UNIVERSITY OF CAPE TOWN

CENTRE FOR
SOCIAL SCIENCE RESEARCH

Hard and soft medicine: Doctors' framing and application of the disability category in their assessments of grant claimants' fitness to work in South Africa

Gabrielle Kelly

CSSR Working Paper No. 384

Legislating and Implementing Welfare Policy Reforms

July 2016

This Working Paper can be downloaded from:

http://cssr.uct.ac.za/pub/wp/384/

About the author:

Gabrielle Kelly is a postdoctoral fellow in the CSSR and the Sociology Department at the University of Cape Town.

Acknowledgements:

Hard and soft medicine: Doctors' framing and application of the disability category in their assessments of grant claimants' fitness to work in South Africa

Abstract

Using the framework of street-level bureaucracy theory, this paper examines the work of medical doctors in assessing eligibility for disability grants (DGs) in South Africa. Observations of doctor-patient encounters showed that, despite the state's attempts to standardise disability assessment, significant variation remains in doctors' decision-making. I argue that doctors' divergence from rules and guidelines is driven by differences between the government's bureaucratic framing of disability and the alternative frames used by doctors for making sense of cases and thinking about disability, illness and employability in the South African context. Doctors' framing of DG cases was shaped by their social and cultural backgrounds and dispositions, their professional knowledge and values, and their broader discursive framings of rights and social justice. This paper makes an original empirical contribution to the study of conceptions of disability as a category of the 'deserving' poor in a context of high poverty. It also highlights the relationship and potential conflicts between professional expertise, social norms and values, and bureaucratic rules at the street-level, and shows how this shapes policy implementation and the ensuing 'gap' between policy and practice.

Introduction

The South African government provides a relatively generous[1] non-contributory pension called the disability grant (DG) of R1500 ($100) a month people who are disabled and unable to work or to support themselves financially through other means (SASSA, 2016). Applicants' disability must be confirmed by a

---

[1] This 'relative generosity' refers to the size of these benefits relative to the minimum wage. The DG is set at less than the minimum wage across all sectors, but pays more than many informal sector jobs and is very close to the minimum wage in a number of sectors. It is also generous relative to the size of disability benefits available in most developing countries (Gooding & Marriot, 2009).

medical doctor, turning doctors into gatekeepers.[2] Although doctors are typically considered a professional group, as disability assessors doctors operate as *street-level bureaucrats* (Lipsky, 2010)[3] for the South African Social Security Agency, which is responsible for administering the DG and other social grants. Street-level bureaucrats are characterised by their direct (frontline) interaction with the public and the high degree of discretion and autonomy that they have in practically applying the benefits and sanctions of institutions to citizens (Maynard-Moody & Portillo, 2010). Doctors are positioned as street-level bureaucrats to the extent that they work at the interface between citizens and the state, have an important role in the allocation of state benefits and are subject to the bureaucratic constraints and regulations of social security and health policy. Like other street-level bureaucrats, they work in resource-constrained settings where they have to make complex decisions quickly, with limited information and time.

Lipsky (2010) argued that street-level bureaucrats effectively create policy through the ways in which they exercise agency as they interpret and apply policy in their daily work, often in ways that make their difficult work easier. Studies of street-level bureaucracy draw our attention to how professional knowledge and experience is put into action through practical reasoning processes. It also, as Rowe (2012: 15) notes, "takes us further, to the context-dependent ethics of public service (the *phronesis*)". There is an extensive literature on the frontline workers who make the daily decisions about "who gets what, when and how" (Laswell, 1936) in European and North American welfare states, but there are few studies of how frontline public service workers contribute to how policy is realised on the ground in developing countries (see Hoag, 2010; and Bierschenk & de Sardan, 2014 for some exceptions). There have also been few applications of the street-level bureaucracy concept to healthcare policy implementation, both in general and in South Africa in particular (Walker & Gilson, 2004; and Muller, 2016 are exceptions).

In making decisions about patients' eligibility for grants, doctors perform two roles - the role of medical professional, with its attendant norms, responsibilities and knowledge-forms, and the role of bureaucrat within the structure of

---

[2] Doctors make a recommendation on a client's eligibility based on their clinical assessment, but the final decision is made by SASSA who also administer the means test and perform other administrative checks (e.g. age, citizenship or permanence residence). However, claimants cannot not receive the grant without a recommendation from a doctor and SASSA administrators are not trained to interrogate the medical information or assess it in relation to other information (e.g. level of education, skills etc.), applicants would typically receive the grant if they passed the means test. Therefore, in most cases doctors' recommendations DG determined whether a patient received a grant.

[3] Originally published in 1980.

SASSA's disability management system, with its rules and processes. They are also human actors with their own agency and set of personal experiences, norms, moral dispositions and notions of social justice, who are likely to have subjective reactions to claimants and use their discretion to insert their own ideas and values into the assessment process (Barnes & Prior, 2009). As Kaufman argued, bureaucrats enter organisations with "opinions, values, preferences and their own interpretations of the world" (1960: 80-81) that influence their behaviour within them.

There are long-standing concerns amongst policy-makers, implementers and civil society that DG assessments are highly subjective and open to bias and fraud on the part of both doctors and patients (Kelly, 2013). Whilst overt incidents of fraud (e.g. falsified documents and bribes to doctors) has been easier to address with the establishment of SASSA and introduction of new management procedures aimed at preventing fraud, regulating the more regular but often divergent decisions doctors make has been more challenging. One of the reasons why DG assessments are so difficult to regulate is because disability is a complex and multi-dimensional concept.

Ambiguities in defining disability and difficulties in making binary distinctions between disabled and non-disabled people make it difficult to use disability as an administrative category for allocating social rights (Altman, 2001; Bolderson *et al.*, 2002; Priestley, 2010). The South African context creates a number of additional difficulties in accurately targeting intended beneficiaries. These contextual problems include: high levels of structural unemployment and poverty, grant generosity (relative to earnings) inherited from the apartheid welfare state, weak social protection provisioning for working-age adults and an HIV epidemic which has greatly escalated demand for the grant. These factors have created high demand for the DG, including from those who are not disabled, complicating the decision-making of doctors.

Vague policy and medical guidelines leave wide scope for interpretation and the boundaries between what doctors should and should not consider in their assessments are often unclear. As well as individual work capacity, employability is a function of both personal characteristics (e.g. skills, education, personality) and employer demand (Garsten & Jacobsson, 2013). This means medical factors are only a component of what makes someone able or unable to work and support themselves. The significant poverty faced by most claimants also introduces ethical dilemmas into the assessment as doctors must make decisions that have large implications on the lives of those applicants (de Paoli, 2012).

This paper explores the difficult position of doctors within the DG system, focusing on how they interpret and apply DG policy, using their discretion to categorise

patients, especially in spaces between the rules, where specialist medical knowledge and SASSA guidelines do not offer clear answers on eligibility and the degree of disability is open to interpretation. In doing so, it explores the gaps between social policy, medical knowledge and practice.

I argue that doctors' varying decisions reflect different ways of framing the disability 'problem' and therefore interpreting both guidelines and the cases in front of them. As claimants often do not fit neatly into the disabled category, doctors rely on their own categorisation systems or schemas to make decisions about who should get disability grants and to draw boundaries between who is and is not disabled. These are influenced both by their medical expertise and by social constructions which they as individuals tacitly subscribe to. Whilst these framings of disability are, as Lipsky (2010) and others have argued, shaped by the structure of their work and coping strategies they develop to deal with time constraints and other work pressures, they are also related to normative ideas about their role as moral and professional agents.

While some scholars (Maynard-Moody & Musheno, 2003; Dubois, 2010; Hasenfeld, 2000) have paid attention to the influence of norms and values on street-level decisions, in general the literature on street-level bureaucrats has paid insufficient attention to how these are used to categorise people and therefore to ration services (Harrits & Møller, 2011). Although Lipsky (2010) has argued that street-level bureaucrats are governed by professional and occupational ideology, his work and the street-level literature in general, has paid little attention to groups like doctors who have significant discretion and most strongly associate with a defined set of professional norms and values (Hupe, 2007; Evans, 2010). The concept of framing captures the pluralism of subjectivities, norms and ideas that ground street-level actions, whilst allowing us to observe and explain patterns emerging in street-level decisions. It is also useful in examining the relationship and potential conflicts between professional expertise, social norms and values, and bureaucratic rules.

After proposing a number of frames that doctors use in their decision-making, I discuss the effects that these frames have on how doctors make decisions and treat claimants, and how they intersect with or contradict the specific eligibility conditions laid down by SASSA and their obligations to the state. In doing so, I will also reflect on the misalignments between the daily realities of doctor-patient interactions and SASSA's bureaucratic 'script', and what this means for DG policy implementation.

Doctors as gatekeepers and bureaucrats

Doctors routinely make decisions on how to allocate and, in some cases, ration health resources to the public, using both their expert biomedical knowledge and guided by national health policy and organisational policies. The field of medical sociology has long demonstrated that medical settings are sites of social categorisation and that medical decisions and resource-allocation in healthcare are socially complex processes shaped by socio-cultural, moral and professional values, as well as context-specific circumstance (Nurok & Henckes, 2009). The specific literature on the sociology of micro-level rationing in medicine, demonstrates that rationing decisions that affect health outcomes are made in the same way as other categorisations in medicine (Light & Hughes, 2001; Vassy, 2001; Allen, 2004; Mizrahi, 1985), and is relevant to this discussion in that DG assessments are primarily about limiting (or rationing) access to only those with significant disabilities. This literature shows that doctors often become caught in moral dilemmas and are required to juggle the radically different logics and principles of clinical judgement, cost-effectiveness, fairness and their individual obligation to the patient and reach some sort of equilibrium (Willems, 2001).

This places doctors in what Schön describes as the "swampy lowland" of professional practice - a space of messy, confusing but usually important problems that cannot be solved with technical knowledge alone (1987: 3). Decision-making in this context is an interpretive process that relies on doctors' clinical experiences and knowledge of the individual patient as well as medical protocol or bureaucratic guidelines.

Clinical judgment is often described as tacit, action-oriented and context-dependent, rather than a product of technical rationality (Montgomery, 2006; Freidson, 1970; Greenhalgh, 1999; Boshuizen & Schmidt, 1992; Mattingly, 1994; Loftus & Higgs, 2008). The practice of medicine therefore requires a degree of judgement or wisdom or *phronesis*, an interpretive capacity and intellectual virtue that enables doctors to combine medical knowledge and practical skill to address the context-bound particularities and ethical aspects of individual cases (Beresford, 1991; Siegler, 2000; Montgomery, 2006).[4] This capacity is not easily captured by science, learnt in medical school or bound by rules; rather, it is learnt through experience and practice and represents what is often described as the 'art' of doctoring (Meershoek *et al.*, 2007). This more intuitive and situational aspect of medical practice is not captured or easily governed by medical or administrative rules and guidelines and can conflict with administrative, "box ticking" rationality that organisations like SASSA promote.

---

[4] Oakeshott's (1962) concept of *practical knowledge* has parallels with the concept of *phronesis,* as does Polanyi's (1962, 1966) idea of *tacit knowledge.*

As high-status professionals with considerable professional power and expert knowledge, doctors have more discretion and expect more autonomy than many other types of frontline workers. As professionals are generally socialized to comply with the norms and standards of the profession that they belong to (Scott, 1966), they are also more likely to resist outside supervision or control (Freidson, 2001), making their work difficult to manage through rules and managerial tactics. This suspicion of bureaucratic rules does not mean that doctors do not develop routine ways of dealing with patients. In their general work managing medical cases, doctors develop personal working models for managing problems that they encounter on a regular basis (Lock, 1985).

