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Ways of Coping: How medical doctors manage their work within the social security system in South Africa

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Abstract

Healthcare professionals in South Africa face significant challenges working in the overburdened and poorly resourced public healthcare system. Using the framework of street-level bureaucracy theory, this paper explores the coping strategies that medical doctors use in the context of conducting disability assessments for the South African disability grant (DG). Based on observations of medical assessment practice, as well as interviews with medical doctors, findings showed that doctors felt marginalised by the DG system and unsupported in carrying out their work. Many were overwhelmed by large patient numbers; faced significant professional and moral conflicts in carrying out assessments; and struggled with the interpersonal aspects of assessments, particularly pressure from patients to recommend grants. Using their discretion, doctors took short-cuts in their practice and employed coping strategies to simplify, and manage the conflicts and emotional stress of their work. These practices led to poor service standards and inconsistent decision-making. Some coping strategies involved objectifying and distancing claimants, which damaged patient trust in doctors and in the health and social security system more broadly. In outlining these coping strategies and their effects on policy implementation, this paper demonstrates the influence of structural and interpersonal factors on policy implementation, which has been overlooked in studies of frontline bureaucracies.

Introduction

When people enter state organisations, clinics, hospitals, welfare offices or public schools, they experience the state and its policies through their interactions with the frontline government workers who inhabit them (Maynard-Moody and Musheno, 2015). These frontline workers, whom Lipsky (2010[1]) terms 'street-level bureaucrats', deliver services, and act as the public face of these institutions. Frontline governmental employees also shape public access to services or entitlements, both through the quality of the service they provide and in the ways that they employ their agency and discretion in providing access to

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[1] First published in 1980.

services. The public's experiences of these frontline workers is often negative; they are frequently perceived to be delivering poor quality or inconsistent services, or blamed by policymakers for policy implementation failures (Brodkin, 2015).

In the South African public healthcare system, which provides the context of this study, health workers are often criticised for providing low-quality care and treating patients inadequately. While nurses have the worst reputation in communities in this regard, doctors, particularly those in primary care facilities (clinics and community health centres), are also thought to be disinterested, incompetent or insensitive to patients' needs or even demeaning or abusive towards patients (Jewkes et al, 1998; Walker & Gilson, 2004; Harris et al, 2014; Schneider et al, 2010; Fassin, 2008). As a result of these perceptions, high levels of patient dissatisfaction and a lack of trust in health workers has developed (Gilson, 2003; 2005; Harris et al, 2014).

In his account of street-level bureaucrats, Lipsky (2010) seeks to demonstrate that poor service delivery or diversions from policy are not primarily the outcome of badly behaved or incompetent individual workers. Rather, the behaviour of frontline workers is influenced by environmental and organisational factors. In many cases, frontline workers are overburdened, underpaid and work in difficult and resource-constrained settings; often making decisions with limited information and time. Lipsky argues that these bureaucrats use their discretion to develop informal practices, "coping strategies" or "mechanisms" to manage work-related stress and simplify their work in response to ambiguities in policy and environmental conditions. These conditions include high demand for their time, the complexity of decisions they face or conflicting demands. According to Folkman and Lazarus, coping strategies can be defined as "cognitive and behavioural efforts to master, tolerate or reduce internal and external demands and conflicts among them" (Folkman and Lazarus, 1980; cited in Vink *et al*, 2015).

These strategies and improvisations influence policy implementation, as the cumulative actions of street-level bureaucrats shape, or even "re-make", the policy at the coalface, creating a "gap" between policy and practice (Pressmen & Wildavsky, 1984). This agent-centred approach to understanding policy implementation links organisational and institutional arrangements with action, demonstrating how practice is influenced by context (Gale, 2017; Thoren, 2008). Although the concept of street-level bureaucracy emerged from and has been most commonly applied in Northern countries, its focus on the role of discretion and hence the motives that underlie the decisional aspects of frontline work provides an important frame for understanding the "problems" that seem to interfere persistently with policy implementation in African bureaucracies.

This concept is here employed to understand the behaviour of medical doctors responsible for conducting fitness-to-work assessments for the South African disability grant (DG). The DG is a means-tested cash transfer grant, provided by the state to people who are determined to be physically or mentally unfit to earn an income through the labour market. Medical doctors are responsible for conducting these assessments. Their gatekeeping role thus renders them street-level bureaucrats for the South African Social Security Agency – the government agency which administers social grant applications and payments.

While medical doctors are undoubtedly a professional group, their role as disability grant assessors is predominantly a bureaucratic one. Doctors are positioned as street-level bureaucrats to the extent that they work at the interface between citizens and the state, play an important role in the allocation of state benefits, and are subject to the bureaucratic constraints and regulations of social security and health policy. In order to make decisions about patients' eligibility for grants, doctors must apply the protocols and rules that govern DG allocation to individual patients; translating policy into practice. They are simultaneously expected to follow rules and bureaucratic processes and use their professional judgement to evaluate the case at hand by engaging in 'thought-work' (Heyman, 1995) through the use of their agency. South African doctors have been criticised for many years by policy makers, administrators, civil society and the public for conducting subjective and arbitrary DG assessments (Baron, 1992; Segar, 1994; Delany et al, 2005; MacGregor, 2006; Jelsma et al., 2008).

The work of doctors, who tend to be regarded as highly-skilled and powerful professionals, rather than as bureaucrats, has been rarely examined using the lens of street-level bureaucracy (see Harrison, 2016; Gaede, 2016 for exceptions). In general, the individual agency of doctors has not been a central focus in thinking about how doctors adapt to organisational life (Hoff, 2003). In his seminal work, Lipsky (2010) includes doctors in the wide range of professional, semi-professional and white collar public service workers in the street-level bureaucrat category. Nevertheless, empirical research on street-level bureaucrats that has since emerged has been largely limited to lower-level workers, neglecting more professional groups.

While doctors share many of the common experiences and difficulties of frontline work, Evans (2010, 2011) argues that differences in occupational status are important, reasoning that the idea that medical professionals have discretion is fairly obvious. Doctors are not purely bureaucratic functionaries; they have certain commitments to their patients, professional values, and historically have had high levels of discretion, although this is changing in the age of protocols and evidence-based medicine (Timmermans & Berg, 2010).

Nevertheless, the street-level bureaucracy framework remains useful in examining doctors' work because it highlights tensions between professional expertise, discretion, values and bureaucratic accountability, as well as the gulf between their goals as professionals and the realities of their work (Brodwin, 2012; 2015). While the literature on street-level bureaucracy is replete with empirical examples of coping behaviour employed by workers (Tummers et al, 2015; Brodkin, 2012; Dubois, 2010), far less attention has been given to coping behaviour in sociological or anthropological studies of health workers (Karadaghi & Willott, 2015; but see Fassin, 2008 for an exception).The field of medical sociology has shown, however, that medical decisions and resource-allocation in healthcare are not based solely on an objective clinical assessment, but are socially complex processes shaped by social and cultural context (Nurock, 2009: 504).

Schön (1983, 1987) has argued that professional decision-making requires tacit thinking and a pragmatic rationality, but professional action is still exceptionalised as highly technical and objective. By positioning doctors as street-level bureaucrats and workers (Hoff, 2001; 2003), rather than professionals, we can draw on a much broader set of literature in understanding their work. Viewing doctors as workers is humanising and helps us to look beyond the homogenising structure of the medical profession. This lens also helps us to understand the working lives of doctors and the context-dependent aspects of their decision-making and ethics (Checkland, 2004; Kelly, 2016; Hoff, 2003; Rowe, 2012).

This paper focuses on doctors' daily work as DG assessors for the state. I explore the ways in which doctors make morally and intellectually complex decisions in a context of poorly defined eligibility criteria, high structural unemployment, poverty, and which bear a significant burden of disease within and amidst contrasting and unresolved discursive tensions relating to development and welfare, as well as regulatory and budgetary challenges. I begin by examining the tensions, constraints, incentives and disincentives doctors face in their daily work environments. I then discuss the strategies doctors used to cope with uncertainties and work pressures and their need to navigate between their role as medical professionals and that of 'objective' gatekeepers to state resources, thus straddling the often conflicting demands of the South African Social Security Agency, benefit claimants and their own personal and professional interests, morals and values.

It is important to analyse how doctors' work is structured by their environments because the way that individuals exercise agency in managing their work within existing systems and structures can shape the allocation of resources and the structure of institutions, such as the welfare system (Rice, 2013; Maynard-

Moody & Musheno, 2015). Empirically, this study contributes to the small evidence-base that focuses on ways of coping in the public service sector of countries of the Global South. On a more theoretical level, this study expands understandings of the behaviour of more professional groups of public servants. It also demonstrates how macro-level factors, such as the political and economic environment and social institutions, shape street-level work. These factors have largely been neglected in the street-level bureaucracy literature, which has largely focused on the use of discretion in response to working conditions and less on the broader environmental influences that structure their behaviour (Rice, 2013; Garrow & Grusky, 2013; Thoren, 2008).

