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WHY DO NURSES ABUSE PATIENTS? REFLECTIONS FROM SOUTH AFRICAN OBSTETRIC SERVICES

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Abstract—Nurse–patient relationships are a substantially neglected area of empirical research, the more so in developing than developed countries. Although nursing discourse usually emphasises "caring", nursing practice is often quite different and may be more strongly characterised by humiliation of patients and physical abuse. This paper explores the question: why do nurses abuse patients, through presentation and discussion of findings of research on health seeking practices in one part of the South African maternity services. The research was qualitative and based on 103 minimally structured in-depth individual interviews and four group discussions held with patients and staff in the services. Many of the patients reported clinical neglect, verbal and physical abuse from nursing staff which was at times reactive, and at others, ritualised, in nature. Although they explained nurses' treatment of them in terms of a few 'rotten apples in the barrel', analysis of the data revealed a complex interplay of concerns including organisational issues, professional insecurities, perceived need to assert "control" over the environment and sanctioning of the use of coercive and punitive measures to do so, and an underpinning ideology of patient inferiority. The findings suggest that the nurses were engaged in a continuous struggle to assert their professional and middle class identity and in the process deployed violence against patients as a means of creating social distance and maintaining fantasies of identity and power. The deployment of violence became commonplace because of the lack of local accountability of services and lack of action taken by managers and higher levels of the profession against nurses who abuse patients. It also became established as "normal" in nursing practice because of a lack of powerful competing ideologies of patient care and nursing ethics. The paper concludes by discussing avenues for intervention to improve staff-patient relationships. © 1998 Elsevier Science Ltd. All rights reserved

Key words—nurses, South Africa, abuse of patients, obstetric care, nurse–patient relationships

INTRODUCTION

Nurse-patient relationships have been substantially neglected as a focus of empirical research. In the United Kingdom, popular and professional discourses characterise nursing as a profession of dedicated staff, exhibiting qualities of care, nurturing, comfort and concern and motivated by desires to help people (Davies, 1994, pp. 1–2). In many developing countries, professional discourse is similar (e.g. Medlen, 1994), however, many nursing practices are far removed from such images. In many situations nurses in the public sector work in harsh and often squalid conditions and there are extreme power differentials between nurses and their poor, often illiterate or semi-literate patients. In these situations nurses have been reported to employ humiliation, verbal coercion and even physical violence to assert their authority and control patient behaviour. Three examples from diverse social situations are maternity services in North India (Jeffery *et al.*, 1989), family planning services in Morocco (Mernissi, 1975) and maternity services in Jamaica (Sargent and Bascope, 1996). The limited published material which discusses relationships characterised by abuse suggests that such nurse attitudes towards patients should be regarded as a problem as, in addition to being ethically unacceptable, they may be a very important barrier to access to health care (for example, Abdool Karim *et al.* (1992); Eades *et al.* (1993); Gilson *et al.* (1994); Lazarus (1994); Mathai (1997); Wood *et al.* (1997)).

Although nurses' abuse of patients in developing countries is acknowledged to be a widespread and serious problem in some influential quarters (e.g. TDR/GEN/95.2, 1995) the authors have been unable to find any published material which explores this as a central theme. Most notable in the review of published nursing literature is the absence of discussion. This suggests that if it has been identified as a problem by the nursing professional internationally, the profession is not yet ready to publicly acknowledge this and discuss actions to change the situation. This is certainly the case in South Africa, for example, where nurses' "cruelty" to patients has been a feature of popular discourses, as exemplified by newspaper articles (e.g. Moloney, 1997) and township legend (Marks, 1994, p. 196) for decades but the South African Nursing Council and South African Nursing Association (SANA), over the years, have not identified it as a focus for action. In several recent

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cases they have been conspicuous for their failure to investigate cases raised in the media and take action. Ironically, many articles can be found in the SANA mouthpiece *Nursing RSA Verpleging* reminding nurses of their obligations to protect patients from harm by doctors (e.g. Medlen, 1994; Van Tonder, 1994).

This paper aims to open up analysis and debate of the question: why do nurses abuse patients? Focusing on South Africa, it presents and discusses some of the findings of a study which was undertaken in order to explore service users' health seeking practices as well as perceptions of quality of care in parts of the obstetric services in the Western Cape and service providers' perspectives on problems in the workplace. The research was not undertaken specifically with the intention of studying nurse-patient relationships but nurses' abuse of patients emerged as the most important theme in the interviews with both nursing staff and patients. The findings presented here outline the nature of abuse which patients experience and explore, tentatively, why nurses treat patients in these ways. In concluding, we discuss possible avenues for intervention. This paper does not purport to be a definitive analysis of the question in focus, but rather aims to begin a process of stimulating debate and discussion in a public arena with the intention of encouraging further investigation and development of interventions around the issue. The research findings are contextualised by a brief review of the history of nursing in South Africa.

NURSING IN SOUTH AFRICA

The broader context of nursing in South Africa cannot be adequately understood without a brief consideration of the intertwined histories of apartheid and of the nursing profession in the country.

A detailed and critical account of the history of nursing in South Africa can be found in Divided Sisterhood (Marks, 1994), here we briefly summarise some key aspects. The nursing profession in South Africa was established for white English-speaking "ladies" in the last third of the 19th century and was at that time dominated by religious sisterhoods (Marks, 1994, p. 16). The first African* professional nurse qualified in 1907 but for many years after this few African nurses were trained (p. 83). By the 1920s, nursing had become an acceptable and highly prestigious occupation for the daughters of the black elite, but access to training was limited (p. 88). It was not until the Second World War, when faced with a dire shortage of nurses, that the authorities started training African nurses in large numbers (p. 91). By the end of the 20th century the demography of nursing had been transformed into a profession numerically dominated by Africans but controlled in its higher echelons by white Afrikaaner nurses.

The bodies representing and regulating nursing in South Africa were characterised by discriminatory practices since their earliest days. For most of this century, nursing training was racially segregated and the South African Nursing Council members were all white. White nurses could not be employed under the control of Black nurses (p. 139). Until the late 1950s African nurses had little if any chance of promotion and their health hazards were inordinately high (p. 102). Salaries for Black nurses were officially lower than those for their white counterparts until 1986 but differentials persisted due to the operation of promotion and grading procedures (p. 174). In addition, Black nurses had to contend with racism in the wider society as well as that from their white superiors. African nurses had to carry passes at all times and faced the same risks of arrest under the pass laws, with the inevitable humiliating and brutal treatment from white police as any other African adult. Not surprisingly, Black nurses featured strongly in the struggle against apartheid from the 1940s.

From the late 1930s, nursing and teaching were virtually the only professions for Black women, as they were for Afrikaaner women until the 1960s. By the mid-1950s, African nurses and midwives were probably the largest single group of educated women in their communities and were very much part of their elite (Rispel and Schneider, 1990, p. 38; Marks, 1994, p. 158). Many engaged in good work for their communities, for example, raising money for creches and organising women's clubs (p. 159). Relationships with these communities, however, were complex and, at times, contradictory. During the same period there was a popular image of nurses as being cruel (Resha, 1991, p. 21) which has since persisted. Stories of the "bad nurse" are a recurrent theme in popular discourses, in newspapers, among doctors and administrators as well as the lay public (Marks, 1994, p. 196).