Medical training is not only a process of knowledge acquisition but also a process of professional socialisation that initiates doctors into a 'moral community' (Durkheim, 1992) of professionals committed to explicitly normative goals and norms of acceptable behaviour. Doctors learn from other doctors how to interact with and treat patients and how to deal with ethical dilemmas; and through this process doctors come to see and interpret things in very particular ways. Being a doctor, therefore, becomes a "way of being in the world" (Higgs & Loftus, 2008: 214). Parsons (1951) imagined doctors in a normative or moral role, positioning them as altruistic, caring, trustworthy, community-oriented, but ultimately neutral agents. Although this trust in doctor has been eroded to some extent, the idea that medicine is a moral enterprise and doctors should behave in objective and ethical ways remains central to how the profession positions itself and what society expects from it (Freidson, 1970; Freidson & Lorber, 1972; Kleinman, 1995). Doctors are therefore trusted to make scientifically objective and unbiased decisions and have traditionally been given significant autonomy and discretion in terms of how they make decisions and deal with ethical dilemmas. Doctors are, nevertheless, human agents who have the capacity for extreme bias and moral failure.

The small literature on the role of doctors as third-party assessors in social security and occupational health medicine and the doctor-patient relationships that form in these settings have shown that doctors experience conflict in their simultaneous roles of patient advocate, physician and gatekeepers to benefits and struggle to determine whose interests they should be protecting or promoting (Wynne-Jones *et al.*, 2010; Berg *et al.*, 2000; Dodier, 1994, 1998; Meershoek *et al.*, 2007, 2012; Wilde, 2014; Eikenaar *et al.*, 2015; Stone, 1979, 1984; Mashaw, 1983; Wainwright *et al.*, 2015; Cheraghi-Sohi & Calnan, 2013). It also highlights how important professional expertise and socialisation are in shaping how doctors approach the rules and policy structures (McDonald, 2002; Checkland *et al.,* 2004; Meershoek *et al.*, 2007; Eikenaar *et al.*, 2015). The limited number of studies that refer to or focus on doctors' involvement in the DG system in South Africa, indicate that doctors experience similar conflicts and

frustrations in conducting assessments (Baron, 1992; Segar, 1994; Tumbo, 2008; MacGregor, 2006; de Paoli, 2012).

Research methods

Data was collected in the Western Cape Province of South Africa over a period of eleven months between 2013 and 2014. At the time, DG assessments in the Western Cape were conducted at all levels of the healthcare system by both treating doctors in hospitals in the context of inpatient or outpatient work and by 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 outpatient clinics in three hospitals, one of which was a psychiatric hospital, working 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) in hospitals 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. A description of the doctors involved in the study is provided in the Appendix. Interviews and focus groups were also conducted with occupational therapists, social workers, nurses and SASSA officials, including the medical quality assurance officer.

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. On the other hand, my presence in the room may have influenced how doctors made decisions and treated patients because doctors may not have wanted to be seen as making subjective decisions and may have changed their behaviour. I attempted to

minimise my influence on doctors' behavior and the perception that I may be there to 'judge' their work by reinforcing my student and lay-person role.

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

Framework governing DG assessment

According to the Social Assistance Act of 2004, someone is eligible for a DG if "he or she is, owing to a physical or mental disability, unfit to obtain by virtue of any service, employment or profession the means needed to enable him or her to provide for his or her maintenance." Section 3(c) of the 2008 Regulations to the Social Assistance Act further defines eligibility in relation to employability and an applicant is eligible if "he or she is unable to enter the open labour market or support himself or herself in light of his or her skills and ability to work" and does not unreasonably refuse to any income generating employment within his or her capabilities. *Disability* itself is not defined in the Act or its regulations and the lack of a proper definition means that it remains open to interpretation. Given failed attempts to better-define and measure disability in legislation (Kelly, 2013), SASSA attempts to standardize disability assessments through managerial processes.

SASSA has developed a set of medical assessment guidelines to structure doctors' thinking and limit their discretion in interpreting disability. These guidelines provide conceptual definitions of impairment, disability and employability. To help doctors estimate impairment based on diagnosis, the guidelines include a basic table of condition-specific directives in its guidelines for determining the percentage of impairment present based on diagnosis. Based on the tables, doctors then categorised the overall severity of impairment as 'none' (0%), 'mild' (<25%), 'moderate' (25 – 40%) or 'severe' (>40%). Those with mild impairments are not eligible, those with moderate impairments may qualify based on other factors that influence employability and those with severe impairments are considered eligible regardless of other factors. The SASSA tables are basic and provide broad impairment ranges and no instruction on how to combine multiple diagnoses or information on what tests should be used to establish impairment.

The guidelines also provide no instruction on establishing function or assessing Activities of Daily Living and are not aligned with information requested on the standardized form doctors had to complete during assessments. While the

guidelines make provision for considering non-medical factors (age, educational attainment, intellectual capacity, skills, reasonableness of accommodation by an employer) in cases of *moderate* impairment, they do not provide any guidance on how they should be considered in relation to medical factors in determining work capacity and employability. They do, however, emphasise that impairment should remain central to decision-making: "certainly most of our population lives in very poor social circumstances that cause a lot of suffering, but this alone does not constitute grounds for a disability grant" (SASSA, n.d.: 5).

Doctors employed as SASSA assessors receive guidelines and a cursory training on how to conduct assessments. Treating doctors in hospitals, who have little or no contact with SASSA are provided with no official guidance in this regard and most had not seen any guidelines. Those that had access to guidelines were divided in their opinions on their usefulness, while some were happy to directly apply them, many thought them incomplete or impractical and did not help assist them in the most difficult aspect of assessment – deciding how a medical diagnosis actually impacts an individual's ability to work. In the latter case, the disconnect between the guidelines and the actual reasoning required to make decisions resulted in SASSA guidelines being dismissed by some doctors as arbitrary and unhelpful. While doctors in this study appreciated efforts to standardise the system and make their decision-making around DGs easier and more objective, guidelines are not sufficient to guide doctors' practice and limited oversight made it easy for doctors to ignore them (see Kelly, forthcoming).

The ambiguity of the disability category, weaknesses in or non-availability of the guidelines and limited oversight meant that doctors retained significant discretion in conducting assessments. This is not inherently problematic and it is arguably undesirable to completely eliminate professional discretion, but in this case doctors' lack of thorough professional training in disability assessment meant they were faced with significant uncertainty in their decision-making. Therefore, in cases where a claimant's ability to work depended on contextual determinants which they did not know of or have the ability to assess, doctors developed their own rules of thumb to determine claimants' employability that were influenced by their own ideas and assessments of "deservingness".

An analysis of doctors' decision making

During disability assessments, doctors have to make sense of and categorise a claimant's individual case and make a recommendation that can be supported by clinical evidence. They do this by engaging with information from multiple sources and determining what information is relevant to developing a coherent

theory of the situation at hand. This process is both cognitive and conceptual and one that I argue relies on the interactive and intersubjective process of framing. Framing is the active process of arranging medical knowledge, SASSA's rules and standards, and professional and personal norms and values to answer the question of eligibility in individual cases.

When a patient enters the room, a doctor has to think through two different things. Firstly, "what type of applicant is this?" and secondly, "should I recommend a disability grant for this person?" The first question is essentially the framing question that Goffman (1974: 8) argued individuals unconsciously ask when faced with any situation: "what is it that is going on here?" The second question, although directly connected to the first, is a more strategic one: "how do I deal with or treat this person?" The way in which doctors understand the context of the DG application defines what information they look out for when conducting an assessment, how they interpret this information and ultimately what decision they make. In other words, doctors reach different conclusions about patient eligibility based on how they decide to frame a situation (Berg *et al.*, 2000; Dodier, 1998).

The terms 'frame' and 'framing' are widely used by diverse disciplines that include social theory and sociology, cognitive science, communication theory, policy studies and political and finance (amongst others). It is therefore necessary to clarify how I am employing this term and what specific literature I have drawn on in applying this idea to DG assessments.

Goffman (1974) argued that within a given context, people need to define a situation in order to know how to act and interact with others. Drawing on Bateson's (1955) work on animal play, he called this process *framing*. Frames allow people to "locate, perceive, identify and label" social experiences and help to guide further action (Goffman, 1974: 21). Giddens (1984) took up Goffman's notion of framing and used it in developing his theory of *structuration*. Whilst Goffman's work has mainly been applied to understanding social interactions in face-to-face encounters, Giddens's work has mainly influenced theories of institutions. He understood frames to be "clusters of rules which help to constitute and regulate activities, defining them as activities of a certain sort and as subject to a given range of sanctions" (Giddens, 1984: 87). Like Goffman, he saw frames as interpretive schemas used in interactions, that both structured interactions and could also be transformed by reflective and knowledgeable social actors: "Framing as constitutive of, and constricted by, encounters 'makes sense' of the activities in which participants engage, both for themselves and others" (Giddens, 1984: 87).

Separately from Goffman, but also drawing on Bateson's work in his work on reflective professional practice, Schön (1983, 1987) argued that when professionals make decisions they engage in a process of "naming and framing", latching onto particular pieces of information to make decisions.

> 'Through the complementary acts of naming and framing, the practitioner selects things for attention, guided by an *appreciation of the situation that gives it coherence and sets a direction for action*. So problem setting is an ontological process – in Nelson Goodman's (1978) memorable word – a form of worldmaking. Depending on our disciplinary backgrounds, organizational roles, past histories, interests, and political/economic perspectives, we frame problems in different ways' (Schön, 1987: 4).

Together with Rein, Schön also applied the notion of framing to analysing the policy-making process (Schön & Rein, 1994). Drawing on and extending this work, Van Hulst & Yanow (2014) emphasise that framing is a dynamic and action-oriented process of making sense of and organising prior knowledge and values. Frames guide emerging action in intersubjective situations, and "actors bring their own prior knowledge (from experiences, education, and other sources) to situational sense-making" (Van Hulst & Yanow, 2014: 8). In the case of doctors, they bring to their interactions with patients or claimants a classificatory system built from their medical knowledge, clinical experience and social and cultural knowledge – what Harrits & Møller (2011: 241) call an "embodied habitus". This is a set of categorical systems and a position in systems of symbolic and social relations that is ingrained in the bodies of street-level bureaucrats (*ibid*). Also influenced by Bourdieusien notions of *habitus*, Dubois (2010), shows how the dispositions, as well as individual identities, personalities and social roles of both bureaucrats and clients structure their interactions and, consequently, bureaucratic decision-making.

I take a frame to mean an interpretive schema that social agents use to make sense of their situation and guide their actions (in this case, decision-making), which is shaped by their background and dispositions as well their professional knowledge and norms. For example, a middle-class white cardiologist brings to DG assessments her own perspectives and experiences of both the medical and social world, which are informed by her race, class-position, culture, gender, specialist training and collection of past experiences with patients, which she uses to navigate the assessment process and which will inform her practice and decision-making. Following Van Hulst & Yanow's (2014) proposition, I have understood *framing* as an interactive, often tacit process that, in the case of disability grant assessments, facilitates decision-making. The decision frames that doctors develop represent a hybrid arrangement of SASSA's rules and

regulations and doctors' responsibilities as medical professionals, moral and social agents that establish the boundaries and constraints for decision-making.

