

**Nurses and their work in
tuberculosis control in the Western
Cape: Too close for comfort**

by

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Table of contents

Acknowledgements	i
Abstract	ii
Preface: Introduction to the thesis	iv
The main arguments	iv
Outline and organisation of the thesis	iv
A note on methods and presentation style	vi
A note on the use of racial terminology	vi
Identity of the researcher	vi
Chapter One	1
Introduction to nursing in South Africa	1
The historical context	1
The colonial heritage	1
Training and professionalisation	3
The influence of apartheid	3
A note on nursing and gender	5
The primary health care approach	6
Restructuring of health care in the post-apartheid era	8
Working with TB patients in the Western Cape	8
Conclusion	10
Chapter Two	11
Tuberculosis in South Africa: An overview	11
A brief history of tuberculosis in Europe	11
Colonisation and the spread of TB in South Africa	12
Early efforts to control tuberculosis	12
The incidence of tuberculosis in South Africa	13
The “new” tuberculosis	15
The Tuberculosis Control Programme (TBCP)	15
New guidelines for the TBCP	17
Illness experience of patients with tuberculosis	18
Conclusion	19
Chapter Three	20
Research methodology	20
Formulation of the research question	20
Focus and purpose of the study	22

Selection of a research approach	24
Ethnography	25
The influence of Grounded Theory	26
Data collection techniques	29
Interviews	29
Participant observation	30
A research diary	31
Use of personal experience	32
Target group and sampling	33
Access and ethical considerations	34
Analysis of data	35
Strategies to ensure rigour	36
Criteria for evaluating ethnography	37
A note on organisation of thesis and presentation style	38
Conclusion	38
Chapter Four	39
Nurse-patient interaction in the TBCP	39
Introduction	39
Compliance to treatment	40
The context	41
Research methods	43
A description of the service	43
The weekly TB clinic	44
Breaking the news	45
Observation of daily treatment of patients	46
Discussion	47
Task orientation vs patient-centredness	47
Nurse-patient relationships	48
Conclusion	49
Chapter Five	50
Task orientation and patient centredness	50
The origins of task orientation	51
Taylorism	51
Nursing and Taylorism	52
Conclusion	55
Efforts to change task orientation	56
The nursing process	57
A closer look at task orientation and patient-centredness	59
Research methods	59
Task orientation	60

Four examples of task orientation	60 - 62
Discussion of task orientation	62
Interview with a task oriented nurse	63
Discussion	65
A closer look at patient-centredness	66
Three examples of patient-centredness	66 - 68
Discussion of patient centredness	68
Interview with a patient centred nurse	69
Theme one: The difficulties that TB patients experience	69
Theme two: Patients' sense of responsibility	71
Theme three: A patient-centred philosophy of care	73
Conclusion	75

Chapter Six 76

A training intervention to improve case holding practices ... 76

Background

The in-service training course

Research methods

Work settings of the participants

 Vista Clinic

 Deep Valley Clinic

Participants' responses to the training course

Nurses' perceptions of the intervention

 A sense of control

 New insights

 Morale

 Perceived role of outsiders

 Summary

An exploration of the responses to the intervention

 A safe distance?

 Too close for comfort?

 Splitting up the nurse-patient relationship

 The role of patients

 Course dynamics

 Theories on group behaviour

Conclusion

Chapter Seven 96

Too close for comfort: Unpacking the phenomenon 96

Talking about colour

A personal memory of being too close for comfort	97
Provisional hypothesis	98
Research methods	99
Findings	101
The perceptions of nurses	101
Too close for comfort	101
“A very fearful patient and an overbearing nurse”	102
The patient who asks questions	102
Increasing pressure at work	103
Self image and self esteem	104
Coloured nurses’ perceptions of white nurses	104
The perceptions of non-nurses	105
Discussion	106
Identification with victims of oppression	111
Back to the provisional hypothesis	112
Conclusion	114

Chapter Eight **115**

Crossing the line: nurses who become TB patients **115**

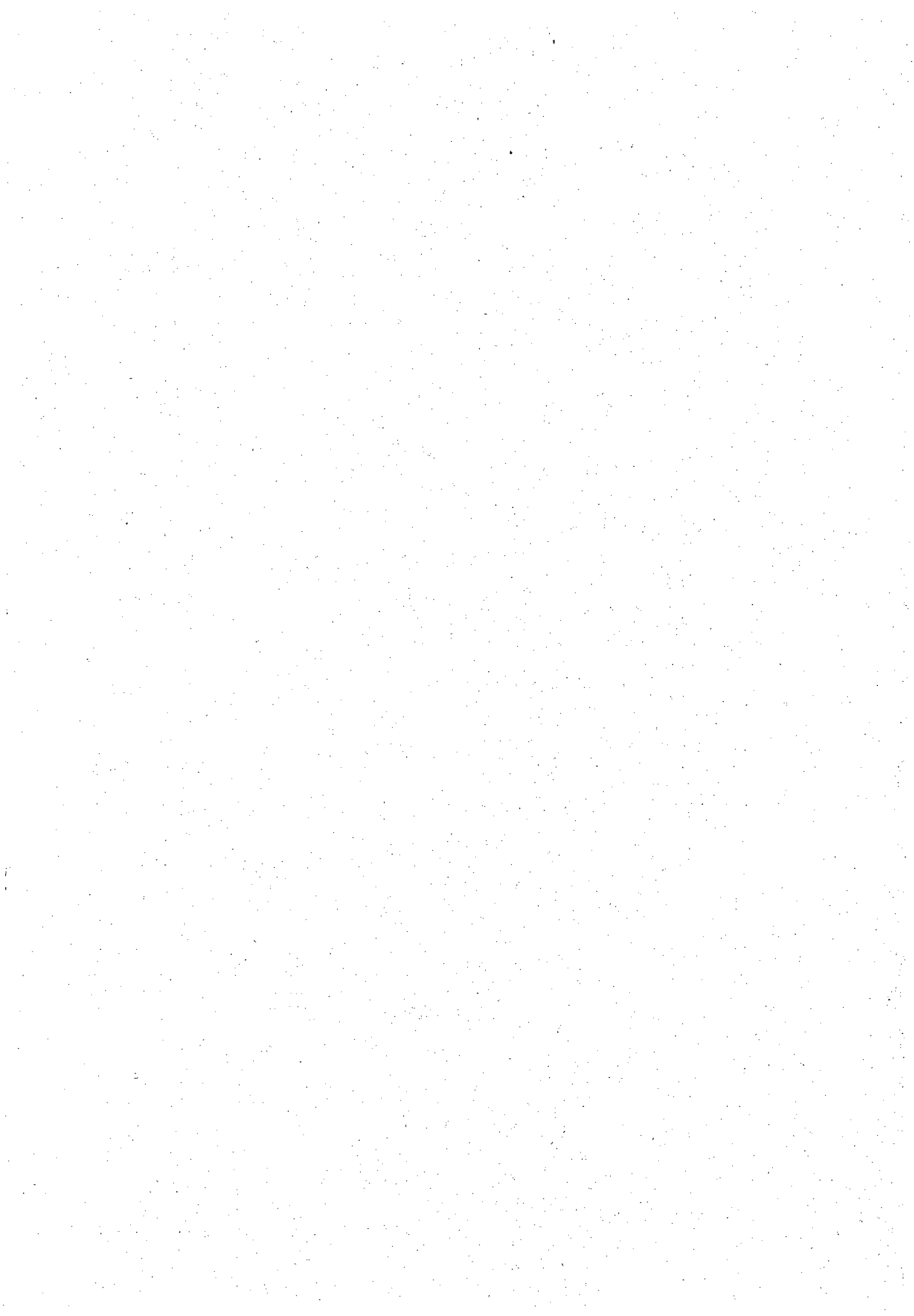
Introduction	115
Part one: Disillusion with doctors and fellow nurses	115
Research method	116
Sylvia: a biographical sketch	117
Sylvia’s need to tell her story	118
Sylvia’s illness experience	119
The first interview: catharsis	119
The second interview: looking back	121
Interactions with doctors	122
Reflections on nurse-patient relationships	123
Discussion	125
The intrapersonal level	125
The interpersonal level	127
Interaction with patients	127
Interaction with nurses	128
Interaction with doctors	129
A note on methodology and the research process	132
Part two: fear of patients	133
Anna’s illness experience	133
Discussion	136
Conclusions on “crossing the line”	137

Chapter Nine	140
Summary and conclusion	140
Summary of the research process	140
Reflection on the research methodology	144
Limitations	144
The topic: Too close for comfort?	145
The rule breaking principle	145
Research approach	146
Two patterns of interaction	146
Task orientation	146
Patient-centredness	147
Synthesis of research findings	148
The interpersonal domain	148
The intrapersonal domain	149
The dynamics of the workplace	150
Implications for change	151
The need for further research	152
Concluding reflection	153
References	154

Figure 1: Research process	27
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Tables:

Table 1: Tuberculosis in South Africa and Proportion associated with HIV infection (1996)	14
Table 2: Nurses' perceptions of the intervention	85
Table 3: Summary of the research process	143



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Abstract

The setting for the research is the urban areas of Cape Town, South Africa where the notification rate of tuberculosis is the highest in the world. Despite the availability of modern drugs the cure rate is low and approximately 40% of diagnosed patients do not adhere to treatment. This has serious implications for the spread of multiple drug-resistant tuberculosis. The relationship between the patient and health care providers is one of the main determinants of compliance to medical treatment.

The main aim of the thesis is to develop an understanding of how nurses experience their work with patients who have pulmonary tuberculosis. The research explores how nurses interact with patients, how nurses perceive their relationship with patients and the processes and organisational arrangements which contribute to the patterns of nurse-patient interaction.

The interpretive research design was largely informed by an ethnographic approach. The iterative research process led to several sub-studies; the analysis of each sub-study led to a further cycle of data collection. Data collection techniques include participant observation of nurse-patient interaction and depth interviews with nurses and key informants. An exploration of opportunities to change the prevailing work patterns yielded data on nurses' responses to change. The data were captured as field notes or audio taped and analysed thematically by using qualitative methods and by the application of psychodynamic theory.

The research identifies task orientation and patient-centredness as the main patterns of nurse-patient interaction. Task orientation was found to be the dominant work pattern. Its origins are traced to the colonial history and to the influence of Taylorist labour practices. Task orientated work patterns are maintained because of complex mechanisms which operate at both intrapersonal and interpersonal levels. It is argued that the history of racial politics and racial identity has influenced the ways in which nurses manage the degree of distance between themselves and patients. The findings suggest that the closer the nurses identify with patients in terms of ethnic background, the more the nurses may feel the need to distance themselves from the patients. The notion of tuberculosis as a stigmatised disease, the concept of compliance, and the implementation of control measures such as directly observed therapy are critically examined. An exploration of the illness experiences of nurses who become

infected with tuberculosis, provides an opportunity to explore how nurses perceive the role of the caregiver when they are in the unfamiliar position of being patients.

The findings have implications for public health interventions aimed at transforming nurse-patient interaction. It is recommended that change management processes explicitly acknowledge the consequences of decades of apartheid policies and practices on the behaviour of health professionals and the users of health services. In the years to come change agents will need to address the emotional pain of the past, as well as the more well known sources of organisational resistance to change.

Preface: Introduction to the thesis

The main arguments

In this thesis I explore aspects of nurses' behaviour and their feelings while working with patients who have tuberculosis. My aim is to find explanations for deeply ingrained work patterns that nurses use for interacting with patients. I attempt to develop an understanding of this complex relationship through an in-depth exploration of nursing practice, and by exploring how nurses view their experience of working with tuberculosis (TB) patients.

Nursing in South Africa cannot be studied without paying attention to the history of racial politics and racial identity, which, I would argue, has particularly influenced the ways in which nurses manage the degree of distance between themselves and patients.

The setting for this research is in the urban areas of Cape Town, South Africa, where the reported notification rate of tuberculosis is the highest in the world. As elsewhere, the biggest concern of health providers is the fact that a high percentage of TB patients leave the lengthy treatment period before an effective cure is reached. This has enormous implications for the spread of a drug resistant strain of tuberculosis. I argue that unless nurses and patients develop partnerships based on an understanding of the dynamics which underlie the nurse-patient relationship, there is little hope of promoting effective treatment for tuberculosis.

Outline and organisation of the thesis

The first two chapters provide the necessary background for the thesis. The purpose of Chapter 1 is to introduce the history of nursing in South Africa and to describe the organisation of public health services where this work is situated. Chapter 2 provides an overview of tuberculosis in South Africa. After a brief discussion of the history of TB and the early efforts to control the disease, I describe the incidence of TB as well as the emergence of people infected with the Human Immunodeficient Virus (HIV) who present with TB.

This is followed by a discussion of the aims and guidelines of the Tuberculosis Control Programme. The chapter ends with a discussion of the illness experience of patients with TB.

In Chapter 3, I present the research methodology. After discussing the history of the development of the research question and its purpose, I explain the rationale for choosing an interpretive study design with an emphasis on ethnographic research methods. This is followed by a description of the techniques used for data collection, sampling strategies, data analysis and measures to ensure rigour.

Chapter 4 describes a case study which provides a picture of the work patterns that occur in community-based health centres where TB patients receive treatment. Chapter 5 presents an historical and theoretical exploration of task orientation, the dominant work pattern among nurses. This is followed by a presentation of case studies which contrast task orientation with patient-centred care. In Chapter 6, I describe how two teams of nurses responded to a training course which presented them with an opportunity to change their routine practice.

Chapter 7 provides an exploration of the findings presented in the previous chapter. I do this by testing my hypothesis that the closer the nurse identify with patients in terms of ethnic background, the more the nurse would feel the need to distance herself from the patient. I make use of further interview data which enable me to refine this phenomenon which I call "too close for comfort".

Chapter 8 contains case studies of the illness experience of nurses who become TB patients. This presented me with the opportunity to explore how nurses view the professional nurse-role from their unfamiliar position as patients. At the same time they reflected on their own professional relationships with patients. This work provided further confirmation of the concepts developed in the earlier part of the thesis.

X Chapter 9 I summarise and synthesise the main findings and conclude that task orientation, a dominant pattern in nurse behaviour, is well established and is maintained because of complex mechanisms which operate at both intrapersonal and interpersonal levels.

A note on methods and presentation style

The dominant practice in writing theses, is to present a single research project which is described in all its phases. It is important to note that this thesis is different, in that it consists of several studies. Each of these are prompted by the questions which were raised in the preceding study. Chapters 4, 6, 7 and 8 contain complete descriptions of these studies. While chapter three provides an overarching description of methodology, each of the subsequent chapters which describes a sub-study contains a detailed section on methods, findings and discussion.

A note on the use of racial terminology

There are no simple definitions for race; it is a contested concept. Four years after the political transition and the acceptance of a democratic constitution the public and academic debates around race and identity continues (de la Rey, 1997a; Ward and Warden, 1998). The accepted, or “politically correct” terminology for referring to people from different origins, ethnic groups, and language groups fluctuates all the time.

In this thesis the term “coloured” refers to “those South Africans loosely bound together for historical reasons rather than by common ethnic identity” (Erasmus, 1997). The descent and heritage of coloured people are varied and include indigenous San, slaves brought to the Cape Colony from Indonesia and Malaysia and the offspring of intermarriage. I use the term “black” or “African” to refer to indigenous South African people who speak indigenous languages, with the exception of Afrikaans. “White” is used to refer to Afrikaans and English speaking South Africans who are of European descent.

Identity of the researcher

It is often said that the researcher is the main, and often the sole research instrument in qualitative research. One of the characteristics of qualitative research is to acknowledge the involvement of the researcher in the research process. Hence I feel that it is necessary to say

something about myself. During my career as a professional nurse which lasted for 15 years, I have worked in both tertiary and primary health care settings. After completing further academic education I have worked in the field of adult education and community development. Since 1990 I have been working in the field of health research where my particular focus is health systems research.

In keeping with the tradition of writing in qualitative research I situate myself in the research by the use of the personal pronoun rather than “the researcher”. In instances where personal experience is especially relevant, I refer to this further.



Chapter One

Introduction to nursing in South Africa

“Nursing was born in the church and raised in the army”.

(Kupe, 1993)

Nurses form the largest cadre of frontline health providers in South Africa. In this thesis the main focus is on the nurses who work in the TB control programme, hence the need to provide background information on the nursing profession. The first section deals with the historical context and explains how the early history of the nursing profession in South Africa was shaped by the British traditions and the early missionaries, and since the fifties, by the apartheid policies of the previous government. For this section I will draw extensively on Marks's (1994) pioneering critical account of the history of nursing. This is followed by an introduction to the practice of the primary health care approach in South Africa. In the final section I focus on the nurses and their work setting in a typical community health centre.

The historical context

The colonial heritage

Before the onset of colonialism the care of the sick and midwifery was performed by family members and indigenous healers. Professional nurse training was first established in Kimberley, South Africa, by Sister Henrietta Stockdale in the 1880s. Prior to this there had been a slow trickle of British professional nurses into the country. Based on the sisterhoods in England at the time, the Anglican sisterhood of St George was made responsible for the nursing care at the New Somerset Hospital in Cape Town in 1871. During the 1899-1902 South African War the army recruited many more British and European nurses. The early influences by English “lady nurses” who were modelled on the Florence Nightingale model

can still be found in our modern nursing traditions. The following is a description of nursing practice in Britain at the time:

“Sick and helpless working people were not only less frightening but also more manageable; stripped of their familiar surroundings, they were forced to follow a regimen alien to their habits. Yet even as she ordered her patients around, a nurse had to keep her distance. Probationers were encouraged to use nursing as an extension of mothering yet were positively discouraged from making friends with the patients.” (Vicinus, 1988).

In her short story “The Pain”, which was first published in 1925, Pauline Smith whose father was a doctor, describes an elderly poor white couple who seek relief for an unbearable pain that the old woman suffers from (Smith, 1981). Filled with hope they make a long journey to the first colonial hospital that was built in the Little Karoo, a sparsely populated arid region of South Africa. They had heard wondrous stories of the miracles that are performed there. When they finally reach the hospital after travelling by horse cart for several days, their expectations turn into a deep sense of alienation:

“The ways of the hospital, the order and routine necessary for the running of it, remained to the end incomprehensible to them both. In this new and bewildering world the kindness of the English doctor, of the matron and of the nurse reached them only as the kindness of human beings reaches the suffering of dumb animals. On neither side was there, nor could there be, complete understanding. The doctor and the matron might know all there was to know about the pain in Deltje’s side. About the pain in her heart and Juriaan’s they knew nothing.” (Smith, 1981, pp 12-13).

“To Nurse Roberts there still remained the bright, hard self-confidence of youth, and in Juriaan and Deltje she saw only two aged innocents whose affairs it was her duty, and certainly her pleasure, to control. Her management of them, she was convinced, was for their good, and in all she did for them there was a certain brusque kindness. It was she who answered for Deltje when the doctor made his daily round. Deltje’s protests were drowned in the brisk common-sense of the nurse. They came to fear the pleasant-faced nurse as they had never before feared any other human being. She stood between them and the doctor; between them and the matron; and, by her refusal to allow that Deltje’s pain was cured and her return to the Aangenaam valley possible, between them and everything that made life dear.” (Smith, 1981, p 15)

The story unfolds to reveal how the old woman surreptitiously leaves the hospital. In the middle of the night Juriaan carries his wife out of the ward and take her back to their home where they find relief from the pain in their hearts. It is clear that defaulting from treatment is by no means a modern phenomenon!

Training and professionalisation

From the 1920s African women were being employed as nurses. Marks (1994, p 78) points out that the acceptance of black women was permitted when the idea of white nurses having to nurse black male patients was unacceptable to the white men who were in charge of hospital boards. It was the missionaries who trained the first professional African nurses. Their motivation was clear:

“The hospital stood for science against superstition, for fresh air, cleanliness and temperance, against overcrowding, dirt and ... infestation and for Christian helpfulness ... as opposed to the fear, the selfishness, the malevolence of heathenism” (Shepherd, circa 1941, quoted by Marks, 1994, p 81).

Afrikaner nurses began to enter the profession during the harsh depression years of the 1930s. In Cape Town the Anglican St Monica's started the training of coloured midwives in 1917. Their missionary zeal was directed at limiting the influence of Islam among coloured people in the Cape (Marks, 1998) (move to refs: Lecture at Summer School, UCT, January 1998). But it was only in 1939 when limited numbers of coloured nurses started to enter training at Somerset Hospital in Cape Town. Their numbers remained small until the 1950s when the nationalist government started an active recruitment policy for the training of “non-European nurses to take care of their own people. By training non-European nurses, European nurses would be free to work in the European sections.” (Rand Daily Mail, 1952, quoted by Marks, 1994, p 171).

The influence of apartheid

Apartheid policies permeated the nursing profession in pervasive ways. Salary scales were based on racial classifications; this meant that coloured nurses earned less than whites, and

African nurses, in turn, earned less than their coloured counterparts. The only equaliser was the qualification system: all nurses wrote the same examinations. Absurd situations arose: for example, during the 1970s nurse tutors at the Red Cross Children's Hospital in Cape Town were forced to teach the same one year post-basic course in Paediatric Nursing in two separate shifts. Each lecture had to be repeated twice: to a small group of white students and to a small group of coloured nurses. On the hospital wards, however, the students worked together on the practical part of their training. While the system gave rise to enormous bitterness and resentment among nurses of colour, there were few attempts at open dissent. This was perhaps due to the draconian forms of hierarchical discipline. Nurses are socialised to obey the rules and not to question the order that come from above. The vast majority of nurses are female and had been raised to quietly get on with the job, not to raise their voices or to stand up for their rights. The very nature of the job made it difficult to protest. Nurses were constantly reminded that nursing is no ordinary job, it was a calling which meant that one had to put the patient's interest first in every situation. During the 1980's, at the height of the popular uprising against the apartheid system, nursing leaders actively discouraged nurses from challenging the unequal provision of health services. The following examples give evidence of these efforts.

"Nurses are to subordinate their own political feelings to the greater good of the people they serve. As nurses they will have a prominent role in helping the population in an orderly way of life, for unhealthy life-styles and social disorder brings death, destruction, misery and ill health and disease, all of which are the conditions the nurse is pledged to alleviate. This will not be easy, for political dissidents are trying to use the nurses to undermine the state's regime" (Searle, 1989).

"Amid the turmoil of social, economic and political changes, nurses must continue to project an image, not only of stability but of neutrality linked to dedicated service" (Roscher, 1985).

What attracted young women to study nursing? Up to the 1970s nursing and teaching were the only professions that were easily accessible to women. Since then more job and study opportunities have opened up to women, but nursing remains the only profession which pays students a salary while they study. The income continues to attract black and coloured women who are not in a position to pay for their studies. In addition, some women are attracted to nursing out of altruistic motives and a deep commitment to help people (Edelstein, 1998).

Up to 1984 all nurses in the Western Cape received their theoretical as well as practical training in racially segregated settings. They wrote the same examinations but in many instances black and coloured nursing training schools and hospitals were not as well resourced as facilities for white trainees. This has led to feelings of resentment and frustration among coloured nurses, feelings of being second rate nurses.

In this thesis I cannot deal at any length with the issue of nurses' resistance against oppression, but it is important to note that there have been deliberate actions to maintain a passive work force who would refrain from asserting their power as workers. The formation of a professional body, the South African Nursing Association (SANA) in 1944, was part of a strategy to prevent nurses from joining trade unions. It was compulsory for nurses to be members of SANA. The Nursing Act no. 50 of 1978 ensured that nurses' strikes became illegal (Marks, 1994, p 166). In 1986 nurses at Baragwanath Hospital, near Soweto began a strike which was later repeated by nurses elsewhere. Nurses in the Western Cape have been less militant, nevertheless in 1989 there were three work stoppages at Groote Schuur Hospital (Marks, 1994, p 203). Since 1994 the post-apartheid constitution grants nurses the right to embark on industrial action but this remains a course of action which is not taken lightly, especially given the uncertainties of job security now that the Western Cape has begun a process of cutting back on its health budget.

A note on nursing and gender

Nursing is the most feminised of all the health professions. Worldwide, approximately 90% of nurses are women (Morrow, 1988). Writing about the formative years of the nursing profession in Britain and the early history of the sexual division of labour, Marks (1994, p 4) cites Florence Nightingale:

["To be a good nurse one must be a good woman"]

Nursing has attempted to professionalise in order to move away from the Nightingale model of nurses as womanly, obedient, dutiful and skilled handmaidens of doctors (Andrews, 1991; Gamarnikow, 1978; Savage, 1985; Stacey, 1988; Witz, 1992). Much has been written about the genderised nature of nursing and its impact on the power relationships between nurses and patients and between nurses and traditionally male doctors. I consider these debates as

important, in so far as they inform both the macro-social and micro-social domains of nursing practice, yet I would like to point out that gender does not form the primary focus of this thesis.

Throughout the thesis I refer to nurses as women and this is not coincidental. Although male nurses are entering the nursing profession in growing numbers, I have not encountered a single male nurse during my fieldwork.

The primary health care approach

I now turn to a discussion of primary health care, a service sector which is specifically aimed at providing essential health care and is largely staffed by nurses.

Primary health care (PHC) is an approach to health and health care that was formulated at a conference at Alma Ata in 1978 (World Health Organisation and UNICEF, 1978). It advocates:

“the provision of first contact services and basic health care; - within the framework of and integrated health service; - and set up with five principles in mind.

These five principles are:

- Equitable distribution of health care resources and adequate quality care for all.
- Active community participation in decision making.
- A focus on preventive and promotive health services.
- The use of appropriate (but not necessarily low cost) technology.
- Redressing of socio-economic inequalities and the use of a multi-sectoral approach”
(McKenzie, 1989).

The South African government adopted the PHC approach eagerly during the 1980s. This was done in a selective and piecemeal manner. Curative health care continued to operate as before. It consumed most of the health budget and was maintained as a parallel system which had no direct managerial links with the PHC system. To add to this, the first principle of equitable provision of health care provision, was not achieved. Marks (1994, p 197-8) argues that PHC provided South Africa with a mechanism to create a cheaper form of health service for poorer and rural black people. There has been widespread criticism of the way in which PHC

was subverted during this period (Drower, 1988; National Progressive Primary Health Care Network, 1992, p 29; Walker, 1995; Wildschut, 1993).

Primary health care forms part of the curriculum of basic nursing studies, but the training of nurses remain hospital based. Nurses receive their first four years of basic professional training in a large curative hospital where patients are nursed in beds. For the practical study of community health students spend one month of placement in a community health centre. A study which describes the problems that nursing students at Carinus Nursing College in Cape Town perceived during their practical training revealed that students felt insufficiently prepared to work in a primary health care environment. They felt that the curriculum prepared them to work in tertiary academic centres where they are required to follow doctors' orders. This did not adequately equip them with problem solving skills and the ability for "independent thinking". Their training did not allow them to view patients in the contexts where they live and work, nor did it give them an understanding of the socio-political factors which affect health (Edelstein, 1996).

More strikingly than hospital nurses, the nurses who work in the public health sector are directly confronted with the effects of poverty and social pathology. On a daily basis they work with people who are malnourished, unemployed and inadequately housed. Often their patients have to cope without the basic needs such as running water and an adequate sewage system. Nurses have to do "health education", for instance to educate mothers about healthy food for children, or to teach about the benefits of personal hygiene. Yet they know all too well that many patients cannot afford to buy the food which children require. In theory the social and economic development of the population should be taken care of by implementation of the primary health care philosophy. The provision of primary health care include access to basic facilities such as clean water and sanitation, economic development programmes, all of which would go a long way in combatting the spread of the TB epidemic. It is precisely these goals which have not been achieved and which frustrate the efforts of health care providers.

One of the main tenets of primary health care is the emphasis on community participation in matters of health care provision. Effective community participation means that democratically elected community structures have a direct say in the management of local community health centres. This principle has been accepted by the post-apartheid authorities but is still in the process of being implemented as part of the restructuring of health services.

Restructuring of health care in the post-apartheid era

The process to develop new legislation is a lengthy one. Draft 10 of the Health Bill has been circulated for comment and tabled in Parliament but has not been released to the public.

There is still no new National Health Act (Stuurman-Moleleki, Sait and Long, 1997), but the government is committed to establish a just, fair and equitable health system.

In comparison to the Northern Province, Mpumalanga and the Eastern Cape, the Western Cape is relatively affluent, and in the past its health services had benefited from a larger budget. The 1997 / 1998 health budget allocation reveals that substantial improvements have occurred in the less developed provinces. As a result fewer resources were allocated to the Western Cape. The process of restructuring is painstakingly slow because it involves a “down sizing” of posts and resources in order to make more resources available to the traditionally disadvantaged provinces. One strategy has been the introduction of a “voluntary severance package” programme to nursing staff in the Western Cape. Unfortunately, ad hoc implementation of this programme has significantly diminished the capacity when some of the most experienced and highly skilled management and clinical personnel left the service (Department of Health, 1997a). Under the new dispensation the uncertainty about job security and the very real prospect of working with fewer staff has added to the stress experienced by nurses in the Western Cape.

Working with patients who have tuberculosis in the Western Cape

The purpose of this section is to focus on that level in the health care system where patients are treated for TB. This will enable me to illustrate how the broad historical trends which I have already described, may influence the daily working situation of nurses. Up to the late 1950s care for TB patients tended to be institution based. The shift towards ambulatory care (community based care) was prompted by the availability of modern drugs which ensured that

patients who had commenced treatment could no longer infect others. In addition, the lack of hospital accommodation forced the government to treat cases on an out-patient basis (Packard, 1991). For the purpose of this thesis I focus on a typical urban community health centre that provides public health services to the population in a demarcated area.

The staff complement of the health centre would consist of professional nurses, enrolled assistant nurses, clerks, a doctor who works on a sessional basis and cleaners. One of the professional nurses functions as the senior nurse who is in charge of the day to day management of the centre. She is accountable to the chief professional nurse (CPN) who takes charge of all the clinics in the sub region. The CPN is part of a middle management team which is based at the head office and visits the centres when necessary. In turn, the CPN is accountable to the nursing manager. The medical doctors have a parallel system of accountability to the chief medical officer who is based at the head office. In terms of their professional status doctors can order nurses to carry out specific treatments for patients, but they have very little say in routine decisions on the running of the health centre.

Because of the distance from head office and from middle and top managers, nurses in community health centres work more autonomously than nurses in hospital settings. The doctors have a limited role to play and senior nursing managers are not routinely present. The absence of night duty and weekend duties is another incentive for working in public health services. The salary and conditions of service are better than that of nurses who work in hospitals.

The community health centres are situated in the neighbourhoods that they service. Under apartheid, these segregated neighbourhoods came to be known as townships. Nurses often fear for their physical safety. In a recent survey conducted in Cape Town homicide was found to be the leading cause of deaths due to injury (52%), with firearms playing a major role (The Cape Metropolitan Non-natural Mortality Study Group, 1996). In the past health workers enjoyed some form of protection against violence and crime, but that is no longer the case. An example is an incident where a doctor was shot while attending a patient inside a trauma unit. The bullet came from a gunfight between rival gangs outside the hospital (Cape Times, 26 November 1996).

In this section I have described the specific institutional context and the physical setting where nurses interact with TB patients on a day to day basis.

Conclusion

The aim of this chapter was to summarise the historical origins of the nursing profession and to provide a background to the setting in which Western Cape nurses work with patients who have tuberculosis. While its roots can be traced to Victorian England, it is clear that colonialism and the local politics of racial segregation have had a profound influence on nursing. Tuberculosis is treated at the level of the community health centre and I have sketched the work setting as well as the different categories of staff that interact with the TB patient. In the next chapter I turn to the specific focus of the research problem and the research methodology.

