a number of features in the design of the clinic and the manner by which it is activated, that specify this space as a place for the treatment for poor, black, that is initially coloured and now African, patients. Some of these features, such as the Doctor's Doors, are built into the ossified apartheid history of the clinic and will probably soon lose their function and potency. Others, such as the mechanistic and silencing treatment routine, and the public visibility afforded to the sick and wounded black body, appear embedded and depoliticised in the functional notions of public health (cf. Comaroff, 1977). Security features at the clinic have done much to increase the efficiency of clinical functioning and the safety of staff and possibly patient alike. They have however amplified the "difference" in the clinical spaces for the poor (and Black), and reinforced the criminal and "othering" construction of township spaces and communities.

Poverty and race have a material reality, a set of textures and smells; the massing of bodies, the level of noise and the indignity ascribed to the body; and the ratio of being seen and seeing. It is about positions in distributions of power and ownership. It is about limited choices, lack of voice, excruciating vulnerability, and a terrain of specific mastery by which limited resources are sought and often violently appropriated (Wilson and Ramphele, 1989). Biomedical treatment and institutions cannot be blamed for creating these conditions, yet they are amplified by the disciplining technology, including the reproduction of carcerial places for the criminalised sick poor.

CHAPTER FIVE

LIVED SPACES, REAL AND IMAGININARY BOUNDARIES

> The very way a space is imagined represents a means of living in those spaces (Allen and Pryke, 1996, p.179).
>
> On the flat space of position, it is possible to imagine secure boundaries which separate "us" from "them". But in an unfolding space of subjectivity, the Swiss roll of politics is bound to be a little messier (Pile, 1996, p.255).

5.1 Lived Space

In the previous chapter I explored the construction and instrumentality of modern biomedical space. However, I have not addressed the question of *how such spaces are currently experienced and interpreted by the staff* — not as mere biomedical technicians, but inhabiting social agents with multiple symbolic meanings and practices. Staff have, over the years, socially imbued the clinic with symbolic and emotional value. "Place" is qualitatively different from generic notions of space, places are "constructed with our memories and affections through repeated encounters and complex associations" (Eyles and Litva, 1998). I have described the rational spaces of disciplining biomedicine, the salience of function, surveillance and efficiency. Symbolic meaning has little descriptive power within Foucault's Panoptic space and, as subjectivity, it is merely the trace of the effect of disciplining power (Foucault, 1976).

I have tried to understand the clinic in terms of the metaphor of a machine or factory, alienating spaces of fractured productivity. Yet this metaphor is never consciously articulated by staff. Representations of (biomedical) space is symbolically mute, it seeks to erase all traces of symbolic and affective content, and seeks to be read as rational and functionally streamlined (Lefebvre, 1991). This is the antithesis of Lefebvre's "lived space", the space of feeling, imagination and symbol, the "hot" space of fantasy and passion (Soja, 1996, p.68).

> Representational space is alive, it speaks. It has an affective kernel or centre: Ego, bed, bedroom, dwelling, house or square, church, graveyard. It embraces the loci of passion, of action and of lived situations, and thus immediately implies time..it is essentially qualitative, fluid and dynamic" (Lefebvre, 1991, p.42)

Spaces of representation are dominated spaces, in this case, dominated by official biomedical space and its standardised and disciplined meanings. Yet such space remains a symbolic and imaginal substratum that uses and overlays the material realities of social space. It supplies unofficial, non-rational and

potentially subversive meaning to the frontal functionally inscribed spaces of the clinic[1]. Lived space is also the space where the effects of time and power are felt (Lefebvre, 1991).

> Lived space...may be public or private, they may overlay or disrupt the dominant spaces, or indeed they may take shape alongside them. Above all, representational space should be understood in relation to the well-defined representations of space (Allen and Pryke, 1996, p.179).

This chapter therefore focuses upon the space " that speaks" (Lefebvre, 1991, p.42), the space which becomes place by virtue of creative social actors and symbolic systems (Moore, 1996). This process binds people and spaces within alternative structures of meaning (as opposed to the official representations of biomedicine) which may sustain and/or challenge dominant constructions of space. Foucault (1976) and Bourdieu (1977) alerted us, however, to naïve notions that such symbolic worlds may escape the effects and productive utilisation of such power[2]. By exploring some of the means by which the clinic space is enmeshed and constructed within such symbolic systems, I am seeking to understand how the functioning and the changes at the clinic are experienced and understood at this level. This exercise will begin to clarify some of the symbolic meanings at stake in the current crisis, and therefore, begin to examine some of the spatio-symbolic strategies used by staff in order to cope with these.

5.2 Metaphoric and emotional worlds

5.2.1 Place making

The most common trope used by the majority of the clinic staff is that the clinic is their "*home*", "*ons se huis*" and the staff are like a "*family*"[3]. The clinic is obviously not *really* a home or the staff a family, it is a biomedical institution, and the staff are paid employees[4]. It is clear however, that such metaphors are used by staff in their narrative construction of the clinic. Furthermore, this is accompanied by social practices, such as mutual co-operation and support, which articulate and reproduce this symbolic construction at the level of the individual and social group[5]. Symbolic anthropologists, notes Moore (1996), have "examined the role of metaphor and metonymy in ordering and reordering social categories and in giving affective power to these categories" (p.81). Bourdieu (in Moore, 1996) emphasised that space is socially and materially organised along sets of "contrasts" or oppositions which "inform the practical and discursive knowledge of social actors" (*Ibid*, p.83). The home conventionally signifies the site of the family. It is the primary site or "habitus" (Bourdieu, 1977) a potent resource for acting in, and understanding, the world. The home is both a lived and abstract space (Lefebvre, 1991), and as such, is accompanied by socially prescribed roles and relations and consensual expectations (*Ibid.*). The home and family are also a physically and socially bounded phenomenon, constructed along gendered and generational axes of production, reproduction and consumption, belonging and exclusion (Lefebvre, 1991, Moore,1996).

It is therefore clear that the metaphoric or symbolic constructions of the clinic is a rich source of insight regarding the manner in which this place is conceived, experienced and lived. Furthermore, such symbolic meanings are not a social given, but need to be explored as spatially accomplished phenomena, which may contest or utilise the biomedical resources described in the previous chapter. Such domestic and familial tropes are one means by which the staff give meaning to the clinic, as a symbolic mechanism of place making (cf. Tuan, 1977). However, it is also a resource by which spatial structuring and events are interpreted in a mutually constitutive relationship between spatial practice and structure and meaning (Moore, 1996).

The clinic is a place of "dwelling"[6], a place has (positive) "*meaning* in direct proportion to the degree that the person feels `inside' that place: here rather than there, enclosed rather than exposed, secure rather than threatened" (Knox, 1995, p.215, my emphasis). Such security implies a place is secure territory, it is appropriated and owned, and there are clear exclusionary principles structuring, who and what belongs, and who and what is inside and outside (Knox 1995, Moore 1996). Thus, writes Eyles and Litva (1998), "place attachments are integral to self-definition" (p.260) and should provide a degree of security amidst flux and instability.

The clinic's meaning cannot therefore be understood without recourse to its symbolic and affective construction, and thus the significance of it as a specific place for the staff (and community). Such constructions will be accessed here through the staff's accounts and their spatial practices, as,

> ..it would seem axiomatic that any penetrating analysis of the interpretation given in and to space by social actors must acknowledge the fundamental interdependency of action and interpretation, *where meaning is established in and through social practice* (Moore, 1996, p.91, my emphasis).

5.2.2 The dysfunctional family

The staff currently juxtapose their sense of the clinic as "*family*" with accounts of the "community" as "*rude*" or "*disrespectful*" or even violent. However, even this counterpoint has been upset and the moral divides are by no means as clear. Sr. G, a founder staff member, who was on the brink of leaving the clinic[7], describes a "*family*" without authority and regulations, "*no rules, no morals*". How, she asked, can a family expect to function without rules, authority, and strictly adhered to practices, such as prescribed dinner times? The clinic is for her also a place of "*waste*" and poor management of resources. She describes visiting doctors who just "*give patients things*" (e.g. piles of swabs and unnecessary medication), and patients who "*show no respect*". Furthermore, reciprocal and economic relations have been disturbed, *"People don't buy things anymore, they just expect...Nobody buys anything, anymore."* Thus, for her, and many others, the clinic is a place of poor household management, lack of parental leadership and authority, invading outsiders who break the rules and waste precious resources, - they are entitled and spoilt patients — or is it children (?).

Extending the metaphor of the dysfunctional family, it emerges from the accounts of non-clinical staff (general assistants) that there is currently mutual abuse and disrespect between staff and patients. Staff may be shouted at, and have been "*smacked*" by patients within the clinic, yet staff are also responsible for angry outbursts, disrespectful attitudes and lack of sensitivity towards patients needs. The moral boundaries are not so tightly drawn, as the following extract suggests,

> I observe, I observe.. I mean the way the doctor talks to the patients, the tone he uses. his whole expression, body language, everything! Dissatisfied, because of the conditions they work under. And now they take it out on the patients. Sometimes the patient come to me here, okay they are new, but they are even more ill when they go home! Because of the treatment! (Mr P, General Assistant)

The clinic may be the site of a family, but it is currently a troubled and abusive family. However, this metaphor still functions to give meaning and provide staff (and potentially patients) with ordering categories (e.g. "us" and "them"), and practical and discursive knowledge (e.g. parental roles and discipline). According to Bourdieu (1977), these are seldom consciously invoked but provide form, meaning and strategies within this antagonistic social field[8]. The "family and home is also a potent site of differentation, a symbolic resource, notes Chidester (1994), for the "sacredization" of space, as sacred spaces gain symbolic value from metaphoric associations with such notions as home and the "heart"[9].

5.3 Dangerous exteriors and porous boundaries

> The ordering activity, the major pastime of modern institutions, is mostly about the imposition of monotony, repeatability and determination; whatever resists this imposition is the wilderness behind the frontier, a hostile land still to be conquered or at least pacified (Bauman, 1995, p.143)

Most of the staff and all of the professional staff do not live in Hanover Park, but are themselves "outsiders" who must travel daily into the township[10]. Professional staff of all races travel into this working class suburb from more affluent neighbourhoods[11]. Staff carry their own constructions of the area, which may patronise as well as pathologise. Staff describe the community as abnormal, illiterate, unhealthy and violent. Doctor A, the only white member of staff explains that he

> ..generally deals with "nice people" who "look after their children", this is "not a naughty bad community", although he believes that there is more "respect" as it is generally an older community (Doctor's interviews).

Most of the staff are stationary and remain within the clinic walls throughout their working day. The District sister is the only staff member to regularly leave the clinic, travel into "the community" and enter patient's homes. It is an unpopular placement and nursing staff are wary of venturing alone out

"into the community". Hanover Park is a dangerous and alienating space within the experience and mythology of the clinic. The boundaries between the clinic and the exterior "street" have thus taken on increased significance as staff seek to maintain the ordered and safe biomedical space within (cf. Jensen and Turner, 1996).

Place making required the presence of secure and socially recognised boundaries which demarcate relationships of belonging and exclusion (Knox, 1995). These boundaries are multiple and occur across a range of ontological realms, that is, at the level of the material, organisational, cultural (including symbolic and moral systems and representations) and subjective. The integrity of a place relies upon its capacity to keep what is unwanted and threatening out; to maintain the clear binary of inside and outside, "us" and "them". Spatial differentiation is required for place making. Yet such difference is itself the product of an ongoing work of differentiation (cf. Chidester, 1994). Indeed, boundaries may become both material and symbolic capital which establishes what is "us" and "other" (Moore, 1996).

> As 'citizens' and 'strangers' are controlled largely through the spatial confines of divided space..the spatial categories through which the lived world is largely thought, experienced and disciplined - imposes a set of interiorities and exteriorities (Goldberg, 1993, p.45).

There is therefore a mutually constituted relationship between spatial positioning *vis a vis* a boundary, and the social meaning or identity attached[12] (Gregory, 1994, Foster, 1997).

In the clinic, "real" boundaries may be both physical (e.g. walls and gates) and procedural (e.g. entrance or exclusion criteria). Professional boundaries (staff/patient, doctor/nurses) may be both legally and socially inscribed. Yet all these boundaries must be accomplished in space and have social meaning within culturally inscribed systems (including biomedicine) which overlay and juxtapose each other in the messy richness and contradictions of lived realities.

5.3.1 Keeping out nonsense: criteria for inclusion and exclusion

How are boundaries established and maintained in the clinic? What are the axes of inclusion and exclusion by which they are structured, and how is this spatially and symbolically accomplished? I will examine two operative, yet challenged, criteria of belonging and exclusion, namely staff and (real) patient status, and community membership. Although these criteria follow closely the contours of biomedical ideology, it will emerge that their emotional meaning and symbolic associations have deep and intractable roots in the imaginal or metaphoric world of home and family, and its associative ontological anxieties.

Clinical space is built upon the binary of doctor and patient (R. Littlewood, 1991), or more loosely staff and patient. Cammock's "Territories" remind us of the centrality of this binary principle in making and remaking biomedical space, and its constitutive roles and identities[13]. According to Parson's "sick role", being the patient, implies roles, responsibilities and not least, the status of "sick" (cf. Lupton, 1995). Kleinman (1988) and others have described the historically and culturally contingent, social constructions of illness and disease categories and models. Inherent in these descriptions is the assumption that there are socially (albeit changing) prescribed criteria or boundaries by which the sick status is determined. These criteria will not be static or universal (even within one so-called culture), but are the product of a range of contextual factors such as the economic resources and moral injunctions to treat such illness.

Who are the sick patients in the clinic, and how can we understand this identity formation in the light of the spatial and symbolic boundary making that is the focus of this chapter? It will emerge that the contours of this boundary are by no means clear and this constitutes a central problematic for the clinic staff.

5.4 Letting in the "real" patients

> People can't just come to hospital with all this nonsense, cough, colds, old wounds, pimples all over their body after months on end (Sister-in-charge interview).

The clinic is attempting to insert more physical and organisational procedures to make sure only "real patients" are seen at the clinic. The criteria for this status here appears to be the seriousness and acuteness of illness and adequate responsible management of ones health and illness. Sick status occurs along a continuum of severity, which is determined by the "*sorting*" undertaken by the doctor in the morning, and the discretion of the receptionist throughout the day. Other processes such as the "*booking*" of appointments has also been used, and partially abandoned, for anything but "*chronic patients*" [14]. As I have already described, the modern spatial principles of surveillance and movable barriers are most evident in the reception area. Here "patient" status is constructed and policed through guarded doorways, permeable barriers and bureaucratic documentation (i.e. files, records and "*cards*"). The clinic is by no means impenetrable, and entry is possible at alternative routes of entry such as the Emergency entrance[15].

> The ambulance men arrive with a groaning woman strapped down on their trolley. She begins to try to get off the bed and appears very intoxicated. Her face and those visible parts of her body are covered in horrible scars, she smells terrible, and is obviously very unwashed. The ambulance men say that she is a vagrant in Wynberg Park[16] and they were received a call to collect her, they say "*there is nothing wrong with her*". She speaks incoherently about a car accident and about her ear being burnt off, although this appears to have happened a long time ago[17]. I ask the ambulance

> men why they then brought her here, they say that *there was no where else to take her.* He knows that they are "overworked' but the secondary hospitals, like Joosta, would have turned her away. I am surprised that the staff make no protest that they are being used essentially as a social service. She is put on a bed in the nebulizing room, much to the distaste of the three patients being nebulized there. I go and visit her, the whole room smells foul, she sees me and mumbles incoherently dribbling, and thrashes around in the bed. She seems to try to get off the high examining bed she is on. I ask her if she wants to go to the toilet. She doesn't reply. I feel disgusted. I try to tell her not to and then relinquish all responsibility and call the nurse. (Field notes, 10.8.97)

Pile (1996) would comment that mine is the fascinated gaze of the bourgeois observer of the "Low-Other" (p.179), whose bourgeois space (Wynberg) is purified by removing this social "dirt" and realigning and affirming the topographical boundaries of class and race within the city. But this is another story...The doors to the clinic are always open. Disgusting, dangerous and dubious things are allowed inside. "Patients" are not what they are meant to be or used to be.

Biomedical spaces are paradoxical in status as they represent the symbolic power of biomedicine, and yet must admit and contain the low-status "polluted matter", the dirt, of sick bodies (cf. Weiss, 1993). Primary health care facilities are the lowest rung of the biomedical hierarchy. They must not only admit the sick poor, but all forms of social dis-order and disease. This boundary slippage is particularly easy within a primary health care discourse which champions intimate proximities and engagement with social and health realities outside the traditional bounds of hospital medicine. Furthermore, the contours of "pure sickness" and pathologised poor (including "degenerative habits" such as drug and alcohol abuse) become more blurred as other forms of social welfare fail to materialise. Thus, the clinic is open to forms of social disorder that cannot be easily rendered into medicalised discourse, or an object of biomedical categorisation. Such problems spill out beyond the binary biomedical categories of wellness and sickness and signify the social chaos to be kept outside.

Bauman (1991) has alerted us to the fact that the "other" of order is chaos, which is "indeterminate.. unpredictable.. uncertain.. irrationality.. ambiguity.. confusion..undecidability [and] ambivalence (quoted in Jensen and Turner 1996, p.8). He proposes that the most contaminating and ontologically challenging identities, are not those that fall within the clear binaries of friend/enemy, that is predictable categories of otherness, but the "waste products of classification" (*Ibid.*, p9). This is the *Stranger*, the unclassifiable, the ambiguous person who is not quite "other". Within the biomedical symbolic system, this suggests that *people who cannot be ascribed clear patient identity constitute the most problematic category of people within the clinic.* Following Douglas (1966), they are therefore dirt, as,

> Dirt is precisely dirt, as it does not fit into the prescribed categories by which we socially organise the world. *As residual matter, "..dirt is essentially disorder.* There is no such thing as absolute dirt; it exits in the eye of the beholder..Dirt offends against order" (Douglas, 1966, quoted in Lupton, 1994, p.33).

Different staff members have different hierarchically determined relationships to this exposure to various forms of biomedical "dirt" and violation (cf. Weiss, 1993, Hart, 1991). Doctors have more access to privacy and safety from physical violation and as I will describe later, symbolic contamination. Nurses have less privacy and are more exposed than doctors, and, potentially security staff. Professionally nurses tend to act as "frontline" workers, as mediators between the physical and subjective worlds of doctors and the patients (Littlewood, J, 1991). Nurses are vulnerable as their's (like the cleaners) is a more proximal relationship with patients, and without the protective status (and often gender) of doctors. As one sister complained, "*If doctor is slow..if patients get excited.. the nurse gets the blame*".

5.4.1 Accessible to gangsters, Mothers (and children)

> The Department of Health is committed to achieving universal access to health services for children including infants, children under five, adolescents and women, while improving the quality of services provided (Department of Health, 1997).

It is not entry into the clinic *per se* that is therefore the problem. The dominant account among the staff is that the clinic is too open to the wrong kinds of people namely "*mothers and gangsters. It's accessible to nonsense*" (Sister in Charge interview).

At first glance this unwanted category appears a strange mix. The presence of gangsters within (and without) the clinic is a complex one which I will deal with in more detail in the next chapter. Suffice to say that within the staff's official accounts they are generally positioned as the dominant enemy of the clinic. What of mothers however? It would perhaps be more accurate to say, and probably less permissible, that the problem with "mothers" is that they are women who arrive at the clinic seeking assistance for their children. Statistics at the clinics (C.H.S.O routine data) indicate that there has been an increase of over one hundred percent of children seen in the last year[18] .

Mothers visiting the clinic with children not considered "sick enough" were often observed as objects of ongoing scolding[19]. This generally occurred in the context of pressure to treat patients with more serious complaints.

> A mother brings in a crying infant, with a high temperature. The sister says angrily to her *why does she keep "running to the Day Hospital every time your child cries for*

Figure 5.1. A mother and her children wait in the Second Waiting area for "Prep."

Figure 5.2. In the Main Waiting area, the Sister-in-Charge hears patient's queries and problems regarding accessing treatment.

> *Sister to sort out?*" This is another regular complaint among the nursing staff, that mothers in the area "abuse" the service by bringing their children in with minor childhood ailments that they should be handling at home. The nurse shows the mother how to wash the child down in a basin of tepid water (the scrubbing basin is used) to reduce its temperature. Staff become more irritable with the constant stream of patients as lunchtime comes and goes (Field notes, Trauma Unit).

Despite such scoldings, I never saw a mother and child being turned away from the clinic[20], although long waits for care or ambulances were seemingly unavoidable. Mothers would bring their children to the clinic after other facilities, such as hospitals, had refused care. There also appeared to be a frequent stream of children injured in pedestrian motor vehicle accidents in Hanover Park's public spaces. I only ever saw children being treated with kindness by staff. While not wanting to erase the staff's agency, it is also evident that such care is inseparable from the entrenched role of nurses as caring (but disciplining) Arch-mothers to the community (J. Littlewood, 1991). There is an associative cohesion between child and patient (Littelwood, R, 1991), and the institutional, gendered and emotionally invested role of nurse as mother and carer. These inculcated pre-dispositions of both staff and institution make the establishment and enforcement of viable exclusion criteria for children problematic. Thus children's illness or patient status remains largely dubious and contested.

Children are an unavoidable moral category, they are the ambiguous moral anchors for this institution[21]. Damaged or wounded children even more so[22]. Furthermore, the clinic's services are one of the few visible signs of the state as carer or provider. The communities dependence on the service for paediatric care, tends to be perceived by staff, many of whom come from similar communities, as pathological or the result of poverty and inadequate education. The discussion below was with a General Assistant,

> P: You get these patients sitting in front of this chemist from 7 in the morning to 5 in the afternoon for 10 Panados ! Now you tell me if that is normal!
> L: How do you understand that?
> P: Financially
> L: Is it, you think its just financial, people can't afford.. Do you think there are other things.
> P: Man, sometimes it's the illiteracy rate here in Hanover Park its very high. Sometimes people, they got a fever..or say, the child, the baby has got a fever, or so. Instead of just taking them to the basin and spraying them with cold water. Its because they don't know these things. Now they come to the hospital and then they get Panado syrup or what ever...

