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**“We want another doctor!” Citizen
agency and contested notions of
disability in social assistance
applications in South Africa**

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Abstract

Problems in fairly allocating welfare and health resources or targeting social programmes are very often located in the spaces where citizens interact directly with state workers. This study draws on observations of doctor-patient encounters in disability assessments for the South African disability grant (DG), to examine how doctor-patient interactions shape social welfare allocation. I show that interactions between doctors and patients are sites of negotiation and contestation over rights to social assistance. Claimants’ understanding of disability differed from biomedical conceptions of disability. Doctors carrying out DG assessments faced both direct and indirect pressure from claimants, who aimed to influence their decisions through narratives of suffering and performances of disability. Frustrated by communication barriers, as well as the perceived unfairness and arbitrary nature of assessments, some claimants used verbal or physical abuse as a form of protest against the system. In order to defend themselves from these pressures and maintain authority in these interactions, doctors employed coping strategies that distanced and objectified claimants, minimising opportunities for patients to bully them or affect their judgment. These strategies strained already tense doctor-patient relationships and made the DG system illegible to the public. This demonstrates the importance of considering trust, power dynamics and the exercise of agency by both patients and providers in understanding policy implementation.

Introduction

On 9 March 2015, a group of middle-aged residents of the Cape Flats gathered in protest at the Heideveld community centre in Cape Town, carrying placards demanding the removal of the doctor who conducted medical assessments for the disability grant at their local clinic (Maragele, 2015). The disability grant (DG) is a means-tested cash transfer available on a permanent or temporary (6-12 months) basis to people deemed unfit to work as a result of functional

impairment and who do not have other sufficient means of support. Access to the DG is defined in terms of the medical model of disability and confirmation of disability by a medical doctor is required for all DG applications. This makes doctors who conduct DG assessments (either as contracted assessors at community clinics or treating doctors in hospitals) extremely important gatekeepers to this highly sought-after form of social assistance. In their gatekeeping role, doctors can be considered *street-level bureaucrats* (Lipsky, 2010);¹ i.e. frontline workers who control access to public services through the ‘application’ – and interpretation – of government laws, rules and policies during their face-to-face encounters with citizens.

Despite the wide reach of the South African social grant system, which serves almost 17 million people and two-thirds of households (Seekings & Moore, 2013),² social grants only target children (via their caregivers), the elderly and disabled people. In a context of high levels of structural unemployment such as prevail in South Africa, which makes it difficult even for the able-bodied to find work, there is high demand for the DG, including from people whom the grant is not intended to target (Kelly, 2013; Delany *et al.*, 2005).

The Heideveld protesters had all been receiving temporary disability grants, renewed once or twice a year by other doctors over the course of several years. The new doctor at the clinic, who was contracted specifically to conduct assessments as a third-party medical assessor, strictly followed SASSA’s medical assessment guidelines. These stipulate that the protesters’ diagnoses of epilepsy, diabetes, arthritis, angina and hypertension are manageable chronic conditions and therefore (in the absence of impairing complications) are not grounds for recommending a disability grant (SASSA, n.d.). These protesters, however, believed that their medical conditions made them unemployable. As unskilled or semi-skilled people in their fifties, they were unlikely to find work in a tight labour market in any case. They were essentially equating the lack of demand for their labour with disability and felt that they were being unfairly deprived of the state support necessary for them to manage their medical conditions. This dilemma was reflected on one of their banners: “how must we use our medication if we don’t have any food?”

¹ Originally published in 1980

² In addition to the DG, the government provides a care dependency grant to parents of disabled children and the grant-in-aid, a small grant given to elderly or disabled people in need of permanent care. The state also makes five other categorically targeted, means-tested cash transfers available: Older Person’s Grant (also known as the old-age pension, for people over 60); Child Support Grant (for children under 18); Foster Child Grant (for legal foster parents); Social Relief of Distress (short-term relief, often in the form of food parcels); and a War Veterans Grant (for those who fought in WWII and the Korean war).

Disability grants have long been used as a ‘ticket’ to an income in poor communities, often in collaboration with sympathetic health and social workers (Segar, 1994; Steele *et al.*, 2006; Kelly, 2013). Given the lack of jobs and social security for the long-term unemployed, being disabled becomes a form of social advantage or a resource and is therefore a status that is sought out. People go to great lengths to apply for disability grants, spending hours waiting in line and, until the government introduced a three month waiting period between applications in 2008, applying repeatedly until successful.

The protest in Heideveld comes in the wake of government efforts to ‘tighten’ and ‘rationalise’ access to the grant after a rapid increase in DG numbers in the mid-2000s, which has limited the availability of an important source of income to many households and left them feeling disregarded by the state (Kelly, 2012, 2013).³ While advocating for a social model of disability (Office of the Deputy President, 1997), the state has simultaneously sought to reduce the scope of the disability category for social assistance purposes. Reform has been driven by a discourse of reducing fraud by non-disabled people and over-generous doctors and since 2008, SASSA has made concerted efforts to reduce medical discretion in decision-making (Kelly, 2013).

Given their prominent decision-making role in the DG application process, doctors bear the brunt of the anger of those who have lost their grants or new applicants that do not qualify and are frequently heckled, threatened or violently attacked by disgruntled claimants who feel unfairly treated during medical assessments. In recent years there have been a number of other cases where communities have demanded that doctors step down. While in some cases doctors have made poor decisions or behaved unprofessionally (see Green, 2015; Interview SASSA Quality Assurance Officer, 2014 March 31), in other cases SASSA’s investigations found that doctors were simply following SASSA’s guidelines (Meeting with SASSA officials, 2016 April 21). This questioning of the legitimacy of medical decision-making and professional behaviour of doctors and presents, represents a serious breakdown in trust in doctor-patient relationships. More fundamentally, what claimants were contesting was the state’s definition of disability and their systematic exclusion from welfare benefits.

³ The number of DG beneficiaries has decreased from over 1.44 million in 2007 to less than 1,1 million in 2016. The extent to which this can be attributed to SASSA’s Disability Management Model rather than other factors, such as the effect of the anti-retroviral roll-out for people with HIV, is not clear. SASSA officials, doctors and patients nevertheless all indicated that SASSA had become stricter in their approach, indicating that this had some effect.

Claimants also employ other less direct tactics to negotiate access to disability grants, contest medico-bureaucratic definitions of disability and protest their exclusion from the social security system. These come in the form of individual, often hidden, acts of protest and subversion what Scott refers to as ‘infrapolitics’ - which occur daily in the individual interactions between doctors and patients inside of the consultation room and which will be the focus of this paper. Drawing on Foucauldian (1979) notions of power as decentralised, productive and dynamic and the work of Scott (1985, 1990), de Certeau (1984) and Barnes & Prior (2009) on subaltern agency and defiance, this paper discusses the micro-politics of resistance and subversion that emerge during face-to-face encounters between doctors and DG claimants. I demonstrate that disability grant assessments are a dialogical and contingent process - a space of resistance and contestation as well as disciplining and control by the state. As Foucault argued: “where there is power there is resistance” (Foucault, 1979: 96). Although not all doctors prescribed to a purely medical-bureaucratic definition of disability, this was official SASSA policy and I have understood claimants’ attempts to convince doctors to stretch or abandon the medical-bureaucratic definition used by the state as contestations of the definitions that structure their exclusion.