Chapter Two

Tuberculosis in South Africa: An overview

A brief history of tuberculosis in Europe

Tuberculosis has been known to humanity for at least 6000 years (Holme, 1997). TB reached epidemic proportions in Europe during the 19th Century, a period associated with industrialism and urban overcrowding. In 1840 it was the biggest killer in Britain, accounting for one in seven deaths (Holme, 1997, p 3). It took its toll not only among the poor, but also among the more affluent literate classes where it had been associated with a morbid romanticism (Holme, 1997, p 4; Sontag, 1978, p 31). The first scientific break through came in 1882 with the discovery by Robert Koch of the causative agent, the rod-like bacilli which was named Mycobacterium Tuberculosis. In the same year William Thomson discovered that TB was spread when healthy people inhaled the micro-organisms which were expelled in the breath of those who were already infected with the disease. During that period there were two main models for treatment. For the wealthier classes sanatoria provided bed rest and fresh air. Where possible these institutions were situated in healthy dry climates. The dispensary provided a more accessible model of free health care and is probably the model on which the contemporary community health centre approach was based. This visionary concept in public health was first established in Edinburgh in 1887 by Robert Philip. It focussed on the family as unit of treatment and contacts of patients were traced by the forerunners of the present health visitors. Although the isolation of infected cases and a healthy diet may have slowed the epidemic to some extent, the steep decline in TB mortality from the middle of the nineteenth century was most likely due to the improvements in living and working conditions.

The discovery of streptomycin in 1943 by Waksman and Schatz provided the first effective chemical treatment for TB. It was successfully tested in a famous randomised trial in 1948 (cited by Holme, 1997, p 16-17). Next came the realisation that the combined use of three drugs, streptomycin, para-aminosalicylic acid and isoniazid showed better results and minimised the dangers of drug reactions. By 1957 Crofton's team in Edinburgh demonstrated that it was possible to halve the notification of TB by treating patients with two years of chemotherapy. This was accompanied by close surveillance to ensure that all medicines were actually taken (Holme, 1997, p 18).

Colonisation and the spread of TB in South Africa

Little is known about the extent and prevalence of TB in South Africa before the beginning of this century. It is unlikely that it was a common disease prior to the onset of colonisation. Reports by travellers reveal that "consumption" was common among European colonists at the end of the eighteenth century. In the early nineteenth century there are reports of TB among the Khoikhoi and the San in the southern parts of South Africa which were colonised earlier than the rest of the country. The perceived absence of TB among black people in the eighteenth and early nineteenth centuries gave rise to the notion that black people represented "virgin populations" who lacked any inherited resistance to the infection. According to oral history the disease probably did exist at a low level of intensity. The "virgin population" theory, however, was used by European colonisers to explain why the native inhabitants of colonised territories such as America, Australia and Africa developed much higher rates of TB than the colonisers (Metcalf, 1991, pp 12-13). The low incidence of TB among indigenous people changed dramatically with the onset of the mining industry and the migrant labour system (Metcalf, 1991, pp 20-31; Packard, 1989).

Early efforts to control tuberculosis

Great faith in the healing powers of the sunny climate encouraged European TB patients to seek healing in the Karoo, an arid semi-desert area of South Africa about 460 km north of Cape Town. There was no concern about the importation of TB patients and no efforts were made to curtail the spread of the infection among the indigenous population. This changed

after the establishment of compulsory death registrations in 1895 when the authorities became aware of the high mortality rate due to TB. In 1904 it became compulsory to register TB cases in the Cape Colony, and in 1907 the City Infectious Disease Hospital provided the first accommodation for TB patients in Cape Town. The Public Health Act of 1919 called for improvements in housing, sanitation and education for controlling the spread of the disease. This act placed the responsibility for treatment of those who could not afford health care on the local authority, who in turn, would be reimbursed by the government. The majority of cases were black and soon there were disputes between local authorities regarding the patients' "real home": the urban authorities claimed that patients were from rural areas and because of limited accommodation, TB cases were reported to Native Affairs Department for repatriation to their home areas (Packard, 1991).

The situation worsened further during the 1940s when thousands of black people migrated to the urban areas to seek work. Since the 1950s, with the discovery of chemotherapy, government expenditure for TB control has increased steadily and by the early 1980s it amounted to R50 million per year. Mass x-ray surveys to identify cases, increased hospital accommodation and educational campaigns were launched. But despite these efforts new cases were being identified faster than existing cases being cured. The apartheid policies of racial segregation and white privilege contributed to overwhelming poverty which was characterised by slum housing, malnutrition and unemployment which rendered most efforts at medical control ineffective (Packard, 1991). I now describe the extent of tuberculosis.

The incidence of tuberculosis in South Africa

The official notification figures reflect the number of new cases that are detected by a country's tuberculosis control programme (TBCP) and are regularly reported by the World Health Organisation. The accuracy of these figures depend on the effectiveness of the TBCP in detecting the cases, rather than simply on the actual incidence of the disease. Incidence rates reflect the number of new cases, while prevalence rates reflect the number of cases in the population with active disease. The extent of TB in the population can also be assessed by estimating the number of people who become infected each year. It has been calculated that a 1% annual rate of infection implies that there will be between 39 and 59 infectious, smear-

positive cases of pulmonary TB per 100 000 members of the population (mean 50/100 000). For every one infectious case, 122 cases of non-infectious, smear-negative pulmonary and non-pulmonary TB must be added to this total (Murray, Styblo and Rouillon, 1990; Dick 1994).

The notification rate of TB in South Africa rose steadily from 43/100 000 in 1921, peaking at 372/100 000 in 1963. It then declined to 162/100 000 in 1986 (Department of National Health and Population Development, 1991). Since then the notification rate has increased to 362/100 000 in 1996 (Department of Health, 1997b). It is interesting that the incidence rate of TB has not remained similar across the different ethnic groups in the country. There has been a sustained and steeply rising incidence of TB among the coloured population in the Western Cape (Department of National Health and Population Development, 1993). In 1996 the Western Cape had a notification of 559/100 00 which is the highest in the country. This can be seen in Table 1 (Department of Health, 1997b; Weyer, 1997).

Table 1: Tuberculosis in South Africa and Proportion associated with HIV infection (1996)

Province	TB incidence rate (per 100 000)	Number of TB cases	Proportion HIV-positive (%)
Eastern Cape	504	34 371	20.4
Free State	282	8 272	32.1
Gauteng	375	26 378	25.2
KwaZulu-Natal	381	34 178	45.0
Mpumalanga	286	8 716	39.5
Northern Cape	340	2 675	13.6
Northern Province	260	13 927	16.7
North West	271	9 557	25.9
Western Cape	559	20 615	12.0
South Africa	362	158 689	27.0

(Source: Department of Health, 1997b)

The “new” TB

The emergence of human immunodeficiency virus (HIV) infection in sub-Saharan Africa has had a major impact on the incidence of TB. The vast majority of people with a healthy immune system cope with the primary TB infection by sealing it off. They are totally asymptomatic but the infection remains dormant in their bodies. People who become infected with HIV are likely to experience a reactivation of the primary TB lesion. TB is often the first indicator that a person is HIV positive. The advent of HIV infection in Africa has swamped TB control programmes which were barely managing with their existing workload. The rate of HIV infection is monitored by passive surveillance in the Western Cape. It is estimated that the threatening epidemic will accelerate the prevalence of opportunistic infection by TB. Table 1 indicates that 27% of TB patients were infected with HIV in 1996. This has resulted in 42 000 more TB patients than would have occurred in the absence of the HIV infection (Weyer, 1997, p 197).

While HIV related TB can be successfully controlled with the use of routinely available chemotherapy, the emergence of multi-drug resistant (MDR) strains of TB has become a serious threat to the ability of medical therapy to treat patients. This occurs when mutant strains develop during the course of intermittent or incomplete treatment. Primary infection with a resistant strain may be passed on to others by individuals who have MDR TB. In these cases, patients show no response to the first line drugs and new and very expensive antibiotics have to be sought. The incidence of MDR TB is still relatively low, but there are 2 000 cases of MDR TB in each year (National TB Control Programme, 1998). Five of the nine provinces report cure rates of below 50% and the cure rate in the Western Cape was only 66.4% (Weyer, 1997, p 198). This has serious implications for the spread of MDR TB.

The Tuberculosis Control Programme

The aims of the control measures are to reduce infection and reactivation of the disease by bringing about socio-economic development, and to provide an efficient health service with an effective TBCP. The TBCP is co-ordinated by the Department of National health which delegates the administrative management via the provincial authorities to the local health

authorities. It provides practical guidelines for the diagnosis and treatment of TB. This includes the prevention of infection through effective case-finding, curative treatment and preventive measures, such as protecting all new born children by means of BCG vaccination.

Despite the fact that the measures needed to control TB are well known and the technology is available, TB control remains unsatisfactory. There has been a worldwide upsurge in TB, but not only is South Africa's notification rate the worst in Africa, it is also the worst in the world. At the end of 1996 it was found that two adjacent townships of Cape Town, Ravensmead and Uitsig, had an incidence of 3 000 cases per 100 000 of the population, with one house in every three reporting at least one case of TB in the previous decade. DNA fingerprinting of the strains suggests this is a reactivation of old latent disease (Action TB News, 1996).

Lee and Buch (1991) suggest several reasons for the failure of the TBCP. Under the apartheid regime the health service was fragmented into 14 departments of health. This led to inefficiency and wastage of resources. Even diagnostic criteria differed from region to region. TB health services were integrated into an inefficient and poorly resourced primary health care system which was inaccessible and unacceptable to many patients. Problems related to poverty have not been prioritised. Community involvement in the TBCP has been particularly difficult to achieve, given the volatile political situation and the mistrust of official health services. There had been insufficient support for health education and a lack of emphasis on skills needed for health promotion and public education. The stigma attached to TB remained a serious matter. Health workers lack the training and supervision to improve their skills, practice and morale. Patients complained of the harsh and hurried attitudes of health workers.

In 1996 a six month review of the South African TB problem was done by World Health Organisation officials, the SA Department of Health and a team of international experts. Dr Enarson, scientific director of the International Union Against Tuberculosis and Lung Disease (IUATLD) said:

"I have investigated the TB situation in over 150 countries, and South Africa's epidemic is the most frightening situation I have ever encountered. In many ways, multi-drug resistant TB is much more frightening than AIDS since you can protect yourself from AIDS by avoiding unsafe sexual

behaviour. But there is virtually nothing you can do to protect yourself from TB, as the primary risk is simply breathing." (South African Department of Health. Pretoria. Press release, June 25 1996)

New guidelines for the TBCP

Urged by these concerns the Department of Health's TBCP revised the practical guidelines for the diagnosis and treatment of TB in 1996. With the new political leadership in place it was possible to renew official links with expertise based in the World Health Organisation. The emphasis is on "ensuring the cure of new TB patients at the first attempt" in order to prevent the risk of MDR TB, and a "patient-centred approach for improving compliance". There is strong emphasis on "standardised, directly observed treatment", for all sputum positive patients. Directly Observed Treatment Short-course is a global initiative, best known under the popular acronym of the DOTS strategy. This implies that every single capsule or tablet must be seen by a health worker to be swallowed by the patient on 5 days per week. This treatment is to be continued for 6 months. If it is more convenient for the patient, this responsibility could be given to a suitably trained and monitored lay person, the "treatment supporter". In practice this usually implies a teacher, employer or a specially trained lay health worker. (Department of Health, 1996).

These guidelines stress the importance of patient-centred care: "A good relationship between patient and care giver leads to good compliance and is the most important factor in determining the completion of treatment." (Department of Health, 1996, p 1). Practitioners are advised to be courteous, to allow two-way communication and to listen to the patient's feelings and problems. The clinic waiting times should be kept short and treatment should be made accessible, even if this means providing care outside of normal working hours. Patients should be followed up by the same member of staff in order to ensure continuity of care. A written contract between the patient and the health care provider is advised. In the prototype contract which is attached, the patient agrees to take the treatment for at least six months and to report any problems to staff. The nurse/doctor undertakes to supply TB treatment and to "try and provide a friendly and efficient service and to listen to and investigate complaints carefully, and to provide regular information on progress." (Department of Health, 1996, Annexure 1). This emphasis on patient-centredness is a new development which can be

explained by the deep concern about the high levels on non-adherence to treatment. In the next section I describe how patients perceive TB services.

The illness experience of patients with TB

It is important to understand the patients' illness experiences against the background of their personal and social world (Kleinman, 1988; Rubel and Garro, 1992; Sumartojo, 1993) In recent years a few qualitative studies have focussed on the illness experience of TB patients in the Western Cape. The first description of TB illness experience was contained in a photo-novel which illustrated a patient's experience of her illness (Dick et al, 1996). The booklet is similar to a comic book but contains photographs instead of cartoon drawings. It is based on a genre of romance and suspense stories which is very popular in South Africa where there is a low level of functional literacy. When the booklet was evaluated, it was found that TB patients strongly identified with the text. Most patients report on the intense shock and despair that they experience when they are first diagnosed with TB. Despite the prevalence of the disease the social stigma associated with TB remains strong. When health workers take a routine history from patients who previously had TB, the patients invariably minimise the event by saying "No nurse, I've just had a touch of TB!" Some patients experience intense guilt feelings because of their fear of infecting others. As a result patients tended to isolate themselves. Some felt that other people would see that they had TB and were unsure of how to "face" others (Schoeman and Hoogendoorn, 1997).

Patients are usually quite ill by the time they are diagnosed but after the first few weeks the symptoms subside. This is the period during which many patients find it tempting to stop going for treatment. To comply with treatment is perceived as very difficult. It takes much discipline and endurance to visit the clinic every weekday for six months simply to be supervised while swallowing tablets. Some patients experience severe side effects from the treatment and there is little effort from health personnel to consider a more flexible approach to medication. Some patients drop out of the treatment programme at a later stage. A case study which describes this process highlights the many different factors which culminate in such a breakdown. (Hoogendoorn and Van der Walt, 1997). It illustrates how the enforcement of a rigid TB treatment regimen becomes just one additional factor in a life already complicated by poverty, an over-crowded house, conflict amongst family members,

and a neighbourhood riddled with crime. When the young man was finally persuaded to return to the clinic for his treatment he was greeted by a nurse who looked at him and made a sarcastic remark: "Oh, I see His Lordship is here..." This had set the scene for further confrontation and he left again without taking his treatment. Afterwards he told the researcher: "If she would have been friendly, I would have been able to explain to her what had happened. But she did not give me a chance. As soon as she saw me she scolded me. She said I was lying and that I did not belong there." This had upset him so much that he walked out of the clinic and so joined the ranks of the "defaulters" from the service. In Chapter 4, I discuss the issue of non-adherence to treatment.

Conclusion

This brief review of tuberculosis in South Africa has highlighted the seriousness of the epidemic as well as the efforts to contain and control it. What is striking is that we have the technical means to do so. In addition we are better resourced than many other developing countries. Dr Cassidy, a famous and well respected South African physician who specialised in treating patients with chest diseases reminisced about his work during the 1940s, prior to the age of modern chemotherapy. He commented on how helpless he used to feel when he had to inform a TB patient of a positive diagnosis. For most patients this amounted to a death sentence. Now that we have scientific knowledge available we still seem to be making little progress. Dr Cassidy said that the best way of "motivating" patients to adhere to treatment, was to treat them like allies. He believed in the power of building partnerships with patients, in simple gestures like greeting a patient with a handshake at the onset of a consultation (personal communication, 1992). Was the art of patient - centredness practised during the era of sanatoria when all that was available was skilled nursing care for patients on strict bed rest? Will it make a difference now in promoting adherence to treatment?

Chapter Three

Research methodology

In this chapter I define the focus and purpose of my research and the considerations which informed this choice. I present a rationale for choosing an interpretive research design and describe how I have drawn on different approaches within the qualitative research tradition. After describing the research design and the data collection and data analysis techniques, I discuss issues of reliability and validity and the ethical considerations of the work.

Formulation of the research question

All research projects start with questions. According to Maso (1989) researchers tend to arrive at a “provisional problem statement” after considering several sources of “starting questions” which arise from various sources, for example, practitioners in search of solutions, the scientific literature, the imagination or personal experience. In my case the “starting questions” came from several sources. From the literature and from communication with health care managers I knew that there was concern about the quality of nurse-patient relationships. These voices reverberated strongly with my own experiences as a professional nurse. What follows is a vivid memory from the time that I was working in a community health centre on the Cape Flats.

Two professional nurses work in the dressing room. Patients queue outside in the passage and file in one by one, all presenting with some surgical problem. The nurses clean and dress minor wounds, remove sutures and apply plaster of Paris casts to fractured limbs. A nurse enters the room with a boy of about thirteen years old. He has been the victim of a violent assault. His face is swollen and discoloured and his shoulders are lacerated by whip-like blows. He limps painfully and his entire body shivers like a leaf. The two nurses immediately turn on him with a

verbal attack. "Why did you get yourself into such a mess? This comes from mixing with gangsters! It serves you right! This will teach you to keep off the streets!"

While they clean and attend to his wounds the nurses continue to admonish him.

The child cowers and weeps.

I have often witnessed scenarios like this. They varied in nature and intensity. Often the patients were adults who were blamed for being ill because of their own negligent or "bad" behaviour, for instance the mother of a malnourished child or an obese woman with diabetes. Invariably the patient's response was to withdraw and to endure the blame passively.

More recently, while I was evaluating a lay community health worker programme, community members at whom the programme was directed, told me that they perceived differences between nurses and community health workers. They saw the nurses as impolite, disrespectful and even cruel:

"Nomphilo (the community health worker) will never throw me around or answer badly or shout at me. When I ask her something she is never wild. The nurse may not even answer me and will ignore me. If I come with a child who is very ill she will say, 'Just sit there, why do you come at this time of day, don't you know the clinic times?'" (Mathews and Van der Walt, 1994).

These perceptions are widespread. An example is the account of a teenage mother who related how nurses insult and even hit young pregnant women.

They treat us very badly at the clinic, so I chose to have my baby at home (Sherriff, 1995).

There are several local research initiatives which are in the process of exploring different aspects of nurse-patient relationships. Meulenberg-Buskens and Daniels (1997) study the concept of care. Fonn and Xaba (1995) at the Women's Health Project developed a training manual to sensitise nurses about the links between gender and health care. Jewkes, Mvo and Abrahams (1997) study the relationship between nurses and patients in obstetric units.

My own unresolved questions from past experience, my own and others' research findings, a growing body of anecdotal evidence as well as stories about nurse behaviour in the popular press prompted me to ask the question: Why are nurses so rude to patients?

Since 1992 I have worked in a research team that evaluates the effectiveness, efficiency and acceptability of tuberculosis control services. My involvement in these studies helped me to define the question further. I realised that nurses' behaviour towards patients was complex and that it would require in depth study. I suspected that the key to understanding this behaviour could be found in a closer investigation of the routine working patterns of nurses and an exploration of the meanings that nurses attach to their interactions with patients.

I decided that the aim of my study would be to gain an understanding of the nature of nurses' behaviour towards patients in primary health care settings.

At this point I defined my research questions as follows:

- How do nurses interact with patients?
- How do nurses perceive their relationships with patients?
- How do patients perceive their relationships with nurses?
- Which processes, experiences and organisational arrangements contribute to the existing patterns of interaction between nurses and patients?

Focus and purpose of the study

In this section I present an argument for confining the study to the micro-social rather than macro-social level and for focussing on the area of tuberculosis care.

Research by Andrews (1991), Marks (1994), and Rispel and Schneider (1989) explored the historical, political and socio-economic context in which nurses deliver health services. This important work falls within the tradition of macro-social research (Swartz, 1989) and provides a broad picture of how class, race and gender inequalities in the colonial and apartheid eras have influenced nursing as a profession and as a public service. While such research is important, it is not enough to know the origins and extent of the unequal power

relations. A micro-social study could reveal how these relations can be observed and understood in a specific clinical setting. In order for these issues to be addressed we need to move beyond the rhetoric of individual blame to try to understand the complexities of nurse-patient relationships. This would enable educators of nurses, public health managers, public health committees which represent the public, and nurses themselves to implement informed and focussed interventions in order to transform nurse-patient relationships.

The entire science system in South Africa, including health research is at present in a process of restructuring aimed at harnessing its efforts and resources to address the country's priority problems. In the area of health research, the Department of Health has adopted the international thrust known as Essential National Health Research (Department of Health, 1997c). The South African Medical Research Council has given its commitment to this approach (Edwards-Miller, 1997). The Health Systems Division of the Medical Research Council, of which I am a team member, collaborates with health care providers to develop, implement and evaluate interventions with the aim of enhancing the effectiveness of health care delivery (Dick et al, 1997; Zwarenstein et al, 1998). The ultimate aim of such work is to influence the Department of Health to adopt policies to institutionalise interventions which have been proven to be effective. In recent years epidemiologists have developed research methods which make it possible to use randomised control trials to test the effectiveness of health care interventions. The work of the Health Systems Research Division is unique in the sense that quantitative research is usually done in conjunction with qualitative research. This enables the researchers to gain an understanding of the perceptions and motivations which underlie the practice of health care givers (Dick et al, 1997).

With its emphasis on human rights, the "new" South Africa opens up opportunities for the democratisation of public services. Nurses have started to assert their right to take industrial action in order to improve their working conditions (Marks, 1994, 203-207). On the other hand, nurses will increasingly be challenged by users of the health services. In Khayelitsha (an informal settlement in Cape Town) members of the African National Congress Women's League marched on the Day Hospital to protest about the quality of services. Until recently health service managers have held the rather naive notion that as professionals they stand above protests and political conflict. As a result of this, nurses have not been equipped to deal

sufficiently with the complex and volatile political situations which characterise most public health settings (Van der Walt, 1994).

Nurse-patient interaction in primary health care settings covers a wide area but for the purposes of this study I will focus on the Tuberculosis Control Programme in the Cape Town metropolitan area. This work constitutes most of the time spent by nurses in community based primary health care centres (Dick and Pekeur, 1995). In Chapter 2 I have demonstrated the importance of TB as a major public health problem, as well as the dangers of non-adherence to treatment and the emergence of new strains of multi-drug resistant TB. In the wake of the rising incidence of AIDS in the population, nurses can be expected to spend even more time and effort on TB care.

Tuberculosis is a chronic illness and the average duration of treatment is between six and eight months. This allows adequate time for nurse-patient interaction to develop and to be observed. In addition to contributing to a better understanding of nurse-patient relationships in TB care, the findings of this study could also make a valuable contribution to the management of other common diseases such as hypertension, diabetes and asthma. All of these require long term treatment and effective partnerships between health workers and patients.

Selection of a research approach

In this section I explain my reasons for choosing an interpretive study design and I describe how I have drawn on different approaches within the qualitative research tradition. In reviewing the following trends I do not claim to have used them in their pure sense, but the influence will be clear.

“The choice of research practices depends upon the questions that are asked, and the questions depend on their context” (Nelson, Treichler and Grossberg, 1992).

In this study my main objective was to understand aspects of the relationship between patients and nurses and to understand how nurses themselves perceived the way in which they interact with patients.

Qualitative research can be characterised by three features, the emic perspective, the holistic perspective and an inductive and interactive process of inquiry (Morse, 1992). The **emic perspective** means to seek out the perceptions from the participant's view, rather than from the viewpoint of the researcher. In order to obtain the emic perspective, the researcher has to identify the informant's beliefs and values that inform a particular set of behaviours, rather than imposing the researcher's prior beliefs and perspectives on the data. This can best be achieved by following an **inductive and interactive research process**, rather than trying to test a set of carefully formulated hypotheses. Through a process of analytic induction the researcher gradually develops an understanding of the phenomena by constantly moving backwards and forwards between the processes of data collection, data analysis and further purposefully selected data. By taking a **holistic approach** the qualitative researcher believes that "all human action and experience is context dependent and can only be understood within those contexts" (Mishler, 1979). This is different from the concept of context stripping which is used in positivist research designs in order to control confounding variables. A qualitative research approach allowed me the necessary flexibility to study firstly the behaviour of nurses in their work setting, and secondly their perspectives on their work. The next step was to choose an appropriate research method from the range of possible qualitative methodologies.

Ethnography

I found ethnography (Hammersley and Atkinson, 1992; Hughes, 1992) an attractive option because it can be used to investigate cultural groups and phenomena associated with cultural groups. Ethnography has the following characteristic features: (Hammersley and Atkinson, 1994)

- * "a strong emphasis on exploring the nature of particular social phenomena, rather than setting out to test hypotheses about them"
- * "a tendency to work primarily with 'unstructured' data, that is, data that have not been coded at the point of data collection ..."
- * "investigation of a small number of cases, perhaps just one case, in detail"
- * "analysis of data that involves explicit interpretation of the meanings and functions of human actions, the product of which mainly takes the form of verbal descriptions and explanations."

Traditionally cultural anthropologists used ethnographical methods to study people in village settings but it is possible to use an ethnographic approach to study smaller scale health care settings (Golander, 1992; Kleinman 1992) or to consider professional groups or institutions in the same way as cultural groups (Cassell, 1992).

Ethnography draws on a wide range of sources of information. While researchers participate in the daily life of people, they observe what happens, listen to what is said, ask questions and collect any available data which may help them understand the phenomena that they study. The use of multiple sources of data provides the possibility for triangulation or comparison of different kinds of data. Interviews are often used for data collection. The formal interviews are open-ended rather than tightly structured. Informal conversations also yield information, but here the researcher ask questions only in response to information and cues provided by the informants. Participant observation is the other commonly used technique for data collection in ethnography. This entails the use of the senses such as vision, hearing, touch, smell and taste for gathering information about a particular setting.

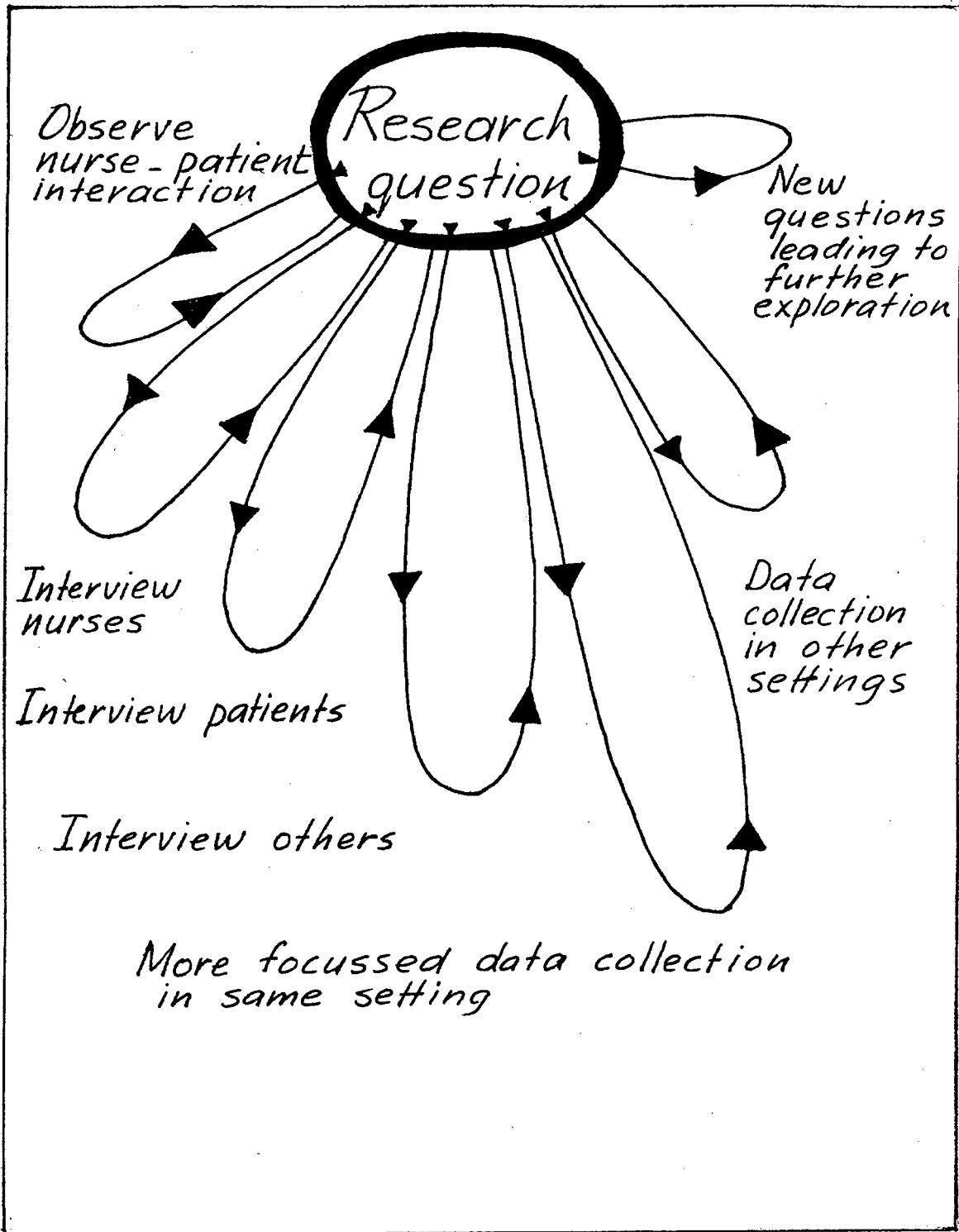
The influence of grounded theory

During the period when I developed my research proposal, I was attracted by the idea of using grounded theory principles for the purpose of generating theory (Strauss and Corbin, 1990). The following principles from the work of Charmaz (1983), and Henwood and Pigeon (1993) had an influence on my research procedure:

1. Data collection and analysis happen simultaneously because grounded theorists shape their data collection from their analytic interpretations. They check emerging ideas by collecting further data. I drew on this principle in the conceptualisation and planning of the structure of my research. I found it helpful to envisage this cyclical process of data collection and data analysis in the form of a flower with several petals (figure 1). The central heart of the flower contains the main research question which guides the process: how do nurses relate to patients? The loop shape of each petal symbolises the collection of a particular set of data. After analysis it is deposited into the heart of the flower as a seed which could potentially steer and inform the development of the next petal-loop of data collection.

FIGURE 1

Research process



2. In grounded theory a detailed set of guidelines for coding the data provides a disciplined method for creating meaning (Strauss and Corbin, 1990). Coding is the process of categorising and sorting data. For instance, in the early phases of the research process there is maximum flexibility to generate new categories from the data given the proviso that the descriptions “fit” the data well. I have found the concept of open coding valuable, especially during the initial stages of the analysis of interview transcripts. Despite this, I have not used the highly structured guidelines for grounded theory, for instance those for axial and selective coding, because I have found them too narrow and restrictive for my purposes.
3. Grounded theorists develop their analyses from the data, rather than from preconceived theoretical frameworks. They make a conscious effort not to rely directly on literature to influence their findings:

“We do not want to be so steeped in the literature as to be constrained and even stifled in terms of creative efforts by our knowledge of it! Since discovery is our purpose, we do not have beforehand knowledge of all the categories relevant to our theory. It is only after a category has emerged as pertinent that we might want to go back to the literature to determine if this category is there, and if so what other researchers have said about it.” (Strauss and Corbin, 1990, p 50)

At the onset of the research process I resisted the notion of adopting an exclusively theoretical framework. I did, however, read widely and selectively on the phenomena that I was investigating and on topics that shed light on my provisional findings. Here my stance differs considerably with the grounded theorists.