Community health locates the first site for health interventions as the domestic household or home (Department of Health, 1997). Mothers are constructed in these discourses as the lay health workers who must create hygienic conditions and provide basic health care for the children and family (Stacey, 1988). Within this discourse, lapses in such competencies is seen as a moral failure, pointing to "bad" mothers (Stacey, 1988). It is also a stark reminder of apparent failure of community health goals in this

area. In the past few years the clinic's little health education and promotion resources have been further reduced in order to concentrate limited resources on curative care. The relationship between the public and health education has been further severed by the closure of the door between the public waiting room and the Health Education room. While this closure has limited unlawful entry into the clinic it has quite literally placed "Health Education" at a dead end.

"Mothers" represent the loss therefore of two types of barriers or exclusion criteria. Firstly, mothers' children cannot be judged according to the adult standards of accountability, and they defy moral, legal and financial sanction within the health services. Secondly, as integral components in the historical construction of primary health care (Armstrong, 1995, 1996), they articulate the contradiction between primary health service ideology and practice. The promotive and preventative aspects of primary health care ideology blur the boundaries between health and illness, especially the healthy or ill child (*Ibid.*). It is also clear that without the practical (as opposed to rhetorical) child health educative practices, this categorical merger is opposing staff's efforts to distinguish "real sick patients" as a permissive social category within the confines of the clinic. This collapse of a clear binary opposition creates ambiguous categories of treatable patients, who quite literally, are flooding the space of the clinic. Many of these dubious patients suffer from social disorder and disease, including violent, deprived and oppressive domestic lives, the disadvantages of age and gender, and the chaos of dangerous streets and devastated communities. They defy easy biomedical disease classification and block and pollute the symbolic and functional mechanisms of the clinic.

5.4.2 Removal of financial barriers

Free services to children are inscribed in law and policy. Indeed most patients at the clinic do not pay for their treatment of medication. Free services are seen to have made care too accessible, open to abuse[23].

> I mean look they try to cut on this and cut on that. At first the patients were paying R10, then up to R15, and a survey showed 60% of that people is, they are in favour of paying that R15. Then they know can get the quality for their money. But because of this new health business is *mos*, its for free now. Now the patients must, they must come and they must just take what they can (General Assistant).

According to the General Assistants, from the patients' perspective, free services are seen as the root of many evils, including loss of choice and consumer power. Its is also an apparent anomaly in an otherwise capitalist market which places great values upon commodities, and those who provide and have access to these (cf. Wiles and Higgins, 1996). Paying for services, may, however, place health care beyond the reach of the poorest sector of the population. In this commodity market, regulation of patient's status is based upon financial rather than overtly clinical criteria utilised by public health[24]. Staff are also clear that they consider the removal of financial barriers the cause of increased patient

attendance, and research seems to support this (Muller *et al*, 1998). As abstract space, the clinic also poses categorical problems along the axis of reciprocity and exchange. It is therefore an anomalous space poised somewhere between the market and the unconditional expectations of home and family. Or, with Lefebvre's (1991) emphasis, there is also a disjunction and contradiction here between capitalist and socialist spaces.

5.4.3 Ambiguous community and ambiguous belonging

Loss of financial barriers are not the only effect of current health policy. With the development of a district based health service, catchment areas for clinics include all the areas in a given district, including those beyond the boundaries of Hanover Park. The realignment of district-based catchment areas and borders has therefore been instrumental in severing those direct ties that linked this facility to the local (coloured) area, making this a more nebulous entity dislodged from historical communities[25].

Indeed there appeared to be a great deal of confusion among the staff as to who actually was eligible to be treated at the clinic - who belongs.

> 4.00pm Saturday afternoon: The day staff are still here. I ask about patient numbers, and am told that many today were not "*ons se mense*" [our people], the staff shake their heads and say that they cannot do anything about this.
> (Field notes, Trauma Unit)

> Dr Z is on duty, he asks a patient from Bonteheuwel why he came here rather than Heideveld which would have been "his" clinic . The man mumbles something about needing to get a taxi here - the taxi rank is right outside the CHC. (Field notes, Trauma Unit)

Black (African) people from the relatively nearby Phillipi "squatter" settlement, which falls within the district, are now also attending the clinic, although numbers remain relatively few. The occasional patient also comes from other black areas such as Gugulethu where health services are extremely poor. When questioned, these patients report that they were happy with the service offered by this clinic and had no complaints. With staff they were quiet, respectful and compliant. Despite my expectations, I observed no discriminatory practices or complaints about black patients using the clinic[26]. The lone (new) black sister and visiting student nurses were often called upon to translate, as language remains a big obstacle here.

Familiar boundaries of community space have been redrawn along the technocratic principle of health districts by townplanners and the health bureaucrats. These official representations of space tend to eclipse and challenge lived and historically constructed boundaries of space and race. It is no longer clear who belongs at the clinic or how geographic location may exclude people from attending the clinic[27].

Current primary health discourse is contradictory here as it stresses "community" ownership and participation of its facilities, yet it bases its management on socially unintelligible "districts". This confusion between ownership, community and belonging is graphically illustrated in the ongoing contestation around care and responsibility of the clinic's spaces, and ultimately ambiguity regarding identity and outsider status,

> It is actually their hospital, for them in their community, but they are not worried about the hospital...This hospital caters for, not just Hanover Park, but for all areas' people. So we can't just say that it's Hanover Park's people, cos there's quite decent people in Hanover Park...we can't say that it's Hanover Parks's people that mess..its just the people that is in the hospital (Mr. C, General Assistant).

5.5 Strategies of differentiation and rituals of belonging

The staff at the Hanover Park Community Health service are resourceful and creative strategists. Multiple physical and symbolic means have, and are, being used by staff to manage the loss of integrity (both spatial and moral) of their clinic. This section will describe (and re-interpret) some of these boundary making and reinforcing strategies.

5.5.1 Rituals of community and cleansing

a) The Praying circle

> 8.00am.Sr D asked the reception to announce a full staff meeting in the treatment room. On entering the room we found a group of about 6 to 8 staff standing in a circle in the middle of the room singing Christian choruses. They looked up as we entered, unperturbed, finally ending off with a prayer while they held hands in a circle, there heads bowed. All the staff were nurses and some GA's were present. Mr M later told me that *the staff tried to meet like this almost every day* (from about 7.45am) and that the group always met in treatment room with full support from the authorities. He said the group provided a support, especially with the amount of stress that the staff were currently experiencing.

The clinic space is multiply inscribed and layered in meaning. Staff daily seek, via group religious rituals, to frame their day and work space with positive spiritual and social meaning. The dominant and official biomedical space is the space of functional efficiency and official roles and ideologies. It is clear, however, that at times of crisis alternative (positive) meanings are invoked through group spatial and discursive practises by which the official meaning of clinic space is openly re-interpreted, albeit temporarily.

Such practices, one may argue, assist the staff at this time, precisely because of the multi-ordered carrying capacity of lived social space. Quite literally, by "sacredising" (Chidester, 1994) the clinic

space, staff seek to realign and reinforce ontological boundaries differentiating this place from the moral and physical chaos "outside". It is tempting to interpret this as an (unconscious) magical device to keep the "*nonsense*" and "*fear*" at bay, while it is also apparent that strong social bonds are daily reinforced and re-enacted, supplying group and moral certainty and cohesion.

Lefebvre (1991) wrote of the development of counterspaces which will be explored in more detail within the next chapter. These spaces occur simultaneously with dominant spatial forms and challenge and resist their official meanings and practices. The Prayer Circle is *not* such a space. It functions as a temporal (spiritual) enclave which, it may be argued, empowers staff to fulfill their dominant biomedical function.

b) Looking after the building, cleaning up the mess

> The clinic is notably relatively clean, sunny and well cared for. The typical clinic smell of urine and disinfectant assailed me as I entered, but the floor gleamed and carefully written names and posters adorned the walls and door (Initial impressions, Field notes).

Biomedical spaces are paradoxical in status as they represent the symbolic power of biomedicine, and yet must admit and contain the low-status polluted matter, the dirt, of sick bodies (cf. Weiss, 1993). I observed staff deal with punctured, bleeding, dirty and urinating bodies as part of their mundane daily routine. General assistants are more intimate with such dirt, and describe with pride regimental cleaning routines as they "*look after the building*"(Mrs P, GA).

The general assistants have also got a less heroic narrative than the clinical staff regarding their experience of "*abuse*" at the clinic. They speak of their current frustration and the conflict with (waiting) patients, who litter and mess in the public areas and refuse to comply with their requests to use the rubbish bins,

> ..Now the people mess a lot, a lot, lady. There are rubbish bins there..they mess a lot, and then a person must speak to them, they say, this is our work [to clean up]. It's unnecessary. I say to them. 'This is your hospital, you must take care of the hospital (Mrs C, General Assistant, *translated interview*)[28]

For the GA"s the "*onbeskofheid*" (rudeness) of patients, is expressed through the "messing" of the patients, especially from children and fear of confronting their unrestraining mothers, who "*are not worried about the hospital*" (Mr C, G.A.).

General assistants[29] are that category of staff most vulnerable at the interface between staff and the public[30], or more particularly the mess of patients[31] and the dirt from the outside. This mixed allegiance

is also reflected in the accounts I received from general assistants which were critical of "the community" and also the staff. At this clinic GA's also assist in many duties usually attributed to nursing assistants, yet they do not receive the respect from the community usually attributed to medical status. They are the staff that clean up the blood and dirty bandages on the floors, or deal with the staff and patients' mess and toilets. Hart (1991) describes some of the individual strategies used by general assistants to cope with this potentially polluting, low status work. These include strong group identity and doing "more than cleaning" (p.100).

The Hanover Park general cleaners take great pride in their work, and value and exercise their membership of the clinic staff body. Cleaning routines in the clinic are fixed and regular, and daily purify and care for the surfaces of the clinic. Currently this routine is being challenged, however, by the long hours that waiting spaces are in use, and their "*messy*" overcrowding, which leaves little time for staff to do their job. Yet despite this overcrowding, the clinic appears relatively clean and well cared for. Jensen and Turner (1996) writing on the strategies used by coloured people in Heideveld to cope with racial stereotypes of coloured identity and the chaos and violence of the streets, describe "respectable" strategies adopted by some homes[32],

> ..households..who had managed to maintain an extreme degree of order and cleanliness inside their homes, made us aware of its powerfulness as a strategy to cope in a seemingly decaying society (p.121).

Such strategies or rituals of order and cleaning are daily undertaken by the staff as they take care of the building. These strategies do not seem to be simply about their own anxiety and proximity to dirt and contamination in the clinic, but also the outcome of a group responsibility to care and clean the clinic. GA's explicitly contrast the dirt of 'the outside", patients homes and streets with the "*clean*" space inside. Thus, keeping the clinic clean is not just about biomedical sanitary practices, but one of the ways that chaos and disorder is kept outside. It seeks to differentiate space and draw boundaries around the (more) pure, "respectable" space. Cleaning is therefore a key component in the "sacredization" or differentiation of the clinic space. It is an ongoing project that can be seen as the result of the "labour of ritual..involving the hard work of attention, design, construction and control of place" (Chidester, 1994, p.212).

5.5.2 Encoded entrances and categorical anxiety

a) Clinic entrances and gates

> In spatial terms the sacred could only be localised by becoming a `position', a significant, valued, and even liberated place carved out from the vast extension of space. A sacred place was a position in which power and the effects of power were repeated Chidester (1994, p.214).

In the previous chapter I described the anomalous clinic entrances and the changes and modifications made to doors and entrances within the clinic. The ongoing modification of these structures signals that doors are potent sites of crisis and renegotiation.

Anthropologists have examined the significance and functioning of apertures such as doors in the sites and settings of research (e.g. Moore 1996). Doors are seen as profoundly significant sites of transition and transformation where key cultural values and meanings are most vulnerable and need to be negotiated in the movement *between* differently coded (or signified) inside/outside areas. Henrietta Moore would argue, that by understanding or interpreting what is at stake at these junctions (in the informants worldview), the grounding of ontological meanings of a culture may be accessed (*Ibid*), and a means of their production (and reproduction) observed.

But doors and entrances are not just a valuable research focus, they are also the current obsession and project of the staff. For the clinic design or building is not static and has been physically modified in line with social practices (Moore, 1996).

> **The Doors that never close.**
> It is about 10.00 p.m. The Trauma Unit is quiet, En. M is telling me about the poor security in the CHC. Apparently, "the other day three men burst into the common room while all the staff were asleep" (the doctor sleeps in a private room). Security were asleep, they had "locked themselves into their room. If they had been *skollies* [ruffians] we would all be dead!"[33] I ask her about doors kept locked and unlocked at night. The staff entrance door is never locked and indeed has no lock[34], she tells me. I show some incredulity and she offers to show me. We go down the staff corridor and sure enough there is a door opening onto the staff parking lot (which is fenced off) which is unlocked, and indeed has no lock. Mrs M is delighted by my surprise. At 2.00 am she asks me again, "Do I want to come and see that the door is unlocked still?" I laugh and tell her its okay, I believe her (Field notes, Trauma Unit).

Doors in the clinic have become powerful symbols and practical sites of contestation. The unlockable door is an apt metaphor for this clinic. Like the thin walls which allowed the gangster's bullet to penetrate the Doctor-in-charge's body[35], open doors make the boundaries of the clinic too penetrable. The clinic never closes, it has no lock, and it cannot sufficiently exclude people. It is an unsafe place into which people "*burst in*". Staff say they don't feel safe in the clinic, one sister commented, and that "*the building is our biggest fear*". It is a space of multiple unpredictable interfaces and encounters with the "outside", and unequal degrees of security within.

Staff at the clinic have built a seeming profusion of physical doors and barriers to manage the entry of patients into the clinic. The clinic may be read as attempting to maintain and reinforce physical

boundaries *which have symbolic and not merely functional significance*. This spatio-symbolic relationship is clearly mutually constitutive, as physical barriers and control help preserve place, yet such barriers are also profoundly emeshed in individual and group anxieties regarding invasion and contamination. Such barriers facilitate social practise which limits and police potentially dangerous, messy and disruptive strangers from entering the clinic.

Physical and symbolic boundaries are therefore potentially porous and precarious, and there is always the risk that what is being kept separate or outside may leak within and contaminate. The doors of the clinic, like the entry and exit point of the body, are perilous liminal sites between inside and out[36]. These places and their activities therefore need to be closely guarded and regulated to avoid contamination and assimilation[37]. Space is therefore "an integral part of the outsider problem" Silby in Pile, 1996, p.89). Yet, as I have described, the line between insider and outsider, interior and exterior, are by no means clear within the clinic.

Young (1989) also explores the manner in which clinical barriers are used to separate the "realms" of the "ordinary" and the "medical". This interface asserts itself *within* the exterior boundaries of the clinic, as this realm of the "ordinary" tends to be re-invoked by the "network of public spaces and connecting pathways" (p.47). She describes the spatial strategies used at these margins, especially when boundary traffic is inevitable or indeed required, where "crossover points are narrowed, partially obstructed, concealed or sealed" (p.47). These are also deployed at points where open boundaries require guardians, such as receptionists, where spaces require caution and monitoring.

> For outsiders, passages between realms is slowed, obstructed, deflected, or sequentized partly *in order to provide interstices in which to accommodate transformations* (Young, 1989, p.47, my emphasis).

The doctors' doors are one set of entrances which mediate access into the inner sanctum of biomedical space, the doctor's consulting room. It is here that some of these anxieties have receive the greatest attention in actual (original) clinic design. I have described these doors as a mechanism of extraction, although it is clear that this may function more successfully at the level of the symbolic, where their significance has its origins. Thus, these spaces may be seen as sites of transformation (Young, 1989), as "persons are not turned into patients, rather they undergo a series of transformations in the course of which they become patients" (p.48).

In this regard I am reminded of Van Gennep's (1960) observation regarding cultural rites of passages. He noted that rituals that occur at moments of social and ontological change are separated into three stages: separation, liminality and reincoperation. Holohan (1977), and others have related these phases to the modern biomedical encounter, and the transition to becoming a patient and ritualised healing

(Fairhurst, 1977). Such steps are also suggested in the spatial passage of the clinic's patient through the doctor's doors. We return again to the layers of symbolic meaning and process beneath the rational functioning of this biomedical space.

CHAPTER SIX

UNORTHODOX SPATIAL STRATEGIES I

> Space provides a key to grasping the essential changes in the possibilities for agency, and the key fields where social intervention is called for (Shields, 1997, p.198).

> Space therefore imposes constraints on agents who occupy it and, at the same time, agents are engaged in inhabiting, transforming and giving meaning to spaces in surprising ways (Hendersen, 1993, p.3).

6.1 Control, escape and appropriation

There is a lot of ground to cover in this section. The objective is to describe ways in which the clinic staff, and to a lesser extent, patients, use space in unofficial and unorthodox but, creative, resourceful ways in order to survive in their pressured and dangerous working and living environment. I have described the forms of biomedical, disciplining power inherent in the spatiality of the clinic and the (orthodox) spatial strategies, such as the modern security features, used to amplify and protect these mechanisms. This chapter shall describe some of the more covert, and potentially more innovative means by which staff and patients used space as a strategic resource to acquire power and authority.

The tension between structure and agency has been a central problematic in the social sciences (Giddens, 1984). The spaces of the clinic structure (and are structured) by certain types of relationships (Lefebvre, 1991), yet the inhabitants are also observed to be able to use spatial form and symbolic meanings as resources to manage their context in surprising ways (Moore, 1996).

In Chapter Five I began to describe Lefebvre's (1991) representational space (or spaces of representation) as a realm of passion, irrationality and symbolism. I have used this space here to refer to the "other" of disciplined space[1]. such,

> Representational spaces are dominated spaces and the spatial practices which produce them are defined by an absence of [dominant] power (Allen and Pryke, 1996, p.187).

Hence, these forms of power are potentially *illegal* and subversive to the dominant order and are not related to disciplining forms of modern governance already discussed. This capacity to resist and act as agents attests to the inability of any form of power to completely and consistently construct reality, which is multiple, unpredictable, contested and contradictory (Laclau, 1990). Inherent in this discussion is an ontology which consists of simultaneous, multiple forms of space which are invoked and utilised in strategic and fluid ways as the situation demands.

Chapter Six and Seven will therefore explore the more unorthodox means by which space is used by staff to cope in the difficult context that the clinic has become. Spatial strategies are thus used by staff precisely as the "problems" of the clinic have an inherent spatial component and provide spatial forms and relationships which become resources for agentic choices. It will also become clear that those choices are limited, not always entirely successful, and may yet indeed challenge the underlying spatial and moral logic by which the clinic is constructed. Chapter Six will examine the manner by which space is controlled and vacated. Chapter Seven will examine these strategies within the context of the Trauma Unit.

6.2 Controlling mobility and making chaos

The daily management of space within the clinic is the responsibility of the sister-in-charge. She allocates nursing staff to set activity areas and polices activities and flows to these sites. The sister-in-charge is also instrumental in managing the spaces in which the non-permanent (and sometimes permanent) doctors hold their consultations (e.g. visiting Paediatric doctors or other specialists). Usage areas within the clinic may therefore be unfixed, especially with the advent of comprehensive services requiring the frequent accommodation of different specialist staff. This constant instability and flux is described as confusing to some staff. This is a general assistants account,

F. This is supposed to be the common room, men's there, but now they can use what ever. Its not like this is the doctors room, today the doctor sitting here, tomorrow the doctors sitting over there. It's not like a fixed thing - I can get Doctor I in Number 2, tomorrow he's in room Number 5 again.
L: You mean when he sees patients?
F: Yes, *even the doctors are confused,* they don't know where they must go...*they must first go and consult, ask the sister..*
L: But why does everyone move around so much?
F: Its because they are unorganised obviously.

Svesson (1996) describes the strategies adopted by nursing staff within clinical settings to gain respect and power within the biomedical arena and the hierarchical doctor-nurse relationship. He describes how nurses utilise "temporary and situational circumstances which can strengthen [their] influence" (p.430). This occurs particularly at times of "uncertainty and disunity" (*Ibid.*). He notes that nurses act as a cohesive force within the hospital ward, providing continuity and "defining the rules of interaction" (p.432). As in the clinic, nurses are instrumental in controlling work for different categories of staff including doctors. He proposes that nurses often use this as an arena of resistance and power in order to cope with their exposed and insubordinate position within the hospital. For, as I have described, "The nurse often experiences this 'shock-absorber' function as very frustrating, and it evidently encourages them to challenge the doctor" (*Ibid.*).

> By regarding the social order on the ward as a negotiated order, attention is directed towards the process which contributes to preserving and recreating that order. It is also focused on the participants' active role in those processes. (Svesson, 1996, p.433)

The management of mobility and place utilisation within the clinic is clearly an ongoing act of power and authority. The general assistants experience when trying to relocate patients in order to clean attest daily to this. The ability to control movement and spatial allocation within the clinic is clearly an act of power. The "*unorganised*" spatial allocation of doctors within the clinic, may be read as a means by which the sister governs the space of the clinic, through an assertion of power over mobility - in this case the doctors'. However, this strategy cannot be completely successful given the Sister-in-charges unhappiness and dissatisfaction with the manner in which the clinic is run and her role within it - she simply feels like "*a policeman*" and dreams of leaving the clinic.

Spatial and organisational uncertainty may upset traditional hierarchies, but its outcome, authority invested the capacity to control space is problematic in this place. The Sister-in-Charge's co-ordinating position within the clinic is a highly contradictory one. Her controlling power is relative to the value placed upon appropriating or owning the clinic space. Furthermore, a preoccupation with spatial control and security has little status in the clinical lexicon of biomedicine. *The meaning and value of spatial control is contingent upon that of the space controlled.* The clinic is not a place one wants to govern or control. The clinic is a place to leave.