Methodology

Data was collected in clinics and hospitals over a period of eleven months between October 2013 and August 2014 in the Western Cape Province of South Africa, the Cape Town Metro, the West Coast, and Winelands districts. At the time of fieldwork, DG assessments in the Western Cape were conducted at all levels of the healthcare system by both treating doctors (in hospitals) and dedicated SASSA assessors (in community clinics).

I conducted research in twelve different community clinics in rural and urban areas, sampled to maximise demographic variation in patients in terms of race and income. I also conducted fieldwork at three hospitals, one of which was a psychiatric hospital, where I worked with doctors in the departments of cardiology, neurology, neurosurgery, orthopaedics, psychiatry, and infectious diseases.

Twenty-four doctors, who conducted DG assessments during the course of their work as treating doctors (12) or as dedicated SASSA assessors (12), were involved in the study. I directly observed the work of seventeen doctors over one or two days. In cases where direct observation was not appropriate or not possible, I conducted in-depth interviews with doctors. In total, 216 consultations were observed, of which 196 were disability assessments. I also attended two training sessions conducted for SASSA assessors, where another eight doctors discussed their experiences of conducting assessments. The process of gaining access to healthcare facilities and doctors made it difficult to purposively sample doctors based on characteristics such as race or gender, limiting my ability to draw conclusions about their effect on doctor-patient interactions.

Over the course of my daily field work, the doctor and I would discuss cases and the rationale for their decision-making. Observing the doctor-patient interaction created opportunities to learn how doctors engaged with, and examined patients. This also enabled me to witness how patients presented both their medical and social cases to doctors, and see how doctors responded to patient behaviour and characteristics. At the end of the day, I would conduct a more formal interview to reflect on the cases seen and address any remaining questions I had about their decision-making and general approach. Combining observation and interviews was useful in stimulating discussions with doctors that were grounded in the concrete particularities of cases and provided opportunities to probe their understanding of cases. While a number of measures were taken to minimise the influence of my presence in the room, this may still have influenced doctor-patient interactions. I also conducted interviews and focus groups with SASSA staff, occupational therapists, social workers, and nurses, along with claimants who were waiting for the doctor to arrive for their consultation.

Data from both studies was coded using NVivo. Coding took place throughout the data collection period, using open coding to identify concepts and categories. Once data collection was complete, data was recorded using themes, while selective coding was used to identify doctor-patient interactions that represented certain themes and patterns of behaviour. I also developed summaries of individual doctors' approaches, based on interviews and observations for comparative purposes. Findings were presented to SASSA officials, doctors, social workers, occupational therapists, as well as to community members and development workers in Blikkiesdorp.

Ethical approval for the study was received from the University of Cape Town Human Research Ethics Committee. In order to preserve the anonymity of the doctors and claimants, pseudonyms are used throughout this study.

Doctors' Work Environments

Street-level bureaucrats are conditioned by their environments to behave in particular ways (Garrow & Grusky, 2013). It is therefore vital to consider policy design, organisational capacity, political factors, and implementation context when assessing street-level bureaucrats' exercise of discretion and their contribution to policy outcomes (Meyers & Vorsanger, 2007).

Studies on street-level bureaucrats have demonstrated that their behaviour is influenced by a range of factors. These include external and internal policy frameworks, institutional and organisational cultures and hierarchies, organisational or bureaucratic procedures, hiring policies, formal and informal incentive structures, performance standards, classification guidelines and service strategies, as well as the capabilities and assets they have available to them to fulfil a job requirement (Gross et al. 2012; Prior & Barnes, 2011; Rice, 2013; Meyers & Vorsanger, 2007). This section will discuss the particular set of structures and circumstances that complicates doctors’ assessment work.

Economic, policy and regulatory environment

Doctors and claimant interactions are influenced by the policy, institutional, socio-economic and political environment they are embedded in. This environment influences both public demand for social grants and doctors’ decision-making. Politico-institutional theory suggests that political history, bureaucratic structures, and policy feedback processes determine the implementation of public policy interventions (Skocpol, 1992). This has certainly been the case with the DG. Two main macro-structural issues create challenges for doctors within the health system: 1) ambiguities in the disability category, which are deepened by high levels of structural unemployment and an inadequate assessment system; 2) demand for the grant, which is driven by high levels of poverty, the HIV/AIDS epidemic, and a history of inconsistent policy implementation.

The disability grant has, for many years, proven extremely difficult to administer and target effectively at “deserving” candidates (Graham et al., 2010; Kelly, 2013). This is partly because of the inherent difficulties in assessing disability, which are common to all disability benefit systems (Bolderson et al, 2002; Gooding & Marriott, 2009; Stone, 1984; Anner et al, 2013). Ambiguities around the definition of disability, coupled with difficulties in making binary distinctions between disabled and non-disabled people, mean it is difficult to use the term disability as an administrative category for allocating social rights. As no single definition of disability is feasible or desirable that will fit all purposes of assessment or all contexts, disability determination is subject to ideological, technical, and administrative challenges and disputes (Gooding & Marriott, 2009: 691; Hickel, 2001). As a result, even countries in the Global North, with well-established disability assessment systems, struggle to target disability benefits (Bolderson et al., 2002).

In South Africa, DG administration is further complicated by socio-economic factors, such as high levels of poverty and structural unemployment, as well as the broader policy environment and design of the social protection system. South Africa has a narrow unemployment rate of over 26% and current unemployment is around 36%, using the expanded definition. In an increasingly skills-intensive economy, large numbers of unskilled South Africans are unable to find work, except in the precarious informal economy, if at all. Those who are perceived as less productive – older workers, people with chronic illnesses and physical and mental impairments – are even less likely to be employed.

South Africa is unusual among developing countries for having such an established and relatively generous programme for disabled people (Gooding & Marriot 2009). Social assistance targeted specifically at disabled people is more common in developed welfare states, where lower levels of unemployment and absolute poverty are present, and which have better systems of support for sick and disabled people and more extensive social insurance coverage for the unemployed[2]. The South African government pays over 17 million cash transfers or social grants to children, the elderly and disabled people monthly; reaching two-thirds of all households. While extensive in terms of numbers, this categorically targeted system excludes large numbers of the working age, able-bodied unemployed, as well as people with manageable chronic illnesses (Nattrass, 2006).

Although there has been some parametric reform and extension of the social grant system (in the cases of the Old Age Pension and Child Support Grant), the South African state has resisted introducing new social grants for either the chronically ill or the able-bodied unemployed (Seekings & Matisonn, 2010)[3]. Disability grant policy has shown strong path dependency and, despite a number of failed attempts at reform, eligibility criteria and the assessment process have not changed significantly since the grant was first introduced in 1946.

As a results of gaps in social protection coverage, the DG has been in high demand from people for whom the grant is not intended, namely the chronically ill (particularly those with HIV/AIDS) and able-bodied unemployed, who view claims of disablement as a means to access a stable form of income, and thus consider even minor ailments as an opportunity to apply for grants, often re-applying repeatedly until successful (Kelly, 2017). This places doctors in a difficult position as they must make decisions that have significant financial implications for patients and deal with significant pressure from their patients to approve grants (Kelly, 2017).

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[2] Although contributory unemployment and disability insurance exists in the form of the Unemployment Insurance Fund, this is very limited and does not include informal sector workers or those who have not been recently employed (Bhorat et al., 2013).

[3] The government has also been reticent to provide financial support to the long-term unemployed outside of its Extended Public Works Programs, which reaches only a small proportion of the over 26% people who are unemployed (Stats SA, Q1 2015).

This can lead doctors to diverge from policy and break or bend rules to accommodate patients who they feel should receive state support. This tendency was particularly widespread during the height of the HIV epidemic in the early 2000s. Unclear policy and poor oversight of the assessment process contributed to a large increase in beneficiary numbers. In this context, the DG became, in effect, an HIV grant and even a general poverty alleviation grant, thereby serving a purpose beyond the one for which it was designed. In some communities, the DG has been called *igrant yokuhlupheka*, translated as "the grant for the poor people" (Delany et al., 2005; Steele, 2006; Hansen & Sait, 2012).This provides an example of what Hacker (2004: 246) calls policy drift: "changes in the operation or effect of policies that occur without significant changes in those policies' structure." Policy drift tends to emerge when shifting social and economic conditions create a gap between the original aims of the policy and new emerging realities – in this case, the HIV epidemic.

