DISCOURSES AND PRACTICES IN INSTITUTIONALISED NURSING IN SOUTH AFRICA: CHALLENGES FOR CARE

ABSTRACT

South African nursing remains a largely feminised and devalued profession, further undermined by the popular construction of nurses as indifferent and the healthcare systems as hindered by multiple challenges. Over the last 20 years of democracy, multiple efforts have been made at the level of policy, practice and knowledge production to address the challenges of the primary healthcare sector where nurses are such central role players. There are clearly resource challenges in South Africa which may undermine caring practices; however, this article also foregrounds the dominant discourses that shape international and local nursing, and which arguably mitigate against care that is democratic, socially responsive and sensitive to the diverse care needs of communities and individuals. Drawing on Tronto's political ethics of care and on Foucaultian frameworks, the paper analyses the processes currently shaping the experience of nurses and practices of care. Key themes are the hierarchical, regulatory framework of surveillance in nursing, the dominance of biomedical discourse and the mechanistic framework which fragments nursing practice. These aspects not only disempower nurses and deny them recognition but, together with institutional disregard for the need for self-care, also reproduce a system which is inherently unable to provide humane healthcare.

Keywords: sociology of nursing, healthcare, ethics of care, gender, hierarchies, managerialism, audit culture, mechanisation, task orientation, regulation, biomedical discourse, evidence-based nursing

INTRODUCTION

The more closely a profession is linked to care practices or seen as women's work, the more likely it is to be devalued, to have low status, and for its practitioners to experience difficult working conditions (Tronto 2006; 2011). As a caring profession, nursing is no exception. Until fairly recently, nursing's links with domestic and care work made it one of the few professions open to South African women given the country's pervasively patriarchal culture. Although nursing has been generally devalued as feminised work, it did evolve during the second half of the twentieth century into a coveted middle class career for South African women from diverse backgrounds, by conferring relative status on local nurses in relation to many other South African women (Horwitz 2007; Marks 1997). By 1990, however, nursing internationally and locally faced enormous challenges due to the restructuring of healthcare systems, the adoption of new managerial practices, the changing socio-political expectations of healthcare provision, and the erosion of the profession's historic values (Marks 1997: 30). In South Africa significant setbacks during the mid-1990s' transformation of the country's health sector resulted in many nurses experiencing 'a sense of lost status and respect' (Foster, 2005: 255), a situation from which the profession has yet to recover.

Efforts to undo apartheid legacies and ensure access to healthcare for the whole population entailed a decisive shift towards free primary health care (PHC) services

1

within a district health system. Nurses bore the brunt of the pressures of increased attendance at hospitals and clinics when the new policy was rapidly introduced in a government health system that was unprepared in terms of staffing and training (Foster 2005). This worsened working conditions in nursing in South Africa in the new democracy at a time when nurses could reasonably have expected the emphasis on human rights and women's rights would work to their benefit rather than disadvantage.

Lobbying by the Democratic Nursing Organisation of South Africa (DENOSA), mass action and the general crisis in the public health sector led, in 2007, to the implementation of the occupation-specific dispensation (OSD), a financial incentive strategy through which government aimed 'to attract, motivate and retain' nurses (Ditlopo, Blaauw, Rispel, Thomas and Bidwell 2013: 139). But it had uneven and limited impact (DoH 2013: 28–29; Ditlopo, Blaauw, Rispel, Thomas and Bidwell 2013), without significantly salvaging the profession's image. Ongoing concerns about adequate remuneration, professional development, support and respect are evident in the Nursing Compact produced at the 2011 National Nursing Summit (DoH 2013: 78–79), as well as in the Positive Practice Environments (PPE) campaign launched by DENOSA and the South Africa Medical Association (SAMA) in 2013.

Nurses form the largest single group of healthcare providers in South Africa and thus play a vital role in health service delivery (Rispel 2010). However, as elsewhere, South African nursing must contend with popular constructions of nurses as uncaring or inhumane (Oosthuizen 2012; Sellman 2012). And while some South African studies indicate that patients and the public may appraise nurses significantly more positively than media reports suggest (Magoro, Hoque and Van der Heever 2011; Meiring and Van Wyk 2013), other patient satisfaction surveys show that unfriendly and rude attitudes of nurses and doctors cause patient dissatisfaction (Khoza, Du Toit and Roos 2010; Phaswana-Mafuya, Peltzer and Stevenson Davids 2011). There is also evidence of patient disregard and neglect in some healthcare institutions (Fassin 2008).

Uncaring attitudes may quite possibly relate to nurses' poor working conditions. Job dissatisfaction, occupational stress and burnout are prevalent among public sector nurses, and problems exist in the private sector too (Ackerman and Bezuidenhout 2007; Bruce and Sangweni 2012; Klopper, Coetzee, Pretorius and Bester 2012; Pillay 2009a; Rothmann, Van der Colff and Rothmann 2006). Studies highlight the exodus of South African nurses, with many quitting the profession for employment in other sectors or leaving South Africa to pursue higher salaries and better working conditions in healthcare institutions abroad (Bagraim 2013; Mokoka, Ehlers and Oosthuizen 2011; Pillay 2009b). Among the many push factors are inadequate remuneration; understaffing; excessive workloads; long, asocial and inflexible work hours; unsafe or dirty working environments; inadequate equipment and supplies; despondency over bad quality care due to large patient numbers; verbal or physical abuse in the workplace; poor management; lack of recognition; lack of career advancement possibilities; and burnout (Mokoka, Oosthuizen and Ehlers 2010; Mokoka, Ehlers and Oosthuizen 2011; Oosthuizen and Ehlers 2007; Pienaar and Bester 2011).

