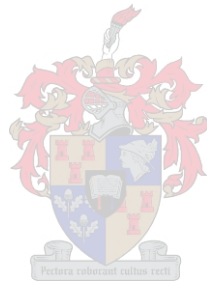**Between Policy and Patients**

Protocols and Practice in HIV/AIDS Treatment

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Declaration

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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Abstract

In recent years the World Heath Organisation (WHO) has recomended standardising HIV/AIDS treatment. Standardisation is based upon a particular model of what occurs within the relationship between a doctor and a patient and is propogated through the application of protocols. This thesis aims to illustrate how a doctor deals with a protocol in the face of contexts over-laden with contingency and excess which the protocol does not account for and which standardisation excludes. In other words, it explores how doctors deal with the failures and restrictions of standardised medicine. The central question this thesis aims to answer is: How do doctors on the ground deal with the standardising demands of global, as well as national, institutions in the face of highly contingent daily realities?

I aim to answer this question by critically analysing the relationship between global institutions and the effects of their policies on the ground level. I argue that global organisation such as the WHO attempt to limit the particularities and contingency of local contexts in order to ensure the internal coherence of their own policies. This is made possible through 'interpretive communities' of experts, as well as, the relative opacity of ground level actions. However, I also illustrate how doctors applying these protocols are not merely pawns in the state's and global health organisations schemes but rather depend upon the opacity at ground level in order to ensure the well-being of those marginalised by protocols.

Furthermore, I explore how the protocol depends upon a 'cognitivist' discourse in modelling the practice of physicians and as such allows a normative framework to be introduced into medical practice. However, in contrast to this model applied by both national and international institutions, I aim to illustrate how a doctor's decision making is indeed grounded by their particular place in a medical hierarchy as well as by the resources, both cognitive and physical, they have at hand. It is as such that many decisions made by doctors can be deemed unscientific due to the fact that their decision making is not grounded in a universal method but is rather contingent upon the present context.

Finally, I explore how standardisation, and a doctor's resistance to it, influences the behaviour of patients in their adherence to anti-retrovirals. I argue that standardisation does not inspire the type of bio-politics which Rose has coined 'ethnopolitics' which aims to inspire the compliance and lay expertise in patients necessary for successfully combating an epidemic such as HIV. As such I aim to ilustrate how standardisation therefore fails in its attempts to sustainably combat disease in the largest number of people due to the fact that it does not treat individuals as individuals but rather as members of particular risk groups.

Opsomming

Die mees resente aanbeveling van die Wêreld Gesondheids Organisasie (WGO) is die standardisering van MIV/VIGS behandeling. Standardisering is gebaseer op 'n spesifieke model van die verhouding tussen die geneesheer en die pasiënt en word uitgedra deur middel van die toepassing van protokolle. Hierdie tesis illustreer die wyses waarop die geneesheer die protokolle hanteer binne die konteks van gebeurlikheid en oorskryding wat nie deur die protokol voorgeskryf is nie en wat standardisering uitsluit. Met ander woorde, die wyses waarop geneesheers die beperkings en tekortkominge van gestandardiseerde medisyne hanteer. Die sentrale vraagstelling van die tesis is: Hoe hanteer die praktiserende geneesheer die eise vir standardisering van globale as ook nasionale instellings ten spyte van gebeurtelikhede binne die konteks van daaglikse werklikhede.

My doel is om hierdie vraag te beantwoord deur 'n kritiese analise van die uitwerking van voorskrifte van die globale instellings op lokale vlak. My argument is dat die globale instellings soos die WGO poog om die partikularistiese en gebeurtelikheid van die lokale omgewing te beperk om so doende die interne samehang van hul eie voorskrifte te verseker. Dit word moontlik gemaak deur '*interpretative communities*' van deskundiges asook die duisterheid van grondvlak handeling. Hoe dit ook al sy, ek bevestig dat geneesheers nie bloot passiewe werktuie van die staat en globale gesondheid instellings se voorskrifte is nie, maar eerder dat hulle die duisterheid van die grondvlak gebruik om die welstand van die wat deur die voorskrifte gemarginaliseer is, te verseker.

Verder word die maniere waarop die protokolle afhanklik is van 'n kognitiwistiese diskoers in die praktyk van die geneesheer ondersoek wat die invoeging van 'n normatiewe raamwerk in die praktyk toelaat. In teenstelling met die toepassing van hierdie model deur beide nasionale en internasionale instellings, beskryf ek hoe die geneesheer se besluitneming inderdaad gegrond is in sy/haar se posisie in die mediese hierargie asook die beskikbare kognitiewe en materieële bronne. Gevolglik word baie van die besluite wat deur die geneesheer geneem word, as onwetenskaplik geag weens die feit dat dit nie op die universieële metodes gebaseer is, nie maar eerder op die kontigente van die daaglikse werklikheid.

Ten slotte ondersoek ek hoe standardisering, en die geneesheer se verset daarteen, die gedrag van die pasient ten opsigte van die nakoming van behandeling beinvloed. My redenasie is dat standardisasie nie die nodige bio-politiek wat Rose '*ethnopolitics*' noem, bevorder nie. Hierdie bio-politiek is essensieël ten opsigte van nakoming en die ontwikkeling van leke deskundigheid onder pasiente in die suksesvolle bevegtiging van epidemies soos VIGS. Gevolgelik poog ek om die mislukking van standardisasie in die volhoubare bevegting van siekte as gevolg van die feit dat hierdie pogings nie die pasient as indivdu maar eerder 'n groep (as 'n veralgemeende risiko groep) te illustreer.

Acknowledgments

Contents

Introduction

Global organisations, the state and the doctor

Since the 1950s studies on the impact and role of global organisations have proliferated. Global organisations here implying development agencies, unilateral, bilateral or multilateral. Although the impact which these organisations have on the daily lives of subjects in the Third World is well examined and critiqued, little has been said about the "middlemen", about the practitioners at the grass roots level implementing the policies of these organisations. By "middlemen" I mean the mediators of global policies who operate at the grassroots level (see Geertz 1960, Whisson 1985, Wolf 1982). These mediators are not the creators of policies but rather the people who implement policies, members of global organisations who operate at the level of the everyday. Examples could be development managers and 'experts' operating in the field or in this case doctors treating the sick .This thesis aims to examine the role of these "middlemen." It aims to examine how policies, or protocols more specifically, are deployed by these individuals operating in face-to-face encounters with the intended beneficiaries of these policies, the intended beneficiaries of these organisations.

The middlemen examined here are doctors working within the context of HIV/AIDS clinics in a peri-urban and urban setting in South Africa. The aim is to illustrate how doctors operate under the demands of protocols in their daily interaction with patients. Doctors, in this regard, can be viewed as "nodes" between international/state level structures and the reality of everyday life in a South African township. In a sense doctors operate in two epistemic and socio-economic "worlds". Firstly, as medical practitioners educated in universities based on "Western" science and a strict scientific rationality. Secondly, dealing with everyday, lay understandings of health and contending with conditions which do not match the idealised, scientific environments espoused by policies, in that they are under-resourced and the life conditions of their patients make their adherence to a medical regiment difficult. The policies brought forward by organisations such as the World Health Organisation (henceforth WHO) or the World Bank and their pragmatic adoption and adaptation by

doctors can therefore be seen as a site of investigation into how doctors inhabit these two separate worlds. However, there is a singular concern which inhabits both life worlds, that is *life*. As will be illustrated, the concerns of global organisations and the state is the *life* of a population, that of a doctor and a citizen of the Third World is the *life* of an individual, a mother, a father, a son or a daughter.

In acting on behalf of an individual, a doctor either acts in dissent or agreement (or both but never neither) with some form of authority. Doctors then, in taking action, in acting, in whatever form, are political actors. As Foucault argued, "the first task of the doctor is therefore political: the struggle against disease must begin with a war against bad government. Man will be totally and definitely cured only if he is first liberated" (Foucault 1973:33). The context and "intention" in which Foucault writes this is to illustrate the ability of doctors to draw people into the state's control, in order to create subjects. The argument of this thesis does not disagree with this role of doctors. However, it does disagree with the critical sentiment of this role of doctors, the context within which the fieldwork here was conducted forces this. For Foucault, in his writing about advanced capitalist countries with strong states, the creation of subjects leads to the oppression of man. In the context of South Africa, and its violent history of exclusion by the state, the only chance of survival for many people is through the state. There is a desire then to *be* subjects, to be recognized by the state, to be liberated from the oppression of dire living circumstances.

In the case of HIV/AIDS, many People Living With AIDS (PWAs) seek this liberation through becoming "biological citizens" (Rose & Novas 2005). "Such citizens use biologically colored [sic] languages to describe aspects of themselves or their identities, and to articulate their feelings of unhappiness, ailments or predicaments [and] the languages that shape citizens' self-understandings and self-techniques are disseminated through authoritative channels- health education, medical advice, books written by doctors about particular conditions" (Rose and Novas 2005: 445-446). The PWA can be seen as an example of a mediated citizen then, a construction provided for by doctors but not constructed by doctors. It is important to note that although doctors provide the language through which AIDS patients describe their lives, this language is actively taken up from 'below' and as such provides another perspective on discourses of the creation of subjects.

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The transformation that many PWAs go through one they accept that they are HIV positive is well documented. Vim-Kim Nguyen (2003, 2005a, 2005b) illustrates how PWAs transform their lives to become "therapeutic citizens…whereby a biological construct-such as being HIV positive- is used to ascribe an essentialized identity" (Nguyen 2005a:126). However, as was described above, this identity forming process does not occur in isolation but is rather the product of "a global therapeutic economy, local tactics for mobilizing resources, and the biopolitical processes through which humanitarian interventions produce particular subjectivities." (Nguyen 2005a:142). The global then, is weaved into the local, as individuals try to make sense and create meaning out of the conditions under which they find themselves. Robins (2006) has illustrated how the discovery of being HIV positive can lead to "a new life" for those diagnosed. The change in subjectivity experienced by members of HIV activist organisations, such as the TAC (Treatment Action Campaign), helps to create the "responsibilized citizen" (Robins 2006) that medical practitioners aim to promote in the engagement with their patients. The therapeutic citizen of Nguyen and the responsibilized citizen of Robins both present the HIV-positive individual as the ideal patient for a medical practitioner. However, within both cases the role of the medical practitioner remains unexamined, despite the fact that for this citizen "new life" is based upon a biomedical discourse of health and medication adherence.

The effects of global pharmaceutical, as well as development forces, create spaces of inclusion and exclusion due to the capitalist neo-liberal logic upon which such interventions are based. This process is well described and documented in Brazil by João Biehl (Biehl 2004, 2005, 2006a, 2006b,). Biehl illustrates how what he describes as the "political economy of AIDS" spans both national and international institutions creating "an environment within which individuals and local AIDS organizations are codependant and simultaneously recraft positions and possibilities with every exchange" (Biehl 2006a:459). This "recrafting of positions" takes place at every level of the system within which a PWA finds himself, from the individual sufferer navigating the benefits between employment and government disability grants (Biehl 2005, 2006a) to NGOs challenging global pharmaceutical companies about patent laws, as the recent case of the Treatment Action Campaign (TAC) illustrates. In this

case I will examine the recrafting of positions by doctors in relation to the protocols designed to craft their current practice.

The recrafting of positions described by Biehl, occurs within a field of intersubjective experiences shared by international organisations, doctors and patients alike. The effect of this system is that a trend or decision in a global organisation has an impact upon the local, upon the individual. Rose (2007) describes ethnopolitics as the "self-techniques by which human beings should judge and act upon themselves to make themselves better than they are" (Rose 2007:27). In the face of neo-liberal logics pointing towards individual responsibility instead of state responsibility "these ethical principles are inevitably translated into microtechnologies for the management of communication and information that are inescapably normative and directional. These blur the boundaries of coercion and consent" (Rose 2007: 29). The medical practitioner in this regard distributes not only medicine but also these ethical and normative values, as he is the connecting point between the medical, global, scientific and the social. In this regard s/he promotes values passed down to him or her provided by national and international organisations and governments. However, the medical practitioner is not simply a mechanism which transmits information but is rather an active participant within the political economy of AIDS, interpreting, influencing and being influenced by the ethics and pragmatics of the task at hand. Furthermore, the demands placed upon a medical practitioner and that which s/he finds ethically truthful to a situation may contradict each other, and it is at this point that the impact of global institutions may take a radically divergent step away from their intended outcomes.

From the above, rather condensed, description of the networks of forces guiding and influencing the lives of both AIDS sufferers and medical practitioners one can witness how the global is intertwined with the local. The typical path chosen by anthropology to illustrate this process has been to describe how an individual or grassroots AIDS organisation is tied in with the global. Little regard has been given to the ways in which a medical practitioner can act as a "node" connecting an "isolated" individual to a global epistemology and ethic. The frame chosen by anthropology in this regard is limited to "the other" without regard for an examination of the apparently powerful. This research hopes to inform this gap.

Along with the South African government's recent turnaround concerning the treatment of HIV/AIDS comes a new set of problems. The "honeymoon" period, during which ARVs were been promised and distributed after years of government neglect, has now passed. What the country's medical services now face is the reality of distributing and maintaining ARV services to an estimated five or six million South Africans (Robins 2006; Coetzee et. al 2004). The pragmatic concerns here deal with how a clinic which is used to serving two thousand HIV/AIDS patients can upscale to serving five thousand patients while maintaining the same quality of service with a similar amount of resources. The rich and informed interaction which a doctor can maintain with a patient in a small scale clinic is drastically undermined with an upscaling of two and half times the current work load. It is therefore vital for the continued success of the HIV/AIDS program that more attention is paid towards the medical practitioner's end of the relationship.

The role of standardisation becomes key to upscaling treatment. Standardising the medical encounter between doctor and patient, clinical processes and treatment regimes all help in creating efficiency within the clinic, allowing a single, resource limited clinic to deal with as many patients as possible. There is a concern here, as will be described throughout this thesis, in treating a population. The danger of this concern for treating a population is that individuals who do not fulfil the requirements of being a part of that population fall by the wayside. As this thesis will illustrate, falling by the wayside does not only include HIV positive people who do not make it to the clinic, but also individuals within the clinic who slip through the cracks of regimented service provision.

Problem statement

Originally, the research proposal for this thesis stated that the central concern would be: How does the doctor choose who will be eligible for ARVs and who will not? The aim of this original proposal was to examine in detail how a universal set of eligibility criteria effects the selection of patients on the ground. However, due to the complexity and time constraints of working in the field this rather specific problem

was broadened to rather look at how processes of standardisation, and the implementation of protocols, effect the practice of doctors working in resource limited settings. The research question has now become: How do doctors on the ground deal with the standardising demands of global, as well as national, institutions in the face of highly contingent daily realities? This problem can also be simply stated as: how do doctors deal with protocols? As will be made clear this problem weaves between idealistic views of the practice of doctors and the everyday realities of these practices, without ever promoting one above the other. These concerns raise questions as to the validity and practicality of guidelines and universal prescriptions whilst at the same time affirming their place within the medical nexus. A question implicated within this research project then is: How do global organisations influence the decision making of doctors in local settings?

The practical reality of managing a disease such as HIV within a resource limited setting such as South Africa brings with it ethical implications. Who should shoulder the responsibility for decisions regarding the distribution of ARVs? In other words, should a doctor comply with universal standards and distribute ARVs according to a particular criteria knowing that some patients who do not meet this criteria will die even though they would have been compliant? Or that others, who fulfil the criteria, will be non-compliant and create and spread drug resistant forms of HIV? Is blindly following a universal criterion ethical? Within all of the above questions it should be kept in mind that scaling up treatment implies a diminution of the doctor/patient relationship and consequently a lower "quality" of treatment if universal criteria are not followed.

It is also important to note that within the medical establishment we are dealing with a bureaucracy of sorts. Attempts to standardise, through implementing a set of protocols, can be viewed as similar to the attempts to regulate the practice of lowly bureaucrats within a system. There are of course differences between bureaucratic systems of previous eras and that of the global heath system today. Spatially, for instance, in classical bureaucratic systems the entire system was housed in a single building whereas in this case study the system is dispersed throughout the world. However, a hierarchy still dominates its functioning and the hierarchy in some classical bureaucracies was so separated (ironically most notably in socialist systems)

that being housed in the same building hardly impacted upon the physical encounters between representatives of the different levels in the hierarchy. Therefore the problems dealt with here could be found in almost any bureaucracy.

In describing the connection between local and global health institutions as a system (as a bureaucracy), we are centralising our concern around a theme. As such I have limited my field of study and have excluded certain things which may impact upon this study if it were conducted from another perspective. However, I have also aimed to illustrate incoherence and what appears to be paradox due to the fact that I cannot include *everything* in this thesis in order for anything to be said. It is important in this regard to realise that the site of this problem exists within a heterogeneous environment. That is, the social environment is not a simple field in which actors act according to a simple, easily explainable and 'rational' logic. As Derrida (2002) stated:

> the context is open and mobile. For this reason, on the one hand, I need to give up a philosophy of the moment, the indivisibility of the *at once*, and I have to give up the purely egological initiative of the political subject as sole master of what he does and of deciding what is done. The ego itself is divisible. This is also why there are delegations, why there is différance with an "a," why contradictory things happen at the same time, why conflictual things cohabit the same institution for example, in the same country, in the same society. The unity of this time is not ensured (Derrida 2002:24 emphasis in original).

What Derrida is attempting to illustrate here is that the complexity of the social environment does not allow for simple singular truths to be revealed in analysis but rather that, even in a single moment, many different interpretations can exist. The environment or context within which a social scientist operates is always laden with more evidence and counter-evidence than a single social scientist can reveal but which we are often aware of. The "egological initiative" for Derrida is the desire to explain things simply or to unite things without contradiction, to assume a single indivisible ego in a single moment. However, as the above quote argues, even the ego is divisible, as the experience of the social scientist illustrates when s/he chooses which evidence to include within an argument and which not.

However, as a social scientist, I must provide some form of understanding. In continuing with Derrida from above,

> nonetheless, for the egological subjects that we also are, the temptation is great to assemble, and think in, a system. System: this means to assemble in a theme. To think these contradictions, or this *double bind* in a system, as the individual subjects that we are: we perceive it as a painful impossibility…Nevertheless, driven as I am by the desire to assemble, which is an indestructible desire, I force myself- if I cannot do everything in the same instant- to produce forms of action or forms of givens, where two contradictory things are as close to each other as possible (ibid:24 emphasis in original).

Derrida then understands the desire to explain, that as social scientists, the outcome of researching material reality over-laden with information should be to provide some explanatory value to the phenomena we are faced with. However, it must be remembered that these explanations are tentatively based upon other, perhaps contradictory evidence, not being brought to light. Yet this counter-evidence is revealed to us in our research. We therefore attempt to create coherent arguments out of the paradoxes which are revealed to us in the field. The contradiction of creating a coherent argument out of contradictory evidence is partly what could be understood by Derrida's notion of a *double bind*. This thesis is an attempt to illustrate this double bind as a research problem but not as a problem to be overcome but as a paradox to be illustrated. The double bind here being the freedom and constraint under which doctors operate, the possibilities and limits which protocols make possible, *at the same time*.

Research Methodology

For this thesis I have conducted eleven months of fieldwork at the clinic of Dr G (see below), and, concurrently, five months of fieldwork at the clinic of Dr Z, with a total of twelve months of fieldwork all together. Engaging in participant observation, I sat in on doctor patient consultations with the various different doctors at Dr G's clinic as

well as with Dr G at the various clinics he manages within his district, roughly two days per week. In the case of Dr Z, being, up until recently, the only HIV/AIDS doctor within the clinic she practices in, I sat in her consultation room roughly once a week. I use the word consultation within this thesis to describe the appointments HIV positive patients have with the doctors on a regular basis. Depending upon the stage of the disease, as well as the doctor making the appointment, the patient may come in as regularly as once a week or as infrequently as once every six months. The ideal case scenario (I say ideal because, as I will shortly illustrate, many consultations are far from ideal) is that a patient sits in a private consultation room with a doctor in order for the doctor to check up on the progress of the disease or treatment. This examination takes the form of the doctor reading the patient's file and asking if he or she has any enquiries or problems, as well as, the doctor touching the patient in examining different problems. Strictly speaking the consultation should be reserved for problems surrounding HIV/AIDS treatment however doctors often examine problems which fall outside of this mandate. The consultations usually last around twenty minutes but range from ten minutes to forty-five minutes depending upon the doctor and the needs of the patient.

During these consultations I would observe how the doctor engages with different patients and how he or she would depart from or conform to the different protocols. Often I would have time to engage with the doctor about different patients, in the gaps between different patients consultations and as such gathered information in this way. The patients would come in for regular check-ups of their CD4 count and in general to check up on the progress of the disease or medication. It is as such that during these consultations one could observe a wide variety of patients at various stages of the disease, from the very first consultation for some, up to others who began ART when it was first provided by the South African government. Engaging with the doctors during their daily activities provided me with insights into the way they practise medicine, as well as apply protocols, or make decisions regarding patients. Sitting in during the consultation allowed me to observe the material reality under which doctors operated. An observation of this quality would not have been possible using any other research methodology.

In sitting in during the consultation I embedded myself within the clinical encounter, not as a quiet observer, but as some form of participant in the engagement between doctor and patient. Sometimes the doctor would take note of something which s/he wanted to make clear to the patient by pointing it out to me, like taking note of an increase in adherence or a loss of weight. Or the doctor would express some frustration to me, and as such, I would increasingly be situated within the clinic, my role increasingly politicised as being part of the medical establishment according to the patients and, as an anthropologist, as having answers concerning the sociality of patients in the eyes of the doctor. Either way my presence was not objective but subjective. As Arthur Kleinman (1995) argues, "the knowledge the ethnographer produces is never impersonal; it represents not only the public, focused accounts of informants but also the subsidiary, tacit knowledge that is part of their (and the ethnographer's) practical life activities (Kleinman 1995:76). The account provided in this thesis does not therefore claim to be impersonal or objective in a strict sense. Rather it is situated and therefore expresses subtleties and complexities which only arise in the interpersonal relations which mark the research methodology of an anthropologist (ibid).

This thesis then is an openly subjective account of doctors and their daily practice of dealing with the HIV/AIDS epidemic. However this admission of situatedness does not imply that what is said is in some sense untrue or empirically improvable. Rather that what I observe is contingent upon circumstances which cannot be repeated, this does not imply that others have not observed the same but rather that they cannot observe the same, only similar. The subjectivity of this account is illustrated by the uncertainty I present, perhaps best expressed by the double bind discussed above. What are the implications for a methodology of this sort for how we determine "truth"? In other words, is the admitted subjectivity, this admitted narrative not a

> return to that frightening possibility of an utter relativism, which always seems
> to make its reappearance in any discussion of the postmodern (narrativity is
> thought to be an essential postmodern slogan), bringing with it the ultimate
> threat of the disappearance of Truth as such? But the truth in question is not
> that of existentialism or psychoanalysis, nor that of collective life and political
> decisionism; but rather the statistic epistemological kind an older generation of

scientists clings to, along with its Platonic translation into a "value" by an older generation of aesthetes and humanists (Jameson 2002:32-32).

Here Jameson is illustrating the anxiety still faced by some social scientists with admitting that the outcomes of their research contain subjective interpretations of evidence they have collected. However, he is illustrating that the threat of an admitted subjectivity is not the loss of 'truth' as such, but the loss of a particular kind of truth, which depends upon methodologies which hide their subjectivity. The threat of utter relativism then, according to Jameson's "older generation," lurks large if we concede to the fact that our research results in subjective truths. However, this threat of relativism seems to only bother scientists dependant upon a "statistical epistemology," separated from the practical and daily workings of political decisionism and the contingent forces of somebody aiming to ease the strife of daily life, such as a doctor.

This same older generation of scientists can be found in anthropology, wherein early ethnographies aimed to provide exhaustive, objective accounts of their fieldwork without granting the subjectivity of their interpretations. "Classical ethnography developed through monographic studies that appeared to be characterized by spatial and social unity, the assumption being that it was possible to provide an exhaustive description of an ethnic group on its territory" (Fassin 2007: 11). Furthermore, according to Fassin, following this, anthropology constructed principles that assumed to have universal applicability, such as Marxist or functionalist principles. It was necessary then, in order to universalise their findings, for anthropologists to exclude the subjectivity and limits of their findings. Anthropologists' findings could only contain a 'truth' value if they were "universally true." In this thesis I aim to explore the relationship between the universal and the particular in a particular context. This thesis therefore does not provide an exhaustive account, whether it be universal or particular, but rather aims to open up the relationship between universal and particular relationships.

The participant observation conducted with doctors is also supported by brief periods of participant observation with other members of staff of the various HIV/AIDS clinics such as nurses or counsellors. Apart from participant observation, this research is also followed up with formal interviews with most of the doctors with whom

participant observation was conducted, as well as, e-mail correspondence with doctors working in the management of grants provided by The Global Fund to fight AIDS, Tuberculosis and Malaria. However, the thesis is focused on the work of two doctors, Dr G and Dr Z. These two case studies arise out of convenience and access, but this was also due to the fact that their positions within the clinics in which they worked provided interesting insights into the problems at hand. The thesis then, although about doctors and protocols, is grounded in two, particular, case studies.

Context

In this part of the introduction I will describe the contexts within which we find Dr G and Dr Z. For a better understanding of this thesis it is important to note the differences (particularities) and the similarities (universals) between the two case studies presented.

Dr G: building bridges between Faith, Emporiums and Creativity

Dr G is a large, Afrikaans-speaking doctor who lives geographically close to the clinic in which he works. Yet he lives worlds apart from the socio-economic conditions that shape the lives of his patients. He lives on his family's wine farm in the beautiful countryside surrounding the poverty of the towns' townships. He is the regional manager for HIV/AIDS clinics in a rural district, a position he is well qualified for with various medical diplomas and previous experience in managing hospitals. His main clinic is in the previously "coloured area" of a large rural town, on the edge of the town but not in the margins as are the townships. As a district manager he has the support to start HIV/AIDS clinics where he deems them necessary, within certain limits which he constantly rallies against. His clinics are well ordered and tidy as well as unusually well staffed. Patients wait in waiting rooms, nurses check the patients' adherence rates (by counting their ARV pills) and take their weight before they have their consultation with a doctor and these are noted in the patients' files. The nurses also take the patients' blood if the doctors deem it necessary. When in a consultation with a patient, the doctor is not disturbed, unless it is necessary, by another doctor. This level of organisation is achieved by the management skill of Dr G who applies for funding from outside the state, such as through international donors and can

therefore keep on extra staff. His hard work is driven by a faith in the equality of mankind and the right of all to decent living conditions. Furthermore, resources are creatively used within his clinics and this is also expressed in a pragmatic attitude towards medicine in which any solution can be found or improved. 'Charismatic' is the best word to describe his interpersonal relations by, with many of the patients within his clinics ascribing their improved condition directly to him, "*Dr G het my help regkom*," rather than to ART or the state. His charisma inspires a dedicated staff although they also complain about being constantly pushed to do more and tease him about his constant drive for improvement. However, his ideas concerning health care are revealed in interviews with them.

Dr G's creativity is revealed in his attempts to broaden the influence of his clinics into the surrounding townships. For this reason he recently established his "Emporium of Care" which is located in an old incinerator building behind the clinic. The Emporium aims to provide social services to the patients of the clinic, such as a beadwork project to create extra income for HIV positive mothers as well as being a venue for medical research into the disease. His creativity leads him to look elsewhere for help in his battle (you get the impression that his work is a very personal affair) against the epidemic. A nice example of both this creativity and drive for improvement can be seen in a speech he gave at the opening to his emporium of care. In this speech Dr G applies the analogy of the "Mathematical bridge" at Queens' college, Cambridge. The myth surrounding the bridge was that Isaac Newton built the bridge without using any nuts, bolts or screws; just by using the correct angles of force with the materials at hand (it is a myth because Newton died 22 years before the bridge was built). The other scientists were so intrigued by this design that they took the bridge to pieces but were unable then to put it back together again and the bridge is now held together by nuts, bolts and screws.

The moral of this story for Dr G is that in the previous decades medicine was viewed as a science which was perfect and was able to function on its own, free from other forces which could hold it together. However, for Dr G the fact that even Newton had to use nuts, bolts and screws to hold the wood together indeed implies that the forces of science are not complete but also need nuts, bolts and screws. The nuts, bolts and

screws, in the fight against HIV/AIDS, are for Dr G the socio-economic aspects of the disease which he aims to overcome through his Emporium.

Dr Z and the masses

Dr Z is a woman born and trained in Eastern Europe and as such was trained in an environment of high healthcare standards. She has a background in medical research, in pathology in particular, and is therefore confident of her ability to diagnose disease. In her view deaths should only be the result of incurable disease, not from bad management or incorrect diagnoses. Her experience in South Africa is that opportunistic infections, such as Tuberculosis (TB), in HIV-positive patients are often misdiagnosed and therefore gets frustrated by what she sees as unnecessary deaths. She has been working as an employee for ARK (Absolute Return for Kids) for about three years which is the extent of her engagement with HIV/AIDS in South Africa. Although working within a state run clinic, Dr Z is not employed by the state but rather by ARK and is therefore a kind of outsider within the clinic in which she works. Due to the hectic pace at which she works, she has little daily contact with the management of the clinic and therefore suffers from a lack of communication with the other staff. She describes herself as a soldier fighting a battle and takes this metaphor to heart at the pace she works, never stopping while she works, eating her lunch while she consults with a patient. In her own way she exudes charisma, and, like Dr G, she drives herself to help as many people as possible.

