# COMMODIFICATION OF HEALTHCARE IN A PRIVATE HEALTHCARE FACILITY: ETHICAL IMPLICATIONS FOR THE NURSE-PATIENT RELATIONSHIP

**Prudence Ramokgopa**

**Student number: 880663**

A research report submitted in partial fulfillment of the degree of MSc. Med (Bioethics & Health Law) Steve Biko Centre for Bioethics, Faculty of Health Sciences, University of the Witwatersrand (Wits), Johannesburg

**NOVEMBER 2017**

**Supervisor:** Dr. Louise Bezuidenhout BA, BSc (Hons), MA, PhD (Cape Town), PhD (Exeter)

**DECLARATION**

I, Prudence Ramokgopa, declare that this research report entitled **Commodification of healthcare in a private healthcare facility: Ethical implications for the nurse patient relationship** – is my own original work, produced with supervisory assistance. I have followed the required conventions in referencing all the relevant sources of knowledge that I have used. It is submitted for assessment for the MSc Med (Bioethics and Health Law) degree and has not been submitted before, for any degree or examination, at this university, nor to any other institution of higher learning.

9 NOVEMBER 2017

**SIGNATURE** **DATE**

**ACKNOWLEDGEMENTS**

I would like to take this opportunity to extend my sincerest appreciation and gratitude to the following:

Dr. Louise Bezuidenhout your patience is only unsurpassed by your attention to detail. Thank you for your academic support, guidance and insight.

To all the academic and support staff at the Steve Biko Centre for Bioethics, University of the Witwatersrand, Faculty of Health Sciences thank you your passion for bioethics is infectious.

My then classmates, now friends, your laughter, support and advice were of comfort throughout this study. Ms. Puleng Khampepe, (WHSL Library Assistant: Research support) your generous spirit will remain in my memory forever. Mrs. Gill Hannat, thank you for everything and for expertly editing my work.

I am eternally indebted to my research site hospital management for your assistance and support during this study and I extend a big heartfelt thank you to all the nurses for giving up your precious time and space, and your willingness to share with me your nursing wisdom, experiences, hopes and dreams. Last, but not least, to my family and friends thank you for without your support and encouragement this report would not have been possible. Ms. Mary Mashifane, thank you for keeping everyone well fed, clean and most importantly sane. A special thanks to my darling husband Mampapatla Ramokgopa, your unconditional love, unstinting support and encouragement make everything possible. My precious gifts Teti and Shimi, you are the air I breathe.

**ABSTRACT**

Most literature on commercialisation of healthcare reports on the effects of the continuing commodification of healthcare on the doctor-patient relationship. It suggests that the commodification of healthcare as a management practice has the potential to alter the power balance between doctor and patient, and affect the care relationship. This has resulted with the global rebranding of patients as healthcare consumers, in the process impacting on the caring value that characterises the healthcare doctor-patient relationship. In contrast, however, these concerns have not been widely investigated in relation to the nurse-patient relationship. This relationship, grounded as it is in care ethics, has the potential to be severely altered by the pressures of healthcare commodification – particularly as nurses continue to be the primary caregivers in hospital settings.

Thus, the study aimed to address this by empirically identifying and exploring areas of ethical tension relating to nurse-patient relationships in a commodified healthcare environment. The objectives of the study were to offer an empirically-based care ethics discussion on nursing care in private healthcare facilities. This study plays a part in addressing the current absence of both theoretical and empirical studies that examine the impact of commodification of healthcare on the actions of nurses.

The study used a qualitative, explorative and descriptive approach to thematically analyse data collected from interviews with 16 nurses working in

a private healthcare facility in Johannesburg. The findings support the argument that the commodification of healthcare transforms the nature of healthcare provision resulting with the replacement of professional ethics with marketplace ethics. This is harmful to the mutual trust and respect between the nurses and their patients. Hence, it is critical to rethink the value of compassionate and humane care as an integral part of ethical nursing practice.

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# CHAPTER 1

## 1.1 INTRODUCTION TO THE STUDY

Over the years global healthcare financing and provision have undergone a series of drastic and rapid transformations. Chief amongst these changes is the transformation of healthcare into a marketable and tradable good or service sold in the open market for profit. Timmermans and Almeling (2009:23) define the commodification process as the marketisation of a good/service that would normally not be considered a saleable or tradable good/service. Commodified healthcare services and spaces challenge the fundamental ethical assumptions about healthcare and healthcare practitioners. This transformation of healthcare has ethical implications for the entire healthcare system – for healthcare provision, for patients and for the healthcare practitioners working in these corporatised healthcare systems (Lown 2007; Pellegrino 1999; Sulmasy 1993).

The practice of medicine involves an intimate and caring relationship between the healthcare practitioner and their patient. As a profit-focused activity, the commodification of healthcare commodification thus raises various ethical and professional concerns about the relationship between healthcare and business (Benatar 2013:154). This has a potential to destabilise the therapeutic relationships existing within these privatised caring spaces with adverse consequences for the entire healthcare system. In his argument

against the commodification of healthcare Pellegrino (1992:261) draws attention to the moral, interactive and caring nature of medicine.

The general concerns about the commodification of healthcare are twofold. First, that the practitioners' decisions or priorities may be guided by the criteria of profitability and not by their professional and ethical values, and second that the patient-as-consumer has the potential to negatively impact on the well-being of the healthcare provider. Interestingly, however, more attention has currently been focused on the former at the expense of the latter.

In relation to the former, it is well-recognized that sick individuals as healthcare users are exposed and susceptible to all sorts of harm and abuse in places of care due to their compromised physical and emotional states. Goodin (2012) cautions that "harm may come from many sources and we are never entirely free from possibility of being harmed" (cited in Gastmans 2013:146). Patients generally bestow high levels of trust in their healthcare practitioners, be it nurses or doctors (or any other member of the healthcare team) and their professional decisions and skills. This is why when they are in these strange environments look up to their healthcare practitioners for guidance during this frightening and confusing time in their lives. Patients have to trust that the healthcare practitioner is guided by their moral and professional values in their practice (Gastmans 2013). Any perceived lack of caring attitude, compassion and trust breeds fear and anxiety in both the healthcare practitioner and the patient.

In relation to the latter, however, for-profit healthcare can interfere with healthcare providers' ability to establish and perpetuate care relationships within these commercialised settings. Pellegrino (1999) worries that invasive marketplace principles and values in the professional healthcare environment contribute towards the increasing lack of concern for the vulnerable. He argues that healthcare with a profit approach interferes with the interpersonal relationship between the professional healthcare practitioner and the vulnerable person seeking medical attention – something that can have dire consequences for the well-intentioned healthcare provider. These concerns suggest that the corporisation and commodification of healthcare can threaten the ethical principle of medicine *Primum non nocere* – First do no harm (Beauchamp & Childress 2013:8).

This morally incongruent work environment creates moral tension for the healthcare professionals working in these care-work spaces (LaSala & Bjarnason 2010). This follows from the observation that the principal purpose of medicine is to alleviate human suffering and to maintain the well-being of others. It is for this reason that Timmermans and Almeling (2009:24) maintain that, "economic and social forces belong to separate spheres." Pellegrino (1999:244) concurs with this view and says subjecting the healthcare system to business principles is "ethically unsustainable and deleterious to patients, physicians and society."

Globally, nurses are the largest group of healthcare workers and are chiefly responsible for rendering professional patient care in various healthcare settings (ed. Geyer 2013). In addition to medical duties, much of their time and efforts are consumed by meeting individual needs and expectations of their patients' and those of their families, with a large part of their work dedicated to patient's care. "Essentially, nursing care aims to lessen the vulnerability of a fellow human being or to deal with it in an appropriate way" (Gastmans 2013:146). In this area of pastoral care, the formation of effective care relationships is key.

The adoption of marketplace values and practices in the private healthcare sector influences everyday managerial and administrative operations and has a bearing on all managerial decisions such as budget allocation. This has a direct impact on the acquisition of resources such as nursing personnel which in turn influences the number of nurses and nursing expertise available on any given nursing shift. This often negatively interferes with the unique relationship existing between the caregivers – nurses - and the care receivers – patients. Geyer (ed. 2013:22) notes: "Dedicated time spent with patients and families at the bedside, in hospitals, … is limited and often rushed and impersonal."

Benatar (2013:154) argues that the subordination of healthcare systems to commercial principles is antithetical to the very notion of good medicine, and the same fears may be extended to nursing professionals. Thus, the question

this study addresses is “how the commodification of healthcare impacts on the caring practices and relationships of nurses in a private healthcare facility.”

## 1.2 BACKGROUND INTO THE COMMODIFICATION OF HEALTHCARE

### 1.2.1 General commodification of healthcare

In a 2013 article, Benatar describes how the commodification of healthcare is re-engineering healthcare financing, provision and consumption, converting professional work organisations into business enterprises focused on profit making. In this article Benatar (2013) voices the generally expressed concerns on the objectification of healthcare professionals, services, products and environments into commodities. He describes the trend towards the “commodification of healthcare” as the increasing presence and hegemony of financial motives and interests in the healthcare arena. Benatar (2013) observes that economic forces in healthcare have transformed a service of healing and wellbeing to a consumerist service to be sold and bought like those of any other services industry. Benatar (2013:154) remarks that commercial healthcare favours profitability over fundamental human values such as compassion and caring for and about one another leading to the erosion of healthcare professionalism. This pressure on market forces can result in healthcare services and environments that lack compassion and respect which negatively impacts on patients’ human dignity.

### 1.2.2 Commodification of healthcare in South Africa

South Africa, a developing country, has a two-tier healthcare system that is operated in parallel. This includes the large state-subsidised system, and a small commercial privatised system (Hassim, Heywood & Berger 2007:34). The public healthcare sector is the responsibility of the National Department of Health. Its nationwide services range from free basic services in primary healthcare clinics to affordable high-tech services in provincial/tertiary hospitals. Private healthcare providers offer patients the opportunity to receive their medical care in a private healthcare environment for a fee.

South African private healthcare providers market their brand of managed healthcare to affluent and/or third party-funded individuals wishing to utilise these private healthcare facilities and services. In the private healthcare sector the providers have the power to determine the terms and conditions of sale. Medical aid, cash and/or any other form of bank guaranteed payment such as credit cards are the acceptable forms of payment (www.saprivatehospitals.com). These patients are expected (and made aware of this prerequisite) to pay upfront fees predetermined by private healthcare facilities in order to access healthcare services and products. Approximately 16% of the South African population has private medical cover (Rowe & Moodley 2013). Given and following on the above statements, the question as to whether it is ethical to request payment upfront and during rendering of care is one that often crops up in healthcare (McQuoid-Mason 2011). Nonetheless, the system persists.

### 1.2.3 Drivers of healthcare commodification

In an attempt to identify causes of commodification Stoeckle (2000:141) pinpoints “corporate medical practice, a market economy, and a consumer culture” as some of the driving forces transforming healthcare. Sulmasy (1993:33) argues that commodification places “necessary” spaces, goods and services under the control of the intensifying market forces, leading to their privatisation/corporisation. Manchikanti and Hirsch (2009: 291) contend that for-profit healthcare providers have had to adopt the managed healthcare approach in order to deliver cost-effective, quality, efficient healthcare to their clients. However, the commodification of healthcare cannot be understood in isolation from other major social trends. It is a result of a confluence of external and internal factors. Lown (2007:40) mentions globalisation, technological and scientific innovation, and advancements in medicine as some of the factors influencing the new developments in the healthcare environment. They all agree that these forces work together and/or independently to influence pertinent issues in healthcare financing and provision.

Benatar (2013:154) commenting on the commodification of healthcare says:
“Endless expectations and increased orientation towards patients as clients have changed the concept of healthcare from a caring, social function, provided through universal access as a social duty to all citizens of equal moral worth.” This paradigm shift forces healthcare and its services to operate like any other market entity or service.

### 1.2.4 Commodification of patient care

Cornwell and Goodrich (2009) argue that healthcare practitioners want to be able to render care that is humane, full of compassion and respect. “To give patients the same kind of care that they would want for themselves or their own family or loved ones” (Cornwell & Goodrich 2009:2). Many prominent bioethicists emphasise and agree that healthcare is a social service beneficial to humanity and as such should not acquiesce to marketplace influences. Pellegrino (1999:251) says treating healthcare as a social good “implies a notion of the solidarity of humanity.” Both Benatar (2013) and Pellegrino (1999) view the involvement and hegemony of business ethics in the healthcare arena as being at variance with compassionate care traditionally expected from healthcare environments and healthcare professionals.

Lown (2007:40) suggests that the intrusion of marketplace values in medicine has fundamentally altered the meaning of healthcare from “a healing occupation dominated by professionals” into “an industrial process run by technicians.” This can be witnessed in the generally accepted and widespread use of the market-based language within these commodified healthcare environments (Lown 2007; Rowe & Moodley 2013; Sulmasy 1993).

Paying for healthcare has two key impacts on patient-care. The first, and more obvious, relates to the ability to access care. Joseph Heath (2003) expands on this, and says a person’s inability to pay should not be reason to deny them access to healthcare. He says doing so ignores a special human

relationship and the needs of the uniquely vulnerable. This negatively impacts on human prosperity, leading to denigration of human dignity. Heath (2003) puts forth two arguments to support his claim. Firstly, he suggests, “commodification involves the observation that certain goods are so closely connected to the integrity of persons that the buying and selling of them is inconsistent with human dignity” (Heath 2003:3). Secondly, he states “goods of this sort are by their very nature unsuited for purchase and sale. Furthermore, the creation of markets for them generates perverse incentives to violate the integrity of persons” (Heath 2003:3).

Heath (2003) and Pellegrino (1999) concede that there is nothing wrong with running a business. They voice their concerns when business interests in the healthcare environment supersede healthcare needs. They argue that under certain circumstances it ought not be sold or bought for profit as this denigrates its status as a special social service. Heath (2003) is arguing that it is morally acceptable to sell and buy healthcare as it costs money to produce and to deliver healthcare products and services. He says ignoring the fact that not all sick people have the power or knowledge to bargain for this valuable service is morally reprehensible.

The second relates to the impact of the market forces on the patients within the care paradigm. One of the goals of managed healthcare is to reduce and contain the ever-increasing costs of healthcare delivery and services. This raises concerns around professionalism and moral obligations of healthcare practitioners in commercialised settings as commercial interests in these

settings may interfere with their ability to optimally care for their patients. Distributing healthcare according to general market principles undermines the altruistic elements of the social contract between healthcare practitioners and society.