6.3 Leaving the clinic

Humanist theorists have emphasised the positive attachments to place as a form of belonging, status and material resource (Kearns and Gesler, 1998). This perspective fails to take into account that spaces can be negative places from which one seeks to detach and vacate.

6.3.1 The escape route

Ask any staff member what alterations or changes should occur in the clinic, and they generally come up with the same suggestion -the need to construct an "*escape route*" for the staff working at night in the Trauma Unit. The logic here is to avoid a situation where staff are trapped inside while the single entrance is blocked by threatening "*gangsters*"[2]. The clinic is depicted by these staff as a trap, where multiple enclosures prevent opportunities to escape and increase the risk of being trapped with the dangers *within*. The space of the clinic is no longer a haven or sanctuary, and safety resides in escaping outside.

6.3.2 Taking the package

Between December 1996 and the beginning of October 1997, eleven staff (out of thirty) left the clinic. These were senior and experienced professional nurses, as well as a few Enrolled nurses and Nursing

Assistants. Most staff "take the package"[3]. One professional nurse was employed to replace her. The previous Sister-in-charge left in May 1997, she "*had had enough of the place..her hair started to fall out because of the stress..she was alcoholic*" (Sister-in-charge interview). According to the sister-in-charge, twelve of the original thirty staff remain at the clinic, one of whom is on study leave bringing the figure down to eleven. "*Most people who are leaving now are stressed, they are carrying the load of three people*" (SIC). The SIC describes herself as "*not staying long*" and hopes to get transferred to another CHC. Subsequent discussions with the Sister-in-Charge indicate that she has managed to leave, and that two staff members have also left, due to a psychiatric breakdown and death.

There is a great deal of talk in the clinic among the staff and some of the most respected general assistants about leaving the clinic. The desire to leave is a refrain to most biographies offered by the staff.

Case 1
Mrs Y (General assistant) has been working in the clinic since its inception. She is woman of few words, but is a powerful and influential member of the staff. She is the only staff member that actually lives in Hanover Park. She has been described by other staff as one of the most dedicated members who assists with all kinds of non-domestic tasks. She describes the community as "rude", the clinic as a "family", but also speaks longingly about leaving.

Case 2
I first met Sr X in the Trauma unit, she is a young attractive woman in her mid-thirties, although she often looks tired and drawn. She said that she "hated" working in Trauma, and has refused to do Night Duty here after being physically threatened by an "threatening" weapon-wielding man, "a gangster", in September 1995. She says that she was "traumatised" by this experience, and described PTSD symptoms[4]. She says she still gets palpitations when she is reminded of the experience, she describes the Unit as "a hell", a "dreadful place", especially on weekends. She wants to leave, and speaks longingly of either being transferred (as she has requested) to a quieter clinic without a 24 hour service. She wishes she could leave the service completely, but cannot for financial reasons.

In the current mythology and value system of the clinic, to be empowered is to leave, to stay is to face the possibility physical, moral and mental collapse. Few staff therefore speak of wanting to be in the clinic, although this was not always the case. Leaving the clinic, especially for the nurses and general assistants who have taken or are contemplating taking the package, is also a subversive and challenging act. The gendered identity of nurses is, like women, one of caring, sacrifice and subordination (J. Littlewood, 1991).

Talk of leaving can take a slightly different angle, thus suggesting that those who remain are clinically deficient

> Dr. K. is on duty. He is a Family Medicine registrar, he has to work in the PHC clinics on night duty. He hates this clinic work and is angry about the clinical services offered..."This is not primary care" he says, "this is not patient care". He "can't last here longer then a year", he will start to accept this poor service. He suggests that doctors who "stay longer can't care". "Nobody wants to work in the Day Hospitals anymore, only the old ones [who can't get work elsewhere]". ..He says the longest period any doctor has worked at Elsies River CHC is eighteen months. (Field notes, Trauma Unit).

In this discourse, mostly observed among the doctors, the public health service in general, and PHC clinics in particular, have become sites of degenerative medicine. A good clinician thus, demonstrates this by distancing him/herself from them.

6.3.3 Illegal absence

Lunch times are also sometimes fraught with controversy among the staff, as some doctors will leave the premises to go home, and are not available to deal with medical emergencies. Other doctors may therefore be called away from their patients or lunch should such patients arrive [5]. Nursing staff in the Nurses Room would complain of this over lunch, although as the guilty included the Doctor-in-Charge, it was felt that they were quite powerless to change the situation.

Doctors therefore have a greater mobility and leave the clinic whenever they can during the day. Mobility is due to practical features such as cars, but more generally their job gives them greater autonomy, less peer surveillance and a status within the clinic which makes censure near impossible. However, other readings have suggested that such absences, whether they come in the form of late arrivals, early departure, or errant lunch-times, are means by which doctors perform their power and status (Lupton, 1994). This performance is particularly significant here as the capacity to escape the clinic is so symbolically loaded.

6.3.4 Private withdrawal

As I noted earlier, doctors have more private spaces in the clinic. They can eat and sleep in the designated Doctor's tea-room, without any apparent complaint or challenge form the other staff[6]. All medical consultation, bar the Trauma Unit, occurs in private Doctor's or Examining rooms. This privacy not only isolates doctors from large groups of (potentially disruptive) patients, but allows them to be unobserved when not seeing patients. Unlike nursing staff who are always visible and expected to assist in other areas when they are less busy, doctors may withdraw behind closed doors,

> Dr. X. admits that he has no particular commitment to PHC philosophy but enjoys working at the clinic as has space to himself. He sees himself as quite isolated among the staff and doesn't socialise much with them. He spends some tea times among them, but generally eats lunch alone and reads in the Doctors' room. He sees 35 to 40 patient a day[7], and say he is not pressurised here - this gives him time to do what he enjoys - and he points to the novels that are placed next to him on the desk. (Doctor interviews)

All categories of staff withdraw from patients at certain times of the day (e.g. lunch and tea times), patients feel this absence most keenly over weekends.

> Lunchtime (2.30pm)
> Staff leave the waiting patients and ambulance people with nobody to supervise them. There are no relief staff and the unit is closed for half an hour. The nursing staff sit in the staff room, the (visiting) doctor disappears. (Trauma Unit, Saturday afternoon).

Doctors utilise their professional power to escape as often and as much as possible from the clinic. Part of the doctors' power, as opposed to the more spatially grounded nurses and general assistants, is their *more fluid relationship to the devalued clinic space*. They come and go, and play little part in caring for, defending or occupying the clinic. Mobility and disinvestment are protective devices in this environment, yet as a strategy are not equally available to all staff. Thus, attachment and groundedness to the physical place of this biomedical and geographic periphery acts dialectically to construct disempowered places and identities.

The clinic is a place to leave. It has seen a slow evacuation of power and status, so that spatial absence and personal disengagement are the envied measure of power within. Writing on what makes a place different, or sacred, Chidester (1994) notes that the "symbols of power which reside *within*" create positive social value and meaning (p.219, my emphasis). For the clinic staff, such symbolism has shifted to the outside, that is outside Hanover Park or the primary health care system. This evacuation of presence is accompanied by a chronic and persistent process of devaluation - the clinic is little more than dirt or "a fear" (Sr. X) from which one hopes to escape.

6.4 Appropriating and subverting spaces

> The most effectively appropriated spaces are those that make symbolic use of what is around them and turn it to their advantage, either by subverting the codes of dominant space or by representing an alternative form of social space alongside them (Allen and Pryke, 1996, p.191-192)

Control of spaces either through direct acts of appropriation or other unorthodox social practices (Moore, 1996) has been discussed as a means by which power is taken up or subverted. Nursing and General assistants have carved out private and alternative spaces for themselves within the clinic. These spaces may be physically separate or occur simultaneously in one place, evoked by alternative routines, or ritualised practices. Furthermore, patients and staff within the clinic interact in the ambiguous public spaces of the clinic, such as the waiting areas and corridors which appear at times to

be a continuation of, or an appropriation by, the unruly street rather than a clinical space (cf. Harries, 1996).

Following Lefebvre (1991), these practises may be seen to undermine and challenge the representational mode of power generated by biomedical spaces. The spatial order of modern biomedicine contains contradictions which allow for the development of local autonomy and counter spaces. In the following section I will examine and seek to understand some of the appropriated spaces within the non-clinical spaces of the clinic.

6.5 Patient strategies: re-interpreting and colonising public spaces

I have to date focused little on the strategies utilised by patients in response to the hierarchies and lack of resources within the clinic. Only two aspects will be discussed here, both of which seek to understand the conflict between staff and patient within the public spaces of the clinic.

6.5.1 Colonising the public spaces

Harries' (1995) in her study on Hout Bay CHC observes the "informalising" and "fading and restructuring of institutionalised borders" (p.67) within the public spaces of the clinic. She describes the "refashioning of formal institutional space into community space", a space of "softened institutionalised borders, as space of familiarity, family, comfort and home" (*Ibid*, p.91). Although Harrie's community "pandemonium" or "carnival" is more benign that the alienated conflict and abuse within the Hanover Park CHC, it points to a similar dynamic by which the public "colonises" the internal (public) spaces of the clinic.

6.5.2 Filling up the absences

In describing how clinical space functions, Foucault (in Gordon, 1980) stressed the role of "the uninterrupted presence and hierarchical prerogatives of doctors" (p.287). This presence is linked to surveillance technologies, although as Chidester (1994) suggests, it has symbolic power within biomedical symbolism. The hierarchical prerogative of the clinic is currently, however, *absence rather than presence*. This evacuation has also a clear spatial trajectory, from inside out. This inverted direction makes better sense when described in Lefebvre's (1991) terms, that is from periphery to centre.

In practical terms this evacuation started from the public areas of the clinic. Clinical staff such as nursing assistants who were involved in managing the external relations and organisation of public spaces, have been replaced by doors and (non-clinical) security guards. Doctors have withdrawn into private or domestic spaces and nursing staff, as they rush from one instrumental encounter to another, have little time for relational interactions with patients. Sheer staff losses have reduced the mediating or

Figure 6.1. Patients spending time in the CHC

Figure 6.2. Locals pose for the camera as they eat lunch outside the CHC main gate.

bridging capacity of nursing staff within this space (Littlewood J., 1991). This role cannot be replaced by security guards and gates.

Corridors and waiting rooms have always had an ambiguous status within biomedicine (Young 1989). The public areas of the clinic are only meant to be activity areas for the domestic cleaning staff. These spaces do not officially inhabit the topographic landscape of clinical practice. This absence of clinical meaning was clearly demonstrated in a cognitive map of the clinic drawn by one of the nursing sisters. All spaces, except the corridors and waiting areas, were ascribed functional names, such as "Injections" and "Preparation". The corridors were left blank and undesignated. They are not included in the nurse's official practices and hence have little meaning within the official biomedical lexicon that she employed.

The meaning of these spaces are therefore fluid and especially vulnerable to community appropriation and re-interpretation (Harries, 1996), especially in the absence of visible signs and signifiers of the biomedical realm. As staff workloads increase, patients occupy these waiting areas for longer periods, such that waiting has become the predominant biomedical experience. These waiting spaces are institutional and austere and make minimal reference to traditional notions of the domestic[8] or biomedical realms. They are however reminiscent of the barrack like modernist barrenness of the Hanover Park landscape (cf. U.P.R.U., 1981), and thus are no anomaly to the state orchestrated apartheid landscape. Indeed, it may also be argued that this space, resembles the interior of a "*prison*" or police station, indeed many new revealing interpretations may be given to this biomedical void.

> Spaces and surfaces should be filled because, if everywhere in the environment there is a sign, the absence of sign becomes a sign of absence... inevitably inviting a motion to fill the void (Goss, 1996, p.216).

Absence has created ontological and semantic voids in the clinic. This is most keenly felt in public spaces, the first point of withdrawal of limited clinical staff defending their medical posts. Waiting patients (and staff) are filling this void with meanings, expectations and behaviours that contradict the formal representation of this in abstract space. The waiting areas are the prime sites of mundane abuse and antagonisms between staff and the waiting public or patients - behaviour that is seldom demonstrated within the clinical areas of the clinic.

The abstract space of the clinic is culturally encoded with acceptable behaviours and social exchanges inherent in the patient-staff relationship (cf. Lefebvre, 1991). It may be argued that within this de-signified space, biomedical identities and hierarchies are never fully accomplished and actively eroded. Waiting areas have become empty, liminal spaces which provide little reference to the biomedical frame and as such provide little prohibition or support for the expressions of frustration (and abandonment) that are easily evoked in patients and staff alike. Visible signs of state power, such as

guards, gates and impersonal bureaucracy also provide a script for resistance practices which point to the new forms of non-biomedical power that are manifest in these evacuated places. Pinnock (1984) wrote of similar appropriations and re-interpretations by gangs of the urban wastelands of the Cape Flats. He observed that these public voids became spaces creatively occupied and terrorised by gangs.

6.6 Staff strategies of appropriation

Examples of spaces appropriated by staff include the Sister-in-charge's "illegal office" in the storeroom. This space has been illegally acquired, but the function and identity of the space does not directly challenge the dominant biomedical order.

6.6.1 The Love and Gossip room

Professional, gender, labour and racial hierarchies are inscribed upon the original plan of the clinic. Hierarchies and clear clinical/non-clinical divides are an integral aspect of clinical social structure and management (Hart, 1991).

These hierarchies have been challenged in the spatial heterogeneity of the clinic tea-rooms. Besides the three professionally designated tea-rooms, the staff have taken over the kitchen store and produced a new tea-room where all boundaries between clinical and non-clinical staff have collapsed.

> Mrs P: And then you get the ladies, general assistants, ladies tea-room, here next door, but we can't find us there because we all come together, they all sit together....
> F: ....That they call the gossip room. (G.A. Interview)

This "Love" or "Gossip" room is constructed by the staff themselves as something alternative and slightly subversive. Professional nurses and general assistants sit here in a haze of smoke talking sedaciously. The space is small and the scale intimate. The chairs do not stretch in a line across the wall like the adjacent official tearoom, but huddle together amidst doilies, magazines and potplants invoking the chaotic domestic world outside. This is an alternative space where all grades of staff get mixed up, escape the clinical world outside and put their feet up on the furniture. This room appears on no plans of the clinic, yet it is the private heart of the clinic for many of the nursing and domestic staff. Membership here does not seem fixed, although I never observed authority figures either enter or challenge the room's presence in any way.

The "Love room" was the one space in the clinic I felt unwelcome. It was clearly staff's private space and any hierarchies or status my professional or researcher role may have given me were not valid here - I was intruding. This space thus functions as a subversive "free space" (Goffman, 1961, in Harries, 1996) in which the official hierarchies and culture of the clinic is subverted – or is it?

6.7 Counter spaces within the clinic

Counter spaces, according to Lefebvre (1991) "represent in a specific way a rejection of all that is signified by a particular dominant space" (Allen and Pryke, 1996, p.192). Counter spaces must therefore challenge the dominant order of the clinic. Is this the case with the appropriated spaces discussed?

The Gossip room is allowed to exist in the clinic precisely because it acts as a functional component in its relational and leisure needs. The role diffusion demonstrated here, and relatively unique to the clinic, is an important component of service efficiency, as an examination of the functioning of the Trauma Unit will describe. Such a domesticated space acts as a counterpoint for the much sought after biomedical order within. This biomedical blindspot is a site of disorder which enables the order within, that is it creates a safe spatial pocket of subversion which lies outside the official biomedical spaces. In this sense, the private domestic and social worlds of the clinic staff (Spaces of representation or representational spaces) is allowed to assert itself here creating enclaves of home to which lower status staff may "escape". It is a controlled and limited escape route within the temporal (lunch and teatimes) and the physical confines of the clinic. The same may be said of the Prayer Circle and the general assistants "domestic" cleansing rituals. These practices therefore enable rather than challenge, the dominant biomedical order. In this sense, like the SIC's office, these do not act as a "true counterspace". The necessity of evoking domestic and religious spaces (the home and the sacred) within the clinic space points to the manner in which the supposedly rational discourse of biomedicine requires the legitimacy and affective resources from the non-clinical world of familial relationships, home and the sacred. Furthermore, the invocation of these spaces is used by staff and patients alike to give meaning and provide resources to cope with this clinical reality.

The "colonisation" of the public spaces of the clinic is a source of stress and conflict for staff and patients alike. Staff and patients must share these unruly spaces, and relationships have begun to mirror the multiple forms of abuse and violence which directly challenge the caring, reciprocal and hierarchical ethos of a biomedical space. These public spaces and their adjacent clinical areas, such as the Preparation and Dispensary areas, are problematic counterspaces in which the failures of the dominant biomedical self-representation are most apparent.

Harries (1995) presents this as an unproblematic act of subversive "resistance and contestation" (p.76), on the part of local patients, and to a lesser extent staff. This allows her to set up a dichotomy between "formal official [biomedical] space versus community space" (*Ibid.*). Again, however, it would appear that this "subversion" is based upon an inaccurate spatial premise. We must question the apparent

subversive nature of the challenge to the boundaries between official biomedical space and "home" and family". Armstrong (1993, 1995), as noted, observed that surveillance medicine seeks to blur the boundaries between home and clinic, thus extending the modern gaze of the state into the heart of "the community". Thus, the "colonisation" or appropriation of biomedical space implies a blurring of the boundaries between public and biomedical spaces, and hence the greater medicalisation and surveillance of public space. The question that needs to be asked here therefore, is why the state health authorities in general, and the clinic in particular, have failed to sufficiently "medicalise" the community, and extend the ambit of the health service into the community and household spaces. The same question is evoked by the flood of "mothers and children" who allegedly clog up these public spaces. These mothers are an all to visible proof of the communities apparent failure to adequately absorb the full lessons of curative care (e.g. self medication and treatment), while it may be argued they have been apt pupils in the medicalisation of their children's ailments.

Thus far I have largely discussed ungovernable *public* spaces. Chapter Seven will examine the counterspaces that co-exist within the clinical areas, namely the Trauma Unit. It will emerge here that counter spaces are necessary in the construction of the extra-ordinary biomedical space and the spatial strategies that it facilitates.

CHAPTER SEVEN

UNORTHODOX SPATIAL STRATEGIES II

> Nothing disappears completely..nor can what subsists be defined solely in terms of traces, memory or relics. In space, what came earlier continues to underpin what follows. The preconditions of social space have their own particular way of enduring and remaining actual within that space (Lefebvre, 1991, p.227).

> The body of the condemned man [provides] the anchoring point for the manifestation of power, an opportunity of affirming the dysymmetry of forces (Foucault, 1977, p.55).

7.1 The Trauma Unit

This chapter continues the exploration into the unorthodox means that are used by staff and patients to manage the clinic context. The emphasis here shall be upon the use of these strategies within a clinical area, the Trauma Unit, as opposed to the public areas of the clinic. In this sense I am examining the manner by which these staff and patients cope at the direct interface between biomedical and public/community realms. The key concepts here are the manner by which these multiple spaces co-exist, and how they are evoked and utilised simultaneously in order to provide the roleplayers with strategies by which to attain and sustain power.

This chapter will demonstrate how "lived space" (Lefebvre, 1991) can be used as a "*strategic location*" (Soja, 1996, p.68) in the contested "field" of the clinic (cf. Bourdieu, 1977).

> Field is a space of antagonistic relations constantly changing, requiring of its agents habituses that are *fluid and contextual rather than fixed, atemporal, ideal and homogenous* ..The field is constituted by institutions, populated by agents who are constantly striving for "prize position". (Pizanias, 1996, p.651, also quoting Bourdieu, 1977, emphasis mine).

In the "field" of the clinic, and the Trauma Unit in particular, physical survival and the maintenance of biomedical status, quite literally depends upon ones capacity to creatively shift between spatially articulated social realms and their contingent strategies. Furthermore, these "realms" are not merely concurrent, but historically layered, such that pre-modern "sovereign" forms of state power are easily perceived and utilised within the overt modern, disciplining forms of governance within the clinic. Pre-modern forms of power, as Foucault (1977) pointed out, are enacted directly upon the body. These include entertaining and didactic displays of physical punishment for perpetrators of crime, in rituals of extraordinary cruelty, humiliation and death. Butchart (1995) has demonstrated how these pre-modern features were never far removed from the colonising and apartheid practices, including biomedical practices, of the more modern state. Such forms of power are barely submerged in all institutional

spaces, especially those historically linked to the medical care of the colonised, and the socially deviant or marginal (cf. Butchart, 1995).

Finally, my lived experience in the clinic points me to other pre-modern notions of ritual and healing which are evoked in moments of awe and humility, and defy the official dominant rationality of the place. For the clinic, as a biomedical institution, remains a site where the finitude and vulnerability of the human body underpins its logic (Foucault, 1976). Biomedicincal technology and care can save lives, and is a place where the immutable reality of disfigurement and death may be temporarily evaded – herein lies so much of its traditional power.

7.2 The Dangerous place

The Trauma unit is a special place within the clinic. It was initially designed as the Recovery Room for the never utilised surgical Theatre. It is now, in many ways the functional centre of the CHC. Open twenty-four hours a day, seven days a week, the Trauma Unit is a site of persistent biomedical presence in the community. It is thus the most open space in the clinic, the space most threatened with the illegality and violence of the outside.

The term "Trauma" is a bit of a misnomer as most of the patients seen at the Trauma unit are not emergency cases[1]. During the day the Trauma Unit functions largely as another doctors consultation unit. This is however a consultation space with a difference, as these details will describe.

7.2.1. Patient classification

Two types of patients are seen in the Trauma unit - those patients who arrive at the clinic without having an appointment[2], and those with emergency medical conditions – usually not serious enough to attend the nearby regional hospital. The use of this service by the community after hours and over weekends is a subject of much complaint as it is felt by staff that the public abuses these services in order to avoid the daily treatment queues. The Trauma Unit is also the place where complaints against "mothers" was most commonly heard (See Chapter 5). Thus the majority of patients here are fall into the clinic's category of the dubious or irresponsible sick.