I used concepts from the literature and theories as additional sources of data which assisted me to engage creatively with the concepts that were “grounded” in my data. Regarding my treatment of theory and literature, I have been influenced by the principles of analytical induction (Znaniecki, 1934; Katz 1983), which was first described by empirical researchers from the Chicago school. In a paper titled : “Theories as heuristic tools in qualitative research” Kelle (1993, p16) presents the following argument for the use of existing knowledge:

“To give a correct account for the process of qualitative reasoning one must refer to a concept that 1) does not neglect the role of previous knowledge in the context of discovery, 2) does not reduce qualitative reasoning to a mere generalisation of observed facts, 3) clearly shows the rational and methodical aspects of discovery. These conditions are fulfilled by the concept of *hypothetical reasoning* based on qualitative inductive and abductive inference. Within this concept the theoretical knowledge of the researcher is neither regarded as an obstacle for discovery (as in inductivism) nor does it serve as an obstacle for open research (as in hypothetico-deductive research). Instead it is used as a heuristic device, ensuring that the researcher enters his field with an open mind and not with an empty head”.

Analytic induction has as one of its aims generalisation, but this has not been my intention.

Data collection techniques

Now that I have explained the rationale for using a qualitative research design, broadly within the framework of ethnography, I discuss the specific techniques that I have used for data collection.

Interviews

In this project I have largely used in depth interviews. I have drawn on the basic technique of “free attitude” interviewing, a controlled, non-directive depth interview as taught by Meulenberg-Buskens (1998). The term free attitude interview is a translation of the Dutch term “vrije attitude gesprek” which was developed by Vrolijk, Dijkema and Timerman (1980). The procedure is simple, yet requires much practice in order to give trainees insight in the many ways that the interviewee can be influenced by the interviewer. What follows is an explanation of the procedure that followed during interviews.

After a brief introduction a single open-ended research question is posed which should contain no suggestions. No further questions should be posed, because that would introduce the possibility of pushing the researcher’s agenda in a preconceived questionnaire-style interview. In my study the question was usually aimed at eliciting the respondent’s views or feelings about a particular topic. I encouraged the respondent to talk freely around the topic, interrupting only in order to clarify concepts. This is important, because of our tendency to assume that we share a mutual understanding of a concept, for instance, when a nurse told me “patients should take responsibility for their

own health”, I had to ask her what she means by “responsibility”. This technique depends on regular reflective summaries by the interviewer. The summaries serve to structure and focus the interview to some extent and to give the interviewee the opportunity to correct any misunderstandings held by the interviewer. At the same time, perhaps because the interviewees find themselves in the rare situation of being truly listened to, the reflective summaries tend to evoke additional information which is often of a more personal nature. Throughout the interview, the researcher’s attitude should be one of unconditional positive regard (Rogers, 1961). Reassurance, agreement and the giving of advice is not permitted.

I used this technique for all formal interviews, that is, those interviews that were conducted with prior arrangement. Most interviews were with individuals, but in a few instances which I describe in Chapters 4 and 6, I used this same technique for group interviews. With the permission of the respondents, the interviews were recorded on audio cassettes. Afterwards I transcribed these in the language used by respondents, either Afrikaans or English.

Participant observation

I used participant observation techniques in order to study the practice of nurses in tuberculosis treatment clinics. This meant that I had to consider my own level of participation carefully. Junker describes a continuum of possible social roles in fieldwork. (Junker, 1960, as cited in Hammersley and Atkinson, 1992). For instance, in the role of “complete participant” the researcher’s identity would be concealed from the study population, while the “complete observer” may have no direct contact at all. For my purpose I chose a comparatively detached role midway between the two extreme roles already mentioned. This enabled me to be true to my real identity, an ex-nurse who is interested to learn from nurses and patients about their experiences. The “ethnographic stance” (Ely et al, 1993) requires that the researcher adopt a learning role in order to attempt to see life through the eyes of the other, or to become “apprenticed” to the other. I preferred to be “intellectually poised between familiarity and strangeness, and socially poised between stranger and friend” (Everhart, 1977). I recorded my observations as descriptive field notes as soon as possible after the observation periods. In the notes I made a distinction between what I observed, what I heard and what I thought and felt about it.

A research diary

Throughout the research period I kept a loose leaf journal which contains the following sections: a record of my meetings and discussions with my supervisor, analytical reflections on the data, theoretical memos from reading various sources of literature and notes on my feelings about the research content and process. Paging through this diary I realise that I have often used it as a means to talk to myself, to encourage and motivate myself as in the following excerpt dated 12 February 1997:

“Once again I have to pick up the threads. Once again I am frightened because of the enormity of this project. Am I up to it? My efforts feel like a fragile seedling”.

At times I grappled with my role as researcher: “Why do you do research? To change the world or to understand it?” The diary reflects the doubts that I experienced during the research process:

“After all, there is an epidemic out there and people are dying. We need to find answers and it may be a luxury to take time in order to understand the dynamics” (Diary, 11 June 1994).

I constantly had to resist the pressure to develop interventions. This pressure was largely due to my own anxiety of being a member of a team of health systems researchers. By its nature health systems research is practical and action oriented, it aims to provide health care providers with answers to everyday problems and this is often done by testing of new interventions. The urgency of TB and the failure of the existing control programme added fuel to the urge to come up with a new intervention. This research occurred shortly after the political transition in South Africa and there was a heady atmosphere of change and progress. Miracles were in the air and more miracles were expected to deliver the promises of change to one of the groups who most needed those changes; the TB patients. Under these circumstances the diary provided an outlet to reflect on the pressures and to come to terms with the value of taking the time to think and to understand prior to planning interventions.

The diary has been valuable not only because it served as a container for my doubts, thoughts and anxieties about my identity and role as a researcher, but also as a vehicle for my own

reflexive processes. Reflexivity is defined as the recognition that we are part of the social world that we study and that instead of making futile attempts to eliminate the influence of the researcher we should try to understand it (Hammersley and Atkinson, 1992: 14-23). The use of the diary enabled me to leave a trail of the methodological choices that I have made along the way. Meulenberg-Buskens defines research methodology as “the science of the road one follows in research” (Meulenberg-Buskens, 1998).

Use of personal experience

The use of the diary has enabled me to reflect on my own experiences as a nurse and to regard that as an additional source of information. I knew that pure objectivity is an impossible goal, but nevertheless I wanted to be increasingly aware of how my own experience and prior knowledge coloured my perceptions.

At a later stage in my research I found a way to draw directly on my own experience. In Chapter 7 I describe the process whereby a reflection on a past experience freed me up to such an extent that I gave myself “permission” to reflect on an observation which I had found too politically sensitive to analyse fully. I subsequently used that same experience as a strategy to collect further data on the topic. Smaling uses the concept of open-heartedness to describe ways in which researchers can choose to reveal themselves in the process of social inquiry (Smaling, 1993). Open-mindedness, the ideal state of mind that the qualitative researcher strives to achieve, can be defined as a one directional or receiving mode of openness. Open-heartedness implies a “sending mode”, or a way of acting towards somebody else. When used as a methodological strategy, open-heartedness could be a threat to objectivity as well as a benefit. At worst it could lead the respondent to react in a socially desirable way or prevent open-heartedness by the respondent. On the other hand though, it could benefit objectivity when, in turn, the respondent feels encouraged to reveal information.

Target group and sampling

The target group for this study is nurses who work in the Tuberculosis Control programme of the Cape Metropolitan Council. I focussed mainly on coloured and white nurses whose mother tongue is either English or Afrikaans because that allowed me to limit the scope of the study and to do my own interviews and observations. I have therefore focussed on groups

who form 81% of the population of the Western Cape (Central Statistics, 1996). This means that the results of the study will be of some relevance to the largest number of people in the Western Cape.

In qualitative research the strategic selection of respondents and research settings is particularly important because of the relatively small number of in depth observations and interviews that can be done. The guiding principle is often the selection of “critical cases”, or cases which would shed light on the phenomena of the study. This procedure is also known as purposive sampling (Patton, 1990). As the study progressed, I have used theoretical sampling (Strauss and Corbin, 1990: 176-193) in order to seek out evidence to verify or falsify the evolving hypotheses. Throughout the study my decisions on whom to interview and observe next was based on my ongoing analysis of data.

The work that I describe here consists of several smaller projects. In some instances I piggy-backed my work onto existing projects by collecting more information than was used by the original projects. This refers to the data that I collected from two large community health centres in the Cape Metropolitan area while I was part of a team of researchers who were involved in research projects in this setting over an extended period of time. The clinics are similar to most of the urban clinics in the region to the extent that they are managed by a central administration according to similar guidelines.

Throughout the thesis I describe the sampling procedure that was used for each particular unit of the work. For example of this, in Chapter 8, I describe how I was approached by a nurse who had heard about my study and wanted to tell me about her experiences. This opened up another trajectory for exploration which required further purposive sampling.

Access and ethical considerations

As pointed out before, the work which is described in this thesis consists of several sub-studies, and for each of these access and permission was negotiated with the relevant health authorities, health centre personnel and with the individual research respondents. This also applies to those instances where my work formed part of larger studies undertaken by a

research team. I designed a document which I have used to obtain informed consent for formal interviews. It contained the following points:

"I agree to participate in a research project about nurse-patient relationships in primary health care. I will participate in the interview under the following conditions:

1. I will allow the interview to be recorded. I understand that the interview is taped so that nothing is missed and so that my words are not changed or misunderstood. I can turn off the recorder at any time during the interview.
2. I agree to allow Hester van der Walt to use the information from the interview in the research report and research publications. However, I understand that my privacy and confidentiality will be protected by disguising names and other identifying information.
3. I understand that I have a right to receive and review a written transcript of the interview. After reviewing and discussing the transcript with Hester, I can suggest changes for accuracy, clarity, or new information".

This research coincided with a period characterised by transition and restructuring of the health service which had left health workers vulnerable and uncertain of their future. I was aware that my research activities and particularly my role as outsider-researcher and insider-"ex"-nurse could be particularly threatening to personnel. I have, however, found health authorities as well as nurses at health centre level welcoming and willing to participate.

In order to protect the anonymity of informants I have made use of pseudonyms for individuals and research settings.

Analysis of data

It is important to note that data analysis was not the final phase of the research process but that it occurred concurrently with data collection and that these two processes informed each other. My first task was to organise all forms of spoken and observed data into text. Audio cassettes were transcribed and observations were recorded as field notes. All texts were referenced with dates and contextual information and kept in files. I will now illustrate the process that I have followed by describing the analysis of an interview transcript.

After reading the transcript several times I write a memo to record my first thoughts and feelings on the interview as a whole. Then I “fracture the data” (Strauss and Corbin, 1990, 61-74) into units of meaning and begin to develop categories. A category is the smallest meaningful piece of narrative that can be given a label. I highlight the keywords and write labels in the margin. At this stage I try to generate as many categories as possible in order to keep an open mind and to avoid reaching a premature decision. The next stage is to write each category on a sticky label and to arrange them on a larger sheet of paper to see if there are links between categories and to try and sort them into main categories and sub categories. It is important to check whether the framework fits the data or whether it has been a forced researcher driven effort. I then write notes about the categories.

After following this procedure with different interview scripts it is possible to detect themes that occur across interviews. A theme can be described as “a statement of meaning that runs through all or most of the pertinent data, or one in the minority that carries heavy emotional or factual impact” (Ely, 1984). The next process is to reflect on differences and similarities and to generate questions about the interview and observational data. This began the process of theorising, “recognising that theory is merely a tool to guide investigation is critical in all methods of inquiry” (Morse, 1994).

In Chapter 5 I describe how I describe two sets of behaviours which I define as “task orientation” and “patient centredness”. A subsequent step in theorising was to ask questions of the data in order to link it to established theory (Morse, 1994, p 33). The ethnographer need not be limited to a single theory within which to analyse data (Hammersley and Atkinson, 1992, p 181). My approach to the use of existing theory was to ask “what in this theory will help me to understand the data?” I have found psychoanalytical theory and organisational theory useful in this regard (see Chapters 6, 7 and 8). The other strategy that I have used for theorising, was theoretical sampling (see Chapter 7).

Strategies to ensure rigour

Qualitative researchers differ considerably on whether the quality of their work should be judged by using similar terminology as in quantitative research. Leiniger, for instance, argues that reliability and validity in qualitative research are so different that quantitative labels should not be used because they could obscure the process (Leiniger, 1994). She proposes the

use of evaluation criteria which fit the philosophical assumptions and purposes of the qualitative paradigm. These criteria include credibility, confirmability, meaning-in-context, recurrent patterning, saturation and transferability. Lincoln and Guba (1985) suggest measures such as prolonged engagement in the field, persistent observation, triangulation and search for negative cases to obtain credibility.

Fetterman (1989), Goetz and LeCompte (1984) and Miles and Huberman (1984) are among the qualitative researchers who continue to use some of the terms of positivist research (Ely et al, 1993). I have found Smaling's arguments in favour of the use of mainstream terminology persuasive. He uses the term objectivity in its original/ traditional/ philosophical form. Prior to its exclusive use as a methodological concept within the positivist paradigm, its epistemological meaning was much broader. He developed the concept of objectivity as "doing justice to the object of study". The domains which can be assessed for objectivity are the domain of psychic attitudes and mental activities of the researcher, the domain of ways of acting, and lastly, the domain of results or products. In striving for objectivity the researcher strives to combine an objective attitude, objective ways of acting and objective results. In order to be objective, research should do justice to the object of the study, that means "... creating a balance between letting the object speak and avoiding distortions" (Smaling, 1989). Thus Smaling argues in favour of a broad and abstract re-interpretation of the traditional terms in order to promote communication between scientists from across the paradigmatic divide.

Criteria for evaluating ethnography

"(The) moral dimension suggests one criterion for recognizing a good ethnography: It should be a tool for enabling us to take a more understanding account of whomever we perceive as 'The Other', or 'Not Me.'" (Muecke, 1994)

I often find the style in which "The Other" is described in academic writing arrogant and offensive towards the subjects of research. For this reason, I find Muecke's (1994: 196-197) set of criteria which focuses on methodological rigour without losing sight of the moral and

ethical issues, particularly helpful. I therefore quote these at length:

1. "The ethnography demystifies the people studied to the point of rendering their behaviour coherent to the reader. An ethnography demystifies and explains, not merely describes; interprets one social group to its larger society or to another society; increases understanding of the common humanity of all people".
2. "The people described would, in general, find it an honest and caring description of them in their situation" (Sanjek, 1990; Werner and Schoepfle, 1987a).
3. "The conceptual orientation of the ethnographer in constructing the ethnography is acknowledged and coherently linked to the study and its field material".
4. "The relationship of the ethnographer to the people in the field is explicitly assessed for its influence on the information reported. (...) The sources of the ethnographer's information are sufficiently clear for the reader to assess the adequacy, appropriateness, and breadth of coverage of the data. The data were collected and recorded in the primary language or dialect of the informant and were translated with utmost care to preserve the meaning believed to have been intended".
5. "Ethnographic depth is achieved through thick description. Thick description analytically explores, compares, and contrasts diverse perspectives and sources of information in the corpus of the field data. It tests links and adjusts inferences to form a coherent interpretation that engenders understanding of differences. The information was acquired through the ethnographer's continuous participant observation in the field or situation studied. The information was obtained from a variety of sources. (...) The information was gathered accumulatively and cyclically, each gathering including comparative analysis with other information and leading to reformulation of questions".
6. "The narrative is competent literature (.....). The style of writing itself embodies meanings that are implicit in the society of the study. (...) The criterion requires that the ethnographer demonstrate understanding of the constraints of her or his own and the informant's rhetoric and conventional modes of expression on reports and fieldwork findings".

A note on the organisation and presentation style

I would like to reiterate that the thesis contains a number of sub- studies which are to be found in Chapters 4, 6, 7 and 8. Each of these chapters contains a methods section which provides a further detailed description of the methods that were in that particular sub-study. Although all the sub-studies were conducted qualitatively and in the same geographical and cultural context, I found it is important to pay attention to the micro-context of each. Each sub-study required a particular set of methodological considerations and options in order to capture the unique setting and relationships.

Conclusion

The purpose of this chapter was to present an argument for the methodological strategies and to broadly describe the methods that I have used throughout this thesis. In broad terms I have described the road that I have taken on my research journey, as well as the “maps” and signposts that I have used as guides along the way. In retrospect it now appears to have been a rational and straightforward process, but I realise that many methodological decisions “happen” spontaneously, without being consciously aware of the choices and therefore, of the options that were not chosen. This is the last of the introductory chapters and the next chapter marks the beginning of the chapters which describe the research process.

Chapter Four

Nurse-patient interaction in the Tuberculosis Control Programme

Introduction

In this chapter I present a case study which provides a description of the work patterns that occur in health centres in Cape Town where TB patients are diagnosed and treated. This account could be regarded as a description of the routine procedures that nurses have developed in order to cope with the work. It illustrates the most widely practised treatment model that is known as "directly observed treatment short-course" (DOTS). This means that a patient has to visit the local health centre to take the tablets under the supervision of a nurse five days a week for at least six months. For a more complete discussion of DOTS, see Chapter 2. This chapter also examines the concept of compliance.

Research indicates that approximately 40% of TB patients do not complete their treatment (Dick, 1994). The cure rate in the Western Cape was 66.4% in 1995 (Weyer, 1997). Patients who leave treatment prematurely are likely to infect others, especially young children, and may over time develop resistance to TB medication (Mitchison, 1985). Increasing numbers of TB patients resist the two most effective drugs available for treating TB, namely isoniazid (INH) and rifampicin (Centres for Disease Control, 1993, Goble et al, 1993). In South Africa more than 2 000 TB patients develop multiple drug resistance per year. Of these fewer than 30% survive and cost of their treatment is high. While it costs about R3 000 to treat an uncomplicated TB patient, the cost of treating an MDR patient would be R60 000 (Weyer, 1996). The major challenge for health service personnel is to ensure that patients complete their full treatment. This process is known as case holding.

Compliance to treatment

Compliance has been defined as "the extent to which the patient's behaviour (in terms of taking medications, following diets, or executing other lifestyle changes) coincides with medical or health advice" (Haynes, 1979). Much has been written about this concept, mostly from the perspective of physicians and health care providers. Trostle argues that the popularity of compliance research can best be understood if we look at compliance as an ideology: "a system of shared beliefs that legitimise particular behavioural norms and values at the same time that they claim and appear to be based in empirical truths" (Trostle, 1988). Most of the research defines patient behaviour in terms of professional expectations and tends to ignore alternative health behaviour by patients. The notion of compliance assumes a dependent layperson and a dominant professional and raises issues of power and control. This has led to terms like non-adherence replacing defaulting or non-compliance among some researchers (Barofsky, 1978; Stimson, 1974).

A review of medical and social work literature found that the literature pertaining to factors associated with compliance could be summarised under the following headings: the medication regime, features of the health care system, and features of the relationship between the patient and the care giver (Black and Bruce, 1998). These will be briefly discussed in turn.

Factors associated with the **medication regime** refer to the length and nature of treatment (Blackwell, 1973). TB patients tend to stop treatment when the symptoms disappear after one to two months of treatment (Barnhoorn and Adriaanse, 1992). Bentley, Rosenson and Zito (1990) found that medication regimens which are tailored to meet the unique lifestyle of a patient, as well as contracts and reinforcement strategies can contribute to increased compliance.

Features of the **health care system** which influence compliance are the setting where care is provided and the costs borne by patients to obtain the treatment (Adriaanse, 1992). Related factors are convenient clinic hours, minimal waiting time, the distance between public health clinics and patients and continuity with the same health care provider (Amir, Rabin and

Galatzer, 1990; Barnhoorn and Adriaanse, 1992; Becker and Maiman, 1975). The social work literature emphasises the importance of patient education in the promotion of compliance (Bentley et al, 1990; Green, 1979; Levy, 1987).

The quality of the **relationship between patient and health care provider** was found to have an influence on compliance to treatment. The role of the physician or clinician seems to be particularly important (De Tullio et al, 1986; Solomon et al, 1988). Barnhoorn and Adriaanse (1992) found that lack of interest among health care providers in the attitudes, beliefs and knowledge of the patient has a negative influence on compliance. Pessimism by the health provider about the patients ability to change has a similar negative effect.

Another body of research looks at patient perspectives and asks what patients do with their medications, ie their drug taking behaviour and self-care activities. A study by Hunt and colleagues indicates that long-term compliance depends on how easily the treatment is compatible with patients' everyday lives. Far from being passive followers of advice, patients actively interpreted their diagnoses and used their treatments to control their symptoms within the constraints of their daily routines (Hunt et al, 1989). Along similar lines, a study of compliance from the perspective of epilepsy patients focuses on the "logic of non-compliance" (Trostle, 1983). Zola points towards the importance of making the patient the ally and not the object of treatment. The culture in typical health service facilities creates structural barriers to communication. He argues for more open communication between doctor and patient. Care givers need to be aware of what it is like to be weak, dependent and vulnerable. Persuasion should be replaced by negotiation and medication compliance by "therapeutic alliance" (Zola, 1980). Black and Bruce (1998) argue for an holistic approach to patients which consider their treatment environment as well as the cultural and socioeconomic factors.

The context

As was mentioned in Chapter 2, during 1993 a case holding strategy comprising the use of a motivational photo-novel (Dick et al, 1996) was demonstrated to staff at TB clinics in the local authority during training sessions. Tobias, head of the local authority's health promotion

department, conducted the training. The photo-novel "Waar daar 'n wil is" (Where there's a will), (Medical Research Council, Child Health Unit, Divisional Council of the Western Cape, 1991), was introduced to staff as a way of initiating discussions with patients around the difficulties of compliance. The main character in the booklet experiences social stigma, problems of poverty and the temptation to give up treatment prematurely. The aim of the booklet is to acknowledge the problems that patients experience and to encourage them to continue treatment despite the difficulties of adhering to a lengthy treatment regimen. A further aim is to involve patients in their treatment by showing them how to plot their own progress by ticking off each week of treatment once it has been completed. At one of the training workshops in which this approach was introduced, the staff raised problems which they thought could stand in the way of implementation. The nurses asked for help and advice on how best to implement the new intervention. At this point my colleague and I were consulted as health systems researchers, with a background in nursing. At our first meeting it became clear that the nurses had delegated the interviewing of new patients as well as the distribution of booklets to a health educator who had not attended the training workshop. This was done, the nurses said, because they were too busy for patient interviewing.

During this meeting the nurses also mentioned their frustration about the patients who drop out of treatment.

"The patients don't take responsibility for their own treatment".

Some patients regarded TB as

"the clinic's problem".

They expected the nurses to give them food before they took their pills. Another perception was that patients willfully prolong their treatment in order to get a disability grant. It is important to note that despite the fact that the social security system in South Africa is rudimentary, poor families are often totally dependent on the small social security grants.

The nurses' frustration about the problem of defaulting was best illustrated by the wistful comment:

"It is a pity you cannot put all the chronic defaulters on Robben Island".

Robben island is an inaccessible island formerly used as a leper colony and subsequently as a prison for political prisoners of the apartheid regime. President Nelson Mandela was one of the most well-known prisoners on this island. The nurses felt that they would need more staff in order to deal properly with the increasing numbers of TB patients.

Research methods

At the end of the meeting my colleague and I agreed to study the working patterns in the TB service in order to advise the nurses regarding the feasibility of implementing the new case holding approach. We used qualitative research methods in order to gain an in depth understanding of the interactions and procedures of the service. Taking the role of non-participant observers, we attended two sessions of the routine TB clinic which is held once a week. These sessions can be considered as typical in terms of staff/patient ratios. In addition I observed patients receiving "directly observed treatment" on non-TB clinic days. Our presence at the clinic did not seem to disturb or influence the behaviour of staff or patients. This could be because of the hectic bustle which typified the general atmosphere of the clinic. The presence of visiting students seemed to be part of the clinic routine, and I had the idea that we were perceived as two additional visitors with notebooks who asked a few questions. We took turns to observe similar aspects of the service and recorded these observations as descriptive field notes. After the data were collected, we met to compare our observations and to analyse the themes that we identified.

A description of the service

Black Haven health centre (a pseudonym) is situated in a part of Cape Town which was designated as a "coloured group area" by the former government. It is surrounded by single storey council houses and a few neighbourhood shops. It is close to a busy highway and an

industrial area. According to the Health Information Section of the Cape Metropolitan Council, the health centre serves a population of approximately 29,000. I first describe the TB clinic and all its different activities and then the daily observed treatment sessions.

The weekly TB Clinic

The main purpose of the Thursday clinic is twofold. Persons who have been in contact with TB patients and who are "suspected" of having contracted tuberculosis are screened by a range of diagnostic tests (this procedure is known as case finding). Doctors interpret the results of diagnostic tests and the case histories taken by nurses and make a diagnosis. They inform patients of the diagnosis and start them on treatment (this procedure marks the beginning of the case holding process). During our observations of the clinic a total of 161 people attended the morning session. Of these 47 were "contacts" while 16 were "new patients". A further group of 99 attenders were classified as "other". This group passed through the clinic for a variety of reasons, such as repeat visits to the doctor, patients coming to get the results of their sputum tests and x-rays.

The overall impression was one of overcrowding. The total package of care is chopped up into a range of separate activities and patients were processed through each activity. Patients waited in queues which formed for each activity. By 8.15 am there was a queue of people outside the clinic door. A nurse sat at a table at the entrance door to screen attenders and to send them to various other queues, i.e. to the "contact" table in the middle of the waiting room, to the hatch of the waiting room and to the table in the record office where new patients' history forms were being filled in by a nurse.

Rows of waiting patients sat on benches in the waiting room, waiting to be called to the hatch of the record office, the "contacts" table, the doctor's office or the mobile x-ray facility which was parked behind the clinic. At 9.30 am there were 60 people sitting in rows in the waiting room.

All staff activities were characterised by writing and recording bits of information onto forms or in books. One nurse spent most of her time searching for previous records and x-rays in filing cabinets. A nurse who came in from another clinic to help (relief duty), joined the clerk at the hatch who was calling patients, and started filling out forms and weighing patients before sending them for x-ray.

The histories of new patients were taken by a nurse in the record room which was buzzing with other activities. Clerks and nurses who came in and out of the room interrupted the interviews from time to time. The interview was a one way conversation: the nurse asked for information and recorded the patient's brief answers on a form. There was no attempt at informal conversation. There was little eye contact and the nurse mostly wrote on the form while she spoke to the patient. The interaction lasted an average of 8 minutes. No information or support was given to patients during these interviews.

Breaking the news

I observed consultations between two doctors and patients. The role of the doctor is to diagnose new patients, to inform them of the diagnosis and to prescribe the treatment which would routinely last for up to six and a half months. The doctor works in a small consulting room which contains a desk with a telephone and different forms, a chair for the doctor and one for the patient, an examination table and a light box for viewing of x-ray plates. I asked one of the doctors to tell me how she approached the first encounter with a TB patient.

"They tend to take everything lightly, so I prefer to talk very seriously to them. People should learn to be disciplined and that is why I am strict with them (ek is kwaai en op die man af). That is how I try to encourage them to take responsibility for their treatment". (My translation from Afrikaans)

Her manner towards the patients was abrupt. She ordered a childminder who brought in a child with TB to sit on a chair quite a distance away from her desk. The child's parents were at work, unfortunately, and the childminder had limited information on the illness history. The doctor prescribed treatment for three months and instructed the childminder to come in for daily observed treatment.

I had the opportunity to observe another doctor who established closer contact with patients. In spite of language limitations she seemed to communicate better. She took an interest in the history and addressed the mother of a child with TB by her surname and occasionally as "Mummy".

On the whole doctors have infrequent contact with patients. They see patients at the beginning of treatment and again at the end on completion of treatment, when they discharge patients. It is the role of the nurse to see the patient on a daily basis for medication.

Observation of daily treatment of patients (DOTS)

I observed daily treatments to learn what happened there and to see whether these sessions could present a possible opportunity for nurses to have discussions with newly diagnosed patients in the planned case holding intervention. Patients started coming in as soon as the clinic opens just before 8 am. Those who have to go to work, come on their way to work. No queues formed and patients were seen promptly. There was a set routine. The nurse asked each patient to fill a glass with water. She handed each patient their pills in a small plastic jar. They swallowed their pills and left the room. There was hardly any conversation. Some patients greeted the nurse and were briefly greeted in return. Childminders were asked to hold the children on their laps while the nurse gave the medicine with a spoon. There was little eye contact or warmth. Patients who had failed to fetch the previous dose of medicine were scolded:

"You know you should come every day!"

The nurse told me that if patients stayed away for a week, a staff member would visit the patients' homes in order to try and recall them. Patients took their pills without question or comment. No encouragement or support was given. On the whole the atmosphere was impersonal and rather bleak.

Discussion

Task orientation vs patient-centredness

To walk into a TB clinic, is to enter a world with a particular culture. It is populated with people who act out different roles - each of these is determined by its own set of rules. You walk in as a "contact", as a new TB patient or as an old TB patient. There is a set procedure for each of these categories of patient. From the observations it became clear that the service was chopped up into a set of tasks or activities, for instance, history taking, seeing the doctor and receiving medicines. Each of these activities was preceded by a waiting period. The whole procedure reminded me of a factory with goods moving along an assembly line. It is a task-oriented system which was designed to make the flow of activities as convenient as possible for staff.

The essence of the primary health care approach is to promote a patient centred approach to health care which is based on meeting the needs of people. It strives to "enable ... people to increase control over their lives, and improve their health" (World Health Organisation, 1986). Patient-centredness means putting the patient at the centre of the consultation and attempting to understand the thoughts, feelings and expectations of the person as well as his or her symptoms (Henbest, 1992). People who attend the TB service have varied needs, but they fall mainly within three categories. Firstly, **those who have had contact** with TB patients have a need for information and reassurance. They need to know what symptoms to look out for and when to report these. In the present system they are "processed" through the service without being given information. The most urgent need of the second category, **the newly diagnosed TB patient** is to be listened to. The stigma attached to the disease causes tremendous stress and fear (van der Walt, 1994a). They need support and information about the treatment. They also need to re-plan their lives in order to find time for the directly observed treatment. This would ideally require privacy and the attention of a sensitive and skilled staff member. In the present clinic routine all new patients are seen during the session when the clinic is flooded with people who come for screening. Thirdly, there are **the patients on directly observed treatment** who are coping either well or not well with the 6 to 8 months of required drug therapy. Given the poor adherence rates, this group requires particularly skillful and well targeted interventions. The current practice reminds me of

Trostle's theory of "compliance as ideology" (Trostle, 1988) because it reinforces the power of the professional while disempowering the patient. It could well be a major contributing factor to the poor adherence record of the clinic, because it sets the scene for ignoring the emotional needs of the patient.

Nurse-Patient relationships

The directly observed treatment requires a major intervention into the daily lives of patients. The procedure was initiated to ensure that patients take the required medication and to give support to patients. To an observer the overwhelming impression is one of alienation. There is no meaningful communication in the interaction between patient and nurse. It comes across as a ritual in which the nurse is cast into the role of a police officer and the patient is treated as someone who cannot be trusted to behave like an adult.

A Canadian study describes four types of mutual relationships between nurses and patients which depend on the **duration of the contact** between the nurse and the patient, the **needs of the patient**, the **commitment of the nurse** and the **patient's willingness to trust the nurse**. If the patient is unwilling to trust the nurse she or he will show "difficult" behaviour patterns which could include absconding from treatment. If the nurse is unwilling or unable to be committed to the patient, the patient is likely to use manipulative behaviour patterns in an attempt to increase the nurse's involvement in the relationship (Morse, 1991). The long term nurse-patient relationship is described as a "connected relationship" to differentiate it from shorter clinical relationships. In a connected relationship the nurse sees the patient first as a person and second as a patient. These nurses tend to act as patient advocates and will intercede on behalf of a patient with family or medical staff. The patient often feels that the nurse has "gone an extra mile" and in turn respects the nurse's judgement.