### 1.2.5 Nursing practice in commodified environments

Healthcare professionals are morally and professionally bound to safeguard the well-being of others and to provide care to physically and psychologically vulnerable individuals. Historically, medicine has been recognised as a sacred vocation, a profession considered a social good for the benefit of others (Johnson 2009:3). It is a profession entered by those with an interest in the well-being of others and the desire to care for them in their time of emotional and/or physical pain. Reed, Aquino and Levy (2007:178-193) describe these individuals as having strong core moral values and perceive being of service to others as their moral purpose. Similarly, Hart, Atkins and Ford (1998) describe this moral response as “a commitment to one’s sense of self to lines of action that promote or protect the welfare of others” (cited in Aquino & Reed 2002:1424).

Nurses worldwide confront a multitude of ethical challenges and dilemmas during their daily nursing practice irrespective of their employer. South African nurses offer their services to an employer of their choice, this can be the state or the private sector and some choose to be independent practitioners. Nevertheless, they all have the same responsibilities and duties wherever

they are employed. They are morally and professionally obligated to uphold high moral and professional standards in their clinical settings (Pera & Van Tonder 2011:3).

Patient-centered nursing care recognises the patients' vulnerability and the need to maintain their dignity during caring interventions (Gastmans 2013:146). Caring attitudes and behaviours enable the nurse to render high quality competent nursing care that is responsive to the needs of the patient. This preserves the patient's dignity and humanity and facilitates the nurse's professionalism (Gastmans 2013). Commodified healthcare services and their management have the potential to interfere with the nurses' ability to enact this necessary care.

## 1.3 THE PROBLEM STATEMENT

The commodification of healthcare has been shown to potentially influence healthcare practitioner-patient interactions. However, this is not widely explored in nursing ethics literature, and particularly in relation to the caring relationships vital between nurse and patient. This thesis problematizes this observation, empirically examining the question: how do nurses view care relationships within a commodified healthcare setting?

## 1.4 RATIONALE FOR FOCUSED STUDY

The business ethics and culture embedded in commercial healthcare settings have the potential to shift the nature of the care relationships existing in these settings into transactional ones. Nonetheless, within current bioethics literature, this observation has been overlooked – particularly in relation to nurse patient relationships. With the global drive towards commodified healthcare, and the persistent presence of this health-financing model in South Africa, the need for studies such as this one must be apparent.

In particular, there is a need for more empirical evidence on the commodification of healthcare. Such evidence will enrich current care ethics on nursing, and offer valuable perspectives on furthering our understanding of care relationships in health.

## 1.5 AIM OF THE STUDY

The aim of this study was to empirically identify areas of ethical tension relating to nurse-patient relationships in a commodified healthcare environment and to explore how this impacted on the nurses' ability to engage with their patients in caring relationships. The study used in-depth semi-structured interviews to gather information on the impact of commodification of healthcare from nurses permanently employed at a private healthcare facility.

## 1. 6 OBJECTIVES

The primary objective of this study was to explore the impact of commodification of healthcare on the nurse-patient relationships using the care ethics perspective in order to explore the implications of this tension.

The secondary objectives were to:

- Examine existing literature on nurse-patient relationships in care ethics and contrast that to the provision of healthcare in increasingly privatised settings.
- Empirically investigate opinions of nurses working in a private healthcare facility regarding their ability to engage with their patients in caring relationships.
- Critically analyse the empirical data to formulate a care ethics discussion on nursing care in private healthcare facilities, as without rigorous theoretical and empirical studies, the impact of commodification of healthcare on the actions of nurses will continue to be overlooked.

## 1.7 BRIEF OVERVIEW OF THE RESEARCH DESIGN

The study utilized a qualitative approach, conducting an exploratory descriptive study of nurses in a private healthcare facility in Johannesburg. Data was collected from 16 nurses during semi-structured in-depth digitally

recorded interviews. The data was thematically analysed from a care ethics perspective in order to identify, explore and interpret important underlying themes and subthemes on commodification of healthcare, the nurse-patient relationship and ethics in nursing practice.

## 1.8 THEORETICAL FRAMEWORK

I used care ethics, a moral theory, in conjuction with the South African nurses' pledge of service as a theoretical framework to provide the background for the study and to guide the process of data collection and analysis of this study (Nieswiadomy 2008; Mellish, Oosthuizen & Paton 2010:209; Ryan, Coughlan & Cronin 2007). This approach is elaborated on in the methods chapter.

## 1.9 STUDY OUTLINE

This chapter provides an overview of current discussions surrounding the commodification of healthcare and the structure of the study. Chapter two reviews the related literature focusing on nursing practice and ethics and care ethics that form the theoretical framework used in the empirical study. In chapter three I present the research design used when conducting the study and in chapter four the findings of the study. In chapter five I discuss the findings and chapter five presents the conclusion of my argument and recommendations.

## 1.10 SUMMARY

Globally nurses continue to be the initial point of contact for patients in varied healthcare settings. Commodified healthcare services and spaces disrupt and interferer with nurses' professional and clinical duties as caring practitioners. This raises ethical and professional concerns about the relationship healthcare and business. The next chapter presents the literature review relevant to nursing ethics and care ethics the theoretical framework for the study.

# CHAPTER 2

# LITERATURE REVIEW

## 2.1 INTRODUCTION

This chapter reviews literature on nursing practice and ethics - particularly care ethics and the Nurse' pledge of service – and highlights issues pertinent to the increasing commercialisation of healthcare and the impact of this phenomena on professional and ethical nursing practice.

## 2.2 NURSING ETHICS

Nursing occurs within a social context in which relationships are paramount. Indeed, the nurse-patient relationship serves as the basis for concerned, compassionate and competent nursing care is rendered. As discussed by Dinc and Gastmans: "[t]he nurse–patient relationship is the cornerstone of nursing work, and trust is critical in this relationship because without trust, it is not possible to effectively meet the needs of patients and to improve their satisfaction with nursing care" (Dinc & Gastmans 2013:502). It is through these relationships that the nurses most effectively enact their scientific knowledge and skill.

Ill health makes individuals vulnerable and creates a need for a caring nurse-patient relationship (Gastmans 2013:146). A professionally and morally

competent nurse is concerned with the holistic well-being of the patient. This means being emotionally responsive to the patients' total needs. The modern nurses' role is made up of two functions namely the instrumental function and the expressive function. The instrumental function entails the various tasks and or procedures that the nurse has to perform during her caring practice e.g. maintaining the patients' hygiene status, making them physically comfortable during their ward stay, administration of medications, wound dressings etc. A professionally and morally competent nurse fulfills their expressive function by for an example being available (active listening), supportive, encouraging etc. Effective nursing relationships are thus best understood as a response to vulnerability and need.

Good clinical practice in nursing requires that "the nurse should be completely orientated to supporting the patient, and this support is not limited to the bodily, biological aspects of the problems confronting the patient" (Gastmans 1998:1336). Nurses render a service of a particular and unique kind that is why caring is an important part of their professional makeup (Mellish et.al 2010:13). Bergsma and Thomasma (2000) reason that

> The relation between the one seeking help and the professional offering it is based on profound human values, including the relief of suffering, bonding with others in the community, being at risk for vulnerability, alterations in one's social and familial roles, and the value of existence itself (cited in Thomasma 2000:5).

Eisenberg (2000) and Gilligan (1982) refer to this moral action as "social responsiveness to the needs of others" (cited in Aquino & Reed 2002:1433).

The Nurses' Pledge acts as a moral compass for nurses in all healthcare settings focusing on the nurses' interpersonal interactions. It sets and governs the ethical standards of professional conduct and service and guides ethical behaviours and action. In addition to this pledge, it is assumed that nurses are also guided by their moral values, ethical and legal frameworks such as the Constitution of the country, South African Nursing Council (SANC) regulations and the Nurse's Pledge when fulfilling their duties and obligations, especially during nurse-patient interactions (Mellish et al. 2010:209). Regulations such as the South African Nursing Council as stipulated in the Nursing Act No. 33 of 2005 (South African Nursing Council, 2004-2015) assist the nurse to take morally and professionally sound decisions during her/his practice.

Core professional nursing values such as empathy, human dignity, integrity and social justice are actively espoused in these legal and professional standards. These authoritative statements act as a guide to essential moral and professional knowledge and skill needed to render safe and compassionate nursing care. They adress how nurses ought to relate and engage with patients, members of the healthcare team and the communities they serve.

When read in conjunction with Code of Ethics for Nursing Practitioners in South Africa, professional principles such as the Nurse' pledge give a clear indication of what the nurses' role is and direction as to how they must conduct themselves during their caring practices. As the aim of the study was to empirically identify areas of ethical tension relating to nurse-patient

relationships in a commodified healthcare environment it seemed appropriate to use this professional code in conjunction with the care ethics moral theory to investigate the ethical impact of this environment on the nurse-patient relationship.

The inter-relational aspect of nursing care has been a difficult point to address when dealing with core ethical values of healthcare and nursing practice from the perspective of dominant ethical theories such as deontology and utilitarianism **(**Garrison 2001:5). These traditional normative ethical theories function to guide individuals' behaviours or actions when faced with morally challenging situations. The person's internal virtue lets him/her choose the morally correct and justifiable action. For deontologists the focus is on the rightness of the duty or obligation and not necessarily the outcomes of the action. Utilitarians measure the success of an act based on its consequences (Beauchamp & Childress 2013; Mellish *et al.* 2010). Both these theories fall short when used in the nursing profession as the nursing care rendered is duty-based or focused on achieving positive healthcare outcomes. In recent years, however, there has been a rise in the field of care ethics as a means of interrogating these interpersonal relationships that are at the core of nursing practice.

## 2.3 CARE ETHICS

Care ethics found prominence as a normative moral theory in the 1980s under feminist theorists such as Carol Gilligan and Nel Noddings. It developed from Gilligan's work countering Kohlberg's work on moral development between sexes. Through her study on the feminist perspective on gender differences in the development of moral reasoning, she proposed that Kohlberg's study contained an inherent bias towards male-dominant forms of ethical reasoning as the assessment favoured the autonomous and ethic of principles driven by the male voice (Aquino & Reed 2002; Beauchamp & Childress 2013; Petersen 2011; Rachels & Rachels 2007; Tong & Williams 2005). Care ethics encourages the maintenance of mutually beneficial relationships and acknowledges our interdependence on each other in our quest to meet our needs, goals and interests. According to Pettersen (2011:55) "The normative value of care is universal —it includes not only the caree, but also the carer and other persons for whom she might have a caring responsibility."

### 2.3.1 Care ethics in nursing practice

Caring in nursing is about being present and forming a connection with those in distress so as to relieve their suffering. Compassionate and competent care is an essential part of healing and nursing practice and forms the basis for nurses' moral decisions when interacting with their patients. Manning (1998:98) says our relationships with others obligate us to have "sympathetic understanding" and to be accommodative and responsive to their needs. Thus

the nature of care ethics as a moral theory is useful to illuminate the professional aspects of compassionate and dignified care in nursing practice.

Nurses as moral agents are expected to care for (beneficence) and protect the vulnerable (nonmaleficence). Caring and compassion are normal responses to human suffering. According to Leininger (1988:46) “caring is one of the most critical and essential ingredients for health, human development, human relatedness, well-being and survival.” Pettersen (2011:60) posits that ‘‘Care ethicists have the values, perspective and the analytical tools to identify actions and conducts which are promoting—or curtailing—care.” Compassionate care is dependent on the nurses’ ability to create caring relations with their patients. Gastmans (2013:144) is of the view that “concrete lived experiences (e.g. of caregiving, care receiving, vulnerability and dignity) rather than abstract principles (e.g. respect for autonomy) should be the primary guide for developing a nursing ethics framework.”

Caring acts and decisions are crucial for the alleviation of suffering. Nursing theorist Peplau (1952) says, “The interactive, relational process which develops between the nurse and patient has, … a distinctly therapeutic value” (cited in Gastmans 1998:1316). Thus compassionate and mindful caring is vital for the healing process. Caring for, the concern and consideration for the vulnerable and their holistic well-being, are deliberate and salient parts of professional and compassionate nursing. Noddings highlights this relational aspect of caring and says caring involves two aspects, caring for and being

cared for, that is, not only should we care for others but that we also need to be cared for (Pettersen 2011).

An ethical caring nurse-patient relationship serves to connect the nurse with the patient and facilitates holistic and responsive patient-centered care during the patient's period of incapacitation (Gastmans 1998:1318). Caring is "an act of accepting, enabling, and encouraging an individual by honouring his uniqueness, his complexity, his feelings and needs: by believing that each person's life makes a difference: and by helping a person find his voice and be heard" (Hawthorne & Yurkovich 1996:27). An open and trusting relationship is a prerequisite for caring actions and decisions to occur within any relationship. Gastmans (1998:1318) says, "Since both the nurse and the patient are aiming towards the attainment of the same goal - the promotion of care - we can consider the relationship of care as an ethical relationship." Thus mutual trust and respect are imperative for the establishment and maintenance of a healthy and beneficial relationship between the nurse and her patients.

### 2.3.2 Care ethics concerns

High quality, safe and compassionate healthcare is based on a relationship of trust and mutual respect between the patient and the healthcare practitioner in a supportive environment. There are concerns that commercial markets are transforming medicine from a "moral mission of care" into a profitable

commodity with negative consequences for the healthcare-patient relationship (Stoeckle 2000:141). This transformation can alter the traditional nursing ethic of care, as patients are increasingly viewed as customers and nurses as service providers. This can lead to a process of emotional disengagement amongst nurses through the need to respond to economic pressures over care obligations. To practice competently and with ethical integrity nurses must exhibit some of the key elements common in mutually beneficial care relationships, such as compassion, empathy, understanding and trust. Lown, a medical doctor, says the end result of commodification of healthcare is the "deprofessionalization" of healthcare professionals and the "depersonalization" of the patients (2007:40). Patients in these commercialised healthcare settings may find their nursing and caring encounters unsatisfying and dehumanizing.

Firstly, commodified healthcare influences with how patients experience their illness and care in these environments. Converting a patient-oriented service into a commodity departs from the commonly held position that healthcare practitioners care about and for their patients and their well-being. It follows that ethical concerns arise when healthcare - a moral service - is conceived and consumed as an ordinary consumer good according to marketplace principles. Pellegrino (1999:247) says based on the "quality and nature of personal relationships involved" healthcare ought to be exempt from being regarded as a commodity. He says that healthcare and medical services offered through a commercialised system indicate a lack of concern for the needs and feelings of others. The benefits to the individual and corporate

providers within the system are often pursued at the expense (and sometimes harm) of persons who are in need of healthcare. This emotional detachment from patients has a potential to hinder compassionate and dignified interactions between the healthcare professional and the patient (Benner & Wrubel 1989; Cornwell & Goodrich 2009).

Secondly, the nurses‘ autonomy and control over their practice is challenged by the private healthcare facility management’s business practices and decisions such as the allocation of resources due to budget considerations (ed. Geyer 2013:41-57). These profit driven practices impact on nursing administrative issues such as budget allocation for resources such as nursing labour. This in turn influences the quality of nursing labour and the skills set mix available in the ward at any given time, which may compromise patient safety and the quality of nursing care rendered and received. This has adverse connotations for the healing process and well-being of the patient.