Unable to address the seemingly intractable macro-structural issues that drive demand for the DG, and unwilling to extend the social assistance system to cover the long-term unemployed and chronically ill, the state has taken a managerial approach, seeking to manage access by restricting bureaucratic discretion through managerial procedures, oversights and rules (see Kelly, 2013). SASSA, the street-level organisation charged with implementing DG policy was tasked with managing unresolved conflicts and ambiguities around DG policy and has had to develop its own criteria and organisational structures to control DG policy implementation and outcomes. While there has been a significant reduction in the numbers of people *receiving* DGs since 2007; there has not been the same reduction in the number of people *applying* for grants. The reason for this is that it has been difficult to correct public perceptions that DGs are for anyone who is poor and has a medical condition, causing doctors, and the DG system, to remain under pressure from large numbers of applicants.

Organisational context

The level of support, authority, discretion, role expectations, and workload experienced by frontline workers, combined with their beliefs about their environments, have distinguishable effects on the dynamics of worker-client interactions (Jewell & Glaser, 2006; Meyers & Vorsanger, 2007). This was particularly noticeable in the case of doctors, who were strongly affected by the organisational environment in which they conducted assessments. According to Hoff, doctors think and act subjectively in response to their work environments, in ways that do not always accord with the norms and ideals of the medical profession but which help them to "normalise" their work lives and cope with uncertainty in their surroundings (Hoff, 2001: 54). Understanding the context that doctors work in also helps to understand their decision-making and behaviour towards patients. In conducting assessments, doctors operate within both the public health system and within SASSA's Disability Management Model, each of which presents their own set of challenges, constraints, incentives and demands.

Medical decision-making is by nature complex and doctors often make important decisions in conditions of uncertainty. As a result, they face high levels of stress relative to many other professionals and find it difficult to maintain work/life balance (Siraway et al, 2012). Doctors who work in low resource settings face even more challenges in carrying out their work. The South African public health system has been described as a stressed and poorly functioning institution (Le Marcis & Grard, 2015; Van Holdt and Murphy, 2005). Doctors working in the public sector in South Africa do so in an environment of significant emotional strain, punishingly long hours, staff shortages, high patient loads, a lack of equipment, medication and poor working conditions. They also earn significantly less than doctors working in the private sector and are often forced to make decisions that are not always ideal (George *et al*, 2013; Gibson, 2004).

In case of DG assessments, the daily stress of working in the public sector is compounded by the need to make decisions that can significantly affect the welfare of claimants. During their interviews with me, doctors often described their work as stressful and difficult, especially when they were uncertain about a patient's eligibility; many felt compassion for patients who did not qualify, or experienced pressure from patients to recommend a grant.

In the Western Cape Province, the SASSA regional branch has a Service Level Agreement with the provincial Department of Health (DoH). It uses DoH facilities and doctors, and pays the department for each assessment conducted. Doctors conduct disability assessments either during patient care at the secondary or tertiary levels[4] of the healthcare system or as locum doctors hired specifically by the DoH (and in some areas by SASSA directly) to conduct assessments at the primary care level. The majority of DG assessments in the province take place at the PHC level, and are conducted by physicians contracted to carry out the disability assessments. These supposedly impartial third-party agents, whom I will call "SASSA assessors",

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[4] Secondary healthcare facilities include district and regional hospitals. Tertiary facilities are central hospitals that provide specialised care to patients from across the country and are also often teaching hospitals.

do not treat patients they assess. These doctors tended to move between multiple PHC clinics to conduct assessments.

In the past, all medical officers were able to fill out DG assessments for patients, but SASSA has reduced its reliance on the assessments of treating doctors in primary care settings. Treating doctors in inpatient and outpatient hospital clinics settings in the Western Cape are, however, still expected to conduct assessments themselves. The move towards using third-party assessors sought to reduce pressure on already overburdened treating doctors and assist doctors with established relationships with patients, who may struggle to be objective or have incentives to privilege patients' interests over those of the state.

The healthcare system is generally highly bureaucratised by paperwork and standardised practices. I noticed this bureaucratisation of the physician's role particularly in the case of SASSA assessors, whose interactions were very much structured by SASSA's managerial processes and the standardised assessment tool. Working as a SASSA assessor is repetitive, sometimes mundane work, which is poorly paid relative to other locum work, but is relatively flexible. The work attracts retired doctors, those looking for flexible work arrangements, and those interested in supplementing income from their private practices or as a form of transitory work whilst looking for another post.

The freelance, sub-contracted nature of DG assessment work means that there is little management of these assessors' work and lines of communication and accountability are often unclear. In the case of locum doctors, the low pay they receive per hour or per assessment incentivises them to complete as many assessments as possible in as short a time as possible[5]. Although doctors contracted via locum agencies do have some contact with SASSA through an annual training session, their work is not directly managed by either the Department of Health or SASSA. Their work is thus especially difficult for the DoH or SASSA to oversee, meaning that the DoH struggles to ensure the quality of assessments promised in the Service Level Agreement.

Although they are broadly accountable to the DoH and South African Medical Association and its standards and codes of ethics, SASSA has a limited ability to manage the quality of doctors' work except through auditing, which is limited to 20% of assessments. There is also little accountability to patients, who are not in a position to determine the quality of the assessment or to complain about how they

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[5] SASSA officials and other doctors also provided numerous accounts of doctors rushing through assessments claiming for a full day's work, which had led to formal disciplinary action against at least one doctor.

are treated. Although no longer in practice, during my fieldwork I observed a quality assurance officer, who was able to change their recommendation after reviewing the assessment process. Many doctors felt undermined by this process. As one doctor, Dr Brown, informed me:

> Another doctor will review your work. What other doctor? Who is he? What right has he got to review my work? What is he doing when he reviews my work? Is he looking at the writing or is he trying to understand the patient? He’s not there with the patient so how the hell is he going to know anything about what you really think about that patient and that choice - your choice to give him this or give him that? (Interview, Dr Brown, 2014 April 4)

Poor communication and unclear delegation of responsibility between SASSA, locum agencies, doctors and the clinic resulted in a number of challenges. This arrangement made it difficult for SASSA to manage the work environment of assessors, as they relied on the DoH to provide facilities for assessments.

Assessors at some clinics complained that because they were not treating patients, their needs in terms of space and examination facilities were given low priority. Doctors were often placed in public use areas and beds were not always available as required. In one particularly memorable case, the doctor was sharing a room with nurses, who regularly came into the room to make tea and fetch things from their handbags during assessments, sometimes even making casual conversation with the patient or doctor. This was disruptive, undermined the privacy of the consultation and de-motivated doctors. As locum doctors were not contracted directly to the Department of Health, they were in a weak position to complain to facility managers about the resources made available to them. Because SASSA had no involvement with the employment of these doctors or the facilities they worked in, doctors had to rely on their locum managers to represent their interests, which some complained was ineffective (Observations, SASSA Training, 2014 February 19-20). This left assessors feeling frustrated and isolated from official structures – possibly inclining them to take official rules less seriously.

It was also difficult for doctors to manage their workload and the time they have available to see patients. SASSA offices within local communities are responsible for booking patients and doctors have little control over how many patients they see a day. SASSA offices in the Western Cape do not require a referral letter or any other pre-screening other than to check that the claimant had not applied for a grant in the past three months. Anyone is, therefore, able to request an appointment for a DG assessment, either at their local SASSA office or through their doctor at hospital level. This means that large numbers of people with little to no impairment, but who were desperate for an income, receive appointments to be assessed by doctors. At the time of my fieldwork, the SLA in place between SASSA and DoH districts stipulated that no more than forty claimants should be booked per clinic per day. However, doctors in high-demand areas reported cases where, because of poor process management, up to sixty patients had arrived to be assessed. Large patient loads limited the time doctors had to assess patients.

Challenges prevalent throughout the healthcare system also made DG assessments more complicated. Assessors were heavily dependent on the medical history of the patient to make decisions and the availability and quality of notes, letters and tests were very important. Unfortunately, notes were often illegible and inadequate and patient files often did not contain the necessary test results, reports or scans to allow the assessor to make a fully-informed decision. This was especially likely if the patient had been seen at the hospital level in the past or if the patient had moved between clinics. Although a small minority of patients brought referral letters, or personal copies of reports or x-rays with them to add to the information in their file, the majority of patients lacked evidence of treatment outside their main primary healthcare clinic. If DG assessments did not take place at the patient's regular clinic, the file would have to be sent there, but would often not arrive. In these cases, doctors would have to turn patients away in order for them return with their file or a letter that provided an overview of their medical history. This not only inconvenienced patients, but also frustrated doctors. While doctors could make referrals for further medical or work assessment tests, limited health resources and long waiting times to receive specialised care or testing, meant that doctors' ability to seek additional input and advice on the patients' ability to work was limited.

