



The elementary forms of care An empirical approach to ethics in a South African Hospital

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ABSTRACT

Ethics is generally seen as the application of universal and intangible principles. Empirical studies then consist in verifying the degree of adequacy of practices to the norms. Here, conversely, ethics is considered as everyday practice: professionals, whether nurses or doctors, act within routines and under constraints, and later give an account of their action.

Fieldwork was conducted during one year in the emergency and admission wards of a large South African hospital. It was based on interviews and observation and included feedback meetings for health professionals and focus group discussions with inhabitants of the neighbouring township. Ten elementary forms of care were identified in terms of patients' expectations. Five concerned the person as patient: ailment, problem, pain, agitation, life. Five concerned the patient as person: recognition, sovereignty, respect, privacy, interest. Discrepancies between claimed norms and actual practices were justified by health professionals in terms of workload, lack of resources and social deviance of patients. Ethnography suggests a more complex interpretation: on the one hand, technique-oriented professional ethos and efficiency-oriented organizational imperative are consequences of both historical territorial segregation and present resource inequalities. On the other hand, the lack of social recognition felt by nurses and doctors is in turn reflected in their moral evaluation of patients, which goes beyond concepts of values and worthiness. Although inscribed in the specific context of post-apartheid South Africa, the present description and analysis of practices has a broader scope as it proposes a way of approaching the elementary forms of care.

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Introduction

From the Hippocratic Oath for “ancient doctors” (Lloyd, 1983) to the Tavistock Principles for “everybody in health care” (Smith, Hiatt, & Berwick, 1999), medical and nursing ethics have developed many codes of good conduct. All are based on three premises. First, medical and nursing professions are essentially altruistic (Sieghart, 1985). Second, abstract rules can be formulated to govern their

practice (Gillon, 2003). Third, norms thus defined are universal (Dawson & Garrard, 2007). On these premises, four principles have been proposed, often considered as foundational of medical ethics (Beauchamp & Childress, 2001): respect for autonomy (considering the decision-making capacities of persons based on reasoned informed choices); beneficence (balancing the benefits of intervention against risks and costs); non-maleficence (avoiding harm or reducing it to a minimum); and social justice (fairly distributing benefits, costs and risks). This approach, initially developed for biomedical research and practice, has been expanded and adapted to nursing ethics; in particular, it has been asserted that caring is a specific dimension of nursing

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that implies different moral perspectives (Fry, 1989). Within this framework, the distinction between an ethics of justice and an ethics of care is often used to differentiate medical and nursing professions (Rickard, Kuhse, & Singer, 1996): the former, abstract and universal, is linked to masculine characteristics and to physicians; the latter, affective and particularist, is related to feminine traits and to nurses (Tronto, 1987).

In response to this formal top-down approach, it has been argued that “principlism” should be counterbalanced by “contextualism”: relating the analysis of decisions and actions to concrete moments, circumstances and consequences in order to give a more adequate account of medical ethics (Gracia, 1995). This argument has been presented as particularly relevant for nursing ethics with claims that the specificity of the profession resides precisely in the concreteness of the physical and emotional relationship engaged with the patient. The understanding of “virtue ethics” (Armstrong, 2006) and the “ethos of caritas” (Fredriksson & Eriksson, 2003) implies greater attention to the practical conditions of work and more generally to “nursing practice contexts” (Penticuff, 1991). But this call for empirical work has been mostly developed within normative frameworks, even when authors referred to “pragmatic principles” for medical ethics (Schmidt-Felzmann, 2003).

However, as Lebeer (1998: 32) expresses it, “actors do not pose permanently a critical look on what they do in the light of ethical principles” and reciprocally, “ethics cannot be understood if it is reduced to the more or less imperfect application of principles previously defined and supposedly shared”. Therefore the task of social sciences when they study ethics is not to presuppose its existence a priori and verify its realization a posteriori, but to record and analyze how it is produced and justified in the course of action. In a famous study of verdicts in US courts (the results of which can be extended to health care), Garfinkel (1984: 114) demonstrated that jurors do not make their decision on the basis of their correct understanding of the situation and their satisfactory implementation of principles, but rather attempt to give a proper account retrospectively of their deliberation and their verdict, in particular when they are confronted with discrepancies between their ideal norms and their actual practices. He concluded that in everyday activity more generally, “the outcome comes before the decision” and that “the decision maker’s task is to justify a course of action”.

