CHAPTER 7

Nursing in a new era

Nurses in the developing world face a triple threat from HIV/AIDS: increased workloads, exposure to HIV infection, and stressed morale. (Zelnick 2005: 163)

I was traumatised because of the way the nurses were talking to each other and to the patients and the way the managing nurses talked to the nurses working under them…and then the way the doctors talked to nurses. I could not believe that we could be so abusive to one another. (UKZN nursing academic, after working temporarily in a high-care ward)

After a long day, the patient just goes to you and says ‘thank you’, then you go home and you are happy. (Netcare bridging student, focus group discussion)

In the decade prior to 2006, which is the focus of our quantitative analysis in Chapters 2 to 5, the professional milieu for health professionals underwent many profound changes, most notably the rapid increase in the numbers of people suffering from HIV/AIDS and TB. Many of the students whose aspirations and expectations were recounted in Chapter 6 were unprepared for the realities of nursing in this new era that they experienced in their clinical practice. In this chapter we present an account of those realities as viewed through the eyes of the students and lecturers in our case studies.

We focus on those aspects that featured most prominently in the interviews and focus group discussions: the difficulties associated with working with patients suffering from HIV and AIDS; conflictual relations between doctors and nurses, male and female nurses, staff and students, and nurses and patients; and, finally, the issue of salaries. Because most of these students and lecturers were studying and working in the public sector, the majority – but not all – of their comments relate to this sector. Where they concern the private sector this is stated explicitly.

Having considered in the previous chapter why young people might choose to study nursing, we now ask whether those views hold true once they have experience of the profession. Whether student nurses stay the course of their training and enter the profession depends to a very large extent on the nature of their experiences of clinical practice during their student years. Of course there are other reasons why they might drop out: they might be unable to meet the academic demands or deal with the financial constraints, or, in the worst case scenario, they might become ill, as is increasingly the case given the high prevalence of HIV and AIDS among South African youth, particularly young women. However, in our interviews and focus groups, students made it clear to us that their experiences of ‘what it is like to be a nurse’ were very important factors in their plans either to stay in or to leave the profession.

We were overwhelmed by the negative comments made by students who were gaining their practical experience in the public sector and by the number of students who said they wanted to emigrate. The bleak picture they presented was confirmed by academics who bemoaned the lack of staff and equipment, the drop in standards of nursing and the difficulties of working in wards packed with HIV/AIDS and TB patients. Salaries were a major issue throughout the research, even though public sector salaries were increased substantially in the course of it.
Student nurses training in the private sector were also not entirely happy. They did not complain about conditions – indeed, they were very proud of the high-technology equipment in private hospitals – and seemed to have surprisingly little experience of HIV/AIDS, but they were still setting their sights on emigration. Their main concerns were the low salaries they were going to earn once qualified; the fact that they paid high fees to study but also were a major source of labour in the wards; the doctors’ treatment of nurses; and patients’ ‘unreasonable’ demands.

In the following sections of this chapter we present the main concerns of students in both sectors.

**Working with HIV/AIDS and TB patients**

The difficulties associated with working with severely ill HIV/AIDS and TB patients were emphasised by students and academics in the public sector, and were supported by the organisational representatives we interviewed. The issues seemed particularly marked in KwaZulu-Natal, which has the highest prevalence of HIV in the country. To compound the problem, many of the nurses are themselves infected with HIV. Although we did not raise the issue of personal HIV status and no students volunteered such information, we were told by academic staff that many students are both affected (in their personal lives by the illness of families and in the workplace by the illness of patients) and also infected themselves.

**Academics’ views**

Professor Adejumo, head of the School of Nursing at UKZN, said that while the health system is experiencing a large increase in patients with HIV and AIDS, it is also losing many nurses to the epidemic. The loss of these nurses reduces the nursing workforce while increasing the workload of the remaining nurses. The nurses left behind are emotionally shattered by seeing their colleagues and patients dying in front of them and student nurses are put off the profession. Adejumo described the impact of the epidemic on the remaining nurses in this way:

> They are also human beings. How do they even cope in the first instance? How are they surviving? What do they think when they see people deteriorating and degenerating and disappearing like that? And there’s one thing about human beings, when you see someone die you also think about your own mortality. And who counsels these nurses? Does anyone really care about the trauma these nurses go through?...The younger ones who were supposed to come into nursing, they see all these things and say no, this is not for me. I don’t want to die, I don’t want to really get into this.
A lecturer in the same school said the HIV/AIDS epidemic ‘affects the professionals as professionals’. Nurses who are HIV-positive and do not want to come forward and seek help are doubly affected because they cannot work properly and at the same time are not getting the help they need. They are nursing people with AIDS and TB and live in fear of contracting these diseases; therefore they cannot provide the best possible care for their patients. Nurses often have to care for family members who are not well, which means they cannot relax after work and on their leave days but are still having to care for someone. Moreover, HIV/AIDS is financially draining as well as physically exhausting. Nurses’ salaries are not high, but nurses must support sick family members financially – for example, pay for their medicine or their transport to and from hospital.

This lecturer said there is insufficient support for nurses: there is no system whereby they can be attended to and not stigmatised. They also have inadequate knowledge of the disease itself and its treatment (for example, the administration of ARVs). She suggested there should be relief centres where patients could be admitted from Monday to Friday and then return to their families at weekends. In this way people would be able to work during the week and take care of their ill family members over the weekends.

**Students’ views**

In our interviews and focus group discussions with students, we were struck by the extent to which they feared contracting HIV/AIDS and/or TB. They were also dissatisfied with the lack of equipment, with the risky practices they experienced during their clinical work and with the lack of counselling. The following is a summary of students’ complaints.