In the mythology of the clinic, it is the real emergency patients that hold centre stage in this place. It is here that the public health service must respond to the frequent acts of violence (criminal and domestic) in the community (Bhagwanjee and Muckart, 1997, Stucky, 1998). Yet it was not the many women and children, victims of domestic violence (Jacobs, 1997) or motor vehicle accidents, who were observed to hold the centre stage - but the frequent male assault victims and their potentially dangerous, punctured bodies.

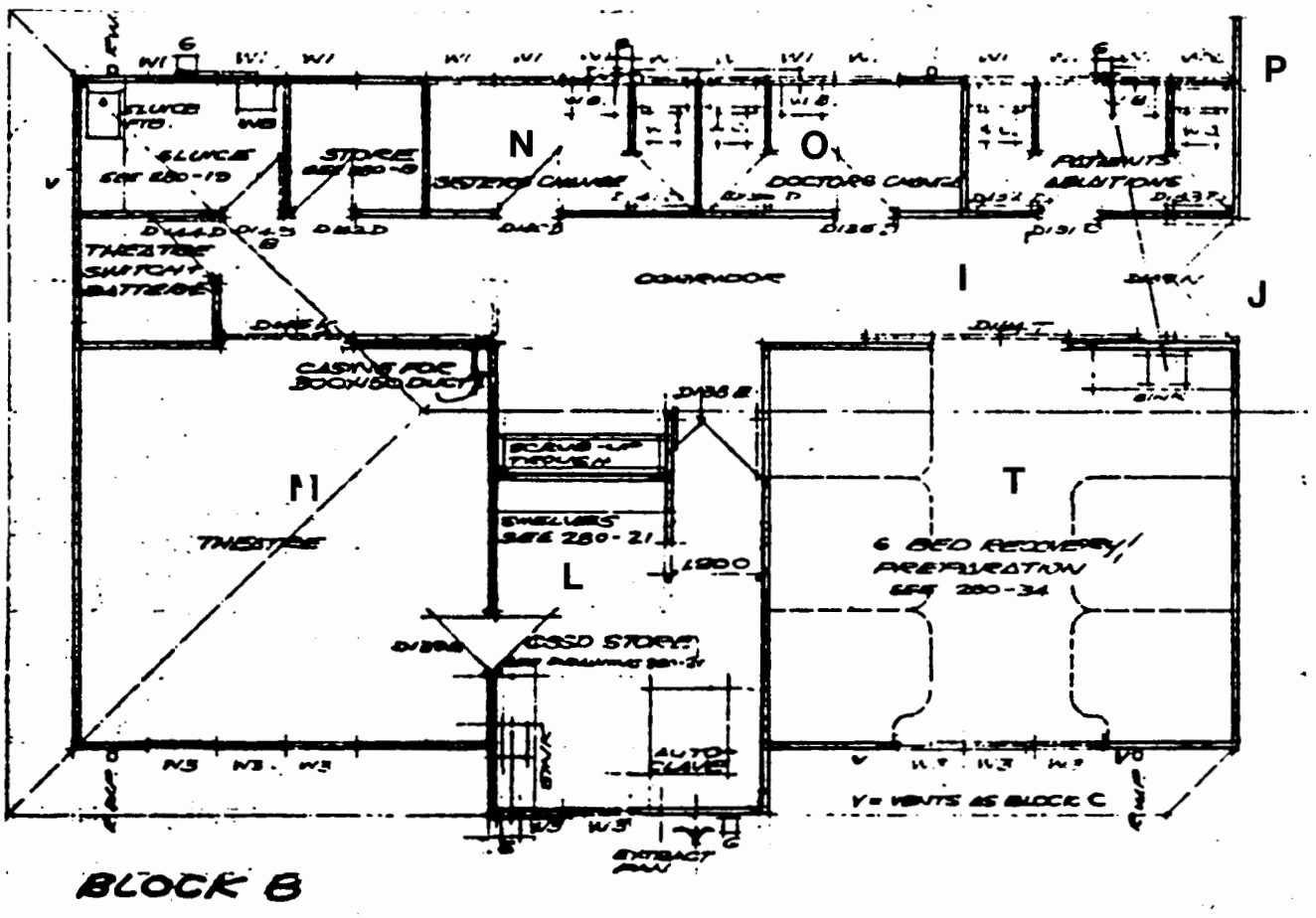


Figure 7.1: Plans for the Trauma Unit

Legend
Current usage areas (original design in brackets)

I	Corridor
J	Trauma Unit Waiting area (Corridor)
L.	Trauma Staff Room (Store)
M.	Nebulizing Room (Surgical Theater)
N.	Women's toilet (Sisters' Changeroom)
O.	Men's toilet (Doctor's Changeroom)
P.	Corridor to MOU
T.	Trauma treatment room (Recovery Room)

The Trauma Unit is therefore one of the sites where the state and the health service interact with crime, violence, deviance and illegality. Descriptions by the staff emphasise this as a site which must cater for the treatment of wounded gangsters, dangerous men, part of multiple violences and social problems that spill out of the streets beyond.

7.3 Unorthodox spaces

The Trauma unit is a remarkable biomedical treatment area. It functions as a more conventional out-patients clinic and a emergency or trauma unit. As a Trauma unit it is also anomolously placed at a primary care level, a largely Western Cape CHC phenomenon (Flisher *et al*, 1998). What is striking about the Trauma Unit are the variety of activities that occur simultaneously or at different times in the same, relatively small multi - purpose space. Not only are these spaces used in unorthodox ways, but clinical tasks are undertaken by unorthodox nursing and domestic staff (GA's), often with improvised materials.

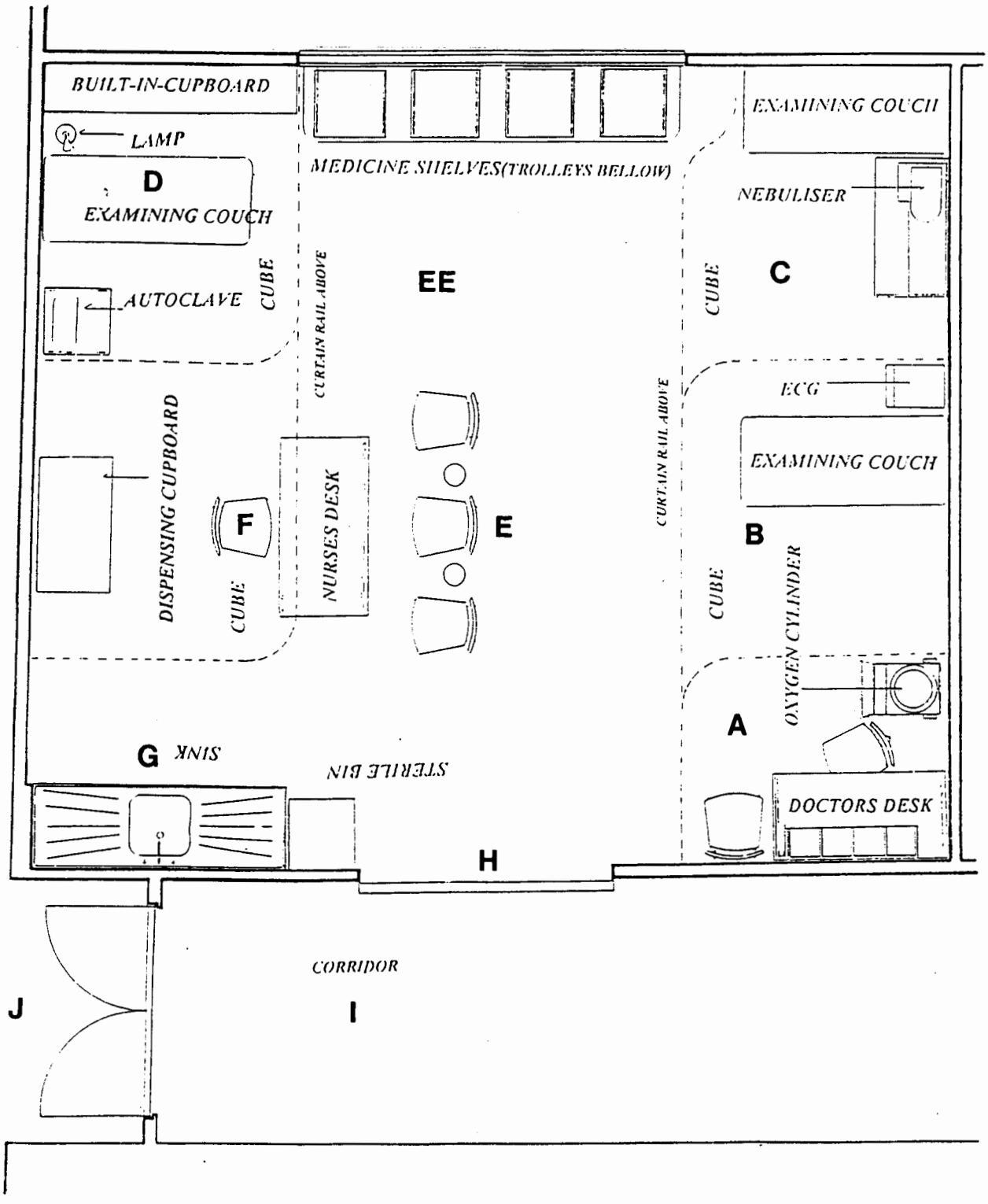
I spent more time in the Trauma Unit than any other. It was a place of constant action and (seemingly) fluid rules regarding access to clinical treatment spaces. This space has strong emotional and symbolic resonances with staff, who describe it as the most unsafe space in the hospital, and that never shuts, etching its constant accessibility onto the routines and adjoining spaces of the clinic.

7.3.1 Trauma space usage

Figure 7.2 depicts the plan of the Trauma Unit (main treatment area), while Figure 7.3 indicates how these spaces are physically used by staff and patients. Specific points have been indicted here (Note the Trauma Unit also consists of the Nebulising room, not depicted here).

The plan of the room nominally consists of examination, administration and work areas. The room is entered through a large, wide door (H) which remains permanently open. The space is therefore highly visible from the corridor at (I).

The doctor's examination generally occurs in the first curtained off area (A). Here the doctor sits at the desk and the patient on the accompanying chair. Cursory examination can be observed occurring on this chair, such as checking eyes and throat and limbs. Patients appear to seldom undress. Depending on the doctor and the nature of the case, the curtain is sometimes closed. This space is, however, easily penetrated, for instance, the only telephone available in the room is mounted on the wall within this area and is answered and used by staff during consultations. Furthermore, other patients will interrupt the doctor asking questions or requesting to be seen. The curtain therefore acts as a largely penetrable barrier.



LAYOUT PLAN of TRAUMA UNIT

Figure 7.2 Groundplan of Trauma Unit (main treatment area)

The nurse on duty will generally sit at (F), here she often acts as a receptionist, seating the next patient and escort on the chair around her table (E), and eliciting and recording their "presenting problem". Many administrative tasks, such as writing in patients' files, and keeping statistics are undertaken here. After hours this space and that around the sink (G), may be involved in some preparation procedure, such as testing urine, which is usually done in Prep Room.

Patients who need treatment procedures, such as dressings or suturing may also be seen on the chairs (E), or occasionally upon the other examination tables. At times it is hard to determine who is a patient or an escort, as chairs at point (E) are utilised by both. Occasionally a patient awaiting an ambulance will be left in Cubicle B with the curtain closed. It is impossible to close off the area around examination bed in (C). All the patients I observed with stab wounds, and this is a common trauma, were men and were always treated on the public chairs (E) or examining bed (D). Sometimes a chair may be drawn closer to the medicine shelves to allow easy access to cleaning and suturing materials (E2). Women with similar violence-related trauma injuries, usually as a result of domestic violence, were generally treated in the closed off cubicle (A), which allowed greater privacy for the examination of injuries. Different areas of the Unit may be simultaneously used for different kinds of patients,

> The Enrolled nurse begins to clean up the wounds of the assault victim (gloves, bloody swabs and refuse bucket) while he sits next to a waiting patient [E]. He sits uncomplaining through what appears to be a hasty and ostensibly painful process. There is little time for sympathy. The nursing sister is dispensing medication from the portable dispensing cupboard to more waiting patients. The doctor comes to check the open wounds on the stab victim's face, he inspects the wound and attempts to address him in broken Xhosa, but is called away by the arrival of another local child (6yrs) injured in a MVA[3]. The nurse completes the stab victim's suturing with the assistance of the GA, who (without being asked) collects the various materials and tools from the shelves. Gloved, she stands next the nurse, passing materials much in the role of the theatre nurse All this occurs still in area [EE]. The child is seen in a curtained off cubicle [B], he has a fractured femur and waits with his mother, weeping loudly on a drip while the ambulance is called to take him to Red Cross Hospital. There is no splint for his leg (Dressing room closed). The EN finds a long then cardboard box which they bandage onto the leg (Night duty, Trauma Unit).

It is clear that staff in the unit work with a high degree of teamwork, even between clinical and non-clinical staff. It is also common to observe the "illegal" use of the enrolled nurse to undertake the suturing task[4]. I was struck also in the above incident by the innovative and unorthodox use of materials to provide a splint for this patient. I was also impressed by the bravery of this patient in this very public context.

During the day, and at busy times of the night, patients wait to be seen at the Trauma Unit in the outside corridor (I and J), which has been converted into a waiting room by two benches against the wall. There is often insufficient space here, and patients or their escorts stand against the wall. The

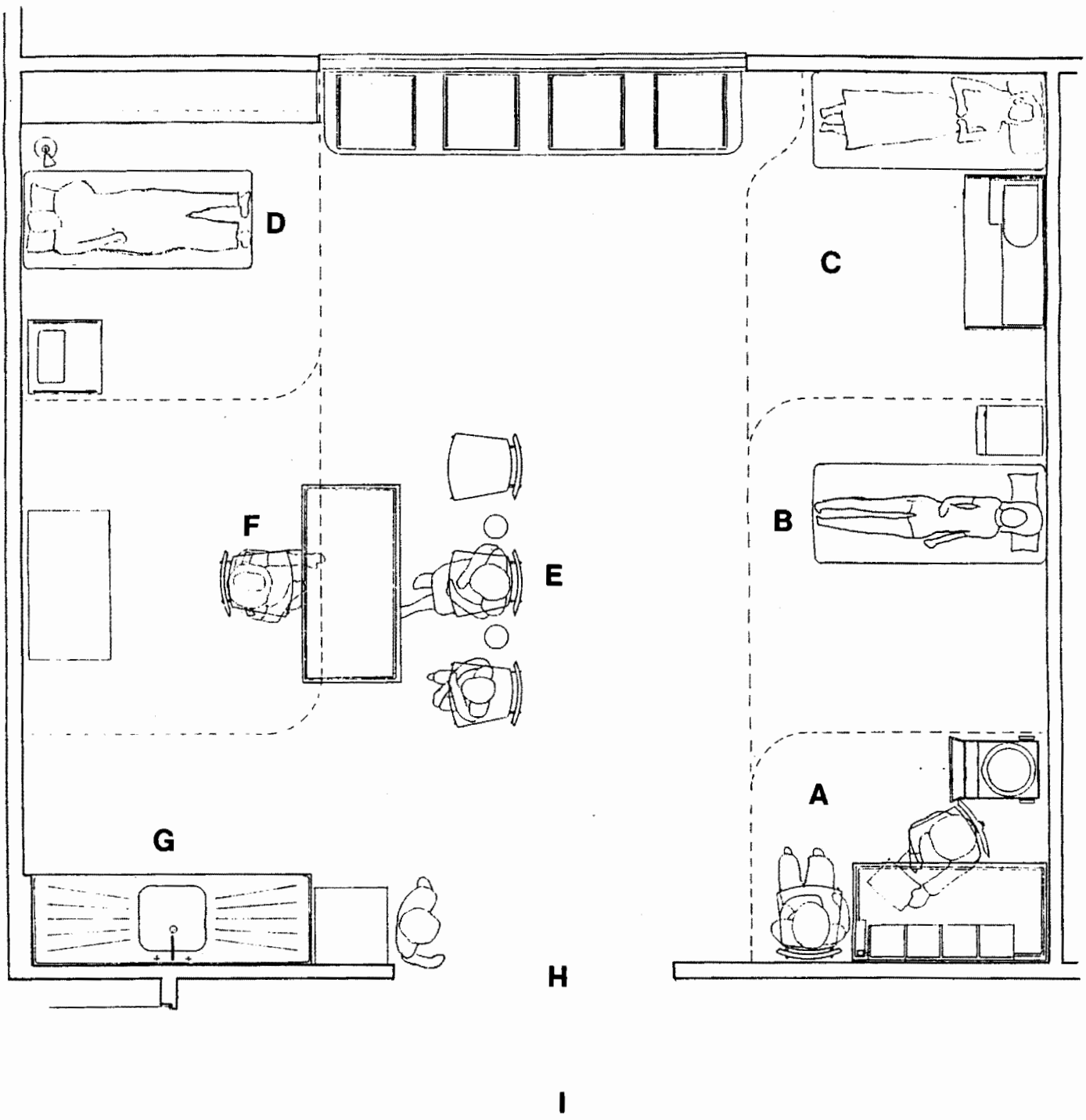


Figure 7.3 Groundplan of Trauma Unit (main treatment area) showing area usage

entrance to the Trauma complex (the entire area) is kept closed by double swing doors. During the day these are constantly monitored by a security guard, although this did not seem to be the case at the beginning. During the research period the Trauma Unit waiting area shifted to the outside corridor. This may be read as an attempt to create a boundary, and further demarcate the clinical treatment area. The following extract indicates the need for this increased differentiation:

> There is no sign of the clerk and security guard that appear to be busy trying to manage the growing numbers of angry patients outside. The doctor goes into the corridor to call the next patient. The room is getting full of people, so that the doctor orders the patients' escort outside. There are no quiet places for any form of private interview, and staff voices are being raised to speak above the growing noise. The security guard is back and speaking kindly to an African patient who can only speak Xhosa. (Saturday Afternoon, Trauma Unit).

The Trauma unit is often noisy, chaotic and disordered. Access to the Unit seems very fluid. For, instance family members will enter the Trauma room and ask the nurse or doctors questions. Or patients will return from other areas where they have been referred (e.g. Dressings), and consult the doctor in the corridor (I and J) as to their next course of treatment. Examination of patients has been observed to occur in all areas of the room, such as in the administration areas (E), on all examination couches (B, C, D), and even informally in the corridors (I). Areas do not have single function designations, and space is used as the need arises (when other areas are full) or where it appears to be most convenient.

In the evening or during the day at busy weekends the space seems to become more informal. The table (E) functions both as a clerical surface, but also a surface where a distressed child will be placed to wait or to be quickly examined. The clerk on night duty will enter and leave to deliver files. It is also very common to see Examination Bed D being used as a table for note taking by the clerk and nursing staff while the patient is treated at (E or EE). Administrative details are also gathered simultaneously in this space, for instance the clerk will interrupt a patient's examination to check a name or address, and such personal details will be called across a busy examination room. At such times the unit is also a place of laughter and chaos,

> The GA goes off to change the oxygen cylinders in the nebulizing room. The security guard is helping her carry these. There are explosions of laughter from the corridor with which the sister joins in (I never quite got the joke). A woman comes in having been bitten by a dog. The files are in a jumble on the table and the staff do not know whose file belongs to whom! (Night duty, Trauma Unit).

The Trauma Unit is clearly at times a muddle of people, roles and objects which bares little resemblance to biomedical order. Staff appear to be constantly battling to set spatial limits and define and redefine who is legitimate and belongs:

> The nurses also scold patients who are just "walking in" and tell them to "*gaan terug na die bank*!" [Go back to the bench!]"Where are Security?" asks the doctor, nobody seems to know. The telephone on the wall is ringing and we are all having to talk above the noise. The clerk rushes in and looks harassed, "the mothers are looking at me ugly", she says. The clerk is trying to screen the more severe cases, there are seven children still to be seen and another 17 people outside the door. Someone closes the door onto the waiting patients to stop them coming through to the Trauma room (Saturday afternoon, Trauma Unit).

7.3.2 Functional chaos

The most remarkable feature of the Trauma Unit is its capacity to function at all with such limited resources and evidently high patient utilisation. It is able to continue to offer this service precisely due to its "rule breaking", namely its remarkable performances and spatial and functional fluidity (cf. Garfinkel, 1967). It remains in a functional state of dis-order which reaches spectacular heights during the "frontier" times (Giddens, 1984) of night, weekends and the festive season. The public "pandemonium" that Harries (1996) describes in the waiting areas of the clinic invades and co-exists in this space alongside the functional activities of biomedicine. This is a heterogeneous space, an ordered dis-order. Biomedical rule breaking takes many forms: Spaces are used in a multi-functional manner; many clinical activities, especially those involving trauma, are undertaken in public; treatment surfaces include chairs and tables; boundaries between clinical and non-clinical areas are fluid and often violated. Clinical activities are undertaken by unofficial staff members (GA's and enrolled nurses); and innovative and unorthodox materials and tools are used.

The Trauma unit is a uniquely public biomedical treatment space. Noisy, chaotic spaces are often associated with the crowded poor (Mitchell, 1992, Honkalsalo, 1996), although emergency treatment areas are generally by design less private and open (Laufman, 1981, Putnep, 1979). The fluid chaos and the limited spatial resources of the Trauma Unit collapses the traditional biomedical boundaries between private (treatment) and public (waiting) spaces. Again we return to the tendency for public health treatment contexts to provide less visual and auditory privacy to poorer patients (cf. Comoroff, 1977). Thus these public health spaces may participate in the reproduction of dominant constructions of race and class (cf. Foster, 1997).