The history of the profession suggests that relationships with communities were strongly influenced by constructions of nurse identity which were promoted from entry into training. They had their roots in mid-Victorian educational theory and were also prevalent in British nursing of the late 19th and early 20th century (Rafferty, 1996, p. 40). Nurse training was regarded as a socialisation process, initiating students into a very particular ethos and entire way of life. From the early part of this century in South Africa, the training of black

*Apartheid racial classification designated South Africa's population to be White, Coloured, Indian or African. We use these categories in this article because although now the apartheid system has been dismantled, they so completely defined the population's social environment that they remain meaningful categories in defining dimensions of difference among South Africans. The term Black is used to refer to those designated as African, Indian and Coloured.

nurses was seen by the authorities as crucial for the struggle for hegemony in colonial society (p. 78). Marks writes (Marks, 1994, p. 208) "from the earliest days missionaries deliberately inculcated western values which served to distance African nurses from their communities, and create a new middle-class elite. Their education from mission school to nursing college was designed to give them a new identity, far removed from the ignorance and superstition, the barbarity and bestiality of native life. They were to moralise and save the sick and not simply nurse them". South African nurses were taught to see themselves as subordinate to doctors and authority figures in control of the lives of their patients (Marks, 1994, p. 209).

RECENT CHANGES IN NURSING

Since the 1994 elections there have been major changes in nursing and official racial discrimination has been removed. In November 1996, the South African Nursing Association dissolved and transferred its assets to the Democratic Nursing Organisation of South Africa (DENOSA), to form a unitary, non-racial nursing professional association. The South African Nursing Council still regulates nursing but its membership is now more representative of the general population of the country. Although legal discrimination has been removed, black nurses in the public sector still work in very difficult conditions. Hospital overcrowding and staff shortages persist in many parts of the country and most nurses still have to juggle the complex double burden of work and home lives and in addition have to contend with the increasing levels of violence in society. Violence in taxi routes, including the indiscriminate shooting of commuters, is an ever present problem for many nurses who lack private cars; criminal violence is pervasive, with very high rates of rape and murder; and in addition many nurses, as other South African women, have to contend with very high levels of domestic violence.

Setting

The research was undertaken in obstetric public health services in the Western Cape Province of South Africa (around Cape Town) in 1996–1997. At the time of the study obstetric care provision in this area was managed from two tertiary academic hospitals. The tertiary hospital, Grooteberg (all place and facility names are pseudonyms), from which most of the services in this study were managed organised care in its metropolitan catchment area in three tiers, with basic primary obstetric care provided in seven midwife-run units which had geographically-defined catchment areas. Referral of pregnant women with problems to the two secondary hospitals or tertiary care was based on clearly defined protocols, although women without complications who lived locally could also deliver in the secondary hospital.

The midwife units had no doctors on their staff but obstetricians from the secondary and tertiary hospitals would visit each one day a week to see women referred by the midwives to them. Some women with very serious medical complications would receive all their antenatal care at the tertiary hospital, but most women would commence antenatal care at a midwife unit and only go to hospital for investigations, if indicated, if they developed problems in labour or at 36 weeks if a need to deliver in hospital was anticipated. Two midwife units provided the setting for many of the interviews in this study, one was based in an African township (Kwazola), this was staffed almost exclusively by African staff. The second was located in a historically Coloured area (Sweet River) but included a large informal settlement which was predominantly the home to Africans in its catchment area. Its staff were mainly Coloured but some were white and African. Each midwife unit had one male midwife (who declined to be interviewed individually). The informants for this study were also recruited from a secondary and tertiary hospital in Cape Town and from a secondary hospital in a small town in the heart of the Cape wine lands (Groenedal), where all antenatal care was provided by doctors. The working conditions of the study settings were considerably better than most in the public sector in the country as the Western Cape is recognised as the province with the best resourced health services (Strategic Management Team, 1995, p. 15). Neither the staff facilities nor the working areas were squalid and the workload at the two midwife units was not immense. Kwazola had an average of 7.6 deliveries per day and at Sweet River the average was 4.4 (Jewkes *et al.*, 1997).

The health services in South Africa, like every other aspect of life in the country, were profoundly influenced by the oppressive, separate and unequal rule of apartheid. This has left its mark on the human geography of Cape Town, as the Group Areas Act specified where people of different population groups could live and this resulted roughly concentric bands of habitation radiating from "white" central points. These bands of habitation remain largely unchanged. The tertiary hospital lies in a band of residence which was historically white. Immediately surrounding this is an area which historically Coloured people lived in, further from the hospital. Sweet River midwife unit lies about 16 km from Grooteberg. Most Africans live in a third residential band, further still from the white area and Kwazola midwife unit was 26 km from Grooteberg.

Methods

The research was based on the use of ethnographic methods, including individual minimally structured in-depth interviews, non-participant ob-

servation and (focus) group discussions. The data was collected by the three authors (R. J., N. A. and Z. M.), using English, Afrikaans and Xhosa languages, respectively and the paper was written by R. J. Interviews and group discussions were audio-taped and transcribed and if necessary, translated into English. Participant observation in the clinics occurred on each occasion for several hours during the year when the authors attended to recruit and interview women and staff. N. A. and Z. M. would sit in the antenatal area amongst the pregnant women observing and chatting with them before approaching women and asking to interview them. Field notes were written after each visit. The data was analysed ethnographically. Ethical approval for the study was given by the Medical Research Council's Ethics Committee and the Ethics Committee of the tertiary hospital.

The staff informants in this study included midwives, enrolled nurses, family planning advisors, and general workers (who participated in a focus group), to protect anonymity of staff, all will be referred to as midwives or nurses, the terms being used for the most part interchangeable as South African bio-medical sector midwives are all registered nurses and almost all registered nurses now do a four-year course including six months of midwifery. Thirteen individual interviews were held with midwives (9), enrolled nurses (3) and a family planning advisor (1). Five worked at the tertiary hospital in the antenatal clinic and labour ward (two white and three Coloured); four worked at Sweet River midwife unit (all Coloured) and four at Kwazola midwife unit (all Xhosa-speaking Africans). One group discussion was held in the Kwazola unit with midwives, family planning advisors and general workers (cleaners) and two group discussions were held with midwives and enrolled nurses at Sweet River and Kwazola units to discuss a draft report based on the staff interviews. The group discussions included African and Coloured staff and both female and two male midwives.

The individual interviews with the staff focused on their perceptions of their working environment and problems which they encountered at work. They were undertaken using a brief aide-memoire to assist probing around problems and to facilitate inquiry about a range of areas in which problems could occur including study leave, relationships with other staff, educational talks and patient knowledge. The interviewees were substantially free to determine the content and emphasis of interviews. A technical report of these findings is available (Jewkes *et al.*, 1997).