The contrast between the two clinics in which Dr G and Dr Z work is immense. Dr Z's clinic is both literally and figuratively on the margins of the city of Cape Town. From the clinic one can see both the countryside and the viciousness of abject poverty created by being on the economic margins of a major urban centre. As Dr Z herself points out, it is a forgotten place. The clinic is understaffed and up until recently Dr Z was the only qualified doctor working in HIV/AIDS within the clinic. The masses of HIV/AIDS sufferers in the surrounding township would literally wait outside her door for their appointment. Recently, however, ARK built a pre-fabricated building outside the clinic to allow the HIV/AIDS clinic to grow and has also provided funding for another doctor to come in once a week. The new building is an improvement on the previous office. However patients still stream in and out of Dr Z's office during her

consultation with patients. Dr Z is constantly busy, while seeing a patient she would also have at least two or three other patients' files on her desk which she is busy dealing with while being interrupted with inquiries from other patients or staff. Up until the new building was built, and a new nurse was brought in to assist Dr Z (the previous nurse being highly inefficient, sometimes not arriving for work), she had to take the weight of all her patients herself, as well as draw blood and work out adherence rates. While the current, highly efficient nurse takes all the patients weights, Dr Z still has to draw the patients' blood herself and sometimes work out adherence rates due to how busy her assistant nurse is. Although improving, Dr Z's clinic is a chaotic experience compared with Dr G's, due to the sheer number of patients she and her small staff have to deal with on a daily basis.

A note on style

Ceruti (1994), discussing changes in the methodology of science, especially in the presentation of evidence, argues that in recent times there is increased focus on how evidence is produced and presented.

> From an understanding of method as a study of the Archimedean point from which to define and construct the edifice of knowledge, there is a shift towards a more strategic understanding, "which does not necessarily give a detailed indication of what needs to be done, but only of the spirit in which the decision has to be made, and of the global scheme in which the actions must take place"…This allows for the unveiling of both the importance and the irreducible function of the *stylistic*, *thematic* and *imaginative* dimensions of knowledge next to those of a more logical-analytical and empirical nature (Ceruti 1994:xviii, emphasis in original).

The style in which this thesis is written is to remind the reader that this thesis is *a* construction, produced by a particular researcher. As such word choice is essential and at times I have included the dictionary definitions of words as a footnote in order to indicate to the reader the understanding I choose to use of certain words. This is not an attempt to limit or constrain meaning but rather to leave it open to interpretation, to

remind the reader that this interpretation (thesis) is also open to (un)limited interpretation.

In the spirit of keeping this thesis open I have also included long quotes or references. In other words I have not attempted to support my claims with the claims of others by attempting to limit the interpretation of their statements to short one or two line statements. Rather I have left statements long, with my interpretation of them of course influencing how they are read but also allowing the reader to judge the validity of the claims to support I make, in other words, whether other thinkers do in fact agree with me the way I propose they do. Sometimes, it may appear that I have left the reference a line too long, perhaps weakening the support I aim to achieve, but this is done out of a sense of integrity towards the author of the statement, out of a sense of respect for the context in which knowledge is produced. The use of these long quotes also allows other contexts to be co-implicated within "this" context, for other worlds and themes to influence and be influenced. The account offered in this thesis makes no pretence towards exhausting the subject, rather it aims to open up the problem, to a lay a version of the problem bare, to problematise the subject.

Chapter Outlines

This thesis starts off at the macro, global level. In Chapter One I provide a theoretical outline on how global organisations function. I will do this by first of all reviewing how these organisations operate according to critical academic opinion and then will provide my own analysis with these views in mind. That is, I provide a theory on how global organisations maintain legitimacy, and determine success, by means of separating policy from practice. It is therefore more concerned with the 'life worlds' of global organisations and the implications of the structures they create in order to carry out their intended mandates. The vantage point of this chapter does not deal with how local actors adopt and adapt global policies as this is largely the theme of the following chapters.

Chapter One is theoretical due to the practical difficulties in doing empirical work of this nature within the constraints of this thesis. However, it does not aim to provide a theoretical outline for the whole thesis. Rather, its aim is to provide the reader with a

'macro-context' through which s/he can read the thesis. In other words, Chapter One provides an analysis of how global organisations operate, as I see it, and as such provides not only a larger context within which to place the thesis, but also an initial outline of the theoretical strategy adopted. This chapter aims to situate the reader, as well as to provide an understanding of the context which is taken advantage of by local actors in their relations to global organisations. It therefore aims to provide an understanding of the dynamics of global organisations so that I can begin to answer the question of how global organisations influence the decision making of doctors on the ground.

I begin Chapter Two by examining how the manager of a rural HIV/AIDS clinic manages the protocols established by global organisations in the face of the contingency of reality. I attempt to illustrate how this manager adopts and adapts these protocols to further his clinics' ends. This is achieved by taking advantage of the gap between policy and auditing, created by a culture of high managerialism discussed in the first chapter. The opacity at ground level created by the different requirements and grants of different institutions within the same clinic (for example national government, the WHO and the aims of the clinic itself) is furthermore taken advantage of. In an attempt to restrain this type of opacity, global organisations and local government implement protocols in an attempt to standardize decision making within clinics.

What protocols do is attempt to limit the antagonism experienced by global organisations in their implementation of policies globally. This is achieved by distancing practice from local contingency. However, as the second part of Chapter Two will illustrate, protocols are realised only in adaptation to local circumstance. In a sense then, protocols are only successfully employed in resistance to universalisation. I will therefore argue that protocols are made possible not by their strict implementation but rather by their adaptation to local contingency. Resistance to the universalising tendency within a protocol is therefore, in this sense, a requirement for the success of the protocol. It is for this reason that the concept of 'local universality' (Timmermans & Berg 1997) will be espoused. However, as Chapter Two will illustrate, the adaptation or resistance to a protocol is dependant upon the experience and position of the doctor applying the protocol.

In Chapter Three I will look at how doctors 'think.' I begin this chapter by illustrating how an emphasis on a doctor's cognition in the years after World War Two introduced a normative framework into medicine which allows the measurement of a doctor's performance. However, I will contest this emphasis on cognition by examining how the materiality of their practice influences the way they make decisions. I will apply the Aristotelian concept of *phronesis* to show how doctors combine 'universal', scientific knowledge with the particularities and contingency of their patients' circumstances. The use of the concept of phronesis will demonstrate the materiality of decision making, an aspect of medical practice which will be carried throughout this thesis.

Furthermore, I will examine how evidence-based medicine influences the ability of doctors to make decisions. I will therefore illustrate how an emphasis on the cognition of doctors, made possible by the advancement of technologies such as computers, has bred evidence-based medicine to the detriment of doctors intuition. I will then move on to look at how doctors make decisions by using the notion of frames. I will look at two types of frames in particular, the 'administrative' and the 'clinical.' The administrative frame holds the view that all patients belong to specific risk groups and therefore the doctor's decision making can be guided simply by following the rules ascribed to the groups. This frame can be equated with evidence-based medicine. In contrast the clinical frame takes the individual idiosyncrasies of each patient into consideration and therefore resists the type of determinism found in the administrative frame. However, what this chapter will also illustrate is how the material and hierarchical circumstance of a doctor influences their ability to adopt either frame. I will also illustrate how the adoption of a frame by a doctor is also guided by a particular ethos towards medicine.

Chapter Four begins by examining the affective entanglements between doctor and patient. In this chapter I will explore how standardisation affects the relationship between doctor and patient and will aim to illustrate how, in this relationship, the idiosyncrasies of the individual patient can be taken advantage of by the doctor to advance the patient's understanding of the disease. Of course, once again, these idiosyncrasies are only brought to the fore in a relationship with a doctor adoptive of a

particular ethos and frame. I will also illustrate the importance of a relationship between the doctor and patient in terms of the doctor's act of diagnosis. That is, instead of diagnosing a patient from a list of symptoms, I will rather illustrate how a doctor's store of medical knowledge is activated by touch and sight. This is once more an argument for the materiality of medical practice.

In Chapter Four I will explore the pro's and cons of standardisation through the lens of so-called 'problematic patients'. That is, this part of the chapter will aim to demonstrate how standardisation can be used by patients to avoid being immediately detected by doctors as being non-compliant. In the same vein however, standardisation is useful as a tool for ensuring the sustainability of adherence in patients. This part of the chapter explores the position of medical knowledge as it relates to competing discourses, such as 'AIDS dissident' discourse, within the same patient. This part of the chapter will also illustrate how protocols help to establish a general body, such as the WHO or a health department, as a discrete or faceless entity if failure should arise and rather places the blame on a particular body such as a doctor. In conclusion to this chapter, I illustrate how standardisation can viewed as similar to the method of scientific management expounded by Taylor. In this regard I explore the ethics and pragmatics of this method of management and illustrate both their benefits and disadvantages.

Finally, as a form of conclusion, I will add a brief discussion on the implications of this thesis for our understanding of the relationship between structure and agency. In this regard I will aim to demonstrate how an agent is dependant upon structure and therefore we cannot determine, *a priori*, whether a structure will be enabling or limiting. It is important to take note of this 'neutrality' of structure, as it illustrates the creativity of subjects in their relations to broader structures. It is for this reason that ethnography is important because it allows for a small scale analysis of the difficulties and possibilities which these larger structures create. Detail of this type would not be revealed in a broad analysis of these structures. I will also discuss the two forms of knowledge which this thesis has implicitly enaged with, scientific or methodological knowledge and conjectural or intuitive knowledge.

Chapter 1: Global Organisations

1.1 How do we view international organisations?

In this chapter I will offer a view on how global organisations operate. I will therefore explore how these organisations are viewed by academics that are critical of them and then move on to offer an analysis which will operate as a background to the rest of the thesis. I will then examine the ethical implications of the structuring of these organisations viewed in this light. It is important to remember that how we view these organisations influences the way we view how they operate. That is, asking 'what role do these organisations play' would already imply that we have predetermined how they operate. Asking how they operate would rely on preconceived ideas as to what role they play. In asking how we view these organisations, I am implicating both the role they play and how they operate in a single question. It is pertinent not to view these organisations as giant monoliths but rather to grant agency to all levels and spheres of their structures and influences while, at the same time, granting a certain directionality to the aims of the organisation as a whole. In granting this we are adding a level of complexity to the problem presented. This complexity can be seen as the source of the different views of these organisations discussed below. In this chapter I am not aiming to provide an exhaustive account or view of these organisations which will trump all others. Rather, I provide another view on these organisations which aims to overcome the limits of the views discussed but which will produce limits of its own. Yet this view is important for the argument carried out in the rest of the thesis.

I will begin by looking at current academic opinion regarding the role of international organisations. In viewing the role which international organisations play in the local communities in which their policies are carried out, one can discern two poles of critical, academic opinion. The first views these organisations as giant monoliths which carry out their policies of 'Westernisation' to the detriment of local practices and circumstances. I have rather haphazardly labelled this pole an idealist pole due to the fact that its main concern is with the ideology surrounding development practice. The second opinion exemplifies the resistances to these processes of universal health,

thereby obscuring the similarities between diverse locations. This I will label the *instrumental* pole of critique as its main point of criticism lies within the material inadequacies of these organisations' practice within local contexts. As Stacey Leigh Pigg (2005) puts it, "[i]mages of a monolithic process of Westernisation inexorably rolling toward global cultural homogenization obscure too much complexity; images of "difference" as multiple sites of resistance to universalism obscure too many connections" (Leigh Pigg 2005:54). In this section I will attempt to offer a point of reference both supporting and criticising the two poles laid out above. A third perspective which attempts to move away from the dichotomy presented above, in which the local and global both constitute as much as decay each other.

The first position taken above illustrates the view that the "West" has something like modernity which should be desired by "the other". As Jameson (2002) argues, "Never mind the fact that all the viable nation-states in the world today have long since been 'modern' in every conceivable sense….What is encouraged is the illusion that the West has something that no one else possesses- but which they ought to desire for themselves. That mysterious something can then be baptized 'modernity' and described at great length by those who are called upon to sell the product in question" (Jameson 2002:8). These 'merchants of modernity,' so the critique goes, aim to homogenise the world, standardise and universalise western constructs which can then be imposed upon passive, desiring recipients in the "Third World". This is an idealistic or ideological critique of development as its main concern is the cultural or ideological impact of development thinking or "developmentalism".

"'Developmentalism' can be described as a tendency to reduce the problems of improving life in poor countries to one of a compulsion to promote 'development' by looking at them and knowing them only through the lens of 'developmentalism' and what they are *not*" (Jones 2004:393). The populations of the Third World are then defined by lack, by what they are not in contrast to the notion of modernity. Global health policies and the effects of globalisation are therefore portrayed as an imposition of an unachievable desire resulting in a loss of local values and beliefs. Here, "[d]evelopment is not policy to be implemented, but domination to be resisted" (Mosse 2004:643). What this developmentalist critique fails to recognise is that

although many people in the Third World may desire the rewards and benefits of modernity offered by development,

> this desire for things modern does not, however, necessarily make them docile, detribalized, and depoliticized consumers of *everything* manufactured in the West. Neither does this imply the inevitability of processes of cultural homogenization driven by Western discourses of development, consumer capitalism and cultural imperialism (Robins 2003: 281-282).

As I will aim to illustrate, in agreement with Robins, the process of development practice is much more complex than critics of developmentalism may grant.

The second position presented above argues that the attempt to implement universal health policies is bound to fail due to the particular, local circumstances which global policies cannot account for. The work of Helen Epstein (2007) can be seen in this light as she illustrates the failure of PEPFAR's 'ABC' approach in Uganda. This work is important as it seeks to "speak truth to power" (Scheper-Hughes 1995) but it misses many of the nuances and "uses of power" which I will map out later in this thesis[1]. I will borrow Mosse's (2004) label of an *instrumental* view of global policy in this regard due to the fact that this critique takes into consideration the pragmatics of policy implementation rather than their ideological effects.

Modernity under both the views expressed above becomes the universal which all countries, poverty stricken or not, should strive for, and international organisations such as the WHO become either the gatekeepers to this utopia or the propagators of a dystopia. The keys to modernity lie then in the universal policies expounded by universal organisations. But this leads us to question what exactly is entailed under the use of words such as universals?

According to Zizek (2007) "the universal is not the encompassing container of the particular content, the peaceful medium and background in the conflict of

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[1] It must also be noted that Epstein discusses a particular policy in a particular place and therefore does not aim to universalise her critique either.

particularities" (Zizek 2007:126), as the discussion of both poles above would have us believe. But rather "[t]he universal 'as such' is the site of unbearable antagonism, self-contradiction and (a multitude of) its particular species are ultimately nothing but so many attempts to obfuscate/reconcile/master this antagonism. In other words, the universal names the site of a problem or deadlock, of a burning question; the particulars are the attempted but failed answers to this problem" (Zizek 2007:126). Under this understanding, the problem of how a universal operates within a particular setting shifts considerably as the dichotomy of universal/particular is now folded into a space in which one can grant both activity and passivity to both. The universal in this sense is a site or field of antagonisms striving to contain its particularities despite their contradictions. The impetus is no longer on the particulars to prove that they belong to universals but rather for the universals to prove they belong to the particulars. This is achieved through translation and, as will be illustrated later, a certain amount of 'looseness' in the network.

The success of a universal is, therefore, dependant upon an interpretation of its success in constraining its particulars. Mosse (2004) argues that for a policy to be deemed successful depends more upon the interpretation of events and maintaining support than on some pragmatic measure. In this regard "[d]evelopment projects need 'interpretive communities'; they have to enrol a range of supporting actors with reasons to 'participate in the established order as if its representations were reality'" (Mosse 2004:646). A successful project is then dependant upon reigning in various actors in an attempt to illustrate the success or validity of a universal policy or plan. In order to maintain this coherence of successful interpretation requires the constant translation of policies into pragmatic realities, into the different languages of various stakeholders' expectations.

However, one should not regard this process of translation as a means of homogenising and standardising the language and expectations of global policy. In other words, the translation of a policy from the WHO, to national state level and towards a doctor in a clinic is not a process of indoctrination and imposition wherein the doctor is blindly following and implementing values "from above." Rather, incoherence and contradiction exist alongside coherence and order (in fact an organisation like the WHO depends upon it) as actors within the various levels of the

organisation adapt and adopt the policies to suit their needs. One cannot therefore predetermine how a policy is translated but can rather only answer this ethnographically after the fact. As Leigh Star and Griesemer argue:

> The coherence of sets of translation depends on the extent to which entrepreneurial efforts from multiple worlds can coexist, whatever the nature of the processes which produce them. Translation here is indeterminate, in a way analogous to Quine's philosophical dictum about language. That is, there is an indefinite number of ways entrepreneurs from each cooperating social world may make their own work an obligatory point of passage for the whole network of participants. There is, therefore, an indeterminate number of coherent sets of translations (Leigh Star & Griesemer 1989:390).

It is as such that "the ethnographic task is also to show how, despite such fragmentation and dissent, actors in development are constantly engaged in creating order and unity through political acts of *composition*. It involves examining the way in which heterogeneous entities….are tied together by translation of one kind or another into the material and conceptual order of a successful project (Latour in Mosse 2004:647, emphasis in original). In other words, in this case the task is to ethnographically illustrate how the universal manages to constrain the antagonisms inherent within it to such an extent that it can be viewed as a single composition or a single organisation.

The success or failure of a project therefore depends upon the ability to influence interpretation as well as allow various interpretations to co-exist. However, the success of interpretations also rest upon particular understandings of the problems at hand. In this light, the 'experts' housed within global organisations provide particular understandings of problems which can be said to 'guide' interpretation. A "politics of understanding" therefore exists in which the modernist pronouncements of experts prove unreliable. Rabinow (2007), discussing the work of Niklas Luhman, is worth quoting at some length in this regard.

> Understandings are negotiated proviso's that can be relied upon for a given time. Such understandings do not imply consensus, nor do they represent

reasonable or even correct solutions to problems. Instead, they attempt to fix reference points, those things that are removed from the argument to seed further controversies in which coalitions and oppositions can form anew. Understandings have one big advantage over the claims of authority: they cannot be discredited but can only be constantly renegotiated….Luhman's point helps explain why we continue to turn to experts whose predictions of twenty years ago now look ridiculous; they may have been wrong, but at least they helped frame a discussion (Rabinow 2007:101).

Understood in this way, we can see how international organisations, such as the WHO, attempt to limit the destructiveness of "those things removed from the argument" while fixing reference points around which discussions can be framed (for a discussion on framing discourse see Leach & Scoones 2005). Furthermore, by viewing policies as "understandings" one limits the possibility for responsibility to be taken for the actions incurred.

Parker (2000) provides an interesting example of this in his discussion of the global institutions created in order to combat HIV/AIDS. Parker describes three paradoxes related to global AIDS policies, the first two of which are interesting for us here. Firstly, vulnerability to HIV/AIDS has increasingly become connected to positions of inequality and injustice while the response to this vulnerability is increasingly found to be bureaucratic and timid. The policies designed to deal with this inequality "are all too appropriate to an era of globalized capitalist development and neoliberal economic policy" (Parker 2000:40). This is due to the fact that, as Parker illustrates, through the changing institutional power relations[2] involved with HIV/AIDS, one finds the World Bank as becoming one of the key players within policy making. "More or less quietly, over the course of the 1990s, the Bank has emerged as the major funder of HIV/AIDS prevention work in the developing world…Today it is the Bank, rather than the WHO, that issues the most important statements and reports on the status of the epidemic" (ibid:43). In Parker's terms, "much the same institutional constellation that gave us the politics of international debt in the 1970s, and structural

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[2] UNAIDS consists of the WHO, United Nations Development Programme (UNDP), the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the United Nations Educational, Scientific and Cultural Organisation (UNESCO) and the World Bank (Parker 200:43)

adjustment in the 1980s, today leads the global fight against an epidemic that its own previous policies did so much to structure" (ibid:44). This can be viewed as the "palimpsest" of global AIDS policies as the structures and reference points of previous eras reveal themselves under the writing of today.

The second paradox ties in, and can be seen as an effect of the first. International policy, according to Parker, forces a false or unnecessary choice between care and prevention, with organisations like UNAIDS (previously) and PEPFAR especially (Epstein 2007), pushing for the latter. This has created an "exclusionary" policy in which those already suffering from HIV/AIDS are excluded from the possibility of treatment, in contrast to an "inclusive" policy which would not force this choice. As Parker argues:

> This choice between prevention on the one hand, and care and treatment on the other, is fundamentally linked, I believe, to the reconceptualization of AIDS as first and foremost a question of economic development, subject to a relatively crude calculus of costs and benefits, that is not only devoid of any real ethical reflection, but is largely determined (or overdetermined) by the unquestioned assumptions of the late-twentieth-century world capitalist system…Within this framework, primary prevention is understood as cost-effective- convincingly presented as the means to reduce the loss of "disability-adjusted life years," enabling governments to achieve the biggest bang for their buck, the best return for their investment in light of limited health budgets (Parker 2000:44-45).

This point can be illustrated by a recent World Bank publication arguing that "the need to renew the emphasis on prevention was articulated at the XVI AIDS Conference in Toronto in August 2006 in recognition that an "*ounce of prevention is worth many pounds of treatment*, particularly given the potential *fiscal savings* from *treatment costs* avoided when prevention interventions are avoided" (World Bank 2007:27 emphasis added). In an ethical sense the implication of this shift to economics as the basis of policy making results in a "new ethics…focussed on the capacity of professionals and agencies to manage outcomes and actually deliver promised results. Notions of 'can do' (management) rather that 'must do'

(responsibility) are increasingly dominant in definitions of the problems of development" (Quarles van Ufford, Giri & Mosse 2003:5).

It is as such that the constellation of international organisations, Parker discusses above, attempts to set the reference points concerning the battle against HIV/AIDS. These reference points concern the economic advantages and disadvantages of certain policies, through which discourse on the topic is understood and legitimised. The *resistance* to the *exclusionary* polices of prevention, by such organisations as the TAC, rather than the *inclusionary* policies of treatment are then also expressed in these terms[3], as they illustrate that reduced hospitalization costs and increased economic activity of HIV sufferers outweigh the losses experienced in "prevention only policies" (Parker 2000). What is important to note here is not the success or failure of the World Bank's policies but rather their means for establishing reference points concerning how we speak about or understand the HIV/AIDS epidemic globally, even within organisations resisting these policies. The connection which Parker makes between current AIDS policy and the policies of international debt and structural adjustment of previous eras exemplifies Luhman's point that experts provide points of reference around which discussions can take place, whether they are right or wrong.[4] Therefore the resistance to these policies is also understood and expressed in economic terms. Furthermore, the offspring of this understanding generated new forms of understanding and reference points, such as human rights based discourse and corporate responsibility discourse by "big pharma" surrounding the violation of TRIPS agreements by such countries as Brazil and India (and later South Africa). The resistance to these exclusionary policies therefore attempt to illustrate the ethical irresponsibility of ignoring "those things removed from the argument" as they are set by experts.

To summarise, I have begun with a description as to how one should view international, bilateral and multilateral organisations promoting global solutions to local problems. In this regard I have argued, along with Zizek, that one should regard these organisations as attempts to constrain the particulars within them. That is, to

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[3] This tactic has been successfully adopted by Brazilian movements. See Biehl 2004.
[4] This is not to deny that these discussions take place within politically charged atmospheres or to state that these institutions are apolitical but rather just to illustrate the means through which these discussions take place.

constrain the particularities of the contexts within which their policies are implemented. The universal in this regard is "de-essentialised" as it no longer contains some essential harmony but rather is a site of antagonism. In the promotion of standardisation one can view this process in action, as one can view standardisation as an attempt to master the antagonism experienced by global health policies in the heterogeneity of local contexts. I argue that the mastering of this antagonism is not dependant upon some pre-determined or transcendental measure but rather on the ability, following Mosse, of global health organisations to maintain "interpretive communities" which legitimise certain development discourses over others. Winning the support of members of such communities thereby determines the future role such policies will play. However, the playing field is not even in this regard as experts frame discourse around certain reference points which allow discussion to take place. Interpretive communities therefore may have shared or even conflicting interests within certain policies, however their interpretation of these policies is framed by reference points originating from experts, often based within the very institutions seeking support for their programmes. The result of setting these reference points is the "tendency to ignore disjuncture and to press for coherence and closure, to assert one or another *a prioi* logic of development- the logic of the state or of the market, of management or criticism" (Quarles van Ufford, Giri & Mosse 2003:4).

1.2. Messiness and coherence

The attempt to "press for coherence and closure" can be seen as an attempt to limit the uniqueness within each local context a policy may find itself implemented. This is achieved through universalising policies and standardising procedures in different locales despite perhaps conflicting demands from local circumstance. It is important to note that in policies, "the international templates always include a statement about adapting materials to local cultural circumstances. This injunction, however, conveys the neutrality- and hence natural universality- of the frameworks and the information they contain by relegating cultural difference to a problem of fine-tuning information delivery" (Leigh Pigg 2005:47) rather than realising the presumptions inherent within the templates themselves. For instance, a policy document of the WHO states that, "while recognising that countries will need to tailor testing and counselling strategies to their particular setting, the WHO and UNAIDS emphasize that provider-initiated

testing must be implemented within the context of a national plan" (WHO & UNAIDS Secretariat Statement 2006a). In this regard we can notice that, "biomedical rationalities and the drug regulation they support are by definition global, locating control and stability in clinical dominance and exacting compliance to universal norms. Global drug rationality cannot surrender any part of its systematic order to local contingency and culture, without becoming internally contradictory. Unable to accrete, hybridize, or appropriate and build on local formations, it ends up dependent on centralized initiative to push its rationalities further out into local practice" (Craig 2000:121). The nature of global policies is therefore based upon centralisation, although later in this thesis I will explore the dynamics of centralisation and critique this view of the coherence of policy implementation.

Basing policy on a centralised, universal rationality is made possible by a certain distance being maintained between policy and practice. "The political processes of aid, then, work successfully to construe their policies as structural necessity just as they conceal underlying complexity. Modern development policy is abstracted and separated from the social order it governs….It substitutes universal rational design for the messiness of contingent practice, and actively maintains the gap between policy and practice that is necessary to preserve policy as a structure of representation and 'the rule of experts'" (Mosse 2005:27). What is important for now though is the emphasis that a considerable disjuncture exists between the global health policies of international organisations and the contingent reality of local clinics. This becomes a problem not only of implementation but also of maintaining projects in an ever changing environment.

For example in a typical day at a rural, township-based clinic a doctor could easily see the following three patients one after the other. Firstly, Soné, a twenty six year old mother of three children with two different fathers, both now distanced from her and her children. The history she provides the doctor of her encounters with the medical establishment stands as testament to a life of suffering. She was stabbed in the back by her uncle when she was eleven years old and had a stomach operation at the age of eighteen for another violence-inflicted wound. She has had TB twice in her life and has never worked, up until now she has relied on government grants. She was diagnosed HIV positive in 1999 but hasn't started on ARVs yet. Soné states she

doesn't want to begin with ARVs. She has come to the clinic this morning to find out whether she qualifies for a disability grant (DG) due to her HIV status. When the doctor asks her why she doesn't work rather than relying on grants, she says that she doesn't want to work.

Following Soné is a 36 year old man, Erol. Erol has three children with three different wives but states that he has good relationships with all his ex-wives and their children despite not living with them, although his eldest son has problems at the moment by being part of a gang. He lives alone and is currently not married. He is employed. He was diagnosed HIV positive in 2002 and states that he used to smoke dagga (marijuana) and drink excessively but his diagnosis helped him turn his life around. He hasn't begun ARVs yet due to the fact that his HIV clinical staging hasn't required it. But he has got good knowledge of his condition and profited from the counselling sessions. He has come in for his regular blood checks.

Following Erol is an old man who does not state his age, Michael. A few years ago Michael lost his job when he became too weak to work due to TB. Through his disability grants he was able to begin his own business selling fruit on the street corner and states that he is trying to become independent of the state and other people. Michael has defaulted from his medication before but currently has a good adherence rate. Although he states that he is turning his life around the nurses in the clinic (who live in the same community as him) don't trust him.

Finally, Marti comes in. She was battered the previous night by a group of vigilantes who accused her brother of robbing from their neighbours, a crime she does not deny. By the looks of it, she has a broken arm which she hopes the doctor can take care of. She has a terrible adherence rate and is completely non-compliant to her ARVs as well as keeping appointments and has taken today's appointment to get her wounds looked at.

