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Pathways to Inhumane Care: Masculinity and Violence in a South African Emergency Unit.

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Abstract

Inhumane treatment of patients by health care providers is reported around the world. A range of explanations has been proposed, indicating the complexity of the multiple factors involved. This article reports on an ethnographic study conducted in a South African public sector emergency unit, exploring the possible contribution of hegemonic discourses of masculinity to delivery of inhumane care in this context. Using ethnographic methods, including participant observation, interviews, audio-recordings of verbal interaction, and narrative analysis, the study on which this article reports explored the discursive practices surrounding incidents of abuse. The article argues that the pressure doctors experience to display strong masculine identities and simultaneous feelings of powerlessness in the face of material realities generates the potential for inhumane acts. It concludes that understanding the metaphors through which doctors interpret their experiences is important both to comprehending and subverting the forces that drive inhumane care.

Keywords

inhumane care, violence, medical culture, masculinity, hospital ethnography, emergency medicine, South Africa

Introduction

Humane care, here defined as care that is delivered respectfully and in a manner that upholds patients' rights, has acquired the status of a "taken-for-granted concept" (Brittis, 2011, p. 25)—a quality natural to caregiving, and not something that needs to be taught, nurtured, and reinforced. Evidence suggests, however, that delivery of health care around the globe is often far from humane (D'Oliveira, Diniz, & Schraiber, 2002; Reader & Gillespie, 2013; Swahnberg, Thapar-Björkert, & Berterö, 2007). In South Africa, routinely abusive practices continue to be reported within its public sector facilities. Incidents of abuse include lack of interest, empathy, and respect; failure to provide patients with important information; as well as verbal violence, neglect, and denial of care (Chadwick, 2014; Chadwick, Cooper, & Harries, 2014; Coetzee, 2013; Crush & Tawodzera, 2014; Goudge, Gilson, Russell, Gumede, & Mills, 2009; Joyner, Shefer, & Smit, 2014; Keikelame & Swartz, 2016; Kilian, 2013; Kruger & Schoombee, 2010; Lewin & Green, 2009; Mthembu, Essack, & Strode, 2011; Vivian, Naidu, Keikelame, & Irlam, 2011).

A few qualitative studies have generated in-depth understandings of the contexts within which health care is delivered in South Africa, and thus within which these practices occur (Gaede & Gaede, 2016; Lewin & Green, 2009), and a number of explanations have emerged. Structural conditions, including poor working conditions and inadequate staff and resources, inevitably play their part (Pires, d'Oliveira, Diniz, & Schraiber, 2002). However, it has also been suggested that these factors are important not so much in themselves, but in the conditions they engender, producing exhaustion and diminished capacity for empathy (Ojedokun, Idemudia, & Kute, 2013; Reader, Gillespie, & Minnelli, 2014). With reference to South African public sector services, Jewkes, Abrahams, and Mvo (1998) argue that structural conditions encourage lack of accountability (Jewkes et al., 1998), at the same time enhancing the difficulty of ethical decisions (Baldwin-Ragaven, de Gruchy, & London, 1999; Gibson, 2004). For example, medical staff in the South African public sector struggle to make decisions with life or death consequences in the face of resource shortages such as too few beds and other essential inputs (Gibson, 2004). Overwhelming patient need and inadequate resources mean that doctors have to make decisions about who should receive optimal care, based on such factors as prognosis and patients' history of

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compliance to health regimens. Although the right to health care is enshrined in South Africa's Constitution, the system struggles to meet this ideal. Instead, doctors work in the space between policy, legislation, and guidelines and the realities of an underresourced, overburdened system. Sometimes this involves using their discretion to compensate for system inadequacies. But at other times, they perpetuate these, for example, by using their discretion to reduce their own workloads at the expense of offering acceptable care (Gaede & Gaede, 2016). Joyner et al. (2014) argue that the biomedical and neoliberal discourses prominent in South African health care institutions render them "uncaring institutions," which diminish rather than support providers' capacity to deliver care. Others suggest the importance of symbolic and relational factors, including system values, providers' personal values, emotions, and beliefs (Gaede, Mahlobo, Shabalala, Moloi, & van Deventer, 2006) and social norms (Lucas & Stevenson, 2005). Kruger and Schoombee (2010) argue that abuse of birthing women by nurses is related to power and control. And Jewkes and Penn-Kekana (2015) suggest that professionals who treat women badly in maternity services tend to be those who are themselves poorly paid, disempowered, and subject to abuse. Their own abusive behavior may thus represent a means of compensating for their lack of power in other aspects of their lives.