My research suggests that, whilst they were neither fixed nor exclusive, four main frames informed doctors' decision-making and behaviour towards DG claimants in Cape Town: the *bureaucratic frame*, *the clinical frame, the moral frame and the social frame*, all of which represent different arrangements of rules and definitions of disability, employability, need, entitlement and deservingness.

This typology of frames is influenced by Nicholas Dodier's (1994, 1998) work on frames. Applying the notion of framing to decision-making in the practice of occupational medicine, Dodier (1998: 53) argued that, "a person adjusts to a situation not by using discrete resources, but through arrangements of resources (words, rules, objects) in which past experiences are inscribed, that is, through frames". Dodier put forward a number of different frames, including the *administrative, clinical, psychological* and *solicitude frame*s, as alternative ways of understanding and assessing patient's complaints and attributing health-based 'rights' to patients in occupational medicine. His concept of frames has been employed in Human's (2011) study of doctors' practical use of treatment protocols in HIV clinics in South Africa. Eikenaar *et al.* (2015) has also applied this concept to explore the normative aspects of professional judgements made by street-level bureaucrats involved in work reintegration programmes in the Netherlands. Although not drawing on Dodier's work, Fassin (2012) presents a similar typology of local justice in medical decision-making around humanitarian-based immigration based on professional, political, deontological and ethical factors.

The likelihood of a doctor adopting a certain frame was shaped by their *habitus* and the nature of their social interaction with an individual patient. Particular influences on doctors' adoption of certain frames were their medical speciality and training, institutional environment, personal norms and values and notions of justice, social background, approach to patient care, previous experiences with patients requesting the grant (especially negative ones), and views about the healthcare and welfare system.

The table below presents the broad distinctions between the four different frames used by doctors.

	Bureaucratic	**Clinical**	**Moral**	**Social**
Knowledge system	Rules & guidelines	Professional experience and specialized knowledge	Personal experience	Social model of health and disability
Ethical framework	Administrative fairness / legalism	Professional ethics	Social /cultural norms and values	Socio-economic justice / human rights
Political	Neutral	Neutral	Ideology is influential (conservative)	Ideology is influential (social democratic)
Focus	Collective / state	Individual health	Individual desert	Societal / structural issues
Professional role definition	Bureaucrat	Independent medical professional / clinician	Citizen-agent	Community / public health professionals
Outcome	Rigid / strict	Flexible	Varied based on deservingness	Generous

Although I present four framing options, these were neither discrete nor mutually exclusive ways of making sense of cases. Capable of reflection, doctors are social actors able to apply "a wide range of different and even incompatible schemas and have access to heterogeneous arrays of resources" (Sewell, 1992: 17). When practically applied in medicine, social norms and values may clash or contradict each other, shift or coexist (Timmermans & Haas, 2008: 671). Doctors moved between or combined different frames and thinking was very often shaped by their specific interactions with individuals, the particularities of certain cases and material circumstances. Doctors might also frame their decisions in ways that help them to cope with the stressors and constraints of the system, for instance framing eligibility as a purely administrative issue to avoid feeling sorry for people, as was sometimes the case with the *bureaucratic frame*.

The way in which doctors framed disability claims inclined them towards handling cases in ways which may coincide or conflict with SASSA's framing of the disability issue and the type of decisions it expects doctors to make. The

frames doctors used affected their attitude - and adherence to – SASSA's rules.

For instance, doctors who framed disability as a multi-dimensional or social phenomenon might prioritise the consideration of economic, social and environmental factors over strict adherence to SASSA's guidelines and might stretch or bend the rules to accommodate them. The same might apply to a doctor who believed that the rules undermined their broader commitment to professional medical ethics. On the other hand, a doctor who valued administrative justice, equity and impartiality might focus on strictly applying rules and guidelines, refusing to make individual exceptions. This is not to say that doctors simply do what they wish - they are of course constrained by their legal and professional obligations. But, where they have discretion, their framing of certain situations might make them more or less likely to rigidly apply or bend or stretch the rules to accommodate people that meet their own private understanding of disability but not the state's. There is also an important difference between conscious rule-breaking (which was less common) and interpreting a general rule in a way that makes the best possible case for one's patient (Blustein, 2012: 252).

While doctors did not admit to falsifying information to support their recommendations, in some cases they might exaggerate them because of their social circumstances.

> 'I think in terms of the way in which you fill in a form you can actually make it sound worse than it is. I've had a couple of patients where they're borderline so you've sort of given them the benefit of the doubt because of their social circumstances and their social circumstances do unfortunately affect their healthcare and so for example, if you're hypertensive you really should be able to do your job, but you know if you have to go to the clinic every month it becomes really difficult when you have difficult social circumstances' (Dr Harvey, interview, 15 April 2014).

One doctor in the study described the distinction between a flexible, sympathetic doctor, who bent the rules in favour of the patient, and a doctor who strictly applied SASSA guidelines and focused exclusively on clinical factors, as the difference between being a 'hard' or a 'soft' doctor. This distinction is useful, not because I want to provide a structuralist analysis of doctors' decision-making, but because 'hardness' and 'softness' provide a useful description of the two different sets of behavioural options or strategies available to doctors when they interact with patients and make decisions. The majority of doctors sat on a continuum between soft and hard and varied between strictness and leniency, responding to patients based on how they framed a particular patient and their

situation. In short, doctors pursued strategies for action based on how they understood a particular case as deserving, and such exceeded the bounds of medical evaluation criteria. This does not mean that eligibility was merely a social construct or a function of culture. Even if doctors interpreted cases differently, their decisions were, for the most part, rationalised by the physical realities of patients' bodies and their medical expertise.

It is also important to note that doctors, especially those working as SASSA assessors who had to conduct assessments day after day as consistently as possible, did not necessarily have the time or inclination to think through the complexities of each case. Doctors were therefore likely to develop quick and standardised ways of identifying and treating certain clients. In this way frames can harden into routine ways of classifying clients, treating clients based on existing categories or stereotypes (e.g. the malingerer).

Bureaucratic framing

SASSA's guidelines promote the objective categorisation of patients according to set criteria, simplifying decision-making by effectively limiting the options or possible solutions available. Doctors strictly applying SASSA's directives in their work can be said to be employing a *bureaucratic frame.* The bureaucratic frame is the equivalent of what Dubois (2010) would call *bureaucratic formalism,* what Jonsson (1998) called a *bureaucratic administrator strategy.* It also bears strong similarities to what Eikenaar *et al.* (2015) called a *procedural frame of reference.*

Using this frame, medical knowledge is applied in a reductive and objectifying way, placing patients into categories and applying a strictly biomedical approach to disability as advised in the guidelines. Disability grants were understood as a specific intervention for a certain group, not a general poverty intervention and in their gatekeeping role doctors saw it as their responsibility to protect the boundaries of the disability category by using their medical knowledge to detect malingerers, fakers and defaulters.

Doctors can easily apply SASSA's bureaucratic framework in cases where patients clearly did or did not qualify on medical grounds. Most SASSA assessors did so. What distinguished doctors with a bureaucratic ethos from others was that even when a patient's eligibility was less clear, these doctors would lean towards conservative decision-making, seeking out further clinical evidence through objective tests or referrals rather than considering more contextual and subjective factors. Applying a kind of deontological ethics, they justified their decision-making in relation to the rules, regardless of a claimant's

individual circumstance. In short, they would err on the side of SASSA rather than the patient. While in fact the guidelines do provide some leeway for the use of professional discretion, doctors approaching the assessment of a patient through this frame positioned themselves as SASSA workers, denying that they had any discretion and claiming that they were strictly following procedures and interpreting guidelines in a very conservative and restrictive way. Doctors working as SASSA assessors, who were specifically employed to conduct assessments and had received SASSA training were most likely to employ a bureaucratic frame in their decision-making.

Dr Bury, for example, framed his decision in completely bureaucratic terms. When I met him, he been conducting assessments for SASSA for eight years and took his job as an assessor very seriously. He strictly applied SASSA's guidelines and impairment tables to make decisions and avoided considering any non-medical or contextual factors, even in cases of moderate impairment when the SASSA guidelines gave him discretion to consider factors such as the age, education level or employment history of a claimant. According to SASSA guidelines, doctors should consider disability and employability in terms of a person's physical ability to do any sort of work in the open labour market, regardless of the *availability* of employment. Applying this principle, he understood 'open labour market' to mean an individual's ability to do any kind of work, regardless of whether they actually had the skills or education to do this. He expressed disinterest in the subjective experiences of claimants and justified this by reiterating that his role was to conduct a medical assessment, not consider other factors related to disability. When he had doubts about a patient's eligibility, he erred on the side of caution, refusing to recommend the grant because he was a taxpayer. Legally, those defaulting on treatment are not eligible for the DG. SASSA did, however, expect that the medical ethics of beneficence and non-maleficence be brought to bear in cases where defaulting patients were severely ill, provided that it could be clinically justified (Dr Marite, interview, 2014 June 27). Dr Bury was, however, unwilling to make these exceptions, even in the case of advanced AIDS.

Their strict application of the rules did not mean that doctors applying this frame were necessarily insensitive to claimants' suffering. For some it was a professional ethical stance (Zacka, 2015) in that they were doing what they were both paid to and legally required to do. The bureaucratic frame is grounded in the idea of equal treatment or what Mashaw has called 'bureaucratic justice' – the notion that applying the rules in the same way in every case is the most procedurally fair and just way to handle DG assessments. In this way, the guidelines become a normative framework for action.

For doctors, applying the rules in a very literal way could also be a way to cope with what was otherwise a very stressful and morally taxing job. For example, ones of the reasons Dr Bury so rigidly applied a medical was approach was because:

> '…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'.

Invoking rules and denying discretion or professional autonomy can be used by frontline workers as a defence "against the possibility that they might be able to act more as clients would wish" (Lipsky, 2010: 149). "Bureaucracy offers a formal structure to withdraw from social relationships and concomitant feelings of reciprocity and social duty" (Bartels, 2013: 470). Thus, even choosing to "go by the book is a discretionary judgment" (Maynard-Moody & Portillo, 2010: 19). Hupe & Hill (2007) argue that professions may impose rules upon themselves to manage their work and would use the guidelines as a way to legitimise their decisions to patients who questioned their decisions. For example, in the US Cassell (2004) found that medical doctors may ignore patient's stories out of concern that they may interfere with their objectivity and thus, patient care. Taking a hardline approach could make SASSA assessors very unpopular with claimants who perceived them to be inflexible and insensitive and found assessments depersonalizing (see Kelly, 2016).

Clinical Framing

In contrast to bureaucratic framing, doctors employing a *clinical frame* were less concerned with SASSA's rules, guidelines and set procedures and instead made decisions based on what Bourdieu described as their 'feel for the game' (Bourdieu, 1990). Doctors employing a *clinical frame* generally justified the need for DG on a clinical basis, based on a claimant's medical history and individual circumstances. While SASSA wants doctors to make standardized decisions that provide grants to only the most serious cases, medical professionals are trained to respond to individual need. Medical professionals also have a set of norms of acceptable behaviour, and standards and ethics that guide their practice; one of which is putting the patient first. Their strongly engrained professional values and commitment to patients' well-being could also result in doctors feeling torn between their goals as bureaucrats and responsibilities to assist patients (Wainwright *et al.*, 2015).