Based on a similar approach of ethics, an ethnographic study of medical and nursing practices was conducted in a large general hospital situated in one of the former townships of South Africa. Using a formulation of Durkheim (1912/2001), this paper tries to identify the elementary forms of care that arise from fieldwork. Its objective is to propose through simple typologies and mundane examples concrete tools for a critical reflexivity in medicine. It is not an evaluation of ethical practices in South Africa, although the analysis is empirically grounded in this specific context. The aim is to specify instruments based on data collected in a particular setting but that have a broader scope. In other words, it is an attempt to bring some clues to the quandary evoked by Kleinman (1999) between the “social and

personal realities of moral life” and the “application of a universal standard”.

Ethnography in a hospital

The national health system in South Africa is profoundly marked by the history of segregation, and later apartheid, which throughout the 20th century separated racially defined groups. Although a tremendous amount of work has been done to restructure it since 1994 in order to make it more equal and efficient, it still bears the legacy of the previous regime (Blaauw, 2004). In particular, former township health facilities remain understaffed, poorly equipped and insufficiently financed. The hospital under study shares these characteristics. However, health professionals and administrators pride themselves on a past of social medicine, with doctors and nurses acting in favour of the under-privileged groups during apartheid and continuing to see in themselves an ideal of justice and dedication, claiming for instance that unlike other hospitals, even when confronted with large numbers of patients “they never close the door”. Tensions between health supply and demand have nevertheless increased in the last 10 years because of the AIDS epidemic. According to a 2005 survey, of the 159 000 patients admitted during the year in general and paediatric wards, 43.9% of the adults and 31.5% of the children had HIV-related medical conditions (Schneider, Kellerman, Oyedele, & Dlamini, 2005). The common view health professionals have of the hospital is illustrated by the following comment of a medical doctor: “If you have worked here, you can work everywhere, even in war medicine”.

In this context, medical and nursing ethics has recently received more interest (Williams, 2000). In particular, violence against patients within health facilities has become a concern; studies have shown high levels of abuse in South African obstetric services (Jewkes, Abrahams, & Mvo, 1998) and psychiatric institutions (Lucas & Stevenson, 2006). As is often the case in these matters, investigations rely mainly on interviews of patients, a technique that implies not only a subjective vision limited to one side of the problem, allowing only a partial picture of the situation (Gibson, 2001), but also a specific focus on the most traumatic episodes better recorded in the victims’ memories (Laney & Loftus, 2005).

In order to obtain a broader perspective and account for more ordinary practices, an ethnographic approach was developed over long periods of participant observation in the wards combined with formal and informal interviews with health professionals. The research team was composed of five social scientists and three medical doctors (the author of this paper having both training and practice). The protocol was reviewed and approved by the University of the Witwatersrand Faculty of Health Sciences Ethics Committee. The administration of the hospital and the head of the medical and nursing staff in each ward gave their agreement to the study. Health professionals were informed about the goals and methods of the research. When interviewed they gave a written consent to be recorded anonymously. When included in participant observation of their everyday work they gave their acceptance verbally. Patients

were not interviewed. On the whole, 1200 hours of participant observation, on day and night shifts, were completed with 30 formal interviews (15 with nurses and 15 with physicians), covering a wide variety of professional experiences and hierarchical positions (from the recently recruited to senior management nurses and from interns to professors). In-depth immersion was facilitated by the fact that three members of the team were accommodated in the hospital during their intensive presence in the field. Three meetings were held with three groups of doctors and nurses to provide feedback on the results of the research (their comments and critiques were taken into consideration for the present paper). A focus group was conducted with persons living in the neighbouring township who described their experience of health care facilities in general and the hospital under study in particular (this collective interview helped to formalize and validate field observations and interviews). All the data obtained have been collectively assessed and qualitatively analyzed in order to propose a typology of ethics as practice.