The paramount *raison d’etre* for nursing is to maintain and restore optimal health and to promote wellbeing to those experiencing physical and emotional pain. They render this care from within the safe boundaries of a therapeutic relationship based on values such as mutual respect and trust. This obligation to care places nurses in vulnerable and potentially abusive situations in their various places of work, this more so in the complex private healthcare work environments. Complications such as loss of autonomy and stewardship of nursing are some of the ethical dilemmas faced by nurses in

these care settings, affecting both the nurse and the organisation detracting from the quality of care.

## 2.4 SUMMARY

A common assumption in the healthcare literature is that the quality of nursing care is, in part, achieved by means of nurses' emotional commitment to those in their care (Huynh, Alderson, and Thompson 2008 cited in Johnson 2015:114). Market forces in a commercialised healthcare environment potentially influence nurses' professional and clinical duties as caring practitioners interfering with their ability to establish and perpetuate care relationships with patients. The next chapter discusses the research methodology used when conducting this study.

# CHAPTER 3

# RESEARCH DESIGN

## 3.1 INTRODUCTION

The rationale of my study was to explore the impact of commodified healthcare from a care ethics perspective in order to illuminate the ethical implications of nursing-patient relationships in a private healthcare setting. This study adopted a qualitative research approach to explore and describe the ethical impact of commodification of healthcare on the nurse-patient relationship in a private healthcare facility in Johannesburg. Guba and Lincoln (1994) define qualitative research as “an interpretive, naturalistic approach to the world” (cited in Burden & Roodt 2007:11).

I used care ethics, a moral theory, together with the Nurses’ Pledge of service the South African nurses’ pledge of service as a theoretical framework to ground the study (chapter 2), and to direct the process of data collection and analysis of this investigation (Mellish et al. 2010:209). Data was thematically analysed in order to gain insight and knowledge into the commodification of healthcare, the nurse-patient relationship and ethics in nursing practice and the findings were critically compared to existing local and international data.

## 3.2 THE RESEARCH PROCESS FOR THIS STUDY

Before commencing with the study, I approached and obtained approval from the Postgraduate Committee and obtained ethical clearance from the Human Research Ethics Committee (Medical) of the University of the Witwatersrand (APPENDIX A). I also sought permission from the facility's management and research operating committee to gain access to the facility (APPENDIX B).

On receipt of all the necessary written permissions, I made contact with the hospital to set up a meeting with the hospital manager and the nursing services manager who operated as ad-hoc gatekeepers. At the meeting held on the 21st of July 2015 I was requested to report to any of the nursing managers each time I was on site. An administrative assistant was tasked with introducing me to the nursing unit managers as per the nursing services manager's suggestion. This facilitated my entry into the wards and access to the nurses.

The purpose of the meeting was to introduce myself in person and explain to the hospital management the study in detail. Morse and Field (1996) emphasise the importance of building rapport with the participants as it fosters trust between the researcher and the participants and helps the researcher to establish and maintain credibility.

## 3.3 PILOT STUDY

Before commencing with the study I conducted a pilot study to test the suitability of the questions in the interview tool designed for this study. Bailey (1991:183) says a pilot study is important when the researcher wants to "check feasibility of various components of the project." The pilot study was conducted at the boardroom of Folateng unit, a private healthcare unit within the Charlotte Maxeke-Johannesburg Academic Hospital on the 20th of February 2015 whilst awaiting permission from my intended research site. Permission to access the pilot healthcare facility was sought and granted by Mr. Magainyane, the administrative officer in charge of the unit, and Matron Rikhotso, the unit's nursing services manager. It was conducted under the supervision of Dr. Louise Bezuidenhout.

The plan was to conduct individual semi-structured interviews of at least 10 to 20 minutes with two nurses from each professional category but due to staff and time constraints in the unit I instead conducted a focus group interview with two registered nurses and one enrolled nurse. An interview tool guided the focus group interview and revealed valuable information regarding the wording and structure used and as a result of the pilot study findings, the research instrument was modified accordingly. For example, questions on the participants' workload were left out in the final interview questionnaire as it was deemed superfluous.

## 3.4 EMPIRICAL RESEARCH

### 3.4.1 Contextual setting

The study was conducted in a large private healthcare facility owned and run by one of the largest private hospital networks in South Africa. The hospital caters for patients with various acute and chronic healthcare needs with a special focus on child and maternal healthcare. According to Polit and Beck (2004:28) the researcher's decision as to where to conduct his or her study is influenced by "the nature of the research question and the type of information needed to address it." I used my nursing and medical contacts that I had established during my days working as a professional nurse in the private sector to identify this particular hospital as a suitable research site.

The hospital is located in a culturally and ethnically diverse residential area in the south-west of Johannesburg, Gauteng province. It has a nursing staff complement of mostly Black Christian females who live in Johannesburg. They represented a variety of different cultural backgrounds. It became apparent during the study how issues of race and religious differences impact on the level and quality of the nurse-patient interactions. Participants also brought up these significant socio-cultural issues but they were not pursued as they fell outside the scope of this study.

## 3.5 RESEARCH DESIGN

Burns and Grove (2007:18) describe qualitative research methods as forms of social inquiry with roots in “behavioural and social sciences, as a method of understanding the unique, dynamic, holistic nature of human beings.” Qualitative researchers study the phenomena, behaviour or event of interest as it occurs within its natural setting. The aim of qualitative research is to understand and interpret the social and cultural contexts of the phenomenon under study from the participants’ perspective. Participant perspective is a characteristic of qualitative research that affords the researcher to understand and attach meaning to why and how the behaviors or phenomenon under study occurs.

### 3.5.1 Qualitative research design

Permanently employed private healthcare facility nurses were interviewed at work. Qualitative research methods were developed in the natural and behavioural sciences to study the natural phenomena occurring in these sciences. I used semi-structured interviews in conjunction with participant observation and document review to collect data from sixteen nurses employed at a private healthcare facility in Johannesburg at the time of study. I asked participants to share and describe to me their positive and negative experiences on how their work environment has impacted on their nurse-patient relationship and patient care.

### 3.6 Rationale for research approach

Focusing on the nurses' perspective ensured a better understanding and interpretation of their lived experiences of private healthcare facility nurses. I chose this approach to guide this research study because of my own personal experiences and understanding of how commodification of healthcare in private healthcare facilities impacts on nursing activities in these settings. As a professional nurse with work experience in both public and private healthcare facilities in various capacities, I was interested in exploring private healthcare nurses' experiences, perceptions and views on how a commodified healthcare environment influenced their nurse-patient interactions.

I found its interpretative nature consistent with the aim of the study, which was to identify areas of ethical tension relating to nurse-patient relationships in a commodified environment and to explore how this impacted on the nurses' ability to care for patients.

## 3.7 POPULATION AND SAMPLING PROCESS

### 3.7.1 Population

The population for this study comprised all the nurses involved with bedside patient care, employed at the private hospital during the time of the study (Babbie & Mouton 2001; Bailey 1999; Burns & Grove 2007).

### 3.7.2 Participant recruitment and sampling process

The hospital's nursing services manager assisted me to identify relevant wards for the study and the nursing unit managers were comfortable to be involved and facilitated the recruitment process. Their cooperation and involvement was important for the study as I did not work at the facility and as such it was not going to be possible/easy for me to successfully identify and reach potential participants. The nurse managers were motivated by our common understanding as nurses and the needs of the nursing profession to assist me with the project. The sample consisted of sixteen professionally diverse nurses spread across the three nursing professional categories (professional nurses, enrolled nurses and enrolled auxiliary nurses).

Purposive sampling techniques are useful, for an example, when investigating the impact of a phenomenon in a homogenous group (Bailey 1991; Burns & Grove 2007; Brink, van Rensburg & van der Walt 2012). Most participants were recruited by word of mouth via the nursing unit managers and I personally invited those who showed an interest in the study. This approach allowed me to select a group that would provide me with relevant information. I continued to collect data from new participants until data saturation.

### 3.7.3 Inclusion and exclusion criteria

Participants were assessed using specific criteria in order to be included in the study (Bailey 1991: 44-45). They had to be permanently employed at the facility at the time of the investigation, English-speaking and 18 years or above, of any race and gender, with at least two years of private sector nursing experience. Participants had to be working in general adult wards at the time of the study. I anticipated that this sample would have the necessary experience to form and articulate an opinion about the topic.

The study sample excluded nurses from the Casualty, Critical Care Units (High Care and ICU) and the paediatric unit due to the markedly different relationship they have with their patients which is beyond the scope of this study. Theatre nurses were excluded for the same reason. The study also excluded nurses in senior management positions such as the hospital nursing services managers as they were not rendering patient care and 'moonlighting nurses' as they may not be able to give unbiased opinions. 'Moonlighting nurses' refers to nurses who hold secondary jobs in addition to their primary nursing jobs. The global shortage and low salaries of nursing staff have made 'moonlighting' an unfortunate reality in the nursing work environment. Private nursing placement agencies source and place nurses in these secondary jobs (Bateman 2009; ed. Geyer 2013; Oulton 2006; Rispel, Blaauw, Chirwa & de Wet 2014).

### 3.7.4 Participants' demographics

The study sample comprised a total of sixteen nurses between the ages of 26 and 52. The participants were at different professional levels: eleven were junior nurses, three senior professional nurses and two nursing unit managers. In a ward setting junior nurses of all professional levels are typically responsible for the everyday nursing activities. Nursing unit managers or the charge-sisters occupy dual roles in most healthcare settings as caregivers and unit managers. They form part of middle management and are responsible for facilitating operational nursing unit activities and continuous and ongoing professional development and training of nurses at ward level (ed. Geyer 2013; Muller 2000). Senior professional nurses function as caregivers as well as operational managers or charge-sisters in the absence of the unit manager. Participants had nursing experience ranging between two and twenty years.

All participants, with one exception, have worked in private hospitals and only one had international nursing work experience. They all reported having worked in a variety of specialised wards including the intensive care unit, operating theatre and paediatrics. Of the sixteen participants, only one was male. This was not unusual nor was it unexpected as historically the nursing profession has been and continues to be embedded in gender politics. The separation of genders in the nursing profession is largely based on the social construction of what is women's work. Patriarchal notions of respectability and

proper roles for women shape the description of nursing as women's work for women (Johnson 2015: O'Lynn & Tranbarger 2007).

Nursing as a profession is founded on ethical principles such as caring and nurturing - universal values that societies predominantly attribute to women - leading to relatively fewer males entering the profession as compared to females. There are many reasons for this skewed state of gender distribution in nursing. In their book O'Lynn and Tranbarger (eds. 2007) discuss and address how gender issues in nursing act as barriers in nursing education and practice of male nurses. The issue of gender disparity in the nursing profession was not dealt with in this study as this is beyond the scope of the study.

## 3.7 CONSTRUCTION OF INTERVIEW QUESTIONNAIRE

The question "how does the commodification of healthcare impact on the caring practices and relationships of nurses in a private healthcare facility" informed this study. I used an interview questionnaire containing a uniform set of nine open-ended questions to guide data collection during semi-structured interviews. Parahoo (1997:281) says, "Verbal communication is the most effective means available to humans with which to convey our feelings, experiences, views and intentions." Open-ended questions allow participants the opportunity to give detailed accounts of their personal experiences and

affords the researcher the opportunity to use exploratory questions to follow-up and probe the participants' responses for clarity (Bailey 1999:136).

The interview tool was divided into two sections. The first section contained two preliminary questions exploring participants' motivation for entering the nursing profession. These were used to identify and measure the nurses' motivation and commitment to core professional nursing values such as empathy, caring and compassion for others in need for relief from suffering as per care ethics dictum and Nurses' Pledge. These questions also served as icebreakers with the nurses as I did not know them – I was not employed at the facility and thus did not have a working or personal relationship with them. They helped me to establish a common bond with the nurses.

1) 'Why did you choose nursing as a profession?'

2) 'In your view what makes a good nurse/what are the qualities of a good nurse?'

The second section (see Table below) was designed to identify challenges and opportunities when working in a private hospital environment and to demonstrate how this environment influences nurses' interactions with patients. These questions were used to illuminate the nurses' job satisfaction, which could be used as the means to measure their commitment to practicing in an ethical and professional manner as per core nursing values such as autonomy, integrity and the preservation of human dignity of individuals etc.

**TABLE 1: INTERVIEW QUESTIONS**

1. What do you like and dislike the most about your job?
2. What is it like working in a private hospital environment?
3. How does your work environment influence your interaction with your patients?
4. As a nurse, how important is it that you feel an emotional connection with your patient?
5. What would you consider as inappropriate behaviour from patients and how do you manage it?
6. How do you set professional boundaries?
7. Do you think your training has sufficiently equipped you to meet the demands of your profession?

Interviewing the nurses allowed me to explore areas of interest for the study. These are professional nursing practice and nursing ethics in a commodified environment in order to illuminate any ethical implications created by this tension. Based on the nurses' responses I used probing and iterative questions to ellicit detailed responses.

## 3.9 DATA COLLECTION PROCESS

One of the key characteristics of qualitative data collection is direct observation of the study within their natural setting. The data was collected

using narrative data collection methods such as interviews over an extended period of time. The data is analysed using interpretive techniques to establish the meaning of the phenomenon being studied and why it occurs. According to notable authors such as Sandelowski (1999), Lal, Suto & Ungar (2012), storytelling can be a powerful tool to use to collect information when exploring an individual's or group's lived experience. For example, in his book *The Wounded Storyteller: Body, Illness, and Ethics* published in 2000, Arthur Frank employs narrative theory to analyse stories on illnesses. The data gathered using this approach are usually non-statistical and text-based resulting in a thick narrative description of how people live and experience life.

On my first visit to the facility, I explained the study to the unit nursing managers. I also explained their role in the study – facilitating the recruiting process by identifying suitable and willing participants for the study. I allocated at least an hour for each interview to allow participants enough time to discuss and share in detail their views, opinions and experiences. This ensured that the interviews produced data rich in information in order to have an in-depth understanding of the impact of commodification of healthcare on the nurse-patient relationship (Creswell 2013).

The hospital's nursing services manager advised me to set up interview times with the nursing unit managers for each unit concerned. In addition to this and with the permission of the unit managers, I only conducted interviews during tea/lunch times or when the wards were not busy. This was to ensure continuous patient care and safety. For instance on three occasions I had to

reschedule, as it was not possible for nurses to accommodate me due to various reasons such as heavy patient workload and shortage of nursing staff in the ward.