*The availability and use of gloves*

Students said the only available precautions against infection are gloves and sometimes there is no time to put them on. In an emergency, they said, the first reaction of nurses is to help, not to protect themselves first and then provide help, and this exposes them to infections. Some of the old-age homes where UKZN students worked did not have gloves. Sometimes students were discouraged from wearing gloves because they are ‘too cold and uncaring for the patients’.

*Information about the status of patients*

Lecturers told us that students are taught to treat all patients as if they are HIV-positive and to take the necessary precautions. Students told us that in hospitals nursing staff often distinguish between patients who are HIV-positive and those who are not and accord them differential treatment. The students expressed concern that they are not always informed of the status of the patient.

WCCN second-year students told us that first-year students were more likely to contract HIV because they might not understand the various abbreviations used in the folders to indicate the status of the client and therefore might not take the necessary precautions.

A third-year UKZN student working in the private sector said that an HIV diagnosis is not disclosed to the nurses. A fourth-year UKZN student said that the doctors in that sector ‘hide patients’ status’ and patients pay to have it hidden, but in the public sector ‘it’s there in red’. She argued that disclosure of the diagnosis makes nurses more compassionate:
If you are aware of what the person is suffering from, you understand their predicament and you treat them in an appropriate way. Hiding HIV is not helping.

However, other students felt that nurses treat HIV-positive patients with less caring because they are afraid of contracting the disease themselves, particularly in cases where the patient also has TB.

**Needle-prick injuries**

Students expressed great fear of needle-prick injuries. At one institution, we were told by a senior member of staff, who did not wish to be identified, that there had been six needle-prick injuries between January and August of the year we conducted our research (2007). Of these, four involved patients who were HIV-positive. She said second-year students had the highest rate of needle-prick injuries and the department was examining the reasons for this. When such an injury happened the student was referred immediately to the student health department, where they would receive the necessary tests with counselling and would be put on ARVs for a period.

WCCN students complained that although there are universal precautions, nurses are still unprotected by careless actions – for example, when doctors carelessly ‘leave needles lying on the bed’.

**Counselling**

Several students expressed the need for counselling, not only in the case of needle-prick injuries, but also for staff who nurse terminally ill patients, especially those diagnosed with AIDS, because this causes great stress to the nurses concerned. A fourth-year student from UKZN said: ‘In the medical ward a patient dies every five minutes. I go home thinking about this but I do not get counselling.’ Another student in the same group said there are debriefing sessions in some hospitals, but there is generally no time for nurses to do anything else but nurse.

The need for counselling was also expressed by students training in the private sector. However, a Netcare bridging student felt counselling was impracticable. She said: ‘If they were to offer us counselling, the whole hospital would be queuing for counselling, because just about all the nurses are under stress.’

**Working with TB patients**

The most intense fears expressed to us by student nurses were of contracting TB, particularly the multi-drug-resistant (MDR) and extensive drug-resistant (XDR) forms.

Several college and university students from KwaZulu-Natal told us that TB is worse than HIV and AIDS. One student said: ‘Many of us have contracted TB. Every day you think you can never be too sure.’ Many students said they are afraid that the current precautions are insufficient. They complained of a lack of masks in the public hospitals and of having to pay for masks in the private institutions where they worked. They felt gloves are unreliable: ‘You put gloves on, thinking you are safe, but when you take them off you find that your hands are wet.’

Several students complained of not being informed that patients have TB or other infectious diseases. One third-year UKZN student said she spent two days with a new patient and was then told to isolate the patient because the patient had MDR TB. She was
devastated because she had not been warned that she had been exposed to contracting the deadly disease.

Another UKZN student said she was with a patient a whole week before she realised he had hepatitis B:

I was with the patient for the whole week, bathing him, handling him, then the doctors came to see the patient. They asked for a mask. When the nurse asked what the mask was for, the doctors said, ‘Well, the patient has got hepatitis B, and it’s highly infectious’.

Students were also concerned about the abrupt changes in the treatment of patients once they are diagnosed with TB. Because nurses get involved in the patient’s holistic well-being, they develop rapport with their patients. Suddenly withdrawing nurses from the ward does little to boost patients’ self-esteem.

Professional relations

Many students complained of poor interpersonal relations in nursing: between doctors and nurses, nurses and nurses, and nurses and patients. We will discuss each of these in turn.

Doctor–nurse relations

Although it began as the work of men (Evans 2004; Searle 1965), nursing has been conceptualised as a female profession since at least the nineteenth century, when Florence Nightingale promoted the career as ideally suited to the temperament and abilities of women and designed to support the work of doctors, who were male. Because of the gender hierarchy in society at the time, the practice of nursing came to be regarded as inferior to the practice of medicine (Nightingale 1860; Palmer 1983; Porter 1992). Today many doctors are women – indeed, women form the majority of students in medical schools in South Africa and internationally (Breier & Wildschut 2006) – but the professional hierarchy between doctor and nurse persists.

In our research, academics presented a reasonably positive view of nurse–doctor relations, probably because of their own higher status in the medical hierarchy. They said relations are better where nurses and doctors work and are trained in multi-disciplinary teams. In practice, medical and nursing students are taught separately, and are combined only for certain science subjects. One academic did speak of the persistence of ‘male arrogance’ among medical practitioners and said the fact that there are fewer white doctors now than before does not make much difference. Another said that ‘old-school’ doctors find it difficult to relate to the ‘new breed of more assertive nurses’. ‘Old-school’ nurses still act in a subservient manner towards doctors, while the ‘new breed’ do not. It was also argued that doctor–nurse relations are deteriorating where doctors perceive nursing standards to be dropping.