Fieldwork was conducted from May 2006 until April 2007, with intensive presence of the team by periods of 10–20 days over the year. Although the study was also carried out in medical wards where patients are hospitalized, this article refers only to the part carried out in the emergency department, which is the main entry point of the hospital, and in the admissions unit, where further investigation is done and therapeutic decisions are made (usually within 24 hours). The description of the two wards seems coherent since they are functionally related and manage short-term stay patients. The emergency department sees an average of a little less than 300 patients per day in consultation, while the admissions unit receives approximately 150 persons daily. The data presented in this paper result from the author's own observations and interviews in both wards.

Rather than gross violations of patients' rights as reported in the surveys previously mentioned, the present study leads to a more complex and contrasted picture. As a result of the participant observation (presented at feedback meetings with doctors and focus groups with people of the neighbourhood), 10 distinct items that correspond to elementary forms of care were identified. They are called expectations, as they represent what the patients generally, although not always, expect from health professionals. They can be differentiated into two large groups: expectations referring to the person as patient and expectations referring to the patient as person. For each of them, two symmetrical attitudes from the doctors and nurses are reported: one is qualified as adapted and the other one as defaulting. The next two parts of the paper describe the two series of items. The last two parts explore possible explanations of the discrepancies. They distinguish justifications given by health professionals themselves to account for the discrepancies between expected and observed attitudes, on the one hand, from interpretations elaborated by the research team on empirical grounds, on the other hand. In order to focus the analysis on these discrepancies, examples given in the paper more frequently correspond to defaulting than to adapted attitudes. Moreover observations are voluntarily restricted to the emergency

department and the admissions unit where pressures facing health care workers are greatest and where the possibilities of supply remain limited. Therefore the following analysis should not be read as an evaluation of care in this hospital; this was not the goal of the study and was anyhow beyond its scope. It only attempts to describe ideal-typical practices based on ethnographic findings rather than general principles.

The person as patient

A first series of items concerns the medical dimension of the expectation for care. It is related to the pathology, its symptoms and consequences. Five items can be distinguished (Table 1): ailment, problem, pain, agitation and life.

Ailment

Patients consult because they – or their family – believe that they suffer from a pathological condition and that the hospital may have a solution for it. Due to the constant increase in the number of inpatients, this assumption is systematically challenged as it is considered that many of them should not come to the hospital but rather go to a primary health care clinic as their medical condition is not sufficiently severe or urgent. At the entrance of the emergency department, a specially trained nurse implements a recently developed triage system designed to reduce queues for the priority cases. Notably, very few patients are sent back home without having been checked by a physician. However, doctors often consider that the patients could and should have gone elsewhere. For example, a 30-year-old Mozambican man has been moaning on a stretcher for several hours when he finally gets a consultation. He explains that he is suffering from high fever and severe headaches; when asked about his history, not fully understanding the question, he explains in poor English that his symptoms have lasted for several years. The doctor replies angrily: "So, you have nothing to do here, you are in an emergency department"; he nevertheless proceeds with the clinical examination and ends up considering him as having malaria. Obviously, the degree of engagement in the treatment depends on the pathology. The more it is seen as justifying a medical intervention, the more active doctors are. Typically, diabetic keto-acidosis benefits from therapeutic protocols and effective measures

Table 1
Patients' expectations and professionals' attitudes

	Objects of expectation	Attitude adapted	Defaulting attitude
Person as patient	Ailment	Treatment	Abstention
	Problem	Listening	Indifference
	Pain	Alleviation	Ignorance
	Agitation	Control	Coercion
	Life	Resuscitation	Abandonment
Patient as person	Recognition	Consideration	Contempt
	Sovereignty	Negotiation	Imposition
	Respect	Attention	Disregard
	Privacy	Protection	Indelicacy
	Interest	Concern	Neglect

for which medical and nursing expertise have been developed. Conversely, HIV infections receive less attention as their prognosis still seems poor to many in spite of the availability of antiretroviral drugs as seen in the case of a 25-year-old woman, weak and wasted presents fever and headaches, whose medical records show she has an HIV infection; the physician refers her to the step-down facility where stable cases are sent without considering further investigation for meningitis.