## 3.10 ETHICAL CONSIDERATIONS

Researchers have a legal and ethical duty to safeguard the dignity and humanity of participants. Dhai and McQuoid-Mason (2011:70) describe informed consent as a participatory "considered and continuous" process based on mutual trust and respect. Thus the study was explained to the participants beforehand and throughout the course of the study. On agreement to participate they were asked to read and sign a Participant Information Sheet (APPENDIX C) as well as the relevant consent forms (APPENDICES D1 & D2). Issues of anonymity and confidentiality were addressed and reiterated in various ways throughout the course of the study. Participants were informed of their right to withdraw from the study at any point during the process, should they wish to do so.

All participants were assured of confidentiality as total anonymity and absolute confidentiality cannot be guaranteed as personal information may be revealed as a result of any presentation and publication resulting from the findings of the study and may be disclosed if required by law. In order to maintain anonymity, transcripts were coded and securely stored in separate locations only accessed by my study supervisor and me (Brink *et al.* 2012; Dhai &

McQuoid-Mason 2011). Participants were asked to maintain the confidentiality of the discussions. Patient care and safety were of paramount concern and always considered and prioritised during the study. Audio files were stored on a password-protected computer to ensure that the integrity and security of the data were maintained. On completion of the study all data will be securely stored in accordance with the university's policy (Brink *et al.* 2012; Dhai & McQuoid-Mason 2011).

### 3.11 INTERVIEW PROCESS

The study was first explained to and discussed with the nurses and consent was obtained from those who agreed to participate. The interviews were conducted on the 21st of July 2015 and the 26th of August 2015 at a particular private clinic in Johannesburg. I conducted individual, in-depth, semi-structured interviews using an interview questionnaire to guide the interviews. Whiting (2008:35) describes in-depth interviews as "personal and intimate encounters." Interviews were between four minutes and 1 hour and 30 minutes long and all were conducted in English. In the instance where the interview took four minutes, I had to terminate the interview early as it became clear during the interview that the participant was not comfortable, even though she had verbally agreed and signed the informed consent forms beforehand.

Before and during the interview process participants were made comfortable and encouraged to describe in depth their perceptions, feelings and experiences about working as private healthcare facility nurses. The interviews were conducted in a private side ward or the nursing unit managers' offices, depending on the ward activities on the day. A private space creates a comfortable and relaxed atmosphere conducive to intimate and honest discussions and ensured the protection and maintenance of their confidentiality and privacy. All interviews were digitally recorded and transcribed verbatim using professional transcription services.

## 3.12 DATA ANALYSIS

The aim of data analysis in qualitative research is to discover patterns, concepts, themes and meaning in the data to produce themes from the collected and analysed data. This iterative process typically begins during the data collection process (Bailey 1991:158-159). Lincoln and Guba (1985) stress that ensuring trustworthiness of a study is vital for assessing the value of the findings of a qualitative study (cited in Babbie & Mouton 2001:276). The data analysis for this study was based on the ethics scheme derived from the nurses' pledge of practice and care ethics was conducted to identify, explore and interpret important underlying themes on the commodification of healthcare, the nurse-patient relationship and ethics in nursing practice (Babbie & Mouton 2001; Bailey 1997; Brink et al 2012).

I repetitively listened to the recording of the interviews and read the interview transcripts to reach an overall understanding of the data. I proofread the transcribed data by reading and simultaneously listening to the recorded interviews. The idea behind data immersion is for the researcher to address relevant questions about the collected data in order to establish the underlying meaning in the data. The researcher may ask themselves questions such as what is important in the data and why is it important? I then identified, extracted and collated words, phrases, sentences etc from the collected data in order to gain possible meanings, differences and relationships in the data. The parts relating to the nurses' experiences of working in a commodified healthcare environment were thematically analysed, anonymised and coded to establish what the interviews revealed about the impact of the commodification of healthcare in private nursing settings.

The data was then thematically grouped around the focal point of clinical nursing practice with a focus on patient care and specifically a strong emphasis on the quality of the nurse-patient engagements during hospitalisation. Additionally, the findings were critically examined against existing local and international data using the South African Nurses' Pledge (APPENDIX E) as the standard care ethics framework. This illuminated ethical issues relating to the nurse-patient relationship in privately owned healthcare facilities.

## 3.13 STUDY RIGOUR

There are four elements used to judge the quality of the research design, methods and findings. These are credibility, dependability, conformability, and transferability (Babbie & Mouton 2001:276-278). The rigour of a study in qualitative method approach refers to “openness, relevance, epistemological and methodological congruence, thoroughness in data collection and data-analysis process, and the researcher’s self-understanding” (Brink *et al.* 2012: 126). The adoption of established qualitative research inquiry and data verification are important to promote confidence and trustworthiness of a scientific study and to promote confidence in the study, that it accurately records the phenomena under investigation. Before commencing with the study I conducted a pilot study to test the content validity of the questionnaire to be used in the study.

I used qualitative research methods to explore the impact of commodified healthcare from a care ethics perspective in order to illuminate the ethical implications of nursing-patient relationships in a private healthcare setting. The participants were interviewed and the interviews digitally recorded to as a quality measure to ensure the credibility and dependability of the collected data. The interviews were conducted over a period of approximately six weeks. Allocating sufficient time to collect data adds to the reliability of the study. As the data was gathered using a purposive sample (in one facility) the construct of transferability may not be fully met, as the information

obtained from this site cannot be generalisable to other similar settings. Instead the study illuminates the ethical impact of the yet to be fully understood phenomena of commodification of healthcare on nurse-patient relationships in private healthcare settings.

## 3.14 SUMMARY

This study explored and described nurses' experiences and understanding of commodification of healthcare, nursing practice and the nurse-patient relationship in a commercialised environment.

# CHAPTER 4

# STUDY FINDINGS

## 4.1 INTRODUCTION

This chapter presents and discusses the findings of collected and analysed data from semi-structured interviews conducted with clinical nurses in a private healthcare facility in Johannesburg. Nurses employed at a private healthcare shared nursing care incidences and experiences they viewed as having being influenced by their work settings and described how they dealt with them. The chapter presents data to address the study question “how does the commodification of healthcare impact on the caring practices and relationships of nurses in a private healthcare facility”?

As discussed in the preceding chapter, the interview transcripts were thematically analysed from a care ethics perspective. The thematically grouped findings were collated into five themes covering nine subthemes based on answers from questions as per the interview guide discussed above. The study and its findings highlighted how these overarching issues affected the nurses’ everyday professional practice and illuminated the ethical atmosphere in their work environment.

## 4.2 FINDINGS

The intertwined emergent themes on professional conduct and work climate were thematically categorized and addressed under different themes:

- **professional practice** focusing on nursing as a profession of choice and the art of nursing and nursing ethics as influenced by the Nurses' Pledge.
- **nurses' lived experiences** focusing on nurses' perception of how a commercialised work environment impacts on their clinical and caring practices.
- **relationships in nursing, focusing** on how nurses apply the principles of care during their interaction with others. Does a commercialised environment allow nurses to practice their profession with conscience and with dignity?
- **expectations focusing on** patients' and management's expectations of the nurses and facility and patient, and nurses' expectations of management and patients. What factors interrupt the nurses from carrying their caring duties during nursing interventions and focusing on communication and mutual respect

In the nursing profession caring is central for the delivery of high quality nursing care. Nursing is a caring profession, existing for the relief of pain and suffering. Nurses pledge themselves to the service of humanity.

Care ethics theory provided the study with boundaries and guided the research stages such as literature review, data collection and analysis. Each of these themes is discussed separately below with a number of sub-themes.

### 4.2.1 THEME 1: PROFESSIONAL PRACTICE

Understanding why participants wanted to be nurses provided a key insight into how they viewed their role as caregivers. Through understanding their motivations to study nursing and the issues that they valued and prioritized as nursing professionals it was possible to structure a clear picture of how they positioned themselves within the nurse-patient care relationships.

**Subtheme 1: Motivation to be a nurse**

Participants were asked what or why they were motivated to "chose" nursing as a profession. They gave various reasons some of which were emotional, with some participants referring to nursing as a "higher calling." This group put forth altruistic reasons such as wanting to work with and help people as motivation for entering the profession. Almost 86% of the participants reported that nursing was not their first choice as a career. Even those who gave altruistic reasons for entering the profession reported that they started in different careers before entering the nursing profession,

P3, an enrolled nurse working in a gynaecology ward, referred to nursing as her true purpose in life. She describes how she initially disregarded this calling and how it took a very personal loss for her to finally realize what nursing was to her. She says, *"…it sounds like a cliché, but for me looking at my life, it is my calling, I can't deny that. It is something that I am supposed to do because I can do whatever else, I never feel fulfilled."* Similarly, P1, an enrolled nurse in an oncology ward, said she abandoned her business to take

up her “spiritual calling” to be a nurse “ …*actually nursing looked for me. Truly it looked for me...it enlightened me.*”

P2, an enrolled nurse working an oncology ward, revealed this about her self *“I always liked nursing growing … I was the first one to help with passion, I wouldn’t complain…that’s when I noticed, ah I have passion for this I can do this thing. I like helping…”* In contrast, however, some of the participants said they never wanted or desired to be nurses but were forced by economic and social circumstances into the profession. For approximately 7% nursing started off as just a paying job. Explanations for this position included an available and easily accessible career, a ticket out of their dire economic and social situations - they saw nursing as a means to an end. P13, an enrolled nurse working in an ortho-surgical ward was the only male participant in the study and was the most straightforward about his motivation for entering the profession *“… to be honest with you…I wanted a quick way of making money…”* And for some it was just another stable career choice. *“I was always interested in medicine…my dad used to attend to (participant’s brother’s) wounds and I used to see them heal and all that…so I felt that nursing was not such a bad thing… “* P14 a registered nurse works in a surgical ward. This group was also more vocal on the shortcomings of nursing as a salaried profession.

About 7% of the participants had wanted a different career for themselves. P15, a charge sister in a surgical ward said, *“… it was not my choice in the beginning… I always saw myself as this CEO…”* P6 an enrolled nursing

auxiliary in a medical ward says she had dreams of following in her father's footsteps as an auditor but after matric she realized that her heart was not in auditing. *"But then after completing my matric, it was, like, no, I really, I had that love for nursing like looking after, like I was thinking maybe I only got love looking after older people, you see.* She reports that she soon realized that she really enjoyed being a nurse. *"But then when time goes I was like, no, I really like looking after older people, to look after people, sick people and up to so far I am still enjoying it. But not the pressure, if there is no pressure I enjoy."*

Nursing is a relational practice that relies on personal values of the individual and thus the adoption of globally recognised nurses' pledge and observance of legally set professional standards ensures congruity between personal and professional values. The nurses' pledge is the nurses' promise of their loyalty to the profession and to their patients and communities to serve them with honest and integrity. This promotes and maintains competent, quality and safe nursing care. Therefore understanding the participants' motivation to be nurses provided the study with insight and meaning as to how their conduct as caring professionals was challenged by commodified healthcare environments.

**Subtheme 2: Traits of a good nurse**

Participants were asked to list the traits or qualities make a good or exceptional nurse**.** These included being a good listener, communicator and team player. They described a good nurse as someone who is

compassionate, empathetic and helpful. They identified a good nurse as someone who is intellectually curious, able to work under pressure, in a team and independently, someone with an easy and ready smile who treats patients with dignity and respect. P 16 (RN) said *"you needed to have everything when it comes to nursing."* She listed principles such as *"passion, patience…"*

P 14 described a good nurse as someone with "…*good interpersonal relationship you must be able to love other people unconditionally and you must treat people as individuals… just treat a person with respect…"* For P 3 a good nurse is compassionate and truthful "…and always being friendly to people and participating teamwork and stuff like that…" Participant 16 a registered nurse in a gynaecological ward said her *"…my dignity, my appearance, my respect… to people around me. And helping when they need help…you know what to do"* made her a good nurse.

In this way, all the participants clearly highlighted a combination of professional, intellectual and *care-oriented* characteristics that they felt contributed to nursing excellence.

### 4.2.2 THEME 2: NURSES' LIVED EXPERIENCES OF COMMERCIALISED WORK ENVIRONMENT

Being able to enact the characteristics of a good nurse is, of course, a key element of nursing excellence. To this end, participants were then asked to detail their experiences of working in a commercialized healthcare environment. Participants gave a range of views - some good and some negative.

Most nurses described working as a private healthcare facility nurse as emotionally and psychologically demanding. Nurses reported that it was extremely stressful and the environment pressured with little compensation and or recognition. P7 was the most honest about describing this environment. She said *"working in a private environment, its the paper work that is involved, the complaints, the management end up nursing complaints and caring of complaints more than caring of patients. You find that the patient is complaining that the linen was not changed, not the linen is dirty, the linen was not changed. They won't change the linen, they will start first by fixing the problem saying, we are nursing the complaint more than nursing the problem, they will call you to come and discuss the complaint more than to say, no, Prudence [calling the interviewer by name to illustrate a point], please go do the bed linen first and then come, you understand what I am saying. They will firstly call you to discuss the problem before doing, fixing the problem."*

Participants reported that as a result of their work conditions they found it difficult at times to consistently render individualized quality care. Most of the participants reported that they found their environment disruptive to their nursing practice and that this adversely impacted on the care experience of their patients resulting in poor care or nursing outcomes. P2 had this to say, *"… in the private sector, you are working for the patient, you are not caring as such because they will tell you, I will complain, I will take you to head office, so you are actually nursing the complaint more than you are nursing the patient. The problems or what the patient needs, you end up nursing the families complaints more than nursing, you end up nursing the budget more than nursing the patient, you know. Like, you don't care, you end up nursing, not that we don't care, it is just that there is a lot of things that are put in, then it deprives us from giving the best care that we can, there is a lot of people that are involved, there are a lot of things that are involved more than the care. So it is more, logistics than doing the job its self."* P6 adds, "…*sometimes we feel like we nursing papers because, you know, you have to do everything… if something is not recorded, it is not done, so we have to push more to do everything, update everything on papers."*

**Subtheme 1: Patients conduct and bad attitudes**

A patient with a positive attitude collaborates and responds positively to caring practices and gestures by the nursing staff and other members of the healthcare team. Most of the participants voiced concern about some of the patients' attitudes. *"They thinking that they are in control because they are*

*paying medical aid, they are thinking they are in control because they are in a private sector, they thinking that they are paying our salary because they are here, and then we are, like, just somebody, we have to follow whatever they are saying because they are giving the money they are paying. And we always tell them, no, you are not paying our salary, you are paying the hospital, not my salary, but they are under that impression that, no, I have got the power because I am in a private*" said P8.