The agency of claimants who resist and disrupt the DG assessment process highlights power dynamics is often overlooked in studies of policy implementation, including bottom-up studies that (like this study) draw on Lipsky’s (2010) notion of street-level bureaucracy. The *street-level bureaucracy* concept explains the gaps that emerge between policy and practice as being the result of patterns in workers’ use of their discretion to cope with the realities of work with clients and citizens (Brodkin, 2012). By unpacking the contextual and subjective factors and logics that structure bureaucratic work, this literature has deepened our understanding of policy implementation, but is limited in its presumption that, as decision-makers, street-level bureaucrats hold all the power in social relations at the frontline. Clients (and patients) are typically considered in terms of how they are acted *upon* rather than as contributors to the implementation process who co-construct institutional categories (Eskelinen *et al.*, 2009). In this paper, I contribute to efforts to extend street-level bureaucracy theory to show that it is not only frontline workers who bring their agency to bear on street-level encounters, but also the people who are the supposed ‘targets’ of policy, who can be active participants in public encounters and shape policy implementation through their creative engagements with bureaucratic systems (Barnes & Prior, 2009).

This study also adds to the small but growing literature in Africa and developing countries more generally, on how frontline public service workers (Hoag, 2010; Bierschenk & Olivier de Sardan, 2014; Olivier de Sardan, 2005, 2015; Blundo, 2006), including healthcare workers (Le Marcis & Grard, 2015; Harrison, 2000;

Gibson, 2004; Walker & Gilson, 2004; Müller *et al.*, 2016) shape how services are delivered and thus how policy is ‘realised’ on the ground.

Research Methods and Context

Data was collected in clinics and hospitals over a period of eleven months between 2013 and 2014 in the Western Cape Province of South Africa, in the Cape Town Metro and 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 worked in twelve different community clinics in rural and urban areas, sampled to maximise demographic variation in terms of race and income. I also conducted fieldwork at three hospitals, one of which was a psychiatric hospital, working 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.

Over the course of the day, the doctor and I would discuss patient cases and the rationale for their decision-making, usually between patient consultations. Observing the doctor-patient interaction created opportunities to learn how doctors engaged with and examined patients, how patients presented both their medical and social cases to doctors and 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 real cases and provided opportunities for me to probe their understanding of DG cases. While a number of measures were taken to minimise the influence of my presence in the room, it is important to note that this may, nevertheless have had an influence on doctor-patient interactions.

Observing and participating in the collegial encounters between doctors, nurses, administrative staff and SASSA staff who visited the clinics, deepened

my understanding of the system. By speaking with claimants while we waited for the doctor to arrive, I gained more perspective on how claimants understand and navigate their way through the assessment process. This was complemented by ethnographic work on claimants' perspectives on and attempts to access the DG conducted in 2012 in an impoverished urban community known as Blikkiesdorp⁴ in Delft, Cape Town (Kelly, 2012). Quotes from participants in this study are incorporated throughout this paper.

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 I worked with, I have used pseudonyms throughout this study.

Relational dynamics, power and trust in doctor-patient interactions

The DG assessment, like all healthcare encounters, is a social exchange shaped by the power, relative agency and emotions of social actors involved in the interaction; the forms of communication; and the degree of trust that exists between them. These interactions are an important but understudied site in which conceptions about 'deservingness' of certain groups to public benefits such as social grants are elaborated and deployed (Horton, 2004). In general, relatively little attention has been paid to how the relational, situational and performative aspects of street-level encounters shape policy implementation (Bartels, 2013). Although power dynamics between doctors and patients have been studied extensively by medical sociologists, the power dynamics between patients and providers are often overlooked in terms of how they shape health policy implementation (Erasmus & Gilson, 2008).

Although doctors' work is subject to administrative and legal restraints, physicians have considerable power relative to claimants in the DG assessment. They have obvious gatekeeping and expert authority. This is reinforced by the ceremonial order and bureaucratic format of clinical encounters, which enables and supports the expression of medical authority (Strong, 1979). The notion that clinical encounters produce and reproduce asymmetries of power and knowledge is a well-established idea in medical sociology. Sociological critiques of medicalization in particular strongly emphasise the asymmetry between patient and doctor and often paint patients as victims (Lupton, 1997). While medical imperialism and the caricature of biomedicine put forward in the

⁴ 'Blikkiesdorp' means tin can town and refers to the zinc structures built by the provincial government to house people relocated from other areas.

medicalization thesis⁵ are exaggerated and not necessarily accurate in an age where lay people have more access to information and doctors' work is increasingly regulated by corporations and the state (Williams, 2001; Kelly & Field, 1994 in Williams, 2001), significant power differentials continue to exist between doctor and patient in circumstances where patients are illiterate and poor (Crawford, 1999).

This is often the case in DG assessments, where the fissures created by the history of apartheid continue to structure the South African public health system, entrenching the dominance and paternalistic role of doctors in their relationship with patients and relegating patients to a "submissive, compliant and reactive role" (Grant, 2006: 55; Saohatse 1998; Crawford 1999; Kane-Berman & Hickman, 2003). Doctor-patient interactions are interpersonal and the micro-politics of these also reflect and perhaps (to some extent) support broader social relations (Waitzkin, 1991: 9). The interactions I observed between doctors and claimants were representative of the socio-cultural cleavages that exist in and define relations in broader South African society. These cleavages were created by class, race, educational and cultural differences which accentuate social distance between doctors and patients and encourage "performances of distance and domination" (Heyman, 2004: 492). The significant social and economic inequality between middle class doctors and poor patients contributed to power inequalities in the assessment. This resulted in doctors treating patients as what one doctor referred to as "poor unfortunates" (Dr Brown, interview, 2014 April 4).

Doctors' decisions to recommend the award or renewal of grants can involve significant discretion and can have a large impact on the quality of life of patients living in poverty. This increases doctors already significant power relative to patients. In one study, doctors reported "feeling like God" when making decisions on whether or not to award or re-new grants (De Paoli *et al.*, 2012).

Language and knowledge barriers amplify these inequalities. Watson *et al.* (2006) argue that applicants should take the central position in DG assessments and that they should have the opportunity to express their experiences, opinions and subjectively relevant information. In turn, assessors should strive to understand why claimants are applying and what their perceptions of function are. This was not often not the case in DG assessments I observed and SASSA doctors sometimes asked claimants very little about their experiences, leaving

⁵ Critics of medicalization argue that this power allows medicine to expand its authority to address social problems or forms of deviance from the norm. They argue that this makes medicine a form of social control (Waitzkin, 1999; Zola, 1972; Conrad & Schneider, 2010).

them sit quietly in the room while they filled out the forms – their presence almost a secondary part of the doctors’ work. As well as being a function of a doctors’ particular approach and time constraints, this was the result of the language barriers, illiteracy and claimants’ poor medical knowledge. In many cases I observed, both related and unrelated to the DG, it was obviously difficult for patients to articulate clearly and accurately their medical histories or functional limitations and to communicate their experiences in the way they wanted to. It also made it harder for doctors to ask patients questions about their conditions or explain SASSA processes and requirements to them, leaving many patients confused.