In Black Haven TB clinic the nurses performed mainly clerical and administrative tasks, for instance directing the flow of patients and filling out of forms. It has been suggested that record keeping is equated with seniority and status and that "hands-on" nursing is seen as lower status work (Segar, 1991). Barrett (1988) notes the process whereby writing comes to be treated as a performance which constitutes social interaction. In the directly observed

treatment situation conversation was kept to the level of instruction and reprimand. Patients with tuberculosis require at least six months of treatment and therefore a long term nurse-patient relationship is appropriate. There is a need to form a partnership between carer and patient because no cure is possible without the full cooperation of the patient. The contact between patient and care givers is fragmented because there is no continuity of care. But would nurses be able to cope with "connected relationships" or would these relationships be emotionally too burdensome?

Conclusion

The nurses are in a double bind. They have to process scores of patients through a system (in order to control the epidemic), yet this very system is so impersonal that it turns patients into numbers. It leaves no time for meaningful communication which would allow patients and nurses to get to know each other's concerns. Therefore the nurses at Black Haven were correct when they said that it would be impossible to "fit" the patient-centred intervention into the existing routine. At present their main struggle is to combat the epidemic. The irony is that the carriers of the "enemy" (*Mycobacterium Tuberculosis*) are patients. In order to stamp out the disease they feel that they need to control the patients' medication. There is a perception that the more you control the patient, the more chance you have of controlling the disease. The ultimate form of control would be hospitalisation of "chronic defaulters" on Robben Island.

While the nurses expressed the wish for patients to take responsibility for their own health, it seemed as if directly observed treatment created the opposite effect because it is not based on mutual trust. Can the primary health care approach with its ideals of patient-centredness be implemented in the hectic day-to-day reality of urban public health centres? Whatever the answer, it seems that patient-centredness cannot be tagged on to the present system as a mere procedure - it is an approach which would require a rethink about the role of nurses, doctors and the way in which the service is organised - especially now, while "new" South Africans are restructuring, developing and democratising the health system.

The nurses felt that task orientation is the only way that they could cover all the tasks that they considered to be important. When and where did this work pattern originate and why has it gained such dominance among nurses? In the next chapter I explore these questions.

Chapter Five

Task orientation and patient centredness

The case study which was presented in Chapter 4 described the routine care delivered to patients with tuberculosis at a typical community-based health centre in Cape Town. The work was characterised by task orientation: the splitting up of care needed by one patient into single tasks which are administered by different nurses. This pattern of care can be observed throughout the health system; both in tertiary care hospitals and primary health care centres.

During the period that I worked as a nurse in tertiary care hospital wards (1962-1974), the ward routine was organised around special activities, for instance the “back round”. The purpose of the back round was to attend to patients’ backs and pressure parts in order to prevent pressure sores. For the back round we stocked the “back trolley” with enough clean bed linen, washing basins and towels for cleaning up incontinent patients and lotions for rubbing patients’ backs and pressure areas. Two nurses would then take the trolley around the ward and systematically attend to all patients. This procedure was done at least 4 hourly and was also referred to as “fixing the patients”. This description of the “back round” procedure provides an example of task oriented nursing in recent times.

In this chapter I trace the history of task orientation and further examine the concept by exploring the following questions: What has influenced nurse scholars and practitioners to change the system of task orientation? What, if any, has the response been to efforts to change task orientation? The main part of this chapter presents a more detailed exploration of task oriented interaction and patient-centred interactions between nurses and patients in the context of TB care.

The origins of task orientation

In trying to come to grips with the origins of task orientation in nursing, I explored the following questions: why, in which contexts and at what stage in nursing history did nurse managers introduce routine nursing procedures such as the “back round” on hospital wards? For this purpose I studied literature on the nature of labour processes and management theories and I interviewed two nurses whose careers spanned the period between 1935 and 1975.

Taylorism

In Chapter 3 I described how my observation of TB clinics evoked images of an assembly line: a feature of factory management usually associated with an organisational form known as Taylorism. For this discussion I draw on Littler (1978). Taylorism grew out of the systematic management movement in the USA in the 1880/90's and can best be understood as a form of work organisation. It involved the systematic analysis of the labour process and the division of labour into its simplest elements “in order to seek to limit an individual ‘job’ to a single task as far as possible” (Davis et al, as quoted in Littler, 1978, p 188). The systematic analysis of work enabled management to develop a “science of work” which formed the basis for the calculation of production costs, the standard times required for each task and the associated incentive payment rates.

It is of interest to take a closer look at a few of Taylor’s main “principles’: firstly the principle of task control (Taylor’s Third Principle). According to Littler (p 189) this principle implied the institution of “a planning department which planned and coordinated the entire manufacturing process”. It then became possible to standardise practices which facilitated observation of the task performance of workers. At the same time it created a split between planning and doing (Taylor’s Fourth Principle) which is based on the idea that workers are not capable of understanding their own jobs (Littler p 188).

Nursing and Taylorism

Has nursing been influenced by Taylorism? South African nursing practices and culture as we know it today originated in Britain (Marks, 1994, p 6-8, 15-43). Menzies's (1960) classic study of task allocation in nursing in a general teaching hospital in London was done in the early fifties, and makes it clear that task orientation was already well institutionalised in British nursing during that period. Littler (p 187) argues that Taylorism became institutionally significant in the USA in the 1940s and only during the 1950s in Britain. In a more recent study of the sociology of professional work, Walby and Greenwell et al (1994) find that nursing is currently closest in organisation to the Taylorist model, in that it is "rule bound and relatively closely monitored by a conventional system of line management" (p 137).

What could have attracted nursing managers to the Taylorite form of industrialised work organisation? Surely not purely economic considerations in order to curb costs or rationalise resources? Although there are some analogies with industrial labour, for instance the 24 hour shift system in hospital work, I would argue that the two settings differ considerably. The activities of a busy hospital ward evoke a rather different image than a factory shop floor: A hospital is often a place where battles are being fought in order to save lives. I think that this is one of the reasons for the rigid military style of management. It seems likely that the division of labour enabled nursing managers to exert maximum control over the work force in hospitals which were run as bureaucratic systems. Division of tasks feeds into a system which is geared to simplify and streamline tasks in order to supervise workers more closely. Littler (p 192-194) relates Taylorism to the Weberian concept of bureaucracy, especially the "bureaucratisation of the structure of control" (p 193).

An interview with two retired nurses who have had extensive experience in practical, managerial and academic aspects of nursing provided an additional perspective on the origins of task orientation. Professor P Harrison, who had held the first position of Professor of

Nursing at the University of Cape Town, suggests that task orientation is a practice that was inherited from the very early years of formalised nurse training during the time of Florence Nightingale:

“You came in as a junior probationer, but in those days there was a class distinction between an ordinary probationer and a lady probationer. The lady probationer’s parents could pay for her training, whereas the ordinary probationer was from a working class background. So (...) class distinction permeated there. For a long time the class distinction between who I am and the work I am allowed to do persisted, so that when you start nursing you don’t do a ward round with a doctor until you’re in your third year. So you are confined to the sluice room and the kitchen - that was the servant class area. And then, after you’ve had the benefit of perhaps some education from one of the training school schemes, and a good ward sister who would encourage you to enter the next stage, then you may be allowed to “do a back”.

Harrison regards task orientation as “a deep tradition in nursing”, and added that

“some head nurses strongly resented a student nurse even presuming to ask a question which was considered to be beyond her level.” (Personal communication, 26/8/97).

This picture from the past provides me with yet another angle from which to view the complex origins of task orientation: its linkage to the class division of labour during the early history of nursing. This period is well described by Marks (1994, p15-77), and Dingwall et al, (1988, p 59-60) describe the British nursing traditions at the time. Harrison vividly remembers the moment when she first became aware of the limitations of a narrow task oriented view of nursing practice:

“ I was in the nursery at feeding time taking babies to their Moms, when the staff nurse said to me ‘Nurse Harrison, what is Mrs X’s Esbach reading today?’ She had high blood pressure. I said ‘I don’t know’. She said to me ‘why don’t you know?’ I said ‘I don’t know anything about it!’ I thought what sort of woman is this asking me about this patient’s Esbach. And that was the first time - I’ve already been through my whole general training - that somebody made me realise that you’ve got to treat the whole patient. It’s not just the infant attached to the mom. Look at the mom beyond the infant”.

Miss Barbara Deeks who once held the position of Chief Nursing Officer in Natal, was 85 years old when I interviewed her (26/8/1997). She emphasised the positive functions of task orientation in the practical training of nurses:

“There is another side to this task orientation because I think you have to develop skills. And there is only one way to develop a skill, and that is by repetition. I mean, you can speed it up, because I think they used to keep the student nurses in some places longer than they should. But I mean, to give an injection: how often do you have to give an injection to really know how to give it properly. And to do dressings, and stitching (of wounds) . Even giving out medicines is a very complex and a very responsible thing. I feel you’ve got to have both sides. You’ve got to have task orientation to begin with and then nurses can be graduated to do whole patient care later”.

Seen in this light, task orientation provides a structure for skilling nurses in those aspects of the job which require technical expertise, for instance giving injections and the manipulation of technical apparatus which has become an important feature of modern nursing. It is interesting that Taylorism has been criticised by trade unions for de-skilling artisans involved in craft labour. (Thompson, 1983, p 77). Thompson points out that there are “contradictory processes” involved within the deskilling process:

“Widespread deskilling is often accompanied by an increased ‘qualification’ of a smaller layer of workers involved in planning, programming and similar tasks. But the general tendency (of deskilling) immediately tends to reassert itself as the enhanced skills are subjected to similar sub-specialisation”. (Thompson, 1983, p 81)

It is thus possible that deskilling is associated with a temporary process of enhanced skilling. In order to see whether these concepts from labour processes can be applied to nursing, I now take a closer look at Thompson’s definition of skill. Although there often is a confusion between skill and dexterity,

“skill is largely based on knowledge, the unity of conception and execution and the exercise of control by the workforce” (Thompson, p 92).

It may well be argued that skilling in those aspects of nurse practice which require high technical expertise can best be achieved by repetition, especially during the training of

students. However, we have seen that task orientation has become the routine practice in some non-teaching settings such as the TBCP in Cape Town. Melia (1978, as quoted in Dingwall et al, 1988, p 216) argues that task allocation has an organisational logic and that it is a rational response to the economic pressures of personnel shortages which hospitals have experienced for centuries. She traces task allocation by head nurses back to early nurse training when trainees were the cheapest form of labour. These trainees were mobile since they had to spend a predetermined period of time on each ward. As a consequence the head nurse would not be certain of the individual competence of the students who were assigned to her ward from day to day. This was resolved by structuring the work into tasks to which any student at a particular stage of training could be assigned. I have not found mobility and interchangeability of nurses to be a feature of the TBCP.

Conclusion

It is clear that task orientation has a long and persistent tradition in nursing. The explanations for this are varied and complex and would require further investigation beyond the scope of this thesis. For my purpose though, it is sufficient to note the following reasons why task orientation has become so entrenched in nursing practice.

- * The historical division of labour along class lines had set an early pattern of clean work for ladies and dirty work for the servant class. Thus certain categories of work came to be regarded as more important than others, for instance work associated with the maintenance of hygienic conditions such as cleaning the ward and cleaning the patient were reserved for junior student nurses and nurse assistants. Injections, medication and wound duties were reserved for more senior students.
- * This labour practice ran parallel to, and in tandem with the hierarchical and bureaucratic structures that typify nursing practice. It enabled nurse managers to maintain maximum control over the performance of the workforce.
- * Certain aspects of Taylorism seem to have influenced nursing practice; probably not for the purposes of cost management and increased profits, but for the sake of organising a

potentially chaotic and “dangerous” job with military precision and maximum efficiency. This was done in order to overcome the constraints of time and personnel shortages, and perhaps, the perceived limitations of the staff abilities.

Efforts to change task orientation

In this section I briefly describe some of the attempts that were made to change the task orientation in nursing. Some of these attempts remained at the level of experiments, while others such as the nursing process gained much wider discussion and some degree of implementation.

Harrison remembers an experiment during the mid fifties to change task orientation. It was initiated by Jenkinson, a head nurse based at St Georges Hospital in London:

“I think it is tricky to break down the task orientated approach. They tried it at the St Georges Hospital in London. It was an experiment and each new student nurse had to look after two patients. Two patients! A senior nurse might have six patients. She would be totally familiar with everything that would involve the patient. It wasn't just task orientated. You might think, how can you run a ward where the nursing staff are only responsible for two or three patients? It was a very well planned scheme and a senior nurse would obviously help the junior if she had a very heavy patient she couldn't turn. In the individual training process, no student would leave that ward after three months and not know everything that was needed to be known about a patient”.

According to Harrison these early efforts to change task orientation were led by inspirational nurses who had managed to obtain permission from the hospital matron. But these initiatives were not maintained or implemented:

“Jenkinson was given two years to try it out and then it went to various committees. Ward sisters were very critical about the products (the student nurses) that came out of that. They were very slow, whereas the nurse who's been through the other training gets on with it, she moves fast, she knows what has to be done. So unfortunately it wasn't maintained”

Although these early efforts did little to change the dominant style of nursing practice,

“the general idea of patient centredness persisted: you’ve got to treat the whole patient. It’s not good enough just to worry about the wound”. (Harrison).

The nursing process

The nursing process, a new nursing method, (de la Cuesta, 1983) was originally designed in the 1970s by USA nurse leaders in order to address the poor job satisfaction among nurses. This was thought to be due to the low status of nursing and its dominance by medicine. Nurse leaders attempted to assert the unique professional status of nursing by emphasising the concept of individualised patient care as opposed to the bio-medical concept of “cure”. Its objective was to train nurses to develop systematic care plans for patients. One of the main strategies of the nursing process was to allow nurses to move away from task orientation and to promote continuity of care for a smaller group of assigned patients. The nursing process shows a strong resemblance to similar initiatives in medicine which were introduced to encourage family practitioners to practice more systematically. (Dingwall et al, 1988, p 217; Zwarenstein, 1998).

It seems as if the nursing process became a vehicle for achieving additional managerial purposes. In the USA health managers used it to control the rising costs of health care by requiring nurses to itemise and justify each patient service rendered by them. In Britain too, the practice of the nursing process was disappointing. (Dingwall et al, 1988; as quoted in Marks, 1994, p 211). It had not succeeded in bringing about continuity of care. Hence the search for new initiatives, such as primary nursing (Bowers, 1989).

In South Africa nurse managers attempted to introduce the nursing process during the eighties. As I recall, it was supposedly about moving away from the “back round” phenomenon to the introduction of total care by one or two nurses for small groups of patients. Rispel and Schneider (1991) describe the situation at the time:

“Nursing had become more like a production line in a factory, where ... each nurse is assigned to tasks such as bed-making, back-washing, or distribution of medication ... There is little time for

bedside work, family contact, and personal involvement in the recovery of patients. The introduction of the nursing process ... has done little to alleviate this situation, and has turned out to be a compulsory form-filling exercise ..." (Rispel and Schneider, 1991).

The new nursing method which was aimed at giving nurses more flexibility and authority over their own practice became another tool for control. Why did nurses allow this to happen? There are several possible reasons for this. During that same period there was an effort by nurse educators, led by Mrs Miles from the clinical education department of the Cape Provincial Administration, to update nursing practice. She started a process aimed at developing measurable objectives for regulating and appraising nursing practice. The training modules which were developed for this purpose were based on the behaviourist philosophy of "competency based education" and "learning through objectives": all tasks were split up into its most basic elements and analysed according to Bloom's three domains of learning: knowledge, attitudes and practice (Bloom, 1973). In my opinion these two initiatives, competency based education and the implementation of the nursing process, could have merged, thereby resulting in the principles of patient oriented care being subverted by the rigid and bureaucratic implementation of the behaviouristic training methods.

A further possible reason for the failure of the nursing process to bring about continuity of care is precisely nurses' love-hate relationship with paperwork: Rispel and Schneider's "compulsory form-filling exercise" (Rispel and Schneider, 1991). On the one hand the paperwork acts as a system of control by management - the record is some kind of proof that the nurse has attended to a task and is accountable for it, a way for the nurse to cover herself - the task has been ticked off so she cannot be blamed. But at the same time, writing provides a way to avoid intimacy with patients; to escape the confrontation with the world of the patient. In a British study Smith (1992, p 132, quoted by Savage, 1995, p 8) had found that without the support of more senior nurses, many student nurses avoided continuity of care because of their repeated exposure to emotionally draining experiences.

Paperwork, also referred to as "administration work" by nurses, carries with it a certain aura of importance: it is regarded as a more "senior" activity than those tasks which imply direct patient contact such as bathing or feeding a patient. This ties in well with the early history of the class division of labour into low status and high status jobs which I have referred to

above. For this reason I think that nurses have colluded, perhaps unwittingly, in converting the nursing process into a “form-filling exercise” (Rispel and Schneider, 1989: 117).

A closer look at task orientation and patient-centredness

I now return to the main focus of my research; nurse- patient interactions in the TB control programme. In this section I provide a detailed description of task oriented and patient-centred consultations between individual nurses and patients. This is followed by interviews with the nurses in which they explore their personal perspectives on the care of patients with TB.

Research methods

The data were collected as part of the research process aimed at evaluating the staff training intervention which will be described in Chapter 6. I collected the data in the cyclical manner which I have described in Chapter 2. During the first cycle of data collection I observed the nature of the interaction between individual nurses and patients by sitting in on consultations. I took the role of non-participant observer. After explaining that my purpose was to learn how the system works, and obtaining permission from the nurse and patient I sat in the corner of the room and took descriptive field notes of the consultation process. In preparation for the field work I wrote the following in my research diary on 5 September 1995:

I want to enter the lives of nurses and patients. I want to feel what they feel about each other, hear what they say and what is left unsaid, watch their non verbal behaviour: eye contact, posture, distance and closeness. I will try to be a watchful outsider.

During the process of analysing my field notes I identified two different styles of nurse-patient interaction: task orientation and patient-centredness. The majority of interactions were strongly task oriented. I then purposefully selected one task oriented and one patient centred nurse for in depth interviews.

Task orientation

In this section I present material from four different nurse-patient interactions which I consider to be task oriented.

First example:

A professional nurse of about 40 years old sits behind a table. A male patient of about 50 years old walks into the room and sits down on the chair on the other side of the table.

N: "How are you feeling?" No response from patient.

N: "Are you feeling all right?" The patient looks unhappy but gives no verbal response.

The nurse continues her study of the notes in the folder.

N: "Are you still short of breath?" He watches her while she writes in the folder.

N: (she speaks much louder) "Last time - did you cough in a bottle?"

P: "Yes."

N: "Oh yes... there are no results here" She is still searching through his folder.

The patient tries to talk in Afrikaans (his mother tongue is Xhosa). He tells her that he still has pains in his chest. The nurse tells him that he has to see the doctor while she tries to find the laboratory report on his sputum specimen. Her manner is abrupt and she has raised her voice in an effort to be understood by him.

Second example:

The next patient that came into the room is a young man in his twenties. He explains to the nurse that his sputum is blood stained.

N: "Anyone in the family with TB?"

P: "My Dad.."

N: "Is he staying with you?"

P: "No he is just visiting."

N: "Are you working?"

P: "No, I'm a student."

N: "Where?"

P: "University of Cape Town"

N: "Date of birth?"

The interview continued in the same staccato manner: she asked questions and the patient answered with single words. He was well versed in English and more assertive than the previous patient. The nurse seemed slightly more at ease with him than with the previous patient but there was no attempt at social conversation.

Third example

A nurse of about 35 years old sits opposite a woman in her mid forties. The patient looks ill and depressed. She leans forward and holds her head in her hands. The nurse studies the notes and she makes the observation that the patient has had TB once before.

N: "When have you had TB?"

The patient looks upset. The nurse is rushing up and down to find sputum jars. She fills out a card for the X Ray department. At no point did she seem to notice the patient's display of distress.

Fourth example

A nurse in her thirties sees a patient of about the same age.

N: "Soraya why did you come?"

P: "I was coughing and I lost weight. I was a TB patient in 1993".

The nurse ask about her previous history and make notes in the folder. The door is open because the scale in this room is used for weighing patients from other rooms. There are many interruptions.

N: "Do you feel bad or not too bad?"

P: "I feel terrible / sad.." (Afrikaans: treurig - it could refer to both a mental and physical sense of despair)

Without any recognition of this response the nurse sends the patient off for X Rays and sputum specimens and asks her to come back in a week for the results.

Discussion of task orientation

In all the examples of nurse-patient interaction the central task of the nurse was to establish the main purpose of the patient's visit to the clinic and to respond by directing the patient to the appropriate person who would complete the next task or function. The interactions lasted between four and six minutes. The main activity of the nurses was to scan the folder in order to see what was noted down during the previous visit, or, if this was the first visit, to complete the notes with the required information. The attention of the nurses was focussed on the folder and there was little eye contact with patients. The nurses dominated the discussion. The most common remark was a closed question, for example: "are you feeling all right?" or a question with an inbuilt multiple choice response, for example: "Do you feel bad or not too bad?" When patients responded either verbally or nonverbally that they were not well, for example: "I feel terrible", the nurse showed no response that she had heard the patient. There was neither acknowledgement nor an effort to ask the patient to elaborate further. There was never an attempt to reassure the patient or to give information. There was an atmosphere of rushed "busy-ness", of having to move on to the next patient.

Interview with a task oriented nurse

It was a quiet afternoon at the clinic when I met nurse T for the interview. I had set up the appointment after I had observed her interaction with patients at the TB clinic (see the first two examples in this chapter). The purpose of the interview was to discover how she understands her role as a nurse who work with TB patients. In preparing myself for the interview, I realised that I was tense. I sensed that she was on her guard after having been observed with patients. I tried to “bracket” my preconceptions of her; which were that she treated patients in a task oriented and abrupt manner. I had also noticed that she treated black patients more abruptly than coloured patients and those who were better dressed were treated more politely.

After discussing the TB Control Programme for a while I asked her how she felt about working with TB patients. She replied:

“Well, it’s like working with any other patient, except.. It is just to make them realise how important it is to come for treatment. They do need motivation all the time.”

When I asked her how she motivates patients, she said:

“It all depends on the type of patient. I’ve got some Bergies staying over there. One of them is my TB patient.”

She was referring to a group of homeless people that I had seen on the stoep of the nearby church on my way to the clinic. “Bergie” literally means “mountain person”. It is an Afrikaans term which refers to people who live on the street.

“If one of them get a disability grant you can always tell them, you know, if nothing else helps, that you are going to take the grant away. And that will make them attend: just for the grant. It is important for them to get the money.”

H: “Are you saying that you can threaten them with that..”

T: "Some people need it you know. They don't want to listen. When some of them get food parcels, they sell it for drink. And they will tell you they just can't drink their tablets because they are hungry. And you can't follow them all the way to see what they do with the food parcel."

She sounded angry. When I asked her whether those patients made up a large number of the people that she treated, she said :

"It is not always that you need to do that. As long as they understand. But these are the difficult ones. You get to know them. Some of them already had some liquor before they come to the clinic. And then they don't understand if you talk to them. It is difficult you know. But then they are always complaining they haven't got a place to stay, and they haven't got food. But they are always smoking and drinking! "

Nurse T mentioned more categories of patients whom she could not trust to take their treatment. Another "difficult" group were those who refuse to come to the clinic for medication and who want to take their tablets at home:

".. you get to know the ones who will default, and you know they will not manage at home."

She distinguished between patients "who are not interested" or "just take it lightly"; for instance:

"when I asked the guy for his tick sheet (a patient held treatment record) he simply did not bother to bring it in"

and:

"those who are quick in understanding, who takes it seriously and realise why they must take their treatment".

She told me that she assessed a patient's trustworthiness early on in treatment.

Throughout the interview she spontaneously raised the shortage of time:

"When the clinic is busy we tend to rush through everything, when they actually need to be spent more time with. Time is a problem. We've got a specific time to finish the clinic."

The experiment with a new system of patient-centred work concerned her because,

I still can't work out if it goes quicker. The new system .. in the beginning I felt it was taking ages to get through them. Especially with counselling. Counselling takes a long time. I don't know.. I suppose we must get used to it. Maybe it's just because I'm not used to it".

Nurse T spoke rapidly and came across as someone in a constant hurry. During the interview she often interrupted my efforts at summarising, or started talking before I had completed my question.

Discussion

I was struck by nurse T's suspicions about patients. Whenever I tried to probe her concept of trust and mistrust she conceded that only a few patients are drunks who show no interest in their own health. Nevertheless, she persistently returned the conversation to the "untrustworthy" and "difficult" patients. These were the patients that she felt she needed to control by means of threats of having their grants removed. She displayed a deep mistrust in the patients' ability to take responsibility for themselves.

"Counselling" is a concept that she brought up regularly. Her conception of counselling included breaking the news about the diagnosis and advice to patients. It was an activity that seemed to be of concern to her: patients needed it, in the same way that they needed to be motivated, but she felt that she was neither adequately trained nor did she have the necessary experience to "counsel" patients. In spite of her considerable experience of working with TB patients for about 8 years, she did not see herself as a counsellor and said that counselling was usually done by the doctor.

For me nurse T typifies the clinic nurse who has been socialised to “move fast and get on with the work” (see Harrison above). There is job to be done and she wants to do it as fast and efficiently as possible according to that “deep tradition in nursing” (Harrison). During the interview she told me that the type of nursing she enjoyed most was the casualty department because “there was no time to get bored, always action”. She felt unconfident of her ability to implement the new ideas of listening and facilitating patient care, but she admitted to seeing their value, time consuming though they may be.

A closer look at patient centredness

In this section I present examples of patient centred consultations.

“Today I saw a nurse whose interaction with patients differed completely from the usual patterns of communication. She was so different that she gave me a “yardstick” against which to compare the rest”. (Field note, 5 September 1995)

What follows are excerpts from notes that I made while observing Nurse P at work with three different patients.

First patient

When I enter the consultation room Nurse P is in the process of explaining something about x-rays to a man of about 40 years old. She speaks Xhosa and I am unable to follow the gist of the conversation, but I note that there is good eye contact between them. Nurse P seems unhurried while she listens and speaks. There appears to be a problem with the patient’s medication record. She listens while he gives a lengthy explanation. Then there is further discussion. It turned out that the patient took pills over weekends, when he should have had a break from medication. Later, when I asked her about it she said: “Yes, he said that he had them anyway, so he thought, why not take them!” She seemed to appreciate that the medication procedure was rather confusing and that there was a logical explanation for his “non-compliance”.

Second patient

The next patient is a frail looking man of about 65 years old. He is on crutches and rather unsteady on his feet. Nurse P takes his jacket and parcels from him and helps him to steady himself on the scale. She reassures him in Afrikaans.

N: "Your weight is going up, Bill. Do you feel an improvement?"

P: "Yes I feel better nurse".

N: "How are you coping with the tablets?" (He gets a week's supply of tablets to take at home)

P: "No, everything is OK".

N: (put marks on the tick sheet) "In that case, you may go through to see the doctor".

The patient mumbles under his breath, hardly audible. He asks her whether he could get a disability grant (a small monthly amount from the state welfare department).

N: "When you see the doctor just now, ask him to refer you to the social worker.." She looks apologetic and explains: "Unfortunately this is the way these little things work."
(Ongelukkig werk die goedjies maar so..)

N: While she helps him to his feet and assists him to put on his jacket: "Who is the person that supervises your medication?"

P: "Joan"

N: "Oh yes." The patient now unpacks a paper bag full of hospital card and slips. He seems to be searching for the referral slip with the name of his supervisor. Nurse P watches him patiently and puts him at ease. As she leaves the room with him she says: "I will find out whether there is a food parcel for you."

Third patient

The next patient is a middle aged man who had just been told by the doctor that he has TB.

N: "Has the doctor explained it to you?"

P: Nods. He looks depressed.

N: "TB is one of those diseases, you know, anyone can get it. There are so many germs around and we never know where we pick it up. But if we work well together we can win this illness."

She begins to explain how and when he should take the tablets and that he would have to find someone who will supervise his medication. The patient says that his wife will supervise him.

N: "That is fine." She adds, half jokingly: "As long as you just don't sign your own tick sheet!" She then goes on to explain the need for those who were in close contact with him to come for sputum tests and X Rays.

He is now in a more relaxed mood and feels free to ask for specific information, for instance, "What about those who have visited my house?" He volunteers information about himself, for instance about his symptoms and why he sought medical help.

She asks him whether he works and explains that she would need to fill in a form for his work contacts to be notified. The patient is concerned about losing his job. Nurse P reassures him. "It is not like that any longer. You should be able to continue working normally."

She gives him a two week supply of tablets and tells him that the clinic nurse will visit him at home. He seems much relieved and tells her that he wants to be well soon because he is planning to go on a pilgrimage to Mecca in about seven months' time. When he leaves he tells her that he prefers to come to this clinic because it is a "good place". Nurse P disagrees with him and tells him about a recent incident when someone had broken into her car outside the clinic.

Discussion of examples

What stood out most for me, was not what Nurse P said and did during these consultations, but the quality of her presence. She was fully present in each instance and she responded, not in the "routine nurse mode", but as herself. She appeared relaxed and unhurried and seemed

to handle each patient as an individual. She showed compassion and respect even to a doddering and near incoherent man who asked for a grant. She used humour and patients responded to this by letting go of some of their anxieties. They seemed to be reassured by her attitude which instilled confidence: she is on my side and if we work together I can get well again. She volunteered information about herself and patients then followed a similar pattern. This created a conversation between two adults who had something in common: a common ground from which to work out strategies to get better.

This was very different from the adult-child interaction that was so characteristic of the nurse patient interactions that I had observed. Language could have played a part in this; she seemed equally comfortable in Xhosa and English and Afrikaans and she slipped into the colloquial use of the latter two languages with ease. But there was something more profound than language competence, and I hoped to get more clarity on her unique style of relating to patients during an in depth interview.

Interview with a patient centred nurse

We met in one of the clinical offices and were both nervous, but once the interview started she opened up and soon moved away from “text book” speech. My purpose for the interview was to explore her perspectives on her own role as a nurse and to understand how she views TB patients. In order to do justice to the material I present the data in subsections. I first quote from the interview and then follow up with a discussion of the data. The subsections contain the following themes: The difficulties that TB patients experience, patients’ sense of responsibility and patient-centred philosophy of care.

Theme one: The difficulties that TB patients experience

My opening question to Nurse P was “How do you feel about working with TB patients?” She responded by first describing her views on the gravity of the illness and the reasons why TB control is so difficult:

Nurse P: “I feel TB is such a problem. I would be glad to know that I’m one of the people that have contributed to solving the problem that we have. I think that our people

are not yet well versed in TB. There are some situations where people think that 'it is a sickness that I can't have'. So if I can be one of the people to make it more simple for people to understand what TB is, why you get TB and the good news that TB can be cured."

H: "So if I understand you correctly, you say you see it as your duty to try and explain TB to patients?"

Nurse P: "Yes, so that they can really understand what TB is all about. Because I feel many of us, even people who are middle class still have problems to understand TB the way it is. There is still that stigma to it - to me it sometimes appears that in the Western Cape people would rather admit to having AIDS, but not TB. I say that because where I come from AIDS is still like that.... you wouldn't mention it to anybody. It is still something that's kept under cover. And when I came to Cape Town I met clients who said 'Sister you must be careful with the needles, I've got AIDS'. But TB is just the opposite. They would travel distances to attend clinics where they know people don't know them at all, just to get their treatment, whereas they come to a nearer clinic for AIDS."

H: "Do you think the stigma is particularly strong in the Western Cape?"

Nurse P: "Yes, and it is a problem with so called 'learned people'. They still think that TB is not for them, but maybe for people of the lower socio-economic groups. It is quoted in books that you find TB more in lower socio-economic groups. So I think that is the main cause they associate with TB".

"I noticed that when you were consulting one of the patients you made quite a point of saying to him that anybody could get it.."