Unlike doctors who were specifically contracted to do assessment work, treating doctors were able to assess their own patients in hospital inpatient and outpatient settings. Doctors conducting DG assessments in state hospitals completed assessments forms in addition to their regular and already significant workloads; unlike SASSA assessors, they were not paid for this work[6]. As a result, doctors often considered DG applications burdensome and annoying distractions from their main work in a healthcare system that already required them to spend a large amount of time completing forms. I observed the following during my fieldwork:

> He says that in a busy clinic when a DG form appears 'faces often drop'. This is because people are usually coming forward with

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[6] In a few cases, the hospital was reimbursed for the time doctors spent doing assessments, but doctors received no remuneration for taking on this additional work.

> ‘soft indications’ and the forms are long and time consuming and a lot of doctors feel extremely frustrated by this when they have a lot of patients to see (Field notes, Whitney Hospital, 2014 March 14)

As patients receiving specialist care in hospitals were presumed to be more severely ill and, given the logistical difficulty of training and overseeing all doctors working in hospitals, treating doctors were given significantly more discretion in making recommendations. They were also not involved in SASSA’s training efforts, nor did they have access to assessment guidelines. This meant that doctors in treating settings were often unfamiliar with SASSA’s requirements and processes. Despite opportunities for more multidisciplinary input from other health professionals within the hospital, like at the PHC level, doctors in hospitals were faced with the challenge of missing notes, files, and generally poor recordkeeping, which made assessments difficult.

While SASSA doctors have no further involvement with patients after the assessment, treating doctors became frustrated when patients they were actively treating faced long administrative delays in receiving grants. The majority of doctors I met considered SASSA to be an incompetent and unresponsive organisation. Their lack of engagement with and trust in SASSA left them feeling little responsibility towards the DG system; they were, therefore, more likely to favour their own judgements and patient’s needs over SASSA’s requirements and had little incentive to uphold SASSA’s norms and standards.

Organisational guidelines and training

In 2008, SASSA introduced the Disability Management Model (DMM), a national assessment form and a set of guidelines meant to standardise and “rationalise” the disability assessment process. Although the DMM has significantly reduced fraud and backlogs, and has stabilised DG numbers, budget constraints have limited its full implementation. Uneven application of assessment criteria continues due to poor definition of the disability category and “grey areas” within the assessment process. The DMM was designed to lay the groundwork for the eventual rollout of a multidimensional Harmonised Assessment Tool, which would assess function, activity and participation restrictions rather than simply medical diagnosis by including the input of other health professionals such as occupational therapists and physiotherapists. However, the complexities and high costs of assessing activity limitations in relation to personal, environmental and socio-economic factors, and training health professionals to use this new tool, make it impossible for the current healthcare system to implement effectively. As a result, attempts to introduce this model and a more comprehensive and multidimensional definition of disability that can support it have been unsuccessful due to a lack of support from the Department of Health (Kelly, 2013).

In the absence of this model, SASSA provides a set of medical guidelines to doctors that include diagnosis-specific directives and impairment tables, which assign a value to each body part and assist in categorising the severity of an injury. Relative to other impairment-based systems such as the American Medical Association Guidelines, the SASSA tables are extremely basic and provide only broad impairment ranges. No instruction is provided on how to combine information from the impairment tables or information on what tests should be used to establish impairment. Internationally impairment-based models are recognised as limited because disability is rarely absolute and the effect of an impairment (or set of impairments) on an individual and their employability needs to be considered in terms of his or her activity limitations (especially work-specific activities) and participation restrictions, which may be highly individualised, contextual and ambiguous (WHO, 2002; Swartz & Schneider, 2006; Gooding & Marriot, 2009; Jette *et al*., 2002).

According to my observations, even if a doctor found the tables useful, they still needed to answer the following question on the assessment form: “Does the impairment affect the client’s ability to enter the open labour market?” It was relatively easy for doctors to answer this question when there was clearly no evidence of impairment, or a patient was severely and permanently impaired, but in cases of moderate impairment, it was fairly difficult to determine a person’s ability to work based on their physical capacity alone. For instance, claimants with moderate impairments may be more capable of work or be more employable than others depending on their age, education, occupation, geography, and socio-economic factors. They may also have and more opportunities for re-training and referral. Psychiatric conditions, epilepsy and other chronic health conditions, which are often called “invisible disabilities”, were particularly difficult for doctors to assess because the functional and participation limitations they cause are not easily observed. These “invisible disabilities” are also sometimes driven by stigma and social exclusion, which made establishing claimant’s capacity to find and maintain employment fairly challenging.

The SASSA guidelines provide vague direction to doctors on determining employability, but no information is given in either the guidelines or during training on how non-medical information, such as education, should be incorporated and weighed in decision-making; this was left to the doctors’ discretion (SASSA, n.d.). As a result, many doctors reported that the guidelines were inadequate, often arbitrary and mostly unhelpful. Some believed that the guidelines resulted in a rigid application of a medical model of disability, while others felt that psychosocial and environmental factors were important aspects of the assessment. As they had not been consulted on the guidelines, doctors experienced little ownership in the process and therefore found them easy to dismiss, as was the case below, in which one doctor said that

> there needs to be a transparent process to how guidelines are drawn up, which there hasn't been – none of us really understand how the guidelines came to be. So we don't own them, so we don't really care about them. In South Africa [laughs], laws are meant to be broken. So it’s just another law. (Dr Wright, Interview, 2014, 2 April)

Given limitations in the guidelines, doctors would rely on their own experience and expertise. However, without specialised training, doctors are typically unfamiliar with the tests and measurements that can be used to assess activity or participation restrictions and may struggle to determine how impairment affects the individual outside of the consulting room. They also have limited formal expertise on labour market and vocational issues medicine (Zinn & Furutani 1996; Schneider, interview, 2013 June 14; Occupational therapist, interview, 2014 July 15; Govender & Miji, 2009: 229; Rondinelli & Katz, 2000). No specialised training in disability assessment is necessary to conduct DG assessments in South Africa and only two of the twenty-four doctors involved in this study had received any training in this area.

SASSA does provide assessors (but not treating doctors) with a short SASSA training session focused on the legal and administrative framework of DG assessments and how to complete the form correctly. However, issues related to assessing impairment and employability are not addressed during training. SASSA trainers presumed that doctors would be able to make reasonable recommendations based on their medical expertise and the set of medical guidelines provided to them, but most doctors felt they did not have the adequate knowledge, skills or tools to assess disability in a consistent way. As one doctor pointed out during a SASSA training session I observed, “None of us have specific training related to disability and there is a lot of subjectivity in our choices” (Dr Brown, SASSA training, 2014, February 19).

Role and moral conflicts

The DG illustrates the intersection of two different societal institutions – the health system and the welfare system, which each operate according to different institutional, organisational and professional logics, each with their own sets of norms and principles (Freidson, 2001; Tummers et al, 2009). As disability assessors, doctors take on an administrative role and their decisions are subject to social security laws and regulation, but they are also health care professionals trained to operate according to the norms, principals and standards of the medical profession.

Medical judgement cannot be understood as a singular, universal form of rationality, as doctors have different training, clinical experiences and each brings their own professional and intellectual approach to the practice of medicine. Nevertheless, other studies have demonstrated that many doctors share strongly ingrained professional values, and their commitment to patients' well-being can result in them feeling torn between their goals as bureaucrats and their responsibility to act in the interest of patients (Wainwright et al., 2015). In this study, doctors' decision-making processes sometimes conflicted with the administrative "box-ticking" rationality and the values of equity, efficiency and parsimony that SASSA promotes. While organisational and professional logics are not *necessarily* at odds with each other (Noordegraaf, 2011), in the South African DG grant system, policy and organisational limitations create situations where compliance to social security policy and SASSA's organisational policies undermine doctors' role and obligations as medical professionals. At the implementation level, these incompatible demands can create moral conflicts for doctors (Vink *et al.,* 2015; Cooper, 2012).

Medical decision-making is an interpretive process that relies on doctors' clinical experiences and the individual patient under examination. Clinical judgment is often described as tacit, interpretive and action-oriented, rather than a product of technical rationality (Montgomery, 2006; Freidson, 1970). According to Freidson, the clinical mind is action driven and pragmatic and doctors come to rely on the authority of their own senses and trust in first-hand experiences, more than abstract knowledge or bureaucratic protocol (Freidson, 1970). Some doctors, especially those conducting assessments in treating settings and who were not paid to conduct assessments, thus resisted the idea of classifying patients according to bureaucratic criteria. They preferred to treat each client as an individual case, privileging their own clinical experience and knowledge of the patient over SASSA's externally imposed rules and guidelines, and they disregarded these where they felt they did not apply.