Language barriers between doctors and patients are a general issue, which interferes with the clinical process at all levels of the healthcare system in South Africa (Swartz, 1998; Swartz & Drennan, 2000). The medical profession in South Africa is still predominantly dominated by white English and Afrikaans-speaking doctors who are often unable to speak ‘African’ languages. These barriers make it difficult to build rapport with some patients. Schlemmer & Mash (2006) found that doctors resent and blame patients who can’t speak English.

This can lead doctors to dehumanise patients and to practice what some South African scholars have called “veterinary medicine” (Crawford, 1999; Oppenheimer & Bayer, 2007; Swartz, 1998) – a type of medicine that does not consider patient engagement or voice as part of the practice of diagnosis or treatment. In the case of DG assessments in Cape Town, this puts Xhosa-speaking claimants who did not speak the socially dominant languages of medicine at a distinct disadvantage, even when translation was used. This reinforced racial differences between black patients and white, ‘coloured’ and Indian doctors.

Language barriers were particularly problematic at clinics and hospitals where there was a mix of patients from different racial and linguistic backgrounds and at the primary healthcare level where patient loads were higher, translation services seemed almost non-existent and doctors were extremely time-constrained. Although formal translation services are available in hospitals, they were infrequently used. In most cases where translation was necessary, nurses, administrative staff, and even other patients, were drawn into the room to translate. Both finding and using a translator can be time consuming and frequently SASSA assessors (and occasionally treating doctors) chose to stumble through consultations without translators, focusing on the contents of file rather than interacting with the patient. This disempowered patients and reinforced doctors’ dominant position.

A lack of medical knowledge and information about SASSA's eligibility criteria also hampered claimants' ability to present their case to doctors. For instance, when doctors asked patients why they were applying for the grant or why they could not work, many claimants (particularly first-time applicants) did not understand that doctors were interested in hearing about their medical complaints, how these impaired them and prevented them from working. Social workers at a psychiatric hospital explained that some psychiatric patients would apply on the basis of old scars or injuries, rather than their psychiatric conditions because physical impairment was easier for them to explain to doctors than their experiences of mental illness.

In contrast, patients who could communicate with the doctor in their own language or at least had a good command of English or Afrikaans or were more educated were better able to actively participate in and shape the nature of the assessment. Doctors, in turn, were able to develop better rapport with these patients and were more receptive to their claims. Similar findings have been made in numerous other healthcare (Horton, 2004; Porter, 1990; Beach *et al.*, 2006) and welfare programme settings (Kriz & Skivenes, 2010; Jonsson, 1998).

Communication challenges also prevented the development of trusting relationships between doctors and patients. In her work on trust in healthcare systems in South Africa, Gilson (2003: 1453) argued that "health systems are inherently relational" and reliant on trust. Trust, or in this case, lack of trust in the healthcare relationship, can either reduce or reinforce inequalities in health sector relationships (Ostergaard, 2015). There are a number of studies in South Africa on providers who do not trust patients and therefore treat them in harsh and uncaring ways (Jewkes *et al.*, 1998; Oskowitz *et al.*, 1997; Walker & Gilson, 2004). In turn, patients may be suspicious of doctors who do not show empathy or are rude or moralising towards patients and insensitive in their use of discretionary power (Ostergaard, 2015).

The process of DG assessment itself promotes distrust. Disability testing is based on the assumption that people are likely to misrepresent themselves in order to meet the categorical tests of welfare programmes or for other secondary gains. The political and economic privileges and exemptions that come with being categorised as disabled mean that disability is commonly understood to exist in both genuine and artificial forms and the suspicion that people will *malinge* (feign or exaggerate impairment) is integral to how disability is both defined and understood (Stone, 1984: 28). It is part of a doctor's role to be alert to and guard against fraud, but there is also an implicitly moral judgment made about the archetypal malingerer or faker – people who one doctor called 'chancers and rubbish' who 'spin stories' to get the grant (see Kelly, 2016).

Subjective understandings vs. expert knowledge of disability

Patients' conceptions of disability, which were often different from the formal definitions used by SASSA, are also important in understanding the doctor-patient interaction. Claimants interpret policy (for instance eligibility criteria) based on information they receive from SASSA, past experience, various healthcare professionals, what they see in communities (who is receiving grants), and information that is shared by other claimants.

Strictly applied, the impairment-based model used during assessments can also exclude people who struggle with facial disfigurement, albinism, chronic illnesses (especially stigmatised illness such as HIV/AIDS or epilepsy) or so-called hidden disabilities. In these cases their disability and related labour market exclusion, is created more by slack labour demand or societal prejudice than medically-measurable impairment. However, the disabling nature of these conditions as experienced by individuals is no less real than those caused by physical impairment. Allocating the DG to people with particular impairments and not people with chronic illnesses, who may also struggle to find work or cope with the costs associated with the direct and indirect costs of illness even with free access to primary healthcare (Goudge, 2009) can appear arbitrary to claimants and communities.

Based on questions claimants asked doctors and myself, it seemed that many claimants did not understand why some people would receive grants and others would not, why they would receive a temporary grant from one doctor and not another, or why their eligibility would change from one application to another. In Blikkiesdorp there also appeared to be no clear delineation in people's minds between who should and should not receive the grant except the doctor's decision. *As a result there was some confusion around what pathologies made one eligible for the grant, resulting in many people applying without necessarily fitting biomedical definitions of disability.* Other studies have found that patients think that because they are receiving medication or have a file at the clinic that they are eligible for a grant (Macgregor, 2006). This was echoed by doctors in this study. Some people I spoke with in the settlement of Blikkiesdorp had similar understandings of grant eligibility:

'They say I say I must go and see the doctor in February and maybe I am also going to get a grant because I am on my tablets for my heart, my sugar [diabetes] and the water [blood pressure]. I get the tablets there by Lentegour [psychiatric hospital] also' (Joanie, interview, 2012).

People also understood the DG as a form of social relief for any unemployed person who received regular medical treatment. One doctor told me: “If you are unemployed and have a folder at the clinic then people think that they can apply and people think that being on medication means you are eligible for the grant”.

SASSA does not communicate eligibility criteria to the public and assessing doctors are not in a position to correct misinformation by explaining eligibility criteria to ineligible claimants because they are discouraged from telling claimants about whether or not they qualify to protect them from possible patient retaliation. This perpetuated confusion around eligibility and the perception that the grant system is arbitrary and unfair. One doctor told me that patients would often ask him, “have I been lucky doctor?” at the end of their assessment. The idea that DG applications are a game of chance, speaks to the subjective nature of the assessment process and the confusion this has created amongst the public.