Nurse P: "Yes - I think that is actually the main problem. OK, when it comes to those of a lower socio-economic group it is not ignorance as such - they know what TB is all about - but it is only the sense of responsibility that, I think, has not been well developed as far as their treatment is concerned. And maybe their IQ - I don't know. Maybe they think because treatment is free 'even if I don't finish now, I can still go back at some time, I will still get the treatment'. That's why I think it is wise to tell them what it costs: it is free but it still means that

the state is paying that amount. Somebody else is paying for that although it is given to you for free”.

Discussion

P has developed a framework for understanding how socio-economic circumstances impact on the illness experience of patients. In her approach to patients she draws on this personal framework to assess the needs of patients. She is in touch with the patients’ feelings about the social stigma that surrounds TB . She sees it as her role to reassure patients to accept the illness, because feelings of shame prevent acceptance, and this could affect the patients’ commitment to the treatment regimen. Her experience has led her to believe that patients who are economically better off, are more likely to suffer from feelings of shame because they associate TB with poor people. These patients require reassurance and a boosting of their self esteem. On the other hand, patients who are poor have different problems. She offered several possible reasons why patients interrupt their treatment. She felt that a “poorly developed sense of responsibility” may stem from the perception that free treatment will always be there whenever they need it. Hence her strategy for informing them of the “hidden” cost of the treatment. She has a strong commitment to translate and simplify knowledge and to pass it on to patients, thereby acting as a bridge between the medical domain and the world of the patients.

Theme two: Patients’ sense of responsibility

Early on in the interview P told me that she did not consider the length of TB treatment to be a major obstacle for patient adherence:

“I wouldn’t say the length of the treatment is such a problem, because even after completion of the treatment, they still come back. You get so many of them that have been discharged on the folder, but the clients are still here. Maybe for another check up, even within a month’s time, because maybe they now like to be on the safe side and to protect themselves and to make sure this is not going to happen to them again”.

H: “That is interesting, nurses usually tell me that the patients do not take much responsibility..”

P: “Yes, you do get exceptions here and there. But it is not most of them that are

irresponsible. No, not all of them are irresponsible. The other thing is, it may be that you treat them and they go back to the same circumstances. And they live in those conditions. So irrespective of you treating them adequately, the other part of the story is still there. To give you an example: Have you seen at this clinic we've got so many of these people they call 'bergies'? There was another lady here the other day. She is a re-activation (she has had TB before). She said 'Sister, I would prefer to come to the clinic to take my pills.' And because she is a re-activation, I thought of distance, of where she is staying and I asked her 'How far are you from the clinic?' She stayed at X, and you must know, if you are a bergie you are not sure of your sleeping place every night, you may end up at some different point, but she still wanted to come to us. I said to her, if she is not sure where she will be the next day, she must tell me, then I can give her the treatment for two or more days, because you know, you also build up that relationship with her and begin to trust her. 'We start trusting you, and I know if you are responsible, you will take your treatment'. But every morning I am here at half past seven and she is always here."

H: "Why do you think she prefers to come in?"

P: "She really wants to get cured from this. Maybe she thinks if she takes her treatment regularly.. I don't know.. because according to her file she did take it regularly before, and she ended up re-activated. Maybe she is staying with contacts who have never been treated, and she is the one who is more serious about her condition so she keeps on coming in."

H: "So you are saying that, on the whole, patients are responsible and they want to get cured?"

P: "Yes. And the other thing, some of them, because they sometimes get a grant, they wouldn't like to be off the treatment, because if treatment is completed the grant is taken away. We usually give them bottles to spit in and in some cases they would ask a current TB patient to spit in the bottle. We've had a few cases like that. Some of them are using these tactics to get the grant."

Discussion

Was it purely coincidental that both Nurse T and Nurse P volunteered information of their relationship with homeless TB patients? It is possible, but these stories may also be related to a social group who is easily identifiable and who is highly susceptible to TB. It may even be the most obvious stereotype for a "typical TB patient". Whatever their reasons may

have been, their narratives about the homeless differed radically and provided me with two divergent perceptions of patient responsibility. Nurse P used her anecdote to illustrate how responsible and trustworthy a TB patient could be, even under the worst social circumstances.

Nurse P is not overly idealistic; she is fully aware of the strategies that some TB patients use in order to exploit the system for personal gain, but this does not influence her perception that the majority of patients are responsible and trustworthy. Flowing from this trust, she sets up a procedure in order to negotiate a treatment relationship with patients. Patients seem to respond to her in a warm and open way by volunteering information about themselves. Nurse P uses the detailed information from patients' personal and social histories to inform her own understanding of a patient's inner motivation for managing the illness.

Theme three: A patient-centred philosophy of care

I asked P to comment on my observation that she appears to be unhurried despite the usual rush at the clinic. She first commented on her difficulty in understanding the task oriented clinic routine and the current experiment in transforming clinic practice to be more patient centred. (See Chapter 6 for a full description).

P: "It was so difficult for me to understand that part - where the client goes to this one for this little bit of thing, wait again in the waiting room, then you go to the other one, then you still see a third person. You lose the patient somewhere. But now at least one patient comes to you and you do everything".

H: "You feel that you have more time this way? I'll tell you why I ask you this. What struck me the other day was the way in which you work: you don't seem to be rushed?"

P: (laughs) "I think, even in your private life, if you rush through somebody, you would not get what you really wanted to get from that person. Even if inside you are really worked up, just do it in such a way as if you say 'I am here for you at this present moment'. If you spend OK quality, not quantity, quality time with the client, see, then I think that you really can buy him over to your side, you will get more from that client. And I'm sure, even your relationship concerning his treatment.. he will be more serious in taking whatever is necessary. But if we have the attitude of 'I'm giving you the orders you must carry them out. You must do, you must do, you must do!' When the client leaves, man, he

thinks so many things. He was given the instructions only, but do not understand why he's got to do this and this and this! Then you cannot expect to get results!"

H: "Can I ask you something? Do you think you are different? (P laughs) I mean, from nurses on the whole. Because you've mentioned this thing of instructions: do this, do that - there is a pattern like that in nursing - do you agree with me?"

P: "There is, there is. Especially when it comes to TB. I believe that we actually have to beg TB clients to come for their treatment, and not demand it from them. You know you come down, even if you see your client is now on the other side of the story. You come so low as if he is the one who is correct. And at the same time you try and convince him that this is actually the right thing. Even when he comes two or three times, still thinking that way. Keep on trying, don't give up; you might win him over."

Discussion

In this part of the interview P expands on her personal philosophy of nursing and patient care. She is aware that her own beliefs and practice differs from that of her colleagues: it is based on the belief that a patient's confidence has to be earned by the nurse. The patient's cooperation cannot be demanded by giving instructions, it has to be "won over", even if this costs time and a certain humility; a letting go of your own sense of professional righteousness. She described the negotiation process between nurse and patient as a process of cultural exchange which, over time, develops into a partnership. This was illustrated during the consultation described earlier when she said: "If we work well together, we can win this illness."

It is interesting to note that Nurse P felt that her colleagues as well as patients regarded her as "an outsider". She had been living and working in Cape Town for a few years after having moved to the city from another province. Although she was fluent in all the local languages, Xhosa speakers usually commented that her accent was different from theirs. She indicated that she often felt that she was not fully accepted by her peers.

Conclusion

This chapter has provided a detailed description of task oriented nursing practice and its origins. It is clear that this practice is widespread. Despite peer pressure and the strong influences of being socialised into the dominant tradition of task orientation, there are some nurses who manage to swim against the current and to develop a patient-centred approach. What distinguishes these nurses from the majority of their peer group? Why do they never fully adopt the task oriented role? In the next chapters I explore these questions by examining the intra-personal dynamics which influence nursing practices.

Chapter Six

A training intervention to improve case holding practices

In this chapter I describe how two groups of nurses responded to a training course which aimed to improve the effectiveness of the TB Control Programme by encouraging more patients to adhere to the full treatment regime. I will argue that the different ways in which the nurses responded to the opportunity to change existing practices, revealed some of their motivations for maintaining their routine work patterns.

Background

A decision taken by a sub-committee of the Western Cape Tuberculosis Co-ordinating Committee to pilot a new approach to the control of tuberculosis presented a chance to study nurse-patient relationships. Based on the observations described in the previous chapter, I had a hunch that the proposed changes could stir up feelings and perceptions in nurses that would not come to the fore during the routine practice of their work.

The political developments at the time and the birth of the new democracy highlighted the need for a more consumer orientated approach in the public health services. Due to logistical problems and staff attitudes, health care managers had found it difficult to implement the changes. It was thought that a carefully focussed in - service training would be an appropriate mechanism to stimulate a process of transformation.

The intervention was intended to address several problems. The lack of emphasis on “the more subjective aspects which are associated with patients receiving long term care” and the

“medico-technical approach of health care providers” were factors which were thought to contribute to the dissatisfaction of patients who considered the service to be inconvenient and impersonal (Dick et al, 1994).

A team comprising senior medical and nursing representatives of the two health authorities and researchers of the Medical Research Council was formed. Their task was to design, implement and evaluate an in-service training course. The two local health authorities each chose one primary health care clinic to participate in the project: Deep Valley and Vista (pseudonyms). Each clinic delegated a group of nurses to attend the course. The training team was headed by researchers from the Medical Research Council and included senior managers from both local health authorities.

The in-service training course

The purpose of the course was to stimulate staff to transform their practice in the TB Control Programme at clinic level in order to improve case holding. The course consisted of six three hour sessions which took place at two to three week intervals. It was held away from the workplace at the premises of the Medical Research Council. The course covered the goals of the TB Control Programme, the epidemiological principles which underpin the programme and the implementation of the National TB Register as a tool for monitoring the epidemic. The main part of the course content dealt with the care of the TB patient. The information was put across by means of short lectures by experts on the training team, followed by discussion. Much of the content which dealt with patient care was taught experientially. For instance, nurses were asked to map on large sheets of paper the processes that a TB patient is exposed to at their clinic. This enabled them to critically review their current practice. During another session they were asked to visualise the ideal clinic and afterwards to analyse the potential barriers to implementing changes toward realising their ideal clinic.

At the end of the course the participants planned the changes that they would like to initiate at their clinics. They requested further regular follow up meetings to report on their progress and to give and receive mutual support.

In summary then, the **purpose** of the study was to evaluate a training intervention for clinic nurses in order to improve the outcomes of the TB Control Programme at two clinics in Cape Town.

Research methods

During this project I worked in a research team with two colleagues. While they were responsible for implementing the training intervention and the measurement of the number of TB patients who completed treatment, my task was to conduct the qualitative evaluation of the intervention. I negotiated my own role carefully in order to establish a separate identity from the intervention team.

I had the following specific **research objectives**

- to document the impact of the training intervention in the eyes of the nurses, and the instructors and the evaluators involved in the training intervention
- to monitor self-initiated changes to routine practices in the TB Control Programme

The research was designed to follow three different stages. The **descriptive stage** provided a situational analysis of the TB Control programme at each of the clinics. We used participant observation to study the work processes. In addition, focus group discussions and in-depth interviews with clinic nurses assessed their attitudes to the TB Control programme and their morale.

During the **intervention stage** qualitative data were collected on the response of nurses to the course. The aim of the **evaluation stage** was to establish whether, and to what extent the training intervention had led to a change in the attitudes of the nurses and to a change in morale. Any self-initiated changes and their effects were noted. Both focus group discussions and individual in depth interviews were used to collect data. Completion rates were obtained from the TB register and compared with those before the intervention. For a full report on these measurements, see Dick and Groenewald et al (1996).

Work settings of the participants

Vista Clinic

Situated close to the inner city, Vista has a run-down industrial look about it. Small factories and warehouses line the main streets and compete for space with rows of lower middle class family houses. The clinic had been built shortly after the turn of the century. The Victorian proportions do not lend themselves easily for use as a modern busy clinic. The rooms are too large and cold, the hall too cavernous for a waiting room, the single passage too crowded to cope with patients trying to find their way to their next contact station with a staff member at the busy TB clinic.

While some of the patients live in the surrounding neighbourhood, most of them either work close by, or choose to attend the clinic because they themselves or their family remember it from past times. Some patients told me that they choose to travel there by public transport because the clinic has a reputation for quality care.

Hardly any of the nursing staff or doctors live in Vista. Roughly half of the staff were coloured, yet all five nurses who attended the training course were white and female. The group who attended the course came because of their involvement with the TB programme and because some of their colleagues were not available at the time.

Deep Valley

This township was built in the early seventies during the height of the apartheid era. It resembles many similar segregated housing schemes that were built to house coloured people who were uprooted elsewhere. The rented council houses are overcrowded and poorly maintained. Graffiti by competing gangs mark the walls of public buildings and bridges. The clinic, which dates from the same era, is centrally situated and serves people most of whom live in Deep Valley. On a busy clinic day patients fill the waiting room and the queues spill out onto the veranda. Most of the rooms are used for more than one activity. For instance, one corner of the waiting room is used for weighing patients and the record room doubles up as a venue for history taking.

The nurses and doctors live elsewhere and commute to Deep Valley. All the nurses were coloured and female. The only white people were visiting doctors, medical and nursing students from the nearby nursing college and teaching hospital and visiting researchers. After being notified by their head office that Deep Valley Clinic had been chosen to participate in the pilot project, the entire nursing staff attended the course. They were led by the nurse in charge of the clinic.

Participants' responses to the training course

Before the course

It is important to note that the staff of both clinics were chosen for the training course by their respective health managers. The reasons for their choice is not known. The management team comprises doctors and senior nurses who are based at the local authority head offices. I have described the management structure of community health centres in Chapter 1. When I interviewed them at the onset of the course in order to get some baseline information on their morale, I asked how they felt about their work in the TB Control Programme. Vista staff said they felt proud of their clinic: "It runs like a well-oiled machine." They had some problems, mainly with the lack of time on hand to counsel patients, but on the whole they were pleased with their performance. Deep Valley staff felt that they were doing the best they could under difficult circumstances. They were sceptical as to whether anything could be changed. They saw the patients as being reluctant to take on the responsibility of regular treatment. I picked up a sense of futility, of repressed hopelessness.

During the course

Vista had sent five professional nurses on the course while the entire nursing staff of Deep Valley attended the course. They communicated the image of a united front. During the mapping of the clinic procedures activity each group in turn presented their map for discussion. Vista had made a rather dramatic discovery about their own service. It showed evidence of long patient waiting times and they realised that patients were constantly sent back and forth between different stations. This prevented continuity of care. It was a shocking discovery for them. On the other hand, Deep Valley were rather pleased because their map

portrayed a more rational patient flow than Vista's. Vista staff went into action mode immediately, it was as if they were fired into action by their discovery. Deep Valley, on the other hand, made no startling discoveries. Unlike the other group, they seemed to accept the conveyor-belt-style task orientation of their service as a reality that cannot be changed.

At subsequent sessions the difference in the "energy" of the two groups persisted and became more marked. Vista had embarked on a process of sharing their new insights with their colleagues at the clinic. They were plotting and energetically creating strategies for change while the other group had moved into the position of passive onlookers.

After the course

After the course it was my task to monitor the staff morale and any self-initiated changes in clinic practice. Vista was planning a complete overhaul of the routine at the TB clinic. They met with considerable resistance from their nursing colleagues and the doctors, but they forged on, melting the resistance and mustering resources along the way to assist them. They succeeded in persuading the doctors to give up the practice of having nurses as personal assistants. In this way more nurses were freed up to spend time with patients. They involved all staff in a client flow survey to monitor the total waiting time as opposed to contact time with health providers. The aim of the survey was to describe client flow before and after the implementation of the redesigned clinic process. The study showed that the new clinic routine did achieve its aim of providing more time for counselling of newly notified patients. There was an improvement in treatment completion rate at Vista after the change in clinic practice (Dick, Groenewald et al 1996). The initiatives taken by staff impressed the top management in the Local Health Authority and as a result they were given permission to implement certain changes. They were assured that there may even be a possibility of getting structural improvements to the building in order to improve the patient flow. Head Office was happy because at last staff members were taking the initiative!

Meanwhile the Deep Valley staff ran their clinic as before. They attended two of the post-training course follow-up meetings where they spoke of their plans to improve patient support. Because they felt that they were too busy, their strategy was to encourage patients to run self-help groups. Patient support was to be organised as an additional task which meant that patients had to come back in the afternoon to attend a support group. Not surprisingly

patients were reluctant to participate in this scheme mainly because they were already coming to the clinic for their daily directly observed therapy (DOT). The Deep Valley delegation missed one of the follow-up meetings and they telephoned to apologise. In discussion about the reactions of the Deep Valley team, the trainers thought that it might embarrass them to hear of the changes at Vista when they had nothing to report, so they stopped trying to organise joint meetings of the groups.

Nurses' perceptions of the intervention

Within two months after the end of the training course I conducted a focus group discussion at each of the clinics in order to find out how they had perceived the intervention. What follows is a discussion of the findings.

Sense of control

The Vista nurses commented on the flexibility of the trainers.

“They did not follow the programme blindly - we felt that we had a choice to influence the programme”.

On the other hand the nurses from Deep Valley felt that they had little choice - that everything was predetermined, it was seen as just another top-down order from head office.

“But we are used to that. Every time when new orders come we just go along with it. It is part of doing your job.”

New insights

The nurses at Vista were enthusiastic about the process they had been through.

“It gave us a broader perspective. It took away some of the frustration. Over the years I knew that something had to be done, but I was not sure what or how. We inherited a situation which we just kept on using. We actually came to look at our system as being deficient. If it hadn't been for the workshop, in ten years time we'd still be doing the same thing!”

For the Deep Valley nurses mastering the administration of the TB register was the highlight of the course. They liked the idea that the different bits of information were easily accessible. The register had given them a sense of better control over their work.

“One can see very quickly when the last sputum was sent off and where the patient gets his treatment. It is also easier to see whether patients have been transferred out of the area.”

Morale

There was a marked difference in staff morale at the two clinics. At Vista staff reported that they felt energised and excited. At Deep Valley there was the feeling that they were back to “business as usual” with the same underlying frustrations about patients who fail to take responsibility for their own health:

“I think the frustration where TB is concerned will always be there. We will never get real job satisfaction because some people are not cooperative. Personally it is very upsetting if patients become resistant against drugs. You have tried everything but they default and then become MDR” (multi-drug resistant).

Perceived role of outsiders

I asked the nurses at both clinics how they felt about the role of the course facilitators as “change agents”:

“I know that there is quite a bit of sensitivity among staff when outsiders enter into your situation where you are really the experts. How did you feel about that?”

At Vista the response was:

“I didn’t consider it as an outside interference in any way. You have to keep on learning and changing in order to get things done.... The criticism was not levelled at us in a personal way. We actually came to look at our system as being deficient... we have made the discoveries for ourselves..”

At Deep Valley there was an indication of resentment from past experiences of being undermined:

“Everything is already worked out, and sometimes we feel that we know about the problems because of our experience in the field. Why don’t they ask our opinion about these matters? If they consulted us more often, we would give them valuable suggestions because we know the people and their problems.”

These comments could be interpreted in several ways. Those being referred to in the above quote as “they”, are clearly the managers who are perceived to disregard the valuable insights that staff could make. Hence the practice to send staff to courses. A second interpretation may relate to the status of nurses as clinicians in their own right who are competent to make “valuable suggestions”. As pointed out earlier, though, the interaction on the course was particularly geared towards drawing on the expertise and insider experience of participants. Yet the Deep Valley nurses experienced the course content with the suspicion that “everything was already worked out”. The fact that all the trainers were white, could have contributed to their feelings that they were powerless to make contributions.

The comment that “we know the people and their problems” could simply be interpreted as meaning that it is more likely in a divided society that coloured nurses would have access to experiences which would make it easier for them than for white colleagues to understand coloured patients’ life experiences. This comment could also be interpreted as meaning that only coloured people could know, or understand the behaviour and motivations of other coloured people. Swartz (1989, p 171-2) describes interactions amongst clinicians during psychiatric ward rounds where black clinicians who would normally point out the similarity of all people, chose to use the discourse of cultural “differences” in order to exert a certain power:

“This power cannot be gained through professional status (medical personnel always top the hierarchy) or through being black in a country which so clearly discriminate against blacks. What is necessary, then, for the maintenance of power, is for the clinician to “be” a black person in a particular way - a way, paradoxically, which this same clinician at another level completely rejects”.

Summary

I have presented an account of an intervention which provided nurses with a stimulus to reflect on their work and the option to change their practice in the TB Control programme. The following table provides a summary of the nurses' perceptions.

Table 2: Nurses' perceptions of the intervention

Perceptions	Vista	Deep Valley
Sense of control	"We had choices"	"Just another order to obey.."
Morale	New surge of energy Increased sense of control	Frustration Resignation
Perceived role of outsiders	Facilitators of a process of self-discovery	Top-down initiative, did not feel consulted
New insights	Discontinuity of patient care It is possible to change routine care	Improved administrative skills

An exploration of the responses to the intervention

The nurses at Vista and Deep Valley had attended the same course, they both did similar work and yet their response to the course could not have been more different. I now describe in some detail the differences between the two groups in an attempt to "get under the skin of each group". For this purpose I will use some of the ethnographic data that was collected by doing participant observation, informal conversation and in-depth interviewing. The emerging picture will be held up to the mirror of psychodynamic theories of organisational and group behaviour.

During the course both groups recognised the need for patients to receive support in order to ensure that they adhere to the lengthy and cumbersome period of directly observed treatment. There was however a difference in how they attempted to address this need. The Deep Valley staff attempted to arrange for patient support as an add-on task, ideally to be done by patients themselves or by the health educator. They did not see patient support as an approach which had to permeate the programme, nor as a function that they could fulfil. While doing observations in the clinic I noticed that the nurses busied themselves with technical tasks. They gave top priority to writing in patient folders and on numerous cards and forms. After completing the course they were particularly pleased at having mastered the new national register. The Vista group on the other hand, opted to re-arrange the entire service in order to ensure more contact time between patients and nurses, especially at the start of treatment when breaking the news of the diagnosis and negotiating the DOT.

This was puzzling. I was aware that there may be many explanations for the different responses to the intervention, yet the most obvious difference was the fact that one group was coloured and the other group was white. I found this interpretation uncomfortable and politically incorrect, but it was so striking that I could not ignore it. I decided to interrogate the intriguing question which felt intuitively correct, despite the risks of following this route of inquiry. To quote Haysom (1997): "Racial issues are never far from the surface of our experiences. They have an unpleasant way of flaring up, when we deny their existence." Why would the white nurses be more willing to risk closer contact with coloured patients? In the following sections I explore the response of the two groups in racial terms.

A safe distance?

I was struck by the differences in the way the two groups spoke about patients. There were individual differences within each group, but on the whole it seemed as if the white nurses were less angry and less emotionally involved with patients. Was this perhaps because the patients were further removed from their own personal reality and social identification? If patients were seen by them as different, and therefore separated from them in terms of class, race, income, educational standards, closer contact could be less threatening than for the coloured nurses. This distance enabled the white nurses to make allowances for the

behaviour of coloured patients. They did not have to fear “contamination” by patients when they opened themselves up or made themselves more vulnerable. They could allow feelings of charity to guide their behaviour. Perhaps these feelings were strengthened by guilt. I can imagine that they may have thought: “I have had it so much better because of the colour of my skin.” It is possible that if you have enough, both materially and in terms of self confidence and have little fear about losing your own identity, it is perhaps easier to move closer to patients.

Too close for comfort?

The Deep Valley nurses seemed embarrassed by the “deviant behaviour” of patients. Some of the nurses grew up in similar areas, under similar social conditions. Members of their families and neighbours may have had tuberculosis. Nursing was one of the few career options that offered young coloured women the opportunity for professional qualification. They have “uplifted” themselves out of the situation of the average patient with tuberculosis, probably with great sacrifice and determination. They now expected the same behaviour from patients. This was often manifested in a top-down relationship. The implicit message to outsiders like myself was: “We know our people. We know what is best for them and when we scold them it is only because we care and want to help them. In turn we expect them to take responsibility for their own treatment.”

Some of these nurses spoke with great anger and frustration about patients who failed to comply to the treatment regimen:

“Sometimes you use harsh words and give them a bit of a scolding and explain why we do it: in their interest.”

They were keen to increase their control over patients. This was particularly evident from the earlier comment by the Black Haven nurses that Robben Island should be used as a prison colony for non-compliant patients. (See Chapter 4 for the history of this island).

The entire clinic routine was task-centred and designed to keep patients moving through a series of stations where a nurse fulfilled a single task, for instance history taking, weighing

and collection of sputum specimens. At no point was there any possibility for the patient to get to know one nurse. This system appears to be designed to avoid closer contact. It provides a barrier which prevents the development of closeness. Although the nurses realised the need for patient support, they saw this as just one more task which could be added on to the existing range of one-stop stations, where it could best be offered by the patients themselves or by one of the health educators. Was the Deep Valley nurses' identification with the patients too close for their own comfort? If this is the case, they may feel the need to separate themselves as professionals from the community in which they had grown up.

Splitting up the nurse-patient relationship

One of the most typical features of service delivery in local authority clinics is the depersonalised task orientation. Menzies (1960, Menzies Lyth, 1991) describes how nurses who work in stressful situations develop coping mechanisms to deal with their anxiety. The nurses bear the full impact of the stresses which arise from having contact with patients who, in this case, suffer from a dangerous infectious disease. They feel personally responsible for controlling the spread of the disease. In order to deal with anxiety, members of a work team develop socially structured defence mechanisms. These are then externalised and given an objective reality. Menzies Lyth describes how these defence systems develop over time, often through unconscious collusive interaction. This then becomes part of the organisational culture into which nurses are socialised. The task orientation leads to a splitting up of the nurse-patient relationship.

Splitting as a defence against anxiety is a psychoanalytic concept attributed to Melanie Klein. Kleinian concepts are inaccessible for several reasons. It is part of the human experiences that

“(a)re so very remote from conscious and verbal thought, and so difficult to communicate in a manner that is verifiable outside the particular analyst-patient relationship”. (Hinshelwood, 1991, p 1).

Furthermore, these primitive processes arise before the infant is able to think in words (Klein, 1946, p 8 as cited by Hinshelwood). Nevertheless, during the last decade there has been a growing recognition of the value of the application of psychoanalytic theory to the understanding of dynamics within institutions (Czander, 1993; Diamond, 1993; Kets de Vries,

that makes up health care services, do exercise power. They have the power to withhold their cooperation with the treatment regime and we have seen how this frustrates health care personnel who regard tuberculosis as a major threat to public health.

During my observation of the directly observed treatment (DOT) at clinics I realised that while nurses were pleading with patients to “take responsibility for their own health”, having to take tablets under the watchful gaze of the nurse, had the exact opposite effect: It took away much of the responsibility of the patients and gave the message that they were untrustworthy. A patient at Vista told me of his resistance to DOT:

“At the beginning I really had problems with them. (ek het vasgesit met hulle). They want me to come all the way here to take my tablets. They think I am a child. What they don't realise is that I have been on treatment for high blood pressure and diabetes for many years. I've never had a problem with taking those tablets..”

Several patients who attended Vista clinic told me that they thought it was the best clinic. Most of them had used public transport to get to Vista. They preferred it to the clinic in their own neighbourhood. It occurred to me that patients may construe the mere presence of white personnel as an indication of better service. One young man said:

“This is the best place I've ever been to. I don't feel I'm coming to a hospital - I feel I'm coming to my parents.”

When I asked him to explain what he meant by that, he said:

“Last week the sister 'phoned me to say that I must come to see the doctor today. When she was off duty, she recognised me and greeted me. Another one was pregnant and when she came back we could talk about that..(the baby). The atmosphere is good”.

What was important for him, was that he was seen as an individual and that he could relate to the staff on a more personal level than was possible at the clinic in his own neighbourhood. Other patients commented on the efficiency and the expert knowledge of the personnel.

1991; Obholzer and Zagier Roberts (eds), 1994). Early in childhood splitting and projection are the most common defences for avoiding pain (Halton, 1994). Diamond (1993, p 8) defines splitting as follows:

“(It) involves the separation of a whole psychic (self or other) structure into two part structures. The part structures represent contrary and opposing attitudes toward self or other, which coexist side by side”.

The term projection can have different meanings in psychodynamic theory. I quote Hinshelwood (1991, p 398):

“Projective identification is the more traditional view of projection in which part of the self is attributed to an object. Thus part of the ego - a mental state, for instance, such as unwelcome anger, hatred or other bad feeling - is seen in another person and quite disowned (denied). Klein termed this ‘projective identification’ ”.

I now return to the way in which Menzies Lyth (1991) has applied the concept of splitting to nurses’ work. The total work needed for patients is broken up into tasks. A nurse could perform one or two specific tasks and avoid coming into contact with the total reality of any one patient and his or her illness. At the same time, this mechanism denies the significance of the individual (patient or nurse) by rituals which emphasise uniformity and therefore diminish the risk of too close personal contact. This behaviour is common to clinics, regardless of the colour of staff, but it is interesting that the staff of Deep Valley chose to maintain their distance from patients, while the Vista group, once they became conscious of their task orientation, were prepared to consider changing their routine in order to make closer contact with patients.

The role of patients

But what about the role of patients? They are not simply the passive recipients of care. As participants in the interaction they too have the power to influence and shape the relationship with nurses. In the sense that power is not possessed, but exercised, (Foucault, 1980, as cited by Martin, 1980) patients, although seemingly at the bottom rung of the complex hierarchy

What was at play in the mostly top-down interaction that I had observed between nurses and patients at Deep Valley? The literature on intercultural therapy provided some insight about ethnic matching of therapists and patients:

“While training institutions have not addressed the particular issues that arise both in theory and technique for inter-cultural and inter-racial psychoanalytic treatment, the black therapist/black patient relationship is a complex one in that it also has to deal with the effects of racism. A black professional, raised in what is perceived as a racist society, will need to have acquired a positive self-identity against many odds. A positive identity will be one which resists the common negative and stereotyped views about black people. Some black patients may come to therapy not yet clear about this, harbouring a putative identity at a not-quite-conscious level. Even a black patient who has a sophisticated understanding of racism and its effect on the inner world might have a long-held fantasy of “white is right”. The black therapist by his or her very presence.. presents a challenge to this view.. A black patient’s self-hatred will always provoke a powerful countertransference in the black psychotherapist. One response could be a nurturing concern or a rejecting stance. The black therapist, who has already gone through this process, will always be reminded of their own pain if they had chosen to forget it.” (Thomas, 1992, pp 142-143).

Like projective identification, countertransference is a psychodynamic concept which could shed some light on these complex processes. As noted above, projective identification is an unconscious interaction with another person during which the recipient of the projection unconsciously identifies with the projected feelings. Patients could be projecting their feelings of shame, hatred or envy into the nurse who would experience these feelings as her own (Menzies, 1960). The state of mind in which others’ feelings are experienced as one’s own is known as countertransference. In the practice of psychoanalysis countertransference can be used as a technique for understanding the feelings of the patient as follows:

“...by comparing the feelings roused in himself with the content of the patient’s associations and the qualities of his mood and behaviour, the analyst has the means for checking whether he has understood or failed to understand his patient” (Heimann, 1950, p 10, as quoted by Hinshelwood, 1991, p 255).

The nurses who expressed anger and frustration could in part be carrying the feelings of patients who are angry and frustrated about the system of treatment which turns them into infants. There is also a parallel between the infantilising of patients and the infantilising of nurses in their training and in their treatment in the health care system.

Course dynamics

When evaluating the course, both groups said it was a good experience to meet the other group and it made them realise that they were not the only clinic who was having problems. Initially the Deep Valley nurses were pleased to see that the patient flow at their own clinic seemed to run more smoothly than Vista. Whether this realisation threw them into a mood of false security, or whether they felt too unconfident to open their own practices for public scrutiny is not known. Another possibility is that the energetic strategising and initial successes of the Vista group, highlighted their own feelings of impotence or lack of power to initiate changes.