Problem

At different stages of their stay in the hospital, patients present with what we can define as widely varying problems for which they need help from health agents, whether physician, nurse or attendant. Being dependent for physical as well as institutional reasons, they often rely on the availability and goodwill of the personnel. In some cases, patients can communicate their needs. A 28-year-old man tied to his bed asks for help to go to the toilets. The medical doctor explains to him that he does not want him to run away and proceeds to examine the next patient. In other situations, patients cannot talk. A 25-year-old woman with mental confusion has just had a lumbar puncture; she falls from her stretcher in the admissions room, but the doctor and the nurse who are occupied with patients a few beds further merely turn around, raise their head, and get back to what they were doing. In such cases, health professionals usually explain they are too busy to interrupt their medical or nursing activity. Conversely, examples may be given as well of patients who are helped, for instance, to go to the toilet when they are too weak to walk or to eat their meal when they cannot feed themselves.

Pain

Many persons coming to or staying in the hospital experience pain. For doctors, physical suffering appears above all as a symptom within the clinical picture; they investigate its presence, localization, duration, expression, but are less inclined to treat it *per se*. Sometimes, they explain that they do not want to modify the symptomatology which could make diagnosis more difficult and they may even express suspicion, feeling that the patient is using pain to attract attention. Often, they simply seem to be unconcerned about the pain, especially as most patients tend to refrain from complaining about it. For example, a 49-year-old woman with diabetes consults for severe epigastric pain. She is checked by a doctor who decides to have her admitted to another hospital and sends her there with a note explaining her condition – but she receives no treatment. Significantly, in the emergency ward, where specific criteria to identify urgent patients who should not queue and should be attended to immediately have been conceived, the existence of pain, however acute, does not lead to fast-tracking through the system, and patients doubled up with pain stay in the queue. Exceptions exist: one doctor almost systematically prescribes anti-inflammatory injections to patients with pain, but interestingly he is seen as deviant by his colleagues and the nurses.

Agitation

Whether due to psychiatric problems or to extreme but understandable anxiety, some patients present signs of agitation, often benign, seldom threatening, but hardly helpful in the long waiting queues of the emergency department or the overcrowded rooms of the admissions ward. They are generally handled by ward attendants, preferably men, who tie them to their beds with pieces of linen, a procedure which is not explained to the patients and which usually increases their agitation. No psychotropic drug can be given until a psychiatrist sees the patient, which is often after several hours. Whether these practices are well-founded or not, they can have serious consequences; for instance, the knots used to tie the patient may tighten when the patient moves, and thus lead to oedemas of the extremities of the limbs and, after several days, deep sores (J.G., personal communication). In the admissions ward, restrained patients cannot eat by themselves but their plates are left at their bedside. Such coercive measures usually remain unnoticed by the personnel but sometimes provoke amused comments. However they may also arouse protests. Noticing that a 28-year-old woman at an advanced stage of HIV infection is tied up to her bed even though she is apparently calm, a doctor indignantly tells a medical student that “a patient should never be treated like that” and frees the patient.

Life

In extreme cases, patients may be facing life-threatening conditions while in the hospital, as the result of acute problems or terminal stages of a chronic disease. The decision to do something in order to keep the patient alive depends partly on the prognosis derived from the assessment of the clinical condition and underlying disease, and partly on the medical ethos of the health professionals involved. Interestingly, the culture of the emergency ward has recently changed in this respect with the arrival of a new head of the department. Whereas previously the attitude towards patients coming to the hospital with coma was reportedly “there is nothing to be done”, the norm now tends to be that “if a patient came in alive, he must go out alive”. This change has given rise to the acquisition of resuscitation machines and to the training of health professionals in the department. The change in attitudes can be seen in the following situation. A 30-year-old man is brought unconscious to the hospital with a history of bronchitis and a suspicion of tuberculosis. One of the older doctors is inclined to withhold active treatment; however, a younger physician decides to intubate the patient and put him on a respirator. A few minutes later, the patient is transferred to the admissions ward for further treatment and investigation. More often, however, decisions are not so spectacular and occur in the context of advanced stage chronic disease, especially in the cases of HIV positive patients, who may be seen as hopeless.

The patient as person

A second series of items does not specifically refer to the health condition but more broadly to the way the patient is

treated as a person. It can be referred to as the general notion of dignity. Five distinct items are proposed under this designation (Table 1): recognition, sovereignty, respect, privacy and interest.