Local quantitative studies confirm that poor work conditions detrimentally affect nursing care (Eygelaar and Stellenberg 2012; McIntosh and Stellenberg 2009); however, they focus on factors that adversely impact on physical care rather than on nurses' caring attitudes and relationships. In contrast, qualitative studies focusing on nurses' caring concern and relationships with patients show how both the healthcare system's values and practices, together with the nurses' physical and mental wellbeing,

their personal experiences, emotions, beliefs, values and inclinations, impact on care and caring (Gaede, Mahlobo, Shabalala, Moloi and Van Deventer 2006; Van der Wal 2006). Gaede *et al.* point out that while holistic care is promoted as an ideal in vision statements, '[t]he orientation of the whole healthcare system seems not to be towards holistic health' (2006: 6) but rather towards a biomedical approach with a poor integration of 'mental, emotional, social and spiritual aspects' of care (2006: 7). Van der Wal (2006: 55) states that factors eroding 'student nurses' caring capacities stem from both the formal educational setting and the clinical setting'. Students report that they cannot learn caring from theory-oriented teaching; that the fragmentation of nursing work prevents them from caring for patients as people; that financial considerations have become dominant for all involved; that the nursing hierarchy and its strict discipline remove their individuality, creativity and spontaneity; and that advancing in nursing means sacrificing caring (Van der Wal 2006).

Nursing care within South African healthcare institutions faces complex challenges. A combination of practical, resource-based inadequacies and – as highlighted above – deeper systemic dynamics impact on caring practices. In this paper we argue that the dominant discourses and practices in nursing undermine care and caring. In explaining our view, we depart from a perspective informed by the feminist democratic ethic of care elaborated by the political scientist, Joan Tronto (1993; 2006; 2008; 2010; 2011; 2013a; 2013b; 2014) and draw on Michel Foucault's (1973; 1977) work on disciplinary power to argue for a stronger focus on the institutional framework of care in nursing. The paper begins by outlining Tronto's feminist democratic ethic of care as a valuable framework for understanding the situation of care workers, in particular nurses. It then analyses contemporary discourses and practices in nursing that exacerbate the contextual challenges outlined above, exploring the interlinked discourses of surveillance, biomedicine, mechanisation and fragmentation within institutionalised nursing in both training and practice. We argue that these undermine the provision of care that is democratic, humane, socially responsive and sensitive to the diverse care needs of communities and individuals.

TRONTO'S FEMINIST DEMOCRATIC ETHIC OF CARE

The feminist democratic ethic of care elaborated by Joan Tronto (2010, 2013a) provides a framework for making ethical questions about care, including the allocation of care responsibilities. As observed by Woods (2014: 95), Tronto's ethic of care is 'as much a political and social discourse as it is an ethical one.' Her approach should thus be distinguished from virtue ethics, feminine versions of care ethics and a bioethics model, all of which have shaped more traditional interpretations of nursing ethics but have not provided sufficiently critical perspectives for transforming unequal power relations in healthcare institutions and society at large (Bowden 2000; Tronto 2014: 14–18). By focusing on making care realities more democratic and just, Tronto's approach holds promise for transforming decision-making structures, interpersonal relationships, professional codes of ethics and care practices in political and social institutions, including in healthcare and nursing (Gallagher 2014).

Broadly, Tronto (2006; 2011) looks from a feminist perspective at the allocation of care work in societies, uncovering the oppression, exploitation and marginalisation experienced by those individuals and groups (mostly girls, women, immigrants, the working class and the poor) who are responsible for the greatest burden

of the world's care – whether in the form of unpaid, taken-for-granted care work performed within their own homes, families and communities, or as paid care workers employed by richer households, private or public institutions (cleaners, domestic workers, home carers and nurses).

Tronto draws attention to the political dynamics within care relations where subordinated groups perform care work and the elite exercise privileged irresponsibility, distancing themselves from care practices by purchasing the caring services they need while ignoring the care needs of caregivers (Tronto 1993; 2006). Certain groupings, such as men or those in the middle classes, are more likely to avoid caring responsibilities, this being justified by their contribution to other activities (Tronto 2013a: 33). In her recent work, Tronto (2013a: 30) argues that, in order to democratise care realities, 'democratic politics should center upon assigning responsibilities for care, and for ensuring that democratic citizens are as capable as possible of participating in this assignment of responsibilities'.

A further analytical distinction is made by Tronto (2013a) around five aspects of the care process. These are firstly, caring about, the act of noticing that there are certain care needs that have to be met; secondly, caring for, assuming responsibility for meeting these needs; thirdly, caregiving, the actual work of providing care; fourthly, care-receiving, the responses of those receiving care, including an assessment of the adequacy of the caring acts; and lastly, caring with, ensuring that care needs are met in a manner 'consistent with democratic commitments to justice, equality, and freedom for all' (Tronto 2013a: 23). What these different steps signify is that different parties may be involved in recognising the need for care, delivering the actual care and assessing the caring acts. This is relevant to the analysis of nursing care realities that follows, as it assists with identifying how blame for inadequate care is often assigned incorrectly.

Tronto's (2010: 162) framework for assessing caring within public social institutions argues that three aspects must be understood, namely:

> … a clear account of power in the care relationship and thus a recognition of the need for a *politics* of care at every level; second, a way for care to remain *particularistic* and *pluralistic* ; and third, that care should have clear, defined, acceptable *purposes.*

She states that organisations not caring well regard care as a commodity; reduce care to caregiving for dependent and vulnerable persons only; exclude care receivers from decisions as care needs are set organisationally; separate care work along class, caste, gender and race lines; and are perceived by their caregivers as hindering and not supporting care (Tronto 2010: 163–166). She indicates that approaching care as a whole process requires focus on the needs of receivers and care workers alike (Tronto 2010: 162).

As nursing is bound up with practices of care, Tronto's political ethics of care provides a valuable framework for assessing nursing practices. In what follows, we use Tronto's political ethic of care and Foucaultian understandings of disciplinary power to argue that dominant discourses and practices within institutionalised nursing in South Africa undermine the democratisation of care and thus care itself.

PRACTICES OF SURVEILLANCE

Foucaultian understandings of institutional discourses apply an analysis of power as invisible and diffuse, working both positively and negatively through social networks

(Foucault 1977; Hutchinson, Vickers, Jackson and Wilkes 2006). Central to Foucault's (1977) theory of disciplinary power is the notion of the panopticon, the all-seeing eye of authority, which imposes a sense of surveillance. In healthcare institutions, surveillance also involves treating people as docile bodies subject to the continuous observation of the clinical gaze (Foucault 1973). Critical perspectives on nursing have drawn on Foucault to argue that the profession of nursing is framed in authoritarian and controlling relations that set up caring practices in healthcare facilities as mechanised, regulated and under a disciplinary regime of constant surveillance and corrective normalisation (Gastaldo and Holmes 1999; Perron, Fluet and Holmes 2005). A salient example in South African is the use of hierarchical surveillance practices by nurses to enforce tuberculosis patients' compliance with rigid treatment policies in primary health clinics (Lewin and Green 2009). Such disempowering approaches towards patients exhibit a number of Tronto's (2010) warning signs of an uncaring institution, namely, rigid execution by less qualified care workers of care processes arranged by experts, the assumption that the needs of care receivers are fixed and the exclusion of care receivers from decisions regarding their own care.