Masculinity in Medical Culture

While this body of work remains in the early stages of its development, it seems from the emerging explanations that there is an array of complex, multifaceted, and interrelated contributory factors in delivery of inhumane care. Among these, the dominance of traditionally masculine ideals in medical culture is described by a number of authors internationally (Cassell, 1987; Fisher & Groce, 1990; Good & DelVecchio Good, 1993; Hahn, 1985; Heru, 2005; Millman, 1977; Mizrahi, 1986; Wicks, 1998). Those authors writing in this area draw attention to discrimination against women in medical education and practice (Wildschut & Gouws, 2013), and to the male-gendered nature of medical professional values (Fisher & Groce, 1990; Good & DelVecchio Good, 1993; Hahn, 1985; Heru, 2005; Millman, 1977; Mizrahi, 1986; Wicks, 1998). For example, Fisher and Groce argue that strength and status are associated in medical culture with masculinity, and weakness and lack of status with femininity. Erickson (1999) describes "medical machismo," in terms of which "real doctors" are expected to adopt the identity of a "lone ranger." Cassell (1987) describes surgeons' portrayal of themselves as needing "balls" to do their jobs and as "invulnerable, untiring, unafraid of death and disaster" (p. 173). In this context, worthwhile activity and success are defined in terms of dramatic action (Erickson, 1999; Millman, 1977) and actions that fail to produce immediate and tangible results are equated with "doing nothing" (Good & DelVecchio Good, 1993; Hahn, 1985).

A few authors explore the relationship between traditional masculine ideals and the potential for inhumane care, focusing principally on the prevalence of the military metaphor in medical culture. Cassell (1987) quotes surgeons describing their occupation as a "brutal" game and having "to approach an operation like a battle" (p. 174). Others show how this metaphor affects medical students' and doctors' understandings of their identities and purposes, and of the means available to them for achieving these. Mizrahi (1986), for example, argues that medical students describe their experiences in terms applicable to combat, promoting a mode of behavior more suited to the battlefield than to caring for sick people. Within this combative context, Mizrahi shows how patients become the ultimate enemy, frequently described in medical talk using words that connote violence and military action.

In South Africa specifically, Wildschut and Gouws (2013) explore the construction of gender in the South African medical profession and its impact on quality of care. These authors highlight representations of the ideal doctor as necessarily male, arguing that all doctors are judged according to this ideal, and all those not possessing the characteristics associated with it are deemed less valuable to the profession. Women participants in their study reported that, to be successful, they felt they had to become like men, this including an expectation that they should demonstrate toughness, technical skill, and efficiency, as opposed to empathy or caring behaviors.

The Aim of This Article

From the numerous intertwined contributors to the provision of inhumane health care, it is this thread, namely, the possible influence of masculine discourses in medical culture on doctors' practices, that I address in this article. While the discussion of masculinity in medical culture has, with very few exceptions, died down almost completely in recent years, the results of the study on which this article reports suggest that this is a consequence of a shift in research focus, rather than its discontinued relevance. Riska (2008) argues that strategies for redressing the gender imbalance in professional organizations have been reduced to increasing numbers of women within them, pointing out that greater numbers alone are insufficient because the nature of work continues to be understood in gendered terms that prioritize traditionally masculine attributes. I argue that challenging the meanings that underpin medical practice is centrally important to improving it. While acknowledging the host of factors that influence quality of care, I therefore aim in this article to provide insight into this one aspect (the dominance of hegemonic discourses of masculinity) of the culture prevalent in the emergency unit within which this study was conducted, and into its possible contribution to provision of inhumane care.

Theoretical Approach

In addressing this aim, a number of aspects of my theoretical approach are important. These include an emphasis, in exploring doctors' actions, on the interrelationship between the individual, the social, and the material; an understanding of masculinity in these terms; a focus on meaning to gain insight into this subject; use of narrative theory to explore this meaning; and employment of the notion of "defended subjects" to enable insight not only into what people express overtly but also into the subtexts and silences in their accounts.

I thus adopt an approach that highlights the interconnectedness of the individual actor, the sociocultural context in terms of which he or she interprets his or her experiences (Davidson, 2010), and the material circumstances to which he or she responds (Luyt, 2003). I therefore treat the emergency unit that was the context for this study as a "small society," with its own unique culture (Helman, 2001), where locally as well as more broadly shared meanings are actualized by individuals in concrete situations (Mishler et al., 1981). I thereby intend to highlight the web of factors that influence doctors' actions (Halford & Leonard, 2006) and so avoid laying blame for poor quality care on individual "bad" practitioners. I similarly intend to avoid locating responsibility solely within the realm of inanimate social apparatuses and the associated tendency toward simplistic, technical solutions to highly complex problems (Van der Geest, 2005).

I understand masculinity not as a homogeneous experience, but rather as a set of complex, fluid, often contradictory experiences, shaped through interaction within particular social groups. Group members share an understanding of the world in which they live and employ the discourses available within their social context in constructing their own subjectivities (Foster & Nel, 1991; Luyt, 2003). While constructions and experiences of masculinity therefore vary, they nevertheless do so in ways that maintain social relations of domination, in terms of which certain forms of masculinity predominate over others (Luyt, 2003). Enactment of particular forms of masculinity are rewarded, while others are negatively sanctioned. Dominant metaphors thus dictate how "real men" behave, rendering those who display the relevant characteristics preeminent over those who choose otherwise, or fail to do so (Morrell, Jewkes, & Lindegger, 2012). I further do not understand masculine discourses as necessarily tied to maleness. A number of authors draw attention to the possibility for girls and women to adopt masculine identities, or to incorporate components of traditional masculinity into their identities (Cooper, 2002; Paechter, 2006; Wildschut & Gouws, 2013). Discourses of masculinity can therefore be understood as generally available within the social context, albeit more so to some individuals and less so to others.