7.3.3 Remarkable places

Unorthodox practices for an unorthodox space. The Trauma unit is open twenty-four hours a day, seven days a week. Its doors quite literally never close and I never saw it refuse a patient. It is according to Giddens (1984), a region without the temporal boundary of day and night, a region of "broad span that extend[s] widely in time and space" (p.122). Community and clinical realms intersect here in a very real struggles regarding spatial legitimacy, physical location, individualised clerical activities and the

public treatment procedures to which patients are subjected. It is also a site where, at times, the boundaries between the interior and exterior of bodies, the reality of pain, and physical safety and death are immanent. In this sense the trauma unit may be called a heterotopia (Foucault, 1986 in Soja, 1996). Heterotropias are sites where incompatible spaces co-exist, where entry and access are at issue, and which is "outside of [normal] time" (Foucault, 1986, quoted in Soja 1996, p.160). Heterotopias are touted by Soja (1996) as spaces of multiplicity and liminality in which historical binaries and oppositions may be creatively transcended. Such binaries in the clinic would obviously include staff and patients, yet less obvious, is the challenge, as I will demonstrate, to the moral binary of victim and perpetrator.

7.4 Spectacular lessons

Treatment in this area has always an *audience* over and above the doctor-patient (or nurse - patient) dyad. This audience consists of other staff, other patients, the security guard and the odd patient's escort or even ambulance men. Although these audiences are made more permissible by the norms of trauma treatment, they are facilitated and reproduced by the material arrangement, the spacing of the trauma unit.

The Trauma centre is the site which must deal with a regular flow of assault victims seeking treatment. If the assaulted person is a young man, and generally coloured, the immediate reading of the situation by staff is that he is a "gangster", until proved otherwise[5]. The term gangster is often loosely used on the Cape Flats, it is a "pervasive fact of life" in such areas (Jensen and Turner, 1996). In areas like Hanover Park many young men are involved in an array of gangs, with various degrees of violence and organisation (*Ibid.*). Staff give expanding and varied lists of the gangs that surround the hospital[6]. There is a mythology regarding gangsters which makes them on omnipresent threat in this "*death trap*", this "*hell*" as nursing staff refer to this area.

The Trauma area has installed security guards to assist with the control of patients and presumable violent threats within this area[7]. However, it is the multiple levels of visibility and surveillance in this area which provides the greatest security for staff. Potentially dangerous patients were inevitably treated in public spaces with an audience which also served as a means of protection. Lack of privacy was both a condition of the place and treatment methods, yet it was also a powerful strategy for containing and preventing potential attacks on staff.

7.4.1 Theatrical performance: Parodying "die Wet"

At times interactions between nurses and "gangsters" would point to other potential uses of this public space. The following encounter occurred at early evening over a weekend. Sr. T (and long-standing and middle-aged staff member) confronted a young man, who she later described as a "gangster", and made a (belated) return to the Trauma unit to have his sutures (stitches) removed from an old stab wound[8].

> Sr. S speaks angrily to a young man who is here to have his sutures out - he should have come three days ago - he looks sheepish. She tells him he is going to have to wait as there are other patients[9], he must have expressed something about being afraid to wait - his "friends" are at the gates and he is afraid that they are going to fight with him. Sr S tells him that she will not give him any preferential treatment, "*Ek is die Wet hier*" [I am the Law here], she scolds him, and something about him sorting his problems out outside, not in her clinic. He doesn't protest and waits among the other patients..The young man ("gangster") returns, he has missed his place in the queue, Sr. S angrily informs him of this, "*Jy loop op en af! Op en af!*" [You walk up and down! Up and down] and tells him that he will have to wait again. "*Is jy bang?*" [Are you afraid?] she asks with mock concern, perhaps they are waiting for you at the entrance she laughs. "*Dis jou eie saak, jy het rond gedwaal!*" [It's your own fault, you were wondering about] she tells him (Field notes, Trauma Unit).

The gangster here is in a vulnerable position. He has told the sister that he is using the clinic as a potential sanctuary away from "*his friends*" who wish to exert some kind of revenge over him. He was also a physically small man, whose physical presence was that of an anxious wayward teenager rather than a threatening man.

Sr T refers to herself as "*Die Wet*", she is in charge, the law inside the clinic which controls lawlessness and physically and metaphorically seeks to keep people in their place. Parody, is a humorous, exaggerated imitation of an original. Sr. T utilises stereotypic stances and resources drawn from local cultural capital (Bourdieu, 1977) to provide a powerful strategy with multiple outcomes. Sr.T undoubtedly humiliates and scolds the young man. She refers to "*Die Wet*" as a sign of her power and authority within the clinic. "*Die Wet*" is not just any law, but a local term used to describe the most feared law within the gangster structure and hierarchy. "*Die Wet*" is precisely most feared as it pronounces guilt, and a mysterious ruthless punishment within the prison based gangster court of law, *die Kring* (the Circle). This authority is legend and recreated and sustained in the street (Jensen and Turner, 1996). By using local cultural knowledge Sr. T asserts her power in the clinic within the violent and unpredictable power relations of the street and prison.

Sr T claims another local authority, that of the scolding mother, a powerful presence in many of these areas (Jensen and Turner, 1996). Jensen and Turner (1996) describe that within the home, wayward sons are never represented as real gangster, they exist "out there" in the street. Within their home they are simply disobedient sons. Mothers, who often tend to lead matriarchal households, have been observed physically assaulting and scolding their disobedient sons (often quite literally with saucepans) within the public spaces of nearby Heideveld. Within this often sentimentalised dyad of mother-and-son, grown and otherwise violent men, submit to this abuse within the home without retaliation or much resistance (Jensen, 1998, personal communication). Thus, by adopting a mother-son stance, Sr. T has articulated a set of responses and dispositions from home and family which are locally protective of women within an otherwise violent community (cf. Bourdieu, 1977)[10].

Figure 7.4 Patients and staff in the corridor (J) which serves as Trauma Unit waiting area.

Figure 7.5. A patient grimaces as he undergoes treatment from a nurse for an injured foot in the Trauma Unit (treatment area, T). A patients or escort (right) and general assistants look on. More people in the corridor (I) (probably waiting patients) observe through the door (H).

This episode occurred with an audience which has acted as a form of protective surveillance (Rose, 1993). This surveillance and the need to find sanctuary reduced the immediate threat of this "gangster", shifting the balance of power to the scolding and humiliating nurse. This humiliation may also be read as a display of power, a didactic encounter enacted for the benefit of the direct players and the audience. It would however not be accurate to say that visibility was all that this audience provided. It is clear that clinical treatment in the Trauma Unit takes on the form of drama and theatre commensurate with its audience. Medical treatment has always had an element of drama and threat which is most completely expressed in pre-modern forms of dramatological bedside treatment rituals and surgical procedures[11] (Lachman and Stollenberg, 1992, Laufman, 1981). Theatrical forms of medicine appear to be invoked by the current Trauma unit spatial arrangement in a manner which calls upon new and protective cultural roles and stances. The theatrical reality of the "Scolding Mother" is supported by the dramatic illusion and ludic reality of the stage (Fabian, 1990). By publicly displaying her power and conquest of this gangster, Sr. T is doing more than conquering this (seemingly harmless) "gangster", she is publicly realigning both the moral and spatial boundaries and authority of the clinic territory.

7.4.2 The crooning nurse

Spectatorship in the Trauma unit can have multiple outcomes and mechanisms staged in this public treatment display. Change the players and a different narrative emerges with equally powerful didactic qualities.

> It is about 1.00pm, I rush into the Trauma to see if I can collar Dr 1 for that long awaited (avoided) interview before I leave. I meet him at the door rushing out, saying something about "he, should be seeing a District surgeon..." As I enter the room, passing the bulk of a large (somewhat confused) uniformed police man, I see a manacled prisoner seated on the chair by the entrance, I am taken aback, and look away, it is not difficult to be distracted. Framed by the window is a small, half-dressed little girl of five or six. She is seated on the chair [E2], her mother having drawn up the chair next to her [E]. Across her shoulder is a piece of gauze bandage. The little girl stares ahead of her, she has obviously been crying and her thin naked chest is tensely drawn in this public space as if she is willing her body not to cry or the she is rigid in her public nakedness. She is the focus of all our gazes (except the prisoner who looks straight ahead of him). The room is however enveloped by the bustle of the nurse who bears the gauze bandage across the space from the sink as one would a blanket or sacramental vestment[12], she is crooning softly like one would to a wounded animal (she may have been using words but I cannot remember them). The room feels transfixed by this central scene. The security guard at the door is also distracted from her bustle around the prisoner's ambiguous presence, and it feels for a minute that this scene holds "centre stage". I asked the nurse what has happened and she tells me the child has been burnt. I add my own sympathetic noises, and hastily make an exit. It feels somehow wrong to be a spectator here today and I head for the staff entrance (Trauma Unit. Field notes).

I do not know how this child was burnt, the scene was not one of facts or even the comfortable audience afforded by the high drama of the usual assault victims. My narrative is almost Dickensian,

constructed along the moral counterpoints of innocent injured child and guilty criminal. This scene occurred in the hushed participatory performance more akin to the enactment of a sacred sacrament than entertainment. Like the Prayer Circle (Chapter 5) this potent healing ritual transformed the Trauma space that day, with the audience participating in the dramatological and didactic construction of this event (cf. Fabian, 1990). Enacted in the humiliated and vanquished presence of the "criminal", the drama was a powerful means by which the moral landscape of the clinic was realigned, placing the staff safely back in the position as the "healers" rather than the "criminals" in this space. This ritual (and others like it) attests perhaps to an anxiety among staff as to their positioning across the moral boundary of "carers" and "abusers" in the community. The dark side of their unorthodox strategies needs to be further unpacked to understand the source of this anxiety.

7.5 Theatres of Hell

There is another story to tell. Public treatment occurred with the most apparent ease for male assault victims. Their bleeding, punctured and often half-naked bodies made public displays of the effect of violence for all to see. Their treatment became rituals in which all those present in the Trauma unit participated, a bustling performance of chiding nurses and often the howls of the injured patients.

7.5.1 The Laughing Gangster

> It is about 3.00am. EN M comes and calls me from a doze on the chairs in the Trauma staff room. Three staff members, including the doctor are speaking to a (presumably intoxicated) stab victim with a head wound lying on the examination bed. He keeps on trying to get up and is being told to sit still by the nurse who is trying to clean his wound. He is swearing profusely (at her and the world) and pulls away as she wipes the wound. He swoons and shouts. The scene is being watched by all the staff and two ambulance men sitting on the examination beds. Somebody starts to laugh and the swearing and writhing continues. Sr. G approaches him with an injection, "*This will hurt you even more if you swear at me like that*" she says (or words to that affect). The staff instruct him, including the doctor, to keep still while the injection is administered (to his head or arm). His loud shouts and swearing increase. The EN says to me, do I see now how "they" swear and go on. I find the whole scene quite exciting and amusing. The nurses approach him with the suturing material, he begins to protest and tries to get up or push anyone away. At this point I move back afraid of being hurt or bled upon. The doctor comes across and sits down next to him on the bed, telling him to "stop!" this behaviour. *He does and swears and protests in a seemingly theatrical manner, but without any apparent threat.* The whole episode has been punctuated with [nervous?] intermittent laughter. The nurses "tut tut" and scold him as they go along. I am sure that they could have sutured him with less force and more gentleness (Trauma Unit, FN).

The public spacing of clinical treatment within the Trauma Unit has facilitated here another form of didactic theatre that shifts from high drama to apparent comedy. Yet it would be inaccurate to suppose that in this punitive spectacle there is not the active participation and co-acting of the patient. He requires medical assistance and as such must submit to the rough ministrations of the staff. He, like them, adopts a staged identity in which he performs a humorous parody of himself and stereotype

of his gangster and coloured identity. Submitting to punishment and the moral and clinical authority of the staff is accompanied with an air of festival and carnival, an ambiguous, potentially subversive civic expression (cf. Harries, 1996). Describing the enacting of coloured cultural stereotypes at the Coon Carnival, Stone (1973, in Jensen and Turner, 1996) observes that it,

> ..plays out the stereotype of the Coloured man; a fool, laughing, accepting his fate, staging the relationship between himself and his White master (p.162).

The public audience in the Trauma unit enables staff and patients to manage potentially antagonistic and potentially threatening social encounters by resource to local cultural knowledge and identities. These symbolically contain the violence, while giving it didactic and punitive expression. The gangster's parody is a familiar face-saving device which is read as a mocking submission to medical, state, class, racial[13] and even maternal authority. The staff must undertake a clinical task, but must also maintain their dominant clinical authority and hierarchy *vis a vis* the patient and community (Mgodusa and Butchart, 1992).

But it is also clear that another form of power is at times present. Biomedical staff deal with the intimate and vulnerable aspects of human embodiment, including physical pain. In the official realm of medicine, pain is used as a means of diagnosis (Scarry, 1986). In the dangerous arena of the Trauma Unit, physical pain, and the threat of physical pain associated with injury, may be another form by which staff are empowered and hence protected. The infliction and control of physical pain has always been a potent form by which power has been expressed and seized in pre-modern forms of governance (Foucault, 1977, Scarry, 1986). This expression of Sovereign power is made manifest in the ability to inflict pain and control death in the public rituals of torture and execution (*Ibid.*). Torture functioned as an "opportunity of affirming the dissymmetry of forces" (Foucault, 1997, p.55), and become a "political ritual..[a] ceremony by which power is manifested" (*Ibid.* p.47). However the danger of such a public act of power was the paradoxical nature of the spectacle, the "aspect of carnival in which rules were inverted, authority mocked and criminals transformed into heroes" (*Ibid*, p.61). This punishment tended to become a "festival" (*Ibid,* p.111) and boundaries between the drama and theatres of pain and insurrection were often dangerously unstable. Thus, the boundaries between spectacle, theatre and physical violence have always been slippery. Public spectacles of pain have historically been culturally sanctioned forms by which state power was enacted and reproduced. It was deemed "fair", for unlike the private ceremony of modern torture (Scarry, 1986), public acts of sovereign power were shared within the bounds of theatrical participation and contest between "patient" (literally meaning the one that suffers), the torturer and the public (Foucault, 1977).

7.6 Unorthodox strategies reviewed

The embattled staff at the Trauma Unit treat their patients in a public and chaotic space which preceded the individual players in this drama. As such they, and their patients, have limited resources by which

to manage the ongoing struggles that the street and community have become. The Trauma Unit is particularly open to the street and the forms of violence, and violent men that it engenders. The mythology of the "gangster" in the clinic is born in this dangerous space as vulnerable staff must engage with violent men and circumstances officially without access to exclusion criteria and sufficient security. The social sanction and privilege of biomedicine is perceived as insufficient protection for lonely staff in this vulnerable and ambiguous place. Staff and patients therefore use the resources of this space in surprising ways in order to gain and relinquish power within the pervasive criminal lexicon of the street. The Trauma Unit is a chaotic ambiguous biomedical space which has learnt to function precisely due to the innovation, creativity, teamwork and unothodoxy of its spatial and professional practices. These practices may not be officially sanctioned by the official biomedical management, but are permissible as they are the "illegal" means which make this unruly, and peripheral place manageable (cf. Garfinkel, 1967). It is clear also from the history of the clinic that when these strategies fail the staff use the last (illegal) resort available to them – closing down the Trauma Unit, as they did in 1996.

It would appear that new forms of space open up the potential for new forms of relationships, roles, strategies and powers. These may be utilised as unorthodox, but functional means to manage the spatial and social realities in a dialectical manner (cf. Lefebvre, 1991).

CHAPTER EIGHT

CONCLUSION

> The experience of insecurity is at its most acute whenever the sediment of socialisation loses its solidity - and therefore the extant social space loses its transparency together with the constraining and enabling powers. The spontaneous reaction to such an experience is a magnified intensity of spacing efforts (Bauman, 1995, p.184).
>
> Words like "hospitality" and "service" seem out of place in contemporary healthcare settings...only someone who has the *power of the place* can afford to provide hospitality or service (Muff, 1994, p.33, original emphasis).

Hanover Park Community Health Centre, like many other primary health care facilities within the Western Cape, is a site of crisis and survival. Challenged by dwindling resources, growing patient demands and fears for security, clinic staff battle to sustain a health service, and indeed, their own well being. The seriousness of these problems demands, not merely a theoretical, but an engaged and pragmatic response. I wish therefore to end this study, both with a conclusive overview, and an attempt to translate some of these insights into the, imperfect, but I believe necessary, realm of biomedical functioning.

The crisis and antagonisms at the clinic have made manifest the usually "transparent" mechanisms by which it has a social and functional presence in the world (cf. Bauman, 1995). Fears regarding the spatial and cultural integrity of the clinic have signalled the vital role these aspects play in the construction of biomedical realities. Current circumstances challenge the integrity and survival of the clinic, and in the process make it possible to examine its core conditions of its existence (cf. Laclau, 1990). The clinic's problems point to the inherent spatiality by which it is culturally, emotionally and physically constructed and hence functions.

Social life exists only in and through the symbolically mediated experiences and actions of individuals which occur in space, under material conditions which limit and enable our choices (Brubaker, 1985). Thus, an examination of space reveals the symbolic and material scaffolding of personal, social and institutional worlds. Meanings are fluid, contested and multiple, and in the same way, social space has an unstable heterogeneous ontology which needs to be actively stabilised through social power (Lefebvre, 1991). As such it alerts us to the shocking vulnerability of these real and imaginal worlds, and the constant and ongoing acts by which we sustain and remake our realities.

The making of biomedical space[1]

Official biomedical discourse appears incompatible with notions of staff/patient/community antagonism, or the *vulnerability* of biomedical facilities. Such antagonism, noted Laclau (1990), announces the political nature of social reality and the "sedimented", but potentially unstable, power relations inherent in (modern) social structure (p.35). Biomedical and community space are both a mechanism or reservoir of power. Space may be understood to dominate and produce through social practices the hierarchies, meanings, identities and practical acts and knowledge that constitutes biomedicine.

Biomedicine in general, and primary health care in particular, has a specific spatial form and reality which grounds it and gives it a material presence in the world (cf. Lefebvre, 1991). Access and control of biomedical territory is one of the means by which essential biomedical identities are negotiated and reproduced daily. Biomedical spaces require differentiation, governance and ownership in order to function as such. This requires the ongoing territorial appropriation, construction of boundaries, barriers and governance of specific spaces. This differentiation requires both power and resources (material and symbolic), and is constantly open to challenge and resistance. Social spaces are encoded with social roles, behaviour and expectations and social agents, including staff and patients may interpret the clinic's spaces in multiple ways. Biomedical power is therefore most precisely exercised and maintained through controlling and disciplining spatial meaning, such that a biomedical reading is dominant.

Biomedical function rests on stable disciplining and ordering principles (Foucault, 1977). Biomedical institutions must therefore be in-order, and it is axiomatic to this study that ordered biomedical productivity requires ordered biomedical space. This order has tended to reflect the power relations and modes of disciplined state governance and production (Foucault, 1977, Lefebvre, 1991). Order acts on the body (Foucault, 1976), and therefore occurs at the interface of material and symbolic realms (Moore, 1996). Biomedical spaces cannot therefore be simply understood in an instrumental, rational and mechanistic manner. Symbolic meanings, culled from the domestic, commercial and religious worlds provide the necessary symbolic apparel which hides and humanises the dominant factory-like treatment routines of public health. This need for positive symbolic biomedical content creates an unstable and contradictory heterogeneity to biomedical space. This multiplicity may be utilised by social agents (staff and patients) who inhabit and reinterpret its spaces to support or subvert the dominant biomedical order (Lefebvre, 1991). Thus, the vulnerability and multiplicity of any space, and indeed reality, is a source of resistance, creativity and transformation (*Ibid.*). In this sense there has been in this study no single reading of the space of the clinic, as these spaces are themselves multiple.

The unmaking of biomedical space

Primary health care facilities have been put forward in current health policy as the key sites for public health service delivery. However, in practical and emotional reality, these areas have become devalued, stigmatised and interpreted as places of relegation, a dumping ground for the poor and

incompetent, and hence a place from which one seeks to escape. The clinic is experienced by the staff as too open, too penetrable and chaotic. The clinical space is therefore vulnerable and contested as an essentially porous place where boundary maintenance has become increasingly difficult and spaces have lost their surety. Sites of conflict and abuse within the clinic (such as the Preparation and Dispensary areas) tend to be in places where there is heightened ambiguity, where the meaning of spaces needs to be renegotiated between biomedical and public roles and expectation.

Definitions of who belongs, who is the "patient", have become contested boundary-related issues. The discursive and spatial transformation of the "public" into "the patient'" may be more difficult for some identities than others (Swartz, 1991). The staff at the clinic appear to construct most young coloured men as "gangsters'. This frontier identity signifies the ambiguity, chaos and peripheral quality of the internal and external spaces, rather than an attribute of these men *per se* (cf. Bunn and Auslander, 1998). These identities appear to be particularly resistant to biomedical translation into the passive, docile and worthy "patient". Staff appear to adopt official and unorthodox strategies to accomplish this difficult task, such as increased physical extraction (gates and doors to remove escorts), public and visible treatment processes, enacting socially dominant roles, "the chiding mother", and, their last, but most powerful resort – the "gangsters" embodied need for treatment and their fear of pain.

Narratives of incidents and fear of gang violence and attacks punctuate nursing staff's tales and accounts of the clinic. Such incidents become emblematic of ongoing anxieties about their safety and the physical and spatial integrity of the clinic. Feldman (1991) writes that *"The event is not what happens. The event is that which can be narrated"* (p14, original emphasis). Spatial "events" and anxieties are hard to articulate in a dominant discourse in which link between space and subjectivity have been largely severed. Violent accounts appear to articulate and give legitimacy to a range of conditions within the clinic which imply threat and invasion, loss, violation and defilement. Everyday abuse, including mundane mess and the dehumanisation of patients and staff within alienating routines and mechanistic interpersonal encounters, has become condensed in the dominant accounts of extra-ordinary violence and abuse. It is not that the mythology and fear of the gangs are not real, but rather that the boundary between "us" and "them" is not clear enough (cf. Pile, 1996). Paradoxically, "gangsters" provide a more predictable, familiar interpretative frame for the abuse, disorder and uncategorical anxieties of the clinic. This ambivalence can be read in the Sister-in–charge introductory account (p1), where in she shifts between constructing the gangs as the terrorisers and protectors of the clinic.