Students were much more critical of doctors, although they acknowledged there were some doctors who were helpful, allowed them to ask questions and generally communicated well with them, other nurses and patients. There was also a widespread view that in psychiatric nursing nurses are treated with far greater respect than in other branches of nursing. In psychiatric hospitals, the health professionals operate in teams and the nurses’ opinions are valued, students told us.
Nursing students acknowledged that doctors study for more years and acquire a form of knowledge different from that of nurses. This knowledge is less ‘hands on’ and therefore more highly rewarded in society. While their comments indirectly affirm the stigmatisation of manual work which has devalued the nursing profession throughout its existence, these nursing students were adamant that the very large discrepancy between doctors’ and nurses’ salaries is not justified.

Students told us that doctors work fewer hours and less hard than nurses, that they are with patients for very little time in comparison with nurses, and that they often rely on nurses to teach them the ropes when they start working. In addition, students said that doctors continue to regard themselves as better than nurses: they often fail to greet nurses or ignore them in ward rounds, turning to them only when something is wrong.

Students accused doctors of the following:

- **Poor practice.**
  - Leaving used needles around, which could be a danger to nurses.
  - Not knowing how to handle needles.
- **Underestimating the abilities of nurses.**
  - Giving no regard to the advice of nurses.
  - Underestimating the intelligence of nurses: ‘They don’t realise how hard we have to study. They think it is just a crash course.’
  - Being trained differently to them: ‘They always have a mentor with them, basically holding them by their hand. We [nurses] just perform duties.’
- **Poor communication with patients and with other nursing staff.**
  - Saying whatever they like to nurses.
  - Verbally abusing nurses, especially in theatre. One student blamed the nurses for allowing doctors to do this to them.
  - Getting irritated when a nurse phones them while also blaming her if she does not call them when necessary.
  - Making it hard to function because of their poor relationships with nurses.
- **Seeing themselves as superior to nurses.**
  - Being in a different class, being in a high-income group.
  - Being ‘like gods in the hospitals’ while nurses were ‘like gum underneath the shoe’.
  - Expecting nurses in public hospitals to perform many tasks that doctors are supposed to do, and for which the nurses will not be paid.
  - Expecting nurses to be submissive. One student said: ‘Most doctors are male, most nurses female. Society is such that females submit to males and this is the case in nursing.’
  - Being more arrogant at intern stage than when they have been in practice for a longer period.
- **Racial discrimination socially.**
  - Dating only the white nurses. White nurses date the male doctors but coloured and African nurses do not.

In the private hospitals, which virtually owe their existence to the doctors whose patients make use of these facilities, doctors were commonly perceived as arrogant and rude towards nurses. A bridging student from Netcare Training Academy thought that universities should include sociology in the medical students’ curriculum because doctors ‘see themselves as second to God when it comes to the working situation’ and did not even greet the nurses they were working with. Another said the arrogance of the doctors
was ironic because nurses often have to teach them certain procedures when they are still fresh from school.

In a group interview, senior managers from Life Healthcare agreed that doctor–nurse relations are very different in the private sector compared with the public sector. In the private hospitals, doctors are both customers and suppliers. They pay for consulting rooms, theatres and other facilities but also supply the hospitals with patients who pay a great deal for the institutions' services. There was a common but problematic perception that nurses should carry out the doctors’ instructions regardless because the patients are ‘theirs’.

In contrast, in the public sector both doctors and nurses are employees of the hospital and there is more of a ‘professional partnership’ or ‘collegial’ relationship between doctor and nurse, particularly if they adopt a multi-disciplinary team approach to teaching. Sharon Vasuthevan, training and development manager of Life Healthcare, said:

The unit manager in the public sector can tell the doctors, ‘You can’t do a ward round before I serve breakfast here.’ They have that ability, whereas in the private sector if the doctor wants to come in at half past six in the morning, he/she must be accommodated – because it’s all about the doctor.

Nursing education is also affected by the different relations, Vasuthevan said. In the public sector the consultants or professors discuss patients with nurses, interns and registrars and include everyone in their teaching rounds. It is not unusual for a public service doctor to take a nursing student aside to show her something or even call nursing students into theatre. In contrast, doctors at private hospitals have to be approached for permission for a student to be allowed to witness a procedure because the doctor is the ‘customer cum supplier’.

However, when private doctors were asked specifically by management if they would assist with the teaching, they actually seemed to like it and often said they would like to do more. Vasuthevan said it is possible that doctors have been stereotyped based on past perceptions and practices. The younger doctors are a little more open to helping students. However, all private sector doctors are very busy and have little time to teach.

It is a limitation of this research that we did not canvass the opinions of doctors about nurses. Nonetheless, from the HSRC professions study on doctors (Breier & Wildschut 2006), in which doctors complained about lack of cooperation from nurses, and from the reports of misconduct that we discuss later in this chapter, we suspect that the perceived conflict between nurses and doctors is not entirely the fault of the latter. Further research that investigates the perceptions of doctors would be valuable.

Male versus female nurses

The international literature on men in nursing suggests that the subtle social processes, institutions and ‘informal sanctions’ (Evans 1997 in Romem & Anson 2005: 177) that serve to exclude women from male professions are also prevalent – in reverse – in nursing, serving to exclude men.

Until quite recently, men who wished to become nurses were relegated to asylum nursing, where their superior strength was required to restrain violent patients (Evans 2004: 323). However, the psychiatric education of male nurses was inferior in quality and
quantity to that of female nurses (Edwards 1989 in Evans 2004: 323; Mericle 1983), contributing to the low status of males in the profession. Although there have not been any legal restrictions to their entrance to nursing, men who become nurses have been historically viewed as anomalies and labelled as homosexuals (Evans 2004: 324).