I employed an ethnographic approach in conducting the research. In terms of the fundamental assumption of ethnography, namely, that social life is meaningful, human beings are understood to experience their lives and act in ways that are rooted in their interpretations of the world (Atkinson & Pugsley, 2005). Ethnography seeks to understand this meaning-laden context to explain social action (Gobo, 2008), thus directly addressing my aim to provide insight into how discourses of masculinity within the context of medical practice might contribute to provision of inhumane care. I explore the provision of inhumane care through an investigation of the language, as the primary medium of interpretation and communication that comprises and accompanies it. I treat language in a manner that emphasizes the meanings reflected and produced through its use within a particular context (Bakhtin, 1994), and the effects thereof on the ways in which the relevant actors interpret and respond to their experiences (Austin, 1976). I thus approach the talk presented in this article not merely as reflective of the experiences of individual speakers but as representative and productive of shared social meanings, and of possibilities for individual experience and action.

My approach to the analysis of language is further rooted in the concepts of narrative theory. A narrative approach to investigating human experience involves a subject-centered, yet nonindividualist, interaction-based perspective (de Peuter, 1998), facilitating exploration of the meeting point between self and society, or between the contextually structured meanings and individual actions pertinent to this article. Through its focus on sequence, this approach enables exploration of the relationships between different parts of a speaker's account, and thus not only of what is overtly expressed but also of silences, ambiguities, and contradictions (Billig, 1999). Finally, I use this approach to gain insight into what Hollway and Jefferson (2000) term "defended subjects," a notion that rests on the idea that the primary motivation for people's investment in specific discourses is their need to defend themselves against anxiety. Thus, exploration of people's narrative constructions allows for exploration also of those aspects of experience of which we may not be consciously aware or that we may not intentionally convey, but that defend us against anxiety generated by difficult experiences.

The Research Context and Process

This study was conducted in the emergency unit at Greenlands Hospital,[1] a South African public sector hospital located in a very low income area. At the time of the study, Greenlands Hospital served a population of 1.1 million and held 224 beds, processing approximately seven and a half thousand inpatients per month. The percentage of beds occupied during the period in which the data were collected (2008-2009) was 112% and the mortality rate 7.08%. The hospital consisted of two general medical and two surgical wards, a high care unit, an emergency unit, and an outpatients department. Its patients were exclusively Black and poor. The hospital was generally feared by the community it served, where it was dubbed "the morgue." Its doctors were of diverse races

and, by virtue of their salaries, represented a different socioeconomic category from that of their patients. All those who participated in the study lived in middle-class areas, far from the ghetto areas served by the hospital. Of particular relevance within the radicalized South African context, while the doctors represented diverse racial groupings (of those who participated in the study, 11 White; 11 Black), other staff and patients were exclusively Black. Of those doctors who participated in the study, one was head of department, two were consultants, two were senior medical officers, and the remaining 17 were medical officers.

Approval for the study was given by the ethics committee of the psychology department, University of Cape Town, and by the hospital. Twenty-two doctors (13 male, 9 female) and 157 patients participated formally in the study. All participants gave their informed consent prior to participation and were assured of confidentiality. Many more patients participated informally, for example, through casual conversation in the unit's waiting areas. While my informal observations of and conversations with the nurses and security staff did comprise part of my background knowledge of the unit, my primary concern was with the discourse of medical culture and its implications for the interactions between doctors and patients specifically. Furthermore, there are substantive differences between doctors' and other staff's professional identities, values, and so on, in general and in gendered terms. Nursing in particular, for example, has been shown to be a highly feminized profession (Tronto, 2011). I therefore limit my focus to the discursive constructions employed by the doctors that might have relevance for those of their actions that constituted provision of inhumane care.

The unit had an unkempt, dirty, and chaotic feel about it. While there were three doctors' rounds at regular times each day, there was otherwise little evidence of routine. Staff simply responded as and when the need arose and in whatever manner circumstances permitted. In theory, each patient, after passing through the triage system, was either sent elsewhere or "clerked" by a doctor. The patient then waited, often for as long as 72 hr, either on a bed or a bench, to receive treatment and then be discharged, transferred, or admitted. The unit was headed by a senior physician, seconded by two rotating consultants, and two senior medical officers. Assisting them and running the unit independently after hours were 18 medical officers (six on duty at a time) and a number of interns. A registrar admitted patients into the rest of the hospital and the medical staff were supported by the nurses, two of whom were on duty at a time, and by two security guards.

I spent almost a year engaged in participant observation in the unit. At first, the research process consisted simply of watching, listening, and talking to staff, including doctors, nurses, cleaning staff and security guards, and patients, as well as writing field notes. Later, my focus honed in on those events that might be characterized as instances of inhumane care provided by doctors, and on those that offered the potential to explain these lapses—either due to their proximity to the event in question, their relevance to that event, as in the case of a conversation about its occurrence, or their broader thematic relevance, as in the case of doctors' private expressions of antagonism toward their patients. At this stage, I added audio-recording to the data collection, recording ward rounds, consultations between doctors and patients, and conversations between doctors, producing a total of 42 hr of recorded verbal interaction.