This sample of an average day presented above illustrates the complexity of dealing with HIV/AIDS patients and the multiplicity of sources of their problems. The clinical encounter therefore is not limited to the doctor viewing a single disease, a single problem but rather a multiplicity of diseases and problems. The patients'

"qualification" for the encounter may all be the same i.e. diagnosed HIV positive, but their reasons for visiting the clinic are vastly different. Soné has come to enquire about a disability grant, Erol has come in for blood checks and Marti has taken the appointment so that the doctor could look at her battered arm.

The material reality in which a doctor operates is therefore not as clean cut as policy documents construe it to be. There is messiness, and incoherence, due not only to the circumstances the doctor finds him/herself in, in other words the working conditions of the clinic, but also due to the patients' interpretations of the function of the appointment. In this case, the dire circumstances under which the poor exist due to the workings of the capitalist machine, results in the fact that being diagnosed HIV positive is but *just another* trial in an already desperate life. The rhetoric of policy documents take the position of the "Third World patient" to be similar to that of the possibilities offered by a patient within the wealth of the "First World." Implicit within a model or policy therefore is a particular image of a clinic, doctor and patient which is construed as an "ideal" but which can never contain the complexity of reality.

Hirschman (1987) has argued that these ideal constructions of the conditions of the Third World are based upon "a compulsion to theorize." As he states:

> I believe that the countries of the Third World have become fair game for the
> model builders and paradigm molders to an intolerable degree. During the
> nineteenth century several "laws" were laid down for the leading industrial
> countries whose rapid development was disconcerting to numerous thinkers
> who were strongly affected by what Flaubert called "*la rage de vouloir
> conclure.*"[5] Having been proven wrong by the unfolding events in almost
> every instance, the lawmakers then migrated to warmer climes, that is, to the
> less developed countries. And here they really came into their own. For the
> less developed, dependent countries had long been objects of history- so to
> treat them as objects of iron law or rigid models from whose working there is

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[5] Hirschman translates this as "the compulsion to theorize" (Hirschman 1987:184)

no escape came naturally to scholars who turned their attention to them (Hirschman 1987:184).

The argument made within this thesis thus far has illustrated how it is possible for these "lawmakers to come into their own." That is, the distance maintained between policy and practice allows for the possibility of rigid models to be applied and, along with maintaining 'interpretive communities,' for these laws to be deemed successful.

1.3. Agency and Objects, Alternate and Singular Modernities

However, we must be careful to the extent to which we believe that the developing countries are "*objects* of history." To do this one would fall into the same trap as the critics of "developmentalism" discussed above. The policies implemented by global organisations are also subject to interpretation and use from below. In this regard, in personal correspondence with the head of a regional HIV/AIDS programme, the doctor argues that doctors should be "entrepreneurs of health" in this regard not only with access to patients but also in accessing global resources in order to fulfil their needs (see chapter 2). Therefore, doctors on the ground should not be conservative but rather dynamic and willing to change their approaches to health care provision according to the requirements of fighting the disease and the socio-economic circumstances in which patients find themselves.

Furthermore, local activists groups such as the Treatment Action Campaign (TAC), appropriate the language and discourse of human rights and equal treatment opportunities, the very language used by such organisations as the WHO or the Global Fund. Global health policies therefore do not have some power of their own which automatically homogenises, but rather, like all texts are open to interpretation and appropriation from below. The conditions for the success of policies must, however, be met by local doctors.

As such the tensions between the abstract policies of global organisations and the local reality of practice are bidirectional, global organisations impose and resist interpretations from the field as much as local actors impose and resist. However, as we will come to see, this tension exists as the foundation for a certain type of order.

But for the present time, the question remains whether this tension justifies the existence of global organisations? In other words, will the battle against the strife of the poor not be better fought at the level of the grassroots, free from the hamperings of Geneva or Washington? Proponents who support a move away from international organisations propose that local problems are best fought with local solutions. "Alternative modernities" (see Gaonkar 1999; Appadurai 1996) can be constructed in this regard, the Third World can progress free from the homogenising impact of global organisations and the "westernising" forces of globalisation.

A sobering Jameson (2002) is worth quoting at length:

> How then can the idealogues of 'modernity' in its current sense manage to distinguish their product- the information reduction, and globalized, free-market modernity- from the detestable older kind, without getting themselves involved in asking the kinds of serious political and economic, systemic questions that the concept of a postmodernity makes unavoidable? The answer is simple: you talk about 'alternate' or 'alternative modernitites'. Everyone knows the formula by now: this means that there can be a modernity for everybody which is different from the standard or hegemonic Anglo-Saxon model. Whatever you dislike about the latter, including the subaltern position it leaves you in, can be effaced by the reassuring and 'cultural' notion that you can fashion your own modernity differently…. But this is to overlook the other fundamental meaning of modernity which is that of a worldwide capitalism itself. The standardisation projected by capitalist globalisation in this third or later stage of the system casts considerable doubt on all these pious hopes for cultural variety in a future world colonized by a universal market order (Jameson 2002:12-13).

Jameson here opens up various questions and possibilities. Apart from supporting the above argument against the role of global organisations, this quote also casts light onto a new problem precisely that the "fundamental meaning of modernity" is subject to the workings of global capitalism. In this regard a singular system, that of worldwide capitalism, dominates all relations on the planet. Although this system is open to interpretation, contestation and appropriation from below, it still guides any

action taken on an international scale. As Delvecchio Good (2007) argues, "although acknowledging the importance of cultural pasts and cultural differences…it is increasingly artificial to speak of local perspectives in isolation from the global system….the world historical political economy and transnational cultural processes" (Delvecchio Good 2007: 362). A space is therefore opened here for organisations such as the WHO to advocate on such a large scale, where the limited resources of grassroots activism become mute.

This "space" can of course be abused by these organisations as a point from which they can attempt to homogenise the planet. However, as will be illustrated later, their (the global organisations) dependence upon the ability of actors from below to enact and in fact subvert their policies, will render critique of this sort futile. In this regard we can quote Zizek's commentary of the Jameson quote above: "the recourse to the concept of the 'multitude'… is false not because it does not recognise a unique fixed 'essence' of modernity, but because multiplication functions as the disavowal of the antagonism that inheres to the notion of modernity as such. The falsity of multiplication resides in the fact that it frees the universal notion of modernity from its antagonism, of the way it is embedded in the capitalist system, by relegating capitalism to just one of its historical subspecies" (Zizek 2007:125).

Furthermore, as has been stated, universal notions such as human rights can and are appropriated in the cause of the poor. However, keeping in line with our above argument, the 'reference points' set by 'experts' do limit how universal notions such as human rights are used. Therefore the success of human rights discourse globally is "a consequence of what Evans regards as the dominance of a liberal consensus on human rights. One result has been to effect a bias towards civil and political rights rather than social and economic rights. It is not so much that globalisation and rights run on different tracks, therefore, as that human rights have been commandeered by this liberal project in order to lend support to free market economics and the freedom to create wealth" (Jones 2004:389). There is therefore a limit on the meaning of terms such as 'rights.' However, this limit is set from 'below' as much as from 'above' as will be made clear later in this paper.

Global organisations such as the WHO are therefore able to advocate on a large scale. Part of this advocacy requires that standardisation be successful, along with programme evaluations, for statistics to be established as a 'factual ground' upon which advocacy is made possible. Furthermore, the success of advocacy can therefore only be ensured through mechanisms of homogenisation of practice ensured by protocols. The reason for this is that "protocols can create *comparability of activities over time and place*...... [protocols] collapse the two problems of constructing a fact and of exporting it to the outer world into one, by finding a means to construct knowledge in the very place where the protocols will have to be used.... The protocols, thus turn *practice itself into a laboratory*: by prescribing highly detailed sequences of action, they become the means through which facts can be *produced* and, at the same time, a crucial part of the networks through which the facts can be *performed* (Timmermans & Berg 1997:296 emphasis in original). Statistics are produced, as well as produce practice then, in the name of marginalised sections of the population as their suffering is illustrated through a standardised tool to allow for comparisons with wealthier nations.

Within a country, standardisation also functions as a tool which allows equitable allocation of resources (see Scott 1998). In the South African case, a key player in The Global Funds' distribution of ARVs in the Western Cape, argues the following: "national protocols are...used as a basis for making equitable financial resources available to the various provinces. Standardisation is, in that sense, a very useful tool. It is also a very useful tool for the uniform monitoring and evaluation of a programme and its outcomes" (Personal correspondence February 2008). This example could easily be extended to the global scale where an overarching organisation such as the WHO plays the same role as a state in allocating resources to various different parts of the world. One can view this role of distributing resources in how the WHO argues that "the department of HIV/AIDS at WHO headquarters provides overall coordination of the HIV/AIDS programme and is responsible for global advocacy and policy on HIV/AIDS issues and developing technical norms and standards in many intervention areas" (WHO 2006b:34). Standardisation therefore does suit the needs of central organisation and bureaucracy, however, this also aids the equitable allocation of resources.

1.4 Ethics: high managerialism and bad conscience

"Little is gained by installing utopian virtues; in fact, much is lost, since illusion and exaggeration distort the practical realities among which most people on earth live" (Kleinman 1995:28)

In the previous pages we have seen how international organisations can be viewed as organisations which aim to justify their own existence through their particular policies in local contexts. This is achieved through the process of standardisation by attempting to restrain possibilities for local interpretations. Furthermore, these institutions act as 'experts' on the fields within which they operate and thereby set reference points around which discourse is framed. I also argue that the success of projects depends upon interpretive communities deeming projects to be successful or not. The ethics of this type of framing of development will now be worked out.

Arthur Kleinman (1995) has argued that the type of ethics applied by international organisations to local problems and circumstance has become separated from the contingency of the local:

> The use of abstract concepts of justice and beneficence as universal ethical principles in decision making is suspect. This in part restates the cultural critique of individualism. Yet there is also a failure to take into account the local worlds in which patients and practitioners live, worlds that involve unjust distributions of power, entitlements and resources. It is utopian, and therefore misleading, to apply the remote principles of justice and beneficence to ordinary clinical problems, unless we first take into account the brutal reality of the unjust worlds in which illness is systematically distributed along socioeconomic lines and in which access to and quality of care are cruelly constrained by the political economy (Kleinman 1995:48).

This quote, along with the opening quote above, indicate what I have attempted to illustrate throughout this chapter, the danger of applying idealist, universalist principles to local contingency. This is not to imply that these principles and ideals should not exist, or should be done away with, but rather that their uncritically, universal application should be done away with. Kleinman goes on to argue that

"intellectualist perspectives that universalize ethical choice are flawed, at least for application to serious conflicts in the human experiences of illness and care, because they are, in a fundamental way, groundless" (Kleinman 1995:49). The endeavour of ethnography should exactly be to ground the practice of ethics, to illustrate how practice is "rife" with contradiction, which abstract ideals based on "rational" argumentation cannot accommodate.

The role of policy in the ethics of medical practice becomes key to understanding how we can frame an ethical relationship between physicians acting in the field and larger powers, such as the WHO, who claim and aim towards ethical practice. This is especially pertinent in the context of this thesis, which examines the role of policy and its functioning in local practice. Quarles van Ufford et. al. (2003) argue that development projects have begun to privilege policy over action due to the fact that the success of a policy depends rather upon "interpretive communities" measuring success, than on the effects these policies have on their intended beneficiaries[6]. The result of this is a culture of 'high managerialism' in which consultants and actors in the development industry are more concerned with the management of offices than of projects. "In a sense 'high managerialism' firmly privileges policy over action. Donor advisers and specialists are involved in a scramble 'upstream' away from the localised triviality of 'neo-colonial' projects into the offices of national planning. Meanings and opportunities in international development appear increasingly centrally generated. Action at the periphery (in field level programmes) depends upon its ability to contribute to sustaining consensus in policy frameworks" (Quarles van Ufford et. al. 2003:9). The danger of this type of upstream, administrative management of development projects is that "the experience of illness is made over, through the application of ethical abstractions such as those described above, into a professionally centred construct that is divorced from the patient's suffering as is the biomedical construction of disease pathology. The patient's experience is appropriated by the rational technical categories of professionals" (Kleinman 1995:49).

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[6] This paper does not in anyway imply that interpretations of events can be separated from some ideal or "real" reality free from interpretation. Rather what the critical work of notions such as "interpretive communities" does is to raise awareness to the fact that the actions of policies are porous, that in deeming a project a complete success or failure once misses perhaps unintended side-effects which have very real consequences for the (un)intended beneficiaries of these projects.

One can argue that policy creates good conscience. That is, the 'neatness' or 'rationality' of policy does not have to contend with the messiness of local practice, with the tension often experienced in taking action. The power relationship inherent within the field of international health implies that interpretive communities have to consistently sustain consensus with the policies implemented from above, "those that fail to do so lose their reality and 'fail'" (Quarles van Ufford et. al. 2003:9). The separation of the effects of policy and the creation of policy can be seen as a result of "high managerialism." However, later in this thesis I will illustrate how local actors appropriate policies, often in dissent of the intentions of the organisations, but then how these appropriations maintain the success of the policies in the first place. The conscience of the policy makers stay clear as their policies are deemed successful or fail but without any real critical engagement with the effects these policies may have. Good conscience implies that responsibility is not taken for the effects of policy.

Jacques Derrida (1993) has argued strongly against the self-assuredness of good conscience as an ethical imperative. It is worth quoting Derrida at some length here:

> ..one must avoid good conscience at all costs. Not only good conscience as the grimace of an indulgent vulgarity, but quite simply the assured form of self-consciousness: good conscience as subjective certainty is incompatible with the absolute risk that every promise, every engagement, and every responsible decision…must run. To protect the decision or the responsibility by knowledge, by some theoretical assurance, or by the certainty of being right, of being on the side of science, of consciousness or of reason, is to transform this experience into the deployment of a program, into a technical application of a rule or a norm, or into the subsumption of a determined "case." All these are conditions that must never be abandoned, of course, but that, as such, are only the guardrail of a responsibility to whose calling they remain radically heterogeneous (Derrida 1993:19).

Derrida is therefore not calling for an abandonment of action or science, but rather for an abandonment of the good conscience which the certainty of policy can provide. He is calling for active, critical engagement with the consequences of action and taking responsibility for the successes and failures of those actions. The good conscience of

'high managerialism' is incompatible with the risk of action and, as Kleinman argues, distorts practical reality.

There is a particular understanding of ethics at stake within this discussion which assumes that 'the ethical' is a stable referent (Rajan 2006). That is, the ethics inherent within the universalist presumptions made by the WHO, assume, as they do with the functioning of the clinical encounter globally, that an ethics can be eternally fixed and valid despite local contexts. However, if we shift ethics from a metaphysical set of values to a physical encounter, to where ethical decisions must be made, to something that arises within a context and *must* be worked through or resolved we are able to move beyond arguments concerning relativism or universalism. Ethics does not happen, is not resolved within the bureaucracies of global organisations but rather manifests itself in real life decisions doctors have to make concerning the very life of their patients as well as future populations. Can I trust this patient with ARVs? Can I afford to wait for test results to return before I diagnose TB? These are clinical as much as ethical problems. As Rajan states,

> Both transcendental, universal ethical positions and their relativist
> counterparts that simply celebrate particularity assume that the ethical can be
> decided purely with reference to some kind of self-contained value system- the
> only dispute being whether that value system holds across communities or is
> distinct between different communities. Fortun's understanding of the ethical
> points instead to the absolute impossibility of ethics in either universal or
> relative frames of reference unless one recognizes the sorts of incongruent
> discourses and value systems that come into contact in order to create an
> "ethical" question demanding resolution in the first place (Rajan 2006:66).

In the rest of this thesis I will explore the incongruent discourses and value systems found in the field of practice, in the moment of decision making. In the following chapter I will discuss how a manager of a rural ARV clinic manages his clinic in relation to the requirements of global organisations. In this light I will aim to demonstrate how the "gap" between policy and reality is taken advantage of to further the ends of the clinic. This is made possible by the culture of high managerialism found in today's "development industry" and the agency of the clinic's manager. The

agency of the manager, I will demonstrate, is furthermore made possible by a certain opacity at ground level concerning the relationships between international donors and local government. Therefore, even though I have critiqued the culture of high managerialism in this chapter, I will also show how it is taken advantage of by those operating at a grassroots level.

I will then move on to look at how standardisation works and make an argument for how doctors deal with protocols in their relations with their patients. I will illustrate how the universal attempts to limit its antagonism through distancing practice from local contingency. However, what this chapter also illustrates is that universality is only possible, or can only be found, within local contexts. For this reason, the concept of 'local universality' is adopted from Timmermans and Berg (1997) to describe how universality is achieved, by being built upon existing structures. Universality, or the attempt to standardise, is therefore dependant upon a certain amount of looseness in the network in order to adapt to local conditions. It is due to this 'looseness' that doctors are able to resist the tendency to distance practice from policy. However, I will demonstrate that this resistance does not challenge the protocol but rather upholds it.

Chapter 2: In between Global and local

In the previous chapter I examined how international organisations interact with local contexts through the policies they create. In this regard, I looked at how distance is maintained between policy and local reality, and how this maintains the success of many policies, sometimes despite them having little or no positive benefits for their intended recipients. This is achieved through 'interpretive communities' deeming projects to be successful, based upon reference points established by experts often housed within global organisations. This has created a situation in which development projects have begun to privilege policy over action (Quarles van Ufford et al 2003). However, this does not imply that policies are blindly followed at the grassroots level but rather they are often interpreted and appropriated 'from below.' In this chapter I will move from a global level of analysis to look at how organisations at the ground level take advantage of the gap created between policy and action for their own advantage. In this regard, I will look at the constraints placed upon local organisations by their global counterparts and attempt to illustrate how these limits are used by local actors to their own advantage. In a sense this chapter is the 'next step down' on a ladder moving from large scale global organisations and ending in the consultation between a doctor and a patient.

2.1 How international organisations play a role in clinics

The question as to what effect international organisations, such as the WHO, have upon the clinical encounter on the ground, depends upon how one views the interactions of these organisations with local reality. Stacey Leigh Pigg (2005) argues that "public health interest in sexuality presents itself as a hard cusp where a particular kind of modern, reified and biologized concept of sex pushes against other sexualities. In practice, however, what international health interventions produce are frayed and flexible edges where knowledge and practice is transformed" (Leigh Pigg 2005:53). In this chapter I will attempt to illuminate this boundary between the policies and constraints of international organisation and the constraints and possibilities created in their realisation "on the ground." Indeed the argument here is precisely to illustrate, as Leigh Pigg does, that the boundaries between the local and the global are not closed

but rather open, porous boundaries, constituting as much as being constituted by the local.

2.1.1 Relations both global and local

As an illustration of the workings of international organisations within a clinic, I will present a case study of the relationship between the clinic, the national government and international organisations. The clinic I will use as a case study is the one managed by Dr. G, described at the beginning of this thesis. The clinic is based on the grounds of the public hospital in a working class neighbourhood, a few kilometres away from the townships. Due to its location in a rural wineland town, its patients are mainly employed in the surrounding wine industry.

In 2003 the clinic received funding earmarked for HIV/AIDS treatment and began providing treatment in 2004. A part of the earmarked funding for the Western Cape Administration came from a grant provided by The Global Fund to fight AIDS, Tuberculosis and Malaria (grant SAF-30-G04-H) which aimed at the distribution of ARVs. The size of this grant was relatively small in comparison to that provided by national government yet it came with stringent reporting and managing criteria.

The difficulty in the first two years of providing treatment came in the form of a lack of infrastructure and support services for the distribution of ARVs, exacerbated by the fact that little international funding is available for 'non-essential' items such as filing cabinets or basic administration staff. This is due to the fact that it is more difficult for funders to regulate this type of spending in comparison to medication provision through which they can demand statistics on treatment numbers and success rates. Along with the statistics, the donors also request narratives of the clinic and the spending of grants from the head of the clinic. This is perhaps to "add colour" to the rather dry statistics and provide affective content to the numbers, which are often used to advocate on behalf of PWAs in the Third World. The donor agencies therefore demand a certain level of control provided through promised and received results over the recipients of their funding. The delivery of these results builds trust and partnerships between the recipients and the donors allowing for future funding for the clinics. However, as I will later illustrate, this type of 'control through numbers'

approach also provides the clinic with a fair amount of agency through which they are able to set their own targets.

Once the clinic opened, the subsequent flood of patients needing and receiving anti-retrovirals (ARVs) quickly resulted in the targets set by national government being met and surpassed. With the constant surpassing of national targets the clinic was given the right to seek funding independently from national government and it was for this reason that the head of the clinic sought funding from ARK (Absolute Return for Kids). ARK is a UK based NGO which seeks to provide services for either children orphaned by AIDS or by providing ARVs for parents so that they can look after their children in the face of the pandemic. The organisation funded the supply of additional ARVs as well as support services to the clinic for a three year period until they withdrew from the clinic in March 2007.

The arrival of ARK thus facilitated the service provision of ARV distribution as they agreed to sponsor personnel to help with the running of the clinic. ARK receives its funding for its activities from philanthropic hedge funders. Its funding policies thus reflect the attitudes of young professionals living in the First World, making millions off the ups and downs of the capitalist economy, in that they are willing to take risks in the distribution of their wealth and thus provided initial funding in South Africa for clinics such as the one discussed here. Furthermore, the organisation is self-funded and is therefore not accountable to any external donors, which increases the ability of the organisation to take risks as well as allowing them more flexibility and speed in their actions. However, in order to ensure that their funding reaches their target population of mothers and fathers living with AIDS, the organisation includes the use of eligibility criteria forms for doctors to fill in when wanting to place a patient on ARVs. These forms are provided as an "aid" for the doctor to remember the eligibility criteria for adults wanting to be put on ARVs and therefore serve as a "siphoning" mechanism that allows only patients who comply with ARKs' models to receive medication. The organisation in this regard aims to limit certain patients from receiving medication from the grant money provided by ARK through means of criteria worked through by the doctor during a consultation.

This externally generated non-governmental funding provided the clinic with the flexibility to establish a centre which ran operations not strictly abiding to the National Department of Health's service provision criteria. Dr G initially struggled to get the centre off the ground due to a lack of willingness from international donor agencies to provide "start up" funding for such initiatives. The centre has also focused on clinical research as well as providing social and financial support to patients at the clinic. Along with a socio-economic patient data base being built up (through recorded interviews), a clinical database will also be established as part of a research unit affiliated with a regional university. Social support will be provided by means of church groups and patient support groups gathering there.

The Ikhwezi bead project is a community based project established by the centre in order to support HIV positive mothers financially. The centre is used as a place for the mothers to gather to make beadwork items such as broaches and pens. The beadwork is sold either to local organisations or within the Ikhwezi craft shop situated nearby the clinic, which sells such items to tourists on day trips to the area.

In terms of adherence, the head of the project argues that mothers belonging to the beadwork project have improved their adherence rates once joining the project. This is described by Dr G as being due to the fact that previously HIV/AIDS was associated with loss: loss of weight, loss of strength, loss of employment and consequently loss of life. In contrast, receiving ARVs and being part of the beadwork project provides mothers with a means of gaining both in self-esteem as well as financially, as they can now provide for themselves and their children. AIDS now becomes a process of gaining[7]. Furthermore, the additional income contributes towards a healthier diet and consequently lower levels of stress. It is as such that a neo-liberal ethic of financial independence and enterprise aids mothers in overcoming the dire circumstances in which they find themselves, circumstances which were created by global economic policies based upon the same neo-liberal principles.

PEPFAR (the President's Emergency Plan For AIDS Relief) was approached for additional funding for the clinic as well as for the centre once the ARK contract

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[7] For more information on this revival gained through ARVs see Robins 2006.

expired. The director of the clinic hoped to receive PEPFAR funding in order to gain funds for additional infrastructure and staff. PEPFAR eventually agreed to a grant of one million Rand. Meanwhile the national government (albeit it includes a Global Fund grant) has provided between fifteen to twenty million Rand a year for HIV/AIDS services in comparison to the one million Rand provided by PEPFAR. Yet, the reporting criteria from PEPFAR, argues the head of the clinic, is disproportionately large in comparison to the fact that they provide just 5% of the funding used by the clinic.

There is another discrepancy between private, external funding and government funding in terms of budgets. The cost of ARV drugs is approximately one thousand Rand per month per patient. However, if one includes the costs of infrastructure, doctors and general staff, the total cost of ARVs goes up to seven and a half thousand Rand per month per patient. The provision of funding for ARVs by donors is thus dependant upon a health service which provides capital for infrastructure and staff. The medication which a patient thus receives is based upon an unacknowledged collaboration between the national government and the international donor even if the funding is sought independently of government.

2.1.2 Managerial Cultures and Strategies.

From the above we can therefore draw the following analysis of the relationship between the management of the clinic, their patients, national government and international donor agencies. The following analysis will be divided into two subheadings. The first, "Management constraints and liberties," will focus on the structure and agency under which service delivery of ARVs is conducted. The second subheading, "Neo-liberal interpretations," will analyse the "management culture" and strategies associated with the clinic.

2.1.2.1 Management constraints and liberties

Auditing cultures and reactions

As has been noticed the head of the clinic has various reporting requirements stemming from different donors as well as from the provincial government. It would be too simplistic to argue that the reporting procedures required by each institution construct a limiting structure within which the doctor has to provide care. Each organisation requires that certain targets must be met within certain time frames. Furthermore, these targets must match the intended patients for which the donors provide aid. For example, ARK requires that all patients dealt with under their sponsorship must fulfil the pre-established criteria agreed upon by the management of the organisation. That is, "to ensure that fewer children are orphaned by HIV/AIDS, by keeping their primary caregivers (usually mothers) alive" (ARK objectives on website), the intended patients of ARK's funding is HIV positive mothers and fathers. As has been stated, the donors provide funding for patient medication because it is easier to keep track of spending on these matters than it is on basic infrastructure. Furthermore, the statistics help the donors illustrate their contribution towards the fight against AIDS outside of the "international aid" setting such as on their websites or during charity drives. It is because of this desire to illustrate success that a gap is created through which the management of the clinic is also able to set an agenda and make claims upon the donors.

As was explored in the first chapter, this desire to demonstrate success by international organisations can be described as driven by a culture of "high managerialism". High managerialism makes possible a gap between the creators of policies and the effects of these policies "on the ground". This is due to the

> implicit and under-explored relationship between development goals and outcomes which are linked only through the logic of the concealing 'black box'....the black box separating input and outputs/effects is drawn larger and larger, hiding more and further blurring the links between goals and their effects. The instrumentalities of interventions, the praxis of projects, the contingencies of programmes all disappear between proclamations of high level development partnerships on the one hand, and the national/regional statistical record on poverty, illiteracy, morbidity (etc.) on the other (Quarles van Ufford et. al 2003:9).

We can see here how a manager like Dr G takes advantage of the vagueness of this "black box" in order to achieve the aims he sets for his clinic. Once a relationship of trust is established between the donor and the management of the clinic, the management only begins accepting targets based on certain conditions such as the provision of extra funding for infrastructure and staff. Therefore, despite being at the receiving end of funding, the managers of clinics are also able to illustrate a fair amount of agency in order to reach agendas they have set for themselves through their partnerships and the trust they have built with donors.

In this regard the management of the clinic has furthermore created a level of autonomy independent from provincial government through overspending and overshooting targets for ARV distribution. In the case of both donor and government funding the management of the clinic both purposefully (by consciously allowing it to happen) and contingently (there were simply just that many people needing ARVs) overspent their budgets for ARVs and thus overshot their targets. It was because of this that national government allowed the clinic to begin to look for funding independently. By being ambitious, Dr G has managed to create agency for the clinic in its relationship to the large bureaucracies providing funding for the clinic.

There furthermore exists a certain level of opacity at the ground level management of the clinic in terms of both funding and meeting targets. As was stated above the reality of who bears the cost of funding ARVs between donor organisations and government is contested as the government provides for staff and infrastructure whereas the donors often do not. In this regard one can notice that a single patient, whether they qualify for donor medication or not, receives both government and donor support when receiving medication. This is because both funding and targets are "thrown" into a single budget and spending and reporting its justified *post facto*. "[T]he point is that in practice 'rule following' (the application of policy) is nothing of the sort. Rather it is an after-the-event rationalization of the decisions on funding that are based on relationships of trust, identity and social knowledge" (Mosse 2005:21).Therefore the management and clinic once again create autonomy for themselves in that they determine the success of reaching targets and report to donors according to their requirements, both in narratives (life stories) and statistics. This is only possible, however, due to the fact that there unfortunately exists such a wide

range of people suffering from AIDS that any reporting requirement can be fulfilled after the fact.

2.1.2.2 Neo-liberal interpretations

In a move to tackle some of the social and economic complaints given by patients, as well as in an attempt to improve adherence, Dr G established the centre discussed above. Described as an "Emporium of Care," the centre aims to house beadwork projects, facilitate HIV/AIDS research, improve adherence through counselling, and cater for the spiritual wellbeing of patients. The Emporium operates outside the boundaries of functions prescribed by the state to doctors. It therefore exists in a domain between a public and a private institution as it is housed on the day hospital's grounds and serves the clinic's patients, yet it is funded for entirely by independent donors. Yet it cannot be defined as a purely civil society organisation initiative due to its strong connections and collaborations with government.