Most of the pregnant women were recruited on their booking visit at Sweet River midwife unit (10), Kwazola unit (11) and Groenedal hospital (5). Four were recruited on first attendance at Seascape hospital, a secondary hospital which took referrals from Kwazola township. In addition one narrative group discussion was held with ten women living in Kwazola, nine had delivered at the local midwife unit and the tenth at another secondary hospital. These women were recruited through a women's health non-governmental organisation in Kwazola township. Two women were interviewed after unbooked deliveries at Kwazola. The women from Sweet River and Groenedal were Coloured and those from Kwazola and Seascape were Xhosa-speaking Africans. The women were chosen to include a range of age (17–40 yr), socio-economic status (formal housing to very poor), duration of time in an urban area (transient–long established), parity (0–7), complications (or otherwise) and stage in pregnancy at which they booked (including "unbooked"). Some were chosen after examination of their obstetric folder by the interviewer whilst others were approached after a period of observation in the waiting area as they appeared to be women who talked a lot or expressed interesting views. The interviews at Groenedal were undertaken in order to speak with some women who were currently living in rural settings. With the exception of the women in the group discussion, all the others were interviewed repeatedly through out their pregnancy and after delivery, giving between one and five interviews each, depending on the stage at which they were recruited. A total of 90 interviews were held in all with women. Two technical reports are available on the findings (Jewkes and Mvo, 1997; Abrahams and Jewkes, 1998).

All first interviews with pregnant women were held in the antenatal clinic. All the follow-up interviews took place at the homes of the women and each built upon the previous interview with the final interview occurring after the birth of the baby. The scope of inquiry for the interviews with the pregnant women included symptoms and problems which they were experiencing, how they had made to decisions to attend a health care provider, their experiences with and perceptions of the quality of care provided and knowledge and perceptions of pregnancy and use of lay medications. The follow up interviews were usually relaxed occasions, often with lunch or tea and a considerable amount of "baby talk" and breaks for breast feeding (by informants and one of the interviewers) interspersed the more focussed questioning.

After the reports of the study findings were written they were presented to meetings of senior medical and nursing staff in the services and administrators. The findings, interpretations of the data and recommendations were extensively discussed and many concrete plans have been put into place for implementing recommendations (see Jewkes *et al.*, 1998). In developing the arguments which are presented here, the discussions of those meetings have also been treated as data.

The focus of the project was on health seeking practices of pregnant women but a decision was

made to include interviews with staff as we were warned before the project started that should staff factors prove to be important, the staff would not be willing to accept the findings unless they had been interviewed. The finding was thus explained to patients as a study aimed at learning about their pregnancies, their health in pregnancy and what they do when they have problems and their experiences using formal health services. The abuse of patients by staff was not a theme of the initial aide memoires drawn up for patient or staff interviews and had not been anticipated when the study was planned. It is clearly a strength of minimally-structured interviewing that the unexpected can emerge as important and be explored in depth when it does. Data were collected by three interviewers. This has the advantage of removing the need to work with interpreters and provided valuable capacity development opportunities for the two junior researchers. The interviewers met and discussed their work regularly to ensure that ideas were shared. There were possible disadvantages as the personal interests, experience and skill of the interviewers influenced the interviewing but this also added diversity to the data in a positive sense.

Findings

"Inhuman nurses"

From the interviews it was apparent that the abuse of patients by nurses at the Kwazola midwife unit was a dominant feature of popular discourses of health care in the township. Most of the pregnant women expressed expectations that they would have problems delivering at there, in particular being shouted at, beaten or neglected. These were largely based on personal previous experience, or that of friends. Another manifestation of this discourse was the almost apologetic manner in which women "confessed" in interviews to having actually been "properly attended to" at the Unit. Such comments, made by several of the women, were usually prefaced by remarks such as "shame, I won't say bad things about them", which was quite different to the manner in which positive experiences with services elsewhere were described. In keeping with these expectations, the twin problems of abuse and neglect were dominant features of the narrative accounts of labour and delivery of many, although not all, of the women delivering at Kwazola. The women complained that midwives they encountered were "rude", "inhuman" and "not caring". They spoke to them as if "talking to a child" and remarked that "nobody showed any kindness".

Women reported difficulties with the Kwazola Unit from their first moment of contact. In contrast to the Sweet River Unit, where women attended at 8.00 a.m, for booking, at Kwazola, several who went at 5 a.m. were turned away. They were told by staff that they should be there at 3.00 or 3.30 a.m. in order to be sure of being accepted. The clinic only opened at 7 a.m. and had a quota of 30 new patients per day, which was sometimes reduced to 15. The booking system was an early source of confrontation between patients and midwives. South African townships are dangerous places where people do not out of choice travel during night. There is no public transport at night and distances to the Unit for many women were long. The very real dangers faced by pregnant women coming to book at 4 a.m. were demonstrated when one was raped on the way. In the light of this, some patients perceived the early hour of attendance to be a sign that the staff were being deliberately unreasonable or mocking them by making booking such an effort. This provoked resistance in many of the women. One described how she became "really annoyed" and started to "shout" at the staff when they suggested that she should try and sleep at a friend's house near the clinic. Some women responded by not attending again until they were in labour (or did not try to book at all because of the hour), whilst others tried to book in other parts of the city's obstetric service. Most of these efforts were ultimately counterproductive or futile as women only delayed confrontation with the staff, often after being sent back from other parts of the service. The methods of resistance used by patients ultimately failed to challenge the status quo of power relations in health settings and in this respect may have served to restore patients' senses of self-respect and personhood but did not succeed in changing the power relations in the services. Instead, the experiences of resistance for most women provided a chance for reflection on their ultimate vulnerability, as one explained: "we are supposed to accept it because that is beneficial to us... If a person can be cheeky to the nurses and go home (refusing to attend again), she would be digging her own grave not the nurses' ".

Once accepted for booking, several of the women complained about staff scolding and shouting at them in the antenatal clinic. Some were shouted at when they irritated the staff by "talking softly", moving slowly after being called to a room or going to a room after mistakenly thinking they had been called. Others were abused for their 'deviance', including pregnant teenagers or women who were "dirty". When asked whether the women told the staff not to shout at them, one responded "Haa! I did not!" and explained that they are afraid of them. The midwives were well aware that their patients were frightened of them. One explained how she had to tell them specifically not to share their urine as otherwise women would go to produce a sample, find themselves unable to pee and ask for some from another woman. In explaining this she said "they are so scared... may be they respect nurses too much". Only nursing informants,

however, suggested that notions of fear and respect were related.

The women's fear was accentuated by the apparently random nature of the abuse. At times, all the assembled antenatal patients were collectively scolded in an effort to deter those who might consider doing something wrong in future. For example, one woman said that a midwife came and shouted at all the patients one day, complaining that "they" were careless about their health and saying that "they" will all have still-born babies because "they" are stupid, like one who had given birth to a dead baby the previous week. "Their stupidity" was reported to be a particularly common feature of collective scoldings, these were used to emphasise to women the importance of patient education and "responsibility", but also had the effect of reinforcing messages about relations of power and knowledge in the midwife unit.

All but one of the women who delivered in the Kwazola midwife unit reported experiencing shouting, scolding, rudeness or sarcasm of some form which they found unpleasant or hurtful during their time there in labour or during delivery. Some were beaten or threatened with beatings and others were asked to do unreasonable things such as cleaning up the floor. Some of the women were spoken to harshly because they had broken the rules about delivery at the midwife unit, either by not booking, pushing before the midwife told them to, not bringing baby clothes and wash things with them, being about to deliver in the wrong place or delivering without a midwife. Other women were scolded because they tried to argue with the staff about whether they were actually in labour or generally irritated the staff by asking for attention or getting onto a bed (or not doing so) at the wrong times. Several patients also complained of harsh and accusatory things which midwives told them in an attempt to frighten them into compliance, in particular that they were "killing" their babies.