In addition to the informal conversations held with doctors during the course of observation, I interviewed doctors to elicit their reflections on the events observed, as well as more extended stories depicting these events, and thus to gain insight into the ways in which they interpreted their actions. Twelve doctors participated in the interviews and each interview lasted between half an hour and 2 hr. I initiated interviews by telling participants that I was interested in their reflections on life in the unit, so that I could use these in interpreting what I had observed. Interviews thus gave doctors primary responsibility for determining the content, and allowed them to structure their own accounts and thereby to exert as much influence as possible over the discursive forms they used. Further questions were open-ended and limited to requests for clarification or additional information on a subject the doctor had already introduced. Interviews probed for stories in response to abstract reflections and not only for concrete details but also for the meanings doctors gave to the words that they chose (Anderson & Jack, 1991).

I used the concepts and tools of narrative analysis to explore the data. Defined as "a sequence of two or more units of information . . . such that if the order of the sequence were changed, the meaning of the account would alter" (Rapport & Overing, 2007, p. 283), the concept of narrative foregrounds sequentiality, and thus the relationship between elements of discourse. I treat narratives here as comprised of discourse and differentiate between the two terms only in that the former emphasizes this concept of sequence and therefore the relationships between a narrative's discursive components. I use the concept of sequentiality in its broadest sense to refer not only to temporal sequences but also to any form of sequencing, be it spatial, thematic, or in terms of emotional significance (Hollway & Jefferson, 2000). This focus on sequence allowed investigation of such discursive features as the relationships between characters, and between them and the events and actions narrated, providing insight into the roles that might be played by the unit's inhabitants and the actions they might commit. I further treat talk as action and as productive of the social environment (Bakhtin, 1994), focusing my exploration on the potential effects of talk (Austin, 1976; Shotter, 1993). As Billig (1999) observes, even the "fleeting little words" such as "but" and "anyway" serve to change the subject of conversation, "only" to minimize the concept it precedes, "perhaps" to cast doubt on the truth of a statement, and so on. I account in my analysis for the fact that not all experience is outwardly expressed, and for the salience of the "unsaid" (Billig, 1999). I therefore

foreground not only what was said but also the silences and unrealized alternatives, thus generating insights not only into participants' consciously intended meanings but also into those that they may have conveyed unconsciously or unintentionally, and thus, for example, into the doctors' defenses against the emotionally trying nature of their environment.

The analysis presented here does not offer any objective viewpoint on reality. The analytic process facilitated an interpretation of the data, influenced from the beginning by my own perspective. In offering my interpretation, I further make no claim to providing simple solutions to the complex problem of inhumane practices in delivery of health care. However, I hope to provide some insight into the processes through which such practices emerge, and thereby to identify some possibilities for generating improvements.

Results and Discussion

In this section, I explore the ways in which hegemonic discourses of masculinity structure the doctors' representations of their experiences in the emergency unit, inform their identities and actions, and have the potential, especially under stressful material conditions, to contribute to inhumane actions and omissions.

Masculinity in South Africa

It is important to contextualize the findings presented here. South African society is highly patriarchal and characterized by inequities structured according to gender, race, class, and rural-urban divisions (Morrell et al., 2012). The society is one in which violence has historically been afforded cultural legitimacy and is currently fraught with high levels of violence (Jewkes, Sikweyiya, Morrell, & Dunkle, 2011; Machisa, Jewkes, Lowe-Morna, & Rama, 2011, Mathews, Jewkes, & Abrahams, 2014). These sociomaterial circumstances have had a significant impact on the development of masculinities in this diverse society. While different forms of masculinity have become dominant in different local settings, they are nevertheless underpinned by a core set of ideals (Morrell et al., 2012). Features of this hegemonic masculine ideal include control; unemotionality and prohibitions on the expression of emotion; physicality and toughness, as opposed to qualities such as intellectual or verbal ability; competition, except in the face of a common enemy; reveling in contact with the enemy; seeking excitement; and criticism of attributes traditionally associated with femininity (Foster, Haupt, & de Beer, 2005; Luyt, 2003; Mathews et al., 2014; Talbot & Quayle, 2010). Violence features regularly in discussions of masculinity worldwide and, in South Africa in particular, masculine ideals include acceptance of violence (Campbell, 1992; Glaser, 1998; Mager, 1998; Morrell et al., 2012; Wood & Jewkes, 2001). Indeed, within this context, violence represents an accepted means of asserting strength, superiority, and power; regaining threatened respect and control; resolving conflicts; and administering just punishment (Mathews et al., 2014; Wood & Jewkes, 2001). A number of these features of hegemonic masculinity emerged throughout the doctors' talk and, I argue, may represent an important contributor to delivery of inhumane care. In the remainder of this discussion, I identify some of these discursive features as they manifested in the Greenlands hospital emergency unit.