Using the US disability program as an example, Mashaw (1983) argues that these differences between a bureaucratic rationality and professional judgment result in different conceptions of justice and can result in professionals being cast as subversive to bureaucratic ends. In this study, subversion was particularly likely when a doctor was assessing his or her own patient and less likely in cases where doctors worked as third-party assessors. This was because doctors in hospital outpatient settings had little contact with SASSA and felt little commitment to adhering to its criteria, privileging their own experience-based clinical judgement instead. It is for this reason that SASSA is moving towards a model that separates the assessing doctor and the treating doctor. Nevertheless, this dilemma remained significant for doctors participating in the study.

It is important to note that not all doctors have the same training and clinical experience or professional and intellectual approach to the practice of medicine, particularly in relation to the psychosocial aspects of care. Professional judgement therefore cannot be understood as a singular rationality. Ethnographic research has shown that professional beliefs and perspectives on medical decisions may vary depending on position in hospital structure (Nurok & Henckes, 2009) and specialty area (Mol, 2002). Such beliefs or "practice ideologies" (Hasenfeld, 2000) were also learned through the organizational environment doctors found themselves a part of, whether it be through interactions with SASSA officials and other SASSA doctors during training or with other colleagues (especially senior doctors) in hospitals. As Atkinson (1995) argues, we cannot look at doctors' decision-making exclusively in terms of what happens in their consultation rooms during their interactions with patients. Rather, their decisions are also shaped by what he calls 'medical talk' – the collegial interactions that take place in medical settings such as conversations with other doctors, medical meetings and ward rounds.

Doctors using a clinical frame differed in their response to claims based on how they conceptualised their role and responsibilities as medical professionals in relation to disability assessments. There were doctors who saw their role in patient care as limited to the biomedical aspects and took a hardline approach to DG assessments, focused entirely on medical impairment, resulting in similar outcomes to those adopting the bureaucratic frame. Others, with a more holistic and humanistic approach, considered psycho-social factors and patients' individual circumstances in their decision-making.

As medical thinking has evolved in the last two decades, doctors have been encouraged to think more holistically about patient care and in terms of a biopsychosocial model of medicine (Engel, 1977), especially in the context of chronic illness. Doctors, particular younger doctors who had been exposed to this approach in their training, were generally more conflicted about their role in

the assessment process and most likely to disagree with SASSA's guidelines, which were strongly focused on diagnostic categories. As one doctor noted: "it's got nothing to do with whether they've got HIV or HIV and TB or osteoarthritis. What is their state of mind and body and can they work?" (Dr Brown, interview, 2014 April 4).

For these doctors, optimal clinical management of patients extended beyond just medical intervention to include other non-medical issues that impacted on the health of the patient. As one doctor noted, "It's never purely medical. You can make the argument that not having money is going to affect their health, although they are not disabled as such."

In these cases, a DG was considered a way to address social determinants of health or address health system failures. Doctors whose primary role was to treat patients were particularly likely to make exceptions for individual patients where they thought the grant could improve health outcomes. In this way, DGs were included as part of their treatment intervention – a way to fund transport to the hospital, to attend follow-up appointments and fetch medication, and to ensure adequate nutrition to recover their health and alleviate psychological stress. Particularly in the field of mental health, it was seen as helping people get out of a vicious cycle of financial despair and enabling patients to get their lives back in order so that they could find employment. This, as one psychiatrist explained, often became complicated when patients had been working very hard to recover, but were still unable to find work and asked for their grants to be renewed. In these circumstances it was hard to justify following SASSA's regulations knowing they would undermine the patient's newly recovered health and wellbeing.

This feeling was widely shared and one doctor explained the approach of his colleagues as follows:

> 'They do understand that the patients are often unemployed and that it is a process for them to get to us. Although the patients are not necessarily physically disabled, they are disabled by their disease. They will give the patient a 6 or 12 month grant and there is difficulty about loopholes – the reality is that they are sick and unemployed and need to get to the hospital and the grant plugs that hole. Some of them don't necessarily deserve the grant but you put them on a temporary grant. You put them on a temporary grant while they recover – although sometimes by the time they get the grant they are already better' (Xhobani, email correspondence, 23 March 2014).

At the same time, professional values could conflict with the idea of grants as many valorized work on the basis that it was essential for psychological well-being and thinking that receiving a DG could be psychologically 'disabling'. This made them hesitant to recommend permanent grants when there was any (even small) potential for claimants to recover. Although not necessarily blaming individuals for their 'dependence' on the state, they saw the DG as perpetuating a type of dependent mindset that disadvantaged or 'disabled people'. This is a view also held by some disability rights activists that have criticized the government for focusing on social grants rather than empowering people to work (Gatharim, 2008).

Generally, doctors saw taking one's health and recovery seriously as an important individual and moral responsibility and were frustrated by patients who were non-compliant or not motivated to recover and were thus failing to fulfill the responsibilities of the 'sick role' (Parsons, 1951). Nevertheless, most doctors disagreed with SASSA's objectifying simplification of the complex nature of patient adherence issues and felt uncomfortable 'punishing' claimants for non-compliance when there were usually multiple underlying issues. They therefore did not refuse to recommend grants for non-compliant patients whom they felt otherwise qualified and needed the grant to recover their health and would use the grant to motivate compliance, especially in cases of HIV and TB.

Not all doctors took such a holistic approach to medicine. Some understood their role as medical professionals as strictly limited to biomedicine and the treatment of injury and disease. Even if they recognised that poverty and demand for the grant was a systemic rather than an individual failing, many felt the social, economic and environmental position of patients did not concern them as medical professionals.

Fassin (2008) suggests (although perhaps too sweepingly) that because doctors see themselves as technicians and scientists rather than humanists, they are more interested in curative activities and interesting cases than in the social dimensions of care. Good *et al.* (2005), has suggested that the culture of medicine privileges time and efficiency and that doctors will therefore avoid 'problem' patients, including those with complex social issues. For some, taking a technical approach, can be a way to avoid the complexity of thinking through ethical questions (Abrahams, 2006: 2). Criticising his colleagues, one doctor argued that doctors were not interested in disability cases because these were essentially people that were "falling apart" and there was little that could be done from them medically (Dr Brown, interview, April 2014). In one large academic hospital, known for its highly competitive working environment, social workers reported that some doctors saw DG assessments as 'beneath' them. Jeffrey (1979) argues that the prestige of doctors relative to other healthcare

professionals is related to their distance from patients, which is one of the reasons the 'chore' of disability assessments was often passed to interns and junior doctors.

With less interest in the psycho-social aspects of care and complicated personal or social issues, more clinically-focused doctors were more likely to focus on purely objectively assessing a patient's physical state and function and refuse to engage with other issues. Although this bears similarities to bureaucratic framing, their clinical assessments would not necessarily align with SASSA's guidelines. Other aspects of care were seen as the responsibility of social workers and doctors would frequently interrupt patients who were sharing their subjective experiences, telling them that they were only concerned with their medical issues. Some medical specialists in hospitals totally refused to conduct assessments for their own patients, seeing it as a waste of their time and scarce medical resources and, perhaps not understanding the amount of time and money that this would cost claimants,[5] instructed patients to visit their local clinic where they would be seen by a SASSA assessor instead.

This is not to say that by attempting to be objective doctors are necessarily insensitive to the social and economic context of patients, as one reminded me: "Doctors make enormous personal, social and financial sacrifices by being doctors, so it is inherent (for most) to want to help the patient". Rather, these doctors acknowledged their limited capacity to fix claimants' social and economic issues, and as one of his colleagues commented, "it is not our responsibility to fix the unemployment problem".

Moral framing

In assessing patients for DGs, doctors are effectively making decisions on how to allocate the state's resources. In many ways these are ethical decisions because they affect how resources are distributed in society. Implicit in these allocative decisions is the idea that some people 'deserve' DGs whilst others do not. According to Hasenfeld (2000) this makes turns the process of making these kinds of categorical decisions in street-level work into 'moral work'.

These moral categorisations of who 'deserves' social grants have been defined to a certain extent by the state through legislation and regulations and have been institutionalised within SASSA. However, frontline workers often make their

---

[5] Aside from the potential costs of transport, claimants would have to wait in very long queues at SASSA to receive an appointment with a SASSA doctor and then spend hours waiting at their community clinic to be seen.

own moral judgments in their categorising work that either undermine or reinforce these state categories. Maynard-Moody & Musheno argue that in street-level work, "identity based normative judgments determine which and how rules, procedures and policy are applied" (2003: 155).

Doctors are rarely (if ever) neutral agents. They enter the assessment process with a set of existing subjectivities and biases that influences their decision-making. Although as agents of the state doctors should follow rules and procedures in dealing with clients, in reality they "like everybody else, have personal standards of whether or not someone is deserving" (Lipsky, 2010: 23). According to Bourdieu, "agents are both classified and classifiers" (Bourdieu, 1987 in Harrits & Møller, 2011) and therefore doctors are themselves part of the categorical system. Street-level bureaucrats therefore cannot be seen as outside-observing agents and social categorization is reproduced in street-level work. More simply stated: street-level bureaucrats always act "as human beings confronting other human beings." (Harrits & Møller, 2011: 242).

Numerous sociological studies have shown that medical values of 'non-judgmental regard' and beneficence are not always adhered to and that moral evaluation and the designation of patients into 'good', 'interesting', 'bad' and 'rubbish' patients is a regular part of medical settings which influences how patients are treated (Roth, 1963; Strong, 1979; Jeffrey, 1979; Stein, 1990). Doctors rely strongly on pattern recognition, making them highly likely to stereotype patients and classify some as deviant and less deserving of care and attention than others (Jeffrey, 1979; Groopman, 2007). Moral assumptions made about patients tend to derive from judgements about their social worth as individuals, their responsibility for creating their own conditions of ill-health and poverty, their degree of amenability to change and their own desired end results, and the degree to which view they view themselves as object or subject in terms of agency (Hasenfeld, 2000: 332). In his book on the culture of medicine in the United States, Stein (1990: 98) called this an "unofficial, moralistic taxonomy of types of patients". This particularly likely in resource constrained or emergency settings, as has shown to be the case in a number of South African hospitals and clinics (Le Marcis & Grard, 2015; Gilson, 2004; Gibson, 2004; Walker & Gilson, 2004; Fassin, 2008; Schneider, 2010). Moral and social evaluations of claimants' worth are also common in disability compensation claims, where doctors are less likely to trust patients' intentions (Hickel, 2001).

In the case of the DG, beliefs about fairness strongly influenced doctors' decision-making and doctors using a moral frame thought about their decisions in moral terms. Although not necessarily exclusively, doctors often used *moral framing* to make decisions at times where medical eligibility was not completely clear, thinking about eligibility using socially and politically constructed notions

of 'just dessert'. Mechanic (1997: 81) argues that moral concepts help to organize and interpret and give coherence in situations of uncertainty and confusing information, which is often the case in DG assessments.

Doctors considering DG eligibility in moral terms may be less inclined to recommend the grant for those who they feel are responsible for their own poverty and illness and deemed to be taking advantage of the system, and more inclined towards generosity in cases where they see patients as worthy of support for reasons of being victims to external misfortune or bad luck, for example. Research on South African's attitudes towards redistribution shows that South Africans clearly distinguish between people who are deserving and undeserving of social assistance. Disabled people, including people with AIDS are considered as falling into the category of deserving of welfare assistance (Seekings, 2007, 2008a, 2010). In general, doctors in this study also believed the sick and disabled were deserving of state support. Negative attitudes that doctors had towards certain categories of 'undeserving' DG claimants can therefore be seen as doubts about the genuineness of their disability and inability to work rather than a belief that disabled people as a group are undeserving.