At the first meeting of the course The Deep Valley nurses found that the entire training team as well as the other participants from Vista were white. Unwittingly, the composition of those on the course portrayed the old regime. Coloured identity has been deliberately promoted by the policies of the apartheid state. The nurses have been socialised into believing that they are second rate citizens who have little control over any aspect of their lives. They went to segregated schools and nursing colleges and worked in health services situated in coloured areas: those clinics which deal with the health risks of poverty. Coming on the course was just one example of being sent off somewhere by those in authority. They responded by attending the course *en masse*, perhaps feeling that there is safety in numbers.

Theories on group behaviour

The work of Bion (1961; Stokes, 1994; Symington and Symington, 1996; Trist, 1987) may shed some light on the behaviour of the two groups. Bion was a psychoanalyst who developed a framework for studying the unconscious processes in small groups in order to understand the irrational features of group behaviour. According to Bion group behaviour is directed at trying to meet the unconscious needs of its members. This manifests in two main tendencies. He called the tendency towards working on the primary task the “work-group mentality”. The group carries out a task and wants to assess their own effectiveness. The other tendency is to avoid working on the primary task and is known as “basic assumption mentality”. This shows up as the wish to evade reality when it is painful and can lead to

conflict amongst group members. Basic assumption mentality can be used in sophisticated ways by members of professions in order to produce a group culture.

In helping institutions there is often confusion about what the primary task should be. Staff usually lack adequate task definitions and receive little guidance from managers on their effectiveness. Zagier Roberts (1994a, p28-38) explains Lawrence's (1977) theory of the primary task. Lawrence suggests that organisational behaviour can be studied by examining the way in which employees pursue different kinds of primary tasks within an organisation. He distinguished between the **normative primary task** which is the official task which is defined by the senior managers; the **existential primary task** which is the task that the staff believe they are doing; and lastly, the **phenomenal primary task** which can be inferred from people's behaviour, and of which they may not be aware. When a group does not know its primary task, it tends to invent another task. This is usually the case in basic assumption groups who display anti-task behaviour to meet the psychological needs of the group members. The sophisticated work group, on the other hand, gets on with the primary task which relates to the demands of the external environment.

The Vista team operated as an open group whose purpose was to improve the cure rate of patients by re-arranging their clinic routine in order to provide maximum contact time between patients and nurses. In order to achieve this, they operated like a task-focussed working group. Back at their clinic they had to convince colleagues of their vision and to obtain their participation. Deep Valley, on the other hand, closed ranks and turned inward like a closed group that exists solely for the protection of its members. This was already clear in their decision that all would attend the course. Their leader collaborated in this process by protecting them against painful changes. This became evident in the way they held on to their existing clinic routines (their existential primary task) which contained their anxiety, rather than the patients' need for support.

Another feature of group behaviour is its relationship towards authority. Vista acted with authority when they presented their plans to the management. The staff at Deep Valley

described themselves as “adaptable” to any changes which are proposed from head office. Yet there was an underlying anger about not being consulted:

“Everything is already planned and sometimes we feel... look we know a lot about the problems on the ground... why don't they discuss things with us and ask our views..?”

These rumbles remained in the group. In the basic assumption dependency mentality groups assume that authority is based entirely in the hierarchy which calls for unquestioning submission.

Why the complete acceptance of the register and the pride that they are the only clinic who understand the rationale for it? Obholzer (1994, p 169-178) describes the defensive structures in public sector organisations. He uses the concept of containment to describe how employees make their anxieties more bearable or contained. According to Hinshelwood (1991, p 246-253) the notion of containment is derived from Klein's original description of projective identification in which one person could contain a part of another. Bion (1970) developed this theory further and applied it to social systems. Emanuel (1992, p 2, 3) describes the concept as follows:

In Bion's theory, the development of the capacity to think, or be curious in any way, or to pay attention or learn from experience, depends on the baby's experience of being thought about him or her. (...) In the same way as a child will not learn to talk unless he or she has been talked to, so the same applies to thinking, curiosity or attention. (...) From sense data available to the baby from within and without, the baby is faced with the problem of 'what is this object, feelings or whatever?' The bombardment of meaningless data (...) may overwhelm the baby and all he or she can do is to evacuate these sensations. The baby's psyche is not developed enough to contain powerful feelings of any kind and this is absolutely dependent upon the availability of some object into which the baby can rid himself of these feelings. Bion calls this object the container and the stuff put into the container, in this instance, overwhelming incomprehensible sense data, the contained. The container, the mother, then has to try and make sense out of the baby's experience by thinking about whatever it is the baby made her feel. This thinking about the communication from the baby, (...) Bion calls reverie. Once the mother has sorted out what the baby is communicating, she can respond to him and he may feel understood. In other works the container acts upon the contained through the function of reverie and then can hand back the contained to the baby, in a more digested, modified form”.

To return to the situation in public health institutions, health providers may manage defences against the painful realities of the work by arranging the work into certain tasks, rules and procedures. (“Yes, the patients need more support, but limit it to Thursday afternoons from 2-3 pm”). Only if there is an agreement on the primary task of the organisation and a willingness to be in touch with the anxieties inside the container rather than blocking them out, is it possible to deal with or contain anxieties. For this to happen it is necessary to have opportunities for dialogue within the organisation. Unfortunately our public health services do not function like this - managers are kept at a distance from patients. The “caring” component is removed from management and clinical staff have to protect themselves from the realities of pain and illness. This is done through learning to turn a blind eye to the realities and to organise work in such a way that anxieties are pushed back. This could stand in the way of doing the primary task, which in this case is to support patients to adhere to lengthy treatment of a stigmatised infectious disease. The emphasis on administrative work could be part of this process. If we fail to recognise the anxiety containing function of an organisation, changes can create more problems because they lead to the dismantling of structures which were created to defend us against anxiety. In the case of Deep Valley, a change from a task orientation which presently serves to contain anxieties by providing distance between patients and nurses to a more patient centred approach, could lead to staff burn- out and illness.

Conclusion

Human beings are resistant to change, therefore managing change will require managing the anxieties and resistance which arise from the change process. The more well-known sources of organisational resistance are the threat to established power relations, threat to resource allocation, threat to expertise, the limited focus of change, structural inertia and lastly, group inertia (Robbins, 1993). The case of Deep Valley has illustrated a form of “group inertia” and has provided the opportunity to dig beyond that label in order to unearth some of the deeper lying anxieties.

In the next chapter I return to the concept of “too close for comfort”. I search for further evidence of this phenomenon and I explore its meaning for nurses and other professionals.

Chapter Seven

Too close for comfort: unpacking the phenomenon

In the previous chapter I have started to explore the “too close for comfort” concept. In this chapter I take the analysis further by developing a working hypothesis and by reflecting on the meaning of talking and writing about issues of colour and ethnicity. Finally I describe the development and use of a research technique that enabled me to explore politically sensitive ideas with key informants.

Talking about colour

When I first observed the different ways in which the Vista and Deep Valley nurses responded, I was too frightened to analyse the differences. At first I voiced my observations very tentatively, because of the fear of being racist, and the concern for creating another “labelling” device. A few of my colleagues responded with caution and suggested that I put less emphasis on the “sensitive race explanations”. I had vivid memories of twenty years ago when I worked as a newly qualified and inexperienced nurse in a remote rural hospital. Most of the doctors were from Holland and they asked me why the local black nurses were so harsh and uncaring toward patients. Although I was aware of the phenomena that they referred to I brushed their questions aside and refused to entertain such “politically incorrect” thoughts. I found many arguments for explaining the behaviour of black nurses. These included the bantustan policies of the time which had shaped the kind of schooling and professional education that the nurses had been through. Without being aware of it at the time, I was arguing that all nurses are similar and that it was the external and structural realities that shaped our behaviour.

During the years of struggle against the apartheid regime, progressive academics drew on critical theory to support a discourse of **similarities** between cultures in order to counter the government's arguments of **differences** between ethnic groups. Differences were kept out of academic debates (even to the extent of self-censorship) in order to oppose the state's drive for separateness at all levels of society (Kottler, 1996). To talk or write about differences came to be seen as support for apartheid and as being racist.

In discussing the intense fear which prohibits discussion of differences, Kottler alerts us to the discourse of "white guilt". This makes sense to me. As a person classified white in the old South Africa, I am associated with the privileges of the old order. Who am I to criticise, or even to draw attention to the "different" behaviour of coloured or black nurses? It would be much safer to heed the advice of others and to steer clear of these murky waters! Especially so now, in the "new South Africa" where there is great support for the similarities argument. This is evident in the promotion of non-racism, nation building campaigns and the "rainbow nation" (Swartz, 1996; de Kok, 1998). McAllister and Sharp (1993) stated that there are still South African academics who felt that it was politically incorrect to discuss ethnicity, but they felt that the tide had turned. In spite of this I still encountered a taboo against the discussion of differences.

What is my reason for taking the risk of talking about differences? Simply because of the responses that this observation evoked from many different individuals, for instance nurses, social scientists, educationists. They tell me that the idea "talks to them" about their own experiences as a nurse, a teacher, and so on. I do hope that the voicing of this phenomenon will encourage broader discussion and examination of it. Once it has a name it can be recognised, better understood and changed.

A personal memory of being too close for comfort

While I was grappling with these questions I had a vivid memory which took me back to my feelings at a time when I was employed as a nurse in a community based primary health care service. After working in mostly coloured areas for several years, I was transferred to E, a health centre in a different area, to do relief duties. The area was unknown to me, I only knew

that it was close to the market and to the industrial area. I was shocked at what I found there: white people, mainly Afrikaans speaking, like myself, who lived in “sub-economic” housing. Many of the patients had social problems such as unemployment, alcoholism and malnutrition. I found myself comparing the people to the coloured and black people on the Cape Flats. They were white, they were privileged because of their colour, and they had no excuse to be like that! I felt ashamed of them and embarrassed by them. I do not recall ever having had similar feelings about coloured and black patients.

Thinking back of that experience, I do not know whether the patients became aware of my feelings towards them. They probably did. It was only much later that I understood that they too, were victims of the apartheid system which had created a ghetto for white people, many of whom were mentally and socially disabled. In a normal society where skin colour would have been less important, they would have been integrated into other neighbourhoods and they would have been less conspicuous as “poor whites”.

I now recognize how my insider status of being close to the white patients could have triggered my discomfort and shame. At a deep unconscious level, I was probably frightened of being like those patients. I now find these memories reassuring: perhaps my “too close for comfort” hypothesis is applicable at a broader and more universal level! I would have to find ways of verifying that.

Provisional hypothesis

In order to understand the phenomenon I have developed the following “working” hypothesis:

- * The closer the nurse identifies with the patient in terms of background, colour, ethnicity and culture, the more the nurse would feel the need to distance herself from the patient in order to protect herself from her own strong feelings of frustration, anger, anxiety and possibly, her helplessness to change the situation. She may also feel embarrassed or ashamed about being linked to life experiences similar to that of the patient.

- * Conversely, the further removed the nurse feels in terms of background, colour, ethnicity and culture, the less the nurse would feel the need to distance herself from the patient. From a position of relative security she can reach out to form a closer relationship with the patient.
- * The phenomenon is particularly evident in South Africa where there have been deliberate policies of segregation at all levels of society.

Research methods

I had now reached a stage which called for theoretical sensitivity. To quote Strauss and Corbin:

“Theoretical sensitivity represents an important creative aspect of grounded theory. This sensitivity represents an ability not only to use personal and professional experience imaginatively, but also literature. It enables the analyst to see the research situation and ...data in new ways, and to explore the data’s potential for developing theory”. (Strauss and Corbin, 1990, p 44)

I continued by using the concept of hypothetical reasoning (see Kelle, 1993) which I have discussed in Chapter 3. I now describe this process.

I was at the point where I had formulated my observations into the provisional hypothesis mentioned at the beginning of this chapter. The literature on psychodynamic theory provided me with concepts that went a long way in helping me to make sense of the data. I was now faced with the task of checking it out with nurses and other key informants. This felt like a daunting task for two reasons. First, the difficulty of talking about sensitive issues of colour. Secondly, psychodynamic processes happen at an unconscious level, so to what extent would informants be able to recognise and discuss these feelings?

In the end my decision was intuitive; I would present my hypothesis to respondents, tell them about my personal experience and ask them to give their perceptions on my interpretations. In this way, I hoped that I could engage them as research participants with the purpose of helping me think through the issue.

I purposefully chose four participants by using the following criteria: They were coloured women; I particularly wanted them to respond to my observations at Deep Valley . Two of them were professional nurses with extensive experience in clinical work, teaching and research. The other two respondents were academics who had an interest in cultural studies and issues around ethnicity and identity.

I used a flexible approach for the semi-structured interviews. The discussions with the nurses broadly followed the same sequence: After introducing my broad research topic as a study of the relationship between patients and nurses, I asked them to tell me about their relationships with patients, and what factors influenced the relationship. From the discussion I established whether they had worked in intercultural settings and what those experiences were like. During the second part of the interview I introduced my observations at Vista and Deep Valley as well as my personal experiences at E. The following is from a transcript of one of the interviews:

“Let me first share something with you and then ask you what you think of that. Recently I’ve been observing the service in clinics, and interviewing nurses and patients. I saw something which puzzled me a lot. It is quite sensitive to talk about, because it is about racial things. It seemed to me that coloured nurses dealing with coloured patients were more angry and more frustrated than the white nurses who do the same kind of work”.

“When I tried to understand this, I remembered something from my own days of nursing. I worked for the Day Hospitals for quite a few years in places like H and G. Then one day I was transferred to E. Do you know it? I still remember my shock when I got there and I saw all those white patients. Quite poor and a lot of social problems like alcoholism, drugs, nine..ten children. I was relieving the family planning nurse and I felt very irritated. I felt that these people had no excuse, they are privileged and they have all the rights. I was frustrated with them. At the time I wasn’t aware of my reactions, but now, when I think back of it, it feels similar to what I’ve seen at Deep Valley. I think when we are so close to patients there may be something there that irritate us... What do you think?”

In the discussions with the other two non-nurse respondents I first related my research findings and my personal experience as in the interviews with nurses. Thereafter I asked them to respond to hypothesis.

Findings

What follows is a report on the outcome of the interviews. For the sake of clarity I report the views of nurses and non-nurses separately.

The perceptions of nurses

Too close for comfort?

One of the participants immediately recognized the phenomenon of being harsh on “you own”. But she was adamant that she had never allowed prejudice to influence her behaviour:

“I have worked in a setting where I needed to work very close to the community and had to deal with those kind of patients, but my attitude had always been non-judgmental. We might have the same classification but our life experiences are not the same. I can look at you and say but we come from the same kind of community which is working class, so why couldn't you do something (to help yourself), but perhaps your family setting is different from mine. So I don't have the right to be judgmental towards you”.

She recognized the “too close for comfort” scenario because it had been brought to her attention by black nurses and patients.

“Black patients even tell lies to land up at a coloured clinic, to get the care of coloured nurses rather than to go to the black clinic. They will even go as far as to tell you they will not go there because of nurses x, y and z”.

Black nurses have also told her how their colleagues maltreat patients.

Another participant admitted to feelings of shame toward coloured people who have erected makeshift shelters under bridges close to where she lived.

“Coloured people have always had more opportunities than blacks, but they still expect handouts.”

She said that if she would have been required to nurse them, she would probably lack the patience to do so.

“A very fearful client and a very overbearing nurse”

This is how one participant described the relationship between patients and nurses:

“I know there are exceptions to the rule, but if I can give you a general comment, I think that we are still at a place in time where nurses are very much in control; where “I need to tell you what to do”. And patients are in the position where they don’t have the right to ask. At the moment that is how I see the relationship: as one of a very fearful kind of client and a very overbearing kind of nurse”.

The patient who asks questions

In the opinion of one of the informants, several factors contribute to more stressful relationships between nurses and patients. Now that patients are “more educated” they ask more questions,

“It rattles the nurse when a patient asks what they are doing and why. I suppose in the past it has always been when I tell you this is what I am going to do, then this is what I do and you accept it. But now the patients are probing us: must you do it, is it necessary, and I think it is their right to know why it is necessary and if she doesn’t want it, it is her right not to have it.”

This could lead to the patients being victimised. The nurse is likely to discuss the patient’s behaviour with her colleagues and the patient will be noted as “difficult” or “cheeky”. This

would set off a chain reaction of “subtle victimisation”. Certain patients are labelled by nurses as being difficult, and once that happens:

“I have this guard and I don’t treat her the way I would have if I didn’t have that information.”

The labelling of patients changes the openness in the relationship.

Increasing pressure at work

There has, she believes, been a decline in standards of nursing care. She was not sure what the reasons for this were, but she offered a few suggestions:

“There is a never mind (don’t care) type of attitude that has crept into the profession. Is it the transitional phase that the country is going through? Is it the nurse-patient ratio where you have to spread yourself so thin? In the end you just cannot be bothered how you speak or what you do to a patient.”

In order to promote equity in health care and to spread resources to less well endowed provinces, the government has cut back on the health budget in the Western Cape. This has meant a closing down of nursing posts. Highly skilled senior personnel have taken early retirement packages.

She described a general sense of uncertainty about the future. Nurses have always had their personal and family problems.

“But coming to work used to be like a break from the difficult circumstances at home.”

Now that the workplace is so stressful and full of uncertainties there is no place for nurses to unburden.

“In the past they could suppress whatever was causing stress in their personal lives and act properly, but now the situation at work gets too much. It is like there is no time out for them. And they get to a point where it is horrific to hear them talking to a patient. It is like they are projecting their frustration..”

Self image and self esteem of nurses

One of the participants felt that the self esteem of nurses could have an effect on their interaction with patients:

“You know, it is also about how she feels about herself. If she feels good about herself, whatever race she looks after, she is going to give the kind of care that must be given. If she feels insecure, then the patient has to respect her for what she carries on her shoulders. Even when she is your colour or race, there is an attitude that she is better than you. People that are like that, if they take off their uniform, there is nothing that keeps them together. Ask them about things not related to the profession and there is not much they can speak about.

You get the feeling that their work is their life and it's like they are holding onto everything that comes with the profession to make people see them, or to feel good about themselves”.

The more insecure she feels about herself, the more likely she is to use her status, the outwardly visible signs of her profession, for example the epaulettes she wears on her shoulders, to distance herself and put herself above the patient. According to participants, similar behaviour is evident in other work settings, such as teaching, social work and the police service.

Coloured nurses' perceptions of white nurses

In an effort to explain the different response of coloured and white nurses to the patient centred intervention (see Chapters 4 and 5), one of the participants said that there is a widespread perception among coloured nurses that white nurses have better relationships with patients. One of the explanations given for this, was that coloured patients tended to be submissive to white nurses because they were seen as having high status. On the other hand, coloured patients were more likely to be rude towards coloured nurses. Another reason for better relationships was that the white nurse-patient ratio had always been better in the past. This meant that coloured nurses had less time than white nurses to spend with patients. Lastly the phenomenon was laid at the door of nursing education and basic education. White nurses were seen to have had the kind of education which exposed them to critical thinking and new ideas in nursing. Coloured nurses were used to rote learning. As a result they lacked the self confidence which is needed to risk new ways of working. They expected to be given explicit

instructions and they have learnt that any efforts to change the system will be squashed by those in charge. This was confirmed by another participant:

“Coloured nurses have never been agents of change; they have always been performing and receiving instructions.”

The perceptions of non-nurses

The strongest recognition of the “too close for comfort” phenomenon came from the non-nurses. It was interesting that both participants felt that the hypothesis had much wider application than in the field of nursing. One responded with enthusiasm and encouraged me to write about these issues because it was a widespread phenomenon which was seldom discussed openly. It resonated strongly with her experiences as an academic at a university “where I have encountered the laziest coloured lecturers.” She felt that there was an overblown rationalisation of the inequalities and that black professionals tended to blame their poor performance on apartheid. She noted that a similar attitude also occurred at school level among teachers.

The other participant responded to the material at a deeply personal level. Prior to the interview she had read my description of how Deep Valley nurses remarked that they knew what was best for their people and that their only reason for scolding patients is because they care about them. She commented that the description could equally well refer to her relationship with students on campus. She described her past experience as lecturer on the campus of a historically black university catering mainly for coloured students. She experienced the campus as a place of pain and mediocrity. There was a high failure rate and she felt that she was being subtly pulled towards an acknowledgment and acceptance that it was a second-rate university where standards had to be dropped. She responded with a refusal to be dragged down and to accept that it was “a coloured place”, and an insistence on excellence. She told her students that she expected only the best performance from them.

“I told them I knew they had the potential, because I had it, and so they had no excuses for failure.”

Thinking back on that time she now realised that she had been quite “harsh” with the students. She noted that the majority were “too deep into victim mode”, as she put it, to benefit from her approach. She reflected on her current approach to students which has changed considerably. She now works on a formerly white campus which is alien to the black students. While she still urges them to excel, she is much gentler with them. She sees herself as more confident as a lecturer, more secure in her own sense of identity and as a result she can help the black students to experience a “safe place” on campus and she acts as a container for their pain.

While reflecting on her previous attitude towards students she recalled that her harshness could have had its root cause in her wish for coloured students to “be empowered” or to come out of the “victim mode”. She felt that her high expectations of them would act as a spur for them to take full responsibility for their own progress as students.

This same respondent noted that black professionals felt that they constantly have to “prove themselves”. In spite of their training and professional qualifications they felt that they had no authority. There was often a feeling of being regarded as second rate by clients who seemed to prefer being served by white professionals. Some black professionals try to compensate for this lack of self confidence by stressing outwardly correct behaviour, for instance formal dress code.

Discussion

It was interesting that both nurses that I had interviewed, suggested possible reasons for the different responses to the patient centred intervention at Deep Valley and Vista. These explanations ranged from social and political events such as a change in staff allocation and poor basic education to more personal reasons such as low self esteem and stress at home. In this discussion I raise issues of power and authority, shame and the processes by which we assume an identity.

While one respondent immediately recognized the “too close for comfort” phenomenon in other ethnic groups (black nurses and black patients), she attributed the “subtle victimisation”

between coloured nurses and coloured patients to increased work pressure. Her vivid description of “a very fearful client and a very overbearing nurse” captured the image of the power difference and the distance that nurses create between themselves and patients. While she did not link this explicitly to being too close for comfort, she emphasised that the self image of the nurse could determine to what extent she needs to use her status as a protective barrier between herself and the patient. Her own perception of being “non-judgmental” toward patients came from her personal values which she expressed as

“a spiritual component in my life that acts as the foundation to my belief system”, and “your principles influence the way you deal with people.”

The notion that lack of self esteem as a professional could influence the nurse-patient interaction was raised. There were the images of the dominating and powerful nurse and the timid patient and nurses who rely on the signs of status such as epaulettes to keep patients in their “place”, as well as the notion that some black professionals tended to compensate for their lack of self esteem by outwardly correct behaviour. This could mean that in instances where the nurse has a sense of “damaged” identity, she may feel more inclined to rely on her status as a source of power.

De la Rey (personal communication, 1997a) mentioned how women in careers or professions sometimes feel that they have to show (outwardly) that they deserve the position. This often lead them to be very formal and strict towards their (female) underlings. I suppose this is also a way of putting a distance between themselves and women in more traditional roles. This is why women often say they prefer a male boss. This could be part of the same dynamic played out between nurses and patients.

These interviews suggest that the “too close for comfort” phenomenon occurs in settings other than nursing, for instance in the interactions between lecturers and students. The respondent who identified this link, indicated that the harshness of the lecturer may have something to do with a wish to empower the student. Could the harshness of the nurse toward the patient be related to a similar sentiment? Given the evidence that nurses feel threatened by assertive patients, it is doubtful whether they would wish for patients to be more empowered. Empowerment is a more popular concept in the educational setting, where it would take on the meaning of being an active learner rather than expecting the lecturer to provide notes, to

ask critical questions and to grow in confidence. Related concepts in the discourse of the health care setting are responsibility, participation, development, betterment and upliftment. Is there something about the type of work which contribute to the “strictness” and expectations from clients? A reflection on this question raised a few ideas.

Nursing and teaching both expect a response from the client, namely compliance to treatment or advice and active learning. In teaching this two-way process is easy to see. The teacher teaches but if the student does not learn, no education has taken place. The effectiveness of education is evident in good pass rates. In certain types of nursing this applies as well: the success of the TB Control Programme is measured in the number of patients who successfully complete treatment. Poor “statistics” (completion rates) reflect negatively on the quality of nursing care.

Both these professions aim to change people, by educating them and by healing them. This raises a number of questions about the primary task of the profession. Would similar dynamics come into play when the professional has different expectations of the client, for instance in the business sector, or in legal settings? What role does paying for services play? There could possibly be a different dynamic if the client pays for the service.

If coloured nurses feel ashamed of patients, who is the shame for? The nurses are not like the patients. They have a different class position. I think this is true, on a rational level. One of the nurses interviewed here, clearly said that she knew she had a different upbringing although she was from the same community as the patients. I have found the following example from a different context useful, because it helped me to realise that the shame is not a rational and even conscious feeling. Immigrant nurses at a London psychiatric hospital were convinced that a Rastafarian patient was insane. How could they allow white English psychiatrists to tell them that their fellow countryman was exhibiting “native” beliefs? Acknowledgement by the nurses that this was indeed accepted social behaviour associated with their own culture, would have made the nurses feel ashamed of their own background. The nurses may have experienced the acceptance of traditional beliefs as a threat to their own assimilation in their new host country. This example comes from Littlewood and Lipsedge

(1997, p 21-22). In similar ways black West Indian colonial officials working with the French in Africa related exaggerated stories of the primitiveness of the Africans:

“Between whites and Africans there was no need of a reminder: The difference stared one in the face. But what a catastrophe if the West Indian should be taken for an African!” (Fanon as quoted in Littlewood and Lipsedge, 1997, p 22).

From my observations of how nurses interacted with patients I knew that not all coloured nurses avoided closeness, nor were all white nurses willing to experiment with getting closer to patients. I suspect that this is a complex phenomenon which happens at an unconscious level. Furthermore, it may be linked to how we define our own identities in relation to the identity of the other, for instance the patient. I now discuss literature pertaining to black identity.

Erasmus and Pieterse (1997) describe three discourses on coloured culture and identity in South Africa. The white Nationalist discourse constructed coloureds as “left over people” who were represented as drunken, carefree jokers. During the 1970s and 1980s an alternative to this patronising discourse was put forward by activists in the Black Consciousness Movement and the non-racial African National Congress. It emphasised an all encompassing black identity and denied the existence of a different coloured identity. In the mid-nineties a third discourse emerged among “Brown Nationalist” movements in the Western Cape. They claim an exclusive coloured identity with an own language and culture. On this basis they claim the right to land and self governance (Robins, 1998; Ward and Worden, 1998).

Mama (1995) suggests that the use of “identity” may lead us to treat the psychological and the social as separate spheres. She quotes Weedon (1987, pp 32-3) on the definition of subjectivity:

“The terms *subject* and *subjectivity* are central to post-structuralist theory and they mark a crucial break with humanist perceptions of the individual which are still central to western philosophy and political and social organisation. “Subjectivity” is used to refer to the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world...(P)ost-structuralism proposes a subjectivity which is

precarious, contradictory and in process, constantly being constituted in discourse each time we think or speak.”

Mama (1995) notes that subjectivity is constituted socially and historically out of collective experiences. It is not a fixed entity, but rather a dynamic discursive process during which people take up and change positions. Subjective processes are conceptualised as being at once socio-historical and intrapsychic.

She makes use of discourse analysis to develop a theory for understanding how individuals constantly position themselves to take up an identity. In her research with a group of black-identified women who live in London two main and opposing discourses surfaced: a colonial-integrationist discourse and a black radical discourse. The former discourse refers to the colonial values which the women absorbed since early childhood; messages of conformity and acceptance of white hegemony. Mona, one of the research participants, describes her (Jamaican) mother as “very hard on black people. Her own people.” In the Carribean of her youth there was an elaborate system of colour gradation, and as a lighter-skinned woman she did not identify with black people. Therefore she repeats all the racist stereotypes: for her blacks are lazy, unclean and morally corrupt and she is fearful that her children may “revert to type”, especially seeing that they are black. Her “strictness” or harsh attitude is to prevent this from happening. Mona, in response to her mother, takes up a position in the black radical discourse which is typified by a positive assertion of black identity and culture.

Mama then turns to psychodynamic theory to analyse the same data. Mona grew up with negative attitudes toward black people which she had turned on herself. She deals with this by distancing herself from her mother and projecting her earlier negative evaluation toward blackness on to her mother:

“The discursive change, from colonial to black radical discourse, is at the same time a psychodynamic movement involving splitting, the repression of the bad, black object and the idealisation of a good black object.”

Following Mama I understand that identity is not a fixed state which we carry into every experience and interaction. The identities that we take on depend to a large extent on the

situation: our history with similar situations, our current and previous relationships with the people involved, our political stance (colonial or radical) and the inner unconscious material related to the specific interaction.

Identification with the victims of oppression

“Much of what you say about being “too close for comfort” rings true. However, while this may occur less frequently, the reverse may also be true. Experience of discrimination and poverty could make some people (once they are out of the situation) more empathetic”.

This comment was made by a person who works in the field of public health. She comes from a Jewish background and feels that the experiences of her parents' generation during the Holocaust, has had an impact on her, in that she had felt more inclined to resist and speak out against injustices. She raises the possibility that, depending on their political awareness, this same response may have occurred in black and coloured nurses. Their awareness of injustice may have led to a closer identification with patients who suffer from an unjust system. This can be compared to Mama's (1995) notion of the black women who subscribe to the black radical discourse. Although there are radical nurses, I have not encountered them in this study of nurses who work with TB patients. There could be many explanations for this. Radical nurses have found it difficult to endure the peer pressure and the hierarchical structure in nursing and have tended to leave the profession to work in settings that were more accepting to their beliefs, for instance in the trade union movement and the progressive health movement that actively resisted apartheid. Another explanation for what seems like an absence of nurses who identify with the oppressed patient, could be the specific context of nursing which is typified by rigid hierarchical power relations. Related to this, is the evidence that nurses seem to be particularly harsh on women patients (Jewkes and Mvo, 1997; Xaba, 1997). It seems as if their own experiences of being discriminated against as women, do not necessarily sensitise nurses to be supportive of women patients.

NB

NB

In the context of this study, nursing, in particular, seems to evoke the “too close for comfort” response. If we consider the work of another kind of health practitioner, the phenomenon does not seem to apply. Community health workers are lay people who have had a basic training in health and in many ways their work is similar to that of public health nurses. They live in the

same community as the people they serve and can be seen to be similar in every aspect. Given the findings of this chapter, I would have expected them to be “too close for comfort”. Yet I discovered that the opposite was true when I was part of a research team which evaluated the impact and acceptability of community health workers in Khayelitsha, a township near Cape Town. Members of the public perceived their relationship with community health workers as more informal, friendly and open than their interaction with public health nurses at a nearby health centre (Mathews, van der Walt and Barron, 1994). This finding seems to support the idea that “too close for comfort” takes on a particular meaning in the context of professional nursing. There could be several explanations for this. As discussed earlier, nursing is seen as a profession and is therefore associated with higher status than that of lay health workers.