The Importance of Action With Impact

As noted above, a body of literature discussing hegemonic discourses of masculinity in medical culture indicates the importance of dramatic action with immediate impact for maintaining positive medical identities. Describing the potential afforded by resuscitating a patient for doctors to "shine" through their engagement in such activities, Dr. P illustrates the presence of this discursive pattern in emergency room talk at Greenlands:

> It inevitably happens in (One dot represents a momentary pause, two a short pause of a few seconds' duration and three a long pause.) kind of a major . . . resuscitation situation . . .where (.) people just . . . get on with the job . . . and . . . you really see (.) that people shine . . .

Dr. S describes some patients as "sick" and others as "stupid":

> I: So what's the difference between the sick patients and the stupid ones?
>
> Dr. S: "Well the sick patients are half *dead*. They're resusc patients. Then you can just get into it immediately. It's not somebody that you've gotta like (.) fucking *find* a bed for and (.) clamber *around* an- you know, get yourself involved in the whole 'there's no bed' crisis and all that *bullshit*. (.) You can just grab the sick patient, you can toss somebody else off a bed and just sort them out then . . ."
>
> I: "So the resusces are the least frustrating in terms of all those other side issues that crop up?"
>
> Dr. S: "Probably, ja. And they're the most challenging. Medically . . . because if we don't *do* something then the person's gonna *die*."
>
> I: "Yes. . . . And is that not the case with some of the other patients?"
>
> Dr. S: "No. (..) This is an *immediate* thing."

Although not explicitly marked as such, I suggest that these elements of the doctors' narratives resonate with the features of hegemonic masculine discourses described in the international literature (Erickson, 1999; Good & DelVecchio Good, 1993; Hahn, 1985; Millman, 1977). It is true only in terms of immediately observable cause–effect relationships that those patients not requiring resuscitation will not die if the doctors don't "do something." It is also

likely that a whole variety of other patients might be more "medically challenging" than those requiring resuscitation. I therefore argue that the difference between the "sick" and the "stupid" patients (referred to implicitly in the extract above through Dr. S's description of what the "sick" patients are not) refers to the differential opportunities they afford doctors for committing actions with "immediate" consequences as to whether or not "the person's gonna die." These extracts suggest that the doctors are drawn to cases that promise this opportunity, and hence the chance to "shine." Without denying the value of actions aimed at resuscitation, I argue that the differential worth attributed to these and other actions can have dangerous consequences, potentially contributing to neglect of patients whose circumstances do not afford this opportunity.

The Devaluation of Caring

Perhaps related to the devaluation of caring was the lack of reaction to patients' expressions of suffering in the unit. While some patients cried out in pain, or for help, not a head turned anywhere in the room. On one occasion, a man lying in one of the beds was making a disturbing sound with every breath—with hindsight, the sound produced by terminal respiratory secretions. Still in the early phases of my observations in the unit, I was alarmed by the sound and attempted to alert a doctor. But my tentative question, "Is that alright?" was met by Dr. F with a snigger and a corresponding question—"How can it be alright?"—as she continued leafing through the list to choose her next patient, making no subsequent response. The man was dead 20 min later, without having received any further attention.

When asked directly about their feelings with regard to patients' suffering and death, the doctors' responses were strangely barren, suggesting the lack of conscious emotional responses discussed by Good and DelVecchio Good (2000) and the unemotionality and prohibition on expression of emotion identified in the literature describing hegemonic South African masculinities (Foster et al., 2005; Luyt, 2003; Mathews et al., 201; Talbot & Quayle, 2010). Dr. S's reply to my question about her feelings, after a patient she was attempting to resuscitate died, illustrate:

> I: So how do you walk away from those events feeling?
> Dr. S: Well tha- I- ge- just irritated.

While mere irritation suggests the lack of conscious emotional response described by Good and DelVecchio Good (2000), the same doctor's disparaging reply to my suggestion that the doctors might derive support from each other in dealing with their very high exposure to suffering and death—"*No* . . . we don't have big heart-to-hearts"—further suggests a prohibition against expression of emotional vulnerability and absence of any avenue within the social context for dealing with such feelings.

When suffering is acknowledged, it is often with an overtly cynical attitude. Playing on the similarity between a patient's name and the likely outcome of his condition, Dr. L joked, "His surname is Kaput[2] and he's having an MI[3]!"

In response to the disturbing sight of a woman's painful death from liver cancer, Dr. Y suggested that her bed be pushed out into the yard, where she would "die in the rain" instead of "in (his) presence."

And Dr. N, with reference to a disturbing story told by one of the "psych patients," rolled his eyes and observed that "We don't even listen anymore."

That the junior doctors and interns admire and aspire to such cynical responses is evident in a story that an intern told about a senior doctor's approach to diagnosing very sick patients' conditions. The intern described how he, in his naivety, would put considerable effort into arriving at long, complicated diagnoses. Whereas the senior doctor, after affected consideration of the evidence, would routinely say, "I think this patient is (..) *fucked*." The story implies the desirability of an attitude that not only dispenses with careful consideration but displays a total lack of empathy.