Doctors must make decisions that can significantly affect the welfare of claimants and this created another set of conflicts. One doctor described this as follows:

> The truth is doctors, yes we're supposed to be so Hippocratic and **the truth is important, but it comes second to helping people and so you get in these fixes**. This is the problem: when you've

> got that many people going hungry – to expect people who are paid to look after people to then make decisions around whether they get food or not...it's not a good position...it's not going to work. (Dr Wright, interview, 2014 April 8, emphasis my own)

Swartz and Schneider (2006: 243) argue that "It is difficult to apply principles of distributive justice when one is faced with the reality of poverty". South African doctors are aware of the impact that decisions to award or renew grants can have on the quality of life of patients living in poverty. A study of anti-retroviral adherence (ART) and the DG (De Paoli et al., 2012) found that doctors reported high levels of discomfort at what they described as "feeling like God" when making decisions on whether or not to award or renew grants.

Separating the patient's best interest from the eligibility for the grant was also difficult in cases where patients were eligible but were not taking responsibility for their health or engaging in unhealthy practices. Many were very frustrated by people with chronic obstructive pulmonary disease, diabetes, hypertension and arthritis who did not make the effort to lose weight, stop smoking or manage their illnesses, but returned annually or bi-annually to apply for temporary grants. Dr Harvey felt conflicted by this situation:

> Should you give the grant to someone who has chronic obstructive airways disease or emphysema from smoking? They continue to smoke – should you still give a grant? I have another lady who is tik-induced cardiomyopathy but she's got 5 kids, but she's never worked a day in her life – she's 28 and she's got not bad heart and medically she qualifies, but how do I know for sure that she's not going to use, but it would make a real difference to her life if she could have a grant for her kids and for her well-being, but she's never actually worked before that so it's difficult...I don't know, I don't know the answer. (Dr Harvey, interview, 2014 April 30)

Doctors found dealing with these conflicts stressful and many felt unsure about the decisions they made.

The interaction with the claimant

The doctor-claimant interaction was one of the most significant sources of doctors' stress and dissatisfaction with the assessment process. The Weberian bureaucratic ideal presumes that bureaucratic encounters are emotionally neutral and rational spaces. Professional norms of self-control and being in-control (Gastelaars, 2009) also require that doctors manage and contain their emotions and remain rational and objective in assessments, while at the same time being reassuring and empathetic towards claimants. Doctors found fulfilling these expectations difficult. However, there is clearly an unavoidable emotional component to the type of face-to-face encounters that occur during DG assessments, which are ultimately human interactions (Graham, 2002; Eggebø, 2013). While doctors' actions are strongly shaped by their professional and organisational backgrounds, they are also individual actors and their personal interactions with claimants can shape policy implementation.

The literature on emotion in bureaucracy and medicine indicates that bureaucrats and doctors are, in fact, "emotional actors" (Hunter, 1991), who may feel interest and boredom, fear and detachment, sadness and fulfilment, and guilt, as well as anger at being manipulated or at people abusing the system during their interactions with patients (Tumbo, 2008; Eggebø, 2013; Graham, 2002; Rousseau & Foxen, 2010; Fassin, 2005; Butt, 2002; Ticktin, 2006).

While the widespread introduction of anti-retrovirals and SASSA's new systems have resulted in a reduction DG numbers nationally (at least in the Western Cape) this has not resulted in a drop in the number of people applying for the grant. SASSA has been unsuccessful in communicating eligibility criteria, application processes, and appeals procedures. This lack of clarity has exacerbated by claimants' complaints that long lines and unhelpful SASSA officials make it very difficult to obtain information. As a consequence, doctors, who must sit alone in a room with claimants, are often subject to all the frustrations that claimants face. The role of doctors is also misunderstood by patients. According to the doctors I interviewed, SASSA officials at local offices often diverted negative reactions by rejected applicants from themselves to doctors, who they explained had refused to recommend a grant. Although SASSA discouraged this practice, regional and national office representatives acknowledged that officials sometimes failed to communicate that the decision was in fact made by SASSA, not by the doctor. This led rejected angry applicants to return to the clinics to confront doctors, often aggressively.

Claimants' understanding and subjective experiences of disability differed from biomedical conceptions of disability. Disability claims represent an attempt to have their financial hardship and social suffering "seen" and legitimised by the state. Claimants are not passive or docile in assessments (Kelly, 2017) and many actively attempted to convince doctors of their eligibility by feigning or exaggerating impairments, whilst others shared stories of their social and economic suffering to convince doctors they "deserved" support from the state. These efforts put doctors under significant pressure, introducing moral conflicts into their decision-making. Performances by claimants made doctors suspicious of claimants, and this lack of a trusting doctor-patient relationship left many doctors (especially those in a treating role) feeling unsatisfied and discouraged in their work.

I also observed that there were significant language barriers between doctors and patients and the lack of translation services in primary care facilities and the time-consuming nature of accessing these services in hospital made communicating with claimants difficult and frustrating to doctors (Kelly, 2017). High patient volumes mean that patients being treated at primary healthcare level are often poorly managed and are seldom educated on their illness or impairment. With poor medical knowledge and often low levels of education, patients’ ability to give accurate medical histories or give accounts of their functional limitations was restricted, making it more difficult to doctors to conduct assessments.

Frustration caused by communication difficulties, the perceived unfairness and arbitrary nature of assessments, as well as a lack of trust in doctors, led some claimants to verbally harass or use violence against healthcare workers (including doctors, nurses and occupational therapists) (see Kelly, 2017). As a result, doctors, particularly those working in high poverty areas, felt vulnerable to harassment and attack.

In addition to overt pressure from patients, doctors also struggled to come to terms with the considerable human suffering they encountered during their interactions with claimants, which was often emotionally draining. Doctors who work in the public sector, and undertake grant assessments, tend to serve poor populations and must consequently deal with complex socioeconomic problems that are often beyond their scope of practice, but negatively affect health outcomes and which can be overwhelming and leave them feeling ineffective (Aranda & Hart, 2015).

This large burden of emotional labour can lead to stress, burnout, and cynicism (McManus et al, 2002; Roussouw et al, 2013). A number of South African studies and personal reflections of doctors indicate that doctors suffer from high levels of burnout caused by ongoing high levels of stress, particularly in rural areas (Sirsawy, 2016; Roussouw et al, 2013; Phalime, 2014; Gaede, 2015).

Coping strategies

Dealing with such moral and professional conflicts combined with making ethical decisions in the context of ambiguity, heavy workloads, and resource shortages, can result in high degrees of uncertainty and stress for doctors

(Cooper, 2012; Vink *et al*., 2015). In response, doctors used their discretion to improvise ways to cope with the demands, constraint, and frustrations of both the SASSA system and the clinics and hospitals where they worked.

Based on a comprehensive systematic review of the literature on coping, Tummers *et al*. (2015) classify the ways that bureaucrats manage the stresses of their work and the demands from, and conflicts between, bureaucratic rules, client's needs, professional codes and their own values during client interactions. Tummers et al. outline these coping mechanisms in three ways: *moving towards, moving away or moving against clients* (Tummers *et al*., 2015). Coping by moving towards clients may involve bureaucrats bending the rules in favour of the client or bureaucrats, spending extra time on cases, or using their own personal resources to assist clients. Coping strategies that move away from clients include distancing techniques that use bureaucratic categories and processes to limit engagement and services to clients. Coping strategies that move *against* clients may include acting aggressively towards clients or attempting to control clients by being inflexible in applying the rules. Outside of their interactions with claimants, bureaucrats might also use more cognitive coping mechanisms, such as emotionally detaching themselves from clients, becoming cynical about their work, blaming clients. Other coping strategies may include cognitive restructuring, or seeking support from colleagues, and may also cause bureaucrats to mentally withdraw and become alienated from their work more generally (Tummers *et al*., 2015; Tummers *et al*, 2009; Vink *et al*, 2015).

During my study, I found that doctors employed similar strategies to reduce their work burden, protect their professional objectivity, cope with the pressure of making DG decisions, manage the large number of patients that they saw on any given day and to re-assert control over assessments where patients' sought to "take over" the assessment.

Short-cuts and improvisations

Given the high volume of patients seen by both treating doctors and SASSA assessors and the repetitive nature of their work, doctors developed routines of assessment practice and standardised ways of communicating with patients. These routines were aimed at reducing their administrative burden and dealing with patients as quickly as practically possible. Their actions became a form of what Protass terms "people processing" (Protass, 1979).

Although guided by the assessment forms, doctors used their discretion to structure their interaction with the patient as they wished and generally developed their own standard “scripts” and assessment approaches, based on what they thought was important to consider in decision-making rather than what was indicated in the guidelines. In some cases, this led to shoddy practice and many doctors rushed through the assessment forms, crossing out any sections that they felt were not directly relevant to the patient, filling in a bare amount of information in each section. This tendency made quality assurance difficult, as the assessment was conducted purely on the basis of the form (Quality Assurance Officer, Interview, 2014 March 31).