P2 said *"I think patients, some patients come with the mentality that I am paying, they need to do everything for me because I am paying. They come with that mentality that I am paying, you can see some of them, this one has got that attitude of, I am paying, even a person who can walk, come and help me here."* Describing a patient's attitude and how it made her feel, P1 said*"… but it will end up, like, affecting you emotionally, because with the way they will demand a thing, and maybe, let's say, okay, I don't know but I was, she was just so mean, she started calling me names…but she started swearing at me and all that, and you know, sometimes you are also, you know, at your worst point. Though I did not respond, but it fully troubled me*." P7 *"They just come and tell you that I will report you, I know where to, they even tell you the name of the hospital manager. Like when they get here, they tell you, I know the person who is in charge of the whole -names facility-, so if you don't treat me, they even threaten you in that way that if this is not done, I will report you.* And on how these attitudes affect them she says*, "...sometimes you just feel like, you know what, I want to pack my bags and leave, I would rather stay at home than be here."*

P8 explains how patients cross professional boundaries, she says they go as far as passing comments with sexual undertones "...*they will say, yoh, but your bums or eyes, yoh…I wish I could touch those things.*" She says these patients "*will even bribe you and start buying you things and stuff" and when they do not return the favour the patients get abusive by complaining about everything in the ward."* She says she feels unprotected and powerless " *…he was doing this now-now and he's not allowed so you tend to feel and say, okay, you have no leg stand on, we had to let it go, and accept he is always right, he is the client, he is paying money to the hospital. And you are a nurse and you will have to* [inaudible]…"

**Subtheme 2: Patients' lack of respect for nurses'**

P2 says the level of respect the nurse will get from the patient depends on the type or quality of relationship she has with that patient. *"You know, but then depends on the relationship you make, because the patient can come in knowing, I am a client here but if they meet me in the ward and the relationship that I make with them, do I make her feel as a client or do I make her feel as my patient, as my friend, you know. I think that depends on the relationship, you as a nurse make with your patient/client."* P3 concurs with P2's sentiments "*For me, if I show respect then I always get respect back. I have never experienced any patient where I have shown respect and that person was disrespectful towards me. So it also, you are the one that is starting the interaction, whether it is a shift change or whatever, and this is the first time I am seeing this person, the way I interact with that person the very first time I see them, it is going to, it sets the bar for that person's reaction."*

P11 says she teaches her staff about the importance of creating and maintaining professional boundaries when interacting with patients. She says this ensures that the nurses and the patients maintain their respect and dignity *"… I am always teaching them don't go overboard because the patient can always turn around, we never know and then tomorrow you are the bad person. So have that boundary to know where to stop when you are speaking to a patient."* P16 reported that some patients crossed the boundaries of a professional relationship irrespective of the amount of respect they are afforded by the nurses. P16 explained, *"they reach a point where they can become vulgar…they don't understand they will be like, I'm paying for this service you need to do, you know what, they think you need to do (what they want)."* As a result they find it challenging to establish and nurture intimate professional bonds with their patients as required by their profession.

**Subtheme 3: Lack of appreciation and understanding of each other's role in the care of the patient coupled with interference and rude behaviour from patients' relatives.** Identification and discussion of private healthcare concerns with caring healthcare professionals in these settings is important in order to understand realities of commodified healthcare environments. Nurses as healthcare providers are faced with the ever-rising ethical challenges of this work environment on a daily basis. Therefore these need to be investigated and monitored in order to safeguard and promote nursing values such as autonomy, moral agency, human dignity, and stewardship of the profession.

Participants related stories of an unsupportive and uncomfortable work environment with strenuous relationships. P6 describes the important role of effective communication with management "…*But if you not like others, they don't talk, they don't tell her, they are just drowning, if you don't communicate, if you don't talk to her at the end of the day, your patient is suffering, that is why we get more complaints. Because if you are not coping, you are not going to give your all to your patient, that is when you end up getting more complaints."*

P1 related how challenges in her work environment make her feel and their impact on her wellbeing. "*I don't even want to lie, I was not coping, it was just, I think it was emotionally draining to me. It was more than I expected, because you could be slapped, you could, like, they will talk to you like you are nothing. That was just way too much for me. I don't know."*

*P3* succinctly summarizes her feelings *"… I need all my strength, all my courage. You need to pray."* For some the situation can be unbearable at times. P16, a registered nurse working in a medical ward *"… It makes you feel like leaving nursing totally."*

They also described how patients', families, doctors and management's expectations, attitudes and behaviours affected their relationships with them and inadvertently their work. P7 said the effect is that *"It is not nice at all, you just feel like taking your bag and going, you just feel like, you know, I have done so much for this person but this is only what I get. And you work so hard and then there will be people that just come to you and say, this is what*

*you didn't do, and you only slipped once. And that once can take you into big trouble, that is the sad part about it." P8,* a registered nurse in a medical ward, goes on to describe how the doctors are not always available and the nurses have to take charge and are responsibility of both the nursing and medical care for the patient. She says this negatively impacts on their ability to safely and successfully carry out their duties as per their nursing scope of practice.

### 4.2.3 THEME 3: RELATIONSHIPS IN THE NURSING PROFESSION

There is compelling evidence that the health and optimal wellbeing of patients is intimately linked to the quality of their relationship with their healthcare providers. A harmonious relationship facilitates an ethical environment from which compassionate and safe nursing care can be rendered. It is important to recognize that care relationships, while bidirectional, are not exclusive to nurse and patient. Indeed, as part of maintaining the bond of care between nurse and patient, both parties have to mediate with influential stakeholders. For nurses this could be doctors, supervisors and other healthcare personnel, while for patients it includes family members. Failure to protect the interests of the other party in these stakeholder relationships can severely damage the care relationship.

**Subtheme 1: The nurse-patient relationship**

On a daily basis nurses engage in numerous relationships with patients, their families and various members of the healthcare team in their quest to carry out their nursing duties. The nurse-patient relationship is patient-centered and provides nurses with a context for professional caregiving, which is the heart of nursing practice. This helping relationship is characterized by principles and values such as compassion, empathy, mutual trust and respect. Its defined and governed by professional boundaries with the aim of protecting the patients' rights and dignity. P3 speaking on the importance of this specialized relationship, *"It is very important, not only for you to be able to do your job but also for them, how are you going to cultivate the environment where the patient listens to you and does what you tell them… so if you don't have a nice relationship, that patient is just going to think I am not going to take that medication, and then when the Doctor comes, he is going to say I didn't take it, and you are going to say, no, she took it and then you are going to have conflicting stories. So in order, it is more beneficial for the patient, but for you as a nurse, it is beneficial for your working environment."*

A good quality nurse-patient relationship positively contributes towards patient satisfaction and professional fulfillment in the healthcare professional. Patients' core values such as compassion, effective communication, responsibility and accountability for their health influences their attitudes towards nursing care and the quality of the nurse-patient relationship. The absence of values such as kindness and civility from the patient creates moral tension resulting in moral distress for the nurse. Moral distress may result in

nurse burnout a significant concern for both the nurse concerned and their organisation as it negatively affects caring practices in these environments. P8 says she values an emotional connection with her patients as it opens-up and frees their intercommunication she says it allows patients to be comfortable with the nurses and their work making the caregiving and care-receiving experience a pleasurable experience for both nurse and patient. She says "*they get to be more open with you with certain things, they become to trust you in a sense that they will tell you things that they cannot even tell their families*…"

P13, on the important role of this relationship "*This is the one thing I do with all my patients. I build a relationship…once that little bond is formed its easy for the patient to tell me almost everything uh but its easy for them to communicate with me*…" P11 says she teaches her staff about this relationship and its role in their practice. *"… create this patient relationship, communicate with the patient, make the patient at ease…most of our patients are comebacks, …they become good friends with the patients and that is only happening because the patient is always doing that to them…It is important because… they have a trust in you, they have faith and trust that this is a person who has got compassion for what I am doing through* …"

P2 describes her relationships with her patients as more of a friendship as they even share intimate details of their lives with her. *"... Yes, they are able to say anything to me, you know, because some of them, you will find they tell you stories about home, because now they have seen that, you know, this*

*person I can talk to and some of them will even say, I have never told this thing to anyone, you know, especially when you work night shift, when there is time, someone will call you to come and sit and then they will tell you, others newly diagnosed, they will tell you how they feeling, blah, blah, blah. We do make friendship with our patients hence it is so sad if someone passes away because it is someone we have known for a long time and all of a sudden. You know with cancer patient, a person can be fine, fine, fine, and then all of a sudden complicates today and then the next day he is dead, you know, it gets so sad when our patients die."* Besides describing their relationship with their patients participants also narrated stories of the other personal interactions in this environment and how these relationships acted as intangible barriers to nurses forming solid relationships with their patients.

Participants explained that they did not like to refer to their patients as clients as it challenged the way they see their patients. P7 explains "… *now you are thinking this is like Spar Supermarket, you are a teller now because you have got customers. Because now you don't do the care anymore, there is the care but you don't do optimal care that you wanted to do because now you are nursing the client. The client needs to be made happy, the client needs to do this, the clients are complaining because of this, so you end up thinking now, we are nursing papers now more than papers, you understand?"*

Such vignettes demonstrate the importance that all the participants attached to a patient relationship, and the benefits they identified from cultivating these bonds.

**Subtheme 2: It's all professional – nurses' collegial relationship with doctors**

Some of the participants reported doctors' attitudes as having a role in how they experienced their work. P8 had this to say about doctors "…*they got an attitude whereby it is, like, if they are in a good mood, you will hear them like a loud speaker when they enter the gate, that be warned doctor so and so is not in a good mood today so wherever he is going to enter and come out there will be a problem, he will be looking for problem and trouble.*"

P4 a registered nurse in a gynaecology ward describes doctors' rude behaviour as one of the least favourable aspects of being a nurse *"…they wont even listen to you sometime they just leave you and go straight to management*." She describes how such behaviour from doctors mars old and new relationships with their patients and killed the nurses confidence and the patients' confidence and trust in the nurses' professional abilities. P8 says, *"they will have a little issue against you so then you stand then, like, to lose that thing of, okay, now I don't want to work in those rooms."* She says the patients then start to question your judgment and competence, *"… because now they know that somebody has called you stupid what-what in front of them… the trust and the communication and that things, it is going to be gone. The respect for you, it is going to be gone, so now every time you walk in, it is like they don't even trust you…" P4* says this negatively affects their professional relationship with patients.

**Subtheme 3: Relationship with management**

The ethical climate of nursing work settings and how it influences their caring practices remains underdeveloped. A majority of the participants reported that they felt like management revered patients' opinions and prioritized hearing their voices over theirs thus making their demands uninfringeable. They said they felt like management puts them under pressure irrespective of their professional responsibilities and obligations. They say they are expected to meet the patients' demands at all cost disregarding their own physical and psychological safety and wellbeing. And in the process compromising their work environment's moral habitability. Peter, Mcfarlane and O'Brien-Pallas (2004:358) describe morally habitable environments as work environment that promote and safeguard the general, professional and moral wellbeing of the individuals occupying them.

P10 an enrolled nurse in a medical ward reports, "*actually in private they say patient first…they want more (management) and they are getting more sometimes we feel that we need to be paid more*." P8 adds, "*Even if you like, have an incident whereby the staff member is beaten by the patient, and then you call the area manager then you find instead of her siding with you, she will side with the patient.*" She says this "*happens so often…sometimes I used to think that maybe the management involved doesn't like the staff member that was in question or having a problem. Or else you find that the management is buddy-buddy with the doctor…and they would rather take the side of the patient because they are scared of the doctor."*

P8 describes tensions within these relationships and how they affect her at work "…*that we have different managers that, who will piss you off from the start, like, you decide when you wake up in the morning, you say, oh gosh, do I really have to go on duty or do I have to stay, then you just pick up the phone and say, no, I am not coming in, no, I want to extend absent, and you phone sick. It's things that happen, because then you're off, like, a day, you know, the peoples' attitude and stuff that you working with. So sometimes also, I need a support system from colleagues and then from the managers, it also helps to motivate you to wake up in the morning to say, no, I'm looking forward to go work at my hospital, because this is what I'm coming for. Like, and when you find things that are negative, then, ja. Some things you can't control."* She adds, "…*I hate nursing, only when it comes to the fact that you get blamed for something that you didn't do, or people don't recognize you, or the least that you've given the patient, then it's something that I don't like about it, because then very rare will you find somebody saying thank you, or something like, okay, well done, whatever, but every time there is something or negative impacting in your department then you get blamed, so something like that."*

Creating a healthy work environment based on the protection of human dignity and maintenance of mutual respect is an important factor in the healthcare sector. Loss of these values creates unsafe work conditions and can cause serious degradation to human dignity and mutual respect, negatively impacting on the nurses' optimal functioning as caring professional. In their 2004 report, Peter et al (2004:359) found that "…participants

overwhelmingly portrayed nursing work environments as oppressive across multiple dimensions, describing situations of powerlessness, exploitation, marginalization, and physical and interpersonal violence." Therefore understanding the impact of contextual challenges and adversarial relationships in a work environment is valuable when auditing or judging the professional quality and standards of caring nursing practices.

**Subtheme 4: Relationship with patients' relatives**

Almost all participants raised concerns about the relatives' negative attitudes and poor conduct. P2 revealed this about relatives "*Relatives! Ah relatives are something else. I think relatives, they are sometimes more than patients because sometimes you get along with the patient, he understands his medication, he understands everything, then comes a relative, why this is not done."* P3 shares an example of a typical encounter with patients' relatives *"you need to put up a catheter. You can't have the whole family standing here because you must also think of your patient's privacy, because there might be someone there that she doesn't necessarily want to see how we put up a catheter, you know… and then you will find some will say, no, I want to be here, I have the right to be here, this is my sister, this is my whatever. Now you explain, yes, you have the right to be here, but this is, you know, your patient, this person is your family member but they still have the right to privacy, I need to enforce that because it is my patient's right and the patient's right supersedes anyone else's rights at that moment. But they, sometimes they make it difficult for you to get that message, it is like they just don't care."*

P3 says, "…*they think that because my family member is paying to be here, I can just do whatever I want, and sometimes they are really disrespectful towards the nurse."*

P2 acknowledges the fact that there will be patients/relatives who will disrespect the nurses regardless of how professional and principled they conduct themselves. She says, "*And some of them come, like, okay, I wouldn't say older people, but, you know, patients who, maybe of the same age or something. They will come, like, my profession is more important than this nurse so she can't tell me, you know, that attitude that I am better than her."* P4 attributes this attitude to the misguided belief they have about nurses and their duties "they think you are not doing anything for their relatives." *P2 adds, "Why blah, blah… the patient will apologize…and then the other day we had the son of the mother. The mother died and the son was like, but you do treat other cancer patients, why my mother, why did she die so soon."* She went on to narrate a story of a patient with a hard to please relative *"…the other relatives were right but his son, every time he came here he would swear at us, tell us, you are useless, what are you doing. How is my father getting worse when he is in hospital, he was better when he was at home. It was like that, yoh, every time and the family would always apologize for his behaviour, every time he comes in the hospital we would go with securities, because we will phone security because now he wants to, like, strangle us."*

Abusive and disrespectful behaviour from family relatives creates challenges for safe rendering and continuity of quality nursing care. Some relatives

display unqualified lack of trust in the nursing staff and their capabilities, which can ultimately create barriers in care relationships. High quality communication between the nurse and the patient's relatives is essential for an effective nurse-patient care relationship. Respect for human dignity is a basic necessity for the intrinsic worth of all human beings.