Moral judgements also had political aspects and doctors' ideological beliefs about the value and effectiveness of the South African social grant system and poverty alleviation policy also shaped how doctor framed eligibility. Whilst no doctor in the study was totally opposed to a social grant system, many were concerned that it was being abused by lazy work-shy people, and that the government was spending too much money on social grants which created a culture of entitlement and dependency, especially amongst the youth.

> 'Dr Soet said that she has heard from another doctor that many Eastern countries there is no social security for pensioners or the disabled and expressed the view that "people here are so ungrateful" saying: "South Africa is a lazy country. Those in Eastern countries are so productive – they work full days and are so productive and they don't seem so unhappy – they are not living in squalor and have food on the table"' (Field notes, 2014 February 12).

Dr Soet's statement partly signals her belief in a 'culture' of poverty, in which 'living in squalor' is based on values and life choices and dependency on welfare. This was echoed in the words of a doctor from a West African who reported, "in my country there is no grant, you must go work", imputing that the grant system in South Africa had contributed to a culture of dependency or diminished self-agency and resilience.

At a training session SASSA held for its assessors, a number of doctor contrasted the attitudes of South Africans towards work against those of hardworking foreigners.

> Dr Y: "Young people (South Africans) are in the hospital just queuing for grants but Somalis and Zimbabweans are working."
> Dr X: "It's up to us."
> Dr Y: "That dependency."
> Dr B: "It's about social deprivation and 'now I am entitled because society has deprived me' – the grant reinforces this - you are deprived so we will give you the grant poor thing."

These represent only a few of the many times that doctors argued that DGs create dependency and incentives for patients to remain ill, reward laziness, represent an unsustainable cost to the taxpayer (including doctors themselves) or clog up the healthcare system. These demonstrate a set of concerns about the broader social assistance system: its costs, its abuse, the disjuncture between the rights people claimed and their willingness to accept their responsibilities as citizens and so-called perverse incentives. These arguments are framed by bigger policy debates and stories of welfare 'scroungers' in both the South African and international media. The idea of an 'undeserving' poor "lacking the moral fibre to enjoy the benefits of economic growth" (Everatt, 2008: 293) has played a central role in the public discourse about poverty in South Africa. It also reflects middle class values surrounding work and individual responsibility and an insensitivity to structural factors such as high levels of unemployment, which for the most part is involuntary. Doctors' comments on the cost of grants to the taxpayer and the growing numbers of social grants also reflect a real limitation on the willingness to support redistributive policies like social grants.

Although doctors seem to have been influenced by broader anti-welfare discourses, it is difficult to establish the extent to which it was these discourses shaped their decision-making, rather than their legitimate efforts to perform the gatekeeping work that SASSA expects of them. This negative 'talk' about grants does not necessarily reflect how doctors actually interacted with patients or made decisions about DGs, but does point to a frustration with and lack of support for a system in which they played an integral part. In other words, it was possible for a doctor to feel immensely frustrated with the system but simultaneously feel tremendous empathy towards individual patients. Research has shown that people may had hold complex and internally conflicting views regarding distributive justice and the type of welfare state they believe is helpful for both the country and individuals, which has been shown in the case of the United States (Keiser, 2010; Gilens, 1999) and South Africa (Seekings, 2007; 2008).

Concern about disability 'fakers' and malingerers has existed for as long as states have offered programs that compensate work-place injuries, military veterans or provided social insurance or assistance to ill or disabled people (Stone, 1984). It is part of a doctor's role to be alert to and guard against this, 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. Based on their frequent encounters with what they believed to be malingering patients, they actively guarded against illegitimate claims and 'abuse' of the grant system. This has also been shown to be the case in other South African studies (Macgregor, 2006; Segar, 1994). Even doctors with more positive views on DGs and social welfare felt that some claimants abused the system and that the large number of non-eligible people that applied for DGs, burdened both the health and welfare system by absorbing resources that could be better spent on creating a better DG system for the 'truly' disabled. Sometimes this led doctors to be unfairly strict with patients and hospital social workers reported acting as patient advocates in cases where they felt that a doctor was unfairly refusing to recommend the grant.

As well as broader discourses, doctors' framing choices were influenced by their past experiences with patients. One doctor mentioned that although perhaps only a minority of people 'abused' social grants, the nature of their work meant that they tended to encounter more of this 'minority' than the average person, which made him cynical about DG requests. Doctors had seen people coming in drunk and injured after grant payment day, had dealt with people who had stopped taking their medication or refused treatment to access grants, encountered people who applied repeatedly for grants and had experienced bullying from patients who wanted them to recommend the grant (see Kelly, 2016). They had also seen patients who had overcome difficult circumstances, illnesses and disabilities that were not 'dependent' on grants and tended to compare them to those who were. For example, one doctor contrasted the attitude of an older woman with end-stage rheumatoid arthritis, motivated to do absolutely anything to improve, with that of a young, overweight 31-year-old woman with back pain "who someone had stupidly given the DG" in the past and who refused to leave until he recommended its renewal. He described her entering the clinic "with her jewellery and her smart handbag" and said, "she managed to drive herself here, walk up the stairs and find the Kentucky Fried Chicken okay, but felt she could not work because someone had told her she couldn't". He had spent thirty minutes of his time trying to encourage her to work and had found the experience very frustrating. "The only thing that was broken was her attitude. Someone had given her the temporary grant for six months and now she felt she needed it for life". He added, "sometimes the compassion of the doctor shoots the person in the foot". While for the most part, doctors' experiences made them more suspicious of and therefore 'harder' on patients, one doctor described her

guilt at having been irritated by a patient and rejecting an application, only to later discover that he had chronic renal failure. This made her more inclined to be more sympathetic towards people requesting DGs.

As the above examples indicate, as well as general ideas and biases, the individual characteristics of claimants strongly influenced decision-making. Based on how patients looked, spoke and behaved, doctors placed patients into socially constructed categories or made moralistic judgments about an individual patient's character and their relative deservingness. This is not to say that patients fit neatly into categories and I agree with Maynard-Moody & Musheno's argument that citizen-client worthiness is a continuum and that many clients present a mixture of worthy and unworthy characteristics (2003: 111). The comparative and theoretical literature on street-level bureaucrats identifies street- level bureaucrats as responding positively or negatively to the physical attributes, nationality, educational level, perceived morality, attitudes, and character types of applicants (Rice, 2012; Maynard-Moody & Musheno, 2003; Horton, 2004; Dubois, 2010).

Looking at eligibility through a moral frame, claimant characteristics such as age, appearance, previous work history, self-motivation, compliance to treatment and responsibility for their health and economic position and family support structure became important factors in establishing desert. Given South Africa's apartheid past, including the racially segregated medical system and persistent social and economic segregation between races in South Africa, it would be reasonable to assume that racial stereotypes held by doctors in this study would influence who they understood to be the 'deserving' poor. Research on physicians in the US has shown that some associate negative attributes such as non-compliance, low intelligence and drug and alcohol abuse with black and immigrant populations, which affects physicians' engagement with patients and their decision-making and medical decision-making (Van Ryn & Burke, 2000; Krupat *et al.*, 1999; Schulman *et al.*, 1999). This did not appear to be the case with doctors I observed.[67]

---

[6] Seekings (2007, 2008a, 2010) found that despite South Africa's history as a racist state, attitudes towards distributive justice in Cape Town do not appear to be shaped by racial considerations. White respondents were more generous in the amounts of money they suggested should be paid towards the unemployed, which Seekings attributed to guilt about enduring racial economic inequality and which may have contributed to how some white doctors framed disability.

[7] As racism is now considered socially unacceptable and medical professionals are expected to be objective in their decision-making, it was unlikely that doctors would have admitted any racial bias. This did not mean that doctors' ideas about the deserving and undeserving poor were not tinged with racial bias or that overtly racist doctors do not exist. The quality assurance officer told me a few isolated incidences of doctors who had refused to recommend grants to severely disabled people, which he attributed to racism on the part of

It is more likely that doctors' understandings of disability and poverty and their interpretations of particular claimant characteristics were informed more by their middle- class backgrounds than racial stereotypes. Doctors were noticeably more friendly and trusting towards patients that displayed middle-class attributes or behaved in ways that aligned with middle-class values. As Harrits & Moller (2011: 239) argue:

> 'the category of middle class is related not only to possessing a certain amount of cultural and economic capital, or to a specific lifestyle and consumption pattern, but also to a specific taste and morality, associated with, for example, the "right" way to carry oneself, to raise children and to engage in work'.

These are reinforced when confronted with other categories that are different. The *habitus* of middle-class doctors may make it difficult for them to identify with poorer patients and understand their decisions, making them less likely to acknowledge structural factors and more likely to attribute poverty and unemployment to patient characteristics (e.g. laziness), choice or fault than structural factors, leading them to think of individuals as undeserving. This can lead to stereotyping and reinforce notions of the 'culture' of poverty (Chirayath, 2007).

Whilst I did not observe doctors discriminating against patients in any direct way, these patient characteristics did influence how rigidly or flexibly they applied the rules to individual patients. Although doctors attempted to overcome negative biases they had towards particular kinds of patients, they were more likely to rigidly apply rules if they felt a patient was undeserving. They were also more likely to be flexible and generous if they felt sympathetic towards a patient that they 'felt' was deserving.

Groups seen as particularly undeserving were young people, the previously-unemployed, those seen as responsible for their poor health and substance abusers. Young people were seen as better-able to compete for unskilled jobs, gain further education and training or recover their functions and their failure to work was attributed to laziness, despite very high levels of youth unemployment. Some doctors openly chastised young people for applying, telling them that they were young and should find work.

> 'The old people, they can't find jobs, but the young ones…they want only money – especially the HIV - I don't like to give them any

---

these doctors, but emphasised that this kind of behaviour was uncommon.

because they can work. The HIV is not…you have HIV and high blood sugar I can understand, but HIV on its own…you must go work. They don't want to go work, they are lazy. I tell them also "*sisi*, you are lazy, you must go work"' (Dr Mulumba, interview, 2014 February 4).

Doctors sometimes tried to convince claimants that they were capable of work, using examples of resilient patients, colleagues, family members or invoking tropes of the 'heroic' disabled person to demonstrate that it was possible to work despite illnesses or physical impairments. The implication was that claimants who were claiming work disability with relatively minor impairments were just not 'trying' hard enough.

A claimant's contribution to the economy and society was also an important factor for many doctors, which also accounts for why young people were seen as undeserving. People who had never worked were seen as undeserving for one of two reasons: 1) they had never contributed to society through work; and 2) if they had been already been unemployed prior to becoming sick or disabled - often for many years - why should did they now deserve a grant? A doctor at one hospital was so frustrated by this that he stormed into another doctor's consulting room while he was with a patient to voice his anger about patient he had just seen who was receiving a permanent grant for rheumatoid arthritis despite being unemployed for the previous ten years.