Not only do nurses police patients, they also internalise this surveillance and police themselves and each other (Bowden 2000; Darbyshire and Fleming 2008). The system of discipline and scrutiny in which nurses are regulated and in turn discipline patients is framed in a militaristic discourse that inhibits the nurturance and care required for effective nursing. This practice predominates, despite shifts in nursing education towards student autonomy, reflective practice, critical thinking and problem-based learning (Darbyshire and Fleming 2008; De Swardt, Du Toit and Botha 2012; Lekalakala-Mokgele 2006). This results in conflicting pedagogical goals and practices.

Nursing students exposed to progressive educational practices have limited opportunity to practise them in the workplace since, '[d]espite agreeable discourses about nurses' professional autonomy, one cannot help but observe that nurses have never been so heavily regulated'(Perron 2013: 155). In professional nursing, conditions of governmentality and surveillance are intensified through the pervasive audit and self-assessment culture dictated by institutional bureaucracies in an attempt to ensure accountability (Rudge 2011). A study of the effect of this on nurses at a KwaZulu-Natal hospital illustrates how 'audit culture makes use of entrenched workplace hierarchies, rather than challenging or changing them', while simultaneously 'creating an illusion that [staff] have greater responsibility and autonomy than in fact they do', resulting in 'a logic whereby the responsibility for any apparent "failure" to fulfil these and other initiatives falls on individual nurses' (Hull 2012: 619, 626).

Nurses are aware of the unfairness of these practices, as evidenced in DENOSA's 2013 Positive Practice Environments campaign launch which drew attention to 'the sad anomalies in the county's [sic] healthcare facilities which often result in the shifting of the blame towards healthcare workers.' Tronto (2010: 165) argues that such inappropriate blaming of caregivers results where the relationship between caregiver and care receiver is oversimplified to exclude other roleplayers in care, for instance government and management.

Current forms of surveillance try to entrench accountability via data collection (DoH 2011b; 2012). Because of this, healthcare institutions focus on complete patient files as an indicator of professional capability and institutional accountability, making nurses accountable for collecting this information. Rather than leaving gaps in the data, information is reportedly falsified by nurses, resulting in files no longer providing accurate information about patients (Hull 2012). This is a disturbing example of how

surveillance through information management systems can turn care practices into a 'text-action-text sequencing' in which nurses lose sight of actual patients (Rankin and Campbell 2014: 168). According to Hull, 'the preoccupation with administrative procedure and nurse audit actually appears to have a detrimental effect on patient care' (2012: 621); in addition, this kind of new public management ethos also 'becomes a source of intense anxiety [for nurses] and serves to exacerbate [their] workload' (2012: 629). This flags another indication of an uncaring institution, namely one in which caregivers experience organisational requirements as hindrances instead of supportive of care (Tronto 2010).

South African nursing is a very stratified profession, reflected in the codification of several different levels of nursing education qualifications (DoH 2013). Nurses also interact with other health professionals who have their own occupational hierarchies, resulting in a complex web of power relationships emerging in the nursing arena (Hull 2009). The hierarchical division of labour within healthcare institutions entails a disproportionate allocation of domestic labour to junior nursing staff compared to senior nursing staff, doctors and nursing management. While some division of labour is needed due to the specialised knowledge and skills required for certain tasks, Tronto's politic ethic of care would question whether this justifies freeing some healthcare personnel from most or all forms of emotional and hands-on care, and whether it warrants granting excessive status and power to those performing certain tasks while devaluing those engaged in most of the actual care work with patients. This returns us to the need for a democratic allocation of care responsibilities (Tronto 2013a; 2013b) and raises questions around the democratic sharing of knowledge and skills in healthcare institutions.

In the early 1990s, Seedat and Nell (1992) highlighted the reproduction of authoritarian relationships in clinics, an issue not improved through the subsequent restructuring of the health system. Apartheid bureaucracy was replaced with private sector principles (Hull 2009: 137) in the form of new public management, which ironically 'reinforced a hierarchical model of governance that has long characterized health care practice in South Africa' (Hull 2012: 617, 619). Currently, there is even greater separation of actual care contexts from managerial concerns, with a strong focus on auditing rather than on face-to-face interactions in wards (Hull 2012).

The hierarchal working environment disempowers nurses and undermines holistic care. Despite advances in medical and nursing education – with its increased recognition of the importance of interdisciplinary team work, human rights, cultural competence and social responsiveness – actual power relations, as evidenced in the persistent reverence of doctors' orders, must still be transformed (Pijl-Zieber 2013). Describing hospital sociality, Hull (2012: 613–614) illustrates a nurse's deferential behaviour towards an assertive doctor, with the nurse not afforded the opportunity to contribute her assessment of the patient, and the patient not consulted whatsoever. Tronto (2013b) argues that where healthcare institutions are so hierarchical, more mistakes are made and care is diminished.

DOMINANCE OF THE BIOMEDICAL DISCOURSE

During the twentieth century, nursing was strongly shaped by efforts to carve out its own distinctive domain (Holmes, Roy and Perron 2008). From 1891, nurses in South Africa had to register with the state and nurse training fell under the control of doctors

(Digby 2006). In the twentieth century, the medical profession's control over nursing gradually lessened as nursing leaders successfully advocated for professional recognition, higher academic qualifications, greater autonomy and a separate professional council (Horwitz 2011). However, while the integration of nursing into university education aided the professionalisation of nurses, it also created conditions for a stronger emphasis on biomedical subjects, despite the simultaneous inclusion of human sciences in the nursing curriculum (Horwitz 2011: 4–5).