Many of examples of abuse could be interpreted as resulting from attempts to change practices of patients which could be dangerous to the woman and baby or irritating for the staff. Others were clearly punitive and sometimes ritualised. Women attending in labour without booking were routinely punished. A couple of women mentioned that the main reason why they were booking was that they feared being made to wait a long time before receiving attention when they attended in labour if they did not book. Two women, delivering in two different Units (in Kwazola and a Coloured township) reported this happening to them, which suggests that it was an accepted form of punishment/deterrent in the system more broadly. In addition, one of the women complained that when she cried in pain, after finally being attended to, the staff would shout: "(you) shouldn't bother (us) making noise because (you) didn't book". Teenagers were also routinely verbally abused, at Kwazola one reported a sister shouting that "she was not there when we were making love in the shack, so I shouldn't bother her (with my pains)!". Similarly at Sweet River there were reports of staff shouting at teenagers "you didn't shout like that when the men were on top of you".

Two women were slapped on the face as punishment. One woman described how she had gone to the toilet and could not get up on the bed when she got back, was hit by a midwife who found her squatting by a bed on the floor. The midwife refused to help her onto the bed and she had to wait until another came by. Another woman was slapped on the face after delivering on the floor. She had been told to fetch a sheet ("I'll slap you if you deliver on that sheet without a plastic cover") from a cupboard when the baby was apparently already emerging. After the delivery she was told "clean up your mess!" and to pick up the baby as the midwife said should would not "mess (her) hands" with him.

Women who questioned the midwives' knowledge, demanded attention or used initiative were also snapped at or ridiculed by staff. From the women's narratives, it appears that midwives became particularly irritated with patients who claimed to be in labour and did not accept being told they were not, repeatedly reported that they had pain or who asserted that they were ready to deliver. In these situations women were accused of "liking to bother" staff, of being "so irritating!" or simply told "I'm the one who admitted you, I don't think you are about to deliver yet". In these situations the women perceived that neglect and abuse were very closely linked, with the verbal abuse resulting from women's attempts to get attention or to take action in the face of inevitable delivery and the neglect itself being perceived by women as a form of abuse. For example, two teenagers delivered on their own with the help of other patients because they could not raise midwives who were sleeping and had said they did not think they were ready to deliver. After the babies were born the adolescents were also scolded, as were the women who helped them. Similarly, a woman who attended the midwife unit in labour when she was booked to deliver at the secondary hospital complained that the staff first refused to let her use the toilet (she had diarrhoea) and then refused to attend to her, insisting "She is not ours. We are not admitting her". During the argument which ensued between her, her husband and the midwife, she told them she was about to deliver but they just repeated that she should go to Seascape. She related "I simply climbed into bed...I ended up delivering on my own...They only came on hearing the baby cry". She was then scolded, ostensibly for delaying passing the afterbirth.

The women reported that neglect was the most distressing part of their experiences. They interpreted this as a sign that the staff did not care or were unprofessional. All but one of the women perceived that they were neglected by the midwives during pregnancy and, relatedly, five of fifteen who delivered Kwazola midwife unit did so on their own. In most cases patients complained of staff ignoring them when they complained of pains or when they said they felt they were about to deliver. Although some women described having been examined several times by staff before delivery, several complained that after being sent to the waiting ward "nobody comes to check you". Some women reported that on the night they were neglected the Unit was very busy, but their accounts indicated that the staff they tried to raise were sleeping or chatting amongst themselves. The narratives of other women suggest that some of the neglect was perceived but care was probably not outside the bounds of good practice. The perceptions often reflected anxieties and lack of knowledge of first time mothers and the impatience of a woman with labour pains. These problems were aggravated by the midwives' impatient attitudes and rudeness when women expressed concerns or asked for help. The women, in particular, complained of acts by staff which made them perceive that they were not their main concern. These included staff telling them to stop bothering them whilst talking to each other or because they were sleeping; a midwife remarking that a woman was delivering and telling her to wait whilst she goes to pass urine; a midwife taking a (she thought private) phone call in the middle of a delivery; and (in a previous pregnancy) staff expecting delivery to be delayed as they were watching TV.

Scolding at Sweet River and Groenedal

There were some similarities in the reports and interviewer's observations of staff practices towards patients at Sweet River and Groenedal, but there were also very noticeable differences. In both of these units deviant patients were routinely scolded and at Groenedal this was commonly done in a particularly loud voice so that all the waiting patients could hear and a woman's misdemeanours, detection and punishment could serve as an example to others. Teenagers were one of these groups and one Groenedal woman illustrated this when she described an incident between a particular sister and a pregnant teenager.

> Yes they (sisters) scold them (teenagers) really ugly. They ask funny things. They want to know...things that the people cannot answer. So these children remain quiet and look at them as if they are dumb. For example they would ask who is the father of this child, is he still at school, were you still at school when you got pregnant, does the child's father work, how much money do you have to raise this child, will this child be able to eat every day, can this child go to school one day and can he go to university one day and they (teenagers) just sit there. The nurses continue to talk and some of them (teenagers) sit with their heads facing the ground. Then she (the sister) lift their chins and say look at me, look at me, don't just stare into the ground, I am speaking to you...look at me, how do you look at a man, you know about lying with you bums open and now you can't even look at me.

One woman from Groenedal explained that she so much feared being scolded for poor diabetic control that she would pay to visit a private doctor before her antenatal appointment in an attempt to be able to defend herself if she was told off.

Unattended deliveries were few amongst these women, one from Groenedal delivered unattended as the nursing staff did not believe her when she said the baby was ready to be born. None of the Sweet River patients did and a striking difference between their narratives and those of Kwazola women were that they usually described reporting that they felt ready to deliver and the midwives immediately coming and helping them push the baby out. Two women at Sweet River reported being scolded in labour and both cases occurred when staff panicked as they unexpectedly discovered a woman was about to deliver. None of the women reported being slapped. Most of the women were very satisfied with their birthing.

At Groenedal, two of the five women were distressed and angered by being scolded in labour and a third woman described witnessing an episode in which another woman was humiliated after delivery. She described it as follows.

> There was another woman, her name is Cherilyn, she is a big woman, she is 34 yr and she is married already and that is her fourth child, so we met each other there that day...So when she was done they asked her where is your sanitary pad...so she said she does not have pads. So the sister said to her but you know you are finishing at this time and you also know that the hospital does not give you these things. Take that fucking pyjama of yours and tear it up and push it up there in you. I will not give you pads, you know from the paper that you got that you have to bring your own, did you not read the paper or can't you read? So she said to the sister she can't read and write because she did not go to school. Then the sister said yes you are all fucking stupid when you people had a chance to go to school you did not want to go. She just sat there and said nothing.

The narrator continued "with me they did not use my pads they used their own and mine were lying in the bag" so she went and gave the woman some of her pads, and advised her not to answer back but to "behave" herself as "if you are raw with them they will not help you".