Recognition

During their stay in the hospital, patients become objects of interpretations and decisions. Diagnoses are made, tests are performed, treatments are chosen. These interpretations and decisions concern the patients' present condition, future situation and, more broadly, their lives. It is not usual to inform patients about what doctors thought they had, what the next steps in the investigation of their case are, what therapeutic choice would then be made. Linguistic difficulties are often and rightly invoked by physicians to justify the lack of communication with patients. After having vainly tried to have a patient reproduce a gesture exploring neurological functions, a doctor from a different origin comments to her with a kind smile: "OK, you don't understand me and I don't understand you either". Sometimes a relative or a friend is called to help, but in other cases, for lack of mutual understanding the clinical examination is restricted to non-verbal interaction. However the problem is not merely that of language as even within the same ethnic group communication often remains limited. A nurse thus ironically notices: "It's not because we're Black that we understand each other". Interestingly information is more often given to patients whose pathology has a particular educational package, such as diabetes, epilepsy or asthma: in these cases, verbal exchange is pedagogy-oriented.

Sovereignty

Although most patients who come to the hospital leave their case in the hands of the medical authorities, it is generally considered important that they remain actors in their disease, diagnosis and treatment. Ethicists call it autonomy. It might be more correct to talk of sovereignty, referring specifically to the competence of the patient to evaluate and decide about himself or herself. It is obviously related to information, which is supposed to be a premise for consent. More than a formal agreement procedure, consent implies the possibility of a negotiation between patients and professionals on the basis of an adequate explanation about the medical condition and the decisions to be made. This process was rarely observed during the study, as seen in the case of a 70-year-old woman with diabetes and gangrene of the inferior limb. The medical doctor in the emergency department sends her to the surgery ward for an amputation without explanation; when later asked about her health problem, she answers that it is just a benign wound. For doctors and nurses, this way of doing things is generally justified by the fact that they know better than their patients what is best for them. The low educational level of most of the patients seen in the hospital is used to reinforce this assumption. Moreover, doctors and nurses consider that patients rarely claim initiative and prefer to let them decide. It is true that people in the former townships did not have this sort of right. There are two

exceptions. First, some specific situations, such as HIV testing, seem to generally imply an informed consent. Secondly, a few HIV positive patients, in particular those who are connected with activist organizations or support groups, act as experts on their own medical condition.

Respect

It is well known that self-respect is closely related to respect expressed by others. Staying in a hospital with a reduced physical and psychological capacity makes people vulnerable. The concept of respect is both universal and contextual: it is linked to human rights on the one side, and it is embedded in cultural norms on the other. Asked about what image she had of the hospital she first came to work there, a young nurse answered that she had been struck by the fact that "the place was filthy and nurses were rude". She interestingly implied two crucial elements for respect in the local system of value. First, keeping the place as well as the patients clean is considered as a sign of respect not only towards the latter but also towards the profession and the institution, evidenced by the saying, "Cleanliness is next to godliness". In fact, the attention towards places, which are constantly cleaned up, sometimes contrasts with the situation of patients, who may be left in their wet bed for hours. Nurses and auxiliaries often overtly express their disgust towards patients who are incontinent or have diarrhoea. Removing the bed to a less visible corner of the room may then be a tactic to avoid both critique and discomfort. Some, however, show concern. In the admissions ward a nurse takes the time to gently wash the mouth and face of a 30-year-old wounded man, in spite of the overload of work. Secondly, politeness towards the patient is seen as related to respect. For one of the nurses interviewed: "Even if they're not really scolding the patients, they just talk loud to them". The tone and intensity of the voice indicate whether the patient is respected. Distancing themselves from patients, doctors usually speak in a polite and reserved manner. Being socially and physically closer to them, nurses are often described as too familiar or even aggressive.

Privacy

Because of a patient's medical condition, the anxiety it generates, its possible consequences for family, and the psychological effects provoked by illness, the protection of a patient's privacy is of special importance. For health professionals as well as for patients, modesty has to do with both body and name. The body must not be exposed. Most of the time, even in the overcrowded admissions ward, doctors close the curtains around the beds before checking the patients. A nurse comments that she felt ashamed when a white doctor had seen an old black man who had been left naked in the psychiatry ward: "We should have had taken care of our own people", she says implying a historically ascribed racial line. The name should also be protected. Pronouncing it aloud is often considered incorrect both in terms of privacy and danger. It breaks the secrecy of the medical relationship and thus opens potential perils.