On those occasions on which doctors and others did commit caring acts, they were negatively sanctioned by the peer group, who put pressure on one another to respond to events in culturally prescribed ways (Wodak, 1996). The following extract from the field notes illustrates:

> Dr. H arrived in the unit with some bread rolls that she intended to give to the "psych patients." "Are they old?" asked Dr. P. "Have they got salmonella? . . . Perhaps you should put some salmonella on!" And then, more seriously, "No, man, don't give it to them—give it to the nurses rather."

I too received little reprimands for displaying what in other contexts might be considered just ordinary politeness. For example, after I explained to a patient demanding to be seen immediately that he was not being purposefully ignored, but was simply in a queue, Dr. P admonished, "Stop being so nice to people!"

Thus, not just caring but even basic courtesy toward patients is sneered at and negatively sanctioned in the Greenlands emergency unit, whereas cynicism and even malice are advanced as the preferred stances. The defensive nature of such responses has been documented and indeed some emotional defenses are necessary to enable doctors to keep doing their work and to function effectively (Cohn, 1994; Dartington, 1994). However, they all too frequently become maladaptive, producing negative behaviors and leading to compromised care (Back, Meier, & Morrison, 2001; Holman, Meyer, & Davenhill, 2006). While not explicitly grounded in discourses of masculinity, the parallels between these features of the doctors' talk and the hegemonic masculine discourses described as prevalent in medical culture internationally, and in South African culture more generally, are striking. Thus, I argue that, while not

intentionally or consciously employed by the doctors, the availability of these discourses in the context may create an opportunity for them to defend themselves against the very trying realities and difficult emotions they face. While their ostensible purpose is thus likely to be self-preservation, I argue that, in the process, these defenses contribute to delivery of inhumane care.

Powerlessness, Unemotionality, and Inaction

Evident in some of the above extracts and noted by Obholzer (1994), "a great deal of what goes on (in a hospital) is not about dramatic rescue but rather about facing one's relative helplessness in the face of illness and death" (p. 174). The toll that this disjuncture between material realities and expectations of effective action takes, especially on doctors working in a severely stressed system, is evident in the following excerpt from my interview with Dr. R:

> The weekend before that we had a trauma- we had a- we had a big trauma . . . with head injuries and whatever. Came in in a *very* bad way. And we were actually able to sort of (.) not get him right but (.) get him in a stable enough position that we could send him somewhere that *could* get him right. (..) And those are the moments when you feel like (.) you're *doing* something. (..) There's- there's- (laughs) there's need for you to be here. (..) You know, it's just- it's very- it's difficult now with HIV. Because (.) you get the feeling that like why do we even bother? (.) You know, these patients come in in *stage four* . . . they've got PCP[4] pneumonia and they've had like reactions to all the medication they on and (.) you know, there's really nothing you can do at that stage. It's just (.) sit and wait and make them comfortable. And (.) 70% of the patients we're seeing are like that. (.) Hh you know you kind of feel like why did I become a doctor if I'm gonna sit here and say, "Well you a write-off, you a write-off, you a write-off?" . . . You know, you not gonna say to a patient "Well, you a write-off," you gonna say, "Well, let's look for some palliative care or-" and you don't ever feel like you're *doing* something.

Dr. R makes explicit the necessity of clearly identifiable diversion of the course of disease for a doctor's action to be considered worthy of the term. Actions unlikely to produce these effects, for example, those involved in "palliative care," are construed as nonactions—"there's really nothing you can do at that stage"—and produce questions about the value of the effort spent and indeed of their identities as doctors—"Why did I become a doctor . . .?"

Thus, the combined social and material realities of working in this context place a heavy emotional burden on the unit's doctors. The simultaneous prohibition against these emotions leaves doctors no room to procure emotional support or process their feelings—a situation that is unlikely to contribute to their ability to cope effectively under such circumstances. Dr. N describes how feelings of helplessness instead sometimes translate into actions of neglect:

> I think- . . . well- the people who come here are *so* sick that there's (..), you know, (.) if they were motor vehicles they'd be (.) written off and scrapped . . . (.) and you *see* someone and you think, what's the point? (. . .) And (.) then (.) from *thinking* what's the point (.) sometimes it becomes (.) an action of what's the point. (..) So (.) so (.) that patient will (.) get put into a corner (.) and (.) just allowed to die or- or- you know.

Masculinity and Danger

The location of Greenlands in the heart of South Africa's ganglands, insufficient staff trained and employed to handle dangerous patients or intruders, the presence of a multitude of undiagnosed diseases, and inadequate measures for restricting their spread, mean that working at the hospital carries a number of risks, offering doctors the opportunity to display the "balls" described by Cassell (1987) and thus to reestablish powerful identities, despite the feelings of impotence described above.