Patients' explanations of their treatment

When discussing Kwazola without reference to particular incidents, the patients indicated that they perceived the abuse they received to be an inseparable part of the procedures and methods of working of the midwife unit. When discussing particular experiences, however, they perceived that these

depended on the staff on duty, some sisters were "nice", particularly the male midwives, and some were not. A 'rotten apple in the barrel' explanation. This was also the explanation given by the Sweet River and Groenedal women for their scolding. Commonly narratives of abuse or neglect concluded with rescue by a "nice" midwife who, for example, cleaned the floor or lifted the woman onto the bed. "Nice" sisters were said to explain or show women things; be caring towards the mother and baby, bathing them and cuddling the baby or expressing excitement about the birth; praise women for delivering well; and did not shout at or speak rudely to women. Several patients, however, indicated that nice sisters were often not nice all the time and in fact patients did not necessarily require them to be. In what perhaps reflects their very low expectations, some reported satisfaction after moderate abuse, so long as the motivation for this was explained. In one delivery which "went well", a woman described how the midwife was "shouting" and "pleading with me, because she didn't want me to be difficult...but after (the delivery) she became friendly".

Midwives' perspectives on their attitudes and practices

Many of the problems in relationships with staff, which patients discussed, were also prominent themes in the interviews with midwives. In the latter case, they took the form of justifications for unpopular practices, complaints about colleagues or explanations about the difficulties of working with the general public. Discussing their colleagues' problems, staff also attributed them to a 'rotten apple' explanation. When focusing on their own actions, many asserted that they were motivated by concerns about the baby, attempts to teach women proper practices or by attempts to manage competing concerns in their lives, for example not wanting to "die" a midwife and so studying long hours whilst working. Examination of the specific situations in which patients encountered abuse made visible a complex interplay of factors which provided part of the broader context. These included organisational issues; professional concerns, including perceptions that staff were themselves abused by patients; perceived needs to assert control over the environment and patients; social sanctioning of coercive strategies including punitive actions; and, an underpinning ideology of patient ignorance and inferiority. There may well have been others, for example, of a political economic nature, but these did not surface in the interviews.

Exploration of reasons for the Kwazola booking system provides an illustration of the way in which a multiplicity of factors interact to sustain a practice which patients found inhumane. The staff described two reasons why the system was necessary. First, the quota protected the clinic from being swamped. This fear, ironically, was probably caused by the system which required all women receiving antenatal care on a particular day to attend at the same hour. The clinic's routine statistics did not support the staff's perceptions of demand as on average only 23 (not 30) women were booked daily and there were only 7.6 deliveries (Jewkes *et al.*, 1997, p. 23). Another explanation related to the organisation of blood testing. The blood specimens were taken to the tertiary hospital for testing each day at 8.30 a.m. and the patients were detained in the clinic until the results came back. This problem should not have been insurmountable as the Day Hospital next door to the Unit had a lab where syphilis tests could be done at any time. Sweet River unit stopped having a quota during the course of the study and did not give same-day results.

Neither of these explanations satisfactorily account for the failure of staff at the Unit to identify the booking system as a major problem and attempt to solve it. Staff in other parts of the service who strongly indicated in their interviews that they found the Kwazola system an embarrassment. Other considerations may therefore have also been important. The quota also served the purpose of ensuring that the main work of the clinic was over by late morning or lunch time, whilst the staff were employed until 4.30 p.m. It enabled the staff to impose order on their work place: to have lunch, document the day, tidy the clinic and prepare linen and specimen bottles for the next day. The success of their attempts to impose control were attested to by one sister who described working in the clinic as "retirement", compared with labour ward. A further dimension of the quota was revealed through the midwives' descriptions of unbooked mothers. They were characterised as "lazy" to book or "not wanting" to get up early, which in itself was deserving of scolding. The manner in which some midwives said this suggested that, in a perverse way, they quite liked the quota system as women's willingness to rise early to attend at 4.00 am was a demonstration of the value of the service they provided. It also served as a useful introduction to staff patient power relations within the midwife unit.

Professional concerns

Many of the nursing staff members at Kwazola revealed that considerable feelings of insecurity related to their clinical roles and the difficulties of performing these without what they perceived as adequate support. They also perceived that their professional status was undermined by their patients who, rather than respecting their position, abused them. These complaints were scarcely voiced at Sweet River and so this difference between the units may provide part of the explanation of the poorer relationships at Kwazola.

The staff perceived that they were working in a clinical environment in which poor clinical outcomes were inevitable as they were overworked, patients often attended very late and emergency services, particularly the ambulance and flying squad, could not be relied on. They perceived that they were often unfairly blamed when problems arose and that this eroded morale and general work satisfaction. There were indications in the study that work load at Kwazola was heavier than at Sweet River and that the task midwives faced may have been more difficult. Crude indicators of staffing levels and activity (numbers booking, delivering and admitted) suggested that Sweet River had 20% more professional staff than Kwazola and twice as many nursing assistants per delivery (Jewkes *et al.*, 1997). In addition, Sweet River referred more patients to secondary and tertiary levels and received more on-site support from doctors than Kwazola. Given the more socio-economically and educationally advantaged population, it is unlikely that these were because of higher levels of complications, rather easier access. The Sweet River unit was commonly visited by medical students and, in another indication of its privileged status, a policy was introduced after the data collection ended to give all women booking before 22 weeks ultrasound scans.

Part of the vulnerability of Kwazola midwives stemmed from the inherently unpredictable nature of birthing, complications can rapidly develop during an apparently normal pregnancy or birth and this was a particular concern being so far from the nearest hospital with an unreliable ambulance service. This may have been a factor underlying the preoccupation in the Kwazola midwife interviews with controlling the workplace and patients. The midwives' notions of control, however, were linked to ideas about the exercise of power in their working environment more broadly, which at times were neither within the boundaries of good patient care nor primarily motivated by this. For example, in the dismissal of women's reports that they were ready to deliver on the grounds that the staff had predicted a later time on the basis of an earlier vaginal examination or requests that deliveries should be delayed until after a phone call and television programme.

Many of the Kwazola staff expressed perceptions that they were themselves subject to abuse from patients, they perceived that they were vulnerable to this by virtue of their professional position and that it was particularly unjust as they perceived that they deserved respect because of this. They used these perceptions to justify some of their actions towards patients. Kwazola staff complained that women had unrealistic expectations of the Units and would become angry and abusive when these were not met either through their lack of understanding of the patho-physiology of pregnancy or their own contribution. As one exclaimed "they don't want to book, they come here with babies between their legs and they expect good results". They complained that patients lied to them, particularly about why they had not booked, and that they did not show respect but were "cheeky". In most cases such actions generated further conflict. Staff were particularly threatened by collective acts of resistance, in particular, patients using the protective patient space of the antenatal waiting area to generate collective transcripts of their experiences (cf. Scott, 1990). At times, they would shout out the name of a midwife who they identified as particularly rude so that passing colleagues and all the assembled patients could hear. The form of resistance which staff complained about most bitterly, however, was hostility manifested towards nurses in the community. One described how she felt watched where ever she went in nurses uniform. She explained that on public transport, if a nurse in uniform joined the taxi or train the conversation amongst the passengers would immediately change to talk about how terrible the hospital was. She complained "they don't care about us...the community is having a bad attitude towards nurses".