Frustrated by the lack of a holistic approach in dealing with the pandemic, the clinic decided to establish the Emporium independently from government, in an entrepreneurial spirit of risk taking. This is evident in the input of Dr G's own capital in starting the centre due to the difficulty he faced in finding funding for basic infrastructure from international donors. The Emporium was set up by Dr G under the rubric of a neo-liberal approach to health care wherein doctors should be regarded as "Entrepreneurs of Health." In this approach, the doctor argues that the "honeymoon" of ARV distribution is over, where patients used to travel from afar to receive the newly offered medication. In the aftermath of this initial flurry of excitement, it is now the role of health care providers to 'seek out' the suffering and to 'advertise' health care. The Emporium aims to achieve this through beadwork projects such as Ikhwezi wherein patients are able to establish financial independence for themselves as well as through support groups and peer education campaigns. The Emporium's aim at a more holistic approach is seen in the services offered towards spirituality wherein church groups are invited to advise on the spiritual well being of patients within the clinic. The Emporium's aim is therefore not to solely care for the biological aspects of the disease but also to take into consideration the spiritual and financial burdens created by living with HIV/AIDS.

As the state has not allocated a budget for the Emporium it is not audited. Furthermore, within the town the clinic is based in, there is a large 120 million Rand hospital being established, and in comparison, to the forty or sixty thousand Rand budget for the centre, the health department has bigger things to worry about.

However, Dr G does have concerns that the Emporium will attract attention due to the fact that it is offering services outside of those usually offered by government clinics. Although not strictly complying to the New Strategic Plan (NSP) the Emporium is justified by its founder as being part of a pilot project which seeks to find new ways to manage health care, a possibility left open within the NSP. The description of the Emporium as a pilot illustrates the entrepreneurial possibilities held open by the government in health care. The problem with creating policies of the sort that would promote emporiums of this kind is that they become static and limiting. In this regard, the head of the clinic argues that as HIV treatment is such a new field within South Africa, space must be left open for experimentation. It is perhaps here, in the gap between the state and the private, that the neo-liberal ethic of risk taking and the entrepreneurial spirit is important in the fight against HIV/AIDS.

What one can witness in this case study is a particular manifestation of the neo-liberal ethic in which a clinic, forced by the economic circumstances within which it finds itself, adopts the language and goals of neo-liberalism. That is, the manager of the clinic uses phrases such as 'entrepreneurial' and 'independent' to describe the Emporium. In this light, he adopts the hallmarks of neo-liberalism, independence from the state and a spirit of entrepreneurialism, as the guiding ethic in establishing his Emporium. Yet at the same time, and perhaps in contradiction to strict neo-liberalism, the clinic illustrates a hybrid state/civil society ethic, wherein the material requirements necessary to fight a pandemic take precedence over public or private policy. In this regard one can witness how the driving force behind this clinic is a pragmatic approach to health care in which bureaucracy and auditing are dealt with as obstacles rather than requirements for effective service delivery.

Doctor G argues that there is a serious disjuncture between government policy and the reality which a doctor experiences within the local setting. It is because of this

disjuncture that the head of the clinic expounds a pragmatic approach to health care in which local solutions are given precedence. However, the aims of these government protocols are to ensure the long term well being of a population and it is therefore important to synchronize these policies with local reality. It is here that international funding becomes important because of its ability to respond quickly to short term problems. It is as such that the management of an ARV clinic must "play" between the possibilities created by the short term investments of international donors while keeping an eye on the long term well being of the population established by government policies.

What we can witness here is the means by which the material reality of treating a pandemic the size of HIV/AIDS has a direct influence over the strategies the clinic employs. The broader structure within which the clinic thus finds itself can be regarded as limiting (the lack of funding available or the demands of auditors) but it is probably more pertinent in this case to regard these structures and limits as enabling, in that the clinic manager creates a space of agency within which to operate which depends precisely on these structures. As Timmermans and Berg (1997) illustrated, "In observing the utilization of research protocols in medical practices, the first thing that becomes obvious is how patients and medical personnel are *not* turned into mindless followers of some pre-set script. On the contrary, seen from their perspectives, it is the *protocol's trajectory which is secondary* and which is aligned to their own goals and trajectories" (Timmermans and Berg 1997:288 emphasis in original).

The boundaries are furthermore enabling as Doctor G has an interest in illustrating the success of the clinic in order to ensure future funding. As Mosse argues, "the 'public transcripts' of development are sustained by the powerful *and* the subordinate, both of whose interests lead them to 'tacitcally conspire to misrepresent.' In development we cannot speak of policy controlling or disciplining, being resisted or subverted. Policy is an *end* rather than a cause; a result, often a fragile one, of social processes" (Mosse 2004:663 emphasis in original). In this part of the thesis I have aimed to demonstrate how a manager of an ARV clinic subordinates protocols to his own ends, in this regard Mosse's observations above can be tied in with the ethnography of this part of the thesis to show how policy is an end rather than a cause. In the next section I will

move on to illustrate, on a smaller scale, how protocols are subordinated to the ends of the doctor.

2.2 Protocols: Medicine, like Coke, Lite

From the above, one can view how a clinic becomes a site through which the global is mediated into the local. In this sense one can view doctors such as Dr. G and Dr. Z as "middlemen," but not in the "car salesmen" sense ie. only interested in their own gain, but rather as mediators speaking in the interest of their patients (and of course in their own interests). In relation to patients, then, Mosse states:

> international policy regimes do not simply arrive, but are produced by intermediary actors, frontline workers (middle managers, bureaucrats, clinicians, technicians, NGO staff, health workers or engineers) who translate abstract global policy into their own ambitions, interests and values. These actors are both objects and agents of global policy, charged with bringing about the new normative/legal and administrative orders, imposing definitions which categorise people, making them into proper consumers, clients, users or patients (Mosse 2005:20).

These 'intermediary actors' work to make possible the policies of global organisations but then also translate abstract, impractical policies into pragmatic tools for furthering their causes. In this regard it is important to now examine what a protocol is and indeed how it functions in the above case study.

In stating that 'intermediary actors' *translate* the policies of global organisations, I am already indicating the relative position of a policy, that is, its ability to be manipulated or to manipulate. But translation does not imply coherence, that is, in translating a policy into local practice the "paper policy" and the implemented "practiced policy" do not necessarily line up, or cohere with one another in a homogenised fashion. A comparative case study will demonstrate this point. The psycho-social criteria for ARV eligibility state that employment, and stable family lives, are good indicators for positive adherence rates. In this regard one can witness how "Johan," a married policeman with three children, has defaulted once before from his medication, and

currently has a poor adherence rate. In contrast, Louise is a single, unemployed women who lives alone. She has schizophrenia and under the psycho-social criteria (see addendum 2) used for ARV eligibility would not qualify for treatment due to her lack of family support and her mental condition. However, the doctor in charge of these two patients decided to place both on ARVs, with Johan, who complies perfectly to the criteria, defaulting from the medication, and Louise, who would ordinarily be seen to be an unsuitable candidate for ARVs, ends up being successful. In this regard, the 'paper policy' of ARV eligibility would fail in both instances. However, the 'practiced policy' dealing with the contingency and experience of daily life upholds the success of the policy due to a translation in which the key auditing tool, adherence rates, is kept at a suitable level. There is coherence then, but not between "policy and reality" but rather between "policy and auditing." In a successful project what happens in between policy and auditing is incoherent if one were to view the project according to the strictures of the policy.

Protocols are important for standardization as they attempt to structure practice. As Berg (1998), quoting Eddy and Feinstein, states:

> Protocols are "performed recommendations issued for the purpose of influencing decisions about health interventions." By analyzing "decisions before the fact," they prevent the "mental paralysis and chaos" that would otherwise result from having to rationally decide every time again from scratch….Through the branching structure of the protocol, "a clinician can now, at long last, specify the flow of logic in his reasoning, [so that he] can begin to achieve the reproducibility and standardization required for science (Berg1998:227).

A protocol is therefore necessary for the success of standardization as it structures, 'rationalizes' and prioritizes certain ways of thinking above others. In this regard, choosing a policeman as eligible for ARVs appears more rational than allowing a single, unemployed schizophrenic woman the same medication. "The protocol [then] will strive to anchor decision moments precisely and concisely- and redelegate spokesmanship to a few unambiguous and stable items" (Berg 1998:241). Standardization, understood as universally implementing and following a standard of

protocols, is a bureaucratic tool, it is an attempt to create efficiency and accuracy within the confines of certain administrative necessities. However, as in the case of bureaucracies, it is an ideal which comes up against the complexity of reality.

In the words of Dr G, protocols make medicine "lite," like Coca-Cola or Windhoek lite, alcohol or sugar free versions without risk and unpalatable to the discerning tongue of the expert. Like the beer connoisseur, who understands the making of beer, so an experienced doctor will understand the composition of a protocol and can thus determine when it is appropriate to break with protocol and when not, what distinguishes "lager from lite". Like making beer available to a larger market, protocols attempt, in the understanding of Dr G, to make medicine "lite". That is, it gives access to prescribing medicine to a wider staff, a basic knowledge in medicine and the ability to follow instructions which facilitates action against disease by nurses in what have come to be known as sister or nurse-driven programmes. In this regard, protocols serve a valuable function; they assist in treating major disease in the greatest number of people by focusing on problems of health for a population. However, the people prescribing the medicine often do not have the confidence granted by epistemological or experiential authority and therefore may not challenge the protocol in exceptional cases,[8] even though they may believe exceptions can be made. It is in these exceptional cases where much of the critique of protocols comes from. So, in order for medicine to reach the greatest number of people, major health organisations, such as the WHO, establish protocols in order to create "medicine lite", medicine that excludes the work of exceptional cases. This is due to the fact that exceptional patients require expertise and effort in order to maintain their health, which requires expenditure on resources which could be used more efficiently in non-exceptional cases.

A policy or protocol does not arrive in a clinic existing within a vacuum, but rather has to contend with existing structures and counter-structures. "One of the central tensions in creating and achieving universalizations is the relationship with past infrastructures, procedures and practices. Standards will attempt to change and replace those practices but… the same standards need, to a certain degree, to incorporate and

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[8] This argument can be construed as a defence of experts although it is experts of a particular kind and does not exclude the possibility of 'lay experts' or the expertise of experienced nurses

extend those routines" (Timmermans & Berg 1997:274). As was mentioned in the previous chapter, policies do arrive with the injunction that they should be tailored to local circumstance. However, "the success of travelling governmental modes depends on their ability to construct local practice, to distance it from local contingency. [But] rationalities don't arrive on any kind of cognitive or cultural tabula rasa: in the disparate localities to which governmental rationalities travel, they are variously revalued, reworked, hybridized, according to local interests and priorities" (Craig 2000:109). One can now witness the tension which exists between a policy, created in a "neutral" environment in order to govern thought, and how it grates up against the texture of local reality. As a doctor working in the administration of The Global Fund in the Western Cape argues:

> The management of virtually every disease is based on "standardisation" of treatment protocols, although to varying degrees. Those standards should draw from international knowledge and demonstrated "best practice" models. <u>However</u>, what is possible in different countries (and often what is possible in different areas <u>within</u> a country – South Africa being just one example) varies depending on the resources that are available. Strict implementation of international standardisation is therefore seldom possible – best practice models need to be able to be adapted to local settings"
> (Personal correspondence, underlining in original e-mail correspondence).

Timmermans and Berg (1997) argue that a medical standard can be viewed as "*a technoscientific script which crystallizes multiple trajectories*" (Timmermans and Berg 1997:275, emphasis in original). It is worth examining this statement, as they do. Accordingly,

> the 'script' of a technological artefact refers to the hypotheses, embedded in the artefact, about the entities which make up the world in which the artefact will be inserted. A technoscientific script specifies actions, settings, and actors who are defined with specific tastes, motives, aspirations, political prejudices, and a value system (ibid).

A script therefore is seeped within a politics, in the way it understands subjects, localities and values. The role of *trajectories* in the definition is in order to illustrate the temporal nature of a standard. That is, actors and material objects meet within a standard as they follow a temporal path from their past to the present, looking towards the future. Possible futures therefore play a pivotal role in protocols as the various actors are engaged within the present protocol in order to achieve desired outcomes. In this sense different trajectories are *chrystallized* or brought together in the present, and subsequently transformed. "During the crystallization process the prescriptions of the protocol might be 'betrayed,' or altered beyond recognition, by the actors using the protocol. Also, the trajectories of the actors might diverge for many reasons, instead of being brought together by the protocol" (ibid:277). However, the ideal case for the protocol is to bring actors together, and indeed to "construct local practice" while distancing it from "local contingency" (Craig 2000). It is important to note that this is a step towards limiting the antagonism within the universal, discussed in the first chapter, as 'trajectories are crytsallised according to technoscientific scripts' and 'local practice is distanced from local contingency'.

Protocols can then be seen as "inhumane" tools of an administrative order which doctors bravely subvert in the interests of their patients. However, this would be an over simplification of the reality in which protocols function. "In the new configuration created in and through the protocol, new possibilities are opened too….[a] protocol constructs its own, *specific* order, which is *different*" (Berg 1998:242 emphasis in original) from the previous order.

As illustrated, a protocol does not 'arrive' but is 'produced' within local contingency. That is, when the attempt is made to implement a protocol, it has to contend with existing structures, sometimes destroying them, sometimes appropriating them but often being appropriated by them. In this regard achieving standardization does not rely on a central actor but is rather a *distributed activity* as it moves from one actor to the next along its path.. Furthermore, "non-docile actants may well be a *sine qua non* for universality in practice. Rather than being antagonistic to it, a certain looseness in the network may be the preferred (or only possible) way to achieve standardization" (Timmermans & Berg 1997:275). That is, a policy cannot be "followed to the T" or enforced in a totalitarian fashion in order for it to be successful. Looseness is required,

a policy must be open to interpretation and adaptation[9]. "Tinkering, having the leeway to adjust the protocol to unforeseen events and repair unworkable prescriptions is a *prerequisite* for the protocols functioning: in these practices, the overall stability of the network is at the same time challenged *and* dependent upon the instabilities within its configuration" (Timmermans & Berg 1997:293 emphasis in original). It is as such that Timmermans and Berg propose the seemingly paradoxical concept of 'local universality'. "Local universality emphasizes that universality always rests on real-time work, and emerges from localized processes of negotiations and pre-existing institutional, infrastructural, and material relations. 'Universality', here, has become a non-transcendental term- no longer implying a rupture with the 'local', but transforming and emerging in and through it" (ibid).

What is important to note from the discussion so far is that although protocols attempt, ideally, to homogenise practice, in material terms they rarely do. Of course, the extent to which one is able to subvert or resist the universalizing tendencies of protocols, depends largely upon the position of the individual involved. That is, a more experienced doctor would have greater confidence in breaking with protocols, or realising the limits of protocols than would a more junior doctor who relies on these protocols to structure his/her thinking. It is as such that the position of the doctor in relation to a medical hierarchy plays a large role in who follows protocols and who doesn't. The break with protocols also largely depends on the administrative position of a doctor. For instance, a doctor such as doctor G plays a management role within a clinic and is therefore responsible for responding to any failings within the (mis)following of protocols. In a sense the manager of a clinic has an investment in protocols in order for auditors to deem the clinic successful. In contrast to this a doctor who does not need to fulfil management requirements, such as Dr Z, has more of a free reign on breaking protocols, as the success of the individual patient is their sole concern rather than the administrative success of the clinic.

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[9] One can see this looseness in a network much the same way that "strike to the rule" action works within factories. That is, as a form of strike workers will follow the rules like automatons and thus bring the factory's production to its knees. This is because "designed or planned social order is necessarily schematic; it always ignores essential features of any real, functioning social order" (Scott 1998:6).

For example, a healthy looking patient walks into the clinic one day. Dr Z points this individual out (Jonathan) with great enthusiasm stating that just four months ago he was on his death bed. Jonathan had come into the clinic, thin and wasted, assisted by the nurse because he did not have the strength to be able to carry himself. Before having even shook the man's hand, Dr Z. says she could see he had TB and after examining him she diagnosed TB. However, Jonathan stated that he had been turned away from the clinic twice before because the doctors in the TB room could not diagnose TB because he could not produce sputum for a micro-biological test. However, being a doctor working with AIDS patients, Dr Z knew that somebody in Jonathan's condition would not be able to produce sputum due the workings of the HI-virus on the immune system. Dr Z subsequently sent Jonathan to a local hospital and it took that hospital two weeks of testing before they began Jonathan on TB medication on an empirical basis, ie they began him on medication just to see if he would improve. Two weeks later, when Dr Z visited the hospital where Jonathan was being looked after, his condition had considerably improved and it was clear that Dr Z's initial diagnosis had been correct. The micro-biological sputum test is an administrative requirement for diagnosing TB. However, Dr Z's confidence to defy the protocol saved this man's life as her initial diagnosis was applied by the hospital as a last resort. Dr Z's position in the clinic, as well as her experience in HIV medicine, therefore allowed her to defy the protocol to which the TB doctors were complying. As we will come to see later in this thesis, this defiance on behalf of Dr Z is also the product of a particular ethos which she abides by.

Another interesting example of the subordination of protocols has to do with the way in which clinics are accredited as sites for distributing ARVs. Accreditation is a system adopted by the South African government of qualifying a clinic as suitable for the distribution of ART. In contrast with previous care of chronic disease, the introduction of ARVs into the medical nexus introduced a serious demand for sustainability. That is, in pre-AIDS medicine, all chronic care could be dealt with, without a need for the sustainability of treatment. That is, a diabetic could still receive insulin from an emergency ward or somebody suffering from epilepsy could also be dealt with in an emergency ward. However, the introduction of AIDS demanded that the distribution of medication be reliable and sustainable to an individual patient due to the ever present threat of resistance. Accreditation then, served to ensure that sites

offering ART would be sustainable and that medication could be reliably issued from these sites without any mishaps. Accreditation in this sense demands planning, management and quality control, which benefits its patients in the long run. Responsibility for patients is also assumed by accredited clinics due to the ability of government to regulate (audit) these clinics. Initially this control through accreditation served the interests of a government not motivated to distribute ARVs by limiting the rollout of medication and as such served an ulterior motive to that of effective management. However, accreditation has now become part of the structure of managing the epidemic, and as we will see below, can be used effectively to the patient's advantage[10].

As a regional manager of HIV, part of Dr G's mandate is to establish clinics within his region. He therefore has to use the accreditation system in order to establish certain sites as ARV clinics. However, due to the rigid requirements of accreditation (see addendum 1), a few of the sites he uses for ARV distribution will not gain accreditation. In a few small townships surrounding major rural towns this strategy has been adopted. In most cases the clinics within the townships simply do not have the space required by the government in order to achieve accreditation. Furthermore, accreditation demands a certain amount of dedicated staff such as doctors, nurses, counsellors or PA's (patient advocates) which the limited resources of a rural health budget could not afford. Accreditation, then, is resource demanding. How Dr G deals with these limits is to distribute ARVs within non-accredited sites, perhaps once a week. In this case, an accredited "mother clinic" is used in order to distribute medication to non-accredited satellite clinics, with the doctor in charge of the mother clinic taking responsibility for any failures or mishaps within the satellite clinics. In these cases a doctor or nurse from the mother clinic would go to the satellite clinics to manage a HIV clinic there once or twice a week. This allows the doctor in charge to do more with fewer resources, as he does not need to meet the demands of accreditation but can still successfully distribute ARVs through his limited staff.

Like with patients who do not meet protocol requirements perfectly, there is both risk and reward in adopting this strategy. If a patient attending a satellite clinic suffers

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[10] This discussion of accreditation comes from an interview with Dr. G.

major complications the responsibility is on Dr G's shoulder and he will be 'guilty' for breaking with protocol, a protocol established in order to avoid such complications. It is the experience of Dr G, however, which limits damage at satellite clinics, and gives him the confidence, along with a particular medical ethos (see below), to adapt or circumvent the protocols. Dr G upholds the protocol in dissent by managing his resources in a way which questions the content of accreditation requirements but not its form (the sustainable roll out of ARVs).

Non-accredited clinics, are like unique, non-protocol patients, their success upholds the success of the protocol but their failures also uphold the necessity of subscribing to protocols. Accreditation then demands 'perfect' circumstances, and under these ideal circumstances success can be "guaranteed." However, not all clinics can meet this ideal, but they can still be successful, at the risk of failure.

The respective positions of the two doctors discussed above places them in different positions regarding protocols. In the case of Dr Z, she did not have a vested interest in meeting administrative requirements such as micro-biological sputum tests which subsequently gave her the freedom to defy the protocol. Dr G, however, had both a vested interest in accreditation (it ensures the success that he has to take responsibility for) as well as in its subversion in order to successfully distribute ARVs in resource limited circumstances. In these two examples the

> protocol's explicit written demands are tinkered with to make the protocol workable in practice- to articulate the protocol's demands to heterogeneous actor's own trajectories. The strict guidelines of protocols are thus considerably loosened in light of the multiplicity of trajectories which were brought together by the protocol in the first place…..We do not point at these instances in order to demonstrate the 'resistance' of actors to domination. Rather, we argue that the ongoing subordination and (re)articulation of the protocol to meet the primary goals of the actors involved is a *sine qua non for the functioning of the protocol in the first place* (Timmermans and Berg 1997:291 emphasis in original).

But if the 'resistance' to the protocol is the *sine qua non* for its functioning, how can one still view the protocol as universal? In other words, as Timmermans and Berg ask: "how does standardization emerge? How can non-docile elements result in something which, at the overall level, warrants the label 'universality'? The point is that the looseness of the network we witnessed here can be turned into a stabilizing feature ….[the doctors] active (*not* mindless) support is crucial to maintain the protocol's trajectory on course" (ibid:292). The experience of doctors such as those discussed above makes it possible for standardization to be successful. Standardization does not depend therefore on increasing the docility of the participants in its network to some higher authority, but rather the opposite, success depends upon active participation and resistance. "[P]rotocols are not simply the imposition of one world's vision on the rest; if they are, they are sure to fail. Rather, [protocols] act as anchors or bridges, however temporary" (Star & Griesemer 1989:414).

This must not be confused with a Foucauldian analysis of the relational character of power, power/resistance being the operational terms. Discussing the relational character of power relationships, Foucault (1978) argues that "their existence depends on a multiplicity of points of resistance….Resistances do not derive from a few heterogeneous principles; but neither are they a lure or a promise that is of necessity betrayed. They are the odd term in relations of power; they are inscribed in the latter as an irreducible opposite" (Foucault 1978:95-96). Resistance in this case is the odd term of power and is also the very basis of a "power." But to a certain extent here, power is also reducible to resistance. It is not its radical opposite, but on the contrary, its foundation and the possibility for its continued existence. "Power" in this case is predicated upon its "resistance," not in the sense that in order to identify power one must be able to identify resistance, but rather that resistance maintains, constructs and supports power.

Star and Griesemer (1989) argue that protocols are boundary objects.

> Boundary objects are objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly

structured in common use, and become strongly structured in individual site use….They have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation. The creation and management of boundary objects is a key process in developing and maintaining coherence across intersecting social worlds (Star & Griesemer 1989:393).

As such, the doctor previously mentioned in the discussion who has a management role in the department of health on behalf of The Global Fund, argues that the psychosocial criteria used for determining ARV eligibility are "less strictly defined and are intended to guide doctors as to the factors that need to be taken into account in determining whether a patient is likely to adhere to the required life-long treatment. That decision is, however, left up to the doctor" (Personal correspondence). Louise, discussed above, therefore could have been excluded from ARVs due to her "psycho-social composition" but was deemed eligible. The ambiguous nature of the psycho-social criteria defined by the WHO (see Addendum 2) is thus weakly structured but in individual site use it becomes strongly structured as it determines who is eligible for ARVs and who is not. It is for this reason that a degree of coherence is maintained across the different social worlds which protocols intersect.

"Local universality, then, is about being in several locales at the same time, yet being always also *located* as a product of contingent negotiations and pre-existing institutional and material relations" (Timmermans and Berg 1997:297 emphasis in original). To say this is to make the obvious, yet important, claim that in order to exist, something must exist within a context. Protocols are mundane objects then, objects which operate within the mundane reality of daily life. But the word mundane implies both the global (the root to the word is latin *mundus* or world) as well as the everyday, the local as it is commonly used. The mundane then connects both local and the global, as do protocols as they operate within the mundane reality of daily practice yet connect this locality with global organisations.[11]

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[11] mundane *adj* 1. everyday, ordinary or banal 2. relating to the world or worldly matters [c15 from French *mondain*, via late Latin, from Latin *mundus* world][11] Collins English Dictionary

Chapter 3: Knowledge of bodies, bodies of knowledge

3.1 Phronesis: Bodies of knowledge

I began the previous chapter by looking at how the manager of a rural clinic manages the requirements and protocols set by global organisations and national government in relation to the contingency of daily life. I illustrated how this manager takes advantage of the gap between policy and auditing to achieve the goals set by himself, national government and global organisations. I then moved on from the institutional level of analysis, to the interpersonal level of analysis in demonstrating how standardization and protocols 'work' in the context of daily practice. In both of these sections I aimed to illustrate how resistance to these protocols in fact upheld them (or allowed their very functioning) rather than challenged them. I also illustrated how the position and role of the doctor in the clinic influenced the amount of resistance they upheld against protocols and bureaucratic requirements.

This next section will concern the way doctors 'think.' That is, in this section I will explore how doctors make decisions, taking into consideration the attempts at constraining thought introduced by protocols as well as the effects of these protocols. However, before I begin this discussion it is important to first of all frame this discourse. That is, to map out the current and historical factors that allow us to conceive of, and indeed discuss or prioritise, the way doctors make decisions as an aspect of medical practice. Furthermore, a framing of this sort will allow us to critique current medical policy by illustrating how broader factors than a physician's cognition play a role in effective health service provision. This framing will illustrate how medical practice, as conceived in policy, diverges quite radically from practice in contingent reality. However, it is a framing which suits the needs of policy makers and is thus uncritically taken up by them.

In *Pathologies of Power*, Paul Farmer (2005) argues that "in many current discussions of [the] plagues of the poor, one can discern a cognitivist-personalistic pole and a structural pole. Although focus on the former is the current fashion, one of the chief benefits of the latter mode of analysis is that it encourages physicians…to make

common cause with people who are both poor and sick" (Farmer 2005:151-152). This observation by Farmer illustrates the common trend towards regarding the cognition of the doctor as the primary driving force in clinical practice, prioritisng it above that of the structural limitations she may find herself working under. The primacy of cognitive models therefore attempt to limit the possibilities for critique a doctor may place on the structures, or lack thereof, which may hamper the quality of care they provide. However, in this chapter, I will not heed to Farmer's call to analyse the structural pole, but rather illustrate how the structural and 'cognitivist-personalistic' poles co-implicate one another at the expense of the doctor. In this regard Dr G has remarked that when failures arise in auditing, it is not the protocol, but the doctor who is usually blamed for the failure. As we will see this is due to the introduction of cognitive models as a normative framework in determining success.

Marc Berg (1995) argues that pre-World War Two, medical practice was not described as a scientific practice or endeavour to the same extent it is today. On the contrary, it was rather described as an art and as such held in high regard the intuition and "mystery" of the physician's practice and decision making process. In this light Berg illustrates how, post World War Two, medicine has been conceptualised differently and this has effected the problems of medicine. According to Berg, after the Second World War, medicine began to be increasingly associated with the 'hard sciences' implying that it was increasingly distanced from a practice in a particular context. This was an attempt to standardise and universalize medicine for the sake of administrative orders such as insurance companies. The result of a reconceptualisation of this sort was that the problems associated with medical practice shifted from the environment within which a physician practiced to how the physician practiced. In other words, how medicine is conceptualised, for example as a science or not, has also effected how medicine's problems are conceptualised, for instance whether limitations are found in the physician's mind or in her environment. "Contrary to early postwar views, many recent conceptualizations of medical practice locate both its scientific character and the causes of its problems in the physician's mind. This *cognitivist* discourse on scientific medical practice…draws upon *both* the prevalent, positivist rhetoric *and* the notion of the individual, autonomous physician- a notion which has remained crucial to the profession throughout the postwar era" (Berg 1995:439 emphasis in original).

The *practice* of medicine has thus been estranged from the *practical*, contingent reality of life in its description as a cognitive-scientific enterprise. This (re)description of medicine allows various factors to come into play within medicine, which do not necessarily serve the interests of good medical practice. It is worth quoting Berg at some length here. For instance, in describing

> medical practice *itself* as a 'scientific' activity… a general explicitly *normative* framework is introduced, with which this practice can now be scrutinized and judged. It is a yardstick to measure (and find lacking) the actualization of the 'science'. When 'scientific medical practice' means merely the usage of scientific knowledge, one can scrutinize medical practice for places where this knowledge is improperly used, or not used at all. Standardization is then a way to guarantee optimal flow of information so that the benefits of science reach those who need it (ibid 459-460 emphasis in original).