People whose unhealthy lifestyles had contributed to their poor health were also considered less deserving. Patients who were overweight, heavy smokers or drinkers and had developed chronic diseases such as chronic obstructive pulmonary disease, diabetes, hypertension and arthritis were particularly likely to be seen as lazy or irresponsible and received little sympathy from doctors, especially when they did not make the effort to change their behaviour. Doctors expect patients to comply with treatment and take responsibility for their health and may feel little moral obligation to treat patients who aspire to the sick role, do not look after their health or do not cooperate in getting well; though the legal and professional obligation does remain (Nurok & Henckes, 2009). Doctors often openly voiced these judgements to patients. For example, one doctor told a patient who had been a victim of domestic abuse: "you make poor life choices".

Doctors often faced patients who became ill or were injured through drug or alcohol abuse or involvement in criminal activity such as gangs. Doctors could not legally refuse to recommend a grant to someone with a legitimate disability regardless of the source of impairment, unless someone was known to be an active substance abuser (which automatically disqualified them). Doctors were, however, very cautious about recommending the grant for people who they felt

might use their grant money for 'questionable' purposes such as buying alcohol, drugs or cigarettes, or who generally were not 'good' people.

> 'Whereas those patients who are not interested in treatment for a medical condition if it doesn't lead to a DG, that believe they deserve a DG because they are not employed even though they don't have a disability, that make use of *tik* [methamphetamine] or any other drugs and enter the clinic as though they own the place - they can cause a change in the [doctor-patient] relationship from their behavior. I have been confronted with a gangster patient who refused appropriate treatment, whilst stating, "I'll just get the grant" and laughing as he said it, despite understanding that refusing treatment may result in the loss of his limb due to complications. If he later asked me for a DG I'm certain that I would be reluctant to submit the form' (Taylor, email correspondence, 2014 February 13).

As much as doctors guarded against the undeserving poor, doctors using a moral frame were willing to make exceptions for people that had minor impairments who they felt were somehow 'deserving' of assistance. During the face-to-face encounter of the disability assessment process, doctors 'bear witness' not only to the disablement of a patient but to the vulnerability and suffering of another human being. This may create feelings of responsibility and moral obligation towards patients (Olthuis, 1997; Raef, 2006), which could affect how they treated them. According to Swartz and Schneider (2006: 243), "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 and the DG (De Paoli *et al.*, 2010) 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 re-new grants. In the past, doctors regularly recommended grants on humanitarian grounds rather than on actual impairment (Kelly, 2013). As a result, 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".

These feelings of pity were described by a number of doctors as the 'sympathy factor', which 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 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:

> 'I can understand very much that the doctors are very much inclined towards patients 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. When I do it now, on a desktop, I don't have that influence - 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).

Doctors were more likely to feel sympathy for older people, mothers with children and "*ordentlike mense*" (decent people) who fell into the category of the 'deserving' poor. This reflects more the more general conceptions of desert held by South Africans as well as the overall design of the welfare state. Attitudinal surveys conducted in Cape Town showed that respondents considered older people more deserving than younger ones and favoured women and people with dependents more than men (Seekings, 2008, 2010). The South African state treats elderly people as a deserving group and provides non-contributory, means-tested old age pension for people over sixty, which enjoys general legitimacy in South Africa (Seekings, 2010). Underlying this support is the belief that older people are less responsible for their poverty because they are disadvantaged by worsening health and opportunities for employment as well as the disadvantages they experienced in the past under apartheid that prevented them from obtaining a decent education or work and made it harder to save for retirement. (Seekings, 2008).

SASSA is very aware of doctors' tendency to be particularly sympathetic towards older applicants and during a training session held for doctors as SASSA staff member said, "you are a human being first – that is the 55 year-old, I am asking you to be inhumane." The case of Dr Brown and Mrs Majola below is an example of a doctor framing his decision in terms of deservingness rather than medical impairment or function. Dr Brown understood Mrs Majola to be as a decent lady who deserved the state's support, recommending a grant when technically she was not eligible.

The doctor turns to me and explains that, based on her file, she has minor complaints and that she is getting treatment for painful limbs. After thinking for a bit he says, "I could throw her out and make her sell chicken feet [which she had been doing to try to earn an income]. Is it about compassion?" and then

adds, "She is a *decent* lady who has been trying". The clerk chips in that she is 54 years old and Dr Brown says, "good point, there is not much of a market for it". He decides to recommend a 6-month temporary grant, saying that arthritis is about strain and you end up with a condition of ineffective hands and feet and "you can't really do much with that. You can't sell anything with hands that don't work". Dr Brown then tells her that she will be getting the grant. Mrs Majola becomes emotional and says, in English, "I didn't have a hope!" Dr Brown tells me, "giving hope to people is important."

Cases like Mrs Majola's were common and many doctors responded in similar ways to Dr Brown, who by fitting her into his framework for understanding disability stretched the rules to accommodate her within the system. Doctors were sympathetic to patients who were trying to earn their own income or were trying to 'overcome' their circumstances in some way, seeing them as more deserving than those who were categorized as 'lazy' and 'dependent'.

Although doctors may be inclined to feel great sympathy for patients applying on the basis of poverty, this did not necessarily define their decision-making and doctors would not necessarily deviate from SASSA guidelines. Instead they might try to help patients by referring them to social work services; educating, encouraging and motivating patients; providing employment suggestions; and in one case, collecting and handing out clothes to claimants. Several doctors also bent the rules of the Social Relief of Distress award to accommodate patients who did not qualify for a grant but were in clear financial need.[8]

Social framing

Doctors employing a social frame typically understood disability in terms of the social model of disability rather than in terms of SASSA's highly medicalised model and were more likely to take a public health perspective in their decision-making. Using this frame of disability, doctors considered both an individual's medical profile and individual characteristics which influence employability such as age, education and training, ability to speak English, previous work experience and skills. They also considered the structural economic, social and environmental factors shaping employability such as the tightness of the labour market and opportunities for re-training and employment in relation to these individual factors. The economic migration of people from the rural Eastern

---

[8] Doctors are only meant to recommend the SRD on a medical basis to people who are declared disabled for a period of less than six months. Doctors tended to recommend it for people who were not sufficiently disabled to qualify for a DG, but were in clear need of assistance.

Cape to the Western Cape was identified as a major social issue driving the demand for disability grants in the province. As one doctor noted, "you often have people coming from the Eastern Cape with no education and no English ability with HIV and lots of children and that these people will just keep on coming – it's a major social problem" (Field notes, 2014 March 14). The implications of ongoing medical treatment might have on claimants' ability to retain a job (e.g. frequent clinic visits, dialysis, transport or care) might also be considered.

Doctors recognized that a lack of education and age were major drivers of demand for the grant and this seemed to fit the general demographic. Many claimants were older and had not progressed beyond primary school. This is supported by other studies of DG beneficiaries (Mitra, 2010; Govender & Miji, 2009; De Koker, 2006) and SOCPEN data (SASSA, 2014). This is unsurprising given that the incidence of disability increases with age and the lack of jobs available for this section of the population. Without the credentials or skills and lacking the social and cultural capital to secure regular and well-paid employment in an economy that is becoming increasingly skills- intensive, and where most labour-intensive work has been pushed into the precarious informal economy; large numbers of unskilled people are only able to obtain precarious informal work (Seekings & Nattrass, 2005: 2015).

Given slack labour demand, people perceived to be less productive – older people and those with even very mild impairments or manageable illnesses – are placed at the back of the job queue and are therefore unlikely to find work (Reskin & Roos, 2009). Skills development and training programs largely exclude people over forty and older people therefore have little chance of improving their employability or moving to another employment sector (Interview with occupational therapist, Whitney Hospital).

Recognising the difficulties that older people in particular faced in finding employment, doctors often recommended grants for applicants in their fifties with mild health conditions that were not necessarily disabling and age was perhaps the strongest non-medical factor considered by doctors during assessments.[9] This differed from the moral framing of older patients in that these decisions were rationalized more in terms of 'employability' than older patients being more 'deserving' (although these two conceptions of eligibility may of course overlap). Many doctors considered claimants' eligibility for the DG in relation to pension age and are particularly generous towards people who would soon qualify for this pension. A number of doctors admitted to seeking out

---

[9] Even doctors who strictly adhered to SASSA's bureaucratic frame would recommend temporary grants for longer than they might have for a younger person or recommend a permanent grant rather than a temporary grant.

additional conditions such as osteoarthritis in older patients who might not otherwise qualify.[10]

Another important idea in the social framing of disability is the idea that disease and disability are socially determined and a product of structural violence (Farmer, 2004). For example, the social frame takes into account the contribution of South Africa's apartheid past to current patterns of economic, social and, thus, health inequalities in the Western Cape. One doctor commented "there is very little that has been done to address social determinants of health before patients get to me. Health is a manifestation of everything wrong in society". She felt that recommending a grant was one small thing she could do to assist people who were unfairly disadvantaged in life.

This focus on structural factors distinguishes the social frame from a moral framing of eligibility. While the moral frame defines deservingness in terms of individual agency (and failures of agency), a social frame takes a bigger picture view of deservingness, informed by the social structures that drive DG applications.

Through this lens, doctors saw a case of a patient who was clearly not eligible for a grant more as a symptom of bigger social and economic problems than an individual case of malingering. The social frame is very similar to the more holistic version of the clinical frame, which considers psychosocial factors and the provision of income-support as part of health interventions, but is different in that it emphasizes issues of rights, equality and social justice rather than just the health outcomes of individual patients. This reflects the kind of redistributive justice rhetoric promoted by the South African constitution, which promises socio-economic rights, including social security to South Africans.

Dr Du Toit, whose approach most strongly exemplified a social framing of disability, had worked for many years in a European country with a strong welfare state. This experience had strongly shaped his understanding of eligibility and he expressed a strong rights-based approach to social grants and social welfare generally. While he recognised that there were difficulties in managing the DG system given the high demand for grants, he was against restrictive assessment policies, believing that "individual rights should not be subsumed by the greater problems in the system" (Field notes, 2014 March 14). He was highly critical of the DG system in terms of the nature of the assessment process and the approach of his colleagues to health and social issues, believing them to be punitive and

---

[10] The use of grants for disabled people being used as proxy old age pensions is not a new phenomenon. Gevers' (2014) historical account of the emergence of old age pensions shows that the ex-gratia Blind Grant for Africans, introduced in 1937 as the first monetary social grant for Africans, was sometimes awarded to elderly people who were not blind.

short-sighted in their approach. He was particularly perturbed by doctors who, rigidly applying SASSA directives would not take social factors such as age into account in their decision-making, using the example of a doctor he knew not giving a grant to a 59-year old woman with arthritis because she could *technically* still participate in the labour market.

He argued that South African doctors had become hardened to poverty and the severity of diseases such as HIV/AIDS and tuberculosis, which he argued had become normal and uninteresting to doctors. He felt that while manageable, these diseases still significantly impact people's well-being and participation in society. Therefore, rather than objectifying patients, he believed that it was important to listen to people's stories.

This more inclusive approach often resulted in decisions that diverged from SASSA's guidelines and rules. Although guilt and discomfort about the poverty they so regularly encountered was an important part of doctors' decision-making, these decisions were not necessarily driven by sympathy or humanitarianism. Those using a social frame generally felt that their assessment criteria were appropriately grounded in the social model of disability and were made on the basis of people's actual ability to participate in the labour market. Considering social factors did not make medical factors unimportant and doctors using a social frame did not simply recommend the grant to anyone who was unemployed. Dr Du Toit, for example, acknowledged that his decision-making broke with SASSA's medical model but argued that he had never received a work assessment back from an occupational therapist that had not recommended a grant and seemed to feel that his assessments were rooted in a similar approach.

