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Ritual and the organisation of care in primary care clinics in Cape Town, South Africa☆

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ABSTRACT

Few sociological studies have examined care organisation in primary health settings in low- and middle-income countries. This paper explores the organisation of health care work in primary care clinics in Cape Town, South Africa, by analysing two elements of clinic organisation as rituals. The first is a formal, policy-driven element of care: directly observed therapy for tuberculosis patients. The second is an informal ritual, seemingly separate from the clinical work of the team: morning prayers in the clinic. We draw on data from an ethnography in which seven clinics providing care to people with tuberculosis were theoretically sampled for study. These data include participant observation of clinic sessions, and interviews and group discussions with providers and patients, which were analysed using approaches drawn from grounded theory. Our findings suggest that rather than seeing the ritualised aspects of clinic activities as merely traditional elements of care that potentially interfere with the application of good practice, it is essential to understand their symbolic values if their contribution to health care organisation is to be recognised. While both staff and patients participate in these rituals, these performances do not demonstrate or facilitate cohesion across these groups but rather embody the conflicting values of patients and staff in these clinics. As such, rituals act to reinforce asymmetrical relations of power between different constituencies, and to strengthen conventional modes of provider–patient interaction.

Introduction

This paper concerns the organisation of work in primary health clinics in Cape Town, South Africa that deliver care for tuberculosis (TB). It explores the usefulness of considering two rather different elements of organisation – Directly Observed Treatment (DOT) for TB patients and morning prayers in the clinic – as rituals. DOT is the practice recommended by the WHO in which TB treatment taking is observed for the full duration of treatment – usually six months or more – by a health care provider or someone nominated by the patient and the provider to take on this role (WHO, 2002). The development and implementation of DOT, and the wider TB control strategy in which it is embedded, have been described extensively elsewhere (Ogden, Walt, & Lush, 2003; Raviglione & Pio, 2002; Volmink, Matchaba, & Garner, 2000; Walt, 1999). Supporters of DOT have argued that it is required to 'protect' the limited set of TB drugs from the growth of drug resistance,[1] and that it needs to be seen as just one component of a larger TB control strategy (Ogden et al., 2003). By exploring the symbolic content of DOT and morning prayers in the clinic, we aim to contribute to an explanation of seemingly 'non-rational' behaviours in health care work.

In studying care organisation in this setting, we were struck by reports from clinic nurses that TB patients, on hearing that their six months of DOT was complete, sometimes asked whether they could continue attending the clinic until the week ended. That patients would want to prolong what, for many, was a burdensome

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[1] The use of a multi-drug treatment regime helps to ensure that if the tuberculosis bacillus becomes resistant to one of the drugs, it will be eliminated by one of the other drugs, thereby helping to reduce the overall development of resistance. Resistance is problematic because of the relatively limited number of effective TB drugs; the difficulties, in terms of length of treatment, mode of treatment delivery (injection), and costs of treating multi-drug resistant cases; and the danger of multi-drug resistant strains spreading in the community.

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daily clinic visit to receive treatment suggested that DOT had become an integral part of their routine. Yet its completion – a significant event – went apparently unmarked. Staff would record the patient's completion of treatment into the TB register but, for the patient, there was no ritual marker of their reintegration into the social body (Van Gennep, 1960). Health care settings are replete with ritual, from the organisation of surgery in the operating theatre (Katz, 1981), to ward rounds (Strange, 1996), patient clerking and the traditional return of a patient's 'normal' clothes to mark the end of an inpatient stay. Yet, at a point when some ritual might be expected, these patients were left seeking a natural end point, the weekend, to mark their new status as 'healthy'.

The puzzle of this 'missing ritual' raised a more general question of the functions served by the unusual procedure of DOT for both TB patients and health care providers. Why are TB patients in particular treated in this way? Although DOT is now commonplace within TB programmes, there are clearly other ways in which treatment delivery could be organised. Following from McCreery's study of meaning in therapeutic ritual, we address two key questions: "What are the possible meanings of this [ritual] work? What is the audience to which it is addressed and the situation to which it speaks?" (McCreery, 1979 p. 70) Because the care of TB patients includes a set of highly standardised and detailed procedures, some of which are of unproven efficacy (Volmink & Garner, 2007), this care presents an interesting opportunity to examine the role of ritual in the management of a common infectious disease. To illuminate the possible meanings of ritualised activity in this context, we also draw on data on a more obvious ritual in the clinic – that of morning prayers. We suggest that examining the symbolic meanings of these two contrasting work practices contributes to understanding the ways in which care is achieved (or not) in formal health settings.