More recently, however, many male nurses have risen to senior positions within the profession. Evans (1997: 226) attributes this to patriarchal gender relations that operate even in a female profession such as nursing, reflecting ‘a high valuation of all that is male and masculine, [and] playing a significant role in situating a disproportionate number of men in administrative and elite speciality positions’. One manifestation of this high valuation is that male nurses are treated well by their female colleagues, in stark contrast to the non-supportive – and in some cases severely negative and hostile – treatment that small numbers of women very often experience in male-dominated professions (Evans 1997).

In our research, students told us:

- Male student nurses are regarded as homosexual when they are not.
- Some female patients, in particular Muslims and Somalians, do not want to be handled by a male nurse. A male nurse was accused of ‘fingering’ a patient during a vaginal examination.
- Male nurses are treated with greater respect than are female nurses, both by other nurses who refer to them as ‘Sir’ or ‘Mr’ and by patients who often call them ‘Doctor’.
- Male nurses do not like being called ‘Sister’.
- Male student nurses are more easily accepted by nursing staff than female student nurses and sometimes get preferential treatment (this sentiment was expressed by both male and female student nurses). A male student jokingly said, ‘Female staff respect male nurses because they realise that the male nurse will be their boss one day.’ This light-hearted comment has more than a grain of truth in it.

On the other hand, some lecturers (particularly those at WCCN) decried the large increase in male nursing students, saying the men are attracted to nursing not because they want to be nurses but because they can earn money or get a good bursary while studying; and some see it as an opportunity to get into university as well as student politics. The drop-out rate among male nursing students is high.

Thembeka Gwagwa, general secretary of DENOSA, said in an interview that she was shocked to realise the number of males who were assuming leadership positions in nursing, in relation to the large number of female nurses in the profession. She pointed out that in DENOSA, six out of the nine provincial secretaries were males, but 94.7% of DENOSA’s membership was female. The president of DENOSA was a male but the other five national office-bearers were female. As general secretary, she had two deputies, of whom one was male. ‘But as you go lower it becomes critical,’ she said. DENOSA had 12 full-time shop stewards who were elected by members and paid by government to do union work. Only one woman was elected. It seemed that the female nurses felt comfortable having men speaking on their behalf.

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45 Breier and Wildschut (2006), for example, have written about the difficulties experienced by female surgeons.
Relations between nurses themselves

Several male nurses commented on the poor relations between female nurses themselves and said it was better to have a mix of genders in the hospital setting. If only women are present, ‘trouble is inevitable’, one said. ‘Females hate each other in hospital,’ said another. Some students said they saw nurses intimidating their colleagues in front of patients.

A UKZN lecturer said nursing is a caring profession but nurses do not care for each other. Many people were hurt by ‘that very vindictive kind of attitude we see in the nursing profession’. She said nurses were very poisonous towards each other and it was ‘a cultural thing’. She wanted to do research on the issue but was also too involved – ‘my pain is too big’. She said she worked for a long time in psychiatric nursing units and then went back to high-care nursing for three months:

I was traumatised because of the way the nurses were talking to each other and to the patients and the way the managing nurses talked to the nurses working under them. I mean, you’re a registered person, you have worked for so many years...and then the way the doctors talked to nurses. I could not believe that we could be so abusive to one another.

Relations between staff and students

Academic staff, clinical nurse educators and hospital staff we interviewed complained that students see themselves as students, not workers, and some are reluctant to perform duties that are beyond what is necessary for them to learn a new competency. On the other hand, students complained that they were abused by nurses in many different ways. It is likely that the difficult relations between students and hospital staff are among the effects of the disjuncture between clinical practice and nursing education and the lack of coordination between the DoH and the DoE.

Students alleged that nurses abuse students verbally. For example, when a student asked about something in the wards, the nurse would say, ‘I’m only here for the patients, not for the students; you’ve got tutors who are going to teach you.’ The students said degree students were treated worst and this was probably because of jealousy about the qualifications they were soon going to earn:

If you’re a degree student, the nurses in the ward ask you to do things, and if you can’t, they laugh at you because you are thought of as someone who thinks they know better.

At Netcare, second-year EN students collectively told a story of one classmate who had to leave nursing because the sisters and nurses in hospital ‘criticised her’ to an extent that ‘she had a nervous breakdown’. The group described their colleague as someone who was soft and the right type of person to be a nurse, but unfortunately she did not survive in nursing.

At Tygerberg Hospital, Afrikaans-speaking nurses asked UWC students who could only speak an African language and English, ‘How can you be a nurse if you can’t speak Afrikaans?’
The placement of students on weekend shifts was another source of concern. Students said they did not mind being on weekend shifts per se, because sometimes the wards are quieter then and they have more time to learn procedures. The problem is that there are no tutors at weekends and the hospital staff do not want to teach them and in any case cannot assess them. Tutors need to sign that the students have performed the procedures and need to see them doing it.

Students complained that nurses got them to do work that they should have done themselves. Night staff who should leave only at 07h00 asked students to come in at 06h30 to wash patients when they should be doing the washing themselves. Then the staff member would go home early or just sit at the nurses’ station while the student did the work.

The animosity between students and staff extended to staff exposing students to risks they would not take themselves. One WCCN student said she knew students should not touch any body fluids without gloves, but sisters complained that they wasted gloves. Sometimes students found there were no gloves to wear, and if the sister saw them just standing and not treating the patients she would shout at them. This student believed that if a student became infected by HIV, he or she would not be covered financially, which would be very difficult if the student did not have medical aid. Therefore the lack of gloves meant ‘your life is at stake’. She also said there was no counselling for students dealing with HIV-positive patients. They only received counselling if there was a needle-prick injury.

Another third-year WCCN student accused nurses of ‘withdrawing’ from patients with HIV and MDR TB and sending the students to deal with them.