Conclusion

This paper has shown that doctors' decisions on the applications for DGs were strongly shaped by how individual doctors interpreted cases, and that the subjectivity that comes with being a human actor has not been eliminated by greater bureaucratic regulation of the system. Whether because they felt solidarity with an individual whom they felt deserved a grant, saw it as medically important that someone was able to afford nutritious food, or because they knew how unlikely it was that claimants with even minor disabilities were to find work, doctors regularly made decisions that diverged from SASSA's guidelines. This did not happen in every case and given the increased strictness and routinisation of SASSA's disability management system, it appears to happen less frequently than in the past (Kelly, 2013). Nevertheless, variation in decision-making creates unequal distribution of benefits and public confusion

about eligibility criteria. Mismatches between SASSA's assessment model and the alternative frames that doctors used for thinking about disability and the implementation 'gap' that emerges as a result, reveal the limits of this model as well as fault lines in policy to address poverty and inequality and integrate disabled people into South African society.

The patterns that emerge in doctors' decision-making also reveal important aspects of the institutional, organisational and professional logics that structure doctors' work, as well as the discourses and values that shape social development, health and disability policy in South Africa. The frames doctors used to make decisions were derived from broader discursive framings of rights, needs and social justice within the healthcare system and in South African society more broadly. The *moral frame* strongly aligns with popular conceptions of the 'deserving' poor; the *clinical frame* is shaped by professional values and culture, beliefs about the psychosocial aspects of care and the structure of healthcare system; and *the social frame* is rooted in the social model of disability and discourses of socio-economic rights.

While frames help doctors cope with and manage the difficulties of making complex decisions in uncertain and demanding environments, this study has shown that doctors do not only use their discretion to make their work easier. They also bend the rules for people they think are deserving and or rigidly apply the rules in cases where they feel compelled to. This is because they are "citizen-agents" (Maynard-Moody & Musheno, 2003), who are affected by the interactions that they have with claimants. Building on Maynard-Moody & Musheno's definition, I argue that doctors are also *professional-agents,* whose ideas about their role as doctors and the medical ethics, norms and values they hold also influence their decisions and thus, policy implementation. Distinguishing between different frames for decision-making helps to bring some of the professional and bureaucratic values and demands into comparative perspective, showing why, in this case, doctors have been so difficult to manage within the SASSA system.

Efforts to rationalise the assessment process that do not take the normative aspects and complexities of doctors' reasoning into account only obscure the actual logic that doctors employ when making decisions (Meershoek *et al.*, 2007). Rather than enforcing rules and processes that doctors are likely to find unhelpful and ignore, this study highlights the need to create opportunities for multidisciplinary engagement with and contribution to guidelines and facilitate more peer interaction around the challenges of disability assessment.

Appendix

	Pseudonym	Description	Contracted to	Type of facility	Specialisation	Data collection
1	Dr Jacobs	Coloured, 50s, male	SASSA	Community Health Centre	Occupational health	Interview
2	Dr Vrede	Coloured, mid-30s, female	SASSA (previously agency)	Community Health Centre	GP (interest mental health)	Interview, 2 observation sessions
3	Dr Soet	Coloured, mid-30s, female	Agency	Community Health Centre	GP	Interview, observation session
4	Dr Kewasi	Congolese, mid-30s, female	Agency	Community Health Centre	GP	Interview, 2 observation sessions, DG training
5	Dr Du Toit	White Afrikaans, 40s, male	Agency	Community Health Centre	GP	Interview, observation session
6	Dr Brown	White, 60s (retired), male	Agency	Community Health Centre	Forensic medicine and former district surgeon	Interview, observation session, interactions at SASSA training
7	Dr Taylor	White, early 30s, male	DOH	Tertiary	Orthopaedic surgery	Interview, observation session
8	Dr Donaldson	White, early 30s, male	DOH	Tertiary	Neurosurgery	Interview, observation session
9	Dr Elster	White, early 40s, female	DOH	Tertiary	Neurosurgery	Interview, two observation sessions
10	Dr Harvey	White, early 30s, female	DOH	Tertiary	Cardiology	Interview, two observations sessions
11	Dr Richards	White, 50s, male	DOH	Tertiary	Neurology	Interview
12	Dr Isaacs	White, 40s, female	DOH	Tertiary. Also runs paediatric community clinics	Infectious diseases - mainly HIV	Interview, observation session
13	Dr Wright	White, 40s, male	DOH	Psychiatric hospital	Psychiatry	Interview, no observation

14	Quality assurance officer	Indian, 60s, male	SASSA	N/A	Quality assurance officer	Interview
15	Dr Naidoo	Indian, early 30s, female	DOH (now left)	District hospital	Infectious diseases	Telephonic interview
16	Dr Marais	Male, 40s/50s, white	DOH	District Hospital / Tertiary	Orthopaedic surgery	Interview, observation
17	Dr Malik	Coloured, late 30s, male	DOH	District hospital	Infectious diseases	Interview
18	Dr Bhele	Black, 40s, female	Agency	Community Clinic	GP	Observation, interview
19	Dr Haddid	Muslim, 76, male	Agency	Community Clinic	GP	Observation, interview
20	Dr De Villiers	White, 50s, male	DOH	Community Clinic	GP	Observation, interview
21	Dr Rahman	Muslim, 40s, male	Agency / DoH	Community Clinic	GP	Observation, interview
22	Dr Bury	White, 70, male	SASSA	Community clinic	GP	Observation, interview
23	Dr English	White, 50s, male	DOH	Hospital	Infectious diseases	Interview
24	Dr Kruger	White, male	SASSA	Community clinic	GP	Email

References

Allen, D., Griffiths, L. & P. Lyne. 2004. Accommodating health and social care needs: routine resource allocation in stroke rehabilitation. *Sociology of Health & Illness*, 26(4): 411-432.

Altman, B. 2001. Disability definitions, models, classification schemes and applications. In Albrecht, G., Seelman, K. & M. Bury (eds.) *Handbook of disability studies*, 97-122. London: Sage Publications.

Atkinson, P. & P. A. Atkinson. 1995. *Medical talk and medical work*. United Kingdom: Sage.

Barnes, M. & D. Prior. 2009. Examining the idea of 'subversion' in public services. In Barnes, M. & D. Prior (eds.) *Subversive citizens: Power, agency and resistance in public services*, 3-16. Bristol: Policy Press.

Baron, G. 1992. The Long and Winding Road: A look at applications for disability grants in South Africa. *South African Family Practice*, 13(9): 422-428.

Bartels, K. 2013. Public encounters: the history and future of face-to-face contact between public professionals and citizens. *Public Administration*, 91(2): 469-483.

Bateson, G. 1955. A theory of play and fantasy. *Psychiatric Research Reports*, 2: 39-51.

Beresford, E. B. 1991. Uncertainty and the shaping of medical decisions. *Hastings Center Report*, 21(4): 6-11.

Berg, M., Horstman, K., Plass, S. & M. Van Heusden. 2000. Guidelines, professionals and the production of objectivity: Standardisation and the professionalism of insurance medicine. *Sociology of Health & Illness*, 22(6): 765-791.

Bierschenk, T. & J. O. De Sardan. 2014. *States at Work: dynamics of African bureaucracies*. Leiden: Brill.

Blustein, J., 2012. When Doctors Break the Rules. *Cambridge Quarterly of Healthcare Ethics*, 21(02): 249-259.

Bolderson, H., Mabbett, D. & B. Hvinden. 2002. *Definitions of disability in Europe: a comparative analysi*s. United Kingdom: Brunel University.

Boshuizen, H. P. & H. G. Schmidt. 1992. On the role of biomedical knowledge in clinical reasoning by experts, intermediates and novices. *Cognitive Science*, 16(2): 153-184.

Bourdieu, P. *The Logic of Practice*. 1990. Cambridge: Polity Press.

Brown, M. K. 1988. *Working the street: Police discretion and the dilemmas of reform*. New York: Russell Sage Foundation.

Cassell, J., 2004. Stories, moral judgment, and medical care in an intensive care unit. *Qualitative Health Research*, 14(5): 663-674.

Chirayath, H. T. 2007. Difficult, dysfunctional, and drug-dependent: Structure and agency in physician perceptions of indigent patients. *Social Theory & Health*, 5(1): 30-52.

De Koker, C., Waal, L. & J. Vorster. 2006. *A profile of social security beneficiaries in South Africa*. Stellenbosch: Datadesk.

de Paoli, M., Grønningsæter, A. & E. Mills. 2012. The ARV roll-out and the disability grant: A South African dilemma? *Journal of the International AIDS Society*, 15(6): DOI: 10.1186/1758-2652-15-6.

de Paoli, M., Grønningsæter, A. & E. Mills. 2010. *HIV/AIDS, the disability grant and ARV adherence*. Oslo: Fafo.

Dodier, N. 1994. Expert medical decisions in occupational medicine: A sociological analysis of medical judgement. *Sociology of Health and Illness*, 16(4): 489-514.

Dodier, N. 1998. Clinical practice and procedure in occupational medicine: A study of the framing of individuals. In Berg, M. & A. Mol (eds.) *Differences in medicine: Unravelling practices, techniques and bodies*. London: Duke University Press.

Dodson, L. 2011. *The moral underground: how ordinary Americans subvert an unfair economy*. New York: The New Press.

Dubois, V. 2010. *The Bureaucrat and the Poor: Encounters in French Welfare Offices*. Burlington: Ashgate.

Durkheim, E. 1992. *Professional ethics and civic morals.* London: Routledge.

Eikenaar, T., Rijk, A. E. & A. Meershoek. 2015. What's in a Frame? How Professionals Assess Clients in Dutch Work Reintegration Practice. *Social Policy & Administration*: DOI: 10.1111/spol.12151.

Engel, G. L. 1977. The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286): 129-136.

Evans, T. 2010. *Professional discretion in welfare services: Beyond street-level bureaucracy.* Burlington: Ashgate Publishing.

Everatt, D. 2008. The undeserving poor: Poverty and the politics of service delivery in the poorest nodes of South Africa. *Politikon: South African Journal of Political Studies*, 35(3): 293-319.

Farmer, P. 2004. An Anthropology of Structural Violence. *Current Anthropology*, 45(3): 305-325.

Fassin, D. 2008. The elementary forms of care an empirical approach to ethics in a South African Hospital. *Social Science & Medicine*, 67(2): 262–270.

Fassin, D. 2012. *Humanitarian reason: a moral history of the present*. United States: University of California Press.

Freidson, E. 1970. *Professional dominance: The social structure of medical care.* New Jersey: Transaction Publishers.

-----. 1994. *Professionalism reborn: Theory, prophecy, and policy.* Chicago: University of Chicago Press.

-----. 2001. *Professionalism, the third logic: on the practice of knowledge.* Chicago: University of Chicago press.

----- & J. Lorber. 1972. *Medical Men and their Work: a sociological reader*. Chicago: Aldine Publishing Company.

Garsten, C. & K. Jacobsso. 2013. Sorting people in and out: The plasticity of the categories of employability, work capacity and disability as technologies of government. *Ephemera*, 13(4): 825-850.

Gathiram, N. 2008. A critical review of the developmental approach to disability in South Africa. *International Journal of Social Welfare*, 17(2): 146–155.

Gibson, D. 2004. The gaps in the gaze in South African hospitals. *Social Science & Medicine*, 59(10): 2013-2024.

Giddens, A. 1984. *The constitution of society: outline of the theory of structuration.* Berkeley: University of California Press.