Misperceptions about eligibility criteria were also fuelled by the previous lack of regulation and standardisation around eligibility and ongoing differential application of eligibility criteria by doctors. Expectations of support created by previous applications of the DG category, which communicated a fairly generous idea of what disability ‘is’, have been difficult for SASSA to correct (Kelly, 2013). Street-level bureaucrats’ categorising work can influence and reconfigure power relations, social identities and ideas about deservingness as they interact with citizens (Yanow, 2003) and the DG shows how important the historical application of an administrative category by street-level bureaucrats is in creating expectations about who should rightfully be included in that category. Framing eligibility differently, some doctors continued to recommend grants to patients to support health outcomes, in recognition of the challenges that older people and unskilled people with minor impairments face in the labour market or because they see particular individuals as deserving of support (see Kelly, 2016). This has not only resulted uneven application of policy, but also perpetuates the idea that doctors’ decision-making can be influenced by claimants.

These misconceptions about eligibility criteria also appeared to be driven by fundamentally different understanding of what it means to be disabled. In medicine, “proof” of disease lies in biomarkers - objective, quantifiable and comparable indicators of a patient’s medical condition – (e.g. CD4 count, viral load, cholesterol level, blood pressure, ejection fraction or insulin level) which indicate the presence and severity of a disease, as well as treatment response. Although not directly connected to impairment, these details, written in patients files are primarily what guided doctors assessment. Patients’

interpretation of disability on the other hand is based on their daily experiences of suffering and sickness and their experiences of struggling to find work.

‘I tried to do it again when my CD4 was up but they said no, now you are better, you must go look for the jobs you see. I feel sad because I’m not working and I don’t have a husband and I have kids at home you see. I was sad and I don’t find jobs. They look only for if it is under 200. It didn’t matter whether you are taking tablets, whether you are suffering, they only say you can get it when your CD4 count is under 200’ (Nomakhwezi, Blikkiesdorp, 2012).

Various studies in South Africa have demonstrated that lay constructions of disability and illness and DG eligibility differ from the narrow bureaucratic and medicalised definitions of eligibility (Reynolds & Swartz, 1993; Delany *et al.*, 2005; Segar, 1994; Macgregor, 2006; Kelly, 2012). In their ethnographic work in the Eastern Cape, Hansen & Sait (2012: 100) encountered people who had “talk[ed] themselves into disability” and who understood illness, impairment, poverty and distress as disability, even if their embodied experience of suffering did not fit the biomedical definition of disability. Patients tend to experience disease in terms of function and their daily activities and experiences and citizens generally tend to express their experiences as individual problems and want their personal experiences to be taken seriously (Lipsky, 2010: 60; Prottass, 1979; Soss, 1999). This need stands in sharp contrast to the reductive and objectifying nature of the disability assessment. Doctors, on the other hand, tend to think more about patterns of disease (Mechanic, 1995: 1208) and biomedical definitions of disability do not take personal experiences and related suffering into account (Kleinman & Kleinman, 1991; Kleinman, 1995).

Forms of contestation, resistance and insubordination

Although doctors tended to dominate the assessment because of their professional and social status and decision-making power, DG claimants were not necessarily subordinate or passive victims in their interactions with doctors or without options or strategies.

De Certeau (1984) and Scott (1985, 1990, 2009) have both argued that the powerless are not necessarily passive or docile and that small, tactical acts of defiance in everyday life can be used to resist forces of power. In *Asylums*, Goffman (1961) argued that people used “secondary adjustments” to re-assert

their personhood resist the categorization and stripping of the ‘self’ within institutions. A number of other ethnographic studies (Skalnik, 1989) have shown that people employ what James Scott has described as “weapons of the weak” (1985) or “arts of resistance” (1990) and what de Certeau (1984) calls “tactics” or “arts of the weak” – small, everyday and often unnoticeable forms of resistance to systems of domination that show the limits of power, but which are often short-lived in their effects.

Prior & Barnes (2009; 2011) have shown that citizens may attempt to assert their position by engaging in relational or oppositional struggles with street-level bureaucrats or by trying to subvert bureaucratic systems and processes. They argue that the subversion of policy directives and disruption of bureaucratic processes in public service settings is driven by “agencies of resistance” of both street-level bureaucrats and service users. While scholars of policy implementation have paid significant attention to the subversive actions of frontline workers, acts of resistance by citizens and clients in bureaucratic encounters and its effect on policy outcomes has been less studied. Clients do not always accept being placed in administrative categories and may work to assert their agency in street-level interactions by subverting or disrupting existing systems, developing alternative strategies and practices or refusing to participate in systems and programmes in the way institutions and bureaucrats want them to (Dubois, 2010; Barnes & Prior, 2011). This can result in distinctively different outcomes than those intended.

For example, in his work in French welfare offices, Dubois (2010) observed cases where clients would defy the bureaucratic attempts to place them into administrative categories through personalisation - attempting to gain control of the interaction by creating cracks in the bureaucratic or professional façade of bureaucrats or introducing an emotional dimension into interactions through narratives of misery. There are a number of other examples of this in European studies (Bloor & Macintosh, 1990; Salmon & May, 1995; McDonald & Marston, 2005; Ewick & Silbey, 2003). In South Africa, Schneider *et al.* (2010) showed that patients negotiated access to care and preserved their dignity in a resource-constrained public hospital by making tactical use of social networks, complaint mechanisms, narratives of resistance and becoming expert, compliant patients. Also in South Africa, Eyles *et al.* (2015) argue that patients may resist poor treatment by healthcare providers within the healthcare system through non-compliance with treatment which, even despite the potential for self-harm, represents an exercise of agency which can be a coping mechanism for navigating the healthcare system and their relationships within it.

Observations of doctor-patient interactions showed that during DG assessments claimants brought their own agency to bear on the assessment as they presented

their stories and bodies to doctors, along with their own understandings and interpretations of SASSA's eligibility criteria. Some patients actively resisted doctors' dominance and attempted to assert their personhood and demands for inclusion in the social security system. One way of doing this was drawing on one's biology and convincing doctors of the severity of their medical problems by performing their genuine, somatic or feigned impairments to doctors. Another was by presenting narratives of their experiences of poverty and related social and psychic suffering, in the hope of soliciting a humanitarian response from doctors who might stretch or abandon SASSA's eligibility criteria to include them. These 'modes' of resistance are not necessarily conscious or intentional and also have a practical component: survival. Being assessed as disabled provides access to an income via the DG and disability therefore becomes a resource and opportunity for a connection to the state (Petryna, 2004).

It is important to note that not all claimants resisted the assessment process and I am not attempting to distinguish between acts of compliance and resistance in terms of agency, because accepting the rule can also be a form of agency (Hansson & Hellberg, 2015: 31). There is of course also a risk of overstating the agency of claimants and over-interpreting DG claimants' behaviour and self-expressions and labelling them as resistance, or assuming that there is a unity in how the 'weak' think, which is assumed to be antagonistic to power, criticism that has been levelled at Scott and de Certeau (Gupta, 2001; Johansson & Vinthagen, 2014; Howe, 1998). In fact, perhaps one of the most effective way of negotiating access to the grant was by being compliant, well-mannered and demonstrating through appropriate behaviour that one was a 'decent' and therefore 'deserving' person (Kelly, 2016). Harris *et al.*, (2014), for instance, showed that patient compliance and deference and docility in interactions with healthcare staff was a path to inclusion in the South African healthcare contract which the authors interpreted as neither automatically nor unconditionally inclusive.