### 4.2.4 THEME 4: EXPECTATIONS, EXPECTATIONS!

Effective care relationships involve not only mutual respect, but also empathy. To this end, each individual must be cognisant not only of their own desires, but also of the ability of the other party to fulfill them. Such fulfillment, it must be recognized, is not contingent solely on opportunity, but is a carefully balanced process of recognizing rights, responsibilities and reasonable expectations.

**Subtheme 1: Patients unrealistic expectations of the nurses'**

Participants described how they always have to work on their relationship with the patients to prevent negative feedback to management. Participants felt that the patients' expectations and behaviour were directly influenced by the hospitals' business model and this had an impact on how they (the patients) interacted with the nurses. P12, an enrolled nurse auxiliary in a surgical ward, *"…there is this tendency, people who have got medical aid, they always telling you what they want, I don't know what kind of a treatment they are expecting. Like whatever they must be given, they forgot that everything has got rules*

*everything has to be given at a certain time. There is no medication that you can get after 30 minutes, 10 minutes, you understand? And, uhm, I am also taking care of a patient, I can't just sit next to the patient, it is like they are expecting high which is impossible… They have got this money, they are private, I am going to get everything I want, you understand. So the nurses have to be there, you have to be available, yes, we are available, we have to go and be available to another patient, you rotate, you come, are you still okay, no pain? Like that***."** She adds *"…but those who are like where is the nurses, it feels like you must always be closer to him or her, and which is, you can't do that. I can't just be close to the patient doing what, looking at the patient like this, I have to do what I am supposed to do according to my scope."* P 3 (EN) explains*, "…any private sector is customer based, client based, so you always have to please the customer or whatever. So whatever the customer says is right, so for having said that I get that the customer is always right…the customer has more say so they can complain, they can do whatever… So I will go there and I will demand that xyz and they will have to deliver, because that is what is says in their mission. Their mission statement allows me to make those demands."*

*P2* says some patients like to remind the nurses that they are paying to be in the hospital and what they are paying for or expect in return *"I can't waste money and not get help, you know… just to make sure that every time they remind you, you know, I am paying, I am paying, you must do this. But some of them mean well, some of them don't even say that, you know, you get some patients that are so sweet..."* She says her response is "*I say, yes, I*

*know you are paying, I will do everything according to my, you know, limits, I will do everything according to my limits. It is fine, I know you paying and I am sorry if you are not satisfied. Always be down and apologize if you are not supposed to do that (what the patient demands) try to make a way, you know, to explain it nicely, I can't do that, it is beyond us, if ethi ufuna amaseniors - if they want the seniors, okay, fine, I will call them for you."*

Some of the patients' demands were perceived by the nurses as unreasonable and inconsiderate of others P7 an enrolled nurse working in a surgical ward making an example, "*… I was given my medication late, or I gave or I rang the bell and it was like four minutes then nobody was here, forgetting that one person is allocated for 10 patients. And if you are ringing the bell and the next person is ringing the bell, it doesn't mean that I am sitting, I am still attending another patient. Like, those are the complaints, not that medication was not given…"* P 3 also feels passionately about this issue, "O*h the patients' demands, they always exceed. No, in honesty, you do find patients that are demanding and the things they are demanding is not like, it is life threatening that I need to stop whatever I am doing right now… But patient demands for me, you know, it is a hard one because in private sector, there is no such thing that is too small or irrelevant, everything is a major thing* P2 adds, *"They know things, they are educated, they know their rights."*

When asked about patients' expectations P1 responded with an examples of an incident with a patient "*…A patient wanted margarine, and the hospital was providing butter, so I was trying to explain to the patient that, there is no*

*margarine, there is butter, but I can talk to the hostess, she could not even, like, want to listen to me."*

Commodified healthcare misrepresents the nature of healthcare practitioner's duties and obligations. This challenges patients' understanding of caring professional relationships resulting in the arising of ethical conflicts as a result of the different medical values and business values found in these care settings. With these changes, sick individuals are recognised as patients and as consumers. Commodification of healthcare has the power to interfere with how patient and nurses relate to each other as they bring different sets of values into their care experience. Failure to recognise nurses as professional and lack of mutual respect may result in friction and mutual animosity negatively impacting on the nursing care rendered and received.

**Subtheme 2: Managements' expectations**

Management is too demanding and unsupportive – expecting nurses to fulfill their nursing care and services with as little as possible e.g. wards are short-staffed resulting in missed nursing care. P2 says management in private healthcare facilities has high expectations of the nurses "*management are the ones hiring us, so if my employer is happy with my work, I still have the work…and management again on the economical side, I can say maybe they push because they don't want to lose clients…."* P3 (EN) had this to say about the organization's and management's demands on nurses "…*sometimes it is because, you know, as a business, they are very focused on covering themselves in all these legal, all these things. So you have to work within their*

*framework and sometimes helping the patient, which you are the mouthpiece for, you are unable to do that because you are looking at, like, you know, the company expects this from me."* She goes on further to describes how these expectations impact on her ability to do her work *"But this person needs something totally opposite to what the company wants, how am I going to because within my scope of practice, it says I am the advocate for this person. Are they going to listen to me and give me what my patient needs, since I am speaking on behalf of the patient, you know, sometimes they going to tell you what the costs, and a lot of those things, like their budget doesn't allow them to give you what your patient needs at the moment. So it is like financial constraints, it sometimes prevents you from really advocating for your patient."*

Describing her typical day P8 says, *"I am looking after 10 patients with one nurse but at the end of the day I must smile from seven-to-seven…" She also* related an incident involving a male patient who verbally abused her using racial slurs and threatened to physically assault her with a dustbin. She reports that she wanted to lay criminal charges against that particular patient but management discouraged her from doing so and discharged the patient.

P14 had this say about management, "*The one thing that I don't like is the treatment from the upper hand. Because yes, we do this work but it is thankless, you just do it but you are not getting as much credit as you should be getting, like the way you are working."*

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Nurses are dedicated and committed professionals and managements' failure to recognse them as such interferres with their duty to serve in dignity and to competently help those who are suffering.

Due to the nature of their work, as caring professionals, nurses are expected to always respond with compassion and empathy to their patients' needs. They are expected to form care relationships based on trust and mutual respect even in arduous conditions. This expectation to care strips them off of their human dignity as entities with moral agents and as professionals. This vulnerability incapacitates them leaving them unable to form caring relationships with their patients, resulting in mutually unsatisfying caring interactions with their patients.

### 4.3 SUMMARY

The findings make explicit how the commercialisation of healthcare services transforms a benevolent relationship between the nurse and the patient into a morass of ethical concerns. As the sections above detail, the shifts in power that can be attributed to the patient-as-consumer and the hospital-as-a-business significantly impacted on the nurses' ability to form and foster caring relationships with their patients. Interestingly, a twofold impact can be identified from the themes above – both as the nurses felt they were not able to adequately care for their patients in a holistic fashion. Second, that the commercial environment detracted from the respect that the hospitals and patients should have been affording them as professionals. Together, this

created a difficult environment in which many participants struggled to maintain their own – and professional – standards of ethics.

# CHAPTER 5

# FINDINGS 2: BROADER THEMES

## 5.1 INTRODUCTION

Using the care ethics as a framework for analysis, it becomes readily apparent that the highly commodified healthcare setting caused considerable ethical dilemmas for nursing professionals interviewed. As evident from the results presented in chapter 4, this impacted not only on their clinical practice and ability to fulfill their duties of care. This chapter extends the findings of the empirical research, relating it more generally to discussions in care ethics.

## 5.2 FINDINGS ON COMMODIFIED WORKING ENVIRONMENTS

Participants described how their daily clinical practice is affected during interactions with patients, families and other healthcare practitioners, and how the highly bureaucratized working environment shaped these engagements. The findings are discussed under the following headings: the impact of commodification of healthcare on nursing practice, congenial relationships focusing on the nurse-patient relationship, organisational and interdisciplinary tensions and working in a commercialised nursing environment.

### 5.2.1 Impact on nursing practice

There is a general consensus amongst prominent bioethicists such as Solomon Benatar (2013), Edmund Pellegrino (1999) and Bernard Lown (2007) that commerce has become a fundamental and inescapable part of global healthcare. This transformation of healthcare has led to commercialisation of healthcare services and environments replacing healthcare ethics with market place ethics. Market place ethics and values place performance pressure on the corporatised healthcare organisations to financially deliver, exposing them to unethical clinical and business practices. These bioethicists lament the global rebranding of the patient as a healthcare consumer and how it has denigrated the moral value of healthcare and that of the ethical climate in which professional healthcare practitioners have to carry out their duties. They argue that healthcare should exist for the benefit of mankind and not be a commodity to be profited from. Benatar (2013:154) says commodification of healthcare has transformed "a caring, social function into a profitable commodity."

The findings of this study echo these concerns. The nurses interviewed reported that they found their work environment pressurised, demanding and at times demeaning. The nurses said they felt like they had to justify their being employed by giving the employer a good return for his investment by being extremely efficient and productive with as little human resources as possible. P2 said, "*You stretch yourself thin because you are trying as much as you can to assist your patient and keep your patient as comfortable as*

*possible and as happy as possible."* Such quotes strongly highlight the tension between the traditional duties of care and the emerging duties to market forces.

The need for financially profitable models of healthcare provision, and the worldwide shortage of nursing professionals together contribute to chronic staff shortages in many medical settings (Bateman 2009; ed. Geyer 2013; Rispel et al 2014). Indeed, private healthcare administrators attributed the high labour costs as some of the contributory factors to the overall shortage of nurses. In their submissions to the Competition Commission inquiry private healthcare, service providers stated that a large portion of their budget went into nursing salaries and argued that this contributed to the escalating high cost of healthcare in their facilities. For an example Life Healthcare reported that "labour costs accounted for more than 60% of its overhead costs in 2013" whilst Mediclinic said "nurses' salaries comprise 49% of its operating costs" (Watson 2015).

These issues were strongly reflected in this study. Of the nurses interviewed, the majority felt overworked, and under daily pressure to complete a range of tasks. Moreover, most of the permanently employed participants had less than five years' experience, with the exception of the charge-sisters, creating critical gaps in mentoring and skill transferal. As a result, many perceived increased waiting times, missed nursing opportunities and poor nursing outcomes as a direct result of a shortage of nurses on the clinical floor.

In a bid to reduce costs and increase profits these private healthcare facilities reduce non-productive paid nursing hours by hiring nurses or staffing their wards on an as per needs basis with casual nurses. Under utilisation of skilled personnel is also a common practice in these facilities. Participants reported that this practice compromises patient safety and quality care. They described how nursing care opportunities are frequently missed and how nurses end up rendering care they have time for, and not the care needed by the patients. P6 confessed that these poor work conditions even push others to lie about services rendered "…*you look at the time and its already 02h00 in the morning and then you didn't do this and the paperwork has to be done…."* She said to cover up some nurses cheat and record nursing care not rendered, "… *And you look inside and then there is no line for antibiotics, like, it is written and then if it is written it means it is done*…"

The nurses also described how administrative duties took them away from patient care and how they felt like they had to comply with the hospital's rules instead of meeting the care needs of their patients. These significantly influence the quality of caregiving and interaction with the patients. P7 explained: *"… if we can get less amount of patient load and less amount of admin, I am telling you there would be no complaints from patients, because you will be able to do all your patients care and be able to do your paper work. But because now you have got a large amount of patient and there is only one person looking after eleven patients, it is very difficult for you to render total nursing care, or to render best possible care ever because you are only one. That is the strain that we are facing in the wards."* She explained: *"… there is*

*a lot of paper work that we are doing, so you end up neglecting caring of the patient… end up concentrating on the paper work, because the paper work is the thing that gets you in trouble more than what the patient says. Because they need proof of what you did."*

From these observations and the results presented in the previous chapter, it would seem that commodification of healthcare services and environments increasingly alienates nurses from flourishing care relationships with their patients. This can leave both patients and nurses humiliated and demoralised. A perceived lack of compassion and care can also create anxiety and fear for both the patient and the professional healthcare practitioner, negatively affecting a patient's health outcomes (Cornwell & Goodrich 2009). Nursing is a value-driven professional. The nurses' pledge and the legally set nursing standards underpin the values of a harmonious relationship between the nursing profession and the society it serves.

The perception of these negative outcomes created ethical dilemmas for many of the nurses interviewed, as they felt unable to fully realise the beneficence and care they associated with their profession. Indeed, as noted by Cornwell and Goodrich (2009: 2): "[f]or many staff, such a desire may have been a motivating factor in their decision to enter the healthcare professions in the first place." These feelings of frustrated beneficence were further reinforced by a perceived lack of affirmation (or appreciation) from both patients and management. Caring is the praxis of the nursing profession. As personal values may be at variance with professional values, on completion of

their training, nurses take a pledge of service promising to serve with honesty and dignity for the benefit of humanity.

Most participants perceived patients as emboldened and not shy to voice their disappointment when they felt that their expectations and/or demands were not met satisfactorily. P7 gave examples: *" ...Calling you names you do not appreciate and them touching you and swearing at you. Swearing at you, calling you with ugly names, saying stupid nurse…"* P2*, enrolled nurse* noted: "*Here, if they complain, sometimes they will complain, no, but my thing, linen was not changed or my walker was not cleaned, maybe they will complain about the cleaners, they will complain to us that the cleaner didn't do this and this and this. And then sometimes you are employed, like, we do everything."* In this way, efforts of the nurses to establish flourishing care relationships in already difficult circumstances were thwarted by a lack of respect from the patients. Indeed, in many cases these relationships transitioned from instances of care to instances of self-preservation or complaint mitigation.

Participants in the lower categories such as nursing auxiliaries and enrolled staff nurses seemed to be particularly anxious about preventing or reducing the amount of complaints going to management from patients. P6 said: "*You know, we even try sometimes to solve the problem with the patient, like they won't even send, or go to maybe the management or calling our unit manager, we can just talk to the patient, make the patient understand and then come to an arrangement."* P6 added, "…*most of the time you will hear the complaints they write in after they are discharged …That is why even if*

*they sent an email or that thing, Hello Peter, or email to (names facility), they go back in our book (an incident report book) and then they said, okay, Mrs. who and who sent an email, she said she was not happy, from day one there was this and this and this and then our shift leader will say, okay, here is the book, here is this person's signature, every day she is saying she is happy, she doesn't have complaints."* Such observations are particularly troubling for the perpetuation of nursing as a care-focused profession in South Africa, as junior nurses in these situations develop a highly limited interpretation of patient care that they may pass down to subsequent generations of nursing professionals.