Nonetheless, building on the work of Barbara Carper, one way in which international nursing asserted its distinctiveness from medicine was by championing aesthetic, ethical and personal knowledge in addition to empirical medical knowledge (Archibald 2012; Holmes, Perron and O'Byrne 2006).This approach faces a threat in the recent rise of postpositivism and evidence-based nursing as the new normaive paradigm for the discipline. Given that institutional medicine's authority is rarely challenged, nursing followed suit when the former adopted evidence-based medicine as its benchmark (Holmes, Roy and Perron 2008), including terminology such as nursing diagnoses, evidence-based practice, best practices, best evidence and randomised controlled trials (Holmes, Perron and O'Byrne 2006). This approach requires measurable, observable phenomena which thus excludes the emotional, ethical and socio-political dimensions of caring (Holmes, Perron and O'Byrne 2006; Holmes, Roy and Perron 2008). Evidence-based guidelines have also been criticised for diminishing critical thinking and professional responsibility amongst nurses (O'Halloran, Porter and Blackwood 2010).

The evidence-based movement continues to promote dominant biomedical research designs, with most qualitative research designs deemed less important in the evidence hierarchy (Holmes and O'Byrne 2012). However, nurses are promoting efforts to increase the acceptability of qualitative research, as evidenced in the establishment of the Joanna Briggs Institute (Pearson, Wiechula, Court and Lockwood 2005).

With the exception of medicine, nursing tends to be unreceptive to knowledge coming from outside its disciplinary boundaries (Holmes, Perron and O'Byrne 2006). This is particularly problematic in South Africa, as the dominant biomedical paradigm perpetuates a Eurocentric approach to patients and results in the 'reproduction of a monolingual, English-centred approach to health care' and the 'regular exclusion [of African languages] from the hospital setting' (Deumert 2010: 59). While South African student nurses are exposed to diverse cultures and languages in community settings, their training is often not conducive to developing a thorough understanding of cultures and languages different from their own (Beukes, Nolte and Arries 2010), nor of other forms of medicine and healing. This is ironic as some nurses have been found to use other forms of healing, such as African traditional healing, in conjunction with or as an alternative to biomedical care (Digby and Sweet 2002; Wreford 2005).

African traditional healing and nursing both embrace a pluralist and holistic outlook that understands human beings in relation to their larger environment and socio-cultural networks, accommodates human emotion, motivation and meaning, and manifests an openness to different kinds of healing (Digby 2006: 282–284; Van Wyk 2005; Wreford 2005). Nurses could therefore play a pioneering role in creating an integrated healthcare system sensitive to the diverse cultural and healing needs of patients, especially given government policy on the integration of African Traditional Medicine in primary healthcare (Sorsdahl, Stein and Flisher 2013).

Unfortunately, in practice nurses more often introduce patients to and reinforce biomedical values relating to health, work and family life (Petersen 2000). Petersen

(2000) moreover shows nurses' performance evaluations using daily records that focus on quantity over quality, diagnosis over understanding, and drugs administered over emotional care. This narrow range of healthcare is not aligned to the ethical principles of social justice, beneficence, altruism and caring contained in the South African Nursing Council's (2013) *Code of ethics for nursing practitioners in South Africa*. It also does not contribute to the internalisation of a human rights culture (London and Baldwin-Ragaven 2008) or seriously engage with issues of culture, race and oppression in nursing (Vandenberg 2010). The *Code of ethics for nursing practitioners in South Africa* itself often denotes culture negatively, for example as a possible cause for ethical dilemmas in 'situations of conflicting values', and in relation to nurses' duty 'to mitigate harmful cultural practices by communicating and educating communities' (SANC 2013: 7, 8). This may be another instance of a stance borrowed from biomedicine, which fails to recognise its own cultural specificity and only takes note of 'culture' in others when it poses a problem.

A narrow focus on biomedical healthcare can encourage a victim-blaming discourse by conceptualising health problems as diseases, locating problems within the individual patient, and failing to consider psychosocial or other contextual factors. Wong (2004: 10) points out that '[t]here has been some evidence that when the availability of medical services is restricted, there is a tendency for healthcare professionals to conceptualize patients in negative ways'. In South Africa, nurses have been found to ill-treat patients they regard as bad, difficult, irresponsible or uncooperative (Fassin 2008; Lewin and Green 2009; Van der Walt and Schwartz 1999).

MECHANISATION AND FRAGMENTATION

Another key discourse shaping healthcare and nursing is the application of organisational theory to medical institutions (Obholzer and Zagier Roberts 1994). Classical management theory conceives of organisations as rational systems that function with mechanistic efficiency (Morgan 1997). This practice is valorised by Taylor's principles of scientific management and shaped development of nursing management in the early twentieth century (Van der Walt and Swartz 2002).

The principle of splitting the planning and design of work from its implementation is frequently viewed as the most destructive element of Taylor's approach. It entails a division of labour between managers and workers, with the former responsible for planning and supervising the execution of work, and the latter for performing the actual work broken up into small, discrete tasks. The rationale was to simplify jobs so that labour would be cheap, quick to train, easy to supervise and to replace. In nursing, task orientation means one nurse no longer provides the complete care for a particular patient: rather, different nurses perform different tasks, such as dressings, medication or observations, for all patients, in an assembly-line manner. Rispel and Schneider (1991) liken nursing to factory work where nurses perform a series of defined tasks rather than being holistically involved in patient recovery. In a study of factors eroding nurses' caring concern, students reported that the fragmentation of nursing work and also their frequent clinical reallocation to new wards prevented them from caring for patients as people and resulted in situations where 'the patient becomes the Betadine dressing in bed X and the like' (Van der Wal 2006: 65). Students added that schedules did not allow time for caring, since talking with patients was

judged as work evasion. Moreover, routinised work induced boredom and cynicism (Van der Wal 2006).

Task orientation became entrenched in nursing practice partly because it 'enabled nurse managers to maintain maximum control over the performance of the workforce' (Van der Walt and Swartz 2002: 1006). According to Rispel and Schneider (1991), the professionalisation of South African nursing during the twentieth century was undercut by an opposing trend of proletarianisation which entailed the fragmentation of nursing into tasks, the deskilling of individuals and the loss of personal autonomy within nursing practice. This task fragmentation continues today with increasing subdivision of nursing tasks and their reassignment to 'less trained, lower paid workers' (Austin 2011: 159). It is also reflected in the stark mechanistic language of the planning and policy documents of the National Department of Health (DoH), for instance its *Human resources for health (HRH) strategy for the health sector 2012/13 – 2016/17*, which speaks of 're-engineering' primary health care and 'shifting tasks to the category of worker that can most efficiently perform the work' (DoH 2011a: 66). Indeed, current government initiatives within the South African healthcare sector clearly demonstrate a preoccupation with implementing rationalised bureaucracy and its associated ideals of 'extreme efficiency, calculability, predictability, and control' (Austin 2011: 159, citing Ritzer 2011).