Accounting for rituals in health care

The term 'ritual' has been used in multiple ways (Douglas, 1996; Katz, 1981; McCreery, 1979; Turner, 1969), and the growing body of literature on the role of ritual or ritualised practice in nursing work (Chapman, 1983; Holland, 1993; Strange, 1996; Wolf, 1988) draws on a range of theoretical starting points. First, the term 'ritual' has been used atheoretically by some commentators, to merely differentiate those practices that have a good 'evidence base' from those that do not, characterising the latter as 'traditional' practices, or 'rituals'. Such 'rituals' are cited as reducing the effectiveness of nursing care (Walsh & Ford, 1989). Thomson, for instance, notes: "Ritualistic practices have long stood in the way of effective infection control" (Thomson, 1990, cited in Strange (1996, p. 106)). Within this perspective, a ritual has no meaning, being merely an obstacle to greater efficiency rather than a theoretical tool for understanding nursing work.

Others have drawn on social science literature to explore the meanings of ritual. From a functionalist perspective, ritual has been seen as serving: psychological, social and protective functions; the identification of values and rules; and the negotiation of power (Bell, 1992; Helman, 2000; Strange, 1996). From Van Gennep (1960 [1909]) onwards, there has been a particular interest in rituals of transition, and their functions in helping to ameliorate and control danger and anxiety related to changes of state or to a lack of clarity in classifying a category or state. This has been of particular interest in health care, with a focus on how health providers, in their day-to-day work, cope with uncertainties of diagnosis and management and how patients manage the transition between illness and wellness (Helman, 2000). Rituals provide boundaries to categories in the context of transition, for example, between being 'well' and being diagnosed with TB, thus allowing social actors, such as health care providers, family and friends, to respond appropriately (Katz, 1981). Ritual therefore entrenches, through performance, categories created within biomedicine, such as 'sick' and 'well', 'adherent' and 'non-adherent'.

In nursing, one functionalist argument draws on psychoanalytic theory to identify the functions of ritual for individual health care workers, proposing that it is through unconscious defence mechanisms that individuals deal with painful or difficult feelings, such as fear or loathing, that may harm the self (Lupton, 1997). This perspective suggests that providers may experience difficult, even conflictual, feelings as a result of patients' emotional expectations and direct contact with patients' bodies (Menzies-Lyth, 1988; Obholzer & Roberts, 1994; Skogstad, 1997; van der Walt & Swartz, 2000), arousing deep anxieties that may be too difficult to consciously examine (such as helplessness in the face of inability to cure). Psychoanalytic approaches go on to note that ritualistic defensive techniques on both individual and collective levels may protect against these anxieties (Chapman, 1983; Skogstad, 1997).

More sociologically, rituals in nursing work can be seen as having social functions. Turner's definition of rituals as "dramas of social events which emphasize the importance of the event they symbolize or represent" (Turner, 1969, p. 59) emphasises rituals as *performances* that enact and institutionalise culturally constructed categories. Thus, in health care, ritual practice is not only used as a defence against anxiety, but also for social effect, creating and reflecting cultural values regarding the treatment of the sick (Chapman, 1983). Rituals are essential to healing itself, especially in terms of reintegrating the 'sick' person into the 'healthy' social body. For example, the discharge of a patient from hospital involves returning their civilian clothes, indicating that they may rejoin the world of the 'healthy'. Ritual may also be used to maintain boundaries between states, such as dangerous or safe, sterile and non-sterile. This reduces uncertainty and increases the autonomy of actors by indicating clearly which states are operative at any particular time (Katz, 1981, p. 336).

Much work on the social role of rituals assumes that they act to unite a homogenous group, with all those participating sharing values and meanings, as expressed in the enactment and symbols of the ritual (Baumann, 1992). For Leach (1976), for instance, the key aspect of ritual is that there is no separation between performer and audience. Such assumptions of homogeneity are problematic in modern health care organisations, in which different constituencies (of staff groups, of patients) may not subscribe to the same set of meanings. More recent work on ritual has highlighted these potential conflicts. Drawing on the work of Durkheim, Baumann, for instance, argues that rituals may be "performed by competing constituencies" (Baumann, 1992, p. 99) with different relationships to the performance, symbols and meaning of the rituals. Rather than being limited to "insiders", participants in rituals in plural societies may include a range of outsiders with these different parties "each using symbolic forms to stake mutual claims" (p. 101) through the enactment of the ritual. Ritual, Baumann suggests, is therefore a platform for defining and negotiating relationships with others. This paper takes this approach as a starting point, to explore how ritualised practices in primary care clinics may embody and entrench power relations, being potentially functional for some constituencies while being dysfunctional for others.

Methods and setting

This study formed part of a larger ethnographic study of the impact of clinic organisation on professional responses to change in primary health care clinics in Cape Town (Lewin, 2004). The setting was urban and peri-urban municipal primary health clinics within the Cape Town metropolitan area that deliver care to TB patients. The size, patient load and staff complement of these clinics ranged