Space challenges us to move beyond ontological binaries of subject and object. It may be a potent source of agency, creativity, violence and transformation. Material and symbolic spatial elements may serve as resources for counterspaces, which both challenge and transform biomedical functioning. In the apparent failure of the modern health project, professional power and agency

were observed to be spatialised in unexpected ways such as escaping, and appropriating space and the return of moral, punitive and ribald public and violent spectacles. Embattled staff are however, replicating the spatial and power strategies of the streets, and are embroiled in a particular power struggle that ultimately they cannot win. The dominant power relations nurtured and constructed in the prevailing dehumanising modernism of Hanover Park streets has become pervasive (cf. Pinnock, 1984). The clinic has become a place to dominate and territorialise in the gangland strategies of the streets. Gradual fortification and brutalisation within the walls of the clinic has only replicated the space of the gangs without. This has created dangers and contradictions which are too great for many staff and patients

Missing the point: Health care policy and reform

Health care policy, like other forms of state policy, neglects the specific significance of place and space in its conceptualisation or articulation of power (Eyles and Litva, 1998). As such, space is silent and rendered an apolitical and inert context for biomedical and civic activity (cf. Robinson, 1995). It is clear, however, that the "where" is directly linked to the "how" of biomedical treatment, and therefore cannot be ignored. Biomedical identities and practices are constructed through and in space, and in turn go on to give material form and symbolic meaning to biomedical space. Physical space and peoples' interpretation of them matter. Alterations and neglect of clinical spaces, and the cultural and emotional construction of these "places", is significant (Kearns and Gesler, 1998). These variables impact directly upon the behaviour, value, functional capacity and forms of power within these places.

Changes in national governance (and health policy) have done little to address or articulate the powerful mundane and everyday spatiality of apartheid rule (cf. Robinson, 1995, Robins, 1998). This inability to incorporate space and place into transformation discourse and practices has meant that notions such as democracy and participation, central to transformation and health reform (e.g. Department of Health, 1997) are problematic. A non-spatial discourse of governance cannot address a profoundly spatialised world. This "invisibility" (Lefebvre, 1991) has not only rendered certain powerful variables unpredictable and unaccounted for, but has neglected key resources for positive change and participation. State sanctioned PHC policy implies a shift in emphasis to the periphery. Yet, this policy has not begun to address or imagine the specificity and spatial reality of these peripheral and neglected spaces. This geographic and ideological biomedical periphery has, however, the potential to provide new sites of resistance and freedom from the monolithic practices of hospital medicine.

Key health policies such as "access", "comprehensive services", "community participation" and "decentralisation" have been touted as the benefits of such a policy shift. Yet, in a despatialised discourse, the spatial implications of such policy have been unimagined or avoided. How will increased "access" and "community participation" be translated "on the ground". In reality increased "access" has contributed to the "*flooding*" of clinical spaces, and decreased capacity to differentiate clinical boundaries on all levels. Staff cuts and scarce biomedical resources have

resulted in a minimal clinical presence, exacerbated by the ongoing evacuation of staff. In these conditions, there is little "participation" with communities as spatial differentiation and territorial integrity of clinical space has emphasised exclusion and appropriation.

The "governmentality" of the modern state and its biomedical technologies (Turner, 1997) have provided forms of functional modern institutions, which may protect communities from the worst excesses of physical violence and sickness. The aim here is not to valorise modern forms of power, but to make explicit what can occur when modern state spaces are threatened. The violence, ungovernabilty and poverty in the streets of Hanover Park, and similar Cape Flats warzones[2], is also a product of our peculiar apartheid history and social and spatial engineering. Political change has not brought spatial transformation, and hence peoples' choices and environments remain oppressive (Robins, 1998). I do not believe that some anarchistic appropriation of the current health services is in the best interest of these impoverished communities. Such spaces should not reproduce the construction of the criminalised and dehumanised poor, rather these spaces should survive and provide such communities with alternative spaces for positive choices on how to live their lives and manage their bodies and illnesses.

The integrity of biomedical space needs to be made visible and valued in policy and resource allocation. Biomedical treatment, or health care delivery as it is dubbed, cannot occur without due care, development and maintenance of physical and symbolic places. This utilises affective and biomedical resources and cannot be successfully replaced by security gates and guards that only alter the meaning of the place and exacerbate the loss of interpersonal care. Furthermore, the devaluation of biomedical places is destroying their capacity to function. PHC philosophy valorised the periphery, yet the health services have done little to develop these spaces. Major changes in health care policy have not factored the role that space plays in constructing and enabling biomedical activity and power. This is a serious omission which has literally placed "new wine in old wineskins". There is therefore a need to actively create new forms of biomedical space to accompany biomedical reform.

Biomedical spaces need to be reclaimed and transformed. Clinical space at the periphery has become too similar to chaotic communities. In the same vein, community space has not been sufficiently "colonised" or governed by the state or biomedicine. The fluidly of boundaries and proximity between community and biomedical spaces proposed by PHC official ideology cannot exist in this context.

My attempt in this study to demystify space by making it more "visible" should not be read as a endorsement of monologic clarity and control over biomedical space and its "secret places" (cf. Lefebvre, 1991). Traditional biomedical space has become rigid, and depleted. The survival and transformation of a public health service worth saving, lies in its capacity to sustain and nurture a richness and multiplicity of its spaces such that institutions, staff and patients may have more

sources for choice and agency (cf. Soja, 1996). In order to achieve such a creative openness, places like Hanover Park CHC require more support and more autonomy. Positive community and biomedical spaces need to be meshed in new ways to create less alienating and more empowered places. Currently the antagonistic and competitive relationships between the community and biomedicine has created the need for firmer boundaries which only reproduce these negative relations. Mutual investment on a symbolic and economic level in communities and biomedicine may offer the potential to develop more shared spaces where the progressive rhetoric of policy may have a better chance of materialising (cf. Robinson, 1995).

Chaos and crises can lead to "new combinations by breaking down rigid old orders and forms", while providing new forms and sources for constructing new kinds of order and meaning (cf. Honkasalo 1996, p38). These patterns need to be perceived and interpreted in order to work with an organisation and community to give form to something new. The starting point, however, is to recognise the inherent spatiality of life and the implications of these conditions of existence.

REFERENCES

Allen, J., and Pryke, M. (1996). The Production of Service Space. S. Daniels, & R. Lee (Eds.), Exploring Human Geography. (pp.158 - 178). London, New York, Sydney: Arnold.

Armstrong, D. (1993). Public Spaces and the Fabrication of Identity. Sociology, 27, 393-410.

(1995). The Rise of Surveillance Medicine. Sociology of Health and Illness, 17 393-404.

Baer, H., Singer, M., & Susser, A. (1997). Medical Anthropology and The World System. Westport Connecticut: Bergin & Garvey.

Bauman, Z (1995) Life in Fragments: essays in Postmodern Morality. Oxford U.K. and Cambridge U.S.A., Blackwell.

(1997) Postmodernity and its Discontents. New York. New York University Press

Bhagwanjee, S and Muckart, D (1997) The Trauma tunnel – is there light at the end. S.A.M.J. 87 (5) pp665-666,

Bourdieu, P. (1977). Outline of a Theory of Practice. Cambridge:Cambridge University Press.

Brubaker, R (1985) Rethinking classical theory: the sociology of Pierre Bourdieu. Theory and Society, 14, 723-744.

Bunn, D and Austlander, M (1998) From Crooks corner to Thulamela. Unpublished document. Department of English, University of the Western Cape.

Butchart, R. A. (1995). On The Anatomy of Power: Bodies of Knowledge in South African Socio -Medical Discourse.Unpublished doctoral dissertation, University of South Africa,

Cammock, R. (1981). Primary Health Care Buildings. London: The Architectural Press.

Cape Argus, Independent Newspapers, Newspaper House, 122 St. George's Street, Cape Town, 8000

Casement (1985). On learning from the patient. London and New York: Routledge.

(1990). Further Learning from the Patient. London: Taverstock/Routledge.

Chidester, D. (1994). The Poetics and Politics of Sacred Space: Towards a critical Phenomenology of religion. Analecta Husserliana, XLIII, 211-231.

City of Cape Town 1980. (1980).Council Housing in Cape Town [Report].

(1987). Cape Flats Upgrading [Report].

(1997).Summary of the LA 21 Planning Process[Report]

Clifford, J. (1997). Routes. Cambridge, Massachusetts: Harvard University Press.

Comaroff, J (1977) Conflicting Paradigms of Pregnancy: Managing Authority in Ante-Natal Encounters, in Davis, A and Horobin, G, Medical Encounters: the Experience of Illness and Treatment, pp115-134., London, Croom Helm

Comprehensive Health Evaluation Report (1997) Internal Report, Community Health Service Organisation, PAWC. Mountain Rd. Woodstock.

Cox, A., & Groves, P. (1990). Design and Development Guide for:Hospital and Health Care Fascilities. London: Butterworth Architecture.

Crane, J., & Angrosino, M. (1992).Field Projects in Anthropology. Prospect Heights, Illinois: Waveland Press.

Dear, M. (1997). Postmodern Bloodlines. G. Benko, & U. Strohmayer (Eds.), Space & Social Theory. (pp. 49-71). Oxford: Blackwell.

Department Of Health (1997) White Paper for the transformation of health services in South Africa. Government Gazette

Dixon, J, Foster, D, Durrheim, K and Wilbraham, L (1994) Discourse and the politcs of space in South Africa. Discourse and Society, 5(3), 277-296

Draft 11 of the National Health Bill (1998), Department of Health

Elias, N. (1978). The Civilizing Process, Vol 1 & 2. Oxford: Blackwell.

Eyles, J and Litva, A (1998) Place, Participation and Policy, in Kearns, R and Gesler, W (Eds.) Putting Health into Place, pp 248-269, Short, J (Series Editor) Space, Place and Society, Syracuse, New York, Syracuse University Press.

Fabian, J (1990) Power and Performance: Ethnographic Exploration through Proverbial Wisdom and Theatre in Shaba, Zaire, Madison, Univ. of Wisconsin Press.

Fairhurst, E (1977) On being a patient in an Orthopaedic Ward: Some Thoughts on the Definition of the Situation. in Davis, A and Horobin, G, Medical Encounters: the Experience of Illness and Treatment, pp 159-174 London, Croom Helm,

Feldman, A. (1991). Formations of Violence. Chicago and London:The University of Chicago Press.

(1993) Management and Programmatic Study of the Texas Criminal Justice, Institutional Division's Chemical Dependency Treatment Program. [Ethnographic Report for the Texas Criminal Justice Department].

Flisher, A, Lund, C, Muller, L , Dartnell, E, Ensink, K, Lee, Tennyson, Porteus, K, Robertson, B, Tongo, N (1998), Norms and Standards for Psychiatric Care n South Africa. Unpublished Report for Department of Health. Department of Psychiatry. University of Cape Town.

Foster, D. (1997). Space, Place and Race. Anti-Racism Newsletter, IDASA, 12 March,

Foucault, M. (1972) Archeology of Knowledge. London: Routledge.

(1976) The Birth of the Clinic. London: Routledge.

(1977) Discipline and Punish. London: Penguin Books.

Garfinkel, H. (1967) Studies in Ethnomethodology . Englewood Cliffs, New Jersey: Prentice-Hall Inc.

Gibson-Graham, J. K. (1997). Postmodern Becomings: From the Space of Form to the Space of Potentiality. G. Benko, & U.Stronhmayer (Eds.), Space and Social Theory.(pp. 306-323).Oxford: Blackwell.

Giddens, A. (1984). The Constitution of Society . Cambridge:Polity Press.

Goffman, E. (1973). Asylums. Middlesex: Penguin Books.

Goldberg, D. (1993). "Polluting the Body Politic":Racist discourse and Urban Location. M. Cross, & M. Keith (Eds.),Racism, the City and the State. (pp. 45-60). London and NewYork: Routledge.

Good, B., & Good, M. (1993). "Learning Medicine" The Construction of Medical Knowledge at Harvard Medical School. S.Lindenbaum, & M. Lock (Eds.), Knowledge, Power and Practice.Berkely, California and London: University of California Press.

Gordon, E. (1980). Michel Foucault: Power/Knowledge Selected Interviews & Other Writings. Hertfordshire: The Harvest Press.

Goss, J. (1996). The Magic of the Mall: An analysis of form, function, and meaning in the contemporary retail built environment. S. Daniels, & R. Lee (Eds.), Exploring Human Geography. (pp. 180-226). London: Arnold.

Gregory, D. (1994). Geographic Imaginations. Oxford: Blackwell.

(1997). Lacan and Geography: the Production of Space Revisited. G. Benko, & U. Stronhmayer (Eds.), Space and Social Theory. Oxford: Blackwell.

Hammersley, M., & Atkinson, P. (1983). Ethnography: Principles in Practice. London and New York: Tavistock Publications.

Hammersley, M. (1993). What's wrong with Ethnography. New York & London: Routledge.

Harries, J. (1996). Health and Literacy: A Study of Literacy Practices in a Day Hospital in the Western Cape. Unpublished Masters dissertation, University of Cape Town, Faculty of Education.

Hart, L. (1991). A Ward of my own: Social organisation and identity among hospital domestics. P. Holden, & J. Littlewood (Eds.), Anthropology and Nursing. (pp. 84 - 109). London: Routledge.

Harvey, D. (1985). The Geopolitics of Capitalism. in D. Gregory,& J. Urry (Eds.), Social Relations and Spatial Structure. (M.Billinge, D. Gregory, & R. Martin, Series Eds.) (Critical Human Geography). (pp. 128-163). Houndsmill and London: Macmillan.

Heath, C. (1986). Body Movements and Speech in Medical Encounters. Cambridge: Cambridge University Press.

Henderson, P. C. (1993). "House and Street as Locales":Construction of landscape in New Crossroads. Critical Views Seminar. African Studies Resource Centre. University of Cape Town

Hogg, M., & Abrams, D. (1988). Social Identifications. London & New York: Routledge.

Holden, P. (1991). Colonial Sisters: Nurses in Uganda. P. Holden,& J. Littlewood (Eds.), Anthropology and Nursing. (pp. 67- 83). London: Routledge.

Holston, J. (1989). The Modernist City: An Anthropological Critique of Brasilia. Chicago and London: The University of ChicagoPress.

Holohan, A (1977) Diagnosis: The End of Transition, in Davis, A and Horobin, G, Medical Encounters: the Experience of Illness and Treatment, London, Croom Helm, pp 87-97

Honkasalo, A (1996) Environmental Noise as Sign, Semiotica, 109-1/2, pp29-39

Jacobs, T (1997) Breaking the Silence: Health Service Responses to Domestic Violence at a Community Health Centres. Unpublished report. Department of Community Health. University of Cape Town.

Jensen, S., & Turner, S. (1996). Research Report No. 112. A Place called Heideveld. P.O. Box 260 Roskilde, Denmark: RoskildeUniversity.

Kearns, R and Gesler, W (1998) Introduction. In Kearns, R and Gesler, W, (Eds.) Putting Health into Place, Short, J (Series Editor) Space, Place and Society, Syracuse, New York, Syracuse University Press, pp 1-16.

Kleinman, A. (1988). The Illness Narratives: suffering, healing and the human condition. New York: Basic Books.

Knox, P. (1995). Urban Social Geography: An Introduction (Third Edition). Harlow, Essex: Longman Scientific and Technical.

Lachman, J and Stollenberg, G (1992) The Doctor, his Audience, and the Meaning of Illness. The Drama of Medical Practice in the Late 18th and 19th Centuries. In J. Lackman, & G. Stollberg (Eds.), pp 53-66 The Social Construction of Illness Stuttgard: Franz Steiner Verlag.

Laclau, E. (1990). New Reflections on the Revolution of our Times. London and New York: Verso.

Laufman, H (1981). Hospital Special Care Facilities. New York, London & Toronto. Academic Press.

Lefebvre, H. (1991). The Production of Space. Oxford: Basil Blackwell.

Littlewood, J. (1991). Care and Ambiguity: Towards a concept of Nursing. P. Holden, & J. Littlewood (Eds.), Anthropology and Nursing. (pp. 170-189). London: Routledge.

Littlewood, R. (1991). Gender, Role, and sickness: The Ritual psychopathologies of the Nurse. P. Holden, & J. Littlewood (Eds.), Anthropology and Nursing. (pp. 148-169). London:Routledge.

Lupton, D. (1994). Medicine as Culture. London: Sage Publications.

(1995) The Imperative of Health: Public Health and the Regulated Body, London, Sage Publications.

Malan, D. (1979). Individual Psychotherapy and The Science of Psychodynamics. Oxford: Butterworth Heinmann.

Massey, D. (1996). A Global Sense of Place. S. Daniels, & R. Lee (Eds.), Exploring Human Geography_. (pp. 237-245). Arnold:London.

Mgoduso, T and Butchard, A (1992) Authoritarianism and autonomy. Power, politics and alienated nursing care in South African primary health care system. South African Journal of Psychology, 22 (4), 194-201.

Mishler, E. G. (1984). The Discourse of Medicine. Dialectics of Medical Interviews . Norwood, New Jersey: Ablex Publishing Corporation.

Mitchell, T. (1992). Colonising Egypt. Berkley: University of California Press.

Mizrahi, T. (1986). Getting Rid of Patients: Contradictions in the Socialization of Physicians. New Brunswick, N.Y: Rutgers University Press.

Moore, H. (1996). Space, Text, and Gender. New York, London: The Guilford Press.

Muff, J (1994),The Paradox of Containing and Controlling, Perspectives in Psychiatric Care, 30 (4), pp32-34.

Mull, J (1990) The Primary Health Care Dialectic: History, Rhetoric and Reality. In Coreil, J & Mull, J , Anthropology and Primary Health Care, (pp28-47) Westview Press, Boulder,

Muller, L (1994) "Poor" Clinical Interpreting for "Good" psychiatric practice: Xhosa interpreting within a diagnostic interview in an acute admissions unit" Unpublished Honours project, Department of Psychology, University of Cape Town.

Muller, L, Ensink, K, Zissis, C, Leon, N & Robertson, B (1998) District Level Integrated Mental Health in the Western Cape. Unpublished Report. Department of Psychiatry. University of Cape Town.

Noyes, J. (1997). Mobility, identity and the Writing of History .Unpublished manuscript German Language Department, University of Cape Town].

Pile, S. (1996). The Body and the City . London and New York: Routledge.

Pillay, Y (1993) Primary Health Care in South Africa, SAMJ, 83 (Aug), pp 606-608.

Pinnock, D. (1984). The Brotherhood: Street gangs and state control in Cape Town. Cape Town, Johannesburg & London: David Philip.

Pizanias, C. (1996). Habitus: From the Inside Out and Outside In.Theory and Psychology, 6 (4), 647-665.

Pollner, M. (1987). Mundane reason. Cambridge: University Press.

Prior, L. (1992). The Local Space of Medical Discourse, Disease, Illness and Hospital Architecture. J. Lackman, & G. Stollberg (Eds.), The Social Construction of Illness. (pp. 67-84).Stuttgard: Franz Steiner Verlag.

Putnep, E. (1979). Modern Hospital: International Planning Practices. London: Lloyd-Luke Ltd.

Rhodes, L. (1991). Emptying Beds: The work of an Emergency Psychiatric Unit . Berkeley: University of California Press.

Rispel, L, Price, M & Cabral, J (1996), Confronting need and affordability: Guidelines for Primary Health Care Services in South Africa. Johannesburg. Centre for Health Policy

Robins, S (1997) "Transgressing the Borderlands of Tradition and Modernity: "Coloured" Identity, Cultural Hybridity and Land Struggles in Namaqualand (1980-94)". In Journal for Contemporary African Studies, Vol. 15, No 1, January 1997, pp.23-44.

(1998) "Topographies of Resistance: Revisiting the geographies of the (post)apartheid city". Paper presented at the African Studies Association (ASA) Meetings in Chicago; a version of the paper was also presented at the joint Department of Anthropology & Cultural Studies seminar series, University of California, Santa Cruz.

Robinson, J. (1995). Transforming Spaces: Spatiality and Re-mapping the Apartheid City .African Studies Seminar 17 May 1995. University of Cape Town

Rose, G (1993) Feminism and Geography, Cambridge. Polity Press

Rose, J (1996) States of Fantasy, Oxford, Clarendon Press.

Said, E (1978) Orientalism. London, Routledge and Kegan Paul.

Scarry, E (1985) The Body in Pain: the Making and Unmaking of the World, Routledge. London.

Schneider, S. (1991). Managing Boundaries in Organisations. M. &.Associates de Vries (Eds.), Organisations and the Couch. (pp.69-190). San Fransisco: Jossey - Bass Publications.

Segal, H. (1964) Introducing Melanie Klein. London. William Hieneman Medical Books Ltd.

Shields, R. (1997). Spatial Stress and Resistance: Social Meaning of Spatialization. G. Benko, & U. Stronhmayer (Eds.), Space & Social Theory. (pp. 197-202). Oxford: Blackwell.

Shield, V and Dervin, B (1993) Sense-making in Feminist Social Science Research. Women's Studies Int. Forum, 16 (1) pp 65-81.

Silby, H (1996) Outsiders in Society and Space. In Daniels, S and Lee, R (Eds) Exploring Human Geography. London, New York and Sydney. Arnold.

Soja, E. W. (1989). Postmodern Geographies. London and New York:Verso.

(1996). Thirdspace. Oxford: Blackwell.

Stacey, M (1988) The Sociology of Health and Healing. London. Unwin Hyman.

Stucky, C (1998) Policy in Progress: Trauma- A public Health Issue, Update, Health Systems Trust 33, April, pp1-2

Svesson, R (1996) The interplay between doctor and nurses, a negotiated order perspective. Sociology of Health and Illness (12) pp428-443.

Swatz, L (1991) The politics of Black Patient Identity:Ward rounds on the Black side of a South African Psychiatric hospital. Culture, Medicine and Psychiatry 15, p217-244.

Thomas, J. (1993). Doing Critical Ethnography. Newbury Park: Sage.

Tuan, Y (1977) Space and Place, London, Arnold.