**Nurse/patient abuse**

Numerous interviewees raised the issue of abuse: by patients against nurses and nurses against patients. We will discuss each in turn.

**Patients’ abuse of nurses**

This form of abuse appears to be related to the very long queues in which patients have to wait for treatment: often they wait a whole day and are still not attended to and have to return the next day. Then there are the frustrations that patients experience because of insufficient resources, both human and physical. For example, nurses are not able to prescribe medicines unless they are specially qualified to do so. When a patient needs a prescription medicine for pain, for example, nurses have to call the doctor, who often takes a long time to arrive because doctors are also in short supply. Patients then blame the nurses for the situation, often verbally abusing them, not realising that the nurses are innocent in this regard. Some patients act violently towards nurses when in a state of confusion or delirium as a result of their illness. In psychiatric hospitals the managing of violence or potential violence of patients against staff is part of the business of psychiatric nursing and medical staff. In trauma wards, nurses can be assaulted by patients who are drunk or drugged (especially on tik).

Of patients’ abuse of nurses, students said it was under-reported in comparison with nurses’ abuse of patients. They alleged:

- ‘The patients tell you what to do, and then they blackmail you emotionally when you decline their request.’
Visitors also place unfair demands on nurses. 'Some patients tell you how you must perform your duties and this puts the nurse under pressure.'

In midwifery situations, both patients and nurses shout at each other – ‘it's chaotic'. One fourth-year KZNCCN student complained of sexual abuse. She said she was working in a urology ward, where she had to dress wounds on a male patient's genitals. The patient began ‘talking nasty things to me'. She reported the matter to the sister but nothing was done. She requested not to do that particular patient's dressing, but in vain. She went to do the dressing again, and then 'he started touching me, and I slapped him, automatically, and the way the man screamed, everybody ran'. She was required to attend a disciplinary hearing; however, she was still allocated to do that patient's dressing. She had to ask certain staff nurses to be her witnesses when she went into the patient's room, and then the patient said to her, ‘Yesterday you failed', suggesting that she was supposed to cooperate to avoid being fired. That was not the only time this student was ‘abused' by a patient. The second time 'the patient kicked me from the lift down the stairs'. In both instances, the sister said to her, ‘You should have been more careful'.

Patients are sometimes lazy and pushy, and this irritates nurses. Patients sometimes push nurses to the limit. Nurses have even been spat on and kicked by frustrated patients. Patient abuse of nurses is particularly prevalent in private hospitals: 'sometimes it seems like patients cannot distinguish between hospital and hotel'.

Many patients are racist, treating nurses differently according to their race.

A UWC fourth-year student also blamed patients for the fact that nurses worried about patients who might die. She interpreted this as a form of emotional abuse.

A middle-aged second-year bridging student from Netcare Training Academy, who had worked in both the private and public sector, said:

I don't think people really recognise how bad it is. Like, for example, I worked in a trauma unit in a provincial hospital, patients come in, they demand that you help them now, if you tell them to wait they swear at you. I mean, somebody once told me I will rape you, just like that, without blinking...and I said come, do it...I don't think people realise how bad nurses are treated...I was actually attacked one day by a patient, a psychiatric patient, all my buttons were ripped loose...luckily I had a camisole. Afterwards I was so shocked...and my superior said, ‘Oh, it's six o'clock already, you're going home now.'

She added that this behaviour was worse in the private sector, where patients pay for the services. The patients ‘abuse' you and then ‘turn around and tell you that they are paying your salary'.

To emphasise the point, it was said in a focus group with Netcare student nurses that there isn’t a week that goes by without complaints from patients. ‘Every negative letter that management gets from the patient, it is blamed on you,' one student said. ‘We don't see good feedback,' another added. ‘All you ever get as a nurse is “shut up” and “do your job”.'
Nurses’ abuse of patients

On the other hand, each year many cases of nurse misconduct come before SANC, most of them related to poor basic nursing care. Figures on the SANC website (2008) show that in the period 2003 to 2008 a total of 843 nurses appeared before the SANC professional misconduct committee. Of these, 394 nurses (47%) appeared on charges related to poor basic nursing care, 143 (17%) on ‘medication-related’ charges and 135 (16%) on maternity-related charges. Of the 503 findings that had been made by 2008, 363 (72%) were findings of guilty and 42 (8%) not guilty. A total of 48 nurses (10%) had their cases removed from the roll, 44 nurses (9%) had their cases dropped for lack of evidence and 6 nurses (1%) were granted admission-of-guilt fines.

Considering all types of offences, professional nurses represented three-quarters of the nurses charged in this period (629 out of 843) and the greatest proportion of each category of offence. Most of the 629 professional nurses (286 nurses, or 45.5%) were charged with poor basic nursing care, followed by maternity-related charges (20.3%) and medication-related charges (16.7%). Enrolled nurses formed 14.6% of the 843 nurses who were charged; nursing auxiliaries, 8.8%; student nurses, 1.3%; and pupil nurse auxiliaries, 0.7%.

Although these figures form barely 0.5% of the total nursing workforce, there are many other sources of complaint about nurse abuse. In 1999 Manto Tshabalala Msimang, then Minister of Health, told the National Summit on Nursing:

Research shows that many patients are turned away from health services not because the facilities are inadequate or there are no drugs but because of the attitudes of those who provide care for them... It is totally unacceptable that clients are shouted [at], abused and mistreated by nurses in the health services. This practice must stop at once. (DoH 1999)

Jewkes et al. (1998) has reported on abuse in obstetrics services. There are frequent reports in the media about nurses’ disrespectful attitudes or neglectful behaviour towards patients.