The interaction that took place between Mr Khaya, a 33 year-old former miner and Dr Marais, at an orthopaedic outpatient clinic at a Cape Town hospital presents a good example of a patient using physical performance of disability to assert his demand for a DG. Mr Khaya, a new patient at the clinic, entered the room limping and wearing a knee brace incorrectly – it was only half tied up and upside down and he clearly had no need for it. He was there on the premise that he was seeking treatment for his knee, but Dr Marais very quickly said to me, "he's not here for an operation, he's here for a grant – have you not noticed by now?" and busied himself with administration work for some time before addressing the patient. This was quite uncharacteristic of him because he had great rapport with the other patients I had seen him interact with and he seemed

to be avoiding what he expected to be an awkward interaction. Khaya could not understand any English and a nurse was brought in to translate. She explained to Marais that Khaya had been injured during strike action in Rustenberg where he had been a miner and he had ataxia (poor balance) as a result of a head injury. He had been medically boarded in 2011 because he had Stage 4 AIDS and had been paid out R104 000, but this money was now finished. He told the doctor that he was looking for money from SASSA because he was not working. He claimed that he had tuberculosis, but he was not receiving treatment for it or his HIV because he had moved from Philippi to Khayelitsha and did not know where the clinic was.

On examination, it appeared that there was nothing wrong with Mr Khaya's knee, he did however have a sore on his hip and he appeared underweight and unwell. The doctor asked Khaya what he wanted and he responded that if his leg could be healed then he would work, but if it could not be healed then he would like a grant. He added that one of his legs was shorter than the other. Dr Marais told me that he was frustrated because he was not sure what the patient wanted and whether he could help him as his problems were clearly not orthopaedic, despite him claiming that they were. He said to the nurse [a different one by this point], "tell him that no doctor can fix his legs and that he needs to see a doctor for the HIV because this is his main problem at the moment". He told Mr Khaya that he could "get a grant" because of the HIV and the problems related to it. He did not, however, conduct any real assessment of his HIV status. Khaya grinned widely and he and the nurse spoke in Xhosa for some time. The nurse then shared this conversation with the doctor, saying that Khaya had told her that Dr Marais had agreed to lend him money. Dr Marais was very amused because no such discussion had taken place. The nurse spoke to Khaya again and he reiterated that Marais had agreed to lend him money. Dr Marais told the nurse that he never lent or gave patients money and, clearly annoyed, got some pills from his bag, explaining he that he was getting a migraine. After speaking more with Khaya, the nurse told Dr Marais that because he was white, people thought he had money. Whilst we waited for the DG book to arrive, the nurse carried on chatting with Khaya. She didn't seem to think that the Mr Khaya was unjustified in his expectation and joked with him: "instant loan". When Dr Marais finally filled out the form he wrote that Mr Khaya had pulmonary TB, a previous head injury and HIV and recommended a permanent grant without review, clearly never wanting him to return. When Mr Khaya got up to leave, the doctor told him to leave his knee brace behind because he didn't need it anymore.

In this case, almost in collaboration with the nurse, Mr Khaya was able to assert his demand for a grant quite directly, resisting the inherent power disparities between him, the poor black man who could not speak English and the wealthy, white, English speaking medical professional, despite the fact that he was both

non-compliant and feigning illness. Although claimants were seldom so successful in doing this, he succeeded in wearying the doctor to the point that he recommended the grant simply to get rid of him. Dr Marais admitted that he appeased patients in this way fairly often and I also observed him advising a junior doctor who was being pressurised by one of her own patients to recommend a temporary grant if the patient continued to insist on it.

As in the case of Mr Khaya, who used an old knee brace as a prop in his performance of disability, feigning or exaggerating impairments was a commonly used tactic by claimants. Another doctor summed up this scenario quite well: “If you cannot find work then you remember that you have an old injury”. Although extremely difficult to determine whether in fact it is the case, healthcare workers believed that they encountered large numbers of people who were evidently not disabled on the basis of objective medical criteria. There were a number of cases where doctors and OTs had witnessed claimants who had accidentally revealed that they were not in fact impaired or as impaired as they claimed when they were not being observed.

‘I saw recently a patient also, she couldn't walk and she was walking like this [demonstrates someone walking hunched over] inside the room, but I know her because I was working at Driefontein. When she left [the room] I gave her a chance, say 5 seconds, before I looked at her down the passage - she was walking normally’ (Dr Bury, interview, 22 July 2014).

Knowing that doctors were interested in medical diagnoses and treatment history, some claimants would arrive at the assessment with a long list of symptoms and complaints based on anything they had received treatment for in the past – from asthma, to arthritis to healed fractures (Dr Jacobs, interview, 24 October 2013). According to doctors and occupational therapists, back pain, osteoarthritis and pain from old injuries were most commonly exaggerated or feigned by claimants. Officials working for SASSA indicated that there were cases where claimants borrowed medication or mobility aids from others to attempt to fraudulently access the grant, but this was difficult by the need for supporting evidence in the medical file and did not seem to be a frequent occurrence. Occupational therapists also highlighted the frequency with which DG applicants that had been referred to them by doctors for formal work assessment exaggerated their disablement or intentionally underperformed on mobility, motor or functional tests.

‘The person will say that they are in pain, but you can give them test like the ramp and the stairs to do and they will have no indicators of pain. There will be no facial expression of pain, their body language

will tell you they are not in pain but they will SAY they are in pain, even though they are still doing the exercise underneath the normal times taken, they are not using the railings, there's no abnormal gait pattern - those type of things. If they know that we are testing them they will excessively walk much slower on the stairs and then we'll record the time, but they don't realise that we are still assessing them during tea and lunchtime' (Occupational therapist, interview, 23 April 2014).

Claimants with epilepsy were generally aware that only uncontrolled cases of epilepsy are eligible for the DG and because the frequency of their fits was difficult to authenticate, some exaggerated the number of seizures they had per month. Social workers at a psychiatric hospital reported that claimants frequently 'relapsed' shortly before their grants expired. This was not only a perception held by healthcare professionals. In Blikkiesdorp, community members eagerly shared examples of people receiving grants who were not (in their eyes) genuinely disabled.

'She will perform, fall, pee and make all the different things and the doctor will believe that she's not normal and she will bite him and perform and be angry and do all the movements. Then she would come to me and tell me all the movements she was doing for the doctor! I was laughing! People are very clever; people think that if they stay in Delft they are illiterate but they are very clever' (Delft Community Development Worker, Interview, 2012).

Many of the people applying for grants on "false" premises had received temporary grants in the past but had not found work after these grants had lapsed and were looking for new opportunities to re-new these grants and maintain their income. For patients, the prospect of losing their monthly income was devastating. The temporary grant system assumes that once someone's health has recovered that they should be able to re-enter the labour market. This creates incentives to prolong one's time in the sick role because very often claimants are not much more employable after they recovered than they were when they first received a grant.

Although defaulting on treatment may have presented a strategy for retaining a temporary disability grant in the past, few doctors now recommend grants for people who do not adhere to treatment.