Turner, B (1995) Medical Power and Social Knowledge. 2nd Edition. London: sage

(1997) From governmentality to risk, in Petersen, A and Bunton, R, Foucault Health and Medicine (ppix-xxi), London and New York: Routledge.

Urban Problems Research Unit, University of Cape Town (1981) Housing. A Composite Evaluation of Urbanisation in Cape Town.. University of Cape Town

Valins, M (1993) Primary Health Care Centres. Harlow, Essex, Longman Building Studies.

Van Rensburg, H and Fourie, A (1994) Inequality in South Africa health care, Part 1. The Problem – manifestations and origins. SAMJ, 84,(Feb) pp95-98

Von Gennep, A (1960) The Rites of Passage. London. Routledge and Kegan Paul

Weir, D (1977) The Moral Career of the Day Patient, in Davis, A and Horobin, G, Medical Encounters: the Experience of Illness and Treatment, London, Croom Helm, pp135-142

Weiss, M. (1993). Bedside manners: Paradoxes of physical behaviour in Grand Rounds. Culture, Medicine and Psychiatry,17: 235-253.

Western, J. (1981). Outcast Cape Town . Cape Town: Human & Rosseau.

Wiles, R., & Higgins, J. (1996). Doctor-patient relationships in the private sector: patient's perspectives.Sociology of Health and Illness, 25,(2) 23-36.

Wilkinson, D, Sach, M and Karim, S (1997) Examination of attendance patterns before and after introduction of South Africa's policy of free health care for children aged under 6 years and pregnant women. BMJ 314 (March), pp.940-941.

Wilson, F., & Ramphela, M. (1989). Uprooting Poverty. Cape Town and Johannesburg: David Philip.

Woods, K and Maepa, J (1997) Blood Blockage and scolding nurses: barriers to effective contraceptive use among Pedi teenagers, Unpublished Conference Paper, Health Systems Trust Report Back, 1 – 3 October 1997.

Young, K. (1989). Disembodiment: The Phenomenology of the body in medical examinations. Semiotica , 73(1/2), 43-66.

APPENDIX I

END NOTES

Chapter 1

1. This has been appropriated by the Sister-in-charge as her unofficial office. Officially it was a storeroom and boxes of swabs and toilet paper still took up much of the space here. Central nursing management has demanded she move out. She is refusing and resisting.
2. Interview with Sister-in-charge, September 1997

2.a. The facility is officially designated as a "community health centre", or "day hospital", the term clinic is used here for brevity, and is not strictly correct in terms of official health department service classification (cf. Draft Health Bill, 1998).

3. Ethnographic narratives tend to construct their field sites as the bounded world of the "other" (cf. Clifford, 1997). There is also a desire here to heroically construct a dangerous wilderness in which to position myself as researcher!
4. Hanover Park Rd. and Surran Rd.
5. Urban Problem Research Unit, 1981
6. Discourses on the unsanitary, unhealthy conditions of disorderly black spaces have been historically linked to forced removals in South Africa. Such discourse were active in the "justified" eradication of District Six involved the removal of 55 000 people from the city centre to peripheral places such as Hanover Park (Western, 1981, Pinnock, 1984 Butchard, 1995).
7. "Colourness" has been described as an "in-between", hybrid identity linked to discourses on croelization, "miscegenation", and dangerous destabilisating mixing of racial essences. Spatial segregation has been seen as a means of stabilizing such fluid identities (cf. Robertson, 1995; Robins, 1997).
8. Harries (1996) noted a similar vanishing act in her study of another, more isolated Western Cape Community Health Centre. She was informed that clinic signs were unnecessary as the "community" all knew the location of "their" clinic. This raises pertinent question about its visibility for strangers and visitors.
9. To borrow a phrase here from Rose (1996) in her discussion of fantasy.

Chapter 2

1. For a rare example, see Prior (1992)
2. The term is borrowed from Marcus (1993), Ed. Perilous States: Conversations on Culture, Politics, and Nation. University of Chicago Press.

Chapter 3

1. Bear *et al*, (1997) note that forms of biomedicine developed in socialist countries have had the same mechanistic and reductionist tendencies as western-capitalist models.
2. PHC is now a globalised discourse seemingly dislodged from the centre through international organisation such as the World Health Organisation and United Nations (e.g. UNICEF).
3. This is hung outside the SIC's office as a public poster.
4. Until the demise of the tri-cameral parliament the centre was managed by the House of Representatives, the coloured parliamentary house of late-apartheid. Thereafter, the CHC has been managed first by the non-racial state (National Department of Health), and then more local and geographically determined forms of governance - currently the regional provincial administration (C.H.S.O), and in the near future, local authorities at district level (Muller *et al*, 1998).
5. Public health services are staffed and owned by varied forms of government. This is seldom directly articulated but control over facility structure and design is carefully controlled (see Draft Health Bill, 1998).
6. Although this definition of primary health care services did not sit well with apartheid policy, forms of public community based health care have been developed and implemented in this country since the post-war years (Butchard, 1995).

7. Armstrong (1993, 1995) points out that such "surveillance medicine" targetted child health and, via practices such as health education and survey interventions constructed a populace of health vigilant and literate people. This results in the "medicalisation of everyday life" by which "everyone is brought under the benevolent eye of medicine" (Armstrong, 1995, p.399)
8. The distinction is made here as the poorest, most unstable places, such as isolated informal settlements, are *not* sites for primary health care facilities.
9. The building of PHC clinics at Hanover Park can be seen as a means of place-making in this newly constructed and alienating place. A recent example of this is the construction of a CHC in the contested, but state sanctioned informal settlement in Hout Bay (see Dixon *et al*, 1994).
10. The immanent development of the District PHC service will see the Baby clinic and the CHC under unified management.
11. By officially changing the name to a "community health centre" the clinic has also been aligned to global classification of public health establishments.
12. The development of comprehensive services requires the integration of formally "vertical" specialist services such as psychiatry, paediactics and obstetrics into a single facility-based service (Muller *et al*, 1998). Comprehensive PHC also includes promotive and preventative services include health education, screening and community development.
13. Most design manuals are of European and United States origin, although local "criteria" have been developed (Rispel, Price and Cabral, 1996). These appear, however, to only describe principles in accordance with South African health policy (e.g. equity and accessibility) rather than specific architectural forms.
14. "Low tech" primary health facilities are seen as a more "appropriate" import to developing countries. These are based on models developed for historically understaffed First World inner-city or working class facilities (Valins, 1993). Cox and Groves (1990) also stress that PHC facilities in developing countries should emphasize health education, prevention and promotion, including "hygiene and elementary health care" (p.25).
15. It may be asked what authority globally imposes this "orthodoxy"? This notion of centralized and visible authority fails to recognize the integral interrelatedness of design and biomedical practice. Following Lefebvre's (1991) and Foucault's (1977) insight into ideological or discursive spatial forms, such spatial practices cannot be separated from forms of biomedical knowledge-making and ordering as we know it (e.g. positioning of patient *vis a vis* the clinician)
16. It could be argued that this "cultural adaptation" perpetuates poor services and resources in poor areas. An emphasis upon local, "cultural" forms may relativize health care standards and perpetuating inequitable practices and facilities.
17. Putnep (1979) concedes that the latter aspect of this aim is easily compromised as a "maximum number of patients being seen at a given time inevitably reduces the level of privacy and dignity of the patients" (p.611).
18. Ruth Cammock is trained as both a doctor and architect.
19. The recovery bed is a feature of some community health centre designs. Such beds are locally found only in District Hospitals and MOU's.
20. The zones for cleaning staff (domestic general assistants) does not exactly follow the same contours as that of the nurses. It includes non-nursing areas, such as "Chemist", "Waiting areas" and "corridor" suggesting a slightly different topography of the clinic (cf. Allen and Pryke, 1996; Hart, 1991)

Chapter 4

1. Note this includes conceptual and linguistic features, for instance modern forms of categorisation and linear narrative construction (cf. Foucault 1972, 1976).
2. This is currently being functionally reintegrated into the CHC's comprehensive services. Quite literally - the door between the blocks has been unlocked and the spaces joined.
3. This unorthodox design is not specific to this clinic, and is observed as a common local feature of township health facility architecture.

4. A Clinical Nurse Practitioner (CNP) or Primary Health Care Nurse has extra qualifications to provide curative consultations. Since the loss of nurses in the clinic, CNP's are now functioning as general nurses. These Examination rooms were therefore only being used by visiting doctors.
5. This combination of consultation and examination areas in one room is acceptable and indeed lauded as "economical" in private and state PHC clinics (e.g. Valins, 1993).
6. The cubicles also have clothes hooks on the wall, which might suggest that the patients were originally expected to undress here or hang up belongings here before entering (or leaving).
7. According to nursing staff, this surgical area was designed to be used only for family planning purposes, such as vasectomies and sterilisations.
8. Almost half of the doctor's consultations are currently booked (this excludes treatment in the Trauma Unit). Booked patients are usually regular "chronic patients" and these who have access to a telephone or who can travel to the clinic to make an appointment. Unbooked appointments are therefore usually more itinerant, disadvantaged and peripheral patients.
9. Visits to other clinics in the city reinforce the observation that levels of privacy vary (e.g. Preparation processes occurring in front of patients in the main clinic entrance room). This is usually in direct proportion to the socio-economic conditions of the community, and clinic infrastructure and resources.
10. Two to four patients are usually seen here concurrently.
11. Visiting doctors may use the less private "examining rooms" which open onto the various Treatment areas.
12. I am referring here to levels of privacy. I did not actually observe an appointment in the doctor's office (although invited to), but relied on doctor's accounts and procedural observations. Closer observations may have revealed significant differences within the actual doctor-patient encounter. Privacy within this consultation was not ensured. Nurses entered to deliver files or make queries for upcoming patients, the occasional patients "bursting in" to "demand attention" (Doctor B) and loud and erratic messages were broadcast over the ubiquitous loudspeakers.
13. I did not, however, hear accounts of, or from, patients complaining about this lack of privacy.
14. It is clear that staff also experience different degrees of exposure and surveillance within these areas.
15. It may be argued that the process of health seeking - that is becoming the patient - begins prior to the patient coming to the health facility, and that it may be driven by multiple motives beyond overt "health" needs.
16. Complaints from reception staff regarding patient's anger and abuse occurred most frequently at night and over weekends. At these times they are on duty alone and must move out of the more isolated Reception areas (e.g. to deliver files).
17. This individualizing process needs to be seen as a continual process from admission to "discharge". An individualized and bureaucratic patient file accompanies this trajectory, and, it may be argued, that the doctor's rooms are key sites in this process as its complex doors attests (see Chapter 5).
18. Note that new CHC's do not appear to include these features.
19. The slippage between staff, race, and class identity is illustrated at this gate where I was very seldom asked to justify my access into the staff parking area.

Chapter 5

1. The tension between, and the intermeshing of these two realms, has been indirectly articulated by Good and Good (1993), who write of the contradictory polarities within biomedicine between efficiency and caring, or, put another way, the contradictions between the instrumental and symbolic realms of medicine.
2. Bourdieu (1977) is useful in bridging the divides between modernism and postmodernism. He has roots in critical theory and phenomenology, and, like Lefebvre (1991), strives to "maintain an analytic focus upon agents and agency" (Calhoun, 1995, p.135). Bourdieu, (like Foucault), also looks at "the relationships of power that constitute and shape social fields"(*Ibid.*), and the "imbrication of knowledge in relation to power" (*Ibid*, p.132).

3. This sense of place is most strongly articulated among the longer-serving nurses and general assistances, I did not hear doctors (or patients) refer to it is this manner.
4. This assertion of the *real* meaning and function of the clinic should be read as a product of power.
5. Harries (1996) writes of similar constructions of place held by the *patients* at Hout Bay CHC. This was accompanied by social practices which produced and reproduced this sense of meaning (cf. Bourdieu, 1977). For instance, the use of the waiting rooms and clinic environs as a site for community social gathering and play. She also demonstrates how community members weaved the clinic as part of the place of Hout Bay into their self-narratives and biographies.
6. Following Martin Heidegger, "dwelling" is the capacity to form a "spiritual unity between humans and the material world. Through repeated experiences and complex associations, our capacity for dwelling allows us to construct places, to give them meanings that are deeper and qualified over time with multiple nuances" (Knox, 1995, p.216)
7. She is "*taking the package*"
8. Currently the clinic functions as Bourdieu's "field" that is, a place of "forces and struggle, a space of competition for distinction..constant struggle to a) define a position, b) defend against it, c). distinguish it from those below (Pizanias, 1996, p.651).
9. See discussion in the next chapter of the most private space in the clinic, the "Love Room".
10. One of the general assistance lives in Hanover Park and some of the security staff.
11. Clifford (1997) warns against constructing informants as static inhabitants of field sites. The journey into and out of Hanover Park for staff and patients is another tale of space, mobility and territory, which I cannot unpack here.
12. I have found Chidester's (1994) argument regarding the making of sacred places helpful here. He describes the cultural work of "sacralizing" spaces, so that they become sacred places within communities (p211) Chidester draws his arguments from the work of the Dutch phenomenogist of religion, Gerardus van der Leeuw.
13. It is interesting to note Cammock's (1981) construction of this binary does not reveal the mutually constitutive nature of the staff-patient binary. Cammock constructs patient territory in a revealing manner, namely, it is "patient *care*" territory, that is, "patient" status is contingent upon a binary relationship with a staff member, without this co-presence the he/she remains a member of the "public" "Staff " however may exist as a free standing category on its own, thus wiping traces of the co-dependence of these categories. This notion may be said to stabilize and empower staff identity and status, in line with the needs of dominant biomedical ideology (cf. Laclau, 1991)
14. Chronically ill patients or "*chronic patients*", are largely exempt from such scrutiny as familiar visitors with long-term patient status. Their "sick" status is not, however, beyond challenge, and the chronically ill may be a morally and clinically ambiguous status (cf. Lupton, 1994). There are many patients attending the clinic on a monthly or three monthly basis with chronic illnesses, these include diabetes, hypertension, epilepsy, tuberculosis, asthma and increasingly, those with psychiatric illnesses such as schizophrenia, depression and bipolar disorders.
15. The assumption here is that sorting should occur through the discretion of the ambulance service.
16. Questions still need to be asked as to the reason this woman was bought all the way to this clinic, which does not officially serve the Wynberg area.
17. The women, despite her apparent intoxicated state seemed to be constructing herself as a "sick patient". Although it appears this is not necessary.
18. The impact of this must be measured along with the accompanying *loss* of staff.
19. In a paper titled "Blood Blockage and Scolding Nurses" (Wood *et al* 1997) the authors aptly demonstrate that such scolding is a common feature of primary local health care staff/patient interactions.
20. Complaints of mothers and children abusing free health care are by no means confined to this clinic. It is an ongoing national "problem" which links free services to "abuse" of the health service (Wilson **).

21. The trope of the wounded child has been a powerful moral resource for The Struggle and the post apartheid state. President Mandela's first act in the newly democratic South Africa was to declare free health care for children and pregnant mothers.
22. I will examine in Chapter Seven how this morality is actively and spatially performed in the participatory theatre of the clinic.
23. This is a common perception among staff and management of the local PHC services. Harries (1996) describes similar complaints by staff at another Western Cape CHC, referred to as "a culture of entitlement" (p72)
24. This raises tantalising questions regarding contingent constructions off illness/disease and patients status in free public, as opposed to private health services.
25. Local government structures have been seen as an attempt to redraw the apartheid borders of the city, and its multiple racial-based administrations. See Robinson (1995) for her critique of this localising governance process, and its failure to adequately address local issues of class and race.
26. The issue of race once again, challenged my assumption regarding categories of social exclusion and membership. Hanover Park is formally coloured space and the Western Cape is particularly marked for racial tensions between coloured and black inhabitants. This situation is exacerbated in conditions of spatial "trespassing" by blacks into coloured areas or spaces. Although anxieties associated with the facility desegregation were never heard, it is clear that clinic is legally and morally open now to new and different people. Yet, race, currently does not appear the most salient feature of this difference at the clinic (cf. Hogg and Abrams, 1988) - black patients are few and usually quiet and respectful adults. It may be argued, therefore, that they do not (currently) challenge dominant patient/staff binaries.
27. This is especially difficult when this clinic is so conveniently placed besides a large taxi rank.
28. *"..Nou die mense mos baie mors, baie mevrou. Daar is vuilus dromme daar..hulle mors baie, en dan mos' n mens vir hulle sê. Maar hulle sê, dis one se werk. Dis onnodig. Ek sê vir hulle, 'Dis julle hospitaal, jy moet na die hospital kyk"* (Mr C, General assistant, translated interview).
29. These include categories of workers such as cleaners, laborers, domestic workers and dispensary assistants.
30. Note that reception staff are physically separate and protected from the public in their spaces, and security staff are equipped with guns and batons to cope with threats from patients and escorts.
31. In psychoanalytic terms such messing could be interpreted as a primitive expression of rage and anger by the patients towards the (parental) clinic (Segal 1964).
32. I observed similar spotless homes among those visited with the District sister in Hanover Park. This extreme order and cleanliness was often juxtaposed with dirty and crumbling exteriors, and dusty streets.
33. My own fear and unease has not been directly written into this account.
34. This make sense within Cammock's (1981) spatial territories. The door opens onto "Staff Territory" and as such is not conceived of as public space. In reality, however, this territorial distinction is not as secure.
35. Quite literally his buttocks (or bottom). A rather shameful and unheroic injury.
36. Tropes of contamination are invariably embodied, as the body is "one site of intense articulation of power, desire, disgust of the individual, the social and the spatial" (Pile, 1996, p.184). Regulation of the body, which invariable involves managing and distancing from bodily functions has been seen as the symbolic cornerstone of "civilisation" (Elias, 1978) or indeed all forms of social order (Moore, 1996). The social (body politic), its order (and disorder) become symbolised in the trope of body, as "the body is a model which can stand for any bounded system. Its boundaries can represent any boundaries which are threatened or precarious" (Douglas, 1966, quoted in Pile 1997, p.185).
37. A sacred space, Chidester (1994) continues, "can be defines by what it excludes", a "highly-charged, contested, and even violent politics of exclusion" (p.217). He also asserts that the capacity to exclude needs to be linked to the "politics" of property (p.213). Such space is not

merely meaningful but is powerful "because it is appropriated, possessed and owned", a "political conquest of space" (p.216).

Chapter 6

1. Lefebvre (1991) does not make Foucault's distinction regarding non-repressive or productive forms of modern power. I have read his "dominating" forms of power as the dominant modern disciplining power inherent in official Panoptic scheme. Hence, other more "primitive" forms of power may also co-exist in these space, they are therefore "illegal" in term of the self representations of a human-rights orientated modern state. This type of power is more evident in peripheral and ungovernable spaces.
2. The general consensus here may be due to this having been one of the discussed and documented demands put to the Provincial CHC management along with security guards, gates and walls at the end of 1996. The staff report that they are especially vulnerable to attack (or fears of attack) during the Festive Season, when alcohol consumption and assault increases. At one of my last visits to the clinic proceeding this period, intense discussion among staff (nurses and GA's) were underway regarding ways to manage without their desired "Escape Door". It was suggested that the Injection Room functions as a Trauma Unit. This room has may more doors, and nurses had carefully plotted their escape routes out the Doctors office and the Service entrance.
3. "*The Package*" is a relatively large once-off voluntary severance payment (V.S.P) given to government employees who voluntarily leave the state services before retirement age. It is designed as a staff incentive to encourage the rationalization of services without labor disputes.
4. Post Traumatic Stress Disorder
5. Most complaints were directed towards male doctors, while the two women doctors seemed less absent and more likely to provide "back-up" for missing (male) staff.
6. The reason given by doctors for this singular privilege is that they are expected to be on duty again the next night, unlike other staff who rotate such responsibilities.
7. The unofficial C.H.S.O "quota" is sixty patients per day.
8. Official design criteria suggest that waiting areas make reference to the domestic realm (e.g. comfortable chairs, magazines, pictures and potplants), in order to contain patients anxiety regarding visiting the doctor (Valins, 1993).

Chapter 7

1. This is in keeping with international trends which indicate that such units are increasingly being used for outpatients care, where more than two-thirds of cases may nor be classified as non emergency (Laufman, 1981). International standards also state that 24 hour services must consider "the security of staff and patients, access by ambulance, motor car, and on foot, with appropriate signs, lighting and other direction" (*Ibid*, p.394)
2. Since 1998, the clinic has largely abandoned the booking system for patients. Non-emergencies who are seen at the Trauma Unit would still be those who are too late to have a private consultation with one of the doctors.
3. Motor vehicle accident
4. Note that officially the doctor and/or the professional nurse should undertake such suturing. Here the enrolled nurse and the general assistant are undertaking it while the doctor is a background figure, and the professional nurse dispenses medication (again, not an official function).
5. I noticed that staff's stance towards black male assault victims was less predictable. The most sympathetic response I observed towards a stabbing victim was for a black man from Phillipi. Staff engaged with his story (with some linguistic difficulty) to ascertain that he was the victim of a robbery. They then gave him practical and religious advice, tut-tutting under their breath. When the victim is poor and coloured this "victim status" may not have been enough to have illicit such as response. *Gangster labels tend to be applied unless proved otherwise.* This creates a perpetual state of alertness and precaution in dangerous territory.