The dangers of working in the unit feature regularly in the doctors' talk. The relationship between these dangers and the opportunity for achieving impressive masculine identities is especially striking in the case of new doctors, junior doctors, and interns, who often paint pictures of the horrors of the previous hospitals in which they worked—"There'd be weekends where there's stab hearts, gunshots, . . . (the list continued)"—as they attempt to establish their competence within the peer group. But more senior doctors, too, frequently tell stories that depict their exposure to the hazards of the unit. Relating the story of a patient who had waited 2 months after a positive tuberculosis (TB) test to be given treatment, who was now suspected of drug resistant TB, and was likely to wait another 2 months before receiving the appropriate medication, "meanwhile spreading it like wildfire," Dr. N remarked,

> "This is a perfect place for a TB outbreak. (..) It's just a matter of time. (..) Tick (.) tick (.) tick (..). If this were the States, we'd all be wearing masks and be in isolation." However, the air changes required to reduce the spread of airborne disease in the room, he continued, "would require a jet engine."

Dr. P tells a story that illustrates the extreme dangers that doctors are expected to confront:

> Ja (laughs) I mean six policemen came here last night . . . And they- they come up to (.) one of my colleagues who is probably like forty five kilograms, this very (.) um (.) thin girl, ok, and they come up to her, six policemen, and says, "Doctor, we can't get the patient out of the van, he's too violent. Can you go inside the van and sedate him?" I looked at him and I said, "What the *hell* are you talking about? You know, you want *her* to go inside to sedate the patient and *you* are- can't get him out 'cos he's too violent! " Six police officers!

Dr. N's prediction of a "TB outbreak," characterized as a time bomb, in defense against which they should "all be

wearing masks and be in isolation," not only implies the risk to which the doctors are exposed but sets the scene for the emergence of powerful heroes. Indeed, according to Dr. P, what is expected of frail lady doctors is beyond the capabilities of six policemen. And, while the risk is not to herself in this instance, but to the patient, Dr. S's response to the unusually gruesome condition of a patient she is about to see, as she strikes her chest with her fist and roars "Bring it on!" illustrates perfectly the scope created by blood, gore, and peril for the display of muscle. Rather than merely reflecting the risks of work in the unit, therefore, I argue that these representations facilitate the adoption of powerful identities, despite the hard realities in which doctors frequently feel powerless. On occasion, I argue, they further contribute to provision of inhumane care.

Danger, Action, and Violence

As Mathews et al. (2014) have pointed out, a combination of the need for dramatic, effective action with a sense of powerlessness in the face of material realities, can produce a propensity to use more extreme means of reestablishing threatened powerful identities. Within the South African context, violence is viewed as an acceptable means of achieving this (Mathews et al., 2014; Wood & Jewkes, 2001). The more serious displays of aggression that I witnessed in the unit tended to occur around prevention of patients' violence. While material circumstances account for doctors' involvement in these incidents, the availability of hegemonic discourses of masculinity may contribute to the form this involvement assumes. And sometimes, in the process of restraining aggressive patients, for example, by means of a technique known as "the Greenlands take down" and, as explained by one of the doctors, developed on the rugby field, the door is opened for doctors to become involved in the language and practice of violence. Dr. P describes one such incident:

> Um- I mean *I* was- uh- some guy who came in (..). I've been hit *twice* by psych patients. But (.) the one was bad, it was in here, hh um (.) he (.) I don't know, he was talking or something like that, we sat him down and sedated him and he stood up, was a bit drowsy, and then comes at me and said, "I'm gonna f-ing shoot you, I'm gonna kill you." So I said, "*Don't* talk to me like that," and then he just came at me like *that*. So I pulled back and (.) next- then it was no longer hh doctor—patient. Then it was like right, all best to all, let's play this game, buddy. And then the security guards were on him and (.) I mean (.) . . . got (.) some sense *beaten* into him. You know, and that's not the way it should be done, but the point is that (.) should he ever have been allowed to take a swing at me? No. There should have been security guards there holding him. (..) 'Cos once you take a swing, then you change out of that mode and start changing into Rocky mode or- (laughs).

In a further elaboration of the procedure used in dealing with violent psychotic patients, Dr. P explained that the patient is given double the usual maximum dose of valium, in case he has developed a resistance through frequent prior sedation, while having his airways blocked (e.g., as in an incident that I witnessed, by applying a knee to the throat of a patient who had been "taken down" and was lying on the floor) to render him passive until the sedative had taken effect. While in any other context, such actions would be deemed reprehensible and heavily sanctioned, within a context in which both staff and patients are assaulted on a fairly regular basis and in which doctors narrate their experiences in terms of hegemonic masculine discourses, they are seen as inevitable:

> The *problem* is that . . . when you with them you get almost a *feral* reaction, almost- Like an animalistic type of like (..) You know, *take* this person down, (.) you know, destroy this (.) this *threat* (..) as quickly as possible . . . You can- y can ask any one, you ask any doctor who's worked in the casualty here. (.) And (.) probably, well- one of the first things he'll say to you is (.), "Ja, the psych patients (.) ja, we take them down."

Thus, on one hand, the presence of threat creates possibilities for displays of masculine strength, culturally associated with aggression. On the other, it invokes the possibility of justifiable defense, enabling doctors to see aggression and even violence as neutralization of danger, rather than as action that constitute inhumane provision of health care. It seems thus that these very real dangers, in combination with the cultural desirability of the "gung-ho" (Foster et al., 2005) style of delivering health care, where "You can just grab the sick patient" and "bash them on IV," as well as the lack of emotional resources for coping when things go wrong, and the acceptability of violence as a means of regaining threatened power and control, all set the scene in which, under certain circumstances, aggression and even violence become permissible.