Ultimately, the fieldwork showed that many nurses find themselves taking actions they deemed inappropriate just so as to make the patients happy – thus undermining themselves both as healthcare providers and as care-oriented professionals. P6 described their typical patient as "…*very difficult, very difficult. I think we have to go all out to make them happy."* P3 said referring to the patient or treating the patient as a paying customer transforms the way she sees herself. She remarked that she considers herself as "…*basically client services. I am looking after the interests of everybody. But I am looking after the customer first*." This raises serious questions around the environments in which these nurses are working – and how they potentially take away their capacity to make ethical decisions backed up by professional expertise.

### 5.2.2 The nurse-patient relationship

A caring nurse inspires confidence and trust in the patient – elements that are imperative for creating a healthy and caring nurse-patient relationship. Lachman (2012: 21 (2)) says caring takes a compassionate and relational approach to moral reasoning with a strong emphasis on empathy and concern for the needs of others. A conscientious nurse has integrity, compassion and empathy for their patient irrespective of the patient's gender, social status, race or power. These professional virtues capacitate the nurse to positively respond to the patient's physical and emotional vulnerability as guided by her professional ethos (ed. Geyer 2013).

Nonetheless, within these intimate professional relationships with their patients based on compassion, trust and mutual respect, boundaries are of significant importance. The study found that nurses were torn between meeting their patients' needs as governed by their professional codes of practice and conduct, and meeting their employers' demands as per their employment contracts. This "slippage" of expectations and duties, and the continual re-negotiation of boundaries of acceptability between the patient and the nurses left many participants with considerable emotional distress.

Many participants felt that the patients' expectations as paying customers are venerated above the nurses' expertise and professionalism. Moreover, the lack of involvement by the hospital management in managing these expectations led to many relating what they deemed to be unreasonable

demands by patients. This included expecting the nurse to be at their "beck and call." Many participants related stories of patients who acted as if being in a private hospital affords them the opportunity to have undivided attention from the nurse and other members of the healthcare team - that skilled nurses were to account for their every movement to them as paying clients.

In this way, the poor management of the expectations of patients as paying customers negatively influenced the nursing care and services. All participants highlighted what they perceived to be unreasonably high expectations from the patients and their family members, and a punitive attitude of complaints when these expectations were not met. P7 explained: *"They will ask you how long I haven't seen you now, it is two hours, where were you, because they expect you to come sit with them, talk to them but they don't understand that you have got lots of work that you need to do, and you still want to sit with them but it is not possible."* She continued: "*They know about all these internet or social networks where they can complain, remember, they know about Hello Peter because in our boards when you go, I think it was in reception, they written complaint Hello Peter and Facebook page and all these things. So they are told where to complain, these people, they are told what procedures to follow to complain but they do not follow the right procedures, they skip the procedures."*

### 5.2.3 Organisational and interdisciplinary tensions

The lack of intervention by hospital management in mediating patients' expectations was exacerbated by a perceived lack of support as employers.

This resonates with other studies that suggest that situational factors such as "conflicting information about what the organisation expects from staff or what is valued in the organisation" can contribute to stress and burnout in the nurses (Cornwell and Goodrich 2009:5).

A healthy and safe work environment reflects a high level of compassion for patients' well-being and healing. It also promotes the nurses' emotional and physical well-being and preserves their inherent human dignity. Some participants reported that they generally felt let down by management's lack of support. The failure by management and doctors to recognise the nurse as a qualified and skilled autonomous practitioner creates tension between the nurse and these groups (Barlem, Lurnadi, Tomaschewski, Lurnadi, Filho and Schwonke 2013).

During fieldwork I witnessed on several occasions nurses being summoned to management's offices in order to account for alleged shortcomings in their care as reported by patients. P10 said: "*(Patients) would rather go to management and say you treated them badly, and when they get there they (management) won't tell them that, yes, those people were right, but maybe you didn't like the way they told you but they are right, in fact. Instead it is just said, okay, this one has got a bad attitude towards people and that."*

Most participants had an explanation or justified unpleasant behaviour from the relatives. P2, commented: "*I think he couldn't just accept the condition of the father because he was a newly diagnosed cancer patient. So I think it*

*affected him more than the patient, so we do get those kinds of things, you know. So you just have to calm those people down. This other one whose mother died was able to calm down but there are other ones, the ones who usually call security to take him out because he wouldn't listen to anyone, he would just swear at everyone and make noise."* In this way, nurses became the "buffer zone" between the hospital management and the patients – a situation that undermines the ability to establish and perpetuate care relationships based on respect.

# CHAPTER 6

# CONCLUSIONS AND RECOMMENDATIONS

## 6.1 INTRODUCTION

Our site, as a typical private healthcare facility, demonstrated an increasing imbalance of power by patients and hospital managers in healthcare service/s providers and their managers including nursing managers, doctors and patients' families in commercialised healthcare environments. The imbalance of power was evident in many spheres: Firstly, the ability of nurses to care for patients was affected by market forces that dictated their professional time and working environment. Secondly, the nurse's autonomy as a professional was regularly undermined by the facility's management profit driven practices and decisions. It is likely that the findings of this study represent a greater problem within commercialized healthcare in South Africa.

### 6.1.1 Educating for work in commodified healthcare systems

Today's nurse is under constant pressure due to time constraints, staff and equipment shortages, all stemming from the involvement of the markets in the healthcare sector. The modern patient as a consumer of healthcare services is aware of his rights as a paying customer and indeed sees himself as such. The evidence of this study suggests that these challenges need to be

carefully mediated by in order to avoid them impacting on their nursing obligations and activities.

Commodification pressures thus necessitate that caregivers re-evaluate their caring and communication processes in order to efficiently and effectively meet their patients' needs within this paradigm. While the commodification of healthcare can devalue the human aspect of the caring relationship between nurse and patient (Pellegrino 1999) and results in poor interpersonal relations and an undignified workplace culture, such situations could potentially be lessened by constant vigilance and peer support.

Within South Africa, the need for further discussion on care in commercialized environments is both timely and necessary. The current commercial model of healthcare provision, as adopted by the South African private healthcare sector, has led to the evolution and restructuring of healthcare, its services and delivery impacting on how healthcare is consumed. The universal market place values and practices in this sector have transformed a service of healing and well-being into a consumerist service. This is evidenced by the pervasive accepted use of the consumerist /market-based language in these healthcare environments (Lown 2007; Rowe & Moodley 2013; Sulmasy 1993). Referring to and recognising the patient as a consumer, is significantly differential and morally discordant with the essence of professional nursing practice.

Commodification of healthcare has significant ethical and practical implications for the quality and safety of healthcare services such as nursing care and patient health outcomes (Lown 2007; Pellegrino 1999; Rowe & Moodley 2013).

Further research is necessary to examine how the economic values of private healthcare providers are morally incongruent with the nurses' professional responsibilities and ethical obligations and personal beliefs. In order to best instruct trainee nurses in addressing these challenges, a clear picture of how the professional nurse handles or deals with this potential internal moral tension is key and needs to be included in ethics training. This is a particularly important issue that needs to be included in nursing education, which at the moment tends to focus on nursing in the public sector and offers little instruction in how best to mediate the challenges of nursing in a commercial setting.

Such discussions also need to include mediating relationships with the other key role players involved in the maintenance and safeguarding of the patient's well-being. In particular, trainee nurses need to be supported in their transition into professionals concerned with holistic and individualised meeting of the needs of physically and emotionally vulnerable persons. A conscientious nurse has integrity, compassion, empathy, for his/her patient irrespective of the patient's gender, social status, race or power. These virtues determine the caring behaviour of the nurse, which govern the favourable condition under which caregiving can occur. These professional virtues

capacitate the nurse to positively respond to the patient's physical and emotional vulnerability as guided by her Pledge of Service. Thus the commodification of healthcare imposes heavy moral and professional burdens on the nurse as a caring professional, and one for which trainee nurses require considerable support.

### 6.1.2 Bringing care ethics into dialogues on commodified healthcare

Caring is an important component for all healthy and productive human relationships. Thus, care ethics as a moral theory has the power to change the way we evaluate personal relationships and professional conduct. Professional caring should be about relating and responding to another human being's needs and relieving them of their suffering in a humanely as possible manner. It should be a mutually beneficial exercise full of empathetic responses to each other's needs - nurse caring for and about the patient and vice versa. As Van der Wal maintains, "quality healthcare resides in caring" (Mellish et al. 2010: 4).

In nursing the act of caring and empathy are not only required as a moral duty but are requisite as professional skills as well. Care, while a broad concept encompassing all areas of healthcare provision, is also associated with specific traits and skills which can be taught. Such traits could include emotional components such as empathy, respect and attentiveness as well as practical ones such as time management, effective communication and

counseling. In addition, care is evident in maintaining professional boundaries. Failure to establish and maintain such boundaries puts both the nurse and patient at risk, and can undermine the care relationship at the expense of their physical and emotional safety and well-being.

### 6.1.3 Establishing dialogue with workplaces and stakeholders

Nurses are committed to the practice and provision of competent, compassionate, and dignified care. However, this may be hindered by some of the economic practices in private healthcare facilities and result in physical and moral distress, and may manifest as failure to emotionally connect with patients, resulting in care lacking compassion and respect. It is therefore vital to bring these ethical challenges to the attention of employers and establish dialogue between them and their nurses.

A key area of action could be for institutions to support further nursing training and education regulations (as stipulated by No R425 of 1985). This would include continued education and training on clinical practice, nursing ethics, assertiveness skills, interpersonal and communication skills. Supporting employees to engage with such courses and to network with other professionals in their field would undoubtedly address the feelings of isolation and frustration that many of my participants voiced.

Of course, working environments in all healthcare facilities are compounded by a general shortage of nurses, and high patient loads are not the sole province of private facilities. It is therefore likely that revisiting care ethics, as a way of problematizing workplace pressures will also be of use for nurses working in public facilities. Indeed, the inclusion of care ethics in nursing curricula and in continued development would be of use to employers across the board.

Ultimately, however, employers need to re-examine their management and staffing practices to avoid exposing nurses to stressful situations for an extended period of time. Spending less time being exposed to emotionally and physically demanding wards may reduce the risks of stress, physical and emotional burnout and prevent injuries on duty. Nurses have legal rights to function in ethically sound environments (Rights of Nurses South African Nursing Council Policy). This includes protecting nurses against unrealistic demands from patients and supporting them in their professional duties.

The study has shown that prioritising commercial values and principles in the healthcare sphere forces healthcare and its services to operate like any other market entity or service. This creates barriers to the ethical and practical provision of dignified and competent nursing care (Webster & Baylis 2000:4). All healthcare facilities, but especially private ones, need to set up nurses' support groups and ethics committees to assist nurses to identify and deal with ethically challenging situations in their everyday practice. Beumer (2008) noted that nurses showed less signs of moral distress when they shared with

others their feelings elicited by their work experiences (cited in Oh & Gastmans 2015).

## 6.2 SUMMARY

This study offers descriptive evidence about the impact of healthcare commodification on nursing care-relationships. While the study sample is small and restricted to one healthcare facility in Johannesburg, there is little reason to speculate that these findings are not representative of the situation in South African private healthcare more generally. This study therefore raises the question: are we undermining the caring aspect of healthcare in the pursuit of profits? Raising awareness on these issues is the first step towards a vigilant avoidance of such possibilities – or the first step in finding solutions.

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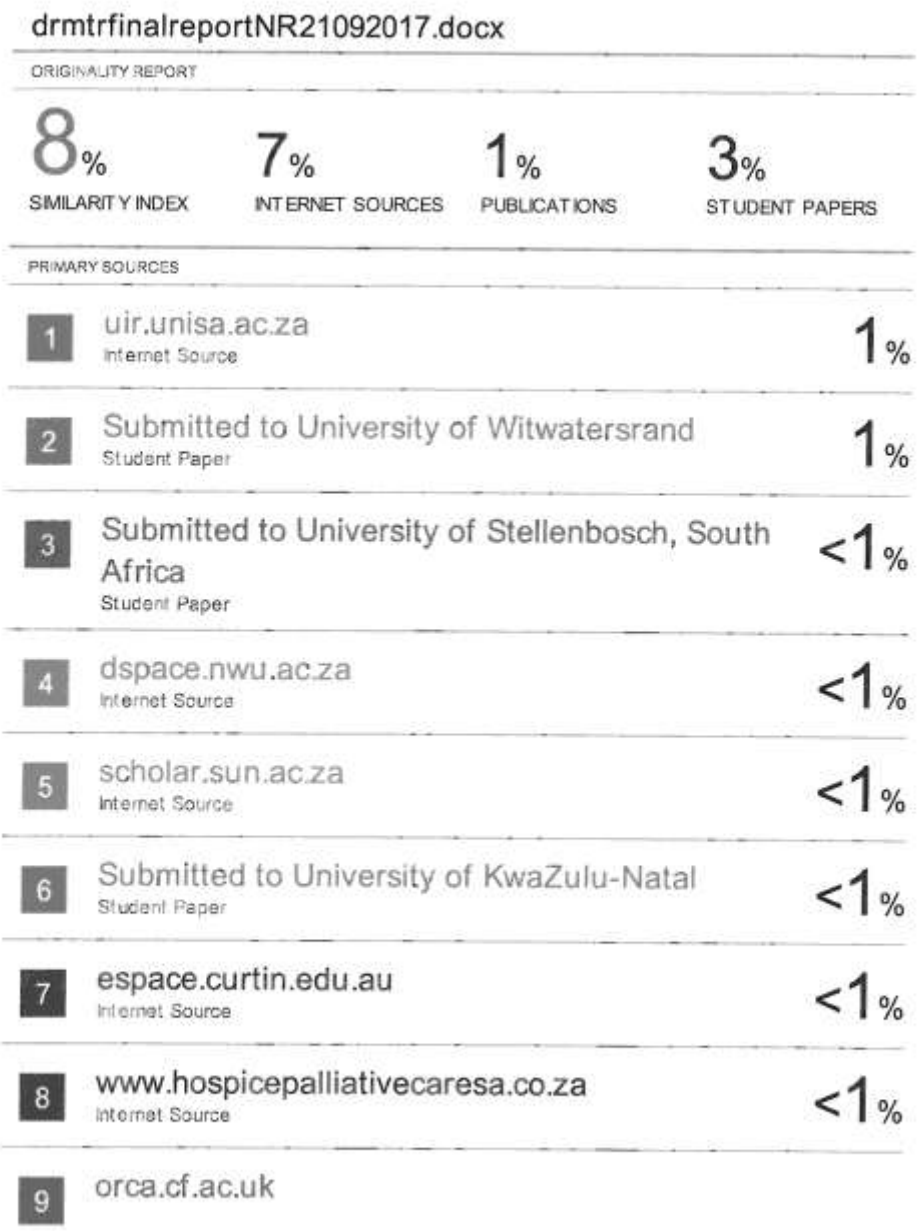
## 8. APPENDICES