Interest

A general condition to social relations is considering others as interesting. In medical or nursing activities, feeling interest for patients is the premise for care. Interest may be shown to the pathology as such or to the patient as person. The expression heard in the wards or read in the files that the patient has “no history” can sometimes be taken literally, since little is known of the history, clinical or social, of the individuals. A 29-year-old man is brought in a state of confusion. His mother, who accompanies him, tries to explain that he is drug addicted and is expected for his psychiatric consultation the next day. The doctor does not listen to her and sends him to the medical ward without recording the information.

Physicians often speak of AIDS in terms of loss of clinical interest. As one of them expresses it: “With this HIV, medicine is not interesting any more. We used to see interesting things. Now it’s so boring. With AIDS, it’s always the same”. Another doctor insists on the desperate lack of perspective related to the new disease: “I was in the surgery department before. There, at least, you can do something for the patients”. This disinterest in patients may have a concrete effect on how they are cared for. A 30-year-old woman with a terminal stage HIV infection stays two days in a medical ward waiting for her transfer to a step-down facility. Meanwhile, as she is supposed to be imminently leaving, she does not receive any treatment or food and remains ignored by the personnel who have left her stretcher in the back of the ward. After 48 hours, someone discovers she is dead. She had no longer been considered as part of the ward, even though she was physically present (FLM, personal communication). Conversely, arousing interest from health professionals is often an important part of the tactics developed by the patients and their families.

Justifying discrepancies

The first thing one notices when entering the different wards of the hospital is the presence of posters all over the walls reminding health professionals about ethical principles, as tends to be the case now in many countries (Sbailh, 2002). One of them is of special interest as it refers to a political slogan of the democratic regime: “*batho pele*”, which means “people first”. The long description of health professionals’ obligations towards patients – re-named “customers” – begins with this general statement: “The principles of *batho pele* are designed to give all service providers a guide to improve customer relations. By following these principles we aim to make our customers happy and derive satisfaction from knowing that we have worked to the best of our ability”. Considering the omnipresence of such prescriptive recommendations, one might be surprised to note the discrepancies between these proclaimed norms and the observed reality. Health professionals are not unaware of them, and they develop arguments to justify what they would otherwise admit as unjustifiable. In the discussions which followed the public presentations of the results of the study, nurses and doctors generally used two sorts of justifications (Table 2): the first referred

Table 2

Justifications and interpretations of discrepancies between expectations and practices

	Justifications	Interpretations
Exercise of medicine	Workload (quantity vs. quality)	Professional ethos and organizational imperatives
Relation to environment	Lack of resources (in the present situation)	Lack of recognition (in historical context)
Attitude towards patients	Social deviance (bad and difficult patients)	Moral evaluation (values and worthiness)

to their workload and their environment, the second to the patients and their attitudes.

First, health professionals account for much of their problem in terms of an excess of work and a lack of human and material resources. This is confirmed by another survey conducted among 217 nurses and 57 doctors in the same hospital: 60% of nurses and 61% of doctors showed signs of high emotional exhaustion; 92% of nurses and 61% of doctors thought the amount of work they had to do was too demanding; 92% of nurses thought there was not enough nursing staff; 75% of doctors believed there was a shortage of medical staff (Schneider, Oyedele, & Dlamini, 2005). The present study is somewhat at variance with that view: on some wards, especially the admissions unit, and at some moments, particularly in the evenings and nights for the emergency department, the workload was very heavy; but on other wards and at other moments, doctors could sit down for some time, and nurses might chat in their break room while stretchers accumulated in the queue. However, doctors’ and nurses’ attitudes towards patients were rarely affected by these differences of places or variations in time. Similar observations have been made in other contexts (Hadley & Roques, 2007), where the low amount of time dedicated to patients was not necessarily related to the workload or lack of human resources.