We heard many anecdotes in our research about nurse abuse of patients. Such abuse has also been documented in the literature, and the records of the SANC disciplinary committee for 2007 reveal some serious cases of abuse in midwifery situations in particular. These include verbal abuse, poor monitoring of the mother and foetus during labour, and leaving a mother in the second stage of labour unattended to give birth by herself. Two cases were particularly horrific.

In the first case, two midwives failed to heed the screams of a woman in labour after she was admitted bleeding profusely late at night. This woman gave birth to a stillborn baby three hours after admission. Later, after she laid a complaint, her file ‘disappeared’. These midwives were found not guilty on most of the charges because the patient’s file could not be found and because the patient could not identify who had verbally abused her.

46 These include the inappropriate administration of drugs (e.g. incorrect dosage or administration of drugs without a doctor’s prescription).
47 Cases are removed from the roll if the matter is found to be trivial or the defendant is deceased.
But both midwives were found guilty of disgraceful conduct for ‘failing to intervene or advocate for the patient’ who ‘came in screaming’ (SANC 2007b: 15). They were suspended for three months each, with the penalty suspended for 12 months provided they are not found guilty of improper or disgraceful conduct in that period (SANC 2007b).

In the second case, a baby fell on its head immediately after birth because midwives allowed the mother to go to the bathroom when she was in an advanced stage of labour and then, when the mother was walking back to the ward and the baby started to emerge, one of the midwives failed to catch it because she did not have gloves and ‘did not know the patient’s status’. One midwife was found guilty of five charges of negligent behaviour and sentenced to one year’s suspension, suspended for three years. A second midwife was found guilty of failing to keep accurate records of the incident and sentenced to three months’ suspension, suspended for six months (SANC 2007b).

In the interviews conducted for this research, numerous reasons were put forward for the abuse by nurses and patients alike: the overcrowding of wards; the very large patient load because of the shortage of nurses; the stress caused by the nature of the diseases with which patients are presenting today (terminal illness such as AIDS, MDR TB, etc.); and the particular hardship of the HIV-positive nurse who has to manage not only her own health (and often does so in secret lest she be stigmatised) but also that of severely ill HIV-positive patients. It was also argued that nurses are not taken seriously enough within the health sector or treated as professionals. This leads them to fight among themselves and sometimes to take out their aggression on their patients. However, SANC records of professional misconduct cases show that in some cases the nurses were not overworked at the time of the abuse but instead were officious and uncaring. This finding is confirmed in a study by Jewkes et al. (1998), who have argued that one cannot simply blame poor working and living conditions and the legacy of apartheid for nurse abuse of patients. Their findings suggest that nurses sometimes deploy violence against patients as a means of creating social distance and maintaining fantasies of identity and power.

Academics’ views
A nursing professor at UWC confirmed that midwives were often verbally abusive; sometimes they even said, ‘But it’s the language of the midwife.’ She said her students were ‘absolutely astonished’ that she could whisper to a patient and still have a safe delivery, because they had learned from their role models that they must shout. She also confirmed that in some facilities young unmarried pregnant women received harsher treatment than others. She said students were very hurt by this and ‘I have to debrief them every week of things that happen in facilities.’

She also said midwifery is one of the most dangerous areas to work in because of HIV. Midwives work with blood all the time and the risk of needle-prick injuries in episiotomies is very high. Intensive-care units are also high-risk wards, but these have one nurse for every two patients. This is never the case in midwifery wards. Each case is urgent and midwives deal with life and death as part and parcel of their work, and this is not acknowledged. In labour wards, not only do midwives abuse patients but patients also abuse midwives. In these cases nurses are spat on, pinched and sometimes hit.

Another professor told of her own abuse by midwives after she became pregnant at 16 years of age. She said the midwives were very abusive and aggressive towards her because she was young. They also did not respect her rights and arranged, without her permission, that she be a model patient to undergo a vaginal examination in front
of 22 trainee nurses. She said she was only told that the next week she should come to the clinic in the afternoon rather than in the morning. When she did she found herself surrounded by a group of 22 nurses with their instructors. Three or four examined her, she said, and ‘nobody asked for my permission and I really felt as I was going home that my rights were violated’. She said that when she worked at UKZN, students used to report abuse by nurses in old-age homes. This was because these homes just took people ‘off the streets’, put them in a white uniform and thought they could then be nurses:

Sometimes [the nurses] want to punish the patient because the patient has been disobedient [or] the patient kept them on their feet the whole night, so they want to punish the patient and they would put the patient in a cold shower or in a – yes, that’s what happens – or in very hot water, just to punish the patient.

A third professor confirmed that verbal abuse was common among midwives, especially directed at teenagers, along the lines of ‘You were not supposed to be pregnant in the first place! Didn’t you know what it was like to deliver?’ When she was working on her PhD she came across such abuse ‘all the time’.

We were also told that it is not uncommon for nurses to reveal the HIV status of patients to other nurses. Thereafter the other nurses would wear double gloves and goggles when approaching that patient.

Students’ views

The following are some of the comments of students on nurse/patient abuse. Referring to the public hospitals and private old-age homes in which they worked, students said they saw the following:

- Nurses physically abusing patients.
  - A nurse ‘punching in the stomach’ a patient who was giving birth.
  - Nurses hitting patients in old-age homes.
  - Nurses not attending to patients’ requirements – for example, not giving patients medication when they ought to.

- Nurses verbally abusing patients.
  - A midwife telling a patient, ‘You opened your legs, open them now’.
  - Nurses ‘violating patients’ rights verbally’.
  - Nurses ‘taking it out’ on the patients after they have been irritated by a doctor.