Given time constraints, SASSA assessors tended to focus predominantly on the contents of the patients’ medical file rather than taking a patient history or physically examining a patient. This is very common practice in community clinics, where even doctors who are diagnosing and treating patients often do not examine patients themselves[7] (Kinkel *et al.*, 2012).

Very few patients received permanent grants[8] and even those who did were re-assessed either every year or every five years. Because many patients had been assessed before, doctors tended to rely on patients’ history of previous grant applications and receipt as a decision-making shortcut, scanning the folder for notes on previous assessments instead of taking a medical history or examining the patient. While useful for identifying cases where a person’s condition was not improving and for identifying cases where patients were repeatedly applying for the grant despite not being eligible, this reliance on past notes could bias doctors’ decision-making and thus disadvantage patients who had been refused the grant in the past. One doctor mentioned that he had seen long negative notes written in claimants’ files, which were likely to influence any doctor conducting assessments in future (Dr Du Toit, interview, 2014 February 21).

If further testing or treatment is required or the patients’ long-term prognosis unclear, doctors may recommend a temporary grant of six months while supporting medical evidence is obtained or until maximum medical improvement is reached. This is only meant to apply to cases where the claimant was clearly impaired. However, in practice, this allowed doctors to avoid making concrete decisions on a patient’s eligibility and many would

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[7] Specialists in hospitals were more likely to conduct physical examinations of DG applicants as part of their diagnostic and treatment practice.

[8] Applicants could only receive the permanent grant if substantial evidence of permanent disablement can be obtained, which was often difficult and, given the perception that SASSA was very strict in reviewing permanent grants, doctors were hesitant to recommend them, recommending one year temporary grants instead.

repeatedly recommend the grant for six-month periods, using them as what de Villiers (2006: 3) described as “convenient half-grants”. During training, one doctor raised her concern that this supported what she called the “culture of the six-month grant” (Medical doctor, training, 2014 February 19). Whilst recommending temporary grants helped doctors to alleviate the pressure on them as decision-makers, this resulted in some patients being on temporary grants for several years, which was stressful and inconvenient for applicants and created misunderstandings around eligibility.

Disclaiming responsibility

In Cape Town public hospitals, where waiting lists to see specialists are long, and doctors feel alienated from DG policy and do not feel assessments should be their responsibility, patients “looking” for grants are quickly placed into the category of “patients undeserving of doctor’s time”. Doctors were quick to pass claimants wanting DG assessments onto more junior doctors, or refer them to work assessment units, where occupational therapists complained that they received large numbers of “inappropriate” referrals from doctors trying to avoid spending time making decisions.

Some doctors were hesitant to recommend temporary grants because of the commonly held view that those who enter the system become stuck there and return repeatedly to the hospital for DG renewals after they have recovered and are no longer receiving care. One head of department at one of the hospitals indicated to me that he had a personal policy of refusing to conduct assessments for this reason. A social worker reported that doctors she worked with had similar policies:

> I’ll get somebody [a doctor] who will say don’t give this person a DG because I’m the one that follows them up at clinic level [outpatient] and then I’ve got to tell them that they can’t get for another year or another 6 months. Then I sit with the problem of having to tell them and we’re the bad object in everything. (Focus group, social workers, 2014 February)

Making categorisations

Doctors overcame their uncertainty and lack of time to see patients and think through decisions by using their own common sense, and took pragmatic approaches in their clinical judgements. They did this by creating ‘rules of thumb' or *heuristics* for making decisions based on their personal experience and conceptual understanding of disability and, in some cases, their own perceptions of the claimants' deservingness.

A number of international and South African studies have shown that in low resource settings decisions have to be made as to who is more "deserving" of doctors' time, health and welfare resources, which can lead to moralising about certain categories of people (Le Marcis & Grard, 2015; Walker & Gilson, 2004; Fassin, 2008; Schneider et al, 2010). For instance, those labelled self-abusers, system-abusers and troublesome or difficult patients may receive minimal attention (Mizrahi, 1985).

This is certainly the case in disability grant applications, where decisions to provide state support to some patients and not to others have an implicitly normative component. In these cases, categorisations of patients were based on doctors' own rules and stereotypes that drew on past experience and value judgements based on claimants' appearances, the visibility of their disability, how they communicated with doctors, their positive or negative behaviour (drinking, smoking, being overweight) and their age. For example, I observed doctors quickly characterising young HIV-positive patients as lazy, non-adherent and undeserving. Categorising a patient as undeserving or blaming the patient for their position was also a way of discounting responsibility by effectively passing over the responsibility to the client for not being eligible (Thoren, 2008). On the other hand, some cases were considered more deserving; for example, a 58-year old grandmother with arthritis who was looking after her grandchildren. In these "more deserving" cases, doctors were more likely to *move towards* patients by recommending a grant despite limited impairment.

Depersonalisation, distancing and getting rid of patients

A range of factors led doctors to employ defensive coping strategies to protect themselves psychologically and manage the demands of their emotional and decision-making work: including the belief that claimants were trying to manipulate, deceive or "abuse" the system, their sympathies for people whom the DG system could not accommodate, as well as the pressures inherent in the medical work environment.

Most of these tactics involved psychological withdrawal and cultivating what Herzfeld (1992) calls "bureaucratic indifference" or what Fassin (2008: 268) refers to as “emotional indifference” tactics that are employed to detach and distance themselves from the needs of clients and patients.

While Maynard-Moody and Musheno (2003) argue that caseworkers see clients as individuals rather than as abstractions, this study has shown that very often doctors preferred to avoid thinking of claimants as individuals. The idea that healthcare workers employ such distancing strategies predates the emergence of the street-level bureaucracy concept. Menzies Lyth (1960) developed a framework for understanding how healthcare workers manage the anxiety and stresses of patient care. She argues that nurses have developed practical strategies that act as *social defence mechanisms* against anxiety created by their work. These mechanisms include focusing on specific tasks rather than on patients, avoiding eye contact and the depersonalisation of patients through the standardisation of care. Mizrahi (1985) argues that to cope with long hours and stress in environments where they felt unappreciated and overworked, doctors learnt to adopt a negative, “getting rid of patients” (GROP) mentality that objectified patients and encouraged them to avoid interacting with patients. In short, doctors felt abused and neglected and this was reflected in their treatment of patients.

Walker and Gilson’s (2004) study of the impact of the introduction of free healthcare on nurses in South Africa found that nurses responded to feelings of being overworked and disempowered by developing coping strategies to rationalise their inability to provide adequate care to patients. These strategies included using simple information to make judgements, categorising patients, exercising favouritism, being suspicious of clients, distancing themselves from clients and developing lower expectations of themselves and their work (Walker & Gilson, 2004: 1259-1260).

Doctors conducting DG assessments used similar ways of avoiding engagement with patients. Doctors found claimant narratives of their experiences with disability either taxing (redolent of the “heard it all” mentality of street-level bureaucrats described by Lipsky), irrelevant or difficult to cope with and attempted to avoid them by either refusing to discuss social issues or by ignoring or interrupting patients when they started to tell these stories, focusing on their paperwork rather than looking at the patient or telling them they were only concerned with their medical conditions.

In many cases, patient’s real problems extended well beyond doctors’ ability to assist them. Struggling to cope with the tragedy of their patients’ poverty, doctors may become frustrated, despondent, disinterested, and suffer from burn-out or compassion fatigue. One doctor commented that because poverty and conditions like HIV and TB are so widespread, they are considered by doctors as "run-of-the-mill and boring" despite the incredible burden that these conditions can place on individuals.

Lipsky (2010) argues that street-level bureaucrats stereotype and mentally discount clients as a means of rationalising their inability to assist them. Numerous studies and historical accounts of the South African health system at the peak of the HIV epidemic, before anti-retrovirals were widely available, detail how healthcare professionals, unable to heal patients or cope with the huge burden that the epidemic placed on the healthcare system, became nihilistic about the epidemic and their inability to cure patients. Doctors found their work repetitive, grew bored, and were neglectful of patients and indifferent to their suffering (Oppenheimer & Bayer, 2007; Le Marcis, 2014, Le Marcis & Grard, 2015). These responses highlight how "withdrawing from a caring relationship is for health professionals a way to carry on working" (Le Marcis and Grard, 2015: 176) and a driver for the standardisation and de-personalisation of care.

Doctors coped with language barriers by stumbling through consultations without translators, focusing on the contents of the file rather than interacting with the patient. For instance, Dr Vrede, worked in a Xhosa area, but spoke no Xhosa and had no translator available to her. Although she sometimes called in other patients or staff to assist, this was too time-consuming to do in every case and she admitted to sometimes fabricating patients' "self-reported" complaints, basing them on what she read on the file, rather than making the effort to try and communicate with patients or find someone to translate. The language barrier also seemed to provide a convenient excuse for doctors to avoid engaging with patients and enabled doctors to get them out of the room as quickly as possible. This is similar to South African psychiatric cases noted by Swartz and Drennan (2000), where clinicians may, in fact, choose not to understand patients. According to them,

> The prospect for the monolingual, white clinician to understand fully the situation of patients for whom there is in reality very little available in terms of mental health care may simply be too overwhelming. Better, in this context, not to understand patients than to risk being overwhelmed by their needs and by the gap between their needs and what help can be offered (Swartz and Drennan, 2000: 193).