Secondly, health professionals consider that the patients themselves are an important part of the problem. A portrait of “bad patients” is easy to draw through the comments regularly heard in the wards: they come to the hospital with no legitimate medical reason, even using an ambulance instead of a car, bus or taxi, so as to impress the staff; they conceal some of their medical or personal history, requiring the nurses and doctors to reconstruct it uncertainly; they pretend to be in pain in order to be taken care of more rapidly; they often complain and sometimes become aggressive. When related to the norm of the good patient, these characteristics can be described in terms of social deviance (Jeffery, 1979). This deviance is aggravated by certain circumstances: if the patient is defined as a defaulter, because he or she has interrupted a tuberculosis treatment; if the patient is thought to be lying, for instance, reporting that she has miscarried when actually she has had an abortion; if the patient is drunk, and even more if he is violent; all these configurations not only weaken the patient’s image but also make him responsible for his or her health problem. Even communication problems may be laid on the patients’: “Why don’t you speak our language?” a Zulu nurse asks a Venda patient. Interestingly,

“bad patients” are clearly distinguished by health professionals from “difficult patients” who require much time and energy because of their medical condition (Spitzer, 2004). Both are undesirable, but for different reasons: moral for the former; practical for the latter.

Interpreting practices

Whereas the arguments given by health professionals are important clues to understanding their practice, they cannot just be taken for granted. Justifications are not explanations (Table 2). It is actually possible to propose an alternative – although not contradictory – reading of each point of the justifications. How to explain wrongdoing in professions is a classical issue in social science (Martin, 1999). To understand the discrepancies between values asserted and practices observed and simultaneously to avoid judgement leading to the blaming of doctors and nurses, two elements seem more specifically crucial here: the historical background of the professions and their moral discomfort.

The professional activity of health care providers is technique- and efficiency-centred rather than patient- and dignity-centred. Nurses do not step out of their routine on the ward rounds to respond to a patient's need because they view their work as the implementation of doctor's prescriptions, the distribution of drugs and the taking of blood samples. Task orientation has been described as the first historical feature of nursing in the United Kingdom and its continued presence in South Africa is analyzed as the consequence of the legacy of the British Empire (van der Walt & Swartz, 2002). Doctors do not spend time talking to patients, getting information about their social context, explaining to them or their relatives about their diagnosis and treatment in the emergency or admissions wards, because their priority in the emergency department is triage while first aid and in the admissions unit it is preliminary exploration and urgent measures: this is not specific since it has long been reported in various cultural contexts (Roth & Douglas, 1983). These orientations reflect two distinct realities. One is the professional ethos: nurses are more valued for fulfilling their technical task than in applying its moral principles (the “back round” is part of their professional routine); doctors see themselves as technicians rather than humanists and are primarily interested in curative activities in which social dimensions are considered incidental (“saving lives” or merely healing the sick is part of their professional ideal). The other one is the organizational imperative: for nurses, the round has to be done and drugs distributed before anything else; for doctors, beds have to be emptied under the constant pressure of new patients. Significantly, health professionals who do not have any consideration for patients' pain when it is related to their pathology appear by contrast very concerned and always apologise if the suffering is due to involuntary hurting when they are tending a bedsores or doing a lumbar puncture. In these cases, suffering becomes a technical issue under their responsibility while if due to the underlying condition it remains secondary, if not suspect. The pre-eminence of technique in the professional ethos under practical and material constraints results in the use of all sorts of tactics to avoid patients' queries, demands, even

their mere presence: not listening, walking away from them, making jokes about them, absorbing oneself in administrative tasks, going to the rest room, and more generally learning emotional indifference. It was remarkable in this study that students and younger doctors or nurses often said they had difficulty adapting their attitude to this form of professional detachment (Becker, Geer, Hughes, & Strauss, 1961): they had not yet acquired the ethos of the job they were getting into.

One can think of this apprenticeship as a psychological defence mechanism in response to the accumulation of patients and dramas, the confrontation with suffering and death. This is even truer for health professionals who encounter difficult situations in their own life and have gone through tragic experiences in the past: illness of close relatives; children's death or imprisonment; everyday violence in the township; hardship of material conditions – all facts which seem to relativize others' problems and lead to distancing oneself from them (Christofides & Silo, 2005). Here again health professionals' behaviours cannot be understood outside the collective and individual historical context. Nursing, in particular, is the emblematic profession of African women under apartheid: during those years, which many comment on with nostalgia as the golden age of their profession, being a nurse represented a social achievement generating respect within their community which they contrast with today's relative diminished status (Marks, 1994). From this perspective, even more than lack of resources, it is the lack of recognition which seems the critical explanation, as has been shown in other contexts (Honneth, 1995). Most interviews of nurses and doctors reveal their disappointment with their symbolic and material recompense: while working in this township hospital and within the public health system often meant a social and even ethical engagement, many considered themselves insufficiently rewarded in terms of image, promotion and salary (Bachmann & Maman, 1997). A young physician commented about nurses: “They have low moral because they have low pay”. More generally misrecognition – or rather the experience of it – is a crucial factor in professional disengagement.