The staff at Sweet River did not express perceptions of being rejected by or locked in battle with their community, although they described occasional instances of abusive, usually drunk, patients and relatives. The interviews suggested that they were much more in control of their working environment than the Kwazola staff, partly because they listened to patients when they reported problems or being about to deliver. Another factor was that their patients had a substantially higher level of understanding of bio-medical language and ideas which made communication with them easier. It also resulted in patients more strongly perceiving that they needed care from the midwives. The Sweet River midwives were therefore more highly regarded and respected by their patients than the Kwazola midwives and the higher levels of overall satisfaction with care reinforced this leading to yet higher levels of respect.

Social sanctioning of abuse

Some of the Kwazola midwives' strategies for enhancing or enforcing control (or trying to ensure it next time), which included giving patients a "mouthful" or beating them, were in their nature abusive although staff did not always perceive them as such. The boundaries between control and punishment were often blurred. At both midwife units, midwives explained that several groups of patients were regularly scolded; these included women who came in labour to the midwife unit when they were high risk and booked to deliver in a hospital, unbooked patients and those whose babies were born before arrival (as they were told when they booked not to let this happen). One midwife

explained how, in the face of perceived insubordination, she would slap a patient on her thighs during labour, "when you are conducting a delivery and you tell your patient to do this she does the opposite and when you say the patient must push, she must push and when you say okey don't push breathe in and out (she must breathe in and out)...I say pant she will just push, if I say push, she just breathes in and out...those are the things that make one to be **furious**" (my emphasis) and as a result you may "incidentally slap your patient on the thigh".

The use of such strategies to gain compliance and control patients were legitimated through a notional contract which staff perceived to govern their work: they were expected to provide the necessary care for the delivery of a healthy baby and in return pregnant women were expected to adopt practices prescribed by the staff (the ground rules). Compliance on the patients' part was not viewed by staff as being entirely voluntary and staff regarded themselves as entitled and even obliged to use various strategies to gain compliance. Apportionment of blame if problems arose was closely linked to compliance with the contract and in Kwazola midwife unit a failure on the part of patients to comply led to some midwives either perceiving that they were no longer bound to give care, so they could leave an unbooked woman to deliver on her own in the corridor or toilet, or that they could use coercive strategies to enforce compliance. It was not interpreted thus at Sweet River but breach could lead to scolding. One Sweet River midwife explained that the terms of the contract were set out to each morning at educational talks i.e. lectures given to the assembled ranks of pregnant women in the waiting area in antenatal clinics. She explained the purpose was "to lay down the ground rules – what to expect and which is expected of them...we provide the service, they must bring the accessories". None of the patients indicated that they had any idea of such rules governing their care.

Although some staff asserted in interviews that it was only some of their colleagues who abused patients, those with "personality" problems, the findings suggest that there was widespread sanctioning of the use of abusive strategies in the obstetric service. One manifestation of this was the willingness of staff to discuss, whilst being tape-recorded, situations in which they were rude to or slapped patients, without any suggestion that they perceived their actions to be wrong or that they feared action being taken against them in any form. Another was the ritualised nature of much of the abuse, in particular the set piece treatments of certain categories of patients at different Units and enduring nature of the Kwazola booking system. Perhaps the clearest indication though was visible in one of the meetings held to discuss the study reports when a senior nurse asserted that she did not think that there was a midwife in the service who had never slapped a patient in labour. She continued to assert that it was a misrepresentation to describe this as "beating" (the patients' word) as, she explained, one would "cup one's hand and slap the thigh" and she proceeded to demonstrate this with gestures.

The importance of the sanctioning of abusive strategies in their perpetuation was possibly also illustrated by the much lower levels of abuse reported at Sweet River. Another difference between the two Units was that some Sweet River staff had been sent on conflict management courses. This was a euphemism for attitude change or the locally popular (if Orwellian-sounding) notion of values clarification, where, one explained, they had been taught not to "judge" patients for being "dirty" without first knowing their home circumstances. Although these courses were said not to be terribly successful, sending staff on them signals non-acceptance of certain forms of behaviour which was important. One of the patients reported that she had been told that the staff were "not allowed to shout at women any more" in the Unit. There was a perception here that abusing patients was wrong and one of the midwives, who by her own admission gave patients a mouthful frequently, was particularly vocal in her descriptions of her efforts to correct her colleagues.

Ideology of inferiority

The forms of abuse described in this article were made possible by ideologies of patient inferiority which pervaded the services, but were most strongly found at Kwazola, with patient virtue being described in terms of the degree of their acquiescence to prevailing power relations. Patient inferiority was chiefly expressed in terms of their "ignorance" or "illiteracy", but some patients were also said to be "dirty", "cheeky", "unmotivated", "lying", "irresponsible", "very obstreperous", "rude", "hostile" and "abusive". "Good" patients were only described by one midwife as being more educated and even she qualified that by adding that sometimes middle class patients could be even more of a problem than less educated ones. In general, "good" patients were humble i.e. they accepted the midwives' version of power relations within the unit.

That "ignorance" was part of nurses constructions of the inherent nature of patients (and by contrast "knowledge" part of being a nurse) was indicated both by the nature and focus of patient education at Kwazola and the distain or, at times, threat with which midwives regarded incidents in which patients asserted their knowledge (see above). Patient education at Kwazola chiefly took the form of educational talks which were delivered in the form of a lecture to booking mothers each morning. Staff perceived the educational talks to be part of a broader process of social engineering which included moral upliftment of patients. As one mid-

wife described it ''making patients from Ciskei and Transkei (rural areas) to be Cape Townian'' or ''making them responsible''. The content was overwhelmingly concerned with the danger signs of pregnancy, to which women should respond by consulting the Unit, and the minor signs which should be tolerated. Some information was also usually given on STDs, family planning and breastfeeding. The women complained frequently about not being told when they were due to deliver, how the baby was getting on, anything about their test results (unless they were positive) or what was expected from them and what would happen to them in labour. The content of health information given to women in antenatal clinics was essentially determined by midwives' perceptions of what is necessary for women to know in order for them to become an extension of the midwives' surveillance system (much as in hospitals nurses perform this function for doctors cf. Armstrong, 1983) as opposed to a notion of patient empowerment. It was notable that at Sweet River midwife unit the staff had a much more relaxed attitude towards information, they promoted a pregnancy book and provided much more one-to-one information during patient contact moments. Their patients also had a higher initial level of bio-medical knowledge and used bio-medical terms with meaning similar to those of clinical staff. Staff at Kwazola also had an ambiguous attitude towards patient attempts to use the information they were given and there were many complaints of sarcasm and ridicule when patients attended the unit claiming to be in labour or bleeding when staff did not think they were.