Although holistic care is mentioned, the overall clinical focus within healthcare is task-oriented and located within a paradigm that equates effectiveness with speed (Gaede, Mahlobo, Shabalala, Moloi and Van Deventer 2006). This is evident in the DoH's (2011c) *National core standards for health establishments in South Africa*, which, notwithstanding prominent display of the phrase 'Towards quality care for patients', embodies a highly corporate and bureaucratic approach focused predominantly on measures and procedures aimed at efficiency gains. Rudge (2011: 170) comments that this approach often functions 'to overcome resistance or dull the effects of alienation on work place conditions', deliberately allowing us little time 'to reflect on where and in what way we could alter our situations'.

The *National core standards for health establishments in South Africa* is filled both with the language of monitoring and surveillance, using terms such as 'compliance', 'assessment' and 'audit', and with impersonal terminology unsuited to holistic care practices (DoH 2011c). Additionally, it includes a customer service model, something that critics deem inappropriate in healthcare contexts as it turns healthcare providers into traders, eroding the ethical responsibilities of healthcare institutions by reducing patients to numbers, denying the intimacy of caring, and effectively silencing the power imbalance and moral relationship between patient and nurse or doctor (Austin 2011; Tronto 2008; Woods 2014). Tronto (2010) states that care that is conceptualised as a commodity rather than as a process is an indicator of an uncaring institution.

The *National core standards for health establishments in South Africa* also omits or reduces linguistic, socio-cultural and religious diversity issues, such as cultural and religious concerns which are reduced to issues concerning waste disposal and food (DoH 2011c: 44, 45). Neither the effect on patient care of the predominance of certain cultures and languages in South African healthcare settings (Deumert 2010) nor the relationship between biomedical care and traditional healing is addressed. Despite the document briefly mentioning the need for community involvement in the planning of local health services and staff participation in decision-making about service quality (DoH 2011c: 30, 34), the standardisation of care practices is assumed and reinforced,

9

leaving little room for sensitivity to specific care needs of individuals, communities or staff members themselves.

The increasing objectification of care practices through authoritative texts with standardised instructions removes nurses' autonomy and discretion, disregards their experiential knowing, and renders unscheduled care in response to actual patient needs unlikely (Rankin and Campbell 2014). While counselling in HIV clinics is understood to require empathetic, supportive and personalised consultation, success is measured on numbers seen and items completed on a checklist. This indicates the same warning signs of an uncaring institution evident in the practices of surveillance and narrow biomedical approach discussed above, namely, a disregard for particularity and plurality in the care needs and practices of communities and individuals (Tronto 2010).

The fragmentation of holistic nursing care into tasks, effectively turning nurses into factory workers, is a source of alienation to the nurse in the Marxist sense and also further removes nursing from the arena of care to that of management and control, where people and their needs are decontextualised into fragmented pieces of labour. Tronto (2011: 170) stresses that we should question the necessity of problematic practices in order to assume responsibility for changing them.

CONCLUSION

Drawing on Tronto's political ethic of care and Foucaultian understandings of disciplinary power, we have argued that the discourses and practices shaping institutionalised nursing internationally, coupled with local historical legacies of gender, class, racial and socio-cultural inequalities, diminish the possibility of democratic, socially responsive and humane care in South African healthcare institutions. Although resource and staff shortages play a significant role in undermining quality nursing care in South Africa, this is greatly exacerbated by nursing being subjected to the dominant discursive frameworks of biomedicine and neo-liberal governmentality. While the importance of holistic care is mentioned in policy, the adoption of new public management in healthcare, the rise of evidence-based nursing and the continued prevalence of a task orientation approach in South African nursing intersect, creating a reductionist framework for nursing care. The resulting hierarchical practices of surveillance, audit culture, narrow focus on biomedical care, and mechanisation and fragmentation of nursing work, all render care practices insensitive to people's diverse care needs. This disempowers and devalues nurses by preventing them from exercising their discretion and nursing expertise in care contexts and by eroding their caring concern. Rather than offering a democratic and socio-politically responsive approach to the predicaments of nursing care, these practices have contributed to the deterioration of South African nurses' working conditions following the expansion and restructuring of the country's health system.

Accordingly, the seven warning signs of uncaring institutions outlined by Tronto (2010) are all discernible in South African healthcare institutions. These include the assumption that only patients are in need of care, thereby disregarding the care needs of all people, including caregivers; ; an approach that takes patient needs as fixed and given, rather than responsive to individual and socio-cultural diversity; a conceptualisation of care as a commodity delivered through a customer service model; the mistreatment of patients, including excluding them from decisions over their own care; a simplistic conceptualisation of care centering only on care-giving, often resulting

in the misplaced blaming of healthcare personnel for systemic flaws and cost-cutting policies; organisational requirements such as task orientation and excessive auditing culture which hinder rather than support care; and allocation of care work along gender, class and racial lines, with nursing remaining feminised and devalued.

These challenges to care seem insurmountable in that they are embedded in institutionalised hierarchies and disciplinary regimes, exacerbated by inequalities in South Africa's healthcare and social context. Yet Tronto's (2013a) feminist democratic ethic of care offers a new approach by refocusing government and society on making care the central value of democracy. A democratisation of care realities within the healthcare system entails giving healthcare personnel, including nurses and healthcare workers who perform the most care work, an equal say in identifying care needs and allocating care responsibilities. According to Tronto (2013b), flattening institutional hierarchies 'is one way to make medicine more democratic and also a way to make it better'. This would, however, go counter to the current culture of top-down managerialism in the South African healthcare sector and to the increasing occupational stratification in nursing and related healthcare professions (DoH 2011a: 2013).