As deception by claimants is a central concern in disability benefit administration, doctors were alert to the possibility that patients were exaggerating their impairments. Experience with claimants who were assessed

as exaggerating or feigning symptoms, made doctors alert to and suspicious of patients' motivations in reporting their symptoms and lived experiences of disability during DG assessments. This meant that these performances were seldom convincing to doctors, and could result in an impatient reaction by doctors who classified the patient as a 'malingerer'. Even so, by disrupting the assessment, patients undermined doctors' authority and introduced a kind of uncertainty that in some cases resulted in doctors recommending temporary grant, sometimes simply to get a patient to leave.

Besides the relatively small a group of people who at least appeared to be intentionally trying to deceive doctors, there were people with what doctors considered relatively minor impairments who appeared to genuinely believe they were disabled based on their lived experience. Self-perceptions of disability may not always align with objective observations of health or disability status (Monks, 2000: 19). "Suffering is an affliction of the person, not the body" (Cassell, 2004: xii) and people conceive of and experience disability and illness differently, displaying different "illness behaviour", responding to bodily indications, interpreting symptoms and taking action in often very different ways (Mechanic, 1995). Feelings of disablement can also be somatic in origin. According to OTs I interviewed, who often spent days with patients during formal work assessments, some patients felt more disabled by their medical impairments than functional assessments would suggest.

'I get a lot of women that have come in here because of abuse - like they are broken because of abuse and you can actually see it in their entire demeanour already, the way they dress, the way their hair is, the way they smell. We do get patients that look horrible, they look really worn out, so life has kind taken from them, just in general - whether it be other people that have broken them down or circumstances that have broken them down or maybe they are just negative people - you get pessimistic people. So there's a lot of reasons why their motivation is not where it should be to return to go out and seek work. They feel like they are victimised, they feel like they just are...they can't do anything' (OT1, interview, 23 April 2014).

Physical pain and suffering that is not connected with or disproportionate to physiological problems can be driven by somatisation, which is a bodily mode of experiencing personal and political distress (Kleinman & Kleinman, 1991: 280). "Both physical and emotional pain can be increased by fear, powerlessness, anxiety, depression, and lack of control" (Francis, 2006). Individuals with low self-esteem and motivation as a result of their life circumstances and subjective experiences of illness or impairment may become

convinced that they are not able to work (Mechanic, 1995) and both doctors and occupational therapists recognised that low motivation drove perceptions of disablement.

In another study of DG applications in South Africa, Macgregor (2006) found that claimants in the Cape Town township of Khayelitsha somatised the stresses of their economic and social circumstances, expressing their suffering as a psychiatric condition they called “nerves”, a local term which she sees as “embodying the distress associated with harsh circumstances and is deemed by supplicants as sufficient to secure a grant”. Mary, a research participant in Blikkiesdorp, who was an HIV positive single mother who had been sexually abused and continued to face physical and emotional abuse from her drug-addicted daughter, somatised her anxiety in terms of her HIV status, describing her stress in terms of her falling CD4 count. Although not connected to attempts to obtain social benefits, Fullwiley (2006) describes how Senegalese women carrying the sickle-cell trait (a benign condition with no symptoms) articulated their emotional, social and physical suffering as “sickle cell crisis”. Fullwiley theorises that this enunciation of suffering in biological form is an expression of biosocial suffering, an idea drawn from Rabinow’s concept of biosociality (1992) and Kleinman *et al.*’s (1997) concept of social suffering. Scheper-Hughes (2002) argues illness can be used as a “passive aggressive weapon of the weak” and that malingering and somatisation are “inchoate acts of protest and defiance against oppressive roles and/or feelings of inadequacy, frustration, or failure” (2002: 153-169). The desire to assume the “sick role” and refusing to continue to look for work also represents another more passive kind of resistance, “a refusal to endure, to cope”. It says, “I will not any longer” (Hopper, 1982 in Scheper-Hughes & Lock, 1986).

As the disabled body is entitled to support from the state, disability becomes a positive collective category people can draw on to assert demands on the state as suffering bodies and form of ‘opportunity’ because it has the potential to offer some kind of income (Hansen & Sait, 2012; Kelly, 2012). In other words, claimants embraced impairment and medicalisation as a route to social inclusion. One doctor in this study noted that in cases of long-term unemployment, claimants people thought of hypertension and diabetes as a “bonus”, because they believed their diagnosis would allow them to receive a grant (Dr Bhele, interview, 30 April 2014). Others have provided examples of people reacting positively to an HIV or TB diagnosis, or, although not necessarily something carried out in practice, wanting to remain ill (Leclerc-Madlada, 2006; Natrass, 2006; Hardy & Richter, 2006; Delany *et al.*, 2005; Natrass, 2006; Hardy & Richter, 2006; De Paoli *et al.*, 2012; Woolgar, 2014; Segar, 1994). This has been characterised as a “bizarre sickness-poverty trap” (Standing, 2008: 22) driven by gaps in the social security system.

While the field of disability studies has avoided considering the impairment related aspects of disability in examining the politics of inclusion, medical anthropologists have considered disability-related claims on the state in Foucauldian terms as *biopolitical*. There is now a fairly substantial literature using disability or illness as a resource and opportunity for a connection to the state (Petryna, 2004, 2002; Ticktin, 2006; Fassin, 2001, 2009; Nguyen, 2010, 2013). Petryna defines this type of embodied demand for support from the state as *biological citizenship* – a link to “a form of social welfare based on medical, scientific and legal criteria that both acknowledge biological injury and compensate for it” (2002: 6).

Embodiment was not the only way that claimants expressed their suffering and performed the role of ‘deserving’ disabled person. DG claimants’ accounts of their disablement were very often expressed as narratives of their everyday struggles of trying to find work, difficult household dynamics and experiences of living in poverty, rather than as descriptions of medical symptoms or physical limitations. In some cases claimants combined this storytelling with other physical complaints, as was the case with Mrs Nkosana. She began her performance as soon as she entered Dr Mulumba’s office. With one hand on her back and the other hand on the table, she lowered herself carefully into the chair, complaining loudly and dramatically about her backache. When asked why she was applying for a grant, Mrs Nkosana told the doctor that for seven years she had had “no food and no job” and had “been waiting for a grant” since 2008. She went on to tell Dr Mulumba that she had “terrible diabetes”. After discussing Nkosana’s medical history and treatment for a while, Mulumba began to fill out the assessment form. While she did this, Nkosana started to tell her about what a terrible disease the “sugar” was. She also described her incontinence, saying that when she went back to the Eastern Cape she had to use babies’ nappies because she was “leaking”. Dr Mulumba was only half listening and did not respond to this storytelling, focusing her attention on the form in front of her instead.

Recognising this, Mrs Nkosana turned and, hoping for some more sympathy from me, complained that her back was sore. Trying to avoid becoming involved, I simply nodded. She was not deterred and added that she also couldn’t see properly. Dr Mulumba intervened by looking up from her paperwork and telling her that she needed to glasses and that she should see someone about this. Mrs Nkosana was not so easily dismissed and started complaining that her nose was running and that it gave her a headache and made a knocking noise in her head, rapping on the table to demonstrate. Dr Mulumba asked her if she had always had sinus problems and Nkosana responded with a complex story about leaving work because of her back pain. Mulumba asked her, “is it your back only or also your knees?” and Nkosana answered that her

knees were also a problem: “Yoh,⁶ my knees are stiff! Sometimes I leave the table and I have no food inside and I say, ‘Hey Jesus, you must look after me’”. The doctor asked Nkosana where her husband was. “Yoh, yoh, yoh!” exclaimed Nkosana. She then continued to tell the doctor about how her husband had retired and returned to the Eastern Cape without her: “He sweet talks you nicely – I hate him. That is why I am getting the diabetes”. She added that her daughter has been smoking and drinking since 2003 - “that is why life is so terrible”. In her story, her physical struggles were closely tied to her social and economic ones and she invoked both in describing her ‘deservingness’.