The normative framework introduced is now a means by which physician's practice can be judged, and subsequently, the possibility of auditing is introduced into medical practice. Cognitive models of scientific practice therefore serve as much the interests of medical practice as they do that of insurance companies or global donors. It is important to note, however, as Berg does, that "standardization is … a way to *guarantee* optimal flow of information so that the *benefits* of science *reach* those who *need it*". The intention, or sentiment of standardization, then, is a means of creating an equitable distribution of resources through efficiency, as was the intention of Taylor and his method of scientific management. This point is argued by the WHO who state that "standardizing [ARV] treatment means that health systems with few resources can maintain a globally accepted quality of care and deal with human resource constraints, promote adherence to treatment and avoid resistance. Most importantly, the number of people receiving ARV treatment will increase, and the quality of that treatment will be improved" (WHO 2003:3). The protocol is then made possible through a cognitivist, scientific view of medical practice and promises greater allocation of resources to the poor. However, as the following section will illustrate, these promises are more a product of this conceptualisation of medical practice than of any material circumstance.

The above view of medical practice described by Berg also illustrates a particular, idealistic view of science. This is science in a perfect world where a single logic and universal circumstance determines the outcome of any experiment and local 'impracticalities' are kept to a minimum. "With its invariable replicability and law-like precision, this view of science is a matter of simple logic with readily deduced details and rule-governed consequences. What characterises the care of patients, however, is contingency. It requires practical reasoning or *phronesis*, which Aristotle described as the flexible, interpretive capacity that enables moral reasoners…to determine the best action to take when knowledge depends on circumstance" (Montgomery 2006:4-5). Phronesis is knowledge gained through practical experience in a contingent world, it depends upon, and is expressed through, practice. Phronesis is the combination of a body of knowledge and collection of well practiced skills. "Its essential virtue is…that [it] enables physicians to fit their knowledge and experience to the circumstances of each patient" (ibid:33). It is a combination of a general body of knowledge combined with the particular idiosyncrasies of the individual practitioner, his experiences with different medications and different diseases which may divert from orthodoxy.

Phronesis describes action related to contingency and the ability to adapt universal rules to particular circumstance. As Dr. G has argued, following rigid rules wastes resources and, instead, he relies more on intuitive decision making. This can then be viewed as the 'art' of medicine, in that the outcomes of the medical decision making process cannot be traced back to a rational decision making trail, but rather are the results of unexplainable "feelings" or intuitions (affects) about the decision. It is important to take note of the use of words such as 'decision'. Doctors make decisions rather than calculations, calculation (program) being the view that proponents of a strict standardisation would like us to follow. As Jacques Derrida (2002) has described, for something to be a decision it must have an element of incalculability within it. A decision is always a risk, a space must be crossed which cannot be explained or rationalised.

> If one were sure of the calculation, it would not be an action or a decision; it would be a programming…. There is no decision without the undecidable. If

there are no undecidables, there is no decision. There is simply programming, calculation. There must be political, ethical decisions, but these decisions are possible only in situations where the undecidable is a necessary dilemma. Thus a certain undecidability…is the condition or the opening of a space for an ethical or political decision (Derrida 2002:31).

In deciding whether a patient is eligible for ART, or must be defaulted from their medication, a doctor is calculating but only up to a point. A doctor will be taking into consideration all the evidence, both clinical and psycho-social concerning a patient, but in the final analysis it is the undecidable, the dilemma of the life of the patient or the life of the population possibly threatened by drug resistant forms of HIV. This is an ethical as well as a political decision. It is an 'ethico-political decision', regarding the life of the patient, the doctors' place within a hierarchy, as well as broader questions concerning resistance to the drugs and the responsibility of medicine and the patient towards the health of the population as a whole. Thus, in making a decision, responsibility inevitably arises due to the fact that a risk was taken, a calculation wasn't made in which failure could be attributed to a 'system' but rather responsibility for crossing a gap is placed on the shoulders of the decision maker. One can note, then, how a protocol aims to anchor these decision moments, aims to make these moments not moments of decision but moments of calculation, but inevitably these are moments of decision as this thesis aims to make clear.

This is not to imply that doctors do not rely upon their scientific training for making decisions (this is neither what Derrida implied) but rather that this training and experience interacts in a complex way which cannot be universally modelled, but can best be described as the balance between the science and art of medicine. Montgomery (2006) suggests the term "clinical judgement" in order to describe this process. "What is neglected by the science-art duality is medicine's character as a practice. It is far more than a body of scientific knowledge and a collection of well-practiced skills, although both are essential. It is the conjunction of the two: the rational, clinically experienced, and scientifically informed care of sick people. Its essential virtue is clinical judgement, the practical reasoning or phronesis that enables physicians to fit their knowledge and experience to the circumstances of each patient." (Montgomery 2006:33). What is important about Montgomery's discussion

is her emphasis on the fact that medicine is a practice and as such is situated within specific sites which, (dis)enable certain types of action.

3.2 Evidence-based medicine: knowledge of bodies

As a practice medicine entails close encounters and affective entanglements between patients and doctors. Even in under-resourced clinics, years of practice with the same patients builds up relationships. Up until now these relationships have been a part of what has driven the argument against standardisation within this thesis. Under the uncertain conditions of medical practice, especially in the field of HIV/AIDS exasperated by the dire living circumstances patients find themselves living in, doctors deal with relatively traumatic narratives on a constant daily basis. There is therefore a need for ensuring the existential well being of doctors as they face these narratives[12]. The practice of science therefore ensures that a certain amount of distance is established between a doctor and a patient as the doctor comes to view the patient through a medical gaze (Foucault 1973). The medical gaze's support is "not the perception of the patient in his singularity, but a collective consciousness, with all the information that intersects in it, growing in a complex, ever-proliferating way until it finally achieves the dimensions of a history, a geography, a state" (Foucault 1973:29). It is as such that through working with a general framework, through not viewing a patient in his singularity but rather as part of a complex, doctors maintain a certain amount of 'distance' from their patients. It is as such that,

> Once the patient's diagnosis is established, the illness seems simply an expression of its etiology in the individual. The patient's malady becomes a particular instance of that disease's general rule, and thus the problem of individual causality is rendered unremarkable….This neatly circular identification of the patient's symptoms as instances of a general rule manifesting itself in a particular patient reinforces the sense that medicine is, after all, a science. On scientific grounds, the teleological question- and an awareness of the patient's suffering that lies behind it- can be set aside or ignored (Montgomery 2006:99).

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[12] See van der Walt & Swartz (1999) for a discussion of this same phenomenon among nurses dealing with TB patients.

Evidence-based medicine contributes towards this line of practice as it statistically categorises patients into groups. There are of course, difficulties with evidence based medicine. First of all, precisely this depersonalization of patients from both a medical and a "care" perspective, limits the efficacy of medical care. From a medical point of view,

> the evidence-based approach, which aims to make clinical decisions follow from statistically valid information-in the form of "systematic" reviews, guidelines, or algorithms- [is] ill-informed by the realities, complexities, and uncertainties of medical practice. A "rigid reliance" on numbers…..will not meet every need of the patient who sits in front of the doctor. Such numbers are needed, but there can never be a purely rational or exact mathematical solution to a patient's predicament (Horton 2007:2).

(Note the attempt to create "calculations" rather than "decisions" in evidence based medicine and the impossibility of this). The singularity of the patient can therefore not be classed into groups to which a patient will completely comply. Furthermore, evidence-based medicine, by restricting the doctor's gaze to the "biological disease," does not allow one to take into consideration the ever changing socio-economic conditions of a patient. However, this restriction may ensure the existential well-being of the doctor, but it is questionable whether a strict reliance on the biological, scientific view of a patient by a doctor does indeed ensure existential well being. The discussions of the doctor's reactions to patients in this thesis have illustrated the existential richness doctors receive from viewing the "whole" patient. Indeed, Dr G. argues that when one looks at a patient one sees two things, disease and illness. In this case "disease" is the clinical-biological syndrome, stage two HIV for instance. In contrast, "illness" is the biological-social-economic syndrome, the "whole picture" if you like of a patient's suffering. In this case, evidence-based medicine considers only disease and not illness.

One can note that evidence-based medicine is exacted upon the same claims of medical practice made by the "cognitivists" at the beginning of the previous section. That is, that if one could control a doctor's decision-making perfectly, their practice

would be perfect. The ideal therefore is to constrain thinking, to narrow it down to possibilities and rational decision making, to minimise creative and intuitive impulses through the use of algorithms. "Clinical algorithms can be useful for run-of-the-mill diagnosis and treatment… But they quickly fall apart when a doctor needs to think outside their boxes, when symptoms are vague, or multiple and confusing…In such cases…algorithms discourage physicians from thinking independently and creatively. Instead of expanding a doctor's thinking, they constrain it" (Groopman 2007:5).This is 'medicine lite' as explained by Dr G, medicine which suits a wide audience *but not everybody* and which does not require the expertise of experienced doctors. Evidence-based medicine aims to place patients within risk groups or categories, within pre-defined populations. This type of thinking serves administrative purposes, as will be clear later in my discussion of framing. The cognitivist model, in its quest for ideal decision making, therefore relies on ideal patients fitting into ideal categories of disease and treatment. It does not take the messiness of practice into account, nor the uncertainty of patient's lives, or even the uncertainty of pharmaceuticals as the next example will illustrate.

This example is drawn from observations and an interview with Dr G. It is presented in the rather incoherent manner below in order to illustrate the messiness of evidence and choice which doctors have to contend with. That is, in the field, evidence does not come pre-packaged in linear form but rather arises out of practice and experiments, drug pamphlets and department of health circulars. The example will also comment on the "degrees of truth" found in the evidence-based medicine approach.

When an HIV positive woman begins ARVs the doctor in charge has to make a decision between two first line drugs with similar effects. That is, apart from prescribing the standard Lamivudine (3tc) and Stavudine (d4t) according to protocol, the doctor has to decide between prescribing Nevirapine or Stocrin. Either drug has advantages and disadvantages to its prescription as will become clear below.

Nevirapine, the acclaimed drug hard fought for by the TAC, is a good drug to provide to potentially or currently pregnant women and is taken twice a day. This is due to the fact that it does not have adverse effects on an unborn baby. However, a disadvantage of using Nevirapine is that it can create complications in patients with TB.

Furthermore, Nevirapine requires regular blood tests (once every two weeks) in the first few months of its use in order to check liver functions. The drug is therefore also very resource demanding for both patient and health services. Stocrin on the other hand is taken once a day and does not cause complications in patients suffering from TB. It does, however, contain the threat of creating deformations in unborn children.

The consensus is that the choice between prescribing these two drugs must be left up to the doctor. In Dr G's clinics, Stocrin seems to be the popular drug with a minority of patients being prescribed Nevirapine (an observation confirmed by Dr G). According to Dr G, trials of Stocrin done on monkeys illustrated that abnormalities formed in pregnant monkeys' babies. However, there is not enough evidence to say that this is the case with human beings, due to ethical concerns of testing on human beings, and in clinical practice Dr G states that he has not yet witnessed any complications. However, the company which produces Stocrin (Merck & Co. Inc) does not insure against this complication and it is mentioned as a possible side-effect in the drugs' pamphlet.

If a blood test is missed after prescribing Nevirapine, research suggests and experience illustrates, that there is a real threat of hepatitis developing and the possibility of patients dying. However, follow ups to this research illustrate that the threat of hepatitis is only there if a patient's prescription is changed from Stocrin to Nevirapine and if the patient has a high CD4 count, but not if the patient begins ART with Nevirapine.

The problem with Nevirapine is that resistance can develop very easily, even a single dose contains this possibility and due to the similarity of effect between Stocrin and Nevirapine, if you create resistance to Nevirapine, you create resistance to Stocrin. A circular letter from the National Department of Health therefore recommended the use of Stocrin due to its cost-effectiveness and the relatively small amount of complications associated with it.

In meeting a female patient, a doctor has to keep all of the above in mind when deciding which drug to prescribe. Furthermore, any experience the doctor has or evidence she can gather about a patient has to be thrown into the cauldron. Is the

patient single, is she married, does she have children, does she want children, can she be relied upon to have safe sex, is she sterilised? Furthermore, does the patient have TB or does she live in an environment prone to TB? Can the patient be relied upon to return for regular blood tests or does her social or economic circumstance limit her ability to return for such tests? Which drug to prescribe is a juggling act between medical knowledge and social circumstance. Evidence-based medicine in this regard would argue primarily for clinical circumstance, is the women pregnant, if so prescribe Nevirapine. Does she have TB or is prone to get TB, does she not want children, prescribe Stocrin. However, in Dr G's experience, the risk of putting a woman on Stocrin, if she is unreliable in keeping her appointments at the clinic, is less than the very real threat of her developing hepatitis because she did not return for blood tests if she was prescribed Nevirapine. Dr G's 'preference' for Stocrin is then based upon his experiences with women at his clinic, as well as with the experience of the side-effects of the drugs, rather than upon strictly scientific evidence provided for by scientific research.

According to Dr G, there is a hierarchy of how evidence is gathered within evidence-based medicine. The epitome of scientific, medical evidence is achieved through a double-blind, randomized, placebo controlled experiment. This is the gold standard of evidence achieved in laboratories. If this standard is unachievable, due to some form of limitation, the results of this experiment are considered of a lower quality, such as the experiment is only a blind test and not a double blind, or the research population is not large enough etc. So you move down a hierarchy of evidence producing trials until you reach the experience of a practicing doctor, whose only 'statistics' are similar cases with similar experiences. This experience is at the lowest end of the evidence scale but it is what serves the doctors the most when making decisions regarding which drugs to prescribe to patients.

Through the propagation of evidence-based medicine, doctors are "being conditioned to function like a well-programmed computer that operates within a strict binary framework" (Horton 2007:2). The use of analogies surrounding thought processes and computers is of special interest here. As was described at the beginning of this chapter, in the years after World War Two, a redescription of medical practice took place from (in overly simplified terms) an art to a science. The result of this

redescription was that medicine could now be viewed as a scientific practice and the improvement of medical care could all be placed within the decision making of doctors. The problems of medicine thus shifted from material problems within the environment of the doctor, to his or her attempts to make rational, scientifically based decisions. This decision making process has now been 'perfected' by evidence-based medicine's cognitivist approach in order to improve the accuracy of the statistical thinking that 'doctors any way do' (Berg 1995). However,

> these are not newly found solutions for pre-existing problems. With cognitive psychology, 'the Mind came in on the back of the Machine'. Human judgement was described, judged *and* explained with models derived from images of the scientific process and computers, and statistical decision analytic techniques. In the same vein, these models will now overcome the faults of medical practice. The point is to see that the tools which are described as solutions lay at the root of the reconstruction of the problems in the first place…The 'solutions' are the tools which *shaped* the cognitive perspective of medical practice. With the construction of the solutions, the *specific shapes of the problems were co-produced* (Berg 1995:463 emphasis in original).

We can therefore view, via Berg, how evidence-based medicine is the result not only of a particular discourse surrounding medicine but also the result of advancements in technologies which shape what are considered problems and what not.

As a practice then, medicine cannot be limited by cognitive models which describe or limit certain problems, but rather, must work with the understandings and limitations allowed by the field within which doctors practice. Generalization becomes dangerous in this field of practice as the complexity of biological disease, auditing according to protocols from higher authorities, social illness and patient's, as well as, doctor's existential well being all have to be juggled[13], not balanced[14], in a dynamic field. As a

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[13] Juggle. *Vb* **1.**to throw and catch (several objects) continuously so that most are in the air all the time. **2.** to arrange or manipulate (facts figure etc)….**3.** *(tr)* to keep (several activities) in progress, esp with difficulty (Collins English Dictionary)
[14] Balance…**3.** a state of equilibrium…**7.** harmony in the parts of a whole..**8.** the act of weighing factors, quantities, etc. against each other (Collins English Dictionary)

group discussion with three female doctors illustrates, the difficulty of this juggling is revealed in patients experiencing either the side effects of ARVs or the onset of TB. These three doctors all agreed (as some other doctors I have interviewed also state) that a balance has to be made between too much and too little care for a patient. Because HIV/AIDS is becoming a chronic disease, long standing relationships are established between doctors and patients due to the monitoring of the disease and the efficacy of the medication. It is as such, these doctors argue, that if one gave too much attention to a patient and monitored them too closely, the individual sense of responsibility for illness being promoted in the patient will diminish. On the other hand, too little attention and care and the patient experiences the clinic as cold and unfriendly, and is therefore less likely to adhere to their medication or to return to the clinic. In this regard protocols[15] do not deal with losing patients, or patients who do not keep their appointments. The different side to this same coin is the existential well-being of the doctors themselves. Furthermore, it is not unusual for side effects to arise in patients who have just begun ARVs. These side effects are often diagnosed by doctors through insight and intuition, and due to their singular nature cannot be explained statistically. Here scientific, evidence-based medicine cannot help the biological disease, in Dr G's terms, but nor does the distance that science creates from social illness help either the doctor or the patient. Intimate experience of the patient is necessary to maintain their adherence to medication and its side effects or to diagnose TB in a patient not revealing "bureaucratic symptoms" necessary for a diagnosis by numbers. This practice then does not hide behind science and numbers but rather lays itself bare to the danger and uncertainty of practice in a contingent world. In order to practice in a world of this sort, a doctor has to juggle all the aspects mentioned above in striving for a positive outcome, however that may be understood.

3.3 Framing: bodies and knowledge (ontology or epistemology)

To argue that a doctor's mind works like a statistical binary machine also does not take into consideration the various ethos under which doctors may operate. The

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[15] As a doctor in the management of The Global Fund has stated "Even with the protocol in place, there is a fairly significant proportion of patients who become "lost to follow-up"- the proportions tend to vary up to~10% at the different treatment sites. This fact, itself, could be an indication of the latitude that medical personnel do have in determining the eligibility of patients for entry to the programme" (pers. Correspondence).

evidence-based medicine approach assumes that doctors all operate under the same ethic and towards the same end, without problematising what this ethic or these ends may be. The social or material circumstance under which doctors operate imply that much more than just clinical decisions play a role in determining the outcome of an interaction with a patient. Furthermore, the position of the doctor within a clinic, that is whether they serve an administrative function or whether they are outside consultants free from the daily hassles of working in the same clinic, all have an impact on the decision making of the doctor. An interesting way of thinking about the impact of social position on a doctor's decision making is through the use of frames.

In approaching a patient, a doctor needs a way through which he can view or analyse the patient. That is, doctors require a means through which to frame their patients and their problems in order to come to solutions to the patients' problems. The framing process essentially amounts to limiting options or solutions. What protocols or evidence-based medicine attempt to do is exactly to create such frames. However, both these approaches assume that frames exist independently of the material conditions under which a doctor finds him- or herself operating. In contrast, Dodier (1998) argues "that a person adjusts to a situation not by using discrete resources, but through arrangements of resources (words, rules, objects) in which past experiences are inscribed, that is, through frames" (Dodier 1998:53). The arrangement that a person finds themselves labouring under therefore has past experiences, present necessities, possibilities and limitations along with future expectations inscribed into the use of resources. There are therefore multiple approaches and resources, along with their limitations, available in any situation and as such there is more than one frame available to each encounter experienced by a doctor. It is an active as much as a passive choice that shapes which frame will be applied to the situation at hand (Dodier 1998). Each frame therefore relies on different points of reference according to what is focused on as a desired outcome (Harper 2005) and what resources, both ontological and epistemological are available. A given frame can then conflict with, mix or succeed another frame within a particular circumstance.

"The introduction of frame analysis offers a supplementary element: 'following a rule' is an activity that can have diverse meanings depending on the status that one accords to this rule with regard to action" (Dodier 1998:54), and the status one

accords to rules depends upon the relative position of the doctor within the clinic or the funding hierarchy. As was argued earlier, the correlation between "reality and auditing" can be viewed through this lens, that is, the status of the rule is open to manipulation, and decisions are rationalised after the fact, according to the relative position of the doctor within a hierarchy. This is not to imply that those "at the bottom" of the hierarchy do not interpret and manipulate rules, but rather that different positions provide different frames through which rules are interpreted. Rules are always interpreted and are never strictly binding in the sense "intended" by the creators of that rule. But this is to get ahead of ourselves.

Dodier (1998, 1994) distinguishes between three frames which I will discuss in this section. The administrative, the clinical and the solicitude frame, although the first two will be the primary discussion here, the solicitude frame will also be discussed as it raises some interesting issues.

In the administrative frame the individual patient is categorised into formal categories according to references to a population. The individual is thus placed within a particular population according to categories of risk established by a central authority. "The administrative frame depends on rules coming from the centre, as in other bureaucratic situations, and it is the administrative frame that has developed massively under the combined influence of scientific networks and those of the law…Dodier also highlights that this corresponds to the diffusion of protocols deeply into the system" (Harper 2005:132). One can note here how the administrative frame corresponds strongly to the framework of evidence-based medicine and the ideal of adhering entirely to the strictures of protocols and auditing requirements.

To risk stating the obvious, the administrative frame serves the needs of administration, of efficiency and bureaucracy. By identifying an individual within a particular risk category, the administrative frame eliminates lengthy questioning and critical reflection as the afflictions of the particular diagnosed population apply to the individual. "The risk factors create a bureaucratic transfer: the individual is characterized by a list of variables, each of them leading to the application of a given rule…The consequence of this administrative status is depersonalization: the individual is considered the point of intersection of different rules" (Dodier 1998:61).

But, the association with a population allows the doctor to take action, to come to a firm decision regarding the patient thereby fulfilling not only the requirements of efficient, scientific practice but of medical practice itself. As Montgomery (2006) argues, one of the practical requirements of clinical medicine is the need for certainty when taking action on behalf of another human being.

> Hans-Georg Gadamer describes such a need…as characteristic of all practice… "Practice requires knowledge…which means that it is obliged to treat the knowledge available at the time as complete and certain" (Gadamer in Montgomery 2006:39).

This type of certainty can only be insured under the ideal type circumstances forced by the administrative frame[16].

The application of rules within the administrative frame depends upon a syllogism, that is a rule applies to a given risk group, this individual belongs within this risk group therefore this rule applies to this individual. "The particularity of the individual is limited to her/his actual existence. You have seen all there is to see of the individual once you have applied, like a label, her/his class membership. This is what makes this type of judgment at once rigid, rapid, economic, and systematic. It explains why judgement is henceforth closed to all complementary information" (Dodier 1998:62).

The categorising of individuals into classes allows one to create groups through numbers, in other words it aids the creation of statistics. The administrative frame then, is concerned with the impact of the disease on a population not an individual. Ian Harper (2005), using Dodier, explains the use of the administrative frame in a case study of tuberculosis in Nepal. The administrative frame in this case allows the creation of 'statistico-tuberculosis,' which is "intimately concerned with a global (and national) prevalence of the disease, which, it is believed, will decrease when enough infective patients are found and effectively treated….For the tuberculosis reified as a population problem, 'statistico-tuberculosis', is the one that has the spectre of multi-

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[16] Certainty must be understood here as deferring doubt to a system of rules, such as the evidence-based medicine data base. This does not mean that doctors operating underneath other frames are not certain of their decisions but rather that decisions made under other frames have to admit the radical uncertainty of practice because they cannot defer their decisions to some "precise" rule.

drug resistance hanging over it" (Harper 2005:136). The administrative frame is more concerned with the control of an epidemic in a population than the care of an individual. One can easily extend the idea of statistico-tuberculosis to that of statistico-HIV or even (the all too real) statistico-HIV/tuberculosis XDR. However, what one must observe is that reification into populations is what makes activism on a global scale possible. Roughly two-thirds of the world's HIV positive population living in sub-Saharan Africa, or five million HIV positive people living in South Africa, are products of the administrative frame. The difficulty is in treating patients as individuals while reifying their disease as a global threat. In other words, the struggle for nurses and doctors on the ground is that between the care of the individual and the control of an epidemic in a population (van der Walt & Swartz 1999).

In contrast to the administrative frame, Dodier proposes the clinical frame. In the clinical frame the individual is treated according to their individual idiosyncrasies. "The individual's points of reference are no longer connected to general categories, but to personal norms….In order to be capable of judgment, the doctor must leave room for particularities" (Dodier 1998:63). The individual here is not part of a population but rather unique and unclassifiable. A doctor operating under the clinical frame will compare various indices of the individual rather than using the indices of a given population as is found in using the administrative frame. "In this way, the doctor aims to delineate the individual's point of equilibrium, while remaining open to conceding discrepancies with the ranges outlined in the texts" (ibid:67). That is, the individual is not assimilated into a single population but rather judgment is delayed until other indices of the individual help to diagnose his/her ailment, perhaps at the intersection of multiple populations. "The clinical judgment intercalates an exploratory stage between the identifications of populations and the diagnosis, in which the group of salient points of reference are integrated for the individual" (ibid:68).

What we can notice here about the contrast between the administrative and the clinical frame ties in with the discussion of decision making above. The administrative frame in this regard aims to minimise decision making to mere calculation. That is, narrow the patient's risk factors down to a category or population

and you will find the solution to the patients' problems. It is about calculating. In contrast, the clinical frame aims to frame the individual by his idiosyncrasies. It frees the individual from categories (while relying upon them) and thus the responsibility for the decision is placed in the hands of the physician who cannot blame a system of thought for some failure within the patient. The administrative frame frees the practicing physician from having to acknowledge failure, frees the physician from ethical responsibility. It aims to distance practice from reality, and, in line with chapter one, we can view the adoption of the administrative frame as an attempt to constrain the particularities within the universal. In contrast, the clinical frame places responsibility and ethics squarely on the shoulders of the physician, the physician places his decision making in a realm of risk.

Evidence-based medicine plays an interesting role here. The contrast between the administrative and clinical frame seems to underline the discrepancy experienced in medicine about the role of evidence-based medicine. This is because "in both the administrative and clinical frame, the point of departure is identical: one uses statistical data that can delimit a range of "risk" values. In the administrative frame, the doctor uses the value as a parameter to decide if the individual is "at risk," and to act immediately. In the clinical activity, the doctor proceeds differently: before coming to closure, s/he will wait to have several values of one parameter for the same individual" (Dodier 1998:67). It is then a matter of how the doctor proceeds from his point of departure which determines the critique or support of evidence-based medicine. In the clinical frame, the doctor patiently opens herself up to the environment, to the possibility of contradiction and failure. In the administrative frame she rigidly applies rules, concealing the environment behind statistics in the name of efficiency. It is then not the point of departure, not the cognitive process which determines the success or failure of evidence-based medicine but rather the frame used by the doctor. However, the frame applied is not an active decision, open to an autonomous physician as the cognitivists' would like us to believe. Rather it is a matter of the position of the physician within a sometimes rigid hierarchy.

In the clinical frame the status of rules for placing individuals into classes are not discarded but changed. That is, they are not seen as constraints, which need to be applied but rather are "put in relation with one another within clinical tables.

'Following a rule' here consists of placing it within the significant reference points of the diagnostic transfer" (ibid: 68). The nature of rules thus change here, they are no longer seen as constraints to action but rather enable action, that is, they assist rather than direct diagnosis. "This framing of the individual transforms considerably the relationships between the producers and users of rules. Here, the actors who must judge the cases are the 'clinicians.' Unlike the 'agents' of the administrative schema, they do not apply rules. They are subordinated to the agents working on a more general level. Clinicians integrate the general rules in their judgment, but in principle they have the initiative in the treatment of cases" (ibid:68-69). One can take note though that the position of the physician in relation to the administrative order will have a huge impact on whether the physician is able to operate under the clinical frame or not. As the positions of Dr. G and Dr. Z will illustrate.

As has been described, the respective roles within a clinic differ between Dr. G and Dr Z. Dr G is the regional manager of HIV/AIDS and is therefore responsible for setting up and managing clinics within his region. He is therefore responsible for the success and failure of the clinics he runs and can be said to be subject to the strictures of auditing, by both government and international donors. One could therefore postulate that Dr G operates under an administrative framework as he has to comply with the requirements of a bureaucratic network. But, as has also been illustrated, Dr G 'plays' this network to the advantage of the patients in the clinic, acting often in dissent to the rules. However, he also maintains the system through his dissent of the rules creating the 'local universality' discussed above. Dr G then is embedded in this network of relations and as such is subject to its strictures, and the possibilities it offers for agency.

In contrast, Dr Z receives her salary from ARK and is therefore privately contracted to work in the clinic. She is not subject in this regard to vigorous auditing as ARK currently has a lax auditing policy (although this is changing), currently being more concerned with implementing infrastructure and services than with their 'performance on paper'. One could then easily ascribe Dr Z to the clinical frame, as she is in a position which does not concern itself with statistics and placing people into bureaucratic categories. As the case study of Jonathan illustrated, the lack of micro-biological proof of infection did not concern Dr Z. Micro-biological proof is an

administrative requirement for diagnosing TB and as such would allow the administrative agent to classify Jonathan as a TB patient. Yet, due to his HIV positive status, Jonathan was not able to produce sputum and thus could not fulfil the administrative requirements for this particular risk group. In contrast Dr Z, using a clinical frame of reference, diagnosed TB in Jonathan by looking at the particular indices presented by his individual body. That is, Dr Z took note of the fact that he was HIV positive, was rapidly losing weight and was having night sweats despite not coughing up sputum. In this regard she took Jonathan for an individual, and despite beginning her diagnosis at the same place that the TB doctors began, that is by using statistical data that delimit a range of risk values (such as he is HIV positive and is therefore even more susceptible to TB bacilli), she ended in a radically different place. She was able to do this because her position in the clinic freed her from the requirements of administrative orders. Dr Z's experience as a physician, and previously as a researcher, furthermore gives her the confidence to diagnose disease despite the display of contradictory symptoms. The confidence of experience thereby allows doctors also to make independent decisions regarding their patients. Dr Z does put herself at risk here, as does Dr. G, in subverting the rules, but it is a risk taken in the confidence of experience and also guided by a particular ethos towards medical practice.