Perceptions were widely expressed at both midwife units that much of the educational efforts were unsuccessful, that patients resisted their best efforts to be educated. There were some difficulties at Kwazola, staff reported that many women slept through the talks after the exertion of rising early. This had the twin effect of rendering part of the task unrewarding and more difficult, especially as levels of knowledge amongst first time mothers were low. It was notable, however, that patients perceived their levels of knowledge after the educational talks to be much higher than the staff did, because the staff were preoccupied with patients' difficulties in accurately reciting the danger signs whilst patients valued the general messages about possible problems and the information that if the unexpected occurred they should report to the midwife unit. This suggests that some of the midwives' dissatisfactions related to their underestimation of the extent of patient knowledge and dismissal of any value in women's processes of reinterpretation of received information. This is perhaps both an inevitable product of and serves to reinforce perceptions of the correctness of ideologies of patient ignorance and inferiority.

The midwife units, like the whole nursing service in South Africa were dominated by rigid staff hierarchies about which some complained. The staff grades ranged from family planning advisors, who initially have only one month training, through enrolled nurses with a two year course to the four year trained midwives. Hierarchies existed between ranks and within a rank according to the year training started. There was a suggestion that some staff at the bottom of the nursing hierarchy had harsher attitudes towards patients, at Sweet River, two staff who were identified as being particular problematic were not registered midwives and a group discussion at Kwazola, in which several different grades of staff participated, less trained grades (but not domestic workers) were most vehement in their assertions of the patients' illiteracy and irresponsibility. This may suggest that staff in lower grades perceived their status to be more vulnerable due to the lesser educational distance between them and their patients and so were more likely to deploy violence as a strategy for emphasising distance between themselves and the patients. At both the units, however, scolding and abuse were attributed by patients and nursing informants to registered staff and, indeed, some of the more senior registered staff. There was apparently no simple relationship between grade and attitudes.

Discussion

This study has shown that patients using parts of the Cape Town obstetric service experience verbal abuse in the form of scoldings, being shouted at and general rudeness; that nurses do not respect patients in general, and their autonomy, in particular; and that many experience arbitrary acts of unkindness, physical violence or neglect. Researchers have found similar types of abuse in health settings in several other South African provinces. In particular, the rudeness to patients (Mathai, 1997; Wood *et al*., 1997), talking to them as if they were children (Mathai, 1997) scolding of deviant groups, notably sexually active teenagers (Mathai, 1997; Stadler, 1997; Wood *et al*., 1997) and clinical neglect, for example giving adolescents contraception but not explanations of how to use it (despite satisfactory levels of staff knowledge) because they were said to be at the wrong clinic (Wood *et al*., 1997). Although patients and midwives in Cape Town prefer a few 'rotten apples in the barrel' explanation for the abuse, the findings suggest that much of it was ritualised and influenced by organisational issues, professional concerns, perceived needs to control the environment and patients, sanctioning of coercive strategies and punishment, and an underpinning ideology of patient inferiority.

Internationally many of the papers which describe abuse and neglect of patients by staff suggest that much of the problem lies in structural

issues (TDR/GEN/95.2, 1995) including salaries, conditions of service (Gilson *et al.*, 1994, p. 779) and shortage of staff and equipment (Sargent, 1989; Sargent and Bascope, 1996). Such perceptions have also been expressed in South Africa, for example Oskowitz *et al.* (1997, p. vi) articulated this as the need for staff to feel supported and cared for themselves. Indeed, part of the explanation for the failure of South African nursing management to take action over nurses' abuse of patients has been guilt over working conditions. For example, Marks (1994, p. 177) cites a report of a Natal nursing inspector who, mindful of the under-resourced, under-staffed, overcrowded hospitals and poor facilities for staff, asserted that "under existing conditions it is idle and utterly unjust to complain of lack of deportment, courtesy and sense of responsibility among the non-European nurses" (KE 2/5/2 Nursing Inspection Record, 25–28 April 1972). Given the political legacy of South Africa, many would hesitate before embarking on a course of action which might be perceived as undermining, or even attacking, a profession of predominantly black women. The findings of this study, however, clearly show that the people who are recipients of nurses' degrading treatment, black (usually women) patients who are often considerably more disempowered than the nurses, and strongly suggest that nurses attitudes and practices cannot solely be attributed to or excused by their working environment.

Both Sargent (1989) and Gilson *et al.* (1994) hint at the importance of other factors. Gilson *et al.* (1994), writing about Tanzania, emphasised the lack of local accountability of staff and services and suggested that this might be related to the treatment of patients in important ways. Sargent (1989) noted that elite and peasant patients in Benin were treated distinctly differently by the same overworked midwives in the same services. These findings, and those of this study, which was undertaken in a relatively privileged part of the South African services, support a hypothesis that structural and historical issues, which are often difficult to remedy, may merely be part of the explanation for or even just accentuate problems which have other roots. These may perhaps lie in constructions of nursing identity which emphasise notions of moral and intellectual superiority and the failure of nursing leaders to impose a system of ethics on the profession which precludes abuse of patients.

Why do nurses abuse patients?

The deeper roots of the problems in nurse–patient relationships are further supported by the family resemblances between features of the treatment of patients in British hospitals described medical sociological literature and that in literature from developing countries. Moral evaluation of patients has been described by many authors (for example, Murcott (1981); Jeffery (1984)), as regular features of British medical settings and has been reported in obstetric contexts in a study of parts of the Welsh midwifery services (Hunt and Symonds, 1995). The devaluing, or dismissal, of patient knowledge appears to be an almost universal feature of obstetrics and nurse–midwifery, as well as possibly generally in bio-medical systems. Hunt and Symonds (1995, p. 93), remarked about it in their study and there is now an extensive literature on authoritative knowledge in child birth, describing the hegemony of knowledge of doctors and nurse–midwives (for example Jordan, 1993; Sargent and Bascope, 1996). Similarly, Jeffery (1984), p. 254, described the use of punishment by staff for "rubbish" patients attending casualty departments in Britain, including being making them wait longer than other patients before being treated, being verbally hostile, or rigorously restraining them. The beating of women in labour was also an occasional feature of midwifery in at least one London teaching hospital in the 1970s (L. Edwards: personal communication). The treatment of patients by midwives in South Africa, appears as an accentuation of the ways in which patients have been and are treated by both nurses and doctors in the United Kingdom.

Nurse–patient relationships in Britain are perceived as amenable to change and there have been deliberate attempts to change them in recent years. These followed the identification by nursing academics, senior nurses and the professional leadership in Britain of relationships between nurses and patients as central to providing quality nursing care (Pearson, 1988, Ersser and Tutton, 1991). The efforts involved a move away from a model in which nurses were encouraged to maintain an emotional distance for patients (Menzies, 1970, Hockey, 1976) and where work was task-oriented and fragmented towards one where closeness and continuity of care were emphasised. The movement which has been dubbed new nursing (Savage, 1995) has as a central thrust the redefinition of caring to include caring for and caring about patients (Savage, 1995, p. 51). The importance of being non-judgmental was heavily stressed in this process. The experiences in Britain suggest that many of the problems in nurse–patient relationships stem from constructions of nurse identity formed and propagated by the profession through its institutions.