Although like Mrs Nkosana, many patients employed pathos to strengthen their cases, this story-telling was not necessarily intended to manipulate or deceive doctors and may simply represent, as in Hansen & Sait’s study (2012), a different understanding of disablement or a sharing of experience. It does, nevertheless, represent a demand for social assistance.

While these patient narratives were ignored or shut-down by many doctors, they made others made profoundly uncomfortable in their role. One Xhosa-speaking doctor explained how the shared language allowed many claimants to convey their stories in great detail she found it very painful to reject people knowing their social circumstances: “But then you still put ‘no’ at the end – it’s not nice. We are human beings also”. She described driving through the squatter camps to the clinic and told me, “you *feel* it, you *know* it, but you don’t have grounds to give the grant. As a doctor you choose this profession to help people, not to be unkind”.

Although less frequently, claimants also asserted their demands and frustrations by verbally harassing or using violence against healthcare workers as a form of protest against the system; disrupting power relations by making them feel vulnerable. In interviews, as well as training sessions I attended, doctors frequently raised safety concerns or shared stories of patients that had threatened or verbally abused them either in an attempt to coerce them into recommending the grant or to express their anger at what they saw as unfair treatment. Doctors attributed attacks to poor screening practices and poor communication of eligibility criteria and the decision-making role of doctors, which led to doctors being blamed: “I wish the community was educated – we become the bad doctor and they are always on our necks”.

Aggression by patients was experienced most commonly at the primary healthcare level by doctors who spend hours presenting the ‘face’ of SASSA to

⁶ “Yoh” is a general exclamation used in South Africa, denoting emphasis.

disability grant claimants. These SASSA assessors were often intensely unpopular with patients because they were perceived as strict and inflexible. They were not only coerced by claimants during consultations, but were sometimes heckled by people waiting in the corridors. One doctor described how people in the corridors of the clinics she visited would regularly swear at her, complaining: “It’s not even her money!”. She had also threatened with a knife at two of the clinics she worked at and had also had a patient return to the clinic to confront her aggressively after learning from SASSA that his application had been rejected. She felt that doctors were often blamed for not “giving” the grant and that patients “made it personal”, not understanding that their decisions were based on SASSA’s guidelines.

In another case, Dr Kruger, a SASSA assessor, was physically assaulted by an angry patient who had hit him with a chair during a consultation. He told me via email, “I have been verbally abused a few times and had patients scream at me and get quite aggressive, but I was never physically abused until now”. When he pressed charges and reported it to a senior SASSA doctor in the region where he worked, he was told that he was the third doctor in the region to be assaulted by a patient. This treatment was not limited to doctors and nurses and occupational therapists also experienced verbal threats and physical abuse from patients. Dr Marais shared the story of the nurse who managed his clinic who had encountered a patient at a local shopping mall who believed that she had discouraged Dr Marais from recommending a grant. The patient had chased the nurse through the mall, insulting and attempting to hit her. Occupational therapists, who are effectively included in the gatekeeping process by doctors who refer patients for functional assessments, reportedly also encountered considerable coercive pressure from patients who swore, shouted and threw objects at them.⁷

Dubois (2010) puts forward three possible reasons why welfare claimants may use or threaten violence in administrative settings. It can be a resort of victims of structural violence who don’t understand the system, are frustrated by it and aren’t able to express themselves in other ways. Violence can also be strategically employed to get attention or expedite bureaucratic processes. It can also be used by people as a way to demonstrate their personhood and their existence beyond administrative categories.

In the case of the DG, aggression by claimants seemed to be mainly driven by frustration and anger at a system that was confusing and unfair or how they were

⁷ An OT at a work assessment unit at a tertiary hospital indicated that they often get inappropriate referrals from OTs working at PHC level in what she described as “dangerous areas” because OTs were too frightened to report that a patient had no functional limitations.

treated by doctors, who could be rude and moralising in their interactions with claimants. One claimant, for example, shared her experience of being told by a doctor: “You are robbing the government, you must go work”. She had responded by swearing at him, which she felt was a legitimate response to being treated so rudely. Her reaction also represents claimants’ frustrations at being “misrecognised” (Fraser, 2008: 58) by doctors who treat them as lazy shirkers unworthy of both grants and their respect, rather than as equal citizens in need of support to achieve parity of participation. Participants in Blikkiesdorp indicated that people who had applied for grants felt unheard and unfairly treated by doctors and the system more generally (Kelly, 2012).

‘I had to be fed with a spoon, even to eat, okay. I was taken to the disability doctor in a wheelchair. Firstly I went with the ambulance up and then I was placed into a wheelchair - was I approved? No. I waited and I waited and I waited and I was found fit. I was only bone and skin. Another time I asked the doctor “Do you think I will be approved?” because she was, quite frankly, shall I say teasing me in the jokes she was making. I said to her “Do you think I will get it?” and she said to me “No but you are still young, you can work”. I said, “you know what, if I stand up and I walk from here to that door then you will probably phone the guys at trauma to fetch me because my chest won’t only be tight, I will be a really extreme trauma case”. She said to me “Ag man, everybody says this stuff” and I said “Can’t you see in my file?” And she said, sir, “You’ve got to come up with better things than this for me to approve you”’ (Samuel, focus group, Blikkiesdorp, 2012).

They expressed frustration with the government and the increasing difficulty of accessing benefits and could not understand why they were not physically examined (this is not a legal requirement and many doctors rely only on the claimants file) or why doctors told them they were capable of working when their daily experiences with illness and inability to find work indicated otherwise. One participant in that study joked, “if you die in the hospital today and they give you a death certificate then they will say ‘okay now you are fit for the disability’” (Kelly, 2012: 101). Not being told by doctors whether they qualified, left claimants them waiting in limbo for the two weeks before they could return to SASSA to have their applications processed, created significant stress and for failed applications, significant time and money wasted on “bureaucratic run-around” for other parts of the application process such as means testing.

‘The doctors are very strict because they don’t care, no matter you are not working, you are still ill, they just look at your face and then they

don't tell you if they give you the grant or they didn't give you. You are struggling, you are doing the grant, you walk up and down, you do the grants and then to at the end there is nothing in the machine' (Nomakhwezi, interview, Blikkiesdorp 2012).

Aggression towards claimants also represents a bigger breakdown in the doctor-patient relationship and trust in doctors, where doctors are seen as functionaries of the state; their work as arbitrary and corruptible as those of other administrators. China has seen a similar but much more widespread phenomenon, where the doctor-patient relationship and respect for and trust in doctors has deteriorated to such an extent that doctors are frequently violently attacked by patients and their families (Beam, 2014).