- Nurses discriminating against certain types of patients.
  - Treating patients of a different race less well than patients of their own race.
    For example, one student said: ‘A black nurse won’t treat the Indian or coloured patient the same way she would treat the black one.’ Another said there was racism shown by coloured nurses towards African patients. Another student said older white nurses were verbally abusive to African patients.
  - Treating patients of a lower social class. A male student said: ‘Before they abuse the patient, they look at the social standing of that patient and then they will treat them accordingly.
  - Becoming irritated with patients who come from different religious backgrounds.
  - Treating patients in psychiatric hospitals ‘like they are psychotic, like they have no rights at all’. The fourth-year UWC student who alleged this said the abuse included swearing at patients and bathing them naked before others.
• Not understanding a patient’s language and performing procedures on a patient without the patient understanding what the nurse was doing or consenting to it.
• Abuse in public hospitals.
• Some students emphasised that the abuse problems were mainly in public hospitals. A fourth-year UKZN student said nurses in public hospitals did not respect patients’ rights: ‘If someone is sick they are nothing to nurses. Instead of helping the patients, nurses sometimes complicate the conditions of the sick.’
• A Netcare Training Academy student said: ‘In the state hospitals they really don’t care. They don’t care. My sister was lying in Jooste Hospital and I saw a catheter of a child and I couldn’t believe it was a child’s catheter. It was full of urine and the nurses were just standing chatting to each other, raising their voices up. So I could not believe that nursing has changed for the better while there were incidences like this. It also depends on where you are placed.’

Reasons for the abuse
A UWC first-year student said that sometimes the abuse happens unintentionally, as it had when she was left alone to deliver a baby. ‘When the head came out, the woman just closed her legs, and there was nothing else I could think of other than to slap her,’ she said. She said that she felt bad about it and reported it to the sisters, who then told her that it was something that always happens. A fourth-year student from UWC said nurses must sometimes be harsh to patients especially in midwifery; otherwise the mothers who fear pain might harm their babies in the birth process.

Students attributed the nurse abuse to
• demanding patients and tired nurses;
• shortage of staff;
• lack of ethical principles by non-professional nurses who needed education in this respect.

Salaries
According to DENOSA (2007b: 1), the year 2007 was ‘a year of blessing’ for nurses in South Africa, when nurses’ salaries, long regarded as abysmally low, were reviewed and substantially increased. Although the increases came close on the heels of a nationwide strike involving nearly one million public service workers and 17 unions, including nurses, the DoH attributed the agreement on the Occupation Specific Dispensation (OSD) to a ‘culmination of extensive engagement that has taken place for over five years’ (DoH 2007c, 2007d). DENOSA acknowledged that the successful outcome was the achievement of nurses themselves. Their persistence in raising the issue of poor salaries through research, lobbying campaigns as well as emigration to other countries helped highlight the plight of nurses.

Students’ views on salaries
As mentioned in the introduction to this monograph, it is one of the limitations of this research that some interviews and focus groups were conducted before the nursing salary increases and some afterwards. We expected there might be a marked difference between the opinions before and after. However, despite the increases, salaries remained one of the most important concerns of the students interviewed. Most were not yet earning salaries themselves. The UWC and WCCN students were mainly on provincial bursaries
amounting at the time to R26 000 per year. The UKZN students had paid their fees like other students at the university. Some had bursaries from the NSFAS.\textsuperscript{49} All the students training in the private sector were paying fees. A few students at Netcare Training Academy had bursaries provided by Netcare. Only the students at KZNCN were receiving salaries while they studied.

Many students said they were delaying thinking about salaries because they did not want to get disillusioned before completing their degrees. Yet they knew nursing salaries were low and were planning to go overseas, for a short while at least, to supplement them.

Among the private students in particular there were several students who had been working as nurses for many years and were well aware of the low salaries. These students were trying to upgrade their qualifications in order to earn more.

Although the increases were substantial for certain categories of nurses – particularly nurses with post-basic qualifications – students in interviews and focus group discussions after October 2007 did not seem particularly impressed. By that stage there had been several petrol price increases, leading to many other price hikes, and electricity rate hikes were on the horizon. To these students, nursing salaries were still poor, compared to those of other professions and in relation to inflation.

\textbf{Will the new salaries make a difference?}

Recent studies on dissatisfaction among nursing staff have found that salaries are a major cause of dissatisfaction, but not the only cause.

Ackerman and Bezuidenhout (2007) studied staff dissatisfaction in the theatre complex of a private hospital that had lost 121 theatre nursing staff and had 6 different theatre unit managers in an eight-year period. A questionnaire was distributed to all 39 members of staff (36 nurses and 3 surgical technicians) and all but one responded. The survey showed that the greatest degree of consensus was on the effects of the staff shortage, followed by dissatisfaction with salaries, lack of support from management and unavailability of stock:

- 90\% of respondents did not regard the staff complement as adequate to render safe and excellent patient care.
- 82\% felt their remuneration was not in accordance with the work expected, stress levels, hours worked and responsibilities.
- 74\% experienced a lack of support and understanding from hospital management, and 71\% felt the total workload was not justly distributed.
- 71\% named the unavailability of stock (including linen and pharmacy stock) as their biggest problem (owing to lack of communication with the pharmacy storeroom).
- 61\% felt teamwork was not in place regarding after-hours work and relief.
- 9\% were dissatisfied with the flexitime system as currently practised in the unit: while it gave nurses time off when the unit was slack, it did not remunerate nurses for overtime in accordance with overtime rates of pay, as in the past.