I similarly observed that avoiding communication with patients was a way to minimise the risk of patient resistance, as well as to avoid potential conflict or feelings of guilt on the part of the doctor. I noted that doctors felt that "People only like you when you give them the grant. People hold community meetings to complain about the doctors" (Field notes, 2014 Feb 12).

If Dr Vrede felt that an applicant was clearly ineligible, she simply wrote "unemployed" or "RVD"[9] under the complaints section of the form, had the patient sign the form, telling them to return to SASSA after two weeks and moved quickly onto the next patient. At least part of her Dr Vrede's approach appeared to be some sort of coping strategy. This became clear when she deviated from her usual pattern of behaviour and attempted to explain to a patient why she did not qualify. Below is a description of the scene:

> A healthy-looking young woman enters, applying for a grant for the first time. Dr Vrede asked her why she was applying and she said that it was because she was still looking for a job. The doctor said, 'So it's not that you cannot work, you just cannot find a job' and woman says said 'yes'. The doctor explains that because 'it's still early in the HIV' and that if SASSA does not give her the grant then they will give her food packages. She explained that you can only receive it if you are disabled. The woman is clearly upset (close to tears) and feeling guilty, the doctor asks her if she wants to say something and then proceeds to explain the system more. After the woman leaves the doctor turns to me and says 'that is why one should just say nothing'. She does not talk about the possibility of rejection to anyone else that day. (Field notes, 2014 17 January)

Doctors were not necessarily dismissive of all patients and were far more open and friendly to patients who were clearly eligible for the grant than those who were not. Dubois (2010) describes frontline workers as having two bodies: that of the impersonal, standardised bureaucrat and the complicated individual with her own individual identity and personality who moves between two extremes – the "institution-made man vs. the humanised institution" (Dubois, 2010: 74). During interactions with patients, doctors can employ either of these identities and respond to claimants in different ways, alternating bureaucratic formalism and strict application of the rules with friendly casualness, compassion and flexibility, depending on the claimant and situation at hand.

Dr Soet, for instance, managed her position within the assessment process by reviewing the file and making a preliminary decision about the patient based on their file before they entered the room. Based on this decision, she treated

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[9] RVD (retro-viral disease) is a commonly used code-word for HIV in the public healthcare system.

people likely to be eligible for the grant differently from those who were unlikely to qualify; she was friendly to people who she thought she would qualify and treated others with suspicion. Although she told me that this made her feel uncomfortable and like a "bad doctor", she felt she could not put forward a friendly front to patients who may not qualify as this could be misinterpreted by patients as a positive sign that they would receive the grant. Her justification was that "if you treat people normally it creates the expectation – if then you don't get the grant two weeks later then they will see you as two-faced" (Dr Soet, field notes, 2014 February 12). She also felt that being too open and friendly would give ineligible claimants the opportunity to tell her about their financial issues. These narratives left her feeling guilty at not being able to assist patients and, in her view, were, therefore, best avoided: "You end up feeling worse because they tell you their story and you still say no. You can't make the person that does not qualify for the grant feel good" (Dr Soet, field notes, February 12).

Rigid Rule following

Framing doctor-patient interactions in purely bureaucratic terms and interpreting and applying SASSA guidelines in a literal and rigid way was another possible defence against the stresses and moral quandaries of decision-making and client interactions. While strictly applying rules can be understood as a professional ethical stance, invoking rules and denying discretion or professional autonomy was also used by doctors as a defence "against the possibility that they might be able to act more as clients would wish" (Lipsky, 2010: 149). As Bartels (2013: 470) argues, "Bureaucracy offers a formal structure to withdraw from social relationships and concomitant feelings of reciprocity and social duty", thus, even choosing to "go by the book is a discretionary judgment" (Maynard-Moody & Portillo, 2010: 19).

For example, Dr Bury took his job as an assessor seriously and understood his role as a gatekeeper for the state. He preferred not to use his discretion and, despite their limitations, strictly applied the guidelines and SASSA's impairment tables to make decisions and avoided considering individual circumstances, socioeconomic factors or subjective experiences. He even did this in cases of moderate impairment when the SASSA guidelines gave him the discretion to consider factors such as the age, education level or employment history of claimants. Furthermore, Dr Bury considered an individual's capability to participate in the labour market in terms of their ability to do any kind of work, regardless of whether they actually had the skills or education to do this. Focusing exclusively on medical factors protected his professional objectivity and helped him to avoid the guilt that many other doctors felt when they engaged with patients. According to him,

> …as soon as you consider anything else then it's not about disease or dysfunction and that's the only thing. Look at the records and examine the patient if necessary –that's that. I don't look at anything else because then you might feel sorry for the patient and you say "yes" to a grant when it's not necessary (Dr Bury, interview, 2014 July 22).

While SASSA does not provide grants to patients who default on treatment, in cases where defaulters were gravely ill and incapacitated, the national manager of the DG program had said that the medical ethics of beneficence and non-maleficence should be applied, provided that it could be clinically justified (Dr Marite, interview, 2014 June 27). However, Dr Bury made no such exceptions:

> SASSA is very, very strict on defaulters. They must use their medication. I had a few that I declined because of that - even AIDS patients in a very bad condition. Especially the HIV positive that is on ARV treatment, if he presents to me with and recently had TB meningitis, or had pneumocystis pneumonia or he had carposi sarcoma – those terrible opportunistic conditions....always a defaulter. (Dr Bury, interview, 2014 July 22)

Although not as rigid as Dr Bury, Dr Bhele also found that invoking the rules and denying that she had any discretion was the easiest way to avoid feeling guilt and to reduce the pressure she felt in the consulting room. Dr Bhele came from the same community and background as many of the applicants she dealt with and felt tremendous pressure from claimants, who expected her to show solidarity towards them through generosity and leniency in her assessments. She found this emotionally difficult and, as a way of coping, strictly applied the rules and made an enlarged copy of the SASSA guidelines, which she stuck to the walls of the clinics she worked at regularly.

Showing patients who questioned Dr Bhele's decision-making demonstrated her lack of authority and created distance between her as an individual and decisions that she knew would make patients unhappy. At the start of the day, Dr Bhele would speak to waiting patients to inform them about SASSA's criteria, emphasising that the DG is not a form of social relief, but a grant specifically for people with disabilities. This approach of showing patients the guidelines was also taken by occupational therapists at a work assessment unit at one hospital, who received significant numbers of inappropriate referrals from doctors who wanted to avoid having to make decisions themselves. Unfortunately, this did not seem to deter ineligible claimants in either case because they had nothing to lose by applying. As Dr Bhele told me, “Everyone wants to try their luck”.

Moving towards patients: Breaking and bending the rules

In some cases, doctors broke or bent the rules to accommodate people they felt were deserving but did not qualify for a grant. Sometimes doctors would recommend Social Relief of Distress[10] on humanitarian grounds, rather than on actual impairment – strategies that alleviated their own guilt or helped glean some satisfaction and hope from a job and organisational environment which is, as doctor aptly described, “gloomy”. These observations support Nielsen’s (2006) and Maynard-Moody and Musheno’s (2003) argument that bureaucrats do not only use coping strategies as a form of self-defense, but as a way to assist clients or maximise job satisfaction. In other words, bureaucratic behaviour that undermines policy objectives or results in the differential treatment of clients may be well-intentioned or positively motivated (Nielsen, 2006).

As a result of some doctors’ generosity towards patients, the DG has been referred to by some as the “ag shame” grant (Interview Margaret Schneider, June 2013). “Ag shame” is a commonly used South African expression of sympathy, which means something akin to “you poor thing” or “I feel sorry for you”. What a number of doctors referred to as the ‘sympathy factor’ was intensified in interactions between doctor and patients who were visibly poor or in social distress. Although some doctors were able to emotionally distance themselves in their assessments or were so clinically minded that they were not interested in these issues, some felt real guilt about rejecting patients knowing that they could offer no other real solutions other than a referral to an overburdened social worker. The doctor working as a quality assurance officer for SASSA explained how his work is easier than those of other doctors because it does not involve seeing the suffering of applicants:

> …it makes it easier unfortunately, from the non-medical point of view, to be removed from the patients because I can understand very much that the doctors are very much inclined towards patients

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[10] Doctors are only meant to recommend the SRD on a medical basis to people who are unfit to work for a period of less than six months. However, doctors tended to recommend it for people who did not meet the eligibility criteria for the DG but were in clear need of financial assistance.