Defended Subjects

It should be noted again, in terms of Hollway and Jefferson's (2000) theory of the defended subject, that rather than implying that doctors use hegemonic masculine discourses intentionally, they may do so as an unconscious defense against feelings of anxiety generated by their situation in an overburdened, underresourced emergency unit, and thus as a means of self-preservation. The defensive nature of certain aspects of medical culture has been noted, in particular with respect to collegiality (Mizrahi, 1986; Obholzer, 1994), patient blame, and emotional detachment (Fassin, 2008). Similarly, with reference to the broader population, various features of hegemonic masculinity have been argued to represent a defense against feelings of vulnerability in general (Emslie et al., 2006). I argue that the Greenlands emergency unit's doctors' employment of certain elements of hegemonic masculine discourse represents a defense against their feelings of powerlessness and anxiety in a context in which they are

faced with overwhelming numbers of sick and dying patients, too few resources, and no emotional support. While some defenses are necessary if doctors are to be able to function effectively, these can and, I argue in this context, have become maladaptive, endangering quality of care (Cohn, 1994; Dartington, 1994).

Conclusion

This analysis has suggested that the hegemonic masculine discourses, identified by previous research as prevalent in medical culture internationally, and also in the wider South African society, influence doctors' constructions of their experiences in the Greenlands Hospital emergency unit. It has further suggested that these discursive patterns, in conjunction with very trying social and material conditions, contribute to doctors' engagement in the abusive and neglectful practices described in this article.

While this article has thus discussed a "thread" in the complex web of factors that come to bear on the manner in which doctors provide care, it is important to note that their employment of elements of hegemonic masculine discourse occurred in this study within the broader context of racial, class, gender, and other dynamics that continue to pervade South African society. These features of the wider society can be assumed to have become intertwined with and contributed to the forms of masculine discourse employed in the unit (Luyt, 2003), despite not having emerged distinctly in this analysis. Possible reasons for the inconspicuous nature of these intersections include the complexity of the analysis that would have been required to disentangle the respective contributions of these intertwined factors, which lie beyond the scope of this article. In addition, the discursive patterns identified here occurred across the talk of all the doctors who participated in the study, despite their different racial and other characteristics, suggesting the importance of an overarching commonality between them that may have overridden other differing social group memberships. However, while the focus here is on the possible contribution of masculine discourses to provision of inhumane care, it is important to note that these should be treated as among the many interacting factors that require redress if access to humanely delivered health care is to become a reality for all South Africans. Further research into the contributions of other social divisions, in particular race and class, to the delivery of inhumane care would represent a valuable contribution to this cause.

A further limitation of this study stems from its focus on the doctors in the unit and its consequent failure to provide insight into the discursive constructions employed by other hospital staff, most notably nurses. Research that includes a broader investigation of hospital culture, including the discourses employed and animated by other staff, seems an important extension of the current limited knowledge in this field.

I believe, however, that the interpretations offered in this article, while not representing a complete picture, are interesting and important in light of their resonance with previous research, their potential to provide insight into the complex factors that drive provision of inhumane health care, and thus the promise that they hold for helping to identify some possible avenues for creating change. With this last possibility in mind, while the influence of both the material and discursive conditions described may be relevant, it is vital to remember that they are not deterministic. As Lakoff and Johnson (1980) have noted, hegemonic metaphors may not be easily amenable to change but they are susceptible to challenge through the emergence of new metaphors. Thus, understanding these metaphors is not only important for comprehending the forces that drive particular practices, but it also provides the basis for subverting those forces that support problematic practices (Wicks, 1998). Through the analysis provided here, I hope, therefore, to draw attention not only to some of the features of discourse that, under certain circumstances, may contribute to delivery of inhumane care, but also to the possibility for both collective and individual resistance to established norms and expectations, and hence for action in support of cultivating the conditions that promote delivery of humane health care.

To this end, I argue for the importance of efforts aimed at encouraging the development of cultural forms that promote humane delivery of care. And I argue that generating change in organizations in which this is not the norm requires an approach that addresses not only the material but also the meaning context whereby providers construct, interpret, and respond to the social and material realities with which they are faced. I further argue for the importance of a greater emphasis on the acquisition of reflective skills in medical education and continued professional development. This would enable practitioners to recognize potentially unhelpful interpretations and to contribute to the production of those that are likely to promote good quality care. Such an emphasis would require greater incorporation in health care education of skills and knowledge traditionally associated with the social sciences, as well as greater emphasis on personal development in medical curricula. With specific reference to South Africa, the manner in which health services are delivered within its public sector is profoundly important to the country's attempt to progress toward equal access to good quality health care. Research and evaluation of approaches aimed at bringing about the above changes thus represent an especially important area for further work in this context.

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Notes

1. Pseudonym.
2. Afrikaans word meaning irreparably broken, and connoting finality.
3. Myocardial infarction.
4. Pneumocystis pneumonia.

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