According to Dodier (1998) one can distinguish between different 'types' of doctors, that is, doctors who privilege one frame above another. In this regard a doctor chooses a particular frame as the guiding force in their decision-making and thereby complies to a particular *ethos* in practicing medicine. We can say that Dr Z operates under a clinical ethos in that she places the well being of the patient before the requirements of a bureaucratic order. In the case of Dr. G we can witness how he interprets the mandate of the HIV clinic and balances it with the auditing culture of governments and donor agencies. According to Dr G, the mandate of the HIV clinic is to stop the spread of HIV. Under an administrative ethos this would entail maintaining patient retention and adherence rates, as well as, insuring that new patients are brought into the clinic. Success will be measured by fulfilling these auditing requirements. However, retention and adherence rates can only be maintained by inspiring patients to adhere to their medication, techniques not offered by the cold calculation of science. The role of the clinic then increases to become one of creating social

awareness and entails affective relationships with patients in order to increase feelings of self-worth and social responsibility. Auditing becomes less feasible due to the difficulty of measuring self-worth and social responsibility by the strict statistical techniques used.

It is important to note that operating under an administrative frame requires outside support. That is, some order or power, must create, allow and impose the creation of categories and classes onto a complex world. This support comes from the hegemonic force of the methodology of science as well as global aid organisations which depend upon this method for governance over their distribution of aid. Furthermore, the messy reality of practice makes this type of hegemony and support possible. The support of decisions made under an administrative frame relies on the relatively subjective nature of diagnosis. That is, as was discussed above, the nature of a diagnosis can depend as much on intuition as on "methodological" evidence [17]. For example, Dr Z has pointed out that in the case of HIV positive patients, especially in the more critical stages of the disease, such as with CD4 counts of between 20 and 100, often the only symptoms revealing TB would be diarrhoea. A doctor such as Dr Z, relying heavily on her experience and intuition, would diagnose TB and would often be proven correct once TB medication has begun. However, a doctor working strictly in terms of the administrative frame would diagnose gastroenteritis as he cannot "find" any symptoms that would reveal otherwise. Due to the critical state of HIV/AIDS in many of these patients, the time wasted trying to treat gastroenteritis often costs them their lives. These patients will then be said to have died of AIDS-related complications rather than TB.

In this sense we can extend Mosses' notion of an "interpretive community" discussed in the first chapter to the realm of diagnosis. The administrative frame depends upon the "interpretive community" which ascribes symptoms to diseases. A doctor like Dr Z takes the risk of running against the medical orthodoxy of these interpretative communities whereas as a doctor operating under an administrative framework can "play it safe" even at the risk of somebody's life. It is as such that one can state that

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[17] I use the term "methodological" to mean evidence based on a procedure or set method. Some could use the term "empirical" evidence to contrast with "intuitive" evidence, however I believe this would deny the empirical nature of intuitive decisions such as traces of evidence revealed through touch or sight.

the success of a bureaucracy, or the imposition of a method, is only possible, not because that method reflects the order of the world nor that the world is ordered by that method. But rather that the "holes" in method, rely upon "the holes" in reality to cover one another up. Symptoms are "evidence" of disease but of which disease is a matter of the discretion of the physician under charge, it is a matter of "chance"[18] whether the physician will diagnose correctly. As Kleinman (1988) argued, "diagnosis is a thoroughly semiotic activity: an analysis of one symbol system followed by its translation into another" (Kleinman 1988:16).   The symptoms ascribed to disease by an administrative network attempt to limit these chances and their success depends upon not being proven incorrect by another diagnosis, by another interpretation. Methods then do not order the world, but rely on evidence to the contrary to slip through unnoticed, such as TB patients who die because their symptoms could be ascribed to other causes. Bureaucracy depends then on complexity and messiness, not order. But bureaucracy can fail, if the "holes don't line up", that is, if patients start dying from causes undescribed by the protocols, that cannot be explained away, examination of the protocols will take place. Protocols can also be changed through doctors, like Dr Z, revealing these cracks or holes in the system, bureaucracy then realigns itself, resets its holes, so that other patients fall through other cracks. The system under administrative conditions can never be perfect.

But in whose name, or under what terms, can international, humanitarian aid organisations claim that the scientific, administrative method is the best for the task at hand? In other words, if the administrative frame depersonalizes individual patients, if it turns these individuals into numbers and categories, how can it still claim to be a humanitarian endeavour? The connection between science and attempts at creating humanitarian utopias can be traced to the Enlightenment. Under this rubric science served as the escape from what was perceived to be the oppressive hegemony of religious doctrine. In terms of this Enlightenment project it could be illustrated that all human beings were equal and humans could not be designated in terms of good and evil, the saved and the doomed. The administrative frame, in the sense described here, perpetuates the divisions of the church as it operates under the divisions of the saved and the doomed, people are categorised, despite their complexity, into classes.

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[18] The word "symptom" has Greek sumptõma (chance) as a root.

Whereas the clinical frame operates without these binding restrictions, a doomed patient can be saved, and the saved may be doomed. Science, then, is not the object of critique here but rather its use, or rather what 'overdetermines' its use. In this case its position within a wider legal and economic network impacts largely upon the ethos under which it is applied. Increasingly strong ties between the legal and medical realms force doctors to abandon many principles held under a clinical ethos. As Dodier argues:

> This ascendancy of law corresponds, on the one hand, with the increasingly strong bonds between medical practice and the mechanisms of social justice, controlling the distribution of care and goods in societies, and on the other, with the implementation of public health policy expressed as rules aimed at populations….The development of an administrative frame that adapts itself more or less well to the demands of the clinical frame also corresponds with the diffusion of scientific protocols in contemporary medicine (Dodier 1998:79).

The mechanisms of social justice are thus what contribute to the use of an administrative frame as the law aids the equitable distribution of resources globally and in society (a questionable assumption but one we cannot deal with here). However, as we have seen, this type of frame also contributes towards the marginalisation of many patients who do not fulfil the bureaucratic requirements of this frame.

Dodier (1998) does grant that in the complexity of practice, the clinical and administrative frame can and do co-exist within a particular doctor. In the case of Dr G then we can see how a clinical ethos has to contend with an administrative frame in the management of 'his clinics'. However, he is at the same time contending with this hegemony and rebelling against its force. He is operating, in a sense as a 'double agent,' playing both sides in order to achieve the goals of his personal ethos. Where then can we place a doctor like Dr G in the framework discussed above?[19] In order to do this we must first explore the nature of the framing process. The 'status' of

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[19] I do not think it is necessary to 'classify' Dr G, indeed as the argument illustrates the ethics of classification is questionable, but the attempt does provide some interesting insights.

the administrative and clinical frames both concern medical decision making. That is, they describe an ethos of how decisions are made i.e. whether a doctor complies to a system of administrative, medical classifications or not. Whether a doctor centres the patient as the measurement of symptoms or uses the ideal case of statistics. So when Dr Z diagnoses TB in Jonathan it is a medical decision using a clinical frame weighed against another medical decision which depends upon an administrative frame. In the case of Dr G we have seen that his role in the clinic forces him to juggle the two frames in order to fulfil the requirements of his personal ethos and that of the bureaucratic system on which he depends. A third frame, also expounded by Dodier, can be used here.

In an early work on the use of frames (an idea borrowed from Goffman) Dodier (1994) outlines what he labels as the 'solicitude' frame. In his own field of occupational medicine, Dodier argues that the solicitude frame is a "patient-centred" approach in that the experience of the patient takes precedence over the "objective" symptoms viewed by the doctor. In Dodier's case study this is done in order for the doctor to solicit on the part of the patient in order for the patient's desires to be fulfilled (by moving the patient to another job or early retirement etc). However, under the legal and scientific bindings of medicine today, as we saw with the role of an administrative frame, objective symptoms are essential to attributing rights to the individual. In this case "the doctor must be capable of appreciating the extent to which the symptoms concur with objective elements, while remaining attentive to the clinical idiosyncrasies of the individuals involved" (Dodier 1994:492). This is what Dodier has entitled "patient centred medicine". "In the classic clinical scenario, the doctor tries to see and act on the body of the patient; the accounts of patients are only intermediary indications. In 'patient-centred medicine', the experience of the patient, on the contrary, becomes the domain of the doctor's intervention, who looks for paths that allow for access to authentic expression of the patient's inner self" (Dodier 1994:508).

For the case of Dr G we have to slightly transform the notion of a solicitude frame, indeed it must be noted here that I am corrupting the meaning of the "solicitude frame," as was intended by Dodier, for the sake of a different context. In his case, what we see is a combination of the clinical and the administrative frame driven by

the ethos of solicitude. That is, Dr G identifies the experience of the patient as the driving force of their treatment. This can be seen in the "Emporium of Care" discussed above, in the desire to fulfil more than the requirements of clinical medicine and to help with the patient's psychic-socio-economic concerns as well. In Dodier's case study the patients are employed, 'First World' citizens, in the case of Dr G the patients are rarely employed, barely citizens of the 'Third World'. There is, therefore, a qualitative difference between the work of the physicians studied by Dodier, and the ones under scrutiny here. Whereas Dodier's physicians treated the psychic well being of their patients, Dr G aims to treat the very survival his patients through the opportunities and the constraints of a bureaucratic network. The administrative network in this regard is used to provide for the patient as it is juggled alongside the clinical frame, in an effort to solicit. The solicitude frame is only possible due to the fact that Dr G, and indeed his patient, are imbedded within a network of rights. That is, the legal framework surrounding medicine and its place in the equitable distribution of goods in society, places opportunities for solicitation at Dr G's door, although as we have seen these same opportunities constrict behaviour through administrative frameworks. The 'objectivity' of science and the law, the 'subjectivity' of the patients' life and the doctor are then all juggled in the solicitude frame in the name of an equitable distribution of resources which benefits the patient.

Frames therefore illustrate how different doctors approach different patients. Out of these approaches one can take note of the different ethos which doctors may comply to and, in the case of the doctors discussed here, one can note that this ethos aims to treat an individual as an individual rather than as a member of a population. What I have tried to illustrate is that an ethos of this kind is essential for success in treating a disease such as HIV in resource limited settings. Furthermore, an approach of this sort allows for qualitative engagements and affective entanglements to arise out of the relationship between a doctor and a patient. In the following chapter I will illustrate how the affective entanglements between doctor and patient inspires ethical behaviour within the patient. In this regard the importance of the material aspects of a doctors practice is once again emphasized and is illustrated in the symbolic rituals of medicine. Finally, the difficulties and ethics of standardisation will be explored in relation to the work of Taylor and his 'scientific-management' method.

Chapter 4: The doctor and patient interaction: touching the patient

4.1 Touching, feeling and being

What we have looked at so far in this paper is how international organisations influence the practice of doctors on the ground. What the previous chapter aimed to illustrate was how an emphasis on the doctors' cognition allows a normative framework to be introduced into medicine. This normative framework is also looked at in terms of the administrative frame which aims to guide doctors' decision-making according to pre-defined risk groups. In contrast to the administrative frame, I have proposed the clinical frame, which grounds a doctor's diagnosis in the individual indices of the patient. Furthermore, I have illustrated how the use of these frames is guided by a particular ethos and the position of the doctor within the clinic. The common theme running through much of the above argument is the extent to which the materiality of practice influences doctors' practice and how a doctor's practice is guided by the Aristotelian idea of phronesis. The politics behind acknowledging material circumstance is that doctors are placed in a position through which they can make common cause with their patients against the severe material inequality they face. Efforts of this kind can be seen in Dr G's "Emporium of Care" but also on a very mundane level by not treating patients as mere members of risk groups but rather as individuals who suffer uniquely. In this part of the thesis I will explore how the processes of standardisation effect the relationship between doctor and patient. This section will then explore the importance of the relationship between doctor and patient and its ability to inspire ethical behaviour in both parties.

In "The Politics of Life Itself" Nikolas Rose (2007) argues for the term "ethnopolitics" as the self-techniques by which individuals judge and act upon themselves through a particular ethics. Rose views "ethnopolitics" as a point existing between the Foucauldian ideas of discipline and biopolitics. "If 'discipline' individualizes and normalizes, and 'biopolitics' collectivizes and socializes, 'ethnopolitics' concerns itself with the self-techniques by which human beings should judge and act upon themselves to make themselves better than they are" (Rose 2007:27). Ethnopolitics can then be construed as an ethics which is both actively

taken up by a subject and enforced by an authority. In our case, and indeed in the work of Rose, the subject and the authority are the patient and the doctor, and their relationship can be construed as a set of "pastoral powers." However, pastoral does not imply a one way relationship in which a "shepherd directs the souls of confused sheep." Rather this relationship, Rose argues

> entails a dynamic set of relations between the effects of those who counsel and those of the counselled. These new pastors of the soma espouse the ethical principles of informed consent, autonomy, voluntary action, and choice and nondirectiveness… these ethical principles are inevitably translated into microtechnologies for the management of communication and information that are inescapably normative and directional. These blur the boundaries of coercion and consent. They transform the subjectivities of those who are counseled, offering them new languages to describe their predicament, new criteria to calculate its possibilities and perils, and entangling the ethics of the different parties involved (Rose 2007:29).

In his use of Foucault, Rose is pointing to an often underrepresented idea within studies that draw on Foucault in the social sciences. That is power, in the biopower sense, "operates by bringing forth and promoting, rather than repressing, the forces and energies of human subjects" (Brigg 2002:422). Subjects to this power therefore have agency, "biopower does not operate in accordance with the symbol of the sword- the symbol of the sovereign-and the right to '*take* life or *let* live'. Rather, it is 'a way of acting upon an acting subject or subjects by virtue of their acting or being capable of action'" (Brigg quoting Foucault 2002:423, emphasis in original). In relations of 'pastoral power' the doctor depends precisely upon the ability of the patient to make independent choices from a multiplicity of discourses, in order for them to be compliant to the requirements of the medication and the 'ethics' of being HIV-positive.

In their interactions with patients, doctors often use metaphors in order to describe the complicated workings of the effects of ARVs on the disease and body. Different analogies are used by different doctors, but the one used by Dr G is a good illustration of the argument made above. The doctor in question would begin by drawing a "street

map" of the blood vessels in the body, representing glands and organs as houses, equating the inner body with that of the outside township. "The CD4" in this township are the community (used in the South African sense of the word), whereas the ARVs are the police and the virus is the "skollies" (gangsters). When the skollies take over the township nobody can go to work and people suffer but when the police take too much control, through roadblocks etc. people are also hampered and experience the side-effects thereof. There is therefore a strong neo-liberal script involved in the use of metaphors of this kind, wherein values about crime, government and self-discipline (going to work etc) are elaborated. One must go to work to take care of the others in your life and not be skollies who harm others. But one must also not allow the police (or state) to interfere too much as this will also influence your economic freedom.

The choice of metaphor is also important. Susan Sontag (1979, 1988) has illustrated how the metaphors chosen to describe disease closely reflect "a reality we find difficult to see clearly" (Martin 1989:44)[20]. In the case of the metaphor above, the doctor is describing the economic conditions of life in the townships which have arisen in post-Apartheid South Africa. As such, he is creating an affective relationship with his patient through describing the predicament they find themselves in, both medically and socio-economically, and making 'clear' what is difficult to see. The doctor in this regard is making use of a neo-liberal discourse, in which a patient is a free agent who should have choice, but at the same time is authorising this particular world view. An 'affective entanglement' with the benefits of science is created by means of describing the fears and inadequacies a patient experiences in the broader socio-economic condition, outside the problems of the body. The metaphors used in the relations between doctors and patients therefore provide a description of the life conditions of patients, which extend beyond the disease within the body. Perhaps this could also explain the radical turn around witnessed in many patients, as they claim 'new life' after being diagnosed HIV-positive, as their social predicament is best (re)described to them, and their previous fears are allayed, by the explanatory power of the metaphor (this is of course not Sontag's argument).

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[20] Emily Martin has also used and expanded the work of Sontag to demonstrate how women's bodies are conceptualised in relation to the social conditions at hand.

The relational aspects of this type of pastoral power must not be underemphasized. The doctor depends upon the affects of the patient as much as the patient depends upon the affects of the doctor. According to Rose,

> these counselling encounters entail intense bidirectional affective entanglements between all the parties to the encounter, and indeed generate multiple "virtual" entanglements with parties not present- distant relatives, absent siblings, potential offspring. In these entanglements, the ethical relations of all the subjects to themselves and to one another are at stake, including the experts themselves. The consultation acts as an intensifier of ethicality (Rose 2007:74).

It is important to note that Rose is talking about a particular *kind* of physician here. That is a physician operating under a particular frame and ethos. It would be hard to imagine someone operating under an administrative frame engaging in the same affective entanglements discussed here. Indeed, the process of pastoral power, discussed by Rose, cannot depersonalise patients in order to be successful, due to the fact that it depends upon the affective entanglements of individuals and their experiences of their socio-economic reality.

It is the affective entanglements between the doctor and the patient which allows the idiosyncrasies of the individuals involved to be revealed. Relying on the affective entanglements for the success of chronic care means each individual must be taken in the context of their individual lives. For this reason a doctor has to "dance" with his patients, as Dr G states. This "dance" depends upon knowledge and experience of individual patients and is therefore only "truly" possible within certain health services. When the South African government initially agreed to ARV roll out, the limited number of patients allowed access to ARVs meant that doctors could develop intimate relationships with their patients. However, with the increase in numbers of patients at public health clinics, as well as the promise of free ARVs for all who need them, developing intimate relationships with patients has become nearly impossible (I say nearly because doctors still do develop relationships with unique or 'reliable' patients). In terms of affective entanglements, doctors now rely on intuition and

experience of similar cases to make decisions regarding how to approach a patient as well as to inspire ethical behaviour within patients.

"You could do all the medical stuff just by looking at the files" says Dr G, "but that won't help the patient much." There is much more to the clinical encounter than pure "objective medicine." Medical practice is not solely a calculating endeavour in terms of the calculation one finds within the hard sciences such as engineering. It contains factors which are incalculable to strict rationality. Doctors like Dr G and Dr Z emphasize that the position of doctors in a social hierarchy, especially marked by their position as outsiders in terms of their patients' lives, requires them to use their positions to enhance the ability of consultations to "act as intensifiers of ethicality." Indeed, a large proportion of the patients a doctor in a HIV clinic sees on a daily basis are not suffering from any side effects or complications caused by HIV or ARVs. They are the "run-of-the-mill" patients that the administrative frame and evidence-based medicine aim to efficiently deal with. Furthermore, these patients do "frustrate" doctors like Dr G, who is interested in the complicated cases as "intellectual challenges" or Dr Z, whose severe work load makes these patients appear as unnecessary "obstructions" to dealing with the epidemic at her clinics' doorstep.[21] It is also for this reason that nurse-driven programmes appear as an option for dealing with the epidemic where the doctors only deal with difficult or new cases. However, it is questionable whether these programmes would be sustainable if even patients who are doing well begin to feel as if they are *just* an administrative obstacle, somebody who *just* needs to be worked through the system. This is of course not to assume that all patients keenly await their appointment with the doctor, as if they are some awe inspiring icon. It is just that in the social circumstances of marginality, the effort a doctor places within a patient can inspire the realisation of the importance not only of their successful combat with the disease but also of their being. You the patient are worth this doctor's time.

There is of course also a medical advantage to personal contact between doctor and patient, even in "run-of-the-mill" cases. As Montgomery argues,

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[21] Of course the doctors do not express these patients in these terms, it is terms I adopt as an observer and use in order to exemplify a point.

but even if computer programs, like textbook descriptions or the protocols given to emergency medical technicians, worked most of the time, they would still be an inadequate substitute for clinical attention. The need for human contact by both parties to the patient-physician encounter goes well beyond the patient's need for reassurance and support….What experienced clinicians possess…is an immense and well-sorted catalogue of clinical cases and the clinical judgement to know how to use it, and that store of knowledge is activated by seeing, touching and questioning the patient (Montgomery 2006:34).

The embodied nature of diagnosis is revealed in interviewing Dr Z who, while discussing the case of diagnosing TB in Jonathan, touches her face around her eyes and says she sees something in the eyes of TB patients which she can't describe but is revealed to us, the interviewers, in her body language. The store of knowledge she is recollecting here is not an epistemological store in her mind, a list of symptoms she recalls. Rather the knowledge is embodied in moments and contexts and can only be relayed by means of body language assisted by words. So an apparent "run-of-the-mill" patient on paper could have radically different problems, detected by the physician by a touch or an answer to a question, which can only be realised in the physical encounter between an experienced doctor and patient.

The WHO recognises the strain placed on doctors working in resource limited settings and aim to relieve this problem by distributing responsibilities to other members of staff. "A public health approach to HIV/AIDS treatment should therefore include strategies to reduce dependence on highly trained physicians. To do this, routine aspects of managing treatment and care should be delegated to other health care workers" (WHO 2003:5). However, as was illustrated above, despite the reality of staff shortfalls in many clinics, the difficulty of assigning patients as 'run-of-the-mill' becomes evident in the complicated process of managing a HIV positive patient and considering which symptoms should be accepted as relevant and which shouldn't.

The importance of a doctors' interaction with a patient however does not imply that one can allocate any doctor to any patient. This is of course possible, but it is not as efficient as a doctor experienced within a particular spatial and temporal context. In a

sense, doctors cannot be employed successfully and efficiently anywhere. As was mentioned above, Dr G uses the model of illness and disease whereby disease is the physical condition and illness is the surrounding psychic-socio-economic difficulties presented by the patients' life (coincidently very similar to Arthur Kleinman's (1988) famous distinction). The problem with standardisation then is that if you standardise disease you standardise illness and care. However, illness and care cannot be standardised due to the uniqueness of each patient and their psychic-socio-economic environments. The doctor's experience of working with particular patients in particular environments, implies that they have unique, intimate knowledge of the conditions under which their patients live. They are therefore able to find patients' problems quicker, able to interpret the problems of both disease and illness quicker.

4.2 Placating and Standardisation

So far the argument within this section on the interaction between patients and doctors has illustrated the difficulty and inefficiency of standardised treatment. However, one must also realise that the context within which HIV/AIDS treatment exists is one which does call for a measure of standardisation. That is, standardisation does carry benefits, for patients as much as for the bureaucracy it supports, in certain facets of managing the disease. As some doctors have pointed out to me, the agency of patients allows them to placate doctors despite perhaps not adhering to treatment or partaking in risky behaviour.

The *bidirectionality* (Rose 20007) of the medical encounter should not be under emphasised. In their "ways of rendering [medical knowledge] morally acceptable and technically useful" (Foucault 1978:21) doctors are not "the masters of truth" but rather mediators of what passes for medical truth and what not. That is, if one grants that agency exists at every level of a bureaucratic structure, as we must in accepting the validity of the argument of this thesis, then we must grant that patients have agency as well. The ideal, complacent patient, the "Foucauldian patient" as a subject solely of medical discourse, existing free of the 'interferences' of other discourses, does not exist in the context of HIV/AIDS clinics within South Africa. The discourse of medical truth expounded by doctors, nurses and counsellors at these clinics has to contend with a multiplicity of discourses, existing outside the clinic walls, most

notably but not restricted to, AIDS dissident discourse. Medical "truth" then is continuously contending with opposing or competing discourses within a single patient. In the experience of "problematic" patients one finds an ability to placate doctors as they learn what is accepted as truth. This is done through discarding unused medication to check their adherence rates or by means of tactfully answering questions. This is both the downfall of standardisation as well as its strength. Its strength is that the only means to reinforce values in patients, over long periods of time and by different doctors, is for all the "doctors to speak the same language." In other words, to standardise the lexicon, reiterating the same message regardless of the encounter. The temporality of a chronic disease is important to take into consideration then when thinking about managing an epidemic such as HIV/AIDS. Unlike other epidemics or disease dealt with within the developing world, HIV/AIDS presents the problem of sustainability, as was revealed in the above section on accreditation. That is, one cannot give a course of medication over a period of time to people living with AIDS and they will be cured, as is the case with TB. Rather, reinforcement of values and motives is necessary due to the strain placed on patients needing to take over a hundred pills a month at exactly the same time twice a day, without indulging in alcohol and maintaining healthy diets despite abject poverty and hardships. This is why standardisation helps, because over a lifetime of regular clinical encounters, the same even message will take effect, creating 'responsible citizens' of health and social life.

Its downside is that once a "crack" is detected in the standardised message, it can and will be used to counter the validity of the discourse. Furthermore, standardised discourse limits the amount of knowledge a patient can receive as well as the "type" of understanding a patient may have of the disease. A single message then, highlighting a single disease and single cure limits broader or deeper understandings of the disease.[22] Finally, due to the necessity of disseminating the "same message", individual responsibility is shifted onto doctors who do not conform to the standardised message. Reiterating a single method or standard protocol upholds the validity of the approach and thereby makes deviance from this approach an act of

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[22] This is not to imply that a standardised "message" cannot be broad but rather that within the functioning of standardisation as a tool to aid doctors in resource limited settings a standardised message will in its very functioning or purpose be limited in order to improve efficiency and distribute resources among any staff members, whether they have experience with the disease or not.

dissent. In this regard the protocol is never challenged despite the idiosyncrasies of individual patients which a doctor may notice. Responsibility for failure within patients whose doctors acted in dissent of the protocol falls on the shoulders of the doctors. As many doctors told me, protocols don't get blamed, doctors do. This same shifting of blame from the protocol to the doctor can be seen in patients who fail despite the doctor following the protocol. In these instances it is the personality or culture of the patient which is deviant, "sy was moeilik" or "he just didn't care about himself" are common explanations for non-compliant patients. This is Farmer's (2005) "personalistic pole" once again at play in medicine, although in another form. However, it is important to note that both standardised and 'non-standardised' health care construct or demarcate deviance or non-deviance. In helping patients, in transforming their lives through ART and creating responsible citizens of health, one is also demarcating a group of people who are not responsible, who are "problematic". As Rose and Novas (2005) argue. "The enactment of such responsible behaviours has become routine and expected, built in to public health measures, producing new types of problematic persons-those who refuse to identify themselves with this responsible community of biological citizens" (Rose & Novas 2005:451).

What Grosz (1995), following Foucault, said about knowledge can be applied here to protocols, "knowledge is an activity; it is a *practice* and not a contemplative reflection. It *does things*. As product or thing, it denies its historicity and asserts its indifference to questions of politics in such a way that it functions as a tool directed to any particular purposes its user chooses" (Grosz 1995:37). The protocol in this regard is 'neutral', a "performed recommendation" (Berg 1998), a tool, and therefore cannot be held responsible for failings but is upheld as an icon of success when successful. As Connolly (1993) states, "Foucault contends… that systematic cruelty flows regularly from the thoughtlessness of aggressive conventionality….Evil, again, not as gratuitous action by free agents operating in an innocent institutional matrix but as undeserved suffering imposed by practices protecting the reassurance…of hegemonic identities" (Connolly 1993:366). One can see that a protocol is also a tool which shifts responsibility from a *general* body, such as a health department or global organisation, to a *particular* body, the doctor acting in accordance with his ethos or the patient and their personality. The protocol helps then in creating the general body as anonymous, as discrete, as apolitical due to the fact that its politics are revealed

only in the failings of a particular doctor who takes responsibility for patients[23]. This is only possible due to the looseness of the network in which protocols operate. This function of the protocol is also what maintains the culture of 'high managerialism' and the 'good conscience' of those working within these large organisations, as was discussed in the first chapter.

A case study used above will make this point explicit. If you remember, Louise is the diagnosed schizophrenic discussed previously, who, due to her socio-economic and psychological condition, should not be put on to ARVs but was by Dr G. In this regard, if Louise were to default from ARVs, the blame for her failure would be put on to the shoulders of Dr G who should have followed the guidelines, or Louise, who was just a difficult patient due to her schizophrenia. The protocol here would be correct, never mind the fact that many potentially successful patients like Louise would die because they do not fulfil a particular understanding of what constitutes a responsible patient. In another case study we can look at Johan, the policeman I contrasted with Louise above. Johan is married with three children and of course is employed. However Johan has a terrible adherence rate despite fulfilling the psycho-social requirements perfectly. Johan's failure can then be ascribed to the doctor who did not counsel Johan sufficiently, or to Johan's difficult personality which does not allow him to accept his status[24]. The politics of the guidelines are not questioned, that is the assumption that if you fulfil the stereotype of the middle class you will automatically be a responsible citizen. The organisations establishing these guidelines are faceless, the looseness of protocols and networks maintain this. There is then a sort of silent violence enacted by protocols as they hide the source of their definitions of subjects, an arche-violence (Grosz 1998) of the origins of what constitutes an eligible subject.