> and there will always be a sympathy factor involved. With me too – I know that if I was involved and I was looking at somebody...you know you will always look at people's social backgrounds and you would probably tend to err on the side of the patients. As opposed to when I do it now on a desktop I don't have that influence - where I don't see the people, I don't see the social circumstances, I don't see the poverty. I'm not influenced by that. (QA officer, interview, 2014 March 31)

Decisions on bending the rules were based on doctors' framings of disability and deservingness (Kelly, 2016) and, as discussed above, these patients fell into the category of the "deserving poor" – older people, mothers with children and people they perceived as "decent" or who appeared to be making some sort of effort to improve their situation and stood out amongst the large numbers of people that some doctors viewed as lazy and dependent.

Making exceptions for patients could also have been a way for doctors to deal with what they understood as a conflict between their obligations to patients and the SASSA system, which some saw as exclusionary. It could also be a way of coping with the patients' lived circumstances that were beyond doctors' control. Research in South Africa has shown that doctors use their discretion to promote their patients' and work beyond the guidelines to compensate for an ineffective healthcare system. To do this they do not only use their medical discretion but also their medical bureaucratic role (Gaede, 2016; Human 2011).

In many cases, doctors also broke the rules to rid themselves of difficult and insistent patients or to reduce conflict in the doctor-patient relationship. This was particularly true in treating settings, where they felt no direct accountability to SASSA and did not want to waste time arguing with a patient; to avoid this, doctors would recommend a six-month grant even if the patient was not eligible.

Although doctors may be inclined to feel great sympathy for patients applying on the basis of poverty, this does not necessarily mean that they would deviate from SASSA guidelines and might *move* towards patients in other ways. For instance, this might be achieved by referring patients to social work services; educating, encouraging and motivating patients; providing employment suggestions; and, in the case of Dr Bhele discussed earlier, collecting and handing out clothes to claimants.

Confronting patients

One quick way for doctors to put a quick end to what they perceived as patient manipulation or resistance, was to confront it directly by asserting their professional and bureaucratic authority to regain control over the interaction. Although perhaps more of an automatic response than a coping strategy, I also observed a small number of doctors treat difficult patients with obvious irritation and impatience, which also re-asserted their dominant position during the assessment.

Dr Brown, for instance, enjoyed interacting with patients and was mostly genial and friendly to them, but sternly kept the assessment on his own terms, refusing to allow patients to emotionally manipulate him with their stories and dealing with pushy and argumentative patients very bluntly. He told me, “A lot of disability grant people are very aggressive and have an axe to grind. They are like Jehovah’s witnesses! You can’t be friendly and accommodating when people want to take over” (Interview, 2014 April 4). This was demonstrated by the following interaction with a patient:

> Dr Brown tells the patient that her listed conditions have effective medications and are not eligible for the DG. He asks her if there is anything else and she does not come forward with any additional complaints. He says, “Disability means unfit for work”. She then tells him about how she is caring for her son with cerebral palsy who is blind and can’t walk, adding that she gets tired easily. He says, “So you can’t work because you are looking after him?” He says, “Your problem is not the diabetes, it is looking after the child. You look grey”. She however seems convinced that she is indeed disabled and says “my sicknesses are also make me feel unwell”. He recommends exploring other options for support such as the Grant-in-Aid (GIA)[11]. She does not seem interested and insists that she had previously been given the grant saying, “Why did they give it to me last time for 6 months?” He says, “Well the other doctor could have given it, but I can’t because there are no grounds. You need the GIA”. The patient then asks, “How many sicknesses must you have to be disabled?” The doctor responds “it’s nothing like that”. She says, “Because the sugar [diabetes] is not going away”. Dr Brown becomes very annoyed at this and says, “I don’t want to argue with you”. “I am not arguing”, she protests. “You are. I have told you about the DG”. The admin clerk wants to chip in at this point, but Dr Brown warns him, “say any

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> more and I will ‘klap’ [hit] you – the subject is closed”. Dr Brown then feels bad about how harsh he has been to the patient and says gently, “I know you are upset and I understand, but we have procedures and rules”. The patient then leaves. (Field notes, 2014 April 4)

Later, Dr Brown explained to me that he had to stop this kind of interaction for the patient’s own good. He called it the “the hyperdermic syringe to the bum” – she had to “swallow the pain and believe that I have her best interests at heart”.

Discussion and Conclusion

The disjuncture between the design of DG policy and how it plays out in practice is shaped strongly by the reality of the environments doctors work in and the stresses they face in making DG decisions. As the data has shown, doctors used their agency to develop coping strategies to manage their work in the context of time constraints, ethical dilemmas, an overburdened health system, poor record-keeping, and pressure from patients. These coping strategies simplified their decision-making work and reduced their workloads, but undermined efforts to standardise assessment outcomes and created confusion about eligibility criteria and problems in doctor-patient relationships.

The shortcuts and defence mechanisms that doctors used during assessments, limited claimants’ ability to participate in the assessment process. This depersonalised patients and led them to see doctors as uncaring, rude and incompetent. Combined with poor communication from SASSA, claimants perceived the DG system as unfair and grant decisions as arbitrary. This frustration led some patients to be highly aggressive with doctors, which created a vicious cycle that further entrenched barriers between patients and doctors, as doctors acted to protect themselves against patients’ demands.

As this and other studies have shown, despite a strong set of professional ethics, the actual nature of medical work and training can result in health professionals applying different ethics in ‘practice’ that undermine health policies and holistic, patient-centered care (Le Marcis & Grard, 2015; Walker & Gilson, 2004). Professional experience and socialisation shape how doctors think, interact with patients and make decisions, as well as how they “cope” with their circumstances (Hafferty & O’Donnell, 2014; Hafferty & Hafler, 2011). This can lead to both good and bad outcomes but in poorly resourced settings such as are common in South Africa, this is most likely to lead doctors to medically objectify patients and erode empathy, professional ethics, and respect for human rights (Vivian et al, 2011). The dilemmas that doctors face “cannot”, as Kaufman suggests, “be dissociated from the institutional, socioeconomic, and cultural contexts from which they emerge” (Kaufman, 1997: 3). As bureaucrats and individuals, doctors are embedded within the SASSA and health systems, but also the broader political, social, cultural, and economic context and system, which push them to behave in particular ways.

This paper has also shown that doctors respond to perceived pressures from patients and the interpersonal dynamics of their interactions with claimants, issues that have not been adequately considered in sociology studies on the health sector (Kelly, 2017). While SASSA can do significantly more to educate patients about eligibility criteria, the application, and appeals processes, much of this pressure is driven by socioeconomic factors and policy gaps which are not within the organisation’s mandate or ability to address. This shows the importance of broader reforms in dealing with implementation challenges at the frontline.

Not addressed in this paper, but also important, is how individual factors such as social position, race, class, values, and norms shape how doctors make sense of, and respond, to patients and their work context. Thus, coping strategies cannot be seen as the primary or even the most important influence on doctors’ decision-making (Kelly, 2016).

I have discussed coping strategies in relation to particular stressors in the system, but doctors’ behavior and attitudes towards patients is also likely based on cognitive coping mechanisms such as lowering their expectations of themselves and their works and a general disillusionment with or cynicism about the system or policy alienation that may lead to similar behaviour to “coping” (Tummers *et al.*, 2011, 2017). Tummers *et al.* (2017) argue that when public service workers are alienated from a policy because they feel it is meaningless or they feel powerless, they are likely to avoid implementing it or sabotage it. Loyens (2014) outlines how frontline workers deal with policy alienation, which has many overlaps with coping strategies outlined in this paper: through acquiescence, emotional habitation (getting tougher) and bonding with the client in order to feel less alienated.

While it is important for doctors to have discretion and flexibility in carrying out their work, it also creates opportunities for doctors to use this discretion to their own advantage. Their ability to exercise discretion in their direct interactions with clients, whose engagement with bureaucracies is often non-voluntary, gives them significant power and the daily decisions they make affect citizens’ lives and their relationships with the state (Lipsky, 2010). Doctors’ coping strategies are also enabled by inequalities in the doctor-patient relationship, as well as their lack of accountability because of the difficulty that SASSA has in overseeing their work. The solution here is not necessarily greater control of doctors, who as a professional group expect a certain degree of autonomy in their work (Freidson, 2001), but rather focusing on the policy gaps and contextual issues that influence their behaviour. The doctors I observed were by no means resistant to standardisation and wanted to achieve consistency in their practice. However, they saw this as best achieved through professional, peer-to-peer engagement and more specialist input on assessment guidelines rather than through SASSA's monitoring approach. Empowering claimants with more information around eligibility criteria, the application process, and their rights, may also allow claimants to have more agency and ability to act as active participants during assessments.

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