It is from this perspective that the moral evaluation of patients becomes an important clue to understanding health professionals' attitudes. It corresponds to a classical form of defence when confronted with difficult situations (Ashforth & Lee, 1990). It consists most notably in differentiating “good” and “bad” patients, or rather in supposing a priori social deviance from the expected sick role, as previously described. This makes it possible for professionals to tolerate their own lack of compassion and even of interest in patients sometimes seen as potential “defaulters”, “cheaters” and “liars”, who are often considered as not completely belonging to the hospital, either because their case could have been taken care of by the clinics or because their ailment is a consequence of their own unhealthy behaviour. The illegitimacy of the patients accounts for how they are often considered and treated. But there is more to this evaluation. It also concerns the worthiness of the patient (Biehl, 2005). Clearly, prisoners brought to the hospital with their stigmatizing clothes and chains were treated more harshly than other patients. And AIDS

sufferers were considered not only as uninteresting patients because of their diagnosis but often also as not worth the medical effort, investigation and treatment because of their poor prognosis. In the end moral evaluation implies an assessment of both quality and quantity of life of patients.

Ethical practices seem to be positively affected by two sorts of facts. The first is personal experience of the health facilities: in the interviews, many nurses and doctors explained how having to engage with hospitals themselves, directly (as a patient) or indirectly (through a relative) had changed their views when they discovered what they saw as the indifference of doctors and the rudeness of nurses. The second is the organizational changes brought about by nursing or, more often, medical management: in particular, the environment of the emergency ward has been noticeably modified by the recent introduction of new methods in decision-making, triage and care, including a revalorization of the nurses' and doctors' sense of work; in parallel, the development of specific units for pathologies like diabetes or renal diseases, far from the tumult of the admissions ward, means there are now areas in the hospital of high clinical and ethical standards where health professionals experience the recognition of their competence.

Conclusion

Ethics is generally considered as the application of universal and intangible principles. Empirical studies then consist in verifying the degree of adequacy of practices to the rules. Here it has been proposed that the analytical process be reversed by beginning with the observation of practices and accounting for the principles at work. From this ethnographical perspective, ethics is about how everyday activity is performed and justified and how it can be interpreted (Das, 1999). Certainly, the hospital under study is a specific institutional context because of its township environment and its flow of patients, and South Africa in the time of AIDS is a unique situation because of its historical background and its epidemiological crisis (Fassin, 2007). However, the facts noted and analysis proposed here are of general significance for public health. Crises of emergency departments have been reported elsewhere (Kellerman, 2006), and discrepancies between patients' expectations and professionals' attitudes have been described in other settings (Eriksson & Saveman, 2002; Reed & Fitzgerald, 2005). But these problems are obviously more crucial in situations of resource shortages.

In developing countries in general and in the African continent in particular, the problem of human resources has been identified as a major challenge (Narasimhan et al., 2004), especially as AIDS is becoming an increasing burden (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). A great deal of research has been conducted looking at the quantitative aspects of the scarcity of health professionals, partially due to the brain drain (Martineau, Decker, & Bundred, 2004), and of the deficiency in training capacity, particularly for complex disease management (Hongoro & McPake, 2004). However qualitative investigation on what doctors and nurses do and do not do has aroused little

interest until now (Jaffré & Olivier de Sardan, 2003). In-depth studies of everyday practices of care in hospitals, where most severely ill patients are treated, are a scientific priority. Although social change does not merely emerge from knowledge, one can argue that adequate description, analysis and interpretation of what is occurring in medical wards and how it is experienced by patients and justified by professionals is a necessary first step towards an evolution of local practices of care.

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