## APPENDIX A: TURNITIN REPORT



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ORIGINALITY REPORT

| 8% | 7% | 1% | 3% |
|---|---|---|---|
| SIMILARITY INDEX | INTERNET SOURCES | PUBLICATIONS | STUDENT PAPERS |

PRIMARY SOURCES

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| 9 | orca.cf.ac.uk | |

## APPENDIX B1: LETTER FROM REGISTRAR

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3 Wits, 2050

Fax: 027117172119

Tel: 02711 7172076

Mrs P Ramokgopa

P O Box 1177

Houghton

2041

South Africa

Dear Mrs Ramokgopa

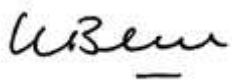
**Master of Science in Medicine: Approval of Title**

Reference: Ms Thokozile Nhlapo E-mail: thokozile.nhlapo@wits.ac.za

09 January 2015 Person No: 880663 PAG

We have pleasure in advising that your proposal entitled *Commodification of healthcare in a private healthcare facility: Ethical implications on the nurse-patient relationship* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely



Mrs Sandra Benn

Faculty Registrar

Faculty of Health Sciences

## APPENDIX B2: HUMAN RESEACH CLEARENCE CERTIFICATE

**Human Research Ethics Committee (Medical)**

Research Office Secretariat: Senate House Room SH 10006, 10th floor. Tel +27 (0)11-717-1252
Medical School Secretariat: Medical School Room 10M07, 10th Floor. Tel +27 (0)11-717-2700
Private Bag 3, Wits 2050, www.wits.ac.za. Fax +27 (0)11-717-1265

09 June 2015

To Whom It May Concern

**SUBJECT:** **CONFIRMATION OF STUDY APPROVAL**

**Protocol Ref No:** M141189

**Protocol Title:** Commodification of Healthcare in Private Health Facilities: Ethical Implications of the Patient Nurse Relationship.

**Principal Investigator:** Mrs Prudence Ramokgopa

**Department:** Steve Biko Centre for Bioethics

This letter serves to confirm that the Human Research Ethics Committee (Medical) has approved the above mentioned study. In order for a clearance certificate with the name of the new site to be issued, the researcher is required to submit written approval to conduct the study in your district/institution.

Should you have any queries, you may contact me at tel 011 717 2656/1234 or by email langutani.masingi@wits.ac.za.

Yours Faithfully,

.....

**Mr Langutani Masingi**
**Administrative Officer**
**Human Research Ethics Committee (Medical)**

UNIVERSITY OF THE WITWATERSRAND
OFFICE OF THE DEPUTY VICE CHANCELLOR RESEARCH
09 JUN 2015

## APPENDIX C: LETTER OF ACCESS TO FACILITY

**RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH**

Approval number: UNIV-2015-0026

Ms Prudence Ramokgopa

E mail: nombusor@gmail.com

Dear Ms Ramokgopa

**RE: COMMODIFICATION OF HEALTHCARE IN PRIVATE HEALTHCARE FACILITIES: ETHICAL IMPLICATIONS FOR NURSE PATIENT RELATIONSHIP**

The above-mentioned research was reviewed by the Research Operations Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Private Hospital, has been approved, subject to the following:

i) Research may now commence with this FINAL APPROVAL from the Committee.

ii) All information regarding the Company will be treated as legally privileged and confidential.

iii) The Company's name will not be mentioned without written consent from the Committee.

iv) All legal requirements with regards to participants' rights and confidentiality will be complied with.

v) The Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from the Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.

vi) A copy of the research report will be provided to the Committee once it is finally approved by the relevant primary party or tertiary institution, or once complete or if discontinued for any reason whatsoever prior to the expected completion date..

vii) The Company has the right to implement any recommendations from the research.

viii) The Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/ Company or should the researcher not comply with the conditions of approval.

ix) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER OR COMPLETION OR DISCONTINUATION OF THE STUDY, WHICHEVER IS THE FIRST.

We wish you success in your research.

Yours faithfully

30/4/2015

Prof Dion du Plessis
Full member: Research Operations Committee & Medical Practitioner evaluating research applications as per Management and Governance Policy

Shannon Nell
Chairperson: Research Operations Committee
**Date:** 17/6/2015

This letter has been anonymised to ensure confidentiality in the research report. The original letter is available with author of research

## APPENDIX D: PARTICIPANT INFORMATION SHEET

**Research study into the Commodification of healthcare in a private healthcare facility: Ethical implications for the nurse-patient relationship.**

Hello**,** my name is Prudence (Nombuso) Ramokgopa, currently studying for a Masters' degree in Bioethics and Health Law with the Steve Biko Centre for Bioethics at the University of the Witwatersrand, in Johannesburg. As part of the degree I am required to complete a research study. Research is just the process to learn the answer to a question. With this research I am interested to learn about nurses' perceptions on working in a private healthcare facility and how and if this affects the nurse-patient relationship.

**Invitation to participate:** I would like to invite you to take part in a research study titled "Commodification of healthcare in a private healthcare facility: Ethical implications for the nurse-patient relationship." In this study I want to learn about the impact of commercialization of healthcare on nurses' caring actions in private healthcare facilities and how this influences the nurse-patient relationship. I would like to ask you questions about what this means to you and how it impacts on your nursing practice.

**What is involved in the study –** You have been chosen because you are a nurse working in a private healthcare facility. I will ask you to share with me your feelings and thoughts about working in a private healthcare facility. The interview will take approximately 30 minutes and will be audio recorded. The audiotapes and collected information will be stored in a safe and secure place that can be accessed by my supervisors and myself.

I anticipate that the findings of the study will provide a better understanding of the registered nurses' perceptions on working in a private healthcare facility. As well as an understanding of whether private healthcare facilities have any influence on the nurse-patient relationship and what are the ethical aspects on nursing practice.

***Risks- There is no foreseen major risk for this study***.

**Benefits** – The study will help to gather empirical data on the impact of working in a commercialized environment on registered nurses. The findings of the study could contribute towards efforts to improve nurse-patient relationship and to uphold the principles of the Nurses' pledge. However there will be no monetary benefit to individual participants. You can request a copy of the interview transcript if you wish.

**Participation is voluntary -** Your participation in this study is completely voluntary. If you decide to participate you will be asked to sign a consent form. You may decide to change your mind about participating in the study at anytime, without having to provide a reason. There will be no penalties or repercussions should you decide not to participate. You are welcome to contact me if you would like any further information.

**Reimbursements –** There will be no monetary reimbursement for taking part in the study. A snack/tea will be offered to you during the interview.

**Confidentiality:** If you choose to participate in this study, your information will be kept completely anonymous and confidential. The collected information will be kept and stored securely and will be accessed only by my supervisors and

myself. The information collected will be kept for two years if published and for six years if unpublished and thereafter it will be destroyed. You will not be identifiable from the publications. Absolute confidentiality cannot be guaranteed. Personal information may be disclosed if required by law.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the Research Ethics Committee. If results are published, this may lead to identification of the healthcare facility.

**Contact details of researcher -** Thank you for taking time to read this information sheet and for your consideration. If you have any questions or require any additional information, please contact me on 0837492013 or email me at nombusor@gmail.com or my supervisor Dr. Louise Bezuidenhout on 0117172635 or louise.bezuidenhout@wits.ac.za.

**Contact details of REC administrator and chair:** Prof. Peter Cleaton-Jones on 0117172635 or peter.cleaton-jones1@wits.ac.za.

**APPENDIX E1: INFORMED CONSENT DOCUMENT**

**Project title: Commodification of healthcare in a private healthcare facility: Ethical implications for the nurse-patient relationship.**

**REC reference number**

I hereby confirm that Prudence (Nombuso) Ramokgopa has informed me about the abovementioned study. I have also received, read and understood the study as explained in the participant information sheet.

I understand that I may, at any stage, withdraw my consent and participation in the study without giving reason and that there with be no negative consequences. I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my personal details will be kept strictly confidential and that all data will be retained for 2 years following any publication or for six years if there has been no publication and thereafter it will be destroyed.

_____ _____

Participant signature Date

I _____have explained the above research protocol to the participant.

Signature of the person taking the consent

_____

Date _____

**APPENDIX E2: CONSENT DOCUMENT FOR DIGITAL RECORDING**

**Project title: Commodification of healthcare in a private healthcare facility: Ethical implications for the nurse-patient relationship.**

**REC reference number**

You have already agreed to participate in the abovementioned study. I am asking for your permission to allow me to digitally record you as part of this research study. You do not have to agree to be recorded in order to participate in the study.

The recording is for the purpose of collecting data and for data analysis by my supervisor and I. Neither your name nor any identifying information will be used in the audio or transcript. Transcripts of your interview may be reproduced in whole or in part for use in writing up this research report.

By signing this form, you are allowing me to digitally record your interview as part of this research. The transcripts from the interview will be kept confidential in a safe and secure place. The recording will be retained for 2 years following any publication or for six years if there has been no publication and thereafter it will be destroyed

By signing this form, I am allowing the researcher to digitally record my interview as part of this research. I understand that my personal details will be kept strictly confidential. I have also received, read and understood the study as explained in the Participant Information Sheet.

Participant's signature: _____ Date: _____

Witness' signature: _____ Date: _____

## APPENDIX F: SOUTH AFRICAN NURSES' PLEDGE OF SERVICE

I solemnly pledge myself to the service of humanity and will endeavour to practise my profession with conscience and with dignity.

I will maintain, by all the means in my power, the honour and noble tradition of my profession.

The total health of my patients will be my first consideration.

I will hold in confidence all personal matters coming to my knowledge.

I will not permit consideration of religion, nationality, race or social standing to intervene between my duty and my patient.

I will maintain the utmost respect for human life.

I make these promises solemnly, freely and upon my honour.

## APPENDIX G: TABLE 2: INTERPRETATION OF THEMES AND SUBTHEME OF THE NURSES' INTERVIEWS AS USING THE NURSES' PLEDGE AND CARE ETHICS

| **Primary themes** | **Sub-themes related to primary themes** | **Sample quotes** |
|---|---|---|
| 1. **Professional practice**<br>– focusing on nursing as a choice professional and the art of nursing and nursing ethics as influenced by the Nurses' Pledge. | 1.1 Motivation to be a nurse<br>Nursing is a caring profession, existing for the relief of pain and suffering. They pledge themselves to the service of humanity. Nurses care for and about others<br><br>For some participants nursing was a means to an end - a gateway out of poverty.<br><br>1.2 What are traits of a good nurse?<br>Nurses are compassionate, empathetic and helpful - they do not want to see others suffering/in pain | *"…I was the first one to help with passion, I wouldn't complain…"*<br>*"…I really like looking after older people, to look after people, sick people…"*<br><br>*"… it was not my choice in the beginning… I always saw myself as this CEO…"*<br><br>"…*good interpersonal relationship you must be able to love other people unconditionally and you must treat people as individuals… just treat a person with respect…"* |
| 2. **Nurses' lived experiences**<br>-focusing on nurses' perception of how a commercialised work environment impacts on their clinical and caring practices. | 2.1 Patient conduct and bad attitudes | *"… in the private sector, you are working for the patient, you are not caring as such because they will tell you, I will complain, I will take you to head office, so you are actually nursing the complaint more than you are nursing the patient."*<br><br>*"They thinking that they are in control because they are paying medical aid, …are in a private sector, they thinking that they are paying our salary because they are here, and then we are, like, just somebody,… they are under that impression that, no, I have got the power because I am in a private..*" |

| | | |
|---|---|---|
| | 2.2 Lack of appreciation and understanding of each other's role in the care of the patient coupled with interference and rude behaviour from patients' relatives | "*I don't even want to lie, I was not coping, it was just, I think it was emotionally draining to me. It was more than I expected, because you could be slapped, you could, like, they will talk to you like you are nothing. That was just way too much for me. I don't know."* |
| 3. **Relationships in nursing environment** – focusing on how nurses apply the principles of care during their interaction with others. Does a commercialised environment allow nurses to practice their profession with conscience and with dignity? | 3.1 The nurse-patient relationship | "*This is the one thing I do with all my patients. I build a relationship…once that little bond is formed its easy for the patient to tell me almost everything uh but its easy for them to communicate with me*…"<br><br>*"They thinking that they are in control because they are paying medical aid, …are in a private sector, they thinking that they are paying our salary because they are here, and then we are, like, just somebody… they are under that impression that, no, I have got the power because I am in a private...*" |
| | 3.2 It's all professional - nurses' collegial relationship with doctors | "…they got an attitude whereby it is, like, if they are in a good mood, you will hear them like a loud speaker when they enter the gate, that be warned doctor so and so is not in a good mood today so wherever he is going to enter and come out there will be a problem, he will be looking for problem and trouble." |

| | | |
|---|---|---|
| | 3.3 Relationship with management | *"It is not nice at all, you just feel like taking your bag and going, you just feel like, you know, I have done so much for this person but this is only what I get."*<br><br>*"…up to so far I am still enjoying it. But not the pressure, if there is no pressure I enjoy."* |
| | 3.4 Relationship with patients' relatives | "*Relatives! Ah relatives are something else. I think relatives, they are sometimes more than patients"* |
| 4. **Expectations**<br>- what factors interrupt the nurses from carrying their caring duties during nursing interventions? | 4.1 Patients and management's unrealistic expectations of the nurses and facility. | *"…there is this tendency, people who have got medical aid, they always telling you what they want, I don't know what kind of a treatment they are expecting. Like whatever they must be given, they forgot that everything has got rules everything has to be given at a certain time."*<br><br>*"The problems or what the patient needs, you end up nursing the families complaints more than nursing, you end up nursing the budget more than nursing the patient, you know. Like, you don't care, you end up nursing, not that we don't care, it is just that there is a lot of things that are put in, then it deprives us from giving the best care that we can, there is a lot of people that are involved, there are a lot of things that* |

| | | |
|---|---|---|
| | | *are involved more than the care. So it is more, logistics than doing the job its self."* |
| | 4.2 Nurses' unrealised expectations of management and patients. | "…*I hate nursing, only when it comes to the fact that you get blamed for something that you didn't do, or people don't recognize you, or the least that you've given the patient, then it's something that I don't like about it, because then very rare will you find somebody saying thank you, or something like, okay, well done, whatever, but every time there is something or negative impacting in your department then you get blamed, so something like that."* |