Back to the provisional hypothesis

The purpose of this chapter was to test and develop the “too close for comfort” concept. It is now time to revisit the hypothesis in order to revise it in the light of fresh insights. An attempt to summarise the data presented in this chapter is difficult. This reminded me of the pitfalls of using hypotheses for this type of research. There is no simple causal relationship pattern. The hypothesis in this case is a thinking tool to assist in the inductive analysis of qualitative data and to sharpen the development of grounded theory (Strauss and Corbin, 1990). I now return to the provisional hypothesis and suggest some changes. Overall there was considerable support for this statement by nurses and non-nurses. It is possible to add to the hypothesis by including new insights. I do this by commenting on the numbered aspects of the provisional hypothesis:

- The closer the nurse identifies (1) with the patient in terms of background, colour, ethnicity and culture, the more the nurse would feel the need to distance (2) herself from the patient in order to protect herself from her own strong feelings of frustration, anger, anxiety and possibly, her helplessness to change the situation. She may also feel embarrassed or ashamed about being linked to life experiences similar to that of the patient.

The work of Fanon (1970) and Mama (1995) extended my understanding of identity

formation. (See 1 above) If identity is indeed a fluid state which is largely dependent on the situation and circumstances, then it would follow that in certain situations, despite their different class positions, nurses experience a painful identification with patients from the same ethnic background. These situations are typically those which evoke feelings of shame or embarrassment for being labelled with the same tag as the patients (irresponsible defaulters, dirty, infectious, poor).

Distancing (see 2 above) between nurse and patient has been confirmed by the participants. It is interesting that the distancing is in response to the closeness of identification described above. There is, however, a new concept which emerged from this data, namely "strictness", as in "the fearful patient and the overbearing nurse". The university lecturer mentioned being "very hard" on students and expecting only the best work from them. In similar vein Mama describes the Jamaican woman who is "hard on her own people". This strictness seems to have something to do with expectations for self-improvement as well as with feelings of responsibility to facilitate the process of development or public health. In the TB Control Programme this is particularly important because the nurse feels it is her responsibility to curb the epidemic, but this can only happen with the cooperation and compliance of the patient.

- Conversely, the further removed the nurse feels in terms of background, colour, ethnicity and culture, the less the nurse would feel the need to distance herself from the patient. From a position of relative security she can reach out to form a closer relationship(3) with the patient.

As a consequence of the new understanding of strictness, I have a different perspective on the issue of distance and closeness (see 3 above). The coloured nurses experience an emotional closeness toward the patients. Evidence for this is their frustration and strong feelings of anger towards defaulters. This is painful and causes anxiety and therefore they create a distance. The white nurses experience a distance which comes from their socio-historical position. It feels safer for them to move closer and to remove the artificial barrier of task orientation. This does not mean that they build a closer relationship with coloured

patients - it is probably a more committed therapeutic relationship which is possible because of the already existing boundaries between them and the patients.

- The phenomenon is probably particularly evident in South Africa where there had been deliberate policies of segregation (4) at all levels of society.

Several participants have referred to the effects of apartheid on the professional development of coloured people. Nursing is not the only profession which bear these lesions. Lack of self esteem could lead to a need to express power and status rigidly and outwardly. Patients seem to reinforce this process by their preference to be treated by white professionals.

Conclusion

In this chapter I have attempted a deeper exploration of, what I term, the “too close for comfort” phenomenon. It is an extremely sensitive topic in the South African context and it requires a high degree of mutual trust to allow for open and frank discussion. I am convinced that “too close for comfort” is one among many factors which influence nurse-patient interaction. Some of the other factors have been mentioned by the respondents who were interviewed here. They include issues related to the use of power, the historical differences in nursing education, the submissiveness of black patients towards white nurses and the burden of increasing pressure at work. Added to these is domestic pressure and the uncertainties of a society undergoing massive social and political changes.

In the next chapter I describe the illness experience of nurses who contract TB. This provides an opportunity to explore how nurses perceive the role of the caregiver when they are in the unfamiliar position of being patients.

Chapter Eight

Crossing the line: nurses who become TB patients

“Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place. (I)t is hardly possible to take up residence in the kingdom of the ill unprejudiced by the lurid metaphors with which it had been landscaped” (Sontag, 1978, p 8).

Introduction

In this chapter I describe the profound experiences of two nurses who become TB patients. The body of the chapter is divided in two parts; in each part I present and discuss the illness experience of one nurse who became ill with tuberculosis. “Illness experience” refers to the subjective experience and includes the way individuals perceive, live with and respond to symptoms. This can be distinguished from the interpretation of practitioners when confronted with a patient whom they perceive to be presenting with a “disease” (Helman, 1990, p 90-91; Kleinman 1980, Chapters 3, 4; Swartz, 1998, Chapter 1).

Part one: Disillusion with doctors and fellow nurses

Sometimes a research process can be steered in an unforeseen and exciting direction by sheer chance or synchronicity. This is what happened when my carefully constructed plans for iterative cycles of data collection and analysis were interrupted by a request from a nurse who had become a TB patient and who wanted to “tell me her story” because she was going

through difficult experiences. Sylvia (a pseudonym) made the request through her colleague who was familiar with my research topic. When I called her, she was keen to meet me. She had never spoken to anyone about her feelings and she hoped that the interview would give her the opportunity to “come to terms with these feelings and to help others who may be suffering”. She chose to meet at her own house, away from her workplace, where we could talk in privacy.

Research method

In preparation for the interview I made the following entry in my research diary:

“How should I conduct this interview? The situation is different: she has expressed a need to tell me her story. My role is to listen, record and facilitate the process. I will tell her about my research topic, but I sense that my need for information will be secondary to her need to talk freely and to be listened to.”

I planned to conduct a Free Attitude Interview: a technique that is useful for controlled, non-directive depth interviews (Meulenberg-Buskens, 1993). I prepared the following broad interview question:

“Tell me about your experiences as a nurse who became sick. Please talk freely. I may interrupt now and then, just to make sure that I understand you correctly.”

The first meeting lasted for nearly two hours and the intense emotional nature of the discussion prompted me to end the discussion and to suggest a second interview. We made an appointment to meet again six weeks later. During this break we both had the opportunity to reflect on the experience. While planning for the second interview I read Mandelbaum’s guidelines for conducting studies on life history (Mandelbaum, 1991). These studies, often conducted by historians and anthropologists, provide accounts of lives and require some principles for selection of the experiences which will be recorded. For my purpose it was important to focus on the psychosocial dimension of Sylvia’s experiences which influenced her illness experience. This dimension includes aspects of her career history, for instance major turning points and adaptation to new roles.

She gave me permission to record both interviews and I undertook to send her copies of the transcripts so that she could have a record of her own “story”.

Sylvia: a biographical sketch

“Sylvia” is a 33 year old, white, qualified nurse who holds a senior position in the public health department of a large town in the Western Cape. She is an articulate, intelligent and dedicated nurse with a high regard for professional standards. Her career as a nurse had been successful. She had come up through the ranks, first working as a clinic nurse, and she was promoted to health visitor. Since her first placement in a community health centre during her student years, she has had a preference for this kind of work. She enjoys the freedom of being able to manage patient care and to apply the principles of nursing autonomously. This differs from hospital nursing

“where the doctor is always in control; you carry out the doctor’s orders. In the community setting the nurse has more authority, she is much more autonomous because she practises according to nursing principles”.

She believes that it is important for nurses to have insight in the essence of person-hood, into

“what it means to be a human being” (“mense moet meer insig hê in menswees..”).

Sylvia describes herself as a nurse who shows her emotions. In this regard she draws the following distinctions between different “types” of nurses:

At one end of the spectrum you have the theatre nurse. She wears a mask and mainly works with patients who are unconscious. At the other extreme is the nurse who stands next to the bed of a cancer patient. She holds his hand and she cries with him.”

She pauses and smiles.

“This last one is me. I have often cried with patients. And my colleagues could never understand that I could allow myself to become so involved. You can imagine that I will never choose to work in an operating theatre!”

When probed on her views on nurse patient relations, she proudly mentioned the rapport that she had built up with patients during the period when she still had day to day contact with patients.

“I still get sent reference letters with my name on it. Although it is already two years since I have left X clinic, patients still ask to be referred to me”.

She described herself as a “serious” person with a strong sense of responsibility. The eldest of five children, she comes from a family with a history of depression. She cited this as the main reason for her wish to enter nursing:

“As a teenager I wanted to be a psychiatric nurse because I knew that I had a problem. I wanted to be able to understand and help myself”.

A few years prior to contracting TB, she had been in therapy for depression. She felt that the therapy had given her a sense of being in touch with herself, because

“I have come through a process of self acceptance after having rejected myself”.

She said that it was a miracle that her present episode of illness had not led to a relapse of her depression.

Sylvia’s need to tell her story

She was extremely anxious at the start of our conversation. She said that she was very emotional and needed to “unload”, especially since she felt that she could not discuss her feelings with colleagues. She felt that even her own family members and close friends would not really be able to understand how she felt, and she was very sensitive about the reactions of others. She warned:

“I am very subjective. I’m going to be critical and ..I nearly want to say.. derogatory, because I have not been able to express these feelings or to come to terms with them”.

In her work setting while dealing with professional matters, she always strives to be objective.

Now her feelings were so intense that she had considered cancelling the first interview because she realised that she would be unable to discuss her experiences in an “objective” manner.

Six weeks later, at our second meeting she said that despite the pain she experienced, the opportunity to talk to me had been therapeutic.

“It was like a raw wound that I have opened. It bled and that was good. Although I still feel aggressive, I can handle it better now.”

She was ready to reflect more broadly on what she had learned from her experience of being on the other side, on her own background and experiences.

Sylvia’s illness experience

The first interview: Catharsis

Sylvia had come through a painful experience. During our first meeting she poured out her feelings of sorrow, anger and frustration. Her illness symptoms were atypical because she had one of the less common forms of non-pulmonary TB. She felt that she had been the victim of medical mismanagement. There was no continuity in care, her pain and suffering were underestimated and she had been made to feel a burden and a hypochondriac. She suspected that she had TB and urged the doctors to do bacteriological examinations. She felt isolated and desperate because she was constantly experiencing pain and discomfort.

“I still cannot believe what has happened to me - all the pain and the mismanagement! The worst thing is that they don’t listen to you..”

She started to cry:

“that is the biggest problem with the medical profession: they don’t listen! They feel so intimidated when you walk in there with a uniform that they close up immediately. They see you as a threat: you are not supposed to know what they should know. You are not supposed to suggest any course of action.”

After several months of treating her with different antibiotics and with no improvement in her condition, the doctor agreed to have her tested for TB. The results were positive, but she was

not notified about this straight away: she discovered it during a casual encounter a week after the results were already known to the doctor. Although she anticipated that she had TB, she was extremely shocked when told about the diagnosis, and this

“in spite of all the knowledge in the world about the illness”.

She came to the conclusion that

“one cannot put a distance between yourself and your illness” (Jou mens wees kan jy nie distansieer van jou siekte nie). “The day after hearing that I have TB, I was sitting on this side of the table and the doctor sat on the other side: on the side where I usually sit when I tell patients that they have an illness. Now I am on the receiving end. Nobody will ever know what it feels like before they sit on this side and someone tells them they have TB...”

By the time she was placed on treatment, there was already considerable tissue damage which failed to respond to the conventional treatment. To make things worse, she reacted badly to the medication. The drugs affected her entire social life: food tasted differently, she had a bad taste in her mouth, she felt that her partner avoided her. She felt bloated and her clothes did not fit her as before. All these problems were brushed aside insensitively by the doctor. She was shocked at the indifference of her colleagues and at their inability to listen. She felt strongly that she had to fit in with their routine; they were not prepared to treat her as an individual, she was just one more case to be treated like a number. This despite the fact that she knew some members of the medical team personally. These experiences had led her to believe that

“experts lose their humanity. You are with TB doctors who are experts and you try to communicate, but they treat everyone according to a regime. They deny the importance of communication!” (Her emphasis)

She explained how this disregard for any form of negotiation had led to defiance. She told me guiltily that she had started breaking some of the rules of “the regime”, for instance she took

her treatment for one month longer than prescribed by the doctor because she was still in pain. She mentioned another occasion when she broke the rules:

“At one stage of my treatment I stopped taking my tablets for a week. I was on leave and I desperately longed for a break from the routine, not to be reminded of being ill. Later on I confessed this to the sister at the clinic. She said that she was disappointed in me. This had such an impact on me. It made me feel that she no longer trusted me.”

Sylvia's prior professional knowledge of the disease did not reassure her or render her less fearful. For example, although she knew that it was not possible, she feared that she would infect her partner through sexual intercourse. She felt extremely isolated from her colleagues at work. She did not feel free to discuss her feelings with them because she felt that she would not be understood. She felt intimidated and humiliated when a junior nurse supervised her “daily observed treatment”. No alternative supervisory options were negotiated with her.

“All of us need a bit of control over our own lives, but TB patients are not allowed any control. You are told. And you have to do as you are told.”

The second interview: Looking back

In this section I report on the second interview with Sylvia. By this time she had started the process of accepting that her recovery period would be much longer than she had anticipated. I asked her whether she would reflect on her illness from the perspective of a person who has experienced what it was like to be on the receiving end of TB treatment. Although she was still experiencing a great deal of physical disability, she felt emotionally stronger and more able to take some distance which allowed her to reflect on her relationship with colleagues. This section deals with her relationship with doctors, her views on nurse-patient relationships and the root causes of non-compliance in the TB control programme.

Interactions with doctors

Sylvia often mentioned the difficulties she had to convince doctors of her pain and distress. This theme is illustrated by the following description of her efforts to be booked off work:

S: "On Monday I was put on the TB treatment and for the next two days I simply couldn't cope at work. I was still in pain and I think my body reacted against the drugs. When I told the doctor he booked me off work for two days. My colleague at work couldn't believe this. At that time I had been sick for months and she felt I needed at least two weeks off. I told her that I didn't know how to get booked off. After all, the doctor had examined me and **knew** how sick I was. How could I tell him: 'my body tells me I can't go on any longer!'" (Her emphasis).

H: "Couldn't you say that to the doctor?"

S: "I couldn't. Because I am in a profession where people (interrupts herself) Where I **thought** people will understand. He **knew** about my condition and about the stresses at work! But because I couldn't infect others, he didn't consider it necessary to book me off. Nobody was at risk, so they didn't have to worry about me. When I finally had the courage to ask him for sick leave, he said 'Well, seeing that you insist, I will fill in a form.'" (Her emphasis)

Sylvia constantly felt that her complaints and symptoms were not being taken seriously by doctors. Earlier on, when she was still being referred from one doctor to another and could no longer endure the pain, her partner intervened and told the doctor that Sylvia needed urgent attention because she could no longer cope with the situation.

"He then told the doctor 'my wife is a nurse, she can explain her symptoms to you'. The doctor then replied that precisely because I am a nurse, I am a difficult patient".

She added bitterly :

"Nurses are always difficult patients because we are a threat to the medical profession!".

On the day prior to the second interview she had seen the doctor and she was told that her symptoms were caused by scar tissue. The doctor then told her that she was "very stressed"

and needed to be referred to a psychologist. Sylvia had burst into tears and had told the doctor that a psychologist could not heal her scarred body: that is the responsibility of a medical doctor.

“I told him that I would be able to deal with my problems if my body was better. He couldn’t expect me to be emotionally stable while I was sick; these things don’t go together.”

She had reached the conclusion that she had expected too much from the medical profession.

“Concerning my aggressive feelings towards the medical profession: I think my expectations of them had been too high. I have to drop these expectations, that is the only way that I’ll be able to find peace. After all, they too, do not have all the answers”.

Reflections on nurse-patient relationships

Sylvia is disillusioned with the nursing profession. She had expected nurses to empathise with her suffering, yet she had to fight an uphill battle to be treated humanely.

My biggest disappointment is the attitude of the nurses. They think that TB is a germ that should be killed. They know little of the impact of the treatment on the patients.”

She thinks that an important reason for the poor cure rate is that patients are seen as numbers rather than individual people.

“The day that we no longer treat patients as numbers and see them as individuals... on that day there will be a turn around in the compliance figures at clinics, and in patient responsibility.”

Sylvia mentioned two reasons why nurses treat people as numbers. The first of these is work pressure. A relatively small number of professional nurses have to deal with large numbers of TB patients. However, the nurses’ lack of empathy with the world of the patients cannot be totally laid at the door of too many patients and too few staff.

S: “Nurses do not want to expose themselves (make themselves available or open - hulleself blootstel aan) to the patient who may be in need of emotional support”.

H: "What do you mean by "blootstel"?"

S: "They do not want to open themselves up to a patient who could possibly be emotionally unstable."

H: "I take it that you are not referring to infection by TB germs?"

N: "No, they want to avoid involvement with the patient. The germs? That is also possible. But I think that they lack the emotional strength to provide the support that patients need. Their shortcoming is that they are not prepared to acknowledge the person behind the folder. They prefer to deal with the disease rather than with the human being."

Sylvia feels that instead of encouraging patients to take charge of their own health, nurses want to be in control of patients:

"We are supposed to allow a patient to choose between several treatment options. I think our problem with TB in the Cape is that (health providers) want to dictate to patients, and nobody wants to be treated like that! There is a certain degree of independence that every human being requires. But as far as TB is concerned, there is no trace of independence. Patients are told what to do and they have no choice."

Even within a rigid treatment regimen, it is possible to allow a measure of flexibility, but

"nurses want to control patients, rather than to allow patients to take control of their own lives. Patients need to feel a sense of independence and unless nurses can acknowledge this we will never find a solution to the problems with compliance."

Patients would gain some measure of control if they were allowed to take their tablets at night in order to avoid the worst side effects during waking hours, or to continue taking their medication over weekends.

According to Sylvia, the tendency of nurses to control patients, has at its root the lack of power that nurses experience in the hospital setting where doctors are always in charge. At clinics nurses have much more authority in terms of day to day decision making. To add to this, primary health care services are in the process of reconstruction and there is considerable

conflict about power and control. Whereas hospital staff are more likely to be moved between wards, the staff at local authority clinics could be stationed at one clinic for many years, as long as 20 years in some cases. She described a past experience which illustrates her point:

“The nurses who worked at X were terribly set in their ways and I was never accepted as one of their group. I was seen as an outcast because I spoke up when I differed from them and refused to fall in with some of their routines. But someone who is not strong enough to resist such peer pressure would simply fall into the same pattern. This is really a management problem. Nurses are allowed to work in the same clinic for too long and then they get totally relaxed in this comfortable zone; they become slack and lose all initiative and drive. The biggest problem is that they lose perspective on why they are there in the first place: to inspire TB patients so that they find the willpower that is necessary to get well again”

Sylvia sees patient support as the essential element and the most important role of the nurse in “patient motivation”:

“The treatment in itself and on its own is no motivation: in order to drink those pills every day of your life for six months on end and to cope with all the side effects and the disruption it causes in your life is very hard. It is unbelievably difficult, and when you start feeling better, you are so relieved that you feel like ending the treatment. That is when you need someone to help carry you to the end of treatment. If you have nobody to support you, you are doomed to fail.”

Discussion

This material is extremely rich and could be analysed on a variety of levels. I will focus on two areas, firstly the intrapersonal level, and secondly, the interpersonal domain where I distinguish between Sylvia’s perceptions of relationships between nurses and patients, relationships between nurses and relationships between nurses and doctors.

The intrapersonal level

It is interesting that it was Sylvia’s vulnerability to personal illness which attracted her to a career in nursing in the first place. Her dream was that once she was knowledgeable and skilful

in the art of healing, she would be able to heal herself and her immediate family. Her strong sense of responsibility was reinforced by the experience of being the eldest child in a family who suffered from mental health problems. This explains her emotional investment in the nursing profession. The reparative wish to be a member of a helping profession has been described in the psychoanalytic literature. Zagier Roberts (1994b, p 110) explains that many people are drawn to the caring professions because they have a need to put something right. The reparative wish, which may be only partially conscious, "arises from guilt or concern, and its aim is to heal emotional wounds: one's own, and those of the damaged figures of one's internal world" (Dartington, 1994, p 106). This is confirmed by literature reporting on the underlying motivations of those who are attracted to psychotherapeutic work (Dale 1997). The presence of a psychiatrically disturbed relative and feelings of guilt or anger towards that relative were found to be associated with career choice among a group of mental health professionals (Krenek and Zalewski, 1993).

The concept of the wounded-healer archetype provides a Jungian perspective on career choices. I quote from Guggenbuhl- Craig :

"The image of the wounded healer symbolizes an acute and painful awareness of sickness as the counter pole to the physician's health, a lasting and hurtful certainty of the degeneration of his own body and mind. This sort of experience makes of the doctor the patient's brother rather than his master. Everyone has within him the health-sickness archetype. But it has a very special fascination for the physician with a true vocation. That is why he chooses the medical profession. For a great variety of reasons those men and women who choose a career in medicine are attracted by the healer-patient archetype. Very often, however, the burden is too great and the pole of sickness is repressed. But if he is capable of experiencing the sickness as an existential possibility in himself, and integrating it, then the student becomes a true wounded healer." (Guggenbuhl- Craig, 1971, p 97)

People who choose a career in medicine or related professions are attracted by the healer-patient archetype, but not all of them are strong enough to continually experience both ends of the polarity. For instance, those who repress their woundedness feel that they are secure and in a different world from their patients. They become "only-healers" and their patients are "only-patients". Guggenbuhl- Craig suggests that the healer-patient archetype has a hidden power. Power in this instance is defined as subject-object relationship in which there is room

for manipulation of one party by the other. Illness can reduce a healthy adult into a helpless child. In such a situation the doctor becomes the source of help. This can lead to the polarity with the childish fearful patient at one end and, at the other, the superior aloof physician. It is the healer within the patient which is needed for healing. He suggests that there is no special healer archetype or patient archetype; both are aspects of the same archetype (p 92-97).

Guggenbuhl- Craig's concept of the wounded healer archetype provides a useful way of looking at healers and patients in general. These inner processes may possibly be heightened in people like Sylvia who experienced acute or chronic episodes of illness.

Recently the concept of the wounded healer is introduced in stress relief programmes aimed at preventing burn-out in nurses. Hall (1998) notes that nurses who sustain satisfying relationships with patients seem to resist burn-out. She has the following to say about the "nursing culture" (Hall, 1998, p 25):

"The pattern of the wounded healer indicates that failure to balance wounding with healing can lead to a number of manifestations which in essence act to separate nurses from each other and their patients and to impede healing. This can include the erection of defence mechanisms that prevent nurses from becoming involved and hence vulnerable. Staff in this situation cannot admit that they are wounded and so find change unnecessary or threatening. This state of defence may well be an inherent part of nursing culture".

The interpersonal level

In this section I discuss Sylvia's professional interaction with others, namely with patients, nursing colleagues and with doctors. However, these different levels overlap considerably and it is not possible to separate them neatly.

Interaction with patients

Sylvia's tendency to identify with patients, to the extent of crying with them, has never been blunted by the institutional mechanisms in nursing which accentuate the distance between nurses and patients. She firmly places herself in a different category to the theatre nurse who prefers to work with anaesthetised patients that they do not have to talk to (Sullivan, 1986).

(For a full discussion of these mechanisms such as rigid hierarchies and an emphasis on task centredness, see Chapters 1 and 5). She consciously sought out work situations which would require personal contact with patients. A Canadian study of nurse-patient interaction uses the concept of “connected relationship” to describe situations in which the nurse sees the patient first as a person, and second as a patient. These nurses tend to intercede on behalf of a patient with family or medical staff (Morse, 1991). The ways in which patients actively tried to trace Sylvia after she had left a previous workplace, confirm that they valued their relationship with Sylvia.

Interaction with nurses

Sylvia’s conscious choice of nursing was based on idealism. She believes passionately in the caring values of the nursing profession, yet these very values have led to painful confrontations with her nursing colleagues. Even before her most recent illness experience, she had found herself at odds with her peers when she failed to toe the line in terms of practices which she regarded as unfriendly to patients. As a result of her critical stance she felt like an outsider; a status which she accepted as inevitable. Nevertheless she remained loyal to “professional values” in nursing, even to the extent of nearly cancelling the interview because she felt it would be unprofessional to express “derogatory” feelings about the system. But in the end, her decision to voice her criticism won the day, because she hoped that others would benefit from her experiences.

Her experience of being a TB patient has left her with a sense of disappointment about the ability of nurses to care for individual patients. Her analysis of the underlying reasons for the routinised and distanced practice of nurses corresponds remarkably closely with Menzies’s theory of defences against anxiety (1960). Taken literally in Afrikaans, the image of being “blootgestel” to a patient’s emotional state, means to be standing face- to- face with the patient, naked or exposed, stripped of all protection. The nurse’s boundaries are shielded by her uniform, her professional status which is signified by badges and epaulettes, equipment such as thermometers and stethoscope and the numerous pieces of paper on which she records details pertaining to the patient. But Sylvia is saying that the nurse feels the need to shield herself against emotional invasion. This the nurse does by focussing exclusively on the

paperwork and the mechanics of “running the clinic”. It is safer for nurses to acknowledge the control of disease and the germs, than to open themselves up to the illness experience and the human needs of the person. She feels that nurses are not “strong enough” to provide the emotional support that patients require. In my understanding, drawing on Guggenbuhl-Craig’s concepts, the inner strength that Sylvia refers to here, is the vulnerability to be more than only-nurse; to acknowledge her own lack of power to cure the patient. For that to happen the nurse would have to awaken the healer or healing power within the patient, thereby giving up some of her own power.

According to Sylvia nurses resist changing longstanding work practices because they feel comfortable with the present routines. This resonates with Bion’s description of basic assumption behaviour in teams (Stokes, 1994). When the main purpose of workers is to maintain a working pattern which provides them with the necessary buffers against anxiety, they lose sight of the primary task of the institution, in this case, to provide a service which effectively curbs the TB epidemic.

Interaction with doctors

Sylvia has ambivalent feelings about the medical profession. She has idealistic expectations of the clinical expertise of doctors to accurately diagnose and cure patients in a way which is also humane and respectful. Yet her experience of being a patient has made her angry and highly critical of doctors. She had experienced inadequate physical treatment as well as the humiliation of not being listened to. This was particularly painful, because of her insider status as a health professional and close colleague. This needs special attention, because she felt that it was precisely because of her status as a nurse that she was not taken seriously by medical doctors. In order to unpack the complexities in this situation, I will discuss two overlapping issues: how do doctors and nurses relate to each other, and how do doctors perceive sick nurses?

Much has been written about the power and gender relationships between traditionally male/ doctors and female/ nurses (Andrews, 1991; Littlewood (R), 1991; Samuelson, 1991). Efforts to professionalise nursing has been one of the most important strategies followed by modern

nurses in order to exert a separate domain and to strive for independence from the medical hierarchy. Sylvia found that the field of public health presents opportunities for nurses to operate more autonomously, away from the “medical gaze” which is much more of a presence in curative health care settings. This could be a strong motivation for nurses to choose careers in public health settings. A psychodynamic explanation for the difficult doctor-nurse communication in teams, points to the splitting between paternal and maternal functions (Hirschhorn, 1988). In the dyad of dominant, intellectual doctor and emotional, nurturing nurse, the patient is equated with a child. However, according to Moylan and Jureidini, (1994, p 237) the “parents” fail to operate as competent professionals, because they act out stereotypic roles:

“Perhaps the frequent inability of doctors and nurses to work together as ‘whole objects’ expressed the need to avoid the pain that love would bring in this setting. Instead of communicating as a professional ‘couple’, the staff find themselves acting out these stereotypical roles with the resultant rigidity causing them discomfort and hampering their creativity. The male/female split is facilitated by the patients who tend to see doctors and nurses in stereotyped ways and develop paternal transferences to doctors and maternal transferences to nurses. It is further facilitated by the very real differentials in power, status and financial reward between the two professions. As individuals, they did respect and admire the skills of other individuals, but as groups of professionals, they would deny the contributions of the other profession, while complaining bitterly and demanding a contribution. Somehow the blamed profession colluded, feeling both guilty and misunderstood”.

Given this age old struggle between the two professions who share the same workplace, it is little wonder that the mistrust and rivalry would be carried over to a consultation between a doctor and a sick nurse. The concept that nurses are “difficult patients” is quite familiar to me and is often discussed among both nurses and doctors. Nurses feel “on the spot” when they have to care for a member of their own profession, especially if the nurse requiring care is in a senior position. They feel as if the quality of their work is continually under scrutiny. Consequently these patients are often avoided as far as possible and may end up receiving inadequate care. Nurses who are admitted to hospital, even for quite normal procedures such as childbirth, often prefer not to reveal their professional status, because they want to be treated “normally” and not with kid gloves. In Sylvia’s case, she was treated by her closest

colleagues. Their seeming indifference added to her feeling of isolation. It is remarkable that both doctors and nurses would accept the role of caring for their close colleagues without questioning the ethics of privacy. This seems to be part of the biomedical denial of the emotional aspects of illness. In psychotherapy where personal boundaries are held as sacred, it would be unlikely that a mental health professional would enter into therapy with a close colleague.

Sylvia constantly felt that the onus was on her to “prove” her illness to the doctors. She suspected that she was being regarded as a malingerer who wanted to shirk her duties. Regardless of her years of experience in the field of TB, she did not want to appear “too clever” because that might offend the doctor’s sense of superiority. Given their position of relative power over nurses and their reliance on nurses as a workforce of doctors’ assistants, doctors could feel manipulated by “clever” nurses who have access to the specialised knowledge of health care providers and who could abuse this privileged knowledge in order to get sick leave. When doctors fail to make sense of a set of signs and symptoms and cannot make a straightforward diagnosis in patients who consistently return to them, they suspect the possibility of “factitious illnesses”. These illnesses are divided into malingering (a consciously motivated fabrication of symptoms) or hysteria (in which case the patient is mostly unaware of producing the symptoms) (Littlewood (R), 1991, p 159). Littlewood argues that doctors have diagnosed the following psychopathologies more often in nurses than in other people: loin pain haematuria, Munchausen’s syndrome and mass hysteria. All of these differ from other more “transparent” forms of neuroses such as agoraphobia, in that they follow a biomedical pattern. According to Littlewood, it is easier for non-health care providers to express personal distress. Health workers are too much identified with being healers to be able to express distress. Therefore they may take extraordinary measures in order to gain access to care.

To conclude the discussion on Sylvia’s perception of the role of doctors, a last observation on her reluctant but realistic conclusion: In the end doctors too are only human, therefore it may be better to “drop expectations” of their ability to provide “all the answers”, or to cure every ailment. This idealism is part of the unconscious omnipotent fantasy which has been described among many who choose careers in the helping professions, yet in many therapeutic relationships the idea of curing the patient is inappropriate. In a discussion of psychotherapy Guy (1987, p 88-89) remarks that it is often the patient’s idealisation (and expectations) that

casts the therapist into the role of “saviour”. This may in turn lead to a sense of omnipotence and grandiosity in the therapist. This could hinder effective treatment in several ways, one of which is that the therapist may feel hesitant to destroy the patient’s expectations and disguise the limitations of the treatment. In Sylvia’s situation, her realisation that doctors are fallible too, was the start of having to confront a prolonged period of coping with a chronic disease.

A note on methodology and the research process

This case study raised several issues on a methods level. I was faced with the choice of letting the material speak for itself, or to embark on a process of theoretical sampling (Henwood and Pidgeon, 1993, Hammersley and Atkinson, 1992, Strauss and Corbin, 1990) in order to seek out further cases of nurses who have contracted TB. I was reluctant to embark on a quest for comparisons and to a large extent I agree with Cottle’s assertion in that I believe that

“at certain times one must speak about the few (..) one knows and no one else, and refrain from comparing them with their age counterparts someplace, or even with other families in their own neighbourhoods. For in the comparison process one can too easily lose an appreciation for the single human being who stand before us, the knowledge and the feelings of the person, and the glory that must be that person’s history and future.” (Cottle, 1991, p 128)

In the end I decided to search for more cases, not primarily for reasons of checking the representativeness of Sylvia’s case study, but to study how nurses from different cultural backgrounds and work situations would perceive the experience of “crossing the line”. I sent a letter to the heads of all the nursing departments and training centres in the Western Cape, with an invitation to nurses who had become infected with TB and who would be willing to be interviewed about their experiences to contact me.