In promoting a conception of 'care as a public value and as a set of public practices' (Tronto 2013a: 18), we can revalue the physical and emotional care work in nursing as a central and important contribution to society, thereby ensuring it receives priority when allocating resources and finances. Doing so would remove the need for the current trends to improve nursing's status, with its focus on more specialised biomedical skills over physical and emotional care practices, and its task delegation of the most denigrated domestic aspects of nursing care to lower-paid and less qualified workers, regardless of whether this serves the healthcare needs of patients and the broader population (Marks 1997). What we need instead is a profound shift in society's values and priorities, and a concomitant reorganisation of its institutions so that all aspects of care are placed at the centre, rather than marginalised to the periphery.

In order to create caring healthcare institutions, we need to shift from the current framework of care in which neither the caregiver nor the patients' needs for care are adequately recognised. This means reversing task fragmentation within nursing care and facilitating care processes where nurses engage more holistically with patients' care. It includes sensitivity towards the particularity and plurality of care needs and realities for communities and individuals, by providing 'attention to human activities as particular and admitting of other possible ways of doing them and to diverse humans having diverse preferences about how needs might be met' (Tronto 2010: 162). It also requires challenging the way in which nurses' inability to acknowledge their own vulnerability is inbuilt in the institutionalised mechanistic framework dominating nursing practices. Facilitating self-care for caregivers is crucial for their own well-being and has been shown to result in improved care for patients.

Finally, Tronto's (2013b) political ethics of care challenges the biomedical paradigm to move beyond focusing on the clinician-patient relationship as a dyad and the distancing of patients as repositories of biomedical deficit (Petersen, 2000a, 2000b). Instead, it conceives of care relations as a broader network also involving nurses, the patient's family and others. This would require considering the purpose of healthcare, involving patients in the decision-making process and reducing the power imbalance between doctors and nurses. A political ethics of care that integrates relational and social ethics effectively offers 'an ideal ethic for health care practices' as it is responsive to the socio-cultural and political contexts of diverse societies (Woods 2014: 107). It

11

offers a way to begin addressing the following concern so aptly captured by Marks (1997: 40):

> Until health systems are rethought as a whole, and the relationships between care and cure, community and clinic, doctor and nurse, patient and 'professional', are transformed, the more flexible and empowering modalities needed for primary and community health care will remain as elusive as ever.

This focus on institutionalised nursing in South Africa has highlighted that redressing dominant constructions of care in our society is long overdue. It indicates that our entire healthcare system requires a different kind of transformation if we are to recognise and value the importance of democratic, humane and holistic care practices within nursing and healthcare more broadly.

ACKNOWLEDGEMENTS

REFERENCES

Ackerman, E.R. & Bezuidenhout, M.C. 2007. Staff dissatisfaction in the theatre complex of a private hospital. *Curationis* 30(3): 68–73.

Archibald, M.M. 2012. The holism of aesthetic knowing in nursing. *Nursing Philosophy* 13(3): 179–188.

Austin, W.J. 2011. The incommensurability of nursing as a practice and the customer service model: An evolutionary threat to the discipline. *Nursing Philosophy* 12: 158–166.

Bagraim, J. 2013. Commitment and the emigration intentions of South African professional nurses. *Health SA Gesondheid* 18(1), Art. #512.

Beukes, S., Nolte, A.G.W. & Arries, E. 2010. Value-sensitive clinical accompaniment in community nursing science. *Health SA Gesondheid* 15(1), Art. #485.

Bowden, P. 2000. An 'ethic of care' in clinical settings: encompassing 'feminine' and 'feminist' perspectives. *Nursing Philosophy* 1: 36–49.

Bruce, J. & Sangweni, B. 2012. The relationship between burnout and job satisfaction among registered nurses at an academic hospital in Johannesburg, South Africa. *Africa Journal of Nursing and Midwifery* 14(1): 89–104.

Darbyshire C. & Fleming V.E.M. 2008. Governmentality, student autonomy and nurse education. *Journal of Advanced Nursing* 62(2): 172–179.

Democratic Nursing Organisation of South Africa (DENOSA). 2013. Nurses and doctors to raise their voice on conditions they work under at the launch of PPE campaign. Media alert, 20 August 2013. Retrieved from http://www.denosa.org.za/upload/Media_Statements/Nurses_and_doctors_to_raise_their_voice_on_conditions.pdf (accessed 4 March 2014).

De Swardt, H.C., Du Toit, H.S. & Botha, A. 2012. Guided reflection as a tool to deal with the theory-practice gap in critical care nursing students. *Health SA Gesondheid* 17(1) Art. #591.

Deumert, A. 2010. 'It would be nice if they could give us more language' – Serving South Africa's multilingual patient base. *Social Science & Medicine* 71(1): 53–61.

Digby, A. 2006. *Diversity and division in medicine: Health care in South Africa from the 1800s*. Bern: Peter Lang.

Digby, A. & Sweet, H. 2002. Nurses as culture brokers in twentieth-century South Africa. In W. Ernst (ed.). *Plural Medicine, Tradition and Modernity, 1800–2000*. London: Routledge, 113–129.

Ditlopo, P., Blaauw, D., Rispel, L., Thomas, S. & Bidwell, P. 2013. Policy implementation and financial incentives for nurses in South Africa: A case study on the occupation-specific dispensation. *Global Health Action* 6**:** 19289.

DoH (Department of Health). 2011a. *Human resources for health South Africa: HRH strategy for the health sector 2012/13–2016/17*. Retrieved from http://www.hst.org.za/sites/default/files/hrh_strategy.pdf (accessed 29 January 2014).

DoH (Department of Health). 2011b. *District health management information system (DHMIS) policy*. Retrieved from http://www.health.gov.za/docs/Policies/2012/dhmis.pdf (accessed 4 March 2014).

DoH (Department of Health). 2011c. *National core standards for health establishments in South Africa*. Tshwane: National Department of Health. Retrieved from http://www.doh.gov.za/docs/notices/2013/NCS_for_Health_FINAL.pdf (accessed 13 September 2013).

DoH (Department of Health). 2012. *District health management information system (DHMIS) – standard operating procedures: Facility level*. Retrieved from http://www.health.gov.za/docs/Policies/2014/5SOPFacilitylevel.pdf (accessed 4 March 2014).

DoH (Department of Health). 2013. *The national strategic plan for nurse education, training and practice 2012/13 to 2016/17*. Retrieved from http://www.health.gov.za/docs/strategic/2013/Strategic_Plan_for_Nurse_Education_Training_and_Practice.pdf (accessed 4 March 2014).

Eygelaar, J.E. & Stellenberg, E.L. 2012. Barriers to quality patient care in rural district hospitals. *Curationis* 35(1), Art. #36.

Fassin, D. 2008. The elementary forms of care: An empirical approach to ethics in a South African hospital. *Social Science & Medicine* 67(2): 262–270.

Foster, K.E. 2005. Clinics, communities, and cost recovery: Primary health care and neoliberalism in postapartheid South Africa. *Cultural Dynamics* 17(3): 239–266.

Foucault, M. 1973. *The birth of the clinic.* London: Tavistock Publications.

Foucault, M. 1977. *Discipline and punish: The birth of the prison.* Harmondsworth: Penguin.

Gaede, B., Mahlobo, S., Shabalala, K., Moloi, M. & Van Deventer, C. 2006. Limitations to practising holistically in the public sector in a rural sub-district in South Africa. *Rural and Remote Health* 6, Article 607.

Gallagher, A. 2014. Moral boundaries and nursing ethics. In G. Olthuis, H. Kohlen & J. Heier (eds.). *Moral boundaries redrawn*. Leuven: Peeters, 133–149.

Gastaldo, D.,& Holmes, D. 1999. Foucault and nursing: A history of the present. *Nursing Inquiry* 6(4): 231–240.

Holmes, D., Perron, A. & O'Byrne, P. 2006. Evidence, virulence, and the disappearance of nursing knowledge: A critique of the evidence-based dogma. *Worldviews on Evidence-Based Nursing* 3(3): 95–102.

Holmes, D., Roy, B. & Perron, A. 2008. The use of postcolonialism in the nursing domain: Colonial patronage, conversion, and resistance. *Advances in Nursing Science* 31(1): 42–51.

Holmes, D. & O'Byrne, P. 2012. Resisting stratification: Imperialism, war machines and evidence-based practice. In A. Broom & J. Adams (eds.). *Evidence-based healthcare in context*. Farnham, Surrey: Ashgate, 43–58.

Horwitz, S. 2007. 'Black nurses in white': Exploring young women's entry into the nursing profession at Baragwanath Hospital, Soweto, 1948–1980. *Social History of Medicine* 20(1): 131–146.

Horwitz, S. 2011. The nurse in the university: A history of university education for South African nurses: A case study of the University of the Witwatersrand. *Nursing Research and Practice*, Article 813270.

Hull, E. 2009. Status, morality and the politics of transformation: An ethnographic account of nurses in KwaZulu-Natal, South Africa. Ph.D. thesis, Department of Anthropology, London School of Economics and Political Science. Retrieved from http://etheses.lse.ac.uk/320/1/Hull_Status,%20morality%20and%20the%20politics%20of%20transformation.pdf (accessed 20 March 2014).

Hull, E. 2012. Paperwork and the contradictions of accountability in a South African hospital. *Journal of the Royal Anthropological Institute (N.S.)* 18: 613–632.

Hutchinson, M., Vickers, M., Jackson, D. & Wilkes, L. 2006. Workplace bullying in nursing: Towards a more critical organisational perspective. *Nursing Inquiry* 13: 118–126.

Khoza, V.L., Du Toit, H.S. & Roos, J.H. 2010. Implementation of the 'Batho Pele' (People First) principles in one public hospital in South Africa: Patients' experiences. *Africa Journal of Nursing and Midwifery* 12(2): 58–68.

Klopper, H.C., Coetzee, S.K., Pretorius, R. & Bester, P. 2012. Practice environment, job satisfaction and burnout of critical care nurses in South Africa. *Journal of Nursing Management* 20(5): 685–695.

Lekalakala-Mokgele, E. 2006. Facilitation as a teaching strategy: Experiences of facilitators. *Curationis* 29(3): 61–69.

Lewin, S. & Green, J. 2009. Ritual and the organisation of care in primary care clinics in Cape Town, South Africa. *Social Science & Medicine* 68(8): 1464–1471.

London, L. & Baldwin-Ragaven, L. 2008. Human rights and health: Challenges for training nurses in South Africa. *Curationis* 31(1): 5–18.

McIntosh, J. & Stellenberg, E.L. 2009. Effect of a staffing strategy based on voluntary increase in working hours on quality of patient care in a hospital in KwaZulu-Natal. *Curationis* 32(2): 11–20.

Magoro, M.T., Hoque, M.E. & Van der Heever, H. 2011. ART patients' satisfaction level regarding comprehensive HIV and AIDS care management and antiretroviral treatment programme in Pretoria. *Southern African Journal of Epidemiology and Infection* 27(2): 71–75.

Marks, S. 1997. The legacy of the history of nursing for post-apartheid South Africa. In A.M. Rafferty, J. Robinson & R. Elkan (eds.). *Nursing history and the politics of welfare*. London: Routledge, 29–44.

Meiring, A. & Van Wyk, N.C. 2013. The image of nurses and nursing as perceived by the South African public. *Africa Journal of Nursing and Midwifery* 15(2): 3–15.

Mokoka, E., Oosthuizen, M.J. & Ehlers, V.J. 2010. Retaining professional nurses in SA – Nurse managers' perspectives. *Health SA Gesondheid* 15(1), Art. #484.

Mokoka, K.E., Ehlers, V.J. & Oosthuizen, M.J. 2011. Factors influencing the retention of registered nurses in the Gauteng Province of South Africa. *Curationis* 34(1), Art. 16.

Morgan, G. 1997. *Images of organization.* London: Sage.

Obholzer, A. & Zagier Roberts, V. (eds.) 1994. *The unconscious at work: Individual and organisational stress in the human services*. London: Routledge.

O'Halloran, P., Porter, S. & Blackwood, B. 2010. Evidence based practice and its

critics: what is a nurse manager to do? *Journal of Nursing Management* 18: 90–95.

Oosthuizen, M.J. 2012. The portrayal of nursing in South African newspapers: A qualitative content analysis. *Africa Journal of Nursing and Midwifery* 14(1): 49–62.

Oosthuizen, M. & Ehlers, V.J. 2007. Factors that may influence South African nurses' decisions to emigrate. *Health SA Gesondheid* 12(2): 14–26.

Pearson, A., Wiechula, R., Court, A. & Lockwood, C. 2005. The JBI model of evidence-based healthcare. *International Journal of Evidence Based Healthcare*, 3(8): 207–216.

Perron, A. 2013. Nursing as 'disobedient' practice: Care of the nurse's self, parrhesia, and the dismantling of a baseless paradox. *Nursing Philosophy* 14(3): 154–167.

Perron, A., Fluet, C. & Holmes, D. 2005. Agents of care and agents of the state: Bio-power and nursing practice. *Journal of Advanced Nursing* 50(5): 536–544.

Petersen, I. 2000. Comprehensive integrated primary mental health care for South Africa. Pipedream of possibility? *Social Science and Medicine* 51: 321–334.

Phaswana-Mafuya, N., Peltzer, K. & Stevenson Davids, A. 2011. Patients' perceptions of primary health care services in the Eastern Cape, South Africa. *African Journal for Physical, Health Education, Recreation and Dance* 17(3): 502–516.

Pienaar, J.W. & Bester, C.L. 2011. The impact of burnout on the intention to quit among professional nurses in the Free State region – a national crisis? *South African Journal of Psychology* 41(1): 113–122.

Pijl-Zieber, E.M. 2013. Doctors' orders and the language of representation. *Nursing Philosophy* 14(2): 139–147.

Pillay, R. 2009a. Work satisfaction of professional nurses in South Africa: A comparative analysis of the public and private sectors. *Human Resources for Health* 7: 15.

Pillay, R. 2009b. Retention strategies for professional nurses in South Africa. *Leadership in Health Services* 22(1): 39–57.

Rankin, J. & Campbell, M. 2014. Care and gender in nurses' institutionally organized work. In G. Olthuis, H. Kohlen & J. Heier (eds.). *Moral boundaries redrawn*. Leuven: Peeters, 153–173.

Rispel, L. 2010. Foreword. In B. Mash, J. Blitz, D. Kitshoff & S. Naude (eds.). *South African clinical nurse practitioners' manual*. Pretoria: Van Schaik.

Rispel, L. & Schneider, H. 1991. Professionalization of South African nursing: Who benefits? *International Journal of Health Services* 21(1): 109–126.

Rothmann, S., Van der Colff, J.J. & Rothmann, J.C. 2006. Occupational stress of nurses in South Africa. *Curationis* 29(2): 22–33.

Rudge, T. 2011. The 'well-run' system and its antimonies. *Nursing Philosophy* 12(3): 167–176.

Seedat, M. & Nell, V. 1992. Authoritarianism and autonomy. Conflicting value systems in the introduction of psychological services in a South African primary health care system. *South African Journal of Psychology* 22(4): 185–193.

Sellman, D. 2012. A shortage of caring in British nursing? *Nursing Philosophy* 13(3): 159–160.

Sorsdahl, K., Stein, D.J. & Flisher, A.J. 2013. Predicting referral practices of traditional healers of their patients with a mental illness: An application of the theory of planned behaviour. *African Journal of Psychiatry* 16(1): 35–40.

South African Nursing Council (SANC). 2013. *Code of ethics for nursing practitioners in South Africa*. Pretoria: SANC. Retrieved from http://www.sanc.co.za/pdf/SANC%20Code%20of%20Ethics%20for%20Nursing%20in%20South%20Africa.pdf (accessed 3 March 2014).

Tronto, J. 1993. *Moral boundaries: A political argument for an ethic of care*. New York: Routledge.

Tronto, J. 2006. Vicious circles of privatized caring. In M. Hamington & D.C. Miller (eds.), *Socializing care: Feminist ethics and public issues*. Lanham, MD: Rowman & Littlefield, 3–25.

Tronto, J. 2008. Consent as a grant of authority: A care ethics reading of informed consent. • In H. Lindemann, M. Verkerk & M.U. Walker (eds.). *Naturalized bioethics*. Cambridge: Cambridge University Press, 182–198.

Tronto, J. 2010. Creating caring institutions: Politics, plurality, and purpose. *Ethics and Social Welfare* 4(2): 158–171.

Tronto, J. 2011. A feminist democratic ethics of care and global care workers: Citizenship and responsibility. In R. Mahon & F. Robinson (eds.). *Feminist ethics and social policy*. Vancouver, BC: UBC Press, 162–177.

Tronto, J. 2013a. *Caring democracy: Markets, equality, and justice*. New York: NYU Press.

Tronto, J. 2013b. The challenges of medical care in a caring democracy. Public lecture presented at Ethos – Interdisciplinary ethics platform, University of Lausanne, Switzerland, 6 June 2013, 74 minutes. Retrieved from http://www.youtube.com/watch?v=91g5IvWDhqk (accessed 15 February 2014).

Tronto, J. 2014. *Moral Boundaries* after twenty years: From limits to possibilities. In G. Olthuis, H. Kohlen & J. Heier (eds.). *Moral boundaries redrawn*. Leuven: Peeters, 9–26.

Vandenberg, H.E. 2010. Culture theorizing past and present: Trends and challenges. *Nursing Philosophy* 11(4): 238–249.

Van der Wal, D.M. 2006. Factors erosive to caring. *Africa Journal of Nursing and Midwifery* 8(1): 55–75.

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

Van der Walt, H.M. & Swartz, L. 2002. Task orientated nursing in a tuberculosis control programme in South Africa: Where does it come from and what keeps it going? *Social Science & Medicine* 54(7): 1001–1009.

Van Wyk, N.C. 2005. Similarities in the meta-paradigm of nursing and traditional healing: An attempt to contribute to the integration of traditional medicine and western medicine in Africa. *Health SA Gesondheid* 10(3): 14–22.

Wong, W.H. 2004. Caring holistically within new managerialism. *Nursing Inquiry* 11(1): 2–13.

16

Woods, M. 2014. Tronto's legacy: The socio-ethical practitioner in contemporary health care. In G. Olthuis, H. Kohlen & J. Heier (eds.). *Moral boundaries redrawn*. Leuven: Peeters, 93–111.

Wreford, J. 2005. Missing each other: Problems and potential for collaborative efforts between biomedicine and traditional healers in South Africa in the time of AIDS. *Social Dynamics* 31(2): 55–89.