\textsuperscript{49} The average NSFAS loan/bursary at the time of the research was around half the amount of the provincial bursaries in Cape Town. Students were expected to top up these amounts from other sources (see Le Roux & Breier 2007). For many students at UWC and WCCN, the provincial nursing bursary was generous enough to seem like a salary and they expected it to spread further than it actually did once they had paid for tuition, accommodation, books, uniforms, and so on.
Selebi and Minnaar (2007) studied job satisfaction among nurses in a public hospital in Gauteng that had experienced a loss of experienced and skilled nurses at a rate of 67 per year for the previous five years (this amounted to 12% of the 578 nurses working in the hospital at the time of their research). A questionnaire was distributed to 230 nurses, of whom 117 responded (51%). A low level of satisfaction was 49% or less; moderate, between 50% and 59%; and high, 60% or above.

The study found that nurses at this hospital experienced a low level of satisfaction (42%) with aspects of their job such as motivation, responsibility, opportunity for creativity and innovation, independence and recognition. They experienced very low levels of satisfaction (22%) with the aspects concerning relationships in the workplace, supervisors’ decision-making skills and supervision, working conditions, policies, job security and compensation.

The study found the following reasons for dissatisfaction (here the percentages in brackets indicate the percentage of respondents who indicated this factor as a source of dissatisfaction):

- salaries (97%);
- promotion and career development (82%);
- working conditions (81%);
- DoH policy implementation (73%);
- lack of acknowledgement from supervisors (67%);
- lack of autonomy in the job (52%);
- a feeling of accomplishment in the job (50%);
- supervisors’ decision-making abilities (43%);
- creativity in the job (44%);
- the way supervisors make nurses feel (43%).

Although the majority of nurses at all levels felt proud of their work (73% of PNs and 80% of nurses at levels below PN), only 42% of PNs and 55% of nurses in other categories felt that they had ‘the opportunity to be seen to be contributing positively to society in their communities’. Very few (34% of PNs and 18% of those in other categories) felt that they did not have to do things that went against their conscience.

A study on job satisfaction among registered nurses in a community hospital in Limpopo (Kekana et al. 2007), which used a self-administered questionnaire to gather data from 34 nurses, concluded that the majority of respondents were dissatisfied with the working conditions and emotional climate in the hospital, while they were fairly satisfied with the social climate in general. Eighty-two per cent felt the workload was too heavy and 79% were dissatisfied with their pay and fringe benefits. Sixty-two per cent indicated that they were not satisfied with the guidance provided by supervisors. Nonetheless 82% ‘still indicated they were interested in nursing as a career opportunity’ and 85% were ‘satisfied with the self-esteem that they experienced in the work that they were doing’ (2007: 31).

In general the three studies discussed above show that salaries are a major issue for many nurses, causing profound job dissatisfaction; however, salaries are not the only issue. Management reforms, greater acknowledgement of the role of nurses and opportunities for career development would go a long way towards improving job satisfaction.
Non-monetary rewards

It is one of the limitations of this study that we did not specifically prompt interviewees and focus group participants to say what they liked about nursing as well as what they did not like. As a result, we heard a great deal of complaints and far fewer reasons why students actually stayed in the profession.

When students did comment positively, they spoke of nursing as being a passion and of the satisfaction of seeing someone get better with their care. They were also inspired by the gratitude of patients:

Helping someone who is sick, lying there, relying on you, made me realise how important life is... It made me want to go further... So for me it’s a passion and I love it...

After a long day, the patient just goes to you and says ‘thank you’, then you go home and you are happy.

When the patient at the end of the day says thank you, [it] gives me a boost to come back tomorrow.

All you need is just a patient to come to you and say thank you.

A lecturer with 30 years’ experience spoke of the unique connection between nurse and patient, which distinguishes the work of nurses from that of doctors and marks good nurses from those who are indifferent. A dedicated nurse is motivated by an intrinsic desire to help the sick and vulnerable and by the particular kind of professional but emotional intimacy and trust that develops between nurse and patient in the course of care.

Conclusion

In this chapter we have considered what it is like to work as a nurse in South Africa today, based on interviews and focus group discussions with students and interviews with academics, as well as secondary research.

We have noted the difficulties associated with working with severely ill AIDS and TB patients, particularly in KwaZulu-Natal. Students fear contracting these diseases themselves, are depressed by the number of deaths and believe that hospitals are not taking sufficient precautions to protect them.
The extent of complaints about interpersonal relations and communication difficulties in the hospital setting was alarming. Students and lecturers complained of verbal and physical abuse between nurses and nurses, nurses and patients, and nurses and students. Some nurses are verbally abused by doctors, while others are said to be overly assertive or passively aggressive in return. The poor interpersonal relations extend to cases of abuse by nurses against patients, as evidenced by professional misconduct cases brought before SANC.

Male nurses seem to occupy a more privileged space than their female colleagues in the hospital hierarchy. Many get selected to senior positions within the profession, where their representation is out of proportion to their numbers in the profession. However, male nurses are concerned about being regarded as homosexual when they are not.

In the course of our research, nursing salaries were increased substantially; but in interviews and focus group discussions conducted after this increase, we found that many were still unhappy. There had been substantial price increases in the interim and nurses in some categories – particularly managers in nursing colleges – were actually earning less than lecturers with less experience. Private sector nurses and those working for municipalities that had not raised their salaries felt left out. Nonetheless the salaries did place renewed emphasis on specialisations. The salaries of nurses with post-basic qualifications were increased by 88%. Other studies have found that salaries are not the only issue leading to nurses' dissatisfaction with their work.

After hearing the many complaints about nursing, we wondered why anyone would stay in the profession. Unfortunately, we did not include specific questions to this effect in our interview and focus group schedules. Nonetheless, some students and lecturers did speak of the rewards of nursing which, cannot be quantified in monetary terms, in particular the gratitude of patients who had been healed with their care. However, these sentiments did not seem to outweigh the problems in the profession, and many spoke of leaving the country to work overseas – if only temporarily.