From the responses that I had, two nurses were willing to be interviewed. The discussions differed from my encounters with Sylvia, in that they were briefer for reasons of time constraints by the respondents. In addition, the discussions were initiated by me and although the respondents were willing to talk about their experiences, they did not have the same pressing need to talk that Sylvia had. In Part Two of the chapter I report on one of these interviews. I choose this particular interview in order to portray both differences and similarities between the two respondents.

Part two: fear of patients

Anna's illness experience

“Anna” is a 35 year old coloured professional nurse who works at a public health centre in one of the large metropolitan areas of the Western Cape. She responded to my written invitation and I interviewed her in my office just a few weeks after she had completed her treatment for tuberculosis. She is married and her youngest child is 4 years old. Anna has had at least 15 years of experience in working with TB patients, both in tertiary care hospitals that specialise in the treatment of seriously ill TB patients and in primary care settings. She is one of the many nurses who deal with the day to day routine of keeping the health services going and who still have the energy and drive to improve their qualifications by following in-service extra mural courses.

During the previous year Anna had completed such a course in community health nursing. It was during a particularly stressful period of writing examinations that she had several episodes of bronchitis. A persistent cough which she could not get rid of, prompted her to collect a specimen of her own sputum and to send it off to the laboratory for a TB test. This was something that she did every year or two as a precaution. One month later, while she was going through routine laboratory results at the clinic, she discovered her own name on the list of those who had tested positive for tuberculosis.

“When the post came, I went through the results to sort them into those who are already on treatment and new patients. On that day there was only one positive result and when I saw the name I couldn't believe my eyes. It was on a Friday afternoon and I was quite shocked. I walked around with it, trying to decide whom to talk to first. Nobody knew that I had sent in the specimen. In the end I decided to call the TB doctor”.

At the time when the positive result came she was no longer coughing, but when she checked, was surprised to find that she had lost 3 kilograms of weight. Her initial reaction was one of shock. How could it happen to her? Next, she started to worry about the type of TB: at the

clinic where she worked there were many patients who were resistant to TB drugs. Would her TB be drug resistant?

“I suppose I am used to working with TB patients, but it was a shock to see my own positive result. And once I got over that, I started to worry about the sensitivity tests. There was some confusion with the lab results and the first results showed that I responded to only one drug. That was a tough time for me to get through.”

However, after several more tests she was reassured that the routine drugs would be effective.

She was surprised at the severity of the side effects of the medication.

“This experience has given me tremendous insight in what patients go through. In addition to the nausea, you feel drowsy and listless and all you want to do is sit down.”

Fortunately one of the doctors suggested that she take her medication at night, and that made a difference. Anna was given a month's supply of medication at a time and she was trusted to take it without having to be directly supervised by a nurse. The length of the treatment was difficult to endure. She had often motivated patients to continue until the end, but found it surprisingly difficult to comply with her own treatment:

“it was like a ball and chain attached to my leg which controlled me. I now have a lot of sympathy for TB patients, especially for parents who have to bring small children for treatment every day. Often those children are not really sick - they are bright and playful and I can well understand that a mother may decide it is not important to bring such a well child in regularly.”

Anna experienced the stigma attached to the illness at first hand. She was particularly sensitive to remarks by colleagues at work.

“I suppose one is a bit over sensitive. For instance, on the day that I heard about my result, a woman at work said: ‘Don't stand so close to me, I have small kids at home!’ I was not supposed to react like that, but that really made me feel bad. And then you begin to notice all kinds of things. One day I noticed that no one used the glass that I drink from at work. I didn't

expect such behaviour from trained health workers. This makes you aware of the trauma that patients go through out there...”.

Anna confronted the situation assertively.

“I told them: We work with TB patients every day. I am the unlucky one who got it, but it could have been anyone of you. I don’t think it is fair of you to make me feel like an outsider!”.

Some of her colleagues tried to hide it from her when they had X rays taken because because they were TB contacts. They did not want to upset her. She found it difficult to cope with peoples’ reactions to her illness:

“Some showed too little concern, while others went over the top. Some people felt very sorry for me, to the extent of crying when they found out about the results.”

Such a response, she felt, was not really appropriate. On the other hand, she also found her husband’s matter of fact response disturbing. He simply asked whether she was “all right”, and

“when I said yes, that was the end of the story. One would like to be pampered a bit. I had one colleague who hugged me in the mornings and asked how I was doing. That made me feel like crying.”

Anna spoke at length about her fear of becoming re-infected. For the first time in her career as a nurse she fears for herself. This makes her feel angry and impatient with patients whom she describes as being wilfully or intentionally non adherent to treatment (“die opsetlikes”). She described her tendency to withdraw from such patients because she feels that her own illness had made her vulnerable:

“I’m not over it yet. I am still angry with them because they are to blame for the MDR’s (multi-drug resistant patients) which is my main concern. I stand back from them because I may lose my temper.”

She recalled the example of a patient who absconded from treatment for three weeks. When he returned he said he went to another town with his friends.

“He simply returns as if nothing has happened”.

She feels that should she communicate with this patient, she would be “exposing” herself or opening herself up. She prefers to avoid him, rather than to say to him:

“It is because you do not take care of yourself and you mess around that you get TB. That is why you endanger us...”.

She would prefer to leave him to her colleagues to deal with. Whereas before her illness, she would perhaps have found excuses for his behaviour, she now feels that he is wilfully irresponsible.

“The TB education is excellent. They are adults, and before they go on treatment they are told what to do. Nobody can say that they do not know or understand why the treatment is so long. They are intentionally neglectful.”

While Anna told me of her feelings, she remembered that her mother became angry long before she did. At first she could not understand her mother’s vehement reaction.

“After all, TB is not something unknown to my mother. She knows others who have had TB. There are two people in our own family who have had TB .. those two are also irresponsible ones...”.

Anna’s mother was looking for someone to blame for her daughter’s illness and she spoke about wanting to take the health authority to court. Anna realised that she, like her mother, had now reached a stage where she was

“angry and impatient with people who simply wouldn’t listen and follow orders”.

Discussion

Having worked in TB hospitals, Anna has had more direct contact with TB patients than most of her other colleagues. She must have considered the possibility of becoming infected, otherwise she would not have sent off her own sputum to the laboratory. Yet she was emotionally unprepared for the shocking experience of crossing over to “the other side”. Her image of herself as the strong and practical nurse who can deal with difficult situations had

been shaken by this experience, to the extent that she no longer felt able to cope with TB patients. She felt vulnerable on two levels. Firstly there is the fear of being re-infected, at worst by a patient who carries the dreaded drug resistant version of TB. Secondly, she feared the emotional contact with patients which would trigger her own anger at those who “willfully” put others like herself at risk. Prior to her illness her professional standing had offered her some protection against patients (with their germs and their deviant behaviour). Now she has had the experience of entering their world and she feels closer to where they are. I suspect that this new awareness will make it hard for her to carry on as before.

Being on the other side has brought her a new awareness and a sense of identification with the burdens of being a patient, for instance the side effects of medication, the length of treatment and the social stigma attached to the disease. There is a naive assumption that “entering the shoes” of patients would lead to enhanced feelings of empathy and therefore equip health care practitioners to improve their capacity to care and to facilitate healing. This well known assumption informs the training initiatives that are commonly used as a basis for experiential learning in groups. But Anna’s response to the reality of being ill, not to a simulated illness experience, has rendered her less rather than more tolerant towards TB patients. This perception may change over time, once she has had more time to work through her own feelings, or it may solidify during her ongoing and inevitable contact with TB patients.

Conclusions on “crossing the line”

What do Anna and Sylvia have in common? Despite the fact that they are both professional nurses in the public health sector who became infected with tuberculosis, their illness experiences have been starkly different. Anna had a more common type of TB which was diagnosed early on and responded along fairly predictable lines to medication. Her relationship with doctors in the health service seemed amicable. Her treatment regime was negotiated with her and flexibly managed and she responded well to the treatment. Sylvia had a much more painful illness experience. Despite these differences there are some commonalities.

The two case studies have shed some light on how difficult it is for nurses to enter the “kingdom of the sick” (Sontag, 1978, p 8). It is paradoxical that while they spend much of

their working hours in close proximity with the sick and weak members of society, they believe that they, as individuals are quite invincible: nurses cannot get sick like other people. Their sense of shock and disbelief seems to indicate a form of omnipotent denial and perhaps their extreme reaction to being ill indicates a shattering of the illusion and the fantasy that there are two distinct worlds, the world of the well and the world of the sick.

In these cases though, the nature of the illness adds a further complication. Despite its status as the fastest spreading and the biggest threat to public health in South Africa, tuberculosis is not a “respectable” condition. It remains a disease of the poor and the socially disadvantaged, and, at least in the eyes of most nurses, a disease that target those who are “uneducated” or “irresponsible”. These notions may make it particularly difficult and embarrassing for nurses to accept the diagnosis of TB. They had assumed that because they were nurses they “had all the knowledge”. They now had a new awareness that knowledge does not necessarily offer protection against this illness.

Both nurses felt that the experience of crossing the line had changed the way in which they relate to patients. Sylvia’s illness experience had lead her to empathise strongly with patients and had encouraged her to advocate patient centredness. Anna, on the other hand, was left with fear and anger towards patients. It is important to pay closer attention to the socio-political context in which these nurses operate. Anna is coloured nurse who works in a health centre situated in a coloured community. She closely identifies with the patients. Two of her family members have had TB and were also labelled as being “willfully irresponsible”. While Sylvia felt protected by her colour boundary, she could move emotionally closer to the life world of patients. Added to this, her prior experiences with being at the receiving end of health care may have contributed to her emotional identification with patients and their rights. Anna’s identification with the social reality of patients does not allow such protection, it leaves her feeling exposed and vulnerable, hence her wish for withdrawal and for reinforcing the boundaries between herself and TB patients. It seems as if the customary devices such as privileged knowledge, status and uniform no longer provided a good enough border between the two worlds. This data suggests additional evidence for the “too close for comfort” hypothesis which was developed in Chapter 7. However, given the small number of respondents, I would like to explore these issues in further research geared towards negative case analysis.

In Chapter 6 I have discussed the notion of containment as the capacity to think and to learn from our experiences (Emanuel, 1992). When our emotions feel too powerful for the internal container we require external containment in the form of someone to talk to. Health care practitioners who receive this kind of anxiety from patients experience a particular form of counter transference. They are called upon to contain the feelings of patients. In order to do this they need to hold the feelings in “reverie” in order to transform and modify them before handing them back to patients at the appropriate time.

It seems that many who choose to perform caring roles do so from an unconscious reparative wish to cure, precisely because their own emotions have not been optimally contained. The development of the capacity to contain is an ongoing experience. It seems as if most nurses find it necessary to behave like a communication rejecting container by not allowing the patient’s emotions to impact on them. In order to fulfill the traditional (task- centred) role in a TB clinic, a nurse has to fully believe in the clear cut rules and practices. Her task is to “motivate” and convince patients to comply with treatment. If she pays too much attention to patients’ complaints about drug reactions, if she allows too much flexibility she may lose control of this process. What really counts is to watch patients swallow their tablets. This is perhaps one of the reasons why nurses may turn a deaf ear to complaints, or why they may tend to focus on the folder rather than on the face of the patient. As we have seen in Chapters 4 and 5 this behaviour protects them from having to respond to the emotions of patients.

Despite the rising incidence of TB and increased pressure on personnel there is no institutional support for nurses who become infected with TB. It is clear that in situations like these staff need support from others to contain their own anxieties. The absence of support and the acceptance that staff can be treated routinely and by their own colleagues, sends out the message that in order to cope with the situation, nurses have to resort to extreme defences in order to protect themselves.

In summary, this chapter focussed on the illness experience of two nurses who crossed the fragile boundary that separates health professionals from patients. Despite their very different experiences both nurses found it hard to be “on the other side” and to realise that their particular knowledge and professional status did not equip them adequately for the patient role. The case studies enabled me to reflect on the intrapersonal and interpersonal processes that influence nurses and patients.

Chapter Nine

Summary and conclusion

In this final chapter I provide a summary of the research process. This is followed by a summary and a synthesis of the main findings. After discussing the implications and the possible implementation of this research, I reflect on the research methodology and the need for further research.

Summary of the research process

The five tables on page 145 provide a condensed mapping of the research process by highlighting how the iterative manner in which exploration of the original research question led to a finding which, in turn, raised a further research question and sub-study. In addition, the map signposts the literature and theories which informed the process. I now summarise each research cycle on the map.

1. How do nurses interact with TB patients?

The first research cycle originated from this question. I used participant observation to study the work of nurses who treated TB patients in a community based health centre. Additional data were collected by means of depth interviews. The findings revealed a work pattern of task orientation. The nurses were frustrated and angry with patients whom they perceived as irresponsible and likely to be non-compliant. This work is described in Chapter 4. It was informed by a literature review of compliance to medical treatment.

2. What are the origins and history of task orientation?

The second research cycle investigated the concept of task orientation. I interviewed two key informants whose nursing careers spanned the period between 1935 and 1975 and I drew on my own experience of nursing. After observing the practice of two nurses, one patient-centred and the other task-oriented, I conducted interviews with them in order to describe their perceptions on their own work patterns. I found that task orientation is deeply rooted in the British and South African history of nursing practice. For this work I reviewed literature on Taylorism, the nursing process and administrative work in nursing which I term "paperwork".

3. How do nurses respond to an opportunity to change their practice?

During the third research cycle I investigated the response of nurses to a training experience which presented them with an opportunity to change the way in which they work with TB patients. I interviewed nurses before, during and after the training and observed their work with TB patients. There were two different responses to the training course. One group of nurses took the opportunity to change their practice from task orientation to a more patient centred approach. The other group maintained their task orientation. I term their response to patient centredness "too close for comfort". The interpretation of this work was informed by psychodynamic theory from the work of Bion, Menzies-Lyth and Obholzer and his colleagues.

4. What is the meaning of "too close for comfort"?

The fourth research cycle explored the concept in more depth in an attempt to examine an emerging hypothesis by means of a process of analytic induction. The research methods used here include a reflection on personal experience, key informant interviews with nurses and non-nurses in order to check the hypothesis, the use of literature on intercultural work, discourses on coloured identity, and a review of psychoanalytic theory on countertransference. There was evidence to support the hypothesis that feelings of being "too close for comfort" can influence the nurse-patient relationship. Related factors are the history and practice of apartheid, racial identification, power relations and work pressure.

5. What do nurses experience when they become TB patients?

Unlike the previous research cycles, this one was not directly generated by the previous cycle, but was prompted by the unforeseen encounter with a nurse who had contracted TB. Data were collected by means of interviews. The illness experience of nurses reveals unanticipated shock and vulnerability, a disillusion with the medical profession, a changed viewpoint on relationships with patients. The literature reviewed includes career choice in the “helping professions” with reference to reparation, omnipotent denial and containment.

Table 3: Summary of the research process

1. How do nurses interact with TB patients?

Method	Finding	Literature
participant observation interviews	task orientation, frustration, anger.	compliance with therapy

2. What are the origins and history of task orientation?

Method	Finding	Literature
interviews and observation personal experience	deep tradition in nursing	Taylorism, nursing process, paperwork

3. How do nurses respond to an opportunity to change their practice?

Method	Finding	Literature
interviews before and after training participant observation	two responses: * too close for comfort * a safe distance	psycho-dynamic theory: Bion, Klein, Menzies- Lyth, Obholzer

4. What is the meaning of “too close for comfort”? (TCFC)

Method	Finding	Literature
reflection on personal experience hypothetical reasoning key informant interviews	TCFC can influence nurse- patient interaction related factors: identity, apartheid, power relations, work pressure	inter-cultural work and shame discourses on coloured identity counter transference

5. What do nurses experience when they become TB patients?

Method	Finding	Literature
interviews	specialised knowledge offers no protection against shame and shock changed relationships with patients: more empathy or fear and anger (confirms TCFC) disillusion with medical profession	psycho dynamic theory on career choices: reparation, omnipotent denial containment

Reflection on the research methodology

In this section I reflect on the methodological choices that I have made and the uncertainties that remain with me at the end of this journey. I do this by considering the limitations of the study, the choice of the research topic, and reflections on the research design.

The limitations of this research

The qualitative research described in this thesis provides an in depth analysis of the work patterns of a small sample of nurses who work in a particular context. The question as to whether qualitative research is generalisable has been hotly debated (see Guba, 1981; Johnson, 1997; Morse, 1997; Sandelowski, 1986, 1993, 1995). Following Morrow (1994), Johnson (1997) points out that

“Rather than framing the argument on two different kind of techniques (qualitative or quantitative), it is perhaps more appropriate to consider whether research is directed toward nomothetic explanations or idiographic interpretations. The idiographic approach assumes a unique case or limited set of cases as the unit of the analysis, and is primarily concerned with interpretation and meaning. In contrast, a nomothetic (interpretation) focuses on more representative samples and the degree to which the findings are representative of a particular sample, and is concerned with explanation (pp 201-202).

I would like to see my work as idiographic. It aims to enrich understanding, and yield new insights. Rather than claiming that the findings apply to other groups and other settings, I hope that it would assist the readers to move “beyond knowing to understanding” (Vendler, 1984 as quoted by Johnson, 1997, p 202), and that the thick description would enable the readers to judge its applicability to similar contexts. As a starting point, the practical applicability will be assessed further through the intervention described at the end of this chapter under the heading of “Implications for change”.

The topic: too close for comfort?

“If the researcher is changed in some way during the process of qualitative research, it is an indication of a successful research project” (Meulenberg-Buskens, 1991).

Soon after embarking on this research I realised that I have an intense personal involvement with the topic. My crude and somewhat judgmental original question “why are nurses so rude to patients?” reflects a personal quest which remained with me long after I left the nursing profession. Over time this question was refined and developed into the provisional problem statement which is described in Chapter 3, and I feel that the research process has changed my understanding and perceptions of nurses’ behaviour towards patients.

While writing this section I was surprised to find a different application of being “too close for comfort”, the term which I have used to describe one of my major research findings. Friedman (1991, p 113-119) uses the term in relation to researchers’ feelings of personal involvement with research participants. These feelings of identification can be seen as positive. This can be compared to Glazer’s use of the concept of “compassionate analysis” which “in combination with a researcher’s determination to understand, often results in rare analytical insights” (Glazer, 1980, p 31). At the start of my research I was aware of feeling more compassion for the patients than for nurses. As the research progressed and I developed an insight into the complexity of nurse- patient interaction, I could let go of my previous prejudice. I now think that my original feelings of prejudice originated from being too close for comfort, too closely identified with nurses, and therefore ashamed of their behaviour. My involvement in this research process has enabled me to adopt a more balanced and nuanced stance towards nurses.

The rule breaking principle

The main aim of this thesis is to develop an understanding of how nurses work with TB patients. I have described the ways in which nurses have organised their routine working patterns. The overall pattern is characterised by task oriented care giving, an organising principle which has deep roots in the history of nursing and which has been maintained over many decades despite some attempts to change it. In order to understand why nurses prefer to uphold task orientated working patterns, I have studied several instances where the prevailing

culture was threatened by organisational change or by a reversal of routine situations. The rule breaking principle, also known as the notion of disrupted social order, is a well known concept which is used by ethnomethodologists to study patterns of work (Garfinkel, 1967; Lawler, 1991). This has made it possible to study the responses of nurses when they are in unfamiliar situations. For instance, when “crossing the line”, instead of being the care givers, the nurses were in need of care. As a result of the changed role it was possible to focus on those role expectations that are nearly invisible because it is accepted in such an unthought through manner, taken for granted. The old Chinese saying, a fish doesn’t know the water that it swims in, is another way of making the same point. Another example is the case study of the nurses’ response to the training intervention aimed at better case holding. In this particular study the difference in the way that two groups of nurses responded has provided a means to investigate the influence of colour and identity on nurse behaviour.

Research approach

The choice of a number of data collection techniques - all within the qualitative paradigm - has enabled me to describe and interpret the ways in which nurses interact with TB patients. The flower shaped research design described in Chapter 3 has been useful, in that each phase of data collection was followed up and informed by the analysis of the previous data collection cycle. I was able to triangulate between different data sources, for instance observations and interviews.

Looking back, I realise that the collage-like use of different techniques and theoretical applications during the different stages of the research can be compared to Levi-Strauss’s term *researcher-as-bricoleur* (1966, p 17). Seen in this way, qualitative researchers shape the tools of their methodological trade through the strategic use of strategies, methods or materials at hand. The choice of research methods depends on the research questions, and the questions depend on their context (Nelson et al, 1992, p 2). Thorne et al (1997) argues that methodological variations are essential when practice knowledge questions are posed for developing nursing knowledge, since the more traditional qualitative approaches (ethnography, grounded theory and phenomenology) were not designed with a practice orientation.

Two patterns of interaction

In this section I summarise task orientation and patient-centredness, the two main features of nurse-patient interaction which I have identified.

Task orientation

At the outset of this study I regarded the way in which nurses interact with patients as impolite and harsh. From my experience as a nurse I was aware that nurses became socialised into this behaviour pattern, but I could not understand why most nurses adopted it so readily. The observation of the way in which nurses organise their work has enabled me to describe the task oriented manner of dealing with patients in a TB clinic. This is similar to the way that nurses manage their work in hospital wards. The underlying motive for choosing a task oriented way is to get on with the task at hand without having to cope with pain and anxiety of accommodating the emotional component of illness. Early on during their training nurses are taught by their peers that there is no place to talk about their feelings. It is also best to avoid getting involved with the feelings of patients. This unwillingness to acknowledge patients' feelings is not based on cruelty but on the inability to cope with them. Nurses are taught to "reassure" patients when they are distressed. Another task of the nurse, very pertinent to TB care, is to "motivate" patients. One of the insights that the nurse who "crossed the line" had, was that motivation meant "being heard", being able to talk about your feelings of fear and anxiety and hopelessness, and of having someone in the health service to accompany you on this long journey to recovery.

Patient centredness

Despite the dominant practice of task orientation, there is evidence that some nurses who, while working in the same context, focus on the individual patient rather than entirely on the task at hand. I think there are few nurses who would fall into this category. Why? Have most of them left nursing because they became disillusioned and could not be "themselves"? Is this a personality trait? Is it an escape from the peer pressure of fit into a behaviour code and a belief system that patients are different from yourself and you need to mistrust them and not treat

them like equals? If this was true, it would mean that a substantial number of nurses who enter the profession are potentially patient centred. They come into the culture of task orientation and they either sink or swim. Sinking means leaving and it is true that there is a high attrition rate among student nurses. I have not explored these questions in this thesis, but they are pointers for further research.

Synthesis of research findings

How can the findings from these various sub studies be drawn together in order to shed light on nurse behaviour? In the following section I summarise the findings under the following headings:

- * the interpersonal domain: nursing practices and patient responses
- * the intrapersonal domain: underlying beliefs and feelings
- * the dynamics of the workplace

The interpersonal domain

Let me recap the situation in the TB clinics observed during this study. Patients queue up and move from one service point to the next for a series of impersonal interactions with nurses. A nurse takes a history by eliciting yes or no responses which she records on a form. The patient is sent off to a series of other nurses in order to obtain an X ray, a urine test and sputum tests. On the patient's next visit to the health centre the doctor examines the X ray, confirms a positive diagnosis of TB. A nurse asks the patient to swallow a handful of tablets and tells her that she has to come back every day for six months to take the pills at the clinic. There is little eye contact and most interactions with patients are in the form of questions or instructions or reprimands. The attention of the nurse is focussed on paperwork in various forms and on conducting the flow of patients through the system. How do nurses and their managers justify task orientation? The more senior nurses prefer it for the purpose of organising a smooth flow of work and to maintain maximum control over the performance of nurses down the hierarchy. This gives them a sense of control over the work situation.

Many patients respond with passive aggression. The majority comply for the sake of getting the treatment in order to become cured. Perhaps a number of these patients comply in the hope of being rewarded with a welfare grant or food parcel. The majority of the patients remain

submissive. A substantial group of patients, approximately 40% (Weyer, 1997), respond by defaulting from treatment.

The intrapersonal domain

The various sub-studies have attempted to shed light on this domain by seeking to understand the conditions that inform the behaviour described above. Why do nurses maintain task orientation? How do they feel about their work and about TB patients? Are they angry with patients and with the system of care? What are their fears and anxieties?

It is likely that some people who choose nursing as a career have a strong reparative wish to contribute to helping to set right the ills of humanity. Ideally these wishes can be fulfilled if there is a receptive patient who has a condition that will respond to a well known cure. Tuberculosis falls largely outside the sphere of control of the nurse. Nevertheless nurses do believe that it is their task to control the TB epidemic. In order to achieve this they have to control the behaviour of TB patients. They see it as their main task to motivate patients to complete their treatment. They believe that this is very difficult because patients cannot be trusted. Nurses are confronted with the poverty of patients and their unmet basic needs. This situation seems to lead to feelings of helplessness and frustration, especially when the poorest patients seem to spend what little resources they have on alcohol. Nurses feel they know “their patients”, and what the patients need is to be treated firmly. They feel frustrated and angry with patients who do not comply with the treatment regimen. Some nurses feel that those patients are dangerously out of control and that they are a threat to society and to the health of the nurses themselves. Hence the fantasy that is expressed in the form of the whimsical thought: “If only we could isolate the irresponsible ones on Robben Island...”

The nearly impossible task (Zagier Roberts, 1994b) is made manageable through maintaining a system of carefully cultivated detachment (Seedat and Nell, 1992) and brisk efficiency (Hall, 1997). That is why task orientation is an important mode of practice. By splitting up the relationship with patients it is possible to deal with sections of patients, therefore the nurse can avoid emotional involvement with the whole person. In this way she can deal with the measurement and recording of urine test results and blood pressure without having to open herself up to the emotions of the patients.

The way that issues of racial identification are played out in the South African society has an influence on how nurses perceive themselves and their patients. The closer the nurses identify with patients in terms of background, ethnicity and culture, the more they may feel the need to distance themselves from the patients in order to protect themselves from their own feelings of shame, anger and helplessness to change the situation. Task orientation makes it possible to achieve the degree of distance which nurses need in order to protect their sense of self identity. Any effort to change existing work patterns toward more emphasis on patient support may be strongly resisted by nurses who feel strongly identified with patients. They will tend to tag patient support onto the existing system as yet another separate task.

The dynamics of the workplace

It is important to understand the institutional context in which interpersonal and intrapersonal dynamics occur. Firstly I discuss the health centres where nurses work, and secondly, I mention the context of the broader health system.

The health centres are situated in areas which were designated for different ethnic groups under the Group Areas Act of the apartheid regime. Top nursing management is based at the central office which is geographically removed from the health centres where TB treatment is given. As a result the supervision system is bureaucratic and remote from the teams of nurses who operate with a good deal of authority regarding day to day management of clinical work. Strong peer pressure among nurses favour the well known patterns of care which have been maintained for decades. Nurses are seldom moved between clinics and they acquire a strong sense of knowing what works best in "their areas".

Health centres are usually situated in bleak neighbourhoods where the level of crime is continually escalating. Nurses often lock themselves into fortress-like structures protected by high security gates. There is a sense of standing together in a laager formation. Nurses close ranks and turn inward like a closed group that exist solely for the protection of its members. This basic assumption mentality (Bion) reflects a tendency to avoid the primary task and to hold on to clinic routines regardless of whether these meet the needs of patients.

Since the start of the transitional phase of political change nurses have felt uncertain about their position at work. There have been cutbacks in the health budgets of the Western Cape in order to spread resources more equitably throughout the provinces. Local authorities have started the slow process of restructuring the health services into a district system where a single health authority will be responsible for both curative and preventative care. These uncertainties coupled with the inevitable pruning of posts has increased the pressure at work.

Implications for change

What does this work mean for implementation of change management? How should one embark on a process of change? In what ways is that different from the dominant approach? The dominant approach to change management is characterised by top-down orders to follow instructions. The way in which the Deep Valley nurses responded to the intervention is an indication of how nurses perceive strategies to introduce innovations:

“We are used to do what we are told. We are seldom consulted about proposed changes”.

This is a reflection of the hierarchical organisation of health services. The change initiative which is described in Chapter 6 was intended to use a different approach, namely the route of action research. The assumption was that if nurses were involved as co-researchers in a process of discovery, they would be able to study their own practice, to detect the shortcomings and to plan and implement a different approach. This approach was accepted by the Vista nurses who made considerable changes to their practice, but it had little impact on the Deep Valley nurses. A reflection on these different responses led me to the conclusion that nurses would tend to resist changes, unless change management processes are informed by an understanding of the underlying anxiety and defences which influence nursing practice.

Change management processes should explicitly acknowledge the consequences of decades of apartheid policies and practices on the behaviour of health professionals and the users of health services. There is a perception and expectations that the differences, mistrust and inequality of the past have evaporated since the birth of the “rainbow nation” in 1994. This is not the case and in the years to come change agents will need to address the emotional pain of the past, as

well as the more well known sources of organisational resistance to change such as threats to the established power relations, threats to resource allocation and structural inertia (Robbins, 1993, p 637).

The research findings reported in this thesis are already being used to inform the design of an intervention which will be implemented in the TB Control Programme of the Western Cape (Dick et al, 1997). As a staff member of the Health Systems Division of the Medical Research Council I am involved in the design of the intervention. Unlike the intervention described in Chapter 6, this one will attempt to acknowledge that task orientation provides an anxiety containing function for nurses and that changes which threaten to dismantle such mechanisms could be particularly threatening. The evaluation of this intervention will take the form of a large randomised control trial. The quantitative nature of the research will measure the effectiveness of the intervention in terms of the cure rates of TB patients. The qualitative research component will describe and interpret the response of nurses and patients to the intervention. Our team will therefore have the advantage of both quantitative and qualitative information in the assessment of an attempt to impact on the cure rate of TB.

The need for further research

This study has focussed largely on the work of coloured and white Afrikaans and English speaking nurses who work with TB patients in the urban areas of the Western Cape. It will be important to do similar research in work settings of black nurses in the Western Cape, as well as in other parts of the country. It would also be important to find out whether similar work patterns occur in non- TB settings.

There are several local research initiatives which are exploring different aspects of nurse-patient relationships. Meulenberg-Buskens and Daniels (1997) studied the concept of care. Fonn and Xaba (1995) at the Women's health Project developed a training manual to sensitise nurses about the links between gender and health care. Jewkes, Mvo and Abrahams (1997) studied the relationship between nurses and patients in obstetric units. It would be important

to liaise with these local researchers in order to enhance future interventions and pilot studies with the findings from this research.

In Chapter 7 I argue that the phenomenon that I term “too close for comfort” is more likely to occur where there had been a history of colonialism or deliberate policies of segregation. It would be important to study this hypothesis in other post-colonial settings, particularly those with a common history of British occupation, since I have demonstrated in Chapter 1 that South African nursing had been influenced by its colonial heritage.

Concluding reflection

In closing, a brief reflection on the national context and the time in history during which this research has taken place. I started the work in 1994, at the time of the first democratic election. At the time of writing, South Africans are in a process of national healing and reconciliation. A Truth and Reconciliation Commission was established to help the nation come to terms with its traumatic past. As a nation we are ready to explore issues of personal pain in more openness. I am aware that the main findings of this study are controversial because I have taken the risk to explore issues of race and colour. Ten years ago this would not have been possible, but I feel that in the current situation, researchers have a responsibility to generate open discussion on sensitive issues. Critical debates are in danger of being silenced in the post-apartheid era by fears of being labelled “politically incorrect”. I hope that my work will stimulate nurses, nurse educators, health care managers and fellow researchers to explore and discuss the sensitive questions which lie so close to the surface of the experiences of nurses and patients.

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