But how do doctors such as Dr G and Dr Z challenge this aggressive conformity, this arche-violence? If one follows Susan Reynolds Whyte et. al. we can view the act of prescription as a form of communication. That is,

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[23] Once again the protocol aims to hide the antagonism in the universal, construing it as an essential rather than as the site of a problem

[24] This argument does not aim to imply that no such thing as a deviant or non-compliant patient or doctor exists. Indeed they can but what this argument aims to illustrate is how responsibility is shifted, in all cases to personalistic/cultural features.

prescribing is also a symbolic act; it is an effective style of communication. In the prescription the doctor signals to the patient who he is…Through the prescription the doctor tells the patient that he understands his problem and can do something about it…For most – not all- patients the prescription is a proof of the doctor's concern and competence (Reynolds Whyte; van der Geest & Hardon 2002:117).

One can extend the symbolism of prescription, as indeed I have in various places in this discussion, to the clinical encounter. As such, in the clinical encounter the doctor tells the patient who he is, that he understands his problems. This symbolism is of course only possible in non-standardised or not entirely standardised interaction,[25] in treating patients as individuals with unique problems.

Interaction which promotes symbolism of this sort, promotes what Helen Epstein (2007a; 2007b) has illustrated as being the successful "cure" to managing the disease. "The key to fighting AIDS lies in something for which public health has no name or programme…..It is best described as a sense of solidarity, compassion and mutual aid that is impossible to quantify or measure…Because our sexuality is shaped by society and because sex itself involves more than one person, behaviour change is a collective act, not one of individuals acting alone" (Epstein 2007b:1). In South Africa, achieving this sense of solidarity is difficult (although organisations such as the TAC have been successful to an extent), especially due to the history of Apartheid racism associated with science and medicine (Fassin 2007). However, as almost all the doctors I interviewed have pointed out, doctors and clinics are in privileged positions from which to begin the process of building this solidarity. Clinics are often located in the literal hearts of townships, as well as commanding respect from the patients they receive through the "miracles" of giving life to the nearly dead.

Slavoj Zizek, extending the work of Althusser, argues for the materiality of ideological practice. In the actions and interactions of daily life one can witness and maintain faith in an ideology. This is expressed by Zizek in terms of religion,

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[25] I say non- or not entirely standardise interaction due to the fact that all interaction, especially in the clinical encounter, is to some extent standardised.

Religious belief…is not merely or even primarily an inner conviction, but the Church as an institution and its rituals (prayer, baptism, confirmation, confession…) which, far from being a mere secondary externalization of the inner belief, stand for *the very mechanisms that generate it*…That is to say, the implicit logic of this argument is: kneel down and *you shall believe that you knelt down because of your belief-* that is, your following the ritual is an expression/effect of your inner belief, in short the "external" ritual performatively generates its own ideological foundation (Zizek quoted in Wolf 1998:94, emphasis in Wolf).

We can see from this the importance of the symbolic act of prescription, of the doctor interacting with the patient, of having one's adherence checked in pill counts, in going to the clinic, in the rituals of medicine. However, in order to keep patients coming to the clinics, to keep going through these rituals, takes constant attention from the doctors, constant care, in order to build faith in the clinic. Patients need to feel as if they have self-worth, that the clinic is worth their time, this can only be achieved through treating each individual as an individual.

Going to the clinic is more than just a physical act (or perhaps *nothing more* than a physical act), an act of receiving pharmaceuticals for a biological condition. This is the view of clinics as seen by international organisations whose main concern is care for a population and the management of a disease. Efficiency is central to this concern, accessing as many patients with as limited resources as possible. The administrative ethos here is of course admirable and indeed ethical in its endeavour. But the problem with standardisation, with its particular approach to efficiency in medicine, can be seen as the same problem that Taylorism and scientific-management encountered in factories.

4.3 Taylorism, therbligs and pills

Jameson (2002) once again provides an interesting analysis of "scientific management" as we can apply it to the case of standardisation. Scientific management works by uncoupling parts from each other. That is, a complex task which was

previously done by a single person is now divided into many different simple tasks, done by many different people. "The meaningless parts are now reshuffled according to the criteria of efficiency: and Ford's assembly line comes into view, along with a considerable bonus for the manager in the loss of control over the process of the worker himself, who no longer sees and grasps it as a meaningful whole" (Jameson 2002:82-83). Standardisation is an attempt to divide the practice of medicine between different actors in the name of efficiency. One can see how terms such as "task shifting" or "nurse driven" drive this type of management approach. In both task shifting and nurse driven approaches doctors begin to act as managers, only seeing especially problematic patients. 'Run-of-the-mill' patients are dealt with by nurses. This argument does not imply that nurses are not capable of dealing with patients suffering from diseases such as HIV, in fact most experienced nurses are more than competent to deal with almost any patient. However, what nurse driven and task shifting imply is that work must be distributed between staff, each staff member will have a particular task that they will repeat with each patient, each patient sharing only a small amount of responsibility, seeing only a small part of the whole picture.

"Now the 'separation' of manual and mental labour is completed by the passage of control and planning to the manager and the 'scientific' experts, while the worker is left with segmentary and repetitive gestures that Frank Gilbreth called 'therbligs', the smallest indivisible units of kinetics" (Jameson 2002:83). The danger here for medicine is obvious, for various levels of the clinical encounter. Firstly, for doctors and nurses, loss of control over their clinic is already becoming obvious as the experts of the WHO, or the Global Fund, 'recommend' actions and management strategies. Furthermore, at the other end of the spectrum we have patients whose only understanding of medicine and disease is the pills, the 'therbligs', they have to take each day. Patients are not given a 'complete' or broader picture in this regard as they are only expected to take their medication and comply to 'the rules'.

One can analyse the approach adopted internationally in the fight against TB in this light. The strategy adopted is that of Direct Observation Therapy (DOT) whereby patients would be observed taking their medication during the critical first three months of the six month course of medication. During this time, patients would have to go the clinic each morning of the week, except the weekend, to receive their

medication and be witnessed taking it. One can notice that disease is dealt with in a way that can be, though not necessarily, equated with the administrative frame above. All patients are dealt with as having TB and are therefore treated equally, the disease being the object of enquiry, not the patient. The patient is not instructed in how the disease works, nor why they're taking the medication, it is purely a mechanical act. Under the approach of DOT the problem to be dealt with is a disease in a population, the threat of resistance developing, not of individual patients.

TB has become 'institutionalised' within the societies surrounding the clinics discussed in this paper. In other words, TB has become such a part of daily life within these townships that it is extremely rare to meet an adult patient who has not contracted TB at least once in their life. Citizens of these communities have experienced the benefits of scientific medicine in dealing with TB and therefore going to the clinic, instead of the traditional healer, has become the standard way of dealing with this disease. Apart from this there are material benefits such as access to disability grants if TB is dealt with at a clinic. In fact, in most clinics a large proportion of patients come to the clinic for TB and while they are there they get tested for HIV. TB is then the entry point for many patients into scientific medicine. Patients understand the process of disease management through their experience with TB. In this regard, often despite the required amount of counselling, patients understand HIV to be a disease that once you take the pills for a required amount of time the disease will be cured. This could explain why patients, who once having been on ARVs for a period of time and have overcome the side-effects, default from their medication believing they are cured. This is also why patients regularly believe they automatically qualify for a disability grant if diagnosed HIV positive, like they would for TB.

Furthermore, a relationship between TB and HIV has developed, in terms of which if a patient has TB they more than likely have HIV. This means that many patients understand the disease in the same terms. The 'frame' under which patients understand HIV is the same frame used for TB. The pills, the 'therbligs', for these patients operate under the same terms, resulting often in defaulting from ARVs, or bad adherence rates when medication is taken only on working days as with TB medication. This can be seen as a result of the uncoupling of various aspects of

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disease from one another. Without any description of their place in a broader picture, patients, at the end of the medical chain, are given access to the smallest component of the fight against the disease as possible, pills. There is a danger then in breaking things into their smallest parts to serve the needs of management and bureaucracy. Scientific management does not recognise the broader implications of this action because the world is not 'atomised' as science would want us to believe.

The interesting fact concerning the similarity between standardised health care and 'scientific management' is that they are based upon similar ethical principles. The ideal of Taylor was to ensure that each worker got the wages they were due according to their productivity. 'Pre-Taylorism' labourers received a daily wage and were not 'motivated' to work harder as they would be with piecework work. In the Taylorist approach the worker would receive what he had earned, and as such Taylorism was presented as in the interest of the workers not management. The ideal was to separate "first class" men, those with good character and a tendency to work hard, from the average working class man. Indeed, as with standardisation, there was (is) ethical value in the work of Taylor as one of his case studies illustrated how more comfortable working conditions and shorter shifts improved the productivity as well as earnings of a group of women (Sheldrake 1996:17). One can see here how standardisations' approach to medicine is similar in its ethical imperative of improving the lives of the poor through efficiency. It also operates on a mechanism designed to separate 'first class' citizens from average citizens. The ethics of Taylorism and standardisation then does not ensure that people who do not fall into categories of 'first class' citizens receive the same opportunities as those who supposedly do.

One is forced to take the integrity of the designers of these policies seriously; conspiracy theories about the subjugation of the poor will not explain the visible successes and advantages of these methods. However, it is equally important to critique these processes, based on empirical research, as to the violence they do. It is also important to take into consideration how standardised processes do in fact operate and to illustrate, as I have attempted to do, that they probably operate with a degree of disorder that would frustrate designers of these methods. "It is true that whenever intelligent and educated men find that the responsibility for making

progress in any of the mechanical arts rests with them, instead of upon workmen who are actually labouring at the trade, that they almost invariably start on the road which leads to the development of a science where, in the past, has existed mere traditional or rule of thumb knowledge" (Taylor quoted in Sheldrake 1996:18). This thesis has aimed to illustrate this point precisely but to illustrate that the "workmen who are actually labouring at the trade", the doctors, depend upon the rule of thumb knowledge which "intelligent and educated men", the 'experts', aim to do away with in the name of efficiency.

To end..

In 1959 Hannah Arendt noted that "modern equality, based on the conformism inherent in society [is] possible only because behaviour has replaced action as the foremost mode of human relationships" (Arendt 1959:41). This observation underlines much of the work done in this thesis. That is, on a smaller scale to society, one can view how there is an attempt to regulate the behaviour of doctors by protocols and standardisation in which doctors are expected to conform to models. We have observed how this shift to a focus on behaviour, or decision making behaviour, is the result of a cognitivist model of how doctors work, conceived in the post World War Two era. In contrast to this model I have attempted to illustrate how doctors 'practice' and, in disagreement with Arendt, have illustrated how the actions which doctors take, although in dissent to the behaviourist requirements necessary for modern equality, still do not challenge the cognitive models upon which the system rests. Indeed one has to grant that the same process of action versus behaviour takes place at the level of the relationship between doctor and patient wherein a doctor attempts to regulate the behaviour of the patient, and grants or withholds life saving medication based on this conformism.

What is revealed quite explicitly within the experiences of a doctor operating in the contexts described in this thesis, is that "experience always takes place within particular social spaces and is inextricable from the shifting exigencies of practical, everyday life within those spaces….This charged engagement with the things of a local world lends experience its intrinsically moral character: experience is the medium through which people engage with the things that matter most to them" (Kleinman & Fitz-Henry 2007:54). Experience, then, is tied to a morality. One can read this statement in two ways, not separate from each other. Firstly, experience is tied to our actions, in this light our actions are always moral actions as they effect the lives of present, future or past others. Secondly, our experience is framed by a particular morality and our morality by particular experiences. If one is operating under an administrative frame, the morality of your action and experience is justified by a particular frame and an experience of practice. Morality then shapes our experience of actions. These two understandings are not separate from each other and

can be brought together by the rather Derridean phrase, experience is always, already moral.

Therefore, "experience is not sheer passivity. Rather, ethical experience is an *activity* whereby new objects emerge for a subject involved in the process of their creation" (Critchley 2007:14 emphasis in original). But what shapes this activity? What sense of duty drives the activities of the doctors? In other words, I have granted that experience is based upon action and that the moral action of doctors such as Dr G and Dr Z are based upon a sense of duty beyond that which is called for them by protocols. The administrative frame or standardisation processes provide or outline a duty for doctors. For example, treat or withhold treatment from this patient because s/he belongs to this population. In breaking with a protocol a doctor transgresses this duty, transgresses a rule by saying that they are willing to take a risk on behalf of this patient against the rule of this population. But according to Derrida this is the paradoxical nature of duty:

> duty must be such an over-duty, which demands acting without duty, without rule or norm (therefore without law) under the risk of seeing the so-called responsible decision become again the merely technical application of a concept and therefore presentable knowledge….But, conversely, who would call a decision that is without rule, without norm, with determinable or determined law a decision?...It is necessary, therefore, that the decision and responsibility for it be taken, interrupting the relation to any *presentable* determination but still maintaining a presentable relation to the interruption and to what it interrupts (Derrida 1993:16-17).

For Derrida then, and as I have attempted to illustrate in this thesis, there is a paradoxical nature to the ethical relation between an agent and a structure. The freedom of a doctor to act in an ethical manner is predicated on the rules of standardisation and the requirements of protocols, yet paradoxically these rules and requirements also attempt to limit the possibilities for what I have described as ethical actions. Modernist, "western" science therefore does contain possibilities for improving life for the suffering yet these 'redemptive possibilities' are achieved in its subversion, in dissent of it. It is important therefore not to discard, wholesale, the

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ideals and instrumentalities of 'development' but rather to take careful consideration of the nuances produced in its dream, in its lieu, in its wake.

However, taking these nuances into consideration does not only imply revealing the particularities of each case but also in revealing the universals. That is, "it is not only that every universality is haunted by a particular content that taints it; it is that every particular position is haunted by its implicit universality, which undermines it" (Zizek 2008:132). In this regard considering the actions of doctors such as Dr G or Dr Z as unique, in praising their dissent, we are hiding the universal in their actions, that is, their upholding of the protocol. This same argument could be applied if we were to lambaste the efforts of the WHO in improving the health conditions of HIV/AIDS sufferers in South Africa by stating that they will always *fail* because South Africa is unique. As Jameson argued in the first chapter of this thesis, this would hide the fact that the world is gripped by the universal of a single capitalist order. What is important then is that we do not separate the universal from the particular, the local from the global but that we examine the relationship or disjuncture between the two, not privileging the one over the other.

In not separating the local from the global we make a move away from the way in which such concepts are classically conceived of. However, it is important to remember that in stating that we cannot think these concepts apart also implies that we must treat them as separate while at the same time granting that they cannot be thought of as apart. This relationship between the universal and the particular is brought forward in the daily practice of doctors. It is also within this practice that paradox is revealed. Mosse (2004) sums up this paradoxical situation nicely: "Paradoxically, the practices of project workers erode the models that they also work to reinstate as representations. Moreover, because it rests on disjuncture and contradiction, the coherence and order of a successful project is always vulnerable; interpretations can fail" (Mosse 2004:665). Mosse's emphasis on interpretation is important to take note of in the context of social science. In as much as development projects are deemed successful or failures based on the interpretations of the stakeholders involved, so too one must be aware of the position of the anthropologist as observer. That is, in fieldwork an anthropologist also interprets the effects of a project and also seeks to create order amongst the disjuncture and contradiction. The

reason we struggle with paradoxical phenomena, according to Montouri (2003), is "because we are not used to 'thinking together' terms that we have, culturally and historically, come to view as oppositions. We have, following Morin's terms, thought about these phenomena in ways that are simplistic, disjunctive and decontextualized" (Montouri 2003:250). In this regard it is important for a better understanding of the phenomena that confront us in the field to be open to these contradictions and paradoxes. This does not imply a laziness in fieldwork, a call to abandon any aspiration towards explanation and to concede to the complexity of our field. On the contrary, this is a call for a more rigorous understanding of the complexity of the field and our position in it, whilst being open to concede that our models and rationalities are also vulnerable, also open to failure. As Ceruti states, "the harmony of the whole is no longer guaranteed by the preexistence [sic] of a plan, whether external or immanent. It is achieved, again and again, through, and despite of, the disharmony of the parts, their conflicts and compromises" (Ceruti 1994: xviii-xix).

Ethics and method

The importance of recognising paradox and disjuncture within ethnography becomes one of recognising the singularity of every time and place. It is also important then to re-examine concepts such as the 'north' or the 'south'; the 'centre' or the 'margin'. Although providing spatial metaphors for various socio-economic situations, these types of metaphors also limit the problem areas within which anthropology operates. An explicit focus on the 'margin' ignores the violence and inequality perpetuated at the 'centre.' This fact was recognised by the Nobel Laureate Prof. Muhammad Yunus, founder of the Grameen Bank, when he recently opened a branch of the bank in New York City, in the heart of the centre. The Grameen Bank started off by providing micro-credit to the poorest of rural Bangladesh, however, Prof. Yunus realised that there was as much suffering in the centre as in the margins of rural Bangladesh, and has therefore begun projects within the USA.

One tends to look outside the walls of the clinic for exclusion or neglect, assuming that those who have 'made it' within the walls of the clinic will be treated. In recognising the 'disharmony', 'conflicts' and 'compromises' of the parts of a whole one must acknowledge that 'holes' exist within a system and therefore the conditions

of the periphery may be found within the centre and, although more unlikely due to the vicious scale of global inequality, the conditions of the centre may be found at the periphery. This was the point of my argument in the third chapter concerning the way in which a method or bureaucracy does not reveal order nor imposes order on a world, but relies instead on the 'cracks' in epistemology to line up with the 'cracks' in ontology. That is, as the case study of Dr Z's diagnosis of TB in patients misdiagnosed by TB doctors reveals, a patient who has been diagnosed by a doctor with gastroenteritis could easily die of TB due to a misdiagnosis based on a reluctance to act contrary to an administrative requirement. However, these patients are only per chance revealed by Dr Z, and it is impossible to tell how many of them have slipped through the epistemological cracks of an administrative order and consequently the ontological cracks of life.

João Biehl (2005, 2004) has coined the term "technologies of invisibility" to illustrate how "bureaucratic procedures, informational difficulties, sheer medical neglect and moral contempt, and unresolved disputes over diagnostic criteria all mediate how these people are turned into absent things" (Biehl 2004:119). Technologies of invisibility can be viewed as the 'cracks' which I discuss and illustrate how people, 'unlitigated' for, uncared for within a legalistic-socio-economic order, slip through the centre of a clinic back to the margins which is their lives, on the peripheries of their deaths. This point was beautifully illustrated by Biehl in his book *Vita: life in a zone of social abandonment* (2005) where he follows the life of Catarina as she constantly slips in and out of the cracks of a health system despite the possibilities for life provided by this system. Technologies of invisibility, which "routinely intersect with patterns of discontinuity of medical care and of medication dispensation" (Biehl 2004: 119), can, in the light of this thesis, be regarded as the result of a particular doctor abiding by, or disregarding, protocols according to an ethos which s/he may subscribe to. However, with the current training of doctors strongly focused on evidence-based medicine, the prospects of future doctors acting in dissent of protocols appears unlikely.

<u>Medicine and jazz</u>

The doctors discussed within this thesis all exist within a particular structure and practice within a particular hierarchy. As was noted above, this space is also structured by an epistemological order which privileges the cognitive functioning of doctors over their material practices. I have attempted to highlight, in contrast to this order, the material practices of doctors and how these engagements with the material effect the relationship between doctor and patient. It is important to note in this regard that my observations, what I have noted as worthwhile or important, is also structured by a discourse related to the one I am arguing against. James Laidlaw (2002) has argued this point in relation to agency. According to Laidlaw, "what the concept of agency…picks out is a matter of the effectiveness of action - specifically its effectiveness in producing, reproducing, or changing the structures within which people act. Agency is therefore a means of pinpointing whose acts are, to various degrees, structurally or transformatively important or powerful" (Laidlaw 2002:315). For Laidlaw, the position of the anthropologist becomes important in defining which actions are deemed as acts of 'agency' and which not. "Only actions contributing towards what the analyst sees as structurally significant count as instances of agency. Put most crudely, we only mark them down as agency when people's choices seem to us to be the right ones" (ibid). 'Agency' is then structured as much by the structure in which the 'object' of research finds itself, as by the epistemological 'structure' upon which the researcher bases his research.

I have illustrated how a doctor acts in dissent of a protocol, yet how this does not challenge the protocol but instead upholds it. I also illustrated how this act of dissent is achieved by framing a patient differently from the requirements of an administrative framework. The study has shown that both sets of framing (administrative as well as clinical) depend upon similar grounds. I have also attempted in this thesis to illustrate a more general point about structure and agency. Of course the position of the observer cannot be ignored. One cannot disregard the fact that certain actions are noted as relevant and others are ignored, all research is based on this premise. However, what is important to note is that the fact that the agency of the doctor is structured (both ontologically and epistemologically) does not imply that this doctor is in some way repressed. All action is structured by some

mechanism and what I have tried to illustrate here is that the actions of doctors, although often in dissent of standardised medicine, depend upon these structures for their action to be possible. Creativity is not stifled by structure but is rather made possible by it. What is also important to note is that the structure is not 'perfect,' it cannot be 'perfect' for it to be successful. As I have illustrated, standardisation is predicated upon a certain 'looseness' in the network, upon allowing actors within the network a fair amount of unspoken freedom. If this were not the case, and this thesis has also aimed to illustrate this point, the system would collapse and standardisation would fail because patients would die due to lack of regard for their personal idiosyncrasies. The network of standardised medicine is then built upon disorder (although unspoken of by the 'high managerialists') as much as order.

If one considers the practice of the doctors discussed in this thesis to be similar to that of improvisation, an interesting analogy arises with jazz. The structures of standardisation within which a doctor operates can be regarded as similar to a written score of music. Like a doctor operating under an administrative frame tries to emulate the administrative, bureaucratic order, so in classical music the ideal would be to follow the score as accurately as possible, to make sure that the sounds created are as 'pure' as the original 'master' intended (note the relationship between 'masters' in classical music and 'experts' in social science). There is no risk involved in straying off the path here, play the keys according to the score. One can subsequently measure a performance according to how accurately it abides by the score. However with jazz a musical score does exist, and to a certain extent jazz musicians follow it, as do doctors who aim to achieve certain aspects of standardised health care. "The musician knows s/he has to get from A to Z, but how s/he does it, how a solo is performed, or even how a soloist is supported….is, within certain mutually agreed upon constraints…wide open" (Montouri 2003:246).

However, a 'mistake' or deviance from the score does not imply failure but rather an opening to different possibilities. "Jazz musicians obviously improvise not because they cannot read music, or because they have temporarily mislaid the music. They have a completely different perspective and set of values. Their assumption is not that there is one correct way of doing things, one score, one right set of notes to play, one order, but rather that we can collaboratively create through the interaction of

constraints and possibilities rather than *either* order *or* disorder….And the creative ways in which the musician deviates from the expected are one of the main criteria for assessing mastery" (ibid: *emphasis* in original). Doctors such as Dr G and Dr Z attempt also to collaboratively create, through the constraints and possibilities available to them, a different order for each patient they are faced with, one which may not be measurable by any standard except its own. 'Mistakes' and 'deviance' are then followed in the hope of another order. Improvisation accepts the reality of practice rather than the metaphysical ideal of an order which exists free of chance events, free of paradox. My use of the word practice has aimed to illustrate a similar point, in which medical practice occurs within a set of constraints and possibilities which make certain actions possible and others impossible according to the circumstance of the doctor and the patient. The 'object' of constraint or possibility then, does not have some inherent force or essence of its own which we can demarcate *a priori* to its use in the field. For example, take the statement: "Development subjugates the citizens of the Third World." Drawing on the method outlined in this thesis, we can only confirm or challenge (often probably both) this view by looking at how development functions in the field, and even then this view is subject to a certain epistemological structure that we are working with.

"The kind of thinking that relegates improvisation to a lesser status operates within a disjunctive paradigm in which order is privileged over disorder, a paradigm of either/or, dichotomous thinking. In a dialogical relationship of order-disorder improvisation takes on a whole new meaning. It shows the potentially generative function of disorder, and its continual presence in our world, not only in our need to react to external aleatory, chance events, but also in our need to create" (Montouri 2003:245). Finally, one could replace the word 'improvisation' with 'practice' or 'phronesis' as I have used these terms as an illustration of their importance in understanding how doctors work in the settings in which they find themselves.

This thesis has looked at how a doctor operates under the attempts at restraining his/her practice through standardisation. I have argued that, at least in the two case studies presented, doctors act in dissent of standardisation. However, this dissent in fact upholds the system. This thesis has examined the 'structure' of global health but it is also important to take note of the fact that it also explores the interface between

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two competing paradigms of knowledge and evidence collection. The model of medicine that the WHO, and other organisations, expounds is that of quantitative science. In this paradigm, evidence must be generalizable, repeatable and representable, that is, evidence must be able to be directly perceived by any observer despite the context. In contrast to this, I have tried illustrate the extent to which a doctor's diagnosis is dependant upon evidence gained through intuition. Carlo Ginzburg (1992) has discussed this historical opposition between the two paradigms and has described the latter as the 'conjectural paradigm'. Due to the qualitative nature of the conjectural paradigm it cannot be formalized, and will therefore always be excluded from the workings of a bureaucracy. This is due to the fact that conjectural evidence depends upon evidence found at the margins of the phenomenon. The look a TB patient has in his or her eyes reveals the disease, rather than the lack of sputum produced by a TB sufferer's lungs, the organ supposedly at the centre of the problem. Collecting evidence from the margins cannot be repeatable, generalisable or representable due to the fact that the skills required to collect this type of evidence depends upon intuition and experience rather than a representation based upon a formalised, systematic schematic.

This thesis is then, in a limited scope, the problem of the relationship between a doctor and a larger bureaucratic system. However, read in broader terms, this thesis has aimed to explore the relationship between two rival forms of knowledge. Doctors can be viewed as a hinge between these two paradigms as they attempt to apply scientific knowledge to the workings of everyday life[26]. The contradiction and paradox of a doctor upholding a system in dissent, will then, remain as long as scientific evidence is valued over conjectural evidence, as it must for science and the secular world to remain successful. What is furthermore important to note from Ginzburg's discussion, is that one must separate *high* intuition from *low* intuition. What doctors are making use of, in their examination of symptoms, is not the *high* intuitions of soothsayers and mystics. But rather,

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[26] I do not in any way believe that doctors are the only hinges between these two paradigms, in fact, if one looks closely, almost all professions which operate outside of the ideal conditions of laboratories can be viewed in this way.

It can be found throughout the entire world, with no limits of geography, history, ethnicity, sex, or class-and thus, it is far removed from higher forms of knowledge which are the privileged property of an elite few. It is the property…of hunters; of sailors; of women. It binds the human animal closely to other animal species (Ginzburg 1992:125)

'Low' intuition, used by doctors, is then a labouring intuition developed in order to deal with the pragmatics of daily survival rather than to serve the needs of an elite few. Doctors in this regard combine the advantages of the scientific method, a method which rests in the hands of a privileged elite class, with the intuition of the lowest order, an animal intuition which depends upon touch, site and smell. A paradigm of knowledge limited to the margins.

Addendum One

Comprehensive HIV and AIDS

Care and Treatment for South Africa

FACILITY ACCREDITATION FORM

Note: All items marked with an asterisk (*) are regarded as minimum requirements for accreditation.

Province: _____

District: _____

Sub-district: _____

Facility Name: _____

Type of facility: **Clinic** ☐   **CHC** ☐   **Hospital** ☐

If hospital, indicate the level: **I** ☐   **II** ☐   **III** ☐

If hospital, indicate total number of beds: ☐

Does the hospital have a designated gateway clinic?   **Yes** ☐   **No** ☐

If yes, name of gateway clinic:

_____

Facility representative: (Name/position):

(Phone): _____(Fax): _____(E-

 mail):_____

Other facility representatives:

 _____

 _____

 _____

 _____

 _____

Date of first accreditation visit: _____(d)/_____(m)/ _____(y)

Date of planned follow-up visit: _____(d)/_____(m)/ _____(y)

Proposed accreditation status: Accredited [   ]   Not
 accredited [   ]

1.	GENERAL

1.1   Recording and reporting of facility.

1.1.1	Is a print out or softcopy of the DHIS PHC data elements / hospital data set of the facility available containing monthly data for the past 12 months*?	Yes	No
1.1.2	If yes in 1.1.1, what is the last reporting month according to the said data set*?		
1.1.3	Is the DHIS PHC data set complete for every month over the past 12 months*?	Yes	No

1.1.4	Is a data set available for the VCT monitoring form for every month over the past 12 months*?	Yes	No
1.1.5	Is a data set available for the PMTCT monitoring form for every month over the past 12 months*?	Yes	No
1.1.6	Is a data set available for TB for every quarter in the past 12 months*?	Yes	No
1.1.7	Is a data set available for nutritional services over the past 12 months*?	Yes	No
1.1.9	Is a data set available for STI services over the past 12 months*?	Yes	No

1.2   Projected HIV & AIDS patient load during the first 6 months (please apply formula).

		Month					
		1	2	3	4	5	6
1.2.1	Number of patients in ARV assessment period:						
1.2.2	Number of patients ready and waiting for treatment:						
1.2.3	Number of patients already on ARV treatment:						

1.3   Physical space, communication and medical waste management.

Intent: Sufficient space is required for consultation and treatment considering confidentiality, and for counselling and for storage in order to accommodate projected patient case load, communication and waste management.