Gilens, M. 1999. *Why Americans hate welfare: race, media, and the politics of antipoverty policy.* Chicago: University of Chicago Press.

Goffman, E. 1974. *Frame Analysis: an essay on the organization of experience.* Cambridge: Harvard University Press.

Govender, T. & G. Mji. 2009. The profile of 'Disability Grant' applicants in Bishop Lavis, Cape Town. *South African Family Practice*, 51(3): 228-236.

Groopman. J. 2007. *How doctors think.* New York: Houghton Mifflin Company.

Harrits, G. & M. Møller. 2011. Categories and categorization: towards a comprehensive sociological framework. *Distinktion: Scandinavian journal of social theory*, 12(2): 229-247.

Hasenfeld, Y. 2000, Organizational forms as moral practices: the case of welfare departments. *Social Service Review*, 74(3): 329-351.

Higgs, J., Jones, M., Loftus, S. & N. Christensen. 2008. *Clinical reasoning in the health professions.* 3rd ed. Elsevier Health Sciences.

Hoag, C. 2014. Dereliction at the South African Department of Home Affairs: Time for the anthropology of bureaucracy. *Critique of Anthropology*, 34(4): 410-428.

Hoag, C. 2010. The Magic of the Populace: An Ethnography of Illegibility in the South African Immigration Bureaucracy. *Political and Legal Anthropology Review*, 33(1): 6-25.

Horton, S. 2004. Different Subjects: The health care system's participation in the differential construction of the cultural citizenship of Cuban refugees and Mexican immigrants. *Medical Anthropology Quarterley*, 18(4): 472–489.

Human, O. 2011. The rings around Jonathan's eyes: HIV/AIDS medicine at the margins of administration. *Medical anthropology*, 30(2): 222-239.

Hupe, P. & M. Hill. 2007. Street-level bureaucracy and public accountability. *Public Administration*, 85(2): 279–99.

Jeffrey, R. 1979. Normal rubbish: deviant patients in casualty departments. *Sociology of Health & Illness*, 1(1): 90-107.

Jonsson, T. 1998, Institutionalized strategies in face-to-face encounters: Focus on immigrant clients. *Scandinavian Journal of Social Welfare*, 7(1): 27-33.

Kaufman, H. 1960. *The forest ranger: A study in administrative behavior*. Washington DC: Resources for the Future.

Keiser, L. R. 2010. Understanding street-level bureaucrats' decision making: Determining eligibility in the social security disability program. *Public Administration Review*, 70(2): 247-257.

Kelly, G. 2013. Regulating access to the disability grant in South Africa, 1990-2013. *CSSR Working Paper No. 330*. Cape Town: Centre for Social Science Research, University of Cape Town.

-----. 2016. "We want another doctor!" Citizen agency and contested notions of disability in social assistance applications in South Africa. *CSSR Working Paper No. 383*. Cape Town: Centre for Social Science Research, University of Cape Town.

-----. Forthcoming. *Ways of coping: how medical doctors manage their position in the South African disability grant system*. In press.

Kleinman, A. 1995. *Writing at the margin: Discourse between anthropology and medicine.* Los Angeles: University of California Press.

Kleinman, A. & J. Kleinman. 1991. Suffering and its professional transformation: Toward an ethnography of interpersonal experience. *Culture, Medicine and Psychiatry*, 15(3): 275-275.

Light, D. W. & D. Hughes. 2001. Introduction: A sociological perspective on rationing: power, rhetoric and situated practices. *Sociology of Health & Illness*, 23(5): 551-569.

Lipsky, M. 2010. S*treet-level bureaucracy dilemmas of the individual in public service.* 30th Anniversary Edition. United States: Russell Sage Foundation.

Lock, M. 1985. Models and practice in medicine: Menopause as syndrome or life transition? In Hahn, R. A. & A. D. Gaines (eds.) *Physicians of Western Medicine: Anthropological Approaches to Theory and Practice*, 115-139. Netherlands: Springer.

Higgs, J. & Loftus, S. 2008. A place for new research directions. In Higgs, J., Jones, M., Loftus, S. & N. Christensen (eds.) *Clinical Reasoning in the Health Professions*, 213-220. 3rd Ed. Amsterdam: Elsevier.

Mashaw, J. L. 1983, *Bureaucratic justice: Managing social security disability claims.* New Haven: Yale University Press.

Mattingly, C. 1994. The concept of therapeutic 'emplotment'. *Social Science & Medicine*, 38(6): 811-822.

Maynard-Moody, S. & M. Musheno. 2003. *Cops, teachers, counselors: Stories from the front lines of public service.* Ann Arbor: University of Michigan Press.

Maynard-Moody, S. & S. Portillo. 2010. Street-level bureaucracy theory. In Durant, F (ed.) *The Oxford Handbook of American Bureaucracy*, 252-277. Oxford: Oxford University Press.

Mitra, S. 2010. Disability cash transfers in the context of poverty and unemployment: The case of South Africa. *World Development*, 38(12): 1692-1709.

Mizrahi, T. 1985. Getting rid of patients: Contradictions in the socialisation of internists to the doctor-patient relationship. *Sociology of Health & Illness*, 7(2): 214-235.

Mol, A. 2002. *The body multiple: Ontology in medical practice*. Durham, NC: Duke University Press.

Montgomery, K. 2006. *How doctors think: Clinical judgment and the practice of medicine.* Oxford: Oxford University Press.

Müller, A., Röhrs, S., Hoffman-Wanderer, Y. & K. Moult. 2016. 'You have to make a judgment call': Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa. *Social Science & Medicine*, 148: 71-78.

Nurok, M. & N. Henckes. 2009. Between professional values and the social valuation of patients: The fluctuating economy of pre-hospital emergency work. *Social science & medicine*, 68(3): 504-510.

Olthuis, J. 1997. *Knowing otherwise*. New York: Fordham University Press.

Parsons, T. 1951. *The social system*. London: Lowe & Brydone.

Priestley, M. 2010. Disability. In Castles, F., Leibfried, S., Lewis, J., Obinger, H. & C. Pierson (eds.) *The Oxford handbook of the welfare state*. Oxford: Oxford Handbooks Online.

Raef, N. 2006. Bearing witness: A moral way of engaging in the nurse–person relationship. *Nursing Philosophy*, 7: 146–156.

Reskin, B. F. & P. A. Roos. 2009. *Job queues, gender queues: explaining women's inroads into male occupations*. Philadelphia: Temple University Press.

Rice, D. 2012. Street-level bureaucrats and the welfare state: Toward a micro-institutionalist theory of policy implementation. *Administration & Society*, XX(X): 1–25

Roth, J. A. 1963. Information and the control of treatment in tuberculosis hospitals. In Freidson, E. (ed.) *The hospital in modern society*, 293-318. London: Collier-Macmillan.

Rowe, M. 2012. Going back to the street: Revisiting Lipsky's street-level bureaucracy. *Teaching Public Administration*, 30(1): 10-18.

South African Social Security Agency (SASSA). 2014. *Annual Report of the South African Social Security Agency, 2013-2014*. Pretoria: Government Printer.

SASSA. No date. *Guidelines for the medical assessment of disability for social assistance purposes*. Pretoria: Government Printer.

Schneider, H., Le Marcis, F., Grard, J., Loveday, P., Blaauw, D. & D. Fassin. 2010. Negotiating care: Patient tactics at an urban South African hospital. *Health Services Research Policy*, 15: 137-14.

Schön, D. A. 1983. *The reflective practitioner: How professionals think in action*. London: Temple Smith.

Schön, D. A. 1987. *Educating the reflective practitioner: toward a new design for teaching and learning in the professions*. San Francisco: Wiley.

Schön, D. A. & M. Rein. 1994. *Frame reflection*. New York: Basic Books.

Schulman, K. A., Berlin, J. A., Harless, W., Kerner, J. F., Sistrunk, S., Gersh, B. J., Dubé, R., Taleghani, C. K., Burke, J. E., Williams, S., Eisenberg, J. M., Ayers, W. & J. J. Escarce. 1999. The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization. *New England Journal of Medicine*, 340: 618-626.

Scott, W. R. 1966. Professionals in bureaucracies-areas of conflict. In Vollmer, H. M. & D. L. Mills (eds.) *Professionalization*, 265-75. Englewood Cliffs, NJ: Prentice-Hall.

Swartz, L. & M. Schneider. 2006. Tough Choices: Disability and social security in South Africa. In Watermeyer, B., Swartz, L., Lorenzo, T. & M. Schneider (eds.) *Disability and social change: A South African agenda*, 234-244. Cape Town: HSRC Press.

Seekings, J. & N, Nattrass. 2005. *Class, Race, and Inequality in South Africa*. New Haven and London: Yale University Press.

----- & -----. 2015. *Policy, politics and poverty in South Africa*. London: Palgrave MacMillan.

-----. 2007. The mutability of distributive justice attitudes in South Africa. *South African Review of Sociology,* 38(1): 20-44.

-----. 2008. Deserving individuals and groups: The postapartheid state's justification of the shape of South Africa's system of social assistance. *Transformation*, 68: 28-52.

-----. 2010. Racial and class discrimination in assessments of desert in post-apartheid Cape Town. In Centeno, M. & K. Newman (eds.) *Discrimination in an unequal world*. Oxford: Oxford Scholarship Online.

Sewell, W. H. 1992. A theory of structure: Duality, agency, and transformation. *American Journal of Sociology*, 98(1): 1-29.

Siegler, M. A. 2000. Professional values in modern clinical practice. *Hastings Center Report*, 30(4): S19-S22.

Stein, H. 1990. *American medicine as culture*. Boulder: Westview Press.
Strong, P. M. 1979. *The ceremonial order of the clinic: parents, doctors, and medical bureaucracies*. Oxford: Taylor & Francis.

Swartz, L. & M. Schneider. 2006. Tough Choices: Disability and social security in South Africa. In Watermeyer, B., Swartz, L., Lorenzo, T. & M. Schneider (eds.) *Disability and social change: A South African agenda*, 234-244. Cape Town: HSRC Press.

Timmermans, S. & S. Haas. 2008. Towards a sociology of disease. *Sociology of Health & Illness*, 30(5): 659-676.

Van Hulst, M. & D. Yanow. 2014. From Policy 'frames' to 'framing': Theorizing a more dynamic, political approach. *The American Review of Public Administration*: DOI: 10.1177/0275074014533142

Van Ryn, M. & J. Burke. 2000. The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science & Medicine*, 50(6): 813-828.

Vassy, C. 2001. Categorisation and micro-rationing: Access to care in a French emergency department. *Sociology of Health & Illness*, 23(5): 615-632.

Wainwright, E., Wainwright, D., Keogh, E. & C. Eccleston. 2015. The social negotiation of fitness for work: tensions in doctor-patient relationships over medical certification of chronic pain. *Health*, 19(1): 17-33.

Walker, L. & L. Gilson. 2004. 'We are bitter but we are satisfied': Nurses as street-level bureaucrats in South Africa. *Social Science & Medicine*, 59(6): 1251-1261.

Willems, D. L. 2001. Balancing rationalities: Gatekeeping in health care. *Journal of Medical Ethics*, 27(1): 25-29.

Zacka, B. 2015. Impossible Situations: On the Breakdown of Moral Integrity at the Frontlines of Public Service. Proceedings of the conference on *Policy-Making on the Ground Floor of Government at the International Conference on Public Policy.* 1-4 July. Milan.