6. Gangs surrounding the clinic according to staff include: Nice Time Kids, Backstreets, Mongrels, Americans, *Sewe Lewes* (Seven Lives), Vultures, Laughing boys, *Bokkies*, Wildcats and Hard Livings. There is no agreement as too whose territory the clinic is in, the general assistants say the clinic falls between the gangs, security guards insist that the clinic is on American territory. There are however accounts of some gang members being unable to use this clinic as it falls within the territory of their enemy and they must travel to adjoining clinics.
7. The security guards here is often a woman, did not feel a very impressive deterrent against male violence.
8. He should have come earlier to have these taken out, and this should have occurred during the day in the Treatment areas.
9. Note that the ongoing "problem with gangsters" is that they demand preferential treatment, and refuse to wait for care when injured. She is directly challenging this stereotype.
10. I observed women attending the clinic after episodes of family violence. These were quite literally *sister and partner*, rather than mothers of the perpetrators.
11. The history of the surgical theatre: Surgical amphitheatre was derived from the classical anatomical amphitheatre in teaching centres of Europe since twelfth century (Laufman, 1981). The surgical theatre has its origins in a tradition of "student and physicians who flocked to witness feats of rapid surgical techniques by master surgeons" (p.16). The operating theatres "was an arena with a dramatic show" (*Ibid.*), a "spectacle of surgery performed before a responsive audience" (*Ibid.* p.17). Process later became more antiseptic and painless and less rent with the "heartrending shrieks of the patients" (*Ibid*, p.16).
12. This is a part of the Christian (Anglican) ritual of Eucharist or Communion.
13. The doctor this night is a white male. I do not think this performance would have differed should he not have been. The staff of the clinic represent official authority and power, which overlaps and intersects here

Chapter 8

1. Apologies to Scarry (1985)
2. Note that the fieldwork of this study was undertaken before the full-scale vigilante action associated with organisation such as PAGAD had developed.

APPENDIX II

THE SETTING

A) Hanover Park

i. Demography and population

Hanover Park is an apartheid-designate coloured township between Lansdowne and Phillipi. Named after a street of the abolished District Six, its original inhabitants were largely the poorer families forcibly removed from the newly declared "White" areas in the apartheid racial cleansing of the 1960's and 1970's (Western, 1981, Pinnock, 1984). These areas included District Six and the lesser-known removals from "white" suburbs like Mowbray, Rondebosch, and Wynberg (Western, 1981).

The township covers about 15 square kilometres with a predominantly working class population of approximately 37 000 (City of Cape Town, 1997). The township was planned by the City Council in 1969, and developed in the seventies as part of a set of "low income" housing projects. It was built along with areas such as Heideveld and Mannenberg, and as such is "typical of the underdeveloped areas of the city as a whole. (*Ibid*, p.9)[1]. Its location between the large thoroughfares of Lansdown and Turfhall Road has made it less marginal than many other poorer areas. As such, it is also currently part of the Cape Town City Council's Landsdowne-Wetton Road Corridor Project - linking the Cape Flats commercial areas and encouraging nodes of development. Despite an active RDP committee involved in the Project, the initiative has had as yet little impact on this area (Personal communication, City Planning Dept.). There is a relatively developed informal sector, but the area remains "economically depressed" and "in dire need of renewal"(City of Cape Town, 1997, p.7). Structural problems include a lack of houses, lighting and recreation facilities. Social problems include high unemployment, gangsterism, and school drop out rates. In all a neglected township synonymous with the social disorder and poverty of the Cape Flats.

As a large-scale apartheid townplanning project Hanover Park "has been conceived and constructed in its entirety" (Urban Problems Research Unit, 1981, p.31). This has resulted in stark landscape where,

> the uniformity and dullness of the environment, coupled with the lack of opportunity for individual self expression, imposes a negative form of anonymity upon the inhabitants (*Ibid.*)

[1] Note here the shift from an apartheid discourse on race to an emphasis upon class and economic disadvantage.

A large part of the population is under nineteen years of age, and the area has been synonymous with gangsterism since its inception. Pinnock (1984) writes that Hanover Park became territory divided up between sixteen gangs, with corresponding high rates of assault, murder, theft and substance abuse. Pinnock saw this as a "reappropriation of space" (p.105) which requires "force" and a "short circuiting of official control and surveillance" (*Ibid.*).

Gang activity in the area appears to have increased and accounts in the press paint a dismal picture of residents "kept 'prisoner' by gangs" (Cape Argus 12.1.1996). There have also been accusations in recent years of police "connivance" with the gangs (21.12 1995). Army troops were briefly deployed in the area in early 1997 to help protect residents in the "gang wars" in the area.

ii. Design and built landscape

The built fabric of Hanover Park consists almost entirely of three story barracks-like block of flats each consisting of 36 - 40 units, and a smaller number of small square free-standing and semi-detached houses (City of Cape Town, 1987). Most of the accommodation is rented, and there is a major housing problem. Structurally the township has been described as,

> mostly high rise buildings of uniform design, located irrespective of terrain and orientation, with empty spaces of windswept soil (City of Cape Town, 1980, p.4).

These open spaces have been described as "unsafe", and sites of much crime and vandalism. These spaces have subsequently become grassed but are often debris strewn and remain generally underdeveloped. The township is rendered "spatially distinct" by its surrounding open buffer regions which serve little recreational function (Urban Problems Research Unit, 1981). There is also a clear separation made between the predominant residential area and the small pockets of business or shopping areas found in the township centre.

Since the eighties there has been as gradual suburbanising of some of the original empty spaces of the township. The original buffer areas have become land for schools and new (more affluent) housing estates. Plants have been eked out of the inhospitable soil and graffiti decorates walls. Residents have put up concrete fences around small yards and gardens, thus carving out more private spaces. There is a growing population of backyard shacks as families enlarge or seek

another source of income. The limited development of light industry, shops and businesses in the area, has not, however, has much impact upon the rising unemployment in the area.

B) Hanover Park Community Health Centre

The Community Health Centre (CHC) was opened in the early eighties. Prior to this Hanover Park was only served by a small City Council "Baby Clinic" designed as part of the original town plans. Although this clinic is across the road from the CHC, there is little contact with this facility - a situation that will soon change with the immanent[2] amalgamation of Local authority and provincial services.

Hanover Park Community Health Centre is one of forty-one primary health facilities provided by the Province Administration of the Western Cape (P.A.W.C.) in the Cape Town Metropolitan region. They are directly managed by the Woodstock based Community Health Service Organisation (C.H.S.O).

There has been an increase in patient attendance of 55% at C.H.S.O facilities between 1996 and 1998 (Muller *et al*, 1998). This has resulted in increased pressures across the board on the PHC system. During 1996, approximately 2 million patients were seen at (provincial) PHC level, indeed over the last two years an additional 200 000 patients attended CHC's and an extra 200 000 were expected this year (Cape Argus 24.6.1997). This has been accompanied by high staff loses and increased staff absenteeism. After a few highly published deaths from alleged neglect at PHC clinics, a task team was established in May 1996, to investigate conditions at these facilities. It is interesting to note that they did not receive direct complaints about standards of clinical care, "but rather the process of admission and an underlying unhelpful attitude [from staff]" (Cape Argus 24.6.1996). Staff at PHC clinics have been accused in the press of being "uncaring" and placing the achievement of their (unofficial) patient "quotas" before patient's needs. There are also accounts of medical officers (MO's) going home early after reaching these quotas of 60 patients per day (*Ibid*).

At the time of this study, Hanover Park CHC was at the crossroads of a number of changes:

a) The integration of formally "vertical services", e.g. Paediatrics, Psychiatry and the Maternity and Obstetrics.
b) A proposed change of health governance to the municipality, with no clarity what this amalgamation will mean.

c) Intensive staff and service rationalisation of the public health system, which has resulted in "Voluntary Retrenchment Packages" to encourage staff to leave the service, and a moratorium on new posts.

d) Increased patient numbers with the advent in 1994 of free health services for pregnant mothers and children under six years, and since May 1996, the provision of virtually free health services for all at PHC level.

Patient numbers have increased with the rationalisation of tertiary services, especially paediatrics and psychiatry, so that more patient are now expected to be managed at PHC level, without a significant increase in resources at this level. This has changed both the number and profile of patient seen at Hanover Park CHC - there has been a 20% increase of patient since 1996, and a 111% increase in the number of children treated between 1996 and 1997.

High patient numbers, complaints from the public and gang abuse has created a very difficult working environment within the CHC. Staff (not surprisingly) described themselves as stressed, burnout and traumatised by all these conditions. Limited staff numbers were further exacerbated by high absenteeism. Previously a stable, experienced and mature staff body, many senior nursing staff were "taking the package" and farewell parties were the norm.

i. Services offered

Hanover Park CHC offers a range of curative and more recently, preventative services. The bulk of patients are seen in curative consultations with doctors, either in the adult or the special "Mother and Child" service. Other services include Immunisation, Family Planning, X-rays/radiology, Psychiatric service, Medication Dispensing, Social work, and a 24 hour Trauma Unit. The curative service also includes nurse run services: Preparation, Treatment and Dressings. Services recently integrated are: District Health, School Health, Psychiatry and in the near future, Dentistry and the Maternity and Obstetrics (currently run by Groote Schuur Hospital).

ii. CHC staff

In terms of medical practitioners, there are four full-time and two part time medical officers (MO's). One full-time and one part-time MO are specifically dedicated to the "Mother and Child service". Most of these doctors are assigned Trauma duties, and they are supported at night by MO's and nurses drawn from nearby CHC's without a 24 hour service.

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[2] Like many "immanent" government plans this amalgamation has yet to occur and predicted dates is July 2000.

The bulk of the staff are nurses. The CHC has eight professional nurses (PN's), three enrolled nurses (EN's), and seven nursing auxiliaries/assistants (NA's). All the nurses, except a single NA, are women. Other staff include: two full time pharmacists and one assistant; a radiologist and radiologist assistant; twelve general assistants, (GA's), a social worker and one psychiatric professional nurse (and another who uses the office space only). Due to ongoing conflict with a community, a Community Liaison Office was recently also assigned to the CHC – the only position of its kind in the C.H.S.O. Working on the premises are also six security guards employed by a private company contracted by the Province.

C) The CHC Building

The community health centre is a prefabricated structure, which, according to the staff's knowledge, was originally built with the "*promise*" that it would soon be upgraded to a more permanent building. This is cited as the government's[3] ongoing lack of delivery and duplicity. It appears that the promise of health facilities was one of the initial "*carrots*" used to persuade the community to accept the move to Hanover Park.

The building is described by staff as "*dilapidated*" and in need of renovation. It is offers little climatic protection, being very hot in summer, cold in winter and leaks in many areas. The plan of the CHC has been described in Chapter Three of the study. Specific areas will be described in more detail below.

i. Large Waiting room and Reception

The Large Waiting Room is the initial waiting area accessed through the front door. It is here that patients arrive, and present themselves at a side window that leads into the Reception area. There are two windows where patients present themselves and give details of their status, i.e. "*booked*", "*unbooked*" or "*emergency*". The windows are only open early in the mornings when the bulk of patients need "*sorting*". There after both windows are closed by a curtain and incoming patients need to knock on the glass to be acknowledged. Reception staff say that this is to stop patients "*passing rude comments*" and give staff some privacy. During the day patients and escorts consult with reception staff at a wood and glass counter opening onto the public section of the Reception Room.

[3] The staff here make no distinction between the apartheid and post-apartheid state in terms of the lack of support to the health services.

The interior of the reception area is largely taken up by rows of wooden shelves upon which patients' files are alphabetically stored. A smaller area (not on the plans) has been partitioned off as a reception staff rest area. A note on the reception door reads, "Admission for receptionist and Sister in charge only", although other staff frequently enter for queries regarding files and admissions.

The Large Waiting room has long fluorescent lights, but is also lit from the inaccessible adjacent courtyard and large windows. It has public toilets and a phone booth and all the walls are decorated with health educational posters, or notices (e.g. "*Attention please make bookings to see doctor and for medication*" or "*Attention all children from 0 - 13 yrs, please queue here*". Almost all posters are in English despite most of the patients and staff appearing to be predominantly Afrikaans speaking. Most of the patients gathered here would be classified coloured, although some black patients attend in the afternoons, most of who appear to be from the Phillipi area. The CHC is generally quieter in the afternoons, and by 4.00pm most patients have been seen and the waiting area is virtually empty. After 4.30pm, patients will be directed by security guards or the single receptionist staff to the Trauma Unit, or they may attend the "*Peads doctor*" available in the Dressing Room until 8.00pm.

The main entrance has large security gates, which I never saw closed, and the sporadic attendance of a security guard. The clinic is announced with a dated sign, using the old "*Day Hospital*" designation and inaccurate staff consultation times. At all times of the day one will find patients sitting in the sun, talking and smoking. Some will be awaiting their appointments, although the majority appears to be waiting for lifts home, or simply resting. Most of these people appear to be young and middle aged women, and young men.

Some of the reception staff have been worked here for twenty years and many of the "*chronic patients*" are greeted and known by name. The reception staff, there are usually three on duty, also manage the busy switchboard, and handle incoming appointment bookings and alterations. They report that some patients are "*rude*", especially psychiatric patients.

All patients must pass through reception which acts as the clinic's bureaucratic gatekeeper. Sometimes this involves actively sending patients home or blocking access to clinical staff. Appointment booking are made telephonically, and there can be up to 2-3 week delay. There is also the option of attending the clinic without an appointment and getting a "*Red Ticket*" which allows

one to wait for a space in the booking register. Appointments are made on Appointment Cards issued by reception and completed for some patients on leaving the clinic.

"*Sorting*" of patients occurs at 9.00am for those people without appointments. "*Sorting*" occurs in the Trauma Unit where the doctor-on-duty will see about forty patients to determine severity of illness. This includes basic questions and a physical examination after which the MO will offer the patient three choices: a) to return at next available appointment, b) receive a "*Red numbers*" to be seen by other doctors during the day, c) become an emergency case that will be seen (after a wait) Later in the afternoon if there are no more emergency cases, some of those "*Red numbers*" may be seen by Trauma doctors in order not "*to leave cases for the doctor at night*".

ii. Second Waiting room for Preparation Area

The Second waiting room is accessed through carefully guarded gates. Patients may only enter when called by a staff member, usually no more then ten at a time. All patients leaving the clinic also pass out through the gates but with no restrictions. This space serves as the waiting area for pre-consultation Preparation which occurs in "Prep." activity area. The wooden benches are in rows, orientated towards the interior of the clinic and the direction of flow.

This area also acts as the main corridor to access the interior of the clinic. But it is also an active clinical area in the sense that patients (or their mothers) must pass through here with their urine samples collected at the (unisex) toilet. Active negotiations with nursing staff also occur here, such as collecting and checking personal details and negotiations regarding clinical visits.

Unlike other waiting areas in the clinic, the orientation of the waiting benches at the Preparation Room entrance facilitates dialogue between waiting patients. This is often therefore the site of discussion between patients and escorts, and indeed myself and patients:

> An elderly woman says that she has visited the clinic for many years where she sees the same doctor. She says she is happy with the clinic as she is known by the staff and the service is close to her home. She has come today collect her 'pills' and doesn't see the doctor at every visit although she will be checked at the Prep and in the Treatment room (blood pressure). Other patients did not seem so satisfied and complained among themselves about needing to have 'patience'. Most appeared to have walked from their homes in Hanover Park (Field notes)

iii. Preparation rooms

The Preparation room is the first point in which the patient receives clinical interventions from the staff. It is a reactively small room whose main function is to provide a space for a basic battery of screening procedures and formal sorting of patients to the various doctors on duty. Patients wait in the Second (or Preparation) waiting room, before they get called into the "Prep" room, where they must wait again on the bench near the door. The room is small and cramped with a single high window that offers no view and little natural light. The "Prep" waiting area leads onto four rooms, these include a public toilet for collecting urine samples, a "Urine test room" (containing a scale, litmus testing materials, sink, various bottles, sluice and cupboard).

The Preparation room, like the Dressing, Treatment and Injection Rooms is run solely by nursing staff. There is always a professional nurse on duty, and usually an enrolled nurse or nursing auxiliary, who appear to undertake the same tasks. The bulk of the people seen here seem to be children accompanied by their mothers and siblings. Adults attend but it is mandatory for all children to pass through here. This is the place of standardised examinations such as weighing, taking temperatures and urine testing which serves as a preparation for subsequent clinical procedures (e.g. doctor's consultation). Although the "preparation" process is largely routinised and staff make basic clinical decisions according to prescribed protocols such as a high temperature. This basic information is recorded in the patient's files and its lack can cause major congestion as patients are asked to return by the consulting doctor.

A key function of the room is as a site of patient sorting to the various doctors on duty. Patients' files are placed in a simple wooden compartment labelled with the doctor's name. Allocation is managed according to the number of patients that doctor is "*clearing*". Patients are not allowed to make appointments for specific doctors, although long-term patients are often allowed their preferences.

The first time I visited "Prep" it was being managed single handedly by a busy nursing assistant while his colleague was having tea. The area was congested and the nurse frantic as he sought to screen, sort and physical delivery the patients' files to the respective Doctors Rooms. Patients usually follow him as he does his rounds in order to see where they must wait for treatment. He then returned to another group of assembled, and often inpatient, patients. Although usually managed by two nursing staff, the multiple clinical and administrative tasks and frequent patient dissatisfaction make this one of the nurses' least favourite "*areas*" in which to work.

iv. Corridors and waiting areas

The central spine of the clinic consists of patients waiting areas (that also serve as corridors), and the four central courtyards. These courtyards are a central feature of the interior space and they pleasantly flood the clinic with sunny, natural lighting through many, burglar-bared windows. The courtyards are paved with concrete blocks and decorated with some pots of sun bleached plants. The courtyards doors remain almost permanently shut, but patients take every opportunity to use these sunny spaces to sit, talk and smoke.[4] The corridors were also at times a site of lively talk and interactions between clinical and security staff and patients. In busy periods there is a high level of noise here from the ubiquitous staff intercom, children's shouting and talking and the clanging of the security gates.

v. Dispensary

The final set of benches is the waiting area is for the Dispensary. The pharmacist stands at a hatch in the wall (towards which the benches are orientated), and calls out the patient's name from the file before him. He/she then hands the pile and medication to the approached patient, after checking the medication and signing the prescription in the patient's file. The actually "Dispensary" is a large area filled largely with shelves on which drugs are packed (and unpacked). A pharmacy assistant (SASO) and a GA do most of the work within the room. Because of the scarcity of staff, the GA is involved in sorting and assessing the drugs in a manner that requires basic pharmacological knowledge.

The Dispensary area is often very crowded, especially when short staffed. The Dispensary caters for nearly all CHC patients and can become very crowded and congested. Many patients must wait long periods to be served and. Such pressures result in short and hasty encounters between pharmacists and patients. Patients have described these encounters as "*rude*", and there is seldom adequate time for queries or consultations regarding the medication dispensed.

vi. The Dressing Room: Treatment Room 1

The Dressing Room is a large, multi-compartmental room on the north side of the hospital.
Initially designed to accommodate a number of practitioners in separate cubicles, the primary usage area is a fair size central room in which patients are treated. Two cubicles have also been separated off to create a separate area for the psychiatric nurses.

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[4] I was informed that the area is usually out of bounds to patients in order to reduce the GA's cleaning load

Currently the area is staffed by two nursing staff, one of whom is always a professional nurse. This nursing area is used for applying and removing various dressings, such as Plaster-of-Paris, postoperative wound care (e.g. suture removal), burns dressings etc. All patients seen here have either come via the doctor or arrive with a referral letter The dressing room closes at 4.30pm, which is problematic for those patients who require dressings or splinting after hours.

In the central treatment area patients are treated on a row of three chairs (with side rubbish bins for dressings, tape etc) or occasionally a single examination couch. Two to three patient may be treated at a time on these chairs. Some of the wounds and clinical procedure exposed here appeared to me to require more privacy than this proximal placing allows. Adjacent private cubicles were never observed used, although, the general tone of the room was usually cheerful and nobody seemed to complain about the relative lack of privacy involved.

Nurses use the various counter surfaces for writing notes, and this process is usually accompanied by some sort of negotiation with the patient regarding their next appointment dates or even the patients medication. The area is described as the most popular nursing placement as staff get "*to know patients*" and can work with greater individual discretion and autonomy despite its busy, "*hectic*" pace.

vii. Injection Room: Treatment Room 2

The Injection Room is the second treatment area similar in design to the Dressing Room – that is a central shared treatment space with smaller examining rooms and cubicles linked by a shared working counter. Patients receive nursing interventions here such as assessments (blood pressure readings and Electro-Cardiograms) and injections. The area is served by at least one professional nurse, and two of the Examining Rooms are used for a paediatric doctor and the Reproductive Health consultant.

viii. The Trauma Unit

The Hanover Park Trauma unit is one of seven 24-hour Trauma units based in primary care facilities in the Cape Town Metropolitan area[5]. C.H.S.O statistics indicate that this is currently one of the smaller trauma units currently operating in the region.

[5]Trauma Units at CHC appear to be a local phenomenon, and other CHC in the country do not have this specified area.

The Trauma Unit consists of a suite of seven rooms. The core being the main Trauma room originally designed as the Recovery room. The original surgical theatre acts as an extra area where patients are nebulized, or occasionally a troublesome patient is left to detoxify. This area is not directly visible from the Trauma room, and therefore cannot be used for clinical observation.

The equipment is described as old and the area can become full of fumes from the ambulance and police cars that use the adjacent emergency entrance. This parking area was closed off and roofed two to three years ago. As a result it offers little direct sunlight, although staff agree that this move was necessary as it stopped unhappy patients from throwing rocks through the window or from using this exterior Trauma entrance.

ix. Doctor's Rooms

The four full time doctors use the Doctors' Rooms for their consultations. Various specialists, usually registrars, visit the hospital on a rotational basis, use these or Examination rooms for consultations.

x. Staff Rooms

The west wing of the clinic is dedicated totally to staff service and rest areas – in short, the various staff common/rest rooms, toilets and kitchen areas. The architectural plans indicate a total of four separate common rooms designated in terms of race and staff seniority. These plans also indicate that the area now dedicated as the Doctors' Common Room, was originally a "Whites only" tea-room. There was also a room for nurses (Nurses Common room), Labourers and Domestic staff. There are many toilets in this area, a replication based again on the racial segregation of staff amenities. Staff members asked about this racial design informed me that the areas never actually functioned in a segregated manner, not least, as there has seldom been "white" staff at the facility. The plans also indicated that this area distinguished between "Domestic" and "Nurses" amenities, again a divide never apparently acted upon. Other staff rooms are those in the Reception area, although the men who work here often also use the Labourers room. The Security staff never use these rooms, but have a small portable plastic hut by the entrance that seems to serve as a rest room and office.