How doctors respond to acts of resistance

Claimants' attempts to disrupt the assessment process made doctors' already work difficult significantly more challenging. It was often difficult for doctors to react objectively and professionally in cases where this occurred and there is clearly an unavoidable emotional component to the type of face-to-face encounters that occur during DG assessments (Graham, 2002; Eggebø, 2013). Doctors are "emotional actors" (Hunter, 2015), who may feel interest and boredom, compassion and guilt, fear and detachment, sadness and fulfilment, anger at being manipulated or at people abusing the system and guilt during their interactions with clients (Tumbo, 2008; Eggebø, 2013; Graham, 2002; Rousseau & Foxen, 2010; Fassin, 2005; Butt, 2002; Ticktin, 2006) and like other street-level bureaucrats, may develop their own approaches or routines for handling the stresses that accompany their work (Fassin, 2008; Walker & Gilson, 2004).

As their interactions with patients are one of the most significant sources of stress, doctors developed coping strategies or social defence mechanisms (Menzies Lyth, 1960) to preserve their professional objectivity, protect themselves psychologically and manage the demands of their emotional and decision-making work. This included guarding against people looking to manipulate or trick them, dealing with people who the DG system could not accommodate and managing aggressive patients.

In many cases, patient's real problems extended well beyond doctors' ability to assist them and unable to deal with people's poverty they may become frustrated, despondent, disinterested, suffering from burn-out or compassion fatigue. Lipsky (2010) argues that street-level bureaucrats stereotype and mentally discount clients to rationalise their inability to assist and in the context of limited resources, doctors may make value judgements about patients to

simplify or justify their decision-making. In the South African healthcare system healthcare workers are overburdened and resources are limited and in this context clinicians have to make decisions that are not always ideal (Gibson, 2004). As a result, decisions have to be made as to who is more ‘deserving’ of support, which can lead to moralizing about certain categories of people (Le Marcis & Grard, 2015; Walker & Gilson, 2004; Fassin, 2008; Kelly, 2016).

A number of South African studies have shown how healthcare workers became nihilistic about their inability to cure patients, and repetitive nature of their work, growing bored and becoming neglectful of patients and indifferent to their suffering, especially in the wake of the HIV epidemic (Oppenheimer & Bayer, 2007; Le Marcis, 2004, Le Marcis & Grard, 2015). Fassin (2008) found that healthcare workers in a South African hospital ‘learned’ emotional indifference and employed tactics to distance themselves from patients. As Le Marcis and Grard (2015) argued, “withdrawing from a caring relationship is for health professionals a way to carry on working” and a driver for the standardization and de-personalisation of care.

Tummers *et al.* (2015) classify the behavioural ways that bureaucrats cope with 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 in three ways: *moving towards*, *moving away* or *moving against clients*. Coping by moving towards clients may involve 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 moves that use bureaucratic categories and processes to limit engagement and services to clients. Strategies *moving away* from DG claimants included: directly confronting patients; moralising about certain groups of patients to simplify their decision-making; getting rid of patients by rushing through their applications; taking a task-oriented rather than patient oriented approach; denying responsibility for decisions or the welfare of applicants; avoiding engagements by limiting opportunities for conversation and, thus, claimant input; psychological withdrawal; and cultivating “bureaucratic indifference” (Herzfeld, 1992) to detach and distance themselves from the needs of claimants. Some confronted patients directly, asserting their professional and bureaucratic authority to regain control over the interaction. As one doctor who used this strategy 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”. Some doctors also moved *towards* clients by bending the rules to accommodate claimants they felt pity for, a strategy that alleviated their own guilt.

While these strategies did help doctors to deal with DG applicants in the short-term, they had negative consequences for the levels of trust between doctors and patients. Relationships between doctors and claimants were often fraught with tensions that were the result of divergent understandings of disability and rights to social assistance. Doctors' defensiveness and ability to dictate the terms of the assessments and cut off patients could limit patients' ability to participate in the assessment process, already constrained by language and education barriers.

Being unable to tell their "side of the story" and being treated dismissively by doctors or even with contempt was frustrating and humiliating to claimants. As noted earlier, this led some to become aggressive with doctors, creating a vicious cycle that further entrenched barriers between patients as doctors acted to protect themselves against patients' demands and re-assert control. This, unfortunately, reinforced existing patient mistrust, and in the case of treating doctors, potentially undermines already weak doctor-patient relationships. Doctors' humanitarian actions toward particular patients they felt sympathetic towards also undermines the principles of equality and fairness in assessments.

Conclusion

This paper has shown that the DG assessment is not only a bureaucratic and medical process, but a social interaction shaped by the subjectivities and agencies of the doctor and claimant involved. Claimants' understanding and subjective experiences of disability differed from biomedical conceptions of disability. Patients' demands for the DG represent a form of protest by the poor about their economic exclusion and the physical and psychic suffering they experience as part of that exclusion.

I showed that claimants could be active participants who creatively engaged in the assessment process, using narratives and physical performances of disablement and suffering to influence doctors' decision-making. The agency of claimants who resist and disrupt the DG assessment process, and the ways in which doctors respond to this, highlight power dynamics that are often overlooked by the street-level bureaucracy literature. This is an important contribution to recent efforts to include the perspective of clients/citizens in street-level scholarship.

The ways in which claimants interpreted eligibility criteria, interacted with doctors and strategically positioned themselves in relation to the disability category put pressure on doctors and the system in general. This shaped doctors' decision-making and thus, policy implementation, however, often not in the way that claimants hoped. Claimants' attempts to perform disability or make direct

demands for the DG were seldom effective in convincing doctors to recommend a grant. Rather, doctors' belief that claimants were trying to manipulate or deceive them, together with the pressures inherent in the medical work environment, led some doctors to employ defensive strategies that distanced them from claimants.

While this study highlights the agency of beneficiaries, it also highlights the profound lack of opportunity that claimants have in creating other viable livelihoods and the lacunae in government strategies to alleviate poverty and integrate chronically ill people into society. The fact that sickness and disability become desirable in the South African context creates a perverse reversal of values and norms around health. Using the disability category to gain access to an income and soliciting compassion from gatekeepers in the hope of being the beneficiary of a humanitarian act, is an undesirable and uncertain way of achieving economic inclusion, especially when one's performance of disability has to be re-enacted every six to twelve months.

As this study has shown, the state's distinction between the deserving disabled and undeserving non-disabled does not necessarily reflect either community or individual understandings of suffering and rights to social security or doctors' understandings of disability. This not only creates potential for doctors to stray from official policy and guidelines, but also brings into question the boundaries between physical and other types of disadvantage and marginalisation. The categorical targeting of people with physical impairment for social assistance may not necessarily be viable or appropriate in a context where large numbers of people are unemployable (and therefore impaired by social and economic factors) and are also in need. The state has focused on reducing medical discretion and tightening eligibility criteria to exclude those who are not physically impaired and therefore 'non-deserving', but this cannot solve the bigger social and economic problems driving demand for the grant. This has distracted policymakers and legislators from developing a DG system that promotes the inclusion and development of disabled people in society.

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