1.3.1	The facility has the following number of consultation/ treatment rooms*	#	
1.3.2	The facility has the following number of counselling rooms*	#	
1.3.3	The facility has sufficient storage space for nutritional supplements	Yes	No
1.3.4	The facility has a Medical Waste Management System in place*?	Yes	No
	Name Medical Waste Management System:		
1.3.5	The facility has a dedicated cell or land line for patient communication*	Yes	No

1.3.6	Patients/ Clients' complaints and compliments are recorded and settled	Yes	No

Other additional comments noteworthy:

2. BASIC HIV & AIDS SERVICES – CURRENTLY AVAILABLE

	Services currently available		Available on-site	Referral off-site	Not available	Comments
2.1	Family Planning*					
2.2	Antenatal services*					
2.3	VCT*					
		2.3.1	Number of VCT clients currently seen per month			#	
		2.3.2	Would facility be able to manage more VCT clients per month?		Yes	No
2.4	PMTCT*					
		2.4.1	Number of enrolled PMTCT patients over past 12 months			#	
		2.4.2	Number of children followed up over the past 12 months			#	
2.5	TB Management*					
		2.5.1	What is the current TB cure rate?				
		2.5.2	What is the current TB Defaulter rate?				
		2.5.3	What is the current TB Sputum turn around time?				
2.6	STI*	2.6.1	1st line management				
		2.6.2	2nd line management				
2.7	PEP [Occupational exp: 24h access]*					

2.8	PEP [Sexual assault victims: 24h]*					
2.9	Nutritional Support*					
		2.9.1	Nutritional supplements			
2.10	Social Worker Support*					

Additional *Basic HIV and AIDS Services* Comments:

3. POLICIES AND NATIONAL TREATMENT GUIDELINES/ PROTOCOLS

3.1	The facility has a written Confidentiality Policy*	Yes	No
3.2	The facility has written Universal Infection Precaution Policies*	Yes	No
3.3	National ARV treatment guidelines for adults are adhered to*	Yes	No
3.4	National ARV treatment guidelines for children (paediatrics) are adhered to*	Yes	No
3.5	National Family Planning guidelines are adhered to*	Yes	No
3.6	National Antenatal Services guidelines are adhered to*	Yes	No
3.7	National VCT guidelines are adhered to*	Yes	No
3.8	National PMTCT guidelines are adhered to*	Yes	No
3.9	National TB Management guidelines are adhered to*	Yes	No
3.10	National STI Treatment guidelines are adhered to*	Yes	No
3.11	National Post Exposure Prophylaxis guidelines are adhered to*	Yes	No
3.12	National Nutritional guidelines for people living with TB, HIV & AIDS are adhered to*	Yes	No

4. LABORATORY CAPACITY

			Yes	No	N/a	Response/ Comments
4.1	There is a laboratory in the facility					If yes, also complete 4.24
	4.1.1	If yes, is there a centrifuge in lab?				

			Yes	No	N/a	Response/ Comments
	4.1.2	If yes, is there cool storage for specimens [2 - 8°C]				
4.2		If there is no laboratory in the facility, is there a laboratory depot?				
	4.2.1	If yes, is there a centrifuge in depot?				
	4.2.2	If yes, is there cool storage for specimens [2 - 8°C]				
	4.2.3	If yes, is specimen details recorded electronically?				
4.3		Facility utilizes the NHLS				
4.4		Utilizes other outside/ private lab services				
4.5		System to transport specimens to lab				
4.6		System in place to receive results from lab				
4.7		Is there a Laboratory Information System currently in use? If yes, which system?				
4.8		Phlebotomist or trained nurse on lab staff*				
4.9		Specimen preparation protocols available*				
4.10		Standard operating procedures are available for all laboratory tests				
4.11		CD4 testing capacity available				
4.12		HIV viral load capacity available				
			Yes	**No**	**N/a**	**Response/ Comments**
4.13		Full blood count capacity available				
4.14		Liver function test capacity available				
4.15		HIV DNA PCR capacity available				
4.16		TB testing capacity available				
4.17		Lipid profile testing capacity available				
4.18		Viral hepatitis testing capacity available				
4.19		An equipment maintenance plan in place				
4.20		All equipment is calibrated to a national standard				
4.21		A copy of the NHLS Safety Manual signed by all lab staff is available				
4.22		The laboratory participates in a Quality Assurance accreditation scheme/ program				

	4.22.1	If yes, what scheme/ program?				
4.23		Biohazard & chemical waste are disposed				
		If yes, how is it done? :				

4.24	Current staffing of laboratory		
		Rank	Number in rank
	4.24.1		
	4.24.2		
	4.24.3		
	4.24.4		
	4.24.5		
	4.24.6		

Additional *Laboratory* Comments

5.   PHARMACY CAPACITY

Please indicate how the drug capacity indicators are performing against current volumes and anticipated increases (refer back to 1.2).

		Drug capacity Indicators	**Yes**	**No**	**N/a**	**Response/ Comments**
5.1		The facility has its own pharmacy				
5.2		Standard operating procedures (SOPs) for drug dispensing are followed				
5.3		A computerised medicine inventory system is in place				
		Drug capacity Indicators	**Yes**	**No**	**N/a**	**Response/ Comments**
5.4		A computerised drug ordering system is in place				
5.5		Storage space sufficient				
	5.5.1	Against current volumes				
	5.5.2	Against anticipated increases				
5.6		Security adequate [according to minimum certification requirements]				

5.7	Dispensing 'Schedule 5' drugs					
5.8	Cold storage for drugs					
	5.8.1	Against current volumes				
	5.8.2	Against anticipated increases				
5.9	At least one Full Time Equivalent pharmacist					
5.10	Currently stocking ARV medication					
5.11	Fluconazole/ Diflucan available					
5.12	Pharmacy meets minimum certification requirements					
	5.12.1	Implementation of SOPs for receiving, storing and dispensing Schedule 5 drugs				
	5.12.2	Four weeks of supply of buffer stock				
	5.12.3	Registered pharmacist on site				

Additional *Pharmacy* Comments:

6.   HIV AND AIDS SERVICE POINT

6.1   Access to care, treatment and support.

Intent: Care, treatment and support to HIV patients are available 24 hours per day at, (a) the facility, and/or (b) on referral.

		Days/week		Hours/day	
		At facility	**On referral**	**At facility**	**On referral**
6.1.1	Casualty/ Emergency Room[s]				
6.1.2	High care unit				
6.1.3	Intensive care unit				
6.1.4	Nursing care*				

6.1.5	Clinician care*				
6.1.6	Outpatients Department				

6.2   Access to expert consultation.

Intent: Access to specialist and sub-specialist services does exist or is being planned.

Speciality		Available on site	Available off-site	If off-site, is transport available?		Comments and/or plans
				Yes	No	
6.2.1	HIV Clinical expertise*					
6.2.2	Gastro-enterology*					
6.2.3	Paediatrics*					
6.2.4	Internal medicine*					
6.2.5	Dermatology*					
6.2.6	Gynaecology & Obstetrics*					
6.2.7	Surgery*					
6.2.8	Neurology*					
6.2.9	ENT*					
6.2.10	Oncology*					
6.2.11	Ophthalmology*					
6.2.12	Pulmonary medicine*					
6.2.13	Oral health services*					
6.2.14	Infectious diseases*					
6.2.15	Antenatal services*					
6.2.16	Cardiology*					
6.2.17	TB services*					
6.2.18	X-ray/ Ultrasound*					
6.2.19	STI services*					

6.3   Appropriately trained staff managing HIV and AIDS services at service point.

Intent: Current number of trained staff members managing HIV and AIDS Services at facility and additional numbers needed to meet projected patient load for ARV treatment.

		Current status	**Additional requirements**	**How determined?**
6.3.1	Medical officer*			
6.3.2	Professional Nurse*			
6.3.3	Staff Nurse			
6.3.4	Enrolled nurse assistant			
6.3.5	Dietician/ Nutritionist			
6.3.6	Pharmacist*			
6.3.7	Pharmacist Assistant			
6.3.8	Social Worker			
6.3.9	Lay counsellor			
6.3.10	Administrative Clerk			
6.3.11	Data capturer			

6.4 Project Management

Intent: A dedicated person is required to supervise ARV programme implementation and expansion. This person may provide a service to more than one service point.

		Yes	**No**	**N/a**	**Comments**
6.4.1	A project manager has been appointed				
6.4.2	The terms of reference for the project manager is available				

[*See Terms of Reference of Project Manager – Annexure C*]

6.5 Access to home/ community based services.

Intent: Home/ community based services are utilised by service points to ensure a continuum of care. Facilities refer patients to or receive patients from these services. [Provide numbers for the past 12 months]

Patients referred to and from home/ community based services				Yes	No	Number of patients	Name services
6.5.1	NGOs	6.5.1.1	Referred to				
		6.5.1.2	Received from				
6.5.2	CBOs	6.5.2.1	Referred to				
		6.5.2.2	Received from				
6.5.3	FBOs	6.5.3.1	Referred to				
		6.5.3.2	Received from				
6.5.4	Other patient support groups	6.5.4.1	Referred to				
		6.5.4.2	Received from				
6.5.5	Traditional healers	6.5.5.1	Referred to				
		6.5.5.2	Received from				

6.6 Patient Management Systems at the service point.

Intent: Systems are in place to, (i) identify, contact, schedule and locate patients, (ii) capture patient information and maintain medical records, (iii) transmit core data to a central data collection point, and (iv) refer patients successfully.

		Yes	No	Comments
6.6.1	Standard patient referral and reporting letter used			
6.6.2	Appointment system for patients in place			
6.6.3	Patient identification system in place [*name system*]			
6.6.4	Patient tracking system in place [*name system*]			
6.6.5	Patient ID & tracking systems can identify defaults and reschedule			
6.6.6	The specific content of clinical records has been			

	determined by the service point		
6.6.7	Standardised diagnosis & procedural codes are used		

		Yes	No	Comments
6.6.8	Clinical records contain adequate information to support the diagnosis			
6.6.9	Clinical records contain adequate information to justify the care and treatment			
6.6.10	Clinical records contain adequate information on the course and results of treatment			
6.6.11	The author can be identified for each patient record entry			
6.6.12	Clinical records of patients include information on the organisation that referred			
6.6.13	Data or information is contributed to a central collection point			
6.6.14	The facility compares its performance using the central data collection point's data			
6.6.15	Core data is transmitted without compromising security			
6.6.16	Core data is transmitted without compromising confidentiality and correctness			
6.6.17	The facility uses a patient-kept patient record			
6.6.18	The facility uses a facility-kept patient record			

6.7   Governance and management.

Intent: The facility (service point) assures that the community actively participates in the planning and monitoring processes of the facility. The facility also builds strong relationships with the relevant official structures of government at local and provincial level.

		Yes	No	Comments
6.7.1	The service point closely interacts with the District Management Team			
6.7.2	The service point closely interacts with the HIV and			

	AIDS Unit in the provincial office			
6.7.3	Agendas and minutes of a well-functioning hospital board are available			
6.7.4	Agendas and minutes of a well-functioning clinic / CHC committee are available			

6.8   Information, education and communication (IEC).

Intent: Initial and ongoing HIV education is provided to patients, family members and the community.

		Yes	No	Comments
6.8.1	An IEC plan is in place			
6.8.2	A Communication Strategy is in place			
6.8.3	HIV & AIDS educational material is available			
		Yes	No	Comments
6.8.4	Mindset Health Channel is available			

6.9   Equipment and building maintenance.

Intent: The building and equipment is viewed as a major asset and thus managed accordingly.

		Yes	No	Comments
6.9.1	A procurement system is in place			
6.9.2	The facility has a maintenance plan for the building			
6.9.3	The facility has a maintenance plan for equipment			
6.9.4	An inventory for equipment is kept & regularly updated			

7.   ACCREDITATION TEAM MEMBERS

(i)   First accreditation visit

NAME	POSITION	E-MAIL	TEL NO
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

(ii)   Follow-up visit

NAME	POSITION	E-MAIL	TEL NO
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

ANNEXURE A

a) **Please list all the public health facilities that are referring to you and indicate the type of facility, e.g. clinic, CHC, hospital:**

    1.   _____   Type: _____

    2.   _____   Type: _____

3. _____   Type:

   _____

4. _____   Type:

   _____

5. _____   Type:

   _____

6. _____   Type:

   _____

7. _____   Type:

   _____

8. _____   Type:

   _____

9. _____   Type:

   _____

10. _____   Type:

    _____

11. _____   Type:

    _____

12. _____   Type:

    _____

13. _____   Type:

    _____

14. _____   Type:

    _____

15. _____   Type:

    _____

16. _____   Type:

    _____

17. _____   Type:

    _____

b) **Provide accurate numbers of patients/ clients that have been referred to your facility <u>over the past 12 months</u>:**

1. From public health facilities as listed in (a) above

    _____

2. From NGOs, CBOs and & FBOs

    _____

3. From the private sector

    _____

4. From traditional health practitioners

    _____

5. TB patients (see also 2.5)

    _____

6. VCT clients (see also 2.3.1)

    _____

7. Pregnant women for PMTCT (see also 2.4.1)

    _____

8. STI patients [due to complications/ 1st line treatment failure]

    _____

ANNEXURE B

a) **Please list all the public health facilities to which your facility is referring to and indicate the type of facility, e.g. clinic, CHC, hospital:**

1. _____   Type:

    _____

2. _____   Type:

    _____

3. _____   Type:

    _____

4. _____   Type:

    _____

5. _____   Type:

    _____

6. _____ Type:

_____

7. _____ Type:

_____

8. _____ Type:

_____

9. _____ Type:

_____

10. _____ Type:

_____

11. _____ Type:

_____

12. _____ Type:

_____

13. _____ Type:

_____

14. _____ Type:

_____

15. _____ Type:

_____

16. _____ Type:

_____

17. _____ Type:

_____

b) Provide accurate numbers of patients/ clients that <u>over the past 12 months</u> have been referred by your facility to the following:

1. Facilities listed in (a) above [added totals for 1.1 to 1.6]

_____

Family planning services (off-site) _____

Antenatal services (off-site) _____

VCT services (off-site) _____

PMTCT services (off-site) _____

TB Management services (off-site)   _____

STI services (off-site)   _____

2.   NGOs, CBOs and & FBOs

     _____

3.   The private sector

     _____

4.   Traditional health practitioners

     _____

{Suggests that this section be prepared by department's HIV & AIDS Cluster. What follows is merely an attempt by Louis to get the ball rolling. The task team held the opinion that Project Management part 5.5.1 to 5.5.8 of existing tool should be taken out and should be moulded into rather the ToR of the Project Manager}

ANNEXURE C

Terms of Reference of the Project Manager

1. Supervises the implementation and local expansion of the ARV component of the Comprehensive HIV & AIDS Care and Treatment Plan for South Africa.
2. Work in close collaboration with the appointed / designated medical director who provides clinical management/ support to the project.
3. Assist the medical director to continuously align his or her clinical support activities with the broader project plan.
4. Recruit and appoint administrative support staff to assist project manager in overseeing basic programme functions.
5. Recruit and appoint a data manager that will manage all project data, including data entry, data validation and data analysis.

<u>Addendum Two</u>

Anti-retroviral therapy (ART) begins with two sets of criteria, one clinical and one psycho-social. The clinical criteria for beginning ART is when the disease has progressed to a level where the patient's CD4 count falls below 200cells/mm3 or the patient develops life-threatening opportunistic infections associated with Stage 4 of the disease. Tuberculosis is not a criteria for beginning ART unless the CD4 count is below 200 and even then the doctor would often wait until the initial intensive three month period of TB treatment is over before beginning ART in order to avoid liver functioning complications.

The psycho-social criteria for beginning ART is listed as follows:

- Reliability
- Compliance
- No active alcohol or other substance abuse
- No untreated active depression
- Safe sex
- Disclosure
- Insight into the disease
- Ability to regularly attend ART clinic
- Contactibility

(wwww.aidsbuzz.org)

The function of this list is to ensure that the patients are reliable in their visits to the clinic and is used as a measure to ensure compliance.Reliability is measured by various factors with one of the main factors being employment, ie whether the patient has a stable job. Compliance is also aimed to be achieved by the presentation of a 'treatment buddy,' a family member or friend in which the patient has disclosed his/her HIV status and who will provide support to the patient. The patient must also guarantee that they will not engage in alcohol or substance abuse. This is also an

attempt to guarantee that the patient will engage in safe sex, which must be ensured by the patient before beginning ART, in order to contain the spread of the virus as well as prevent resistance developing. Patients must also illustrate that they have insight and understanding of the disease and treatment which is usually measured by the doctor asking the patient to explain something about the disease to them. Patients are also asked whether they can regularly attend the clinic in terms of access and convenience.

References

Absolute Return for Kids (ARK). Available at: www.arkonline.org/projects/hiv aids/aids treatment/innovative model.html. Accessed 14/05/2008

Appadurai, A. 1996. *Modernity at Large: Cultural dimensions of Globalization*. Minneapolis : University of Minnesota Press

Arendt, H. 1959. *The Human Condition*. Chicago : The University of Chicago Press

Berg, M. 1995. Turning a practice into a science: reconceptualizing postwar medical practice in *Social Studies of Science* 25: 437-76

     1998. Order(s) and disorder(s): of protocols and medical practices: in *Differences in Medicine: Unravelling practices, techniques and bodies* (pp 226-246). Berg, M & Mol, A. (eds). Duke University Press: London

Biehl, J. 2004. The Activist state: Global Pharmaceuticals, Aids and Citizenship in Brazil in *Social text* 80. 22(3): 105-132

     2005. *Vita: Life in a zone of social abandonment*. London: University of California Press

     2006a. Will to live: AIDs Drugs and Local Economies of Salvation in *Public Culture*. 18 (3): 457-472.

     2006b. Pharmaceutical Governance: in *Global Pharmaceuticals: Ethics, markets and practices* (pp 206-239). Petryna, A; Lakoff, A & Kleiman, A.(eds). London: Duke University Press

Brigg, M. 2002. Post-development, Foucault and the colonisation metaphor in *Third World Quarterly*. 23(3): 421-436

Ceruti, M. 1994. *Constraints and possibilities: The evolution of knowledge and the knowledge of evolution*. The world futures general evolution studies volume 8. Montouri, A (trans). Switzerland: Gordon and Breach

Coetzee, D; Boulle, A; Hilderbrand, K; Asselman, V; Van Custem, G & Goemaere, E. 2004. Promoting adherence to antiretroviral therapy: the experience from a primary care setting in Khayelitsha, South Africa in *AIDS*. 2004. 18(suppl 3): s27-s31.

Connolly, WE. 1993. Beyond Good and Evil: The ethical sensibility of Michel Foucault in *Political Theory*. 20(3): 365-389

Craig, D. 2000.The kings law stops at the village gate: local and global pharmacy regulation in Vietnam: in *Global health policy, Local realities: The fallacy of the level playing field* (pp105-126). Whiteford, LM & Manderson, L. London: Lynne Rienner

Critchley, S. 2007. *Infinitely Demanding: Ethics of Commitment, Politics of Resistance*. London: Verso

Delvecchio Good, M-J. 2007. The medical imaginary and the biotechnical embrace: Subjective experiences of clinical scientists and patients: in *Subjectivity: ethnographic investigations* (pp362-380). Biehl, J; Good, B & Kleinman, A. (eds). Berkley: University of California Press

Derrida, J. 1993. *Aporias*. Trans. Thomas Du Toit. California: Stanford University Press

2002. *Negotiations: Interventions and Interviews: 1971-2001*. Rottenburg, E (editor & translator). California: Stanford University Press

Dodier, N. 1994. Expert medical decisions in occupational medicine: a sociological analysis of medical judgment in *Sociology of health and illness*. 16(4): 489-514

1998. Clinical practice and procedures in occupational medicine: A study of the framing of individuals: in *Differences in medicine: Unravelling practices,*

techniques, and bodies (pp53-85). Berg, M & Mol, A. (eds). London: Duke University Press

Epstein, H. 2007a. *The Invisible cure: Africa, the west and the fight against AIDS.* England: Viking

            2007b. Aids: from morality to mobilisation: in *The Mail and Guardian.* Available at: www.mg.co.za/articlePage.aspx?articleid=325968&area=insight/insight_comment_and_analsysis. Accessed 26 November 2007.

Farmer, P. 2005. *Pathologies of power: Health, Human rights and the new war on the poor*. Berkley: University of California Press

Fassin, D. 2007. *When bodies remember: Experiences and Politics of AIDS in South Africa*. Trans. Jacobs, A & Varro, G. Berkley: University of California Press

Foucault, M. 1973. *The birth of the clinic: an archaeology of medical perception*. London: Tavistock publications

            1978. *The history of sexuality: Volume 1. An introduction.* Translated by Hurley, R. New York: Pantheon Books

Gaonkar, DP.1999. On alternative modernities in *Public Culture*. 11(1): 1-18

Geertz, C. 1960. The Javanese Kijaji: The changing role of a cultural broker in *Comparative Studies in society and histroy: An international quarterly*.2 1959-1960

Ginzburg, C. 1992. *Clues, myths and the historical method*. Trans. By John & Anne Tedeschi. Baltimore: Johns Hopkins University Press

Groopman, J. 2007. *How doctor's think*. New York: Houghton Mifflin Company

Grosz, E. 1995. *Space, Time and Perversion: Essays on the politics of bodies*. New York: Routledge

1998. The time of violence: Deconstruction and value in *Cultural Values* 2(2 & 3):190-225

Harper, I. 2005. Interconnected and Inter-infected: DOTS and the stabilisation of the tuberculosis control programme in Nepal: in *The Aid effect: Giving and Governing in International Development* (pp 126-149). Mosse, D & Lewis, D (eds). London: Pluto press

Hirschman, AO. 1987. The search for paradigms as a hindrance to understanding: in *Interpretive Social Science: A second look* (pp 177-194). Rabinow, P & Sullivan, WM (eds). Berkley: University of California Press

Horton, R. 2007. What's wrong with doctors in *The New York Review of Books*. 54(9). 31 May 2007.

Jameson, F. 2002. *A singular modernity: essay on the ontology of the present*. London: Verso

Jones, PS. 2004. When 'development' devastates: donor discourses, access to HIV/AIDS treatment in Africa and rethinking the landscape of development in *Third World Quarterly*. 25(2):385-404

Kleinman A. 1988. *The illness narratives: Suffering, healing, and the human condition*. New York: Basic Books

1995. *Writing at the Margin: Discourse between anthropology and medicine*. Berkley: University of California Press

Kleinman, A & Fitz-Henry, E. 2007. The experiential basis of subjectivity: How individuals change in the context of Social Transformation: in *Subjectivity:*

Ethnographic Investigations (pp 52-65). Biehl, J; Good, B & Kleinman, A. 2007. London: University of California Press

Laidlaw, J. 2002. For an anthropology of ethics and freedom in *Journal of the Royal Anthropological Institute*. 8(2): 311-332

Leach, M. & Scoones, I. 2005. *Mobilising citizens: social movements and the politics of knowledge*. Citizenship DRC Synthesis Paper. November 2005

Leigh Pigg, S. 2005. Globalizing the Facts of Life: in *Sex in Development: Science, sexuality and morality in global perspective…*(pp 39-65). Adams, V & Leigh Pigg, S (eds). London: Duke University Press

Martin, E. 1989. *The women in the body: A cultural analysis of reproduction*. Milton Keynes: Open University Press

Montgomery, K.2006. *How doctors think: Clinical judgement and the practice of medicine*. Oxford: Oxford University Press

Montuori, A. 2003. The complexity of improvisation and the improvisation of complexity: Social science, art and creativity: in *Human Relations*. 56(2): 237-255

Mosse, D. 2004.Is good policy unimplementable? Reflections on the ethnography of aid policy and practice in *Development and Change* 35(4): 639-671

        2005. Global governance and the ethnography of international aid: in *The Aid Effect: giving and governing in international development* (pp1-36). Mosse, D & Lewis, D. (eds). London: Pluto press

Nguyen, V.K.(2005a) Antiretroviral Globalism, Biopolitics, and Therapeutic Citizenship: in *Global Assemblages: Technology, politics and ethics as Anthropological problems* (pp 124-144). Ong, A & Collier, S.J (eds).2005. United Kingdom: Blackwell Publishing

(2005b) Uses and Pleasures: Sexual Modernity, HIV/AIDS and Confessional Technologies in a West African Metropolis: in *Sex in Development: Science sexuality and morality in Global Perspective* (pp245-267). Adams, V & Leigh Pigg, S. (eds).2005. London: Duke University Press

Parker, R. 2000. Administering the epidemic: HIV/AIDS policy, models of development, and international health: in *Global Health Policy, Local Realities: The fallacy of the level playing field* (pp 39-55). Whiteford, LM & Manderson, L. (eds). London: Lynne Rienner

Rabinow, P. 2007. Anthropological observation and self-formation: in *Subjectivity: ethnographic investigations* (pp 98-118). Biehl, J; Good, B & Kleinman, A. (eds). Berkley: University of California Press

Quarles van Ufford, PQ; Giri, AK & Mosse, D. 2003. Interventions in Development: Towards a new moral understanding of our experiences and an agenda for the future: in *A moral critique of development: In search of global responsibilities* (pp 3-39). Quarles van Ufford, PQ; Giri, AK (eds). London: Routledge

Rajan, KS. 2006. *Biocapital: The constitution of postgenomic life*. Durham: Duke University Press

Reynolds White, S; van der Geest, S & Hardon, A. 2002. *Social Lives of medicines*. Cambridge: Cambridge University press

Robins, S. 2003. Whose modernity? Indigenous land claims after Apartheid in *Development and Change* 34(2): 265-285

2006. From "rights" to "ritual": AIDS activism in South Africa in *American Anthropologist* 108(2): 312-323

Rose, N. 2007. *The politics of life itself: Biomedicine, power and subjectivity in the Twenty- First century*. Oxford: Princeton University Press

Rose, N & Novas, C. 2005. Biological Citizenship: in *Global Assemblages: Technology, politics and Ethics as anthropological problems* (pp439-463). Ong, A & Collier, SJ (eds). United Kingdom: Blackwell Publishing

Scheper-Hughes, N. 1995. The primacy of the ethical: Propositions for a militant anthropology in *Current Anthropology.* 36(3): 409-440

Scott, JC. 1998. *Seeing like a state: How certain schemes to improve the human condition have failed.* London: Yale University Press

Sheldrake, J. 1996. *Management Theory: From Taylorism to Japanization.* London: International Thomson Business Press

Sontag, S. 1979. *Illness as Metaphor.* London: Penguin Books

     1989. *Aids and its Metaphors.* London: Penguin Books

Star, LS & Griesemer, JR. 1989. Institutional Ecology, 'translations' and boundary objects: Amateurs and professionals in Berkley's Museum of Vertebrate Zoology, 1907-39 in *Social Studies of Science* 19 (1989): 387-420

Timmermans, S & Berg, M. 1997. Standardization in action: Achieving local universality through medical protocols in *Social Studies of Science* 27: 273-305

Van der Walt, H & Swartz, L. 1999. Isabel Menzies Lyth revisited: Institutional defences in public health nursing in South Africa during the 1990's in *Psychodynamic Counselling.* 5(4): 483-495

Whisson, MG. 1985. Advocates, Brokers, and Collaborators: anthropologists in the real wolrd in *Social Anthropology and Development Policy* (pp 131-147).Grillo, R & Rew, A. (eds) London: Tavistock

Wolf, C. 1998. *Critical environments: Postmodern theory and the pragmatics of the "outside."* Theory Out of Bounds series. London: University of Minnesota Press

Wolf, E. 1982. *Europe and the People without History*. Berkley: University of California Press

World Health Organisation. 2003. Perspectives and practice in antiretroviral treatment: A public health approach to antiretroviral treatment: Overcoming constraints. Available at: www.who.int/hiv/pub/prev_care/en/publichealthappraoch_E.pdf

2006a.*WHO & UNAIDS secretariat statement on HIV testing and counselling*. August 14, 2006.Available at: www.who.int/hiv/mediacentre/newsreleases/en/index1.html

2006b. *Towards universal access by 2010: How WHO is working with countries to scale-up HIV treatment, prevention, care and support.* Availabe at www.who.int/hiv/pub/advocacy/universalaccess/en/

World Bank. 2007. *Our Commitment: The World Bank's Africa Region HIV/AIDS agenda for action 2007-2011*. Advanced Copy released on June 24 2007**.** Available at: http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT

Zizek, S. 2007. A plea for a return to *Difference* (with a minor *Pro Domo Sua*): in *Adieu Derrida* (pp 109-133). Douzinas, C. (ed) The Birkbeck Institute for Humanities Lectures. New York: Palgrave MacMillan

2008. *Violence: Six Sideways Reflections*. London: Profile Books