The findings of the study indicate that problems in nurse-patient relationships in South Africa are also related to the absence of sanctions against staff who abuse patients. Although processes for these existed, senior managers said that they could only act if specific complaints were made by patients. This study has shown that patient resistance takes different forms, but formal or informal complaints are rarely one of them as patients fear victimisation. In the absence of effective action being taken against staff who abuse patients, it is not surprising

that many nurses have come to view their practices as normal. Since the problems are widespread, have been reported over many years and there is little evidence of efforts to address them, nurses could not be blamed for assuming that their practices receive at least an element of support from nursing management and higher echelons of profession. This suggests that there is a broader need to change the prevailing constructions of acceptable staff-patient interactions and for service management to play a leading role in this and back it up with action locally and through the Nursing Council against nurses who abuse patients.

The study also found that for a variety of reasons the midwives perceived their position and identities to be insecure. South African nurses' assertions of their identity as middle class professionals have been influenced by broader political factors and forces operating at a community and clinic level. These have particularly rendered fragile nurses' claims to be a middle class profession. The apartheid system characterised black nurses first and foremost as Coloureds or Africans, i.e. second or third class people, and this racial classification was far more important in shaping their daily lives than status achievable through class. Claims to privileged class status have been equally hard to realise at work as black nurses have faced very poor working conditions, long and inflexible hours, low pay, poor staff facilities, shortages of drugs and equipment and oppression of lower ranks with the nursing hierarchy. Patient resistance has also continuously undermined nurses' claims to status. In particular, their ambiguous views on the benefits of the services nurses provide, disregarding of health education, undermining of nurses rituals of power through multiple small acts of insubordination, and actions of communities in isolating nurses rather than awarding them the respect which they perceive they deserve.

Nurses are thus engaged in an unremitting struggle to claim a status and respect as a middle class profession within environments in which political, professional, historical and personal factors continuously undermine this claim. Nurses at a clinic level thus become embroiled in continuous struggles to assert a middle class identity through continuous striving to create social distance from patients. In this struggle, uniform and insignia (epaulettes), verbal assertions of distance, displays of lack of compassion and ultimately physical violence are all deployed.

H. Moore (1994), writing about gender violence, argues that experience of identity is bound up with experiences of power and challenges to the exercise of power or its effects in terms of status, strategies and interests are perceived as threats to identity (and vice versa). She argues that violence occurs when self-representations and social evaluations of oneself are threatened by the behaviour of others, although often the threat is perceived rather than real. An inability to maintain the fantasy of power triggers a crisis of identity and violence is a means of resolving this crisis because it acts to reconfirm the nature of powerfulness otherwise denied. Moore argues that violence should not be seen as a breakdown of (social) order but as a sign of struggle for the maintenance of certain fantasies of identity and power. Although there are obvious differences between violence in intimate relationships and in nurse-patient relationships, our data suggest that this theory may be useful in explaining the relationship between nurses vulnerability and abuse of patients.

In South African nursing, verbal abuse, neglect and violence become weapons used by nurses in the course of struggles to assert identities which have roots in ideas shared through the nursing profession internationally. The deployment of violence has become commonplace because of the lack of local accountability of services and lack of action taken by managers and higher levels of the profession against nurses who abuse patients. It has become established as normal also because of a lack of powerful competing ideologies of patient care and nursing ethics.

Improving staff–patient relationships

The problem of poor nurse–patient relationships is clearly a complex one and multiple solutions are required. The findings of this study and their analysis provide some pointers towards these, but considerable further research into the nature of the problem and process of change is required. Undoubtedly the first step in South Africa, and internationally, is for the leaders of the nursing profession to acknowledge that there is a problem and to embrace processes to further investigate this and seek solutions including deliberations on constructions of nurse identity and their implications.

Notions of nurses superiority to patients and obligations to morally judge and correct them are undoubtedly derived from the institutions of the nursing profession, including the nursing bodies and their officers, Colleges of Nursing and university Nursing Departments, content of nursing education and socialisation on wards and in health facilities. Change will therefore need to involve all these levels, in particular opinion leaders in the profession and trainers of future generations of nurses. Although changing ideologies which have been central to constructions of nursing identity for over a century does not happen overnight, a process of critical examination, reflection, curriculum revision and open debate must be started. Similarly debate about nursing roles, particularly with respect to caring need to be stimulated and models of good practice and change developed. These debates need to be conducted in lay as well as professional arenas

so that an imperative for change can be sustained by voices outside the profession.

The nursing profession in South Africa is governed by a set of professional ethics. The findings of this study suggest that the formulation, interpretation, dissemination and enforcement of these need to be revisited to consider the extent to which they provide adequate protection for patients against abuses of the powers of nurses. Critical areas for consideration are notions of patient autonomy and dominant ideas within the profession that nurses have a right and duty to control patients, bodily and spiritually, and impose conformity upon them. Ironically, enhancing ideas of patient autonomy would have the effect of increasing distance between staff and patients, for which nurses strive. The code of ethics needs to be enforced through disciplinary procedures so that nurses are under no illusions that abuse of patients is sanctioned by higher authorities.

Although much of the abuse of patients was ritualised, there were also many examples of conflict arising over misunderstandings related to patient lack of information. One of the problems this study found was that nurses health education was very limited in scope, often ineffectually delivered and that this was a problem recognised by nurses. Patients also were not familiarised with the routines of the clinic and delivery areas and breaches of these were important sources of conflict. Revision of the scope of patient information, of educational methods and improvements in nurses communication skills would considerably assist in reducing levels of tension. The introduction of medical anthropology into nursing curriculae may assist nurses in understanding the relationship between lay and bio-medical knowledge and developing a greater respect for lay knowledge.

Workshop interventions may be useful in changing attitudes of staff who are currently practising. The World Health Organisation's Special Programme for Research and Training in Tropical Diseases (TDR) has recently funded the development and testing of a workshop manual entitled Health Workers for Change designed for use amongst nursing staff in developing countries (TDR/GEN/95.2, 1995). Initial evaluation of the manual in several developing countries has proved positive (S. Fonn, personal communication), however, our findings suggest that it will only be really effective as part of an intervention strategy which involves the whole nursing system.

To be really effective, these changes need to proceed side by side with improvements in working conditions and democratisation of nursing. In particular the leaders of the profession need to send clear messages to the lower ranks that they care about them.

Conclusion

This study has shown that contrary to popular nursing discourses of the caring profession, nurse–patient relationships in parts of the South Africa public health services are at times characterised by conflict, clinical neglect, verbal and physical abuse. Although the nursing profession is undoubtedly grappling with the legacy of apartheid which has had a major impact on the lives of black nurses and the profession as a whole, it is not sufficient to explain the attitudes of staff in terms of poor working and living conditions. Even in one of the best resourced parts of the country such attitudes prevail and disempowered black women patients are the subject to rituals of abuse during the course of seeking obstetric care. The findings suggest that nurses deploy violence against patients as a means of creating social distance and maintaining fantasies of identity and power. The research has demonstrated that the origins of the problems are complex and partly lie in poor conditions within the workplace which may be hard to change in the current economic climate, but they are also influenced by constructions of professional identity which may be amenable to change by the nursing leadership. The deployment of violence has become commonplace because of the lack of local accountability of services and lack of action taken by managers and higher levels of the profession against nurses who abuse patients. It has also been able to become established as normal in nursing practice because of a lack of powerful competing ideologies of patient care and nursing ethics. All these